Australian Government
Department of Health

BE COVIDSAFE

Visitation Guidelines for Residential Aged Care Facilities
February 2021

The Australian Health Protection Principal Committee (AHPPC) recognised early in the COVID-19 pandemic that residents of residential aged care facilities (RACFs) were particularly vulnerable, and at risk of severe illness from COVID-19. Accordingly, the health and wellbeing of this population has been in the deliberations of the AHPPC throughout the pandemic. AHPPC recommends that all RACFs ensure they are sufficiently prepared to manage a COVID-19 outbreak. Detailed guidance for facilities is available.

AHPPC recognises and acknowledges the significant work of aged care providers, the aged care workforce, families, the community and older people themselves to prevent transmission of COVID-19 within aged care homes.

Moving into COVID Recovery phase and COVID Normal

AHPPC considers the personal welfare and mental health of residents in RACFs is of vital importance. As Australia continues to move towards becoming COVID Safe (during this COVID-19 recovery phase), these factors must be balanced against the ongoing risks of COVID-19 outbreaks in RACFs. Levels of community transmission of COVID-19 (at a local area, suburb, region or jurisdiction level) should influence the escalation tiers and aged care provider responses as Australia and the aged care sector moves towards the COVID Recovery and COVID Normal phases.

Preventing the physical, psychological and nutritional deconditioning of residents in RACFs is vital to maintaining residents' wellbeing. Deconditioning can occur quickly, even after a short period of inactivity, bedrest or sedentary lifestyle, and can result in decreased quality of life and functional losses in such areas as mental status, degree of continence, mobility, and ability to accomplish activities of daily living.

The risk of deconditioning is amplified when an older person's routine activities are changed following restriction of visitor access due to COVID-19 lockdown. Increased engagement with residents (face-to-face or virtual) by visitors can help prevent deconditioning. Further information about preventing deconditioning is provided at **Appendix A.**

The following key principles during COVID Recovery and COVID-19 Normal phases are supported by AHPPC:

- AHPPC supports continuing efforts to proportionately implement appropriate infection prevention and control measures with residential aged care and for other vulnerable populations receiving aged care at home.
- Jurisdictional (State and Territory) health directives must be followed, including adherence to physical distancing, personal hygiene and other recommended infection prevention and control measures.
- AHPPC considers the maintenance of nutritional, physical and psychosocial wellbeing of residents in RACFs to be of vital importance, balanced with their personal welfare, and human rights.

- AHPPC supports visitors (including family, friends, visiting health workers and support staff) to residents of aged care homes in the least restrictive manner possible, in line with the known or likely wishes and preferences of the older person/resident.
- An ongoing and dynamic risk assessment should influence the level of limitation on visitation, the type of visitation restrictions implemented and attendance by a resident to locations external to the residential aged care facility.
- The dynamic risk assessment should be based on the current level of COVID-19 community transmission (both at the location of the RACF and the community of the visiting person) and only occur in a manner that is proportionate to the prevalence of community transmission.
- The 'Tiered Escalation' model should be utilised in determining the level of visitation and other restrictions required.
- Aged care providers should be prepared to step-up and step-down based on local or State/Territory public health advice, direction from the Aged Care Response Centre within the relevant State or Territory, or their risk assessment at the local level.
- The restrictions on entry, recommendations on entry to residential aged care, screening and management of staff and visitors and external excursions from residential aged care (for personal or health reasons) outlined in Table 2 below should be followed.
- The Industry Code on Visiting Aged Care Homes during COVID-19, should be followed. In particular, Principle 7 which deals with exceptional circumstances in which visitation should be allowed even during Tier 3.
- State and Territory public health units have the ability for aged care providers (and where relevant, community members) to be able to request consideration, on a case by case basis, of exceptions to relevant jurisdictional directions.

1. Purpose and audience

This document is to provide guidance for aged care providers on actions to be undertaken depending on the COVID-19 situation within the community.

The Department of Health has developed the *Escalation Tiers and Aged Care Provider Responses* framework (Escalation Tiers framework) outlined in Table 1. This has been reviewed against, and is consistent with, the national aged care statements and guidance listed in section 6.

Residential aged care providers are the primary intended audience of this advice.

2. Commonwealth definition of a hotspot (as at 4 June 2021)

The Commonwealth trigger for consideration of a COVID-19 hotspot in **any area** is the occurrence of a case of infection in the community[1] with a more transmissible variant of SARS-CoV-2 and opportunities for wide community exposure.

