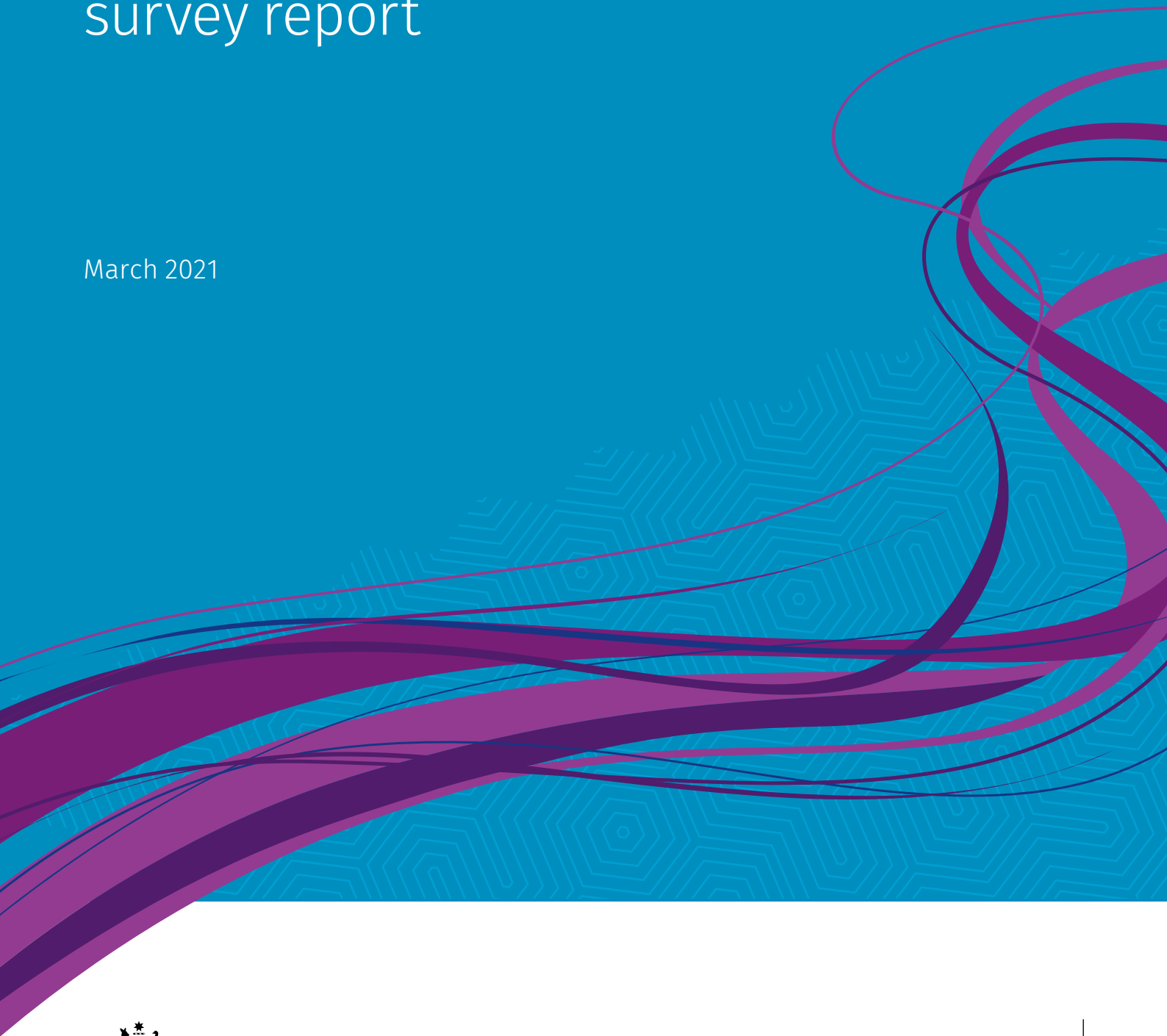
Aged Care Quality and Safety Commission

Residential care visitor access survey report

March 2021



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Background

Purpose of the survey

The Aged Care Quality and Safety Commission (the Commission) conducted the visitor access survey between 16 December 2020 and 19 January 2021. The survey is a vital element of the Commission's visitor access campaign to support the transition of the aged care sector into a COVID-normal operating environment.