The Commonwealth trigger for consideration of a COVID-19 hotspot in a **metropolitan area** is the rolling 3 day average (average over 3 days) of 10 locally acquired cases per day. This equates to over 30 cases in 3 consecutive days.

The Commonwealth trigger for consideration of a COVID-19 hotspot in **a rural or regional area** is the rolling 3 day average (average over 3 days) of 3 locally acquired cases per day. This equates to 9 cases over 3 consecutive days.

Once a trigger has been activated, further analyses are performed by the Commonwealth to assist in the defining of a 'hotspot'.

Further information on hotspots can be found here.

3. Escalation tiers

Table 1 is based on the Escalation Tiers framework. It details three proposed escalation tiers and provides an overview of the:

- situation or scenario that is commonly seen against each tier
- overarching public health objective against each tier
- focus of action that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

4. Provider actions by escalation for visitation and external visits by residents

Table 2 provides a detailed list of the actions that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

It is important to note that:

- the primary focus should be on preventative action;
- any action that is required at Tier 1, will automatically be required at Tier 2 and Tier 3;
- as a matter of best practice, residential aged care providers should review the advice in Table 2 to assist in determining whether current practice is in line with this advice.

[1] Cases identified that have been in quarantine for 48 hours or more before onset of symptoms are not considered in the community

5. Types of Visitors

Visitors can be:

- Essential Care Persons (someone who has frequently and regularly visited a resident to provide aspects of care and companionship to that person). An Essential Care Person is not a casual visitor, or visitor not providing an aspect of care, or visitor who the resident does not want to have assisting with their care. Essential Care Persons are reflected in the Partnerships in Care model.
- Visiting health workers and support staff including:
    - Visiting medical staff, general practitioners and/or nurses;
    - Visiting allied health professionals such as physiotherapists; occupational therapists; podiatrists; psychologists, social workers, dietitians, speech pathologists, and/or exercise physiologists;
    - Visiting support staff such as cultural support workers; disability support workers; community support workers; and/or lifestyle staff.
- Aged care advocates;
- Community visitors (as part of the Community Visitors Scheme);
- Legal practitioners.

6. Aged care response to COVID-19: National statements and guidelines

Key national statements and guidelines reviewed and endorsed by the AHPPC relating to aged care (and developed by the AHPPC subcommittees of Communicable Diseases Network Australia (CDNA) and Infection Control Expert Group (ICEG)) are:

- New National Plan
- CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia
- Coronavirus (COVID-19) Guide for Home Care Providers
- AHPPC Coronavirus (COVID-19) Statement: Recommendations to Residential Aged Care Facilities
- ICEG Coronavirus (COVID-19) environmental cleaning and disinfection principles for health and residential care facilities
- ICEG Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities
- AHPPC advice on residential aged care facilities
- AHPPC update to residential aged care facilities about minimising the impact of COVID-19

- ICEG Coronavirus (COVID-19) – Recommended minimum requirements for the use of masks or respirators by health and residential care workers in areas with significant community transmission
- ICEG guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities
- AHPPC Guide to the Establishment of an Aged Care Health Emergency Response Operations Centre.

The Industry Code for Visiting Residential Aged Care Homes during COVID-19 (Industry Code) has been developed by the aged care sector peaks. The principles and approaches within the Industry Code should be considered in supporting the proportionate controls required to support safe visitation to aged care homes during COVID Safe/COVID Normal. The Industry Code was endorsed by National Cabinet on 1 May 2020, and was updated most recently by the Aged Care Sector peaks on 20 November 2020.

Aged care providers have an obligation to provide care and services in accordance with the requirements of the *Aged Care Act 1997*, including the Aged Care Quality Standards and the Charter of Aged Care Rights. Provider obligations include responsibilities for quality and safety and respecting the rights of consumers, and focus on the outcomes that the community can expect from organisations that provide Commonwealth-subsidised aged care services. In managing the risks of COVID-19, providers need to balance the needs, goals and preferences of consumers to optimise their health and well-being, including in relation to isolation. The Code is not a legislated obligation but complements the regulatory framework by providing clarity on industry expectations of the practices that will support these outcomes for consumers. Evidence of how a service is applying the Code will be considered, where relevant, by the Aged Care Quality and Safety Commission in monitoring and assessing providers in relation to the Aged Care Quality Standards and Charter of Aged Care Rights.