The Commission will use the survey results to inform its regulatory oversight of residential aged care services, and to identify areas where additional guidance and information may be required to help services effectively manage visitors' access.

All residential aged care services across Australia were required to respond to the survey, in accordance with section 67 of the Aged Care Quality and Safety Commission Rules 2018.

Services were asked to provide high-level information about how they manage visitor access and whether they placed restrictions on residents travelling outside the service in a COVID-normal world.

Overview of survey responses

- The survey was distributed to 2,717 residential aged care services.[1]
- 2,559 of those services (94.18%) completed and submitted a response.
- 8 services started but did not submit a response.
- 35 services logged into the survey but did not enter any responses.
- 115 services did not log into the survey.

The Commission is contacting all services that failed to respond.

1 Due to rounding, some figures in this report may not add up to 100%.

Summary of findings

What were services doing well?

- The vast majority of services are establishing appropriate processes for managing visitor access. Across the board, services are focused on ensuring visitor access which is highly beneficial to the health and wellbeing of aged care residents.
- Most services are monitoring and complying with Public Health Directions relating to visitor access arrangements, which can be subject to change at short notice. Services also reported a high level of compliance with the Industry code for visiting residential aged care homes during COVID-19 (the Code).
- Almost all services indicated that they regularly communicate visitor access arrangements and procedures to residents, families/representatives and staff.
- The majority of services have developed written procedures for managing visitor access and infection control, and are communicating these procedures to residents, families/representatives and staff.

What can be improved

- While a majority of services indicated a willingness to safely manage visitor access, there is a greater reluctance to allow residents to leave the service and return without restrictions. Some 40% of services imposed restrictions on residents travelling outside the service, with most of these services indicating that they only imposed specific restrictions on external travel in accordance with current Public Health Directions. Only those services subject to Public Health Directions requiring a full lockdown of residential aged care services completely restricted resident travel. A small number of services required residents to isolate for 14 days after returning from outside the service.
- A small majority of services use paper-based records of visitors entering and residents travelling outside the service. This manual record keeping may be less accurate and may make it harder to compile complete information for contact tracing in the event of a COVID-19 outbreak in the service or local community.
- Although a high proportion of services allow in-person visits, many are not enabling remote visits. Approximately 40% of services do not have systems to facilitate contact between residents and families/representatives during periods when Public Health Directions mandate lockdowns. For the health and wellbeing of residents, it is vital that residents have a continuous connection with their families/representatives, even when physical contact is restricted.

Key messages for providers

The survey findings reveal a number of areas that services should focus on to improve outcomes for residents, their families/representatives and staff in a COVID-normal world.

Facilitating in-person visits

- In-person visits and social contact help maintain the wellbeing of residents. Providers should enable safe visits based on current Public Health Directions whenever possible.
- Providers should not impose blanket restrictions across all services. Only services within areas defined as hotspots under current Public Health Directions should have restrictions in place.
- Visitors who have met screening requirements should be allowed to enter all areas of a facility, unless they have recently been in an area formally declared a hotspot under current Public Health Directions.
- Services should anticipate periods when there is likely to be a greater number of visitors, such as public holidays, and formally assess the increased risk of a COVID-19 outbreak at the facility. When services identify a greater risk, they should develop specific visitor management plans to manage and effectively control potential areas of increased transmission.
- Services should be innovative in supporting safe in-person visits and ensuring that residents maintain contact with their families/representatives during lockdowns. The Commission has examples of innovation available on its website.

Maintaining visitor access when restrictions are imposed

- Services must ensure that residents can maintain contact with their families/representatives, even when Public Health Directions restrict visitors. They must consider using technology and window visits.
- It is important that services continue to offer the option of remote visits, and that this option can be rapidly implemented if Public Health Directions impose mandatory visitor restrictions.

Protecting residents' wellbeing

- Services should revisit the Charter of Aged Care Rights and pay close attention to the rights of aged care residents to maintain choice, control over their personal life, and independence.
- Residents have a right to travel outside their facility, and restrictions should only be imposed in line with public health directions.
- Services must only make isolation mandatory for residents returning from travel in accordance with Public Health Directions. Isolation other than that required by Public Health Directions must not be imposed 'just in case', even if the service has conducted a COVID-19 risk assessment.
- Services should be familiar with the Healthcare of older Australians impacted by COVID-19 fact sheet, with a focus on the effect of isolation on mental health.
- Services must monitor and manage residents daily for the effect of isolation on physical and mental health, using a formal checklist or screening tool. The Healthcare of older Australians impacted by COVID-19 fact sheet contains an example checklist.

Communicating with families/ representatives

- Services should regularly communicate with families/representatives about visiting arrangements, to provide a clear understanding of visitor rights and responsibilities.
- Services must continue to monitor the effectiveness of their communication methods and use multiple media channels to cater for special needs, such as families/ representatives who speak languages other than English and those with visual impairment.
- Services should tailor their communications for residents and their families/ representatives to ensure that vital information on infection control and other important messages are received and understood.
- If services identify a need to impose restrictions in addition to those included in a Public Health Direction, they must clearly explain the reason to residents and their families/representatives. Where possible and practical, services should consult residents and families/representatives before imposing these restrictions.
- Services should be willing to negotiate with families to achieve mutually agreed arrangements for visitor access. Services can review the Commission's visitor access case studies for guidance on resolving common complaints related to visitor access.

Keeping residents, staff and visitors safe

Screening, contract tracing, and infection prevention and control

- Services must screen visitors and regularly monitor Public Health Directions to ensure they are complying with current requirements.
- Where it is feasible to do so, services are encouraged to maintain electronic visitor records. This reduces the risk of losing information and enables more efficient and accurate contact tracing. QR code technology can be a particularly effective tool (an example of this is the NSW Government's COVID Safe check-in tool).
- Services should consider implementing an electronic resident sign-in/sign-out system to ensure records are accurate and easy to use for contact tracing.
- Services must appoint an infection prevention and control (IPC) lead to advise them and monitor compliance with controls. The IPC lead may also help them to develop an IPC plan.

Bookings and procedures

- All services should establish a visitor pre-booking system that can be activated in the event of increased restrictions on visitors or a COVID-19 outbreak.
- Services should have written procedures for managing visitor access in communal areas. These end-to-end procedures should cover pre-booking processes, intake screening, visitors' movement within the facility, sign-out details and post-visit cleaning.

Specialised support staff

- Services may consider providing extra staff for visitor screening to support visitation and offset the workforce effort required in the event of an outbreak.
- Services are encouraged to implement partner in care arrangements to formalise the relationship between the resident, their partner in care and the service, so the partner in care can help deliver services and care to the resident.
- Services should establish written procedures for safe visitor access and communicate these to staff. These procedures should be periodically reviewed to ensure they are up to date and fit for purpose.

Staying informed about important resources

- All services should establish systems for monitoring Public Health Directions daily because these directions can change at short notice, even when there are no COVID-19 outbreaks or cases of community transmission.
- Services should maintain strict compliance with Public Health Directions and the Code. They should make sure families/representatives have access to these documents, to ensure they understand their rights and responsibilities as visitors.
- All services should have written procedures for managing the risks of COVID-19 transmission. Services that are still developing their procedures should refer to the Commission's Outbreak management planning in aged care guidance for further information.

Survey findings

Question 1.

Do you currently allow visitors to enter the service?

The survey posed 21 questions to residential aged care services to determine how they are managing visitor access and resident restrictions in a COVID-normal world.

The survey was distributed to 2,717 services on 16 December 2020, and 2,559 (94.18%) services completed and submitted responses by 19 January 2021. Eight services started but did not submit a response, 35 services logged into the survey but did not enter any responses, and 115 services did not log into the survey.

Visitor access

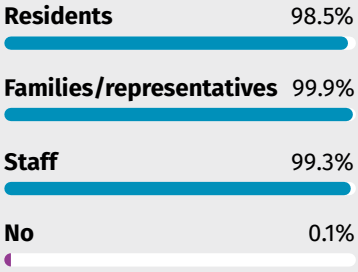
Of the 2,559 respondents, 2,464 services (96.3%) allowed visitor access during the survey period. Of these, 1,552 services (63%) allowed both in-person visits and remote visits. For in-person visits, directly visiting a resident's room was the most common (90%). Of the services offering remote visits, 63.9% used technology (video and telephone calls) to enable these visits.