Table 1: Proposed escalation tiers

	TIER 1	TIER 2	TIER 3
Situation	Epidemic* of no transmission or no locally acquired cases; only cases are those from people who have travelled overseas	Epidemic* of jurisdictionally defined hotspots such as: • localised outbreaks with cases occurring in: - households, - licenced venues, - fitness centres, - shopping centre • **OR** - a single case in a setting with high transmission risk such as a correctional facility or a RACF • **OR** - a flag such as an upstream source not able to be identified	Epidemic* of COVID-19 in the community
Public Health Objective	Prevent introduction of COVID-19	Investigate and control if required Prevent further COVID-19 spread End the chain of transmission	Control COVID-19 transmission Prevent seeding to new areas Clinical care
Focus of Action	Preparedness i.e., getting everything in order	Tier 1 plus a ramp-up of activities such as: • raising awareness • encouraging people in specific locations to come forward for testing • a renewed focus on IPC training • (depending on what is occurring in the community) compulsory mask use; visitation considerations, asymptomatic testing or implementation of single site worker arrangements	Tiers 1 and 2 as well as public health interventions such as: • mask wearing • visitation restrictions • asymptomatic testing • single site worker arrangements • encourage people to work from home • avoiding non-essential travel i.e., a full-ramp up of all activities

*An epidemic or outbreak is the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time
(Source: CDC)

Table 2: Visitation recommended actions by Tier

	TIER 1	TIER 2	TIER 3
RACF RESTRICTION TO ENTRY			
Restriction on entry - staff, including contractors	Limited restriction (as per Appendix B)	Limited restriction (as per Appendix B)	Limited restriction (as per Appendix B)
Restriction to entry - visiting health & other designated support workers (including advocates & CVS)	Limited restriction (as per Appendix B)	Limited restriction (as per Appendix B)	In-reach services (where telehealth or adaptive models of care are not appropriate, applicable or available)
Restriction to entry - visitors	Limited restriction (as per Appendix B)	Limited restriction (as per Appendix B)	Restricted visitation - in line with Industry Code (in particular, Principle 7)
Restriction to entry – groups (more than two people)	Entry with appropriate screening, physical distancing and personal hygiene measures	No entry	No entry
Restriction to entry - new residents & residents returning from hospital (following a non-COVID-19 related illness)	Returning and new residents - appropriate screening and monitoring	Returning and new residents – no entry unless clearance authorised by medical officer/public health unit.	New and returning residents – no entry unless clearance authorised by medical officer/public health unit.
Restriction to entry - new residents & residents returning from hospital (following a COVID-19 positive diagnosis)	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units is met.	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units is met.	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units is met.
Restriction to entry - Essential Care Persons	No restriction	Encouraged – with appropriate orientation/training	Encouraged – with appropriate orientation/training, and in line with Principle 7 of the Industry Code
RESIDENTIAL CARE & SUPPORT			
Resident and visitors - symptom screening	Yes	Yes	Yes
Resident - isolation /quarantine	Asymptomatic - not required Symptomatic – isolation/quarantine required	Asymptomatic – not required Symptomatic - isolation/quarantine required with screening based on medical officer/public health unit advice	Screening and isolation/quarantine when symptomatic, or based on medical officer/public health unit advice for asymptomatic
Resident - common areas	Yes	Limited, with physical distancing or outdoors	Restricted, based on State/Territory directions

	TIER 1	TIER 2	TIER 3
Resident - Physical and mental wellbeing	Implement standard measures to maintain and monitor	Implement standard measures to maintain and monitor	Implement alternative measures to maintain and monitor
Resident - Partnerships in Care support model	Yes	Yes – with appropriate orientation and education, and adherence to infection prevention and control requirements and directions by staff	Yes – with appropriate orientation and education, and ability to use Personal Protective Equipment (PPE) under staff direction
Resident - alternative models of visitation (e.g. digital, window visit)	Offered if requested	Implement alternative mechanisms	Implement alternative mechanisms
Infection prevention & control - Personal Protective Equipment (PPE) - staff and visitors	Implement as per State/Territory directions	Implement as per State/Territory directions	Implement as per State/Territory directions
Infection prevention & control - Personal Protective equipment - residents	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Implement as per State/Territory directions
VISITATION LIMITATIONS & INFORMATION PROVISION			
Infection prevention & control education and information provision - residents and visitors	Yes	Yes	Yes
Visitors - time limitations	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Limitations based on State/Territory directions
Visitor - number limitations	COVID Normal (including small groups) with appropriate risk management procedures in place	COVID Normal (max of 2 visitors at any one time per resident)	Limitations based on State/Territory directions
Visitor - age limitations	Not required	Not required	Limitations based on State/territory directions
Visitation location - within aged care facility	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Limitations based on State/Territory directions
Supervision of visitors	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Escort to and from resident's room
Physical distancing	Yes	Yes	Yes
Personal hygiene measures	Yes	Yes	Yes
Seasonal influenza vaccination	In line with State/Territory directions	In line with State/Territory directions	In line with State/Territory directions