A small minority of 102 services (4.1%) allowed only remote visits during the survey period. These services indicated that Public Health Directions prohibited in-person visits during the survey period, due to community transmission of COVID-19. In most cases, remote visits were available daily and during a broad window of time, although a small number of services only offered narrow windows of time during regular business hours. There was a correlation between services that only allowed remote visits during a restricted window of time and those receiving complaints about lack of visitor access (see Question 20).

Ninety-five services (3.7%) did not allow visitor access during the survey period and did not offer any form of remote visits. The majority of these reported that they were acting in compliance with Public Heath Directions that restricted visitors due to community transmission of COVID-19. A small number of services had incorrectly assumed they were subject to Public Health Directions even though they were outside the prescribed hotspots. Other services were complying with directions from their approved provider, requiring that they impose visitor restrictions beyond applicable Public Health Directions.

Question 2.

Do you regularly communicate with residents, their families/ representatives and staff about the current visitor access arrangements?



Communication about visitor access arrangements

Close to 100% of services were effectively communicating visitor access arrangements with residents, families/representatives and staff during the survey period. Communication with families/ representatives (99.9%) and communication with staff (99.3%) were slightly higher than communication with residents (98.5%).

Restrictions on visitor access beyond Public Health Directions

The large majority of services (87.8%) did not restrict visitor access beyond the requirements of Public Health Directions during the survey period.

This figure rises to around 90% when including services that locked down in response to community transmission of COVID-19 in Sydney's Northern Beaches and Brisbane during the survey period. These additional services are considered to have appropriately met the requirements of Public Health Directions. They indicated that due to the changing nature of restrictions, they now exceed the Public Health Directions prior to any outbreak.

The majority of services that exceeded Public Health Directions did so by restricting visitors to within normal office or reception hours, to ensure adequate staffing so visitors could be properly screened on arrival. In most cases, services indicated that they were flexible and encouraged families to negotiate visits outside business hours on a case-by-case basis if required.

Some services mentioned that they were restricting visits to ensure they did not break social distancing rules by having visitors congregate in communal areas, especially reception areas. They did so by limiting the timing and frequency of visits to reduce the possibility of COVID transmission between visitors.

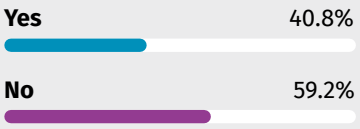
A small number of services imposed restrictions on visitors from 'areas of interest' (an area with an increased number of COVID-19 cases), even though applicable Public Health Directions did not formally declare these areas as hotspots. The responding services did not define how they identified these areas of interest, but it can be inferred that they were not formally declared hotspots.

Question 3.

Do you currently restrict visitor access beyond the requirements of the state/territory Public Health Directive now in place?

Question 4.

Do you currently have restrictions in place for residents travelling outside the service?



Restrictions on resident travel

A large minority (40.8%) of services imposed restrictions on residents travelling outside the service (see Question 4). Only those services subject to Public Health Directions requiring a full lockdown of residential aged care services completely restricted resident travel.

Most of these services noted that they only imposed specific restrictions on external travel in accordance with current Public Health Directions. This included prohibiting travel to declared hotspots and providing exemptions where external travel was considered essential for medical or social reasons.

A small number of services required residents to isolate for 14 days after returning from outside the service. These services did not provide any context for why they imposed the isolation. Other services mandated isolation for returning residents based on the service's assessment of the risks associated with external travel.

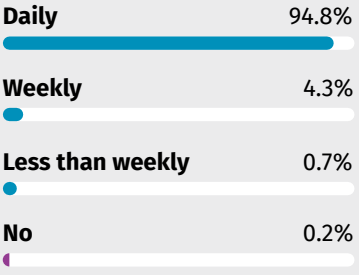
Many services outlined the risk controls they had established to ensure safe travel for residents outside the service. Common controls included briefing residents on hotspot areas prior to travel, tracing the locations that residents travelled to, discouraging visits to high-density areas and screening residents on their return.