RESIDENT EXTERNAL APPOINTMENTS/GATHERING			
Resident external appointments - hospital	Yes	Yes	Yes
Resident external appointments - GP/Allied health	Yes	Yes (where in-reach not available)	Telehealth/In-reach preferable
Resident external excursions - small gatherings	Yes	Yes – numbers/locations per State & Territory guidance, where group is known and with appropriate physical distancing & personal hygiene	Allowed on a case by case basis – where numbers/locations per State & Territory guidance, where group is known and with appropriate physical distancing & personal hygiene, and with a risk assessment and risk management plan
Resident external excursions - groups	Yes	Yes – per State & Territory guidance, with appropriate physical distancing & personal hygiene	No
Resident external - exercise	Yes	Yes	Yes – Allowed on a case-by-case basis with risk assessment

Appendix A Advice from AHPPC on prevention of deconditioning of residents in residential aged care facilities

Preventing the physical, psychological and nutritional deconditioning of residents in residential aged care facilities (RACFs) is vital to maintaining residents' wellbeing.

Prevention of deconditioning

AHPPC advice recommends that aged care providers should consider and plan how they will support residents during lockdown. This should include:

- physical activity: options for residents to maintain their physical mobility and confidence when their movements within the RACF may be restricted. This planning should be person-centred and if required, be informed by advice from allied health professionals. Examples include: prompting regular mobilisation if possible and setting and enabling an individual activity schedule. Monitor level of independent function.
- mental wellbeing: options for residents to maintain emotional connections with their support network as well as workers in the RACF and connections with nature. This planning should be person-centred and if required, be informed by advice from allied health professionals or support workers. Examples include: scheduling visits with cultural or religious community members and having access to green spaces. Monitor for early signs of fear, anxiety, depression, loneliness, withdrawal.
- nutritional support: options for residents to maintain their appetite and intake while isolated. This planning should be person-centred and if required, be informed by advice from allied health professionals or support workers. Examples include: sourcing 'treat' foods or drinks such as pizza or fresh coffee. Monitor unfinished meals and early weight loss.

Special consideration should be given to preventing deconditioning for people living with dementia or other cognitive impairment which may make the above activities more challenging. RACF staff should involve the person living with dementia and their family members in planning and delivery wherever possible.

Further practical advice on prevention of deconditioning is available in Table 3 and in the Aged Care Quality and Safety Commission's Outbreak Management Planning in Aged Care document specifically on maintaining well-being and nutrition.

AHPPC advice recommends that aged care providers should implement arrangements to prevent de-conditioning at the first instance of restrictions in order to reduce the impact of isolation on residents.

Table 3: Potential contributors, personnel involved in prevention and the management of different deconditioning issues

Deconditioning issue	Contributors	Personnel	Actions
Nutritional decline	Loss of appetite Loss of weight Change of food portion and frequency Reduced food desirability and personalisation Mood, anxiety Environment change for dining/socialising	Person/family	Provide advice on food that will actually be eaten
		Nurse/carer	Monitor intake (food chart), record weight, ensure required assisted feeding occurs Offer food and snacks often, encourage
		Dietitian	Assess nutrition, plan strategies and intervention
Physical deconditioning	Confined to small area Deprived of normal activities Lack of stimulation and motivation Physical illness	Person/family	Discuss baseline mobility, independence, function and goals
		Nurse/carer	Encourage continuation of activity and independence Be alert to opportunity for activity
		Physiotherapist/ Exercise physiologist	Assess baseline mobility and goals Plan for maintenance or improvement Monitor for improvement/decline
Psychosocial impacts	Isolation from friends and family Unfamiliar staff and environments Fewer opportunities for interaction Decreased opportunity for pleasurable activities, including connection with nature Fear, trauma, anxiety, grief, depression related to COVID-19 infection or risk of infection	Family/friends	Connection, conversation, involvement, make the person know they are useful or valued Advise on likes and dislikes, pleasures and activities
		Nurse/carer	Interact with person at every opportunity Encourage or set up connection with family Provide opportunities to access green spaces
		Chaplain/volunteers	Interaction, connection and spiritual support
		Social worker, psychologist, GP, psycho-geriatrician, psychiatrist	Assessment, counselling, management and treatment