Monitoring applicable Public Health Directions

The majority of services (94.8%) monitored Public Health Directions daily during the survey period, which is a very positive finding (see Question 5). 5% of services only reviewed Public Health Directions weekly or less than weekly, and 0.2% did not monitor Public Health Directions at all.

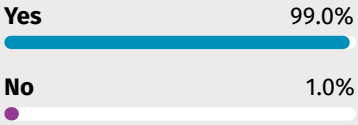
Question 5.

Do you monitor visitor restrictions in Public Health Directions applicable to your state/ territory?



Question 6.

Do you comply with the Industry Code for Visiting Residential Aged Care Homes during COVID-19?



Compliance with the Industry Code for Visiting Residential Aged Care Homes during COVID-19

Almost all (99%) of services complied with the Code during the survey period, indicating strong acceptance of the Code across the sector (see Question 6).

A small number did not fully comply with the Code due to concerns about visitor overcrowding and breaking social distancing rules, and the need to provide efficient screening processes. This was consistent with responses to Question 3, where services reported imposing greater restrictions than those defined in applicable Public Health Directions.

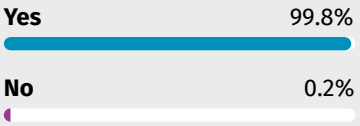
Some services complied with guidance from their approved provider, even if this did not align with the Code. In their responses, these services indicated that their approved provider had previously voiced concerns about the Code during its development.

COVID-19 screening for visitors

The only services without screening processes in place at the time of the survey (0.2%) were those not allowing visitors due to applicable Public Health Directions (see Question 7). These services indicated that they did apply visitor screening processes when restrictions were not in place.

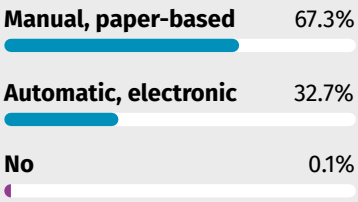
Question 7.

Do you have in place COVID-19 and infectious disease screening processes for visitors?



Question 8.

Do you have visitor registration processes upon entry into the service?



Visitor registration processes

Almost all services had visitor registration processes, which are vital to support contact tracing in the event of a COVID-19 outbreak (see Question 8). Although around one-third (32.7%) of services used automatic electronic records, approximately two-thirds (67.3%) relied on paper-based records, which can be harder to maintain and less practical for contact tracing purposes.

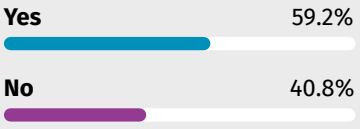
Visitor pre-booking processes

1,514 of the respondents, (59.2%) used a pre-booking process for visitors. Services in non-metropolitan areas (52%) were less likely to have pre-booking processes than those in metropolitan areas (63%), which may indicate that services in lower-density areas believe they were at lower risk of COVID-19 transmission.

Services indicated that a pre-booking system helped them safely manage visits and ensure appropriate social distancing. In most cases, pre-booking required families/representatives to contact the service's reception by telephone, although some services offered booking online or via email.

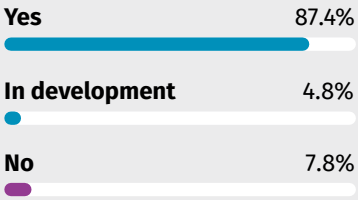
Question 9.

Do you have pre-booking processes for visitors?



Question 10.

Do you have written rules and procedures for the management of access to and movement within service common areas used for visitation?

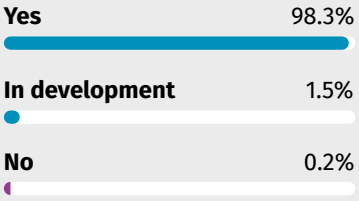


Managing visitor access to communal areas

2,237 (87.4%) of services had written procedures for managing visitor access to communal areas (see Question 10). Narrowing the focus, smaller services and single-service providers were slightly less likely to have written procedures in place or in development, with only 85% of this group of services indicating they had written procedures.

Question 11.