Appendix B Advice from AHPPC

Further to Table 2, the following represents advice from AHPPC about minimising the impact of COVID-19 in residential aged care facilities:

Restrictions on entry into RACFs

AHPPC maintains that the following visitors and staff (including visiting workers) should not be permitted to enter a RACF:

- Individuals who have returned from overseas in the last 14 days
- Individuals who have been in contact with a confirmed case within the last 14 days
- Individuals who are unwell, particularly those with fever or acute respiratory infection (for example, cough, sore throat, runny nose, shortness of breath) symptoms
- Individuals who require isolation or quarantine (unless directed by and managed per the direction of the local public health unit)

Recommendations for entry into RACFs

Based on emerging evidence and given the current epidemiological and public health situation in Australia, with low levels of local transmission, AHPPC recommends that:

- during Tier 1 and Tier 2 escalation periods, children of all ages be permitted to enter RACFs — all visitors, including children, must adhere to restrictions on visitor numbers, social distancing and personal hygiene
- during Tier 2 and Tier 3 escalation periods, visiting service providers such as diversional therapists and allied health professionals be permitted to enter RACFs when their services cannot be provided via telehealth or other adaptive models of care. When entering the RACF, these providers must adhere to equivalent social distancing and hygiene practices, and should be trained in all required Personal Protective Equipment (PPE) use.
- in-reach services by General Practitioners or allied health providers to aged care homes are the preferred model during Tier 3 escalation periods where telehealth or adaptive models of care are not appropriate, applicable or available. Where this cannot occur, external services should be facilitated with appropriate and proportionate infection prevention and control measures so as to not impact the long term health status of the individual or health care access.
- spouse or other close relatives or social supports are not limited in the number of hours that they spend with their spouse/relative, unless limited by State/Territory directions.
- Essential Care Persons, as reflected in the Partnerships in Care model, should be supported to comply with appropriate Infection Prevention and Control (IPC) practices. This could include training in IPC and the use of PPE.

AHPPC recommends that facilities return to a higher level of protection (such as restricting visiting service providers) if there are recent cases of COVID-19 acquired in the local vicinity of the facility. A guide would be that there are cases in the surrounding suburbs or town that have not been acquired overseas.

AHPPC recommends that RACFs which, based on the current environment, need to move to higher Tiers, implement measures to reduce the risk of transmission to residents, including:

- visits should be conducted in a resident's room, outdoors, or a specified area in the RACF, rather than communal areas with other residents
- no large group visits should be permitted at this time, however gatherings of residents in communal or outdoor areas which adhere to social distancing and current jurisdictional requirements for gathering size may be permitted

Visitors must practise social distancing where possible, including maintaining a distance of 1.5 metres. Visitors have a responsibility to supervise any children with them, practise hand hygiene and respiratory etiquette, use PPE as required, and to comply with directions given by RACF staff.

AHPPC recommends that RACF staff should not be required to supervise visits, except during Tier 3 where visitors should be escorted to and from the resident's room. However staff should promote compliance with COVID-19 prevention methods by:

- educating visitors on entry about practising social distancing and hygiene during their visit
- supporting application of required PPE
- placing signage throughout the facility to remind visitors to maintain these measures
- screening visitors on their current health status upon entry to ensure unwell visitors do not enter the facility

In the event a facility needs to return to a higher level of protection (for example, an outbreak of COVID-19 or local cluster in the community), facilities should recommence supervising visitors.

External excursions – groups of residents

AHPPC recommends that external excursions for groups of residents (eg. bus trip) not be permitted in Tier 3 localities. Such excursions can occur under Tier 2, where in line with State/Territory directions, following a risk assessment and use of appropriate infection prevention measures. For example, residents could leave the RACF to go on an excursion but would need to comply with State/Territory directions regarding social distancing.

External excursions – Individuals or small gatherings

Under Tier 2, residents, either on their own or with family members (close friends, partners, couples or siblings/familial groups in an RACF), should be permitted to leave the RACF to attend gatherings, where the group is known (for example, with family or friends), and/or they are accessing the community (for example, going for a walk or shopping), and where such arrangements are in line with State/Territory directions, and use of appropriate infection prevention measures (including physical distancing and hand hygiene).

Under Tier 3, external excursions which involve small gatherings may occur on a case by case basis, where:

- the group is known;
- the size of the small gathering is in line with current jurisdictional advice and physical distancing and hygiene measures is adhered to during the visit; and
- the RACF has conducted a risk assessment for the visit and implemented proportionate infection prevention and control measures based on this assessment, taking into account the purpose of the excursion, local epidemiology, and number of people attending and the feasibility of physical distancing. The RACF should maintain a record of the visit location, number of people in the gathering and the date of visit.

Residents

The AHPPC advice recommends:

- active screening for symptoms of COVID-19 in residents being admitted or re-admitted from other health facilities and community settings should be conducted
- no new residents with COVID-19 compatible symptoms should be permitted to enter the facility, unless the person has very recently tested negative for COVID-19 and clearance authorised by the Public Health Unit (PHU)
- residents admitted from other health facilities should be assessed by appropriate medical staff prior to admission to the facility and appropriate and proportionate infection prevention practices should be implemented for residents returning from treatment or care at other facilities (this does not apply to day visits e.g. for outpatient visits).

There is no requirement for routine testing on admission or re-admission, unless clinically warranted. Clinical judgement should be applied — for example, where a patient is coming to the RACF from an area with known community transmission.

One-off screening on entry or re-entry to the facility should comprise a questionnaire about symptoms of COVID-19 and an initial temperature reading.

If otherwise unexplained symptoms are present or indicated in the response to the questionnaire, or fever is present, the resident should not be admitted to the facility. Note that symptoms of COVID-19 in the elderly may be mild and/or atypical. If admission is unavoidable the resident should be isolated and tested immediately, and appropriate infection prevention and control precautions should be implemented. The resident should be managed as per the CDNA recommendations for suspected COVID-19 cases.

Seasonal influenza vaccinations

Older Australians are at higher risk of morbidity and mortality due to influenza than the general population. Vaccination is a key protective factor against influenza infection. Unvaccinated staff and visitors pose a risk of introducing influenza into a RACF. This would burden the health system and endanger older Australians residing in RACFs.

Approved providers should continue to stay up to date with the published directions and their legislative responsibilities in relation to State/Territory public health orders, and contact the relevant State/Territory government health department as needed. Further information explaining how the directions apply to residential aged care providers and individuals is available on State/Territory government health department websites.

Management of staff and visitors that are ill

COVID-19 can be introduced into RACFs by staff and visitors who are unwell, which can result in significant outbreaks. RACFs must advise regular visitors and staff to be vigilant in monitoring their health for even the mildest of signs of illness, and staying away from RACFs if they are unwell.

RACFs should undertake health symptom screening of all people upon entry as recommended by the Aged Care Quality and Safety Commission. Residential aged care providers need to take responsibility for the health of visitors and staff to whom they grant entry to protect our most vulnerable community members.

Staff, visitors and contractors who have any symptoms of COVID-19 should be excluded from the service/workplace and be tested for COVID-19. Staff must immediately report their symptoms to the RACF, even very mild symptoms, and not go to any workplaces. Sick leave policies must enable employees to stay home if they have any of the COVID-19 symptoms, as outlined on the Department of Health website.

Single site workforce arrangements

AHPPC advice recommends that single site workforce arrangement policies should be applied to workers in residential aged care facilities where practicable and feasible once the relevant threshold has been met. Single site workforce arrangements require workers

to restrict their work to one RACF in order to limit the risk of unintentional transmission of COVID-19.

In regards to aged care staff, AHPPC advice recommends:

- Single site workforce arrangements should be limited to permanent and casual workers employed directly by residential aged care providers including nursing staff, personal care workers, catering and cleaning staff, and administrative workers. This needs to be implemented alongside other infection control measures such as cohorting staff and residents, hand hygiene controls, PPE use, employee training, worker screening and visitation restrictions.
- Where visiting health workers and support staff are engaged through labour hire or contract arrangements, single site workforce arrangements are not required, unless specified in jurisdictional health directives. However additional action should be taken to minimise risk including cohorting staff and residents, hand hygiene controls, additional PPE use, enhanced worker screening on entry, and engaging agency staff in blocks of shifts to minimise movement.