Do you have written processes and procedures for managing the risks of COVID-19 and infectious disease transmission to residents and/or service staff from visitors?

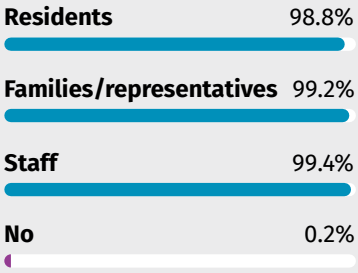


Managing COVID-19 transmission from visitors to residents and staff

Almost all services (98.3%) had written procedures for managing the risk of COVID-19 transmission from visitors to residents and staff, and a further 1.5% were in the process of developing such procedures. Only 0.2% of services did not have written procedures in place and were not in the process of developing them.

Question 12.

Have you communicated the procedures for managing the risk of COVID-19 and infectious disease with residents, their families/ representatives and staff?



Communicating COVID-19 risk management to residents, families/representatives and staff

Almost all services had informed residents, families/ representatives and staff of their procedures for managing the risk of COVID-19 transmission (see Question 12). There is a negligible difference between the percentage of services communicating their risk management approach to residents (98.8%), families/representatives (99.2%) and staff (99.4%). Ideally, all key stakeholders – residents, families/ representatives and residents – should be equally informed of COVID-19 transmission risks and the service's approach to risk management.

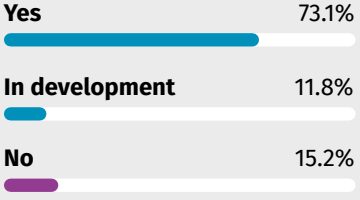
Managing higher visitor volumes during busy periods

1,870 services, or 73.1%) had specific plans to support safe visits during the holiday season, and a further 11.8% were developing plans (see Question 13).

Although these results are positive, only 65% of services that completed the survey before 21 December 2020 had a plan for the holiday season. This suggests that a significant number of services were still establishing their plans for the holiday season in the week leading up to Christmas, which may not have left enough time for proper communication and implementation.

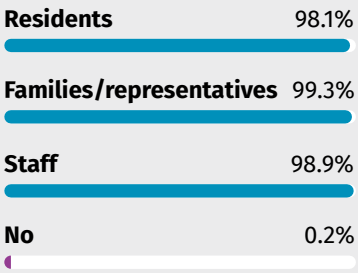
Question 13.

Do you have written plans specific to managing higher volumes of visitors during the festive/ holiday season?



Question 14.

Have you communicated these festive/ holiday season plans with residents, their families/ representatives and staff?



Communicating holiday visiting plans with residents, families/representatives and staff

Almost all services that developed a specific plan for visitors during the holiday season communicated this plan with residents (98.1%), families/representatives (99.3%) and staff (98.9%) (see Question 14). Furthermore, even services that had not developed a formal plan had communicated their changed arrangements for the holiday season. As discussed in relation to Question 12, the goal is to communicate these special plans equally to residents, families/representatives and staff.

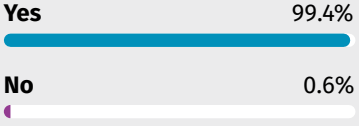
Monitoring and managing physical symptoms of isolation

2,532, or 99.4% had processes in place for monitoring and managing the physical symptoms of isolation on residents (see Question 15).

The majority used a formal checklist or screening tool, monitoring residents for clinical indicators including weight loss, COVID-19 symptoms such as elevated temperature, and the effects of restricted movement. However, the survey results also show a wide discrepancy in the frequency of monitoring. Some services monitored residents daily, while a small number only conducted monthly monitoring. A small number of services only conducted visual monitoring to determine if there were observable changes in residents' behaviour and appearance.

Question 15.

Do you have processes for monitoring and managing the physical signs and symptoms of isolation during the COVID-19 pandemic?



Question 16.

Do you have processes for monitoring and managing the mental health signs and symptoms of isolation during the COVID-19 pandemic?

Monitoring and managing mental health symptoms of isolation

2,470, or 98.9% of services had processes for monitoring and managing the impact of isolation on residents' mental health. Most combined formal monitoring of symptoms with less formal engagement such as increased one-on-one time between personal care workers and residents.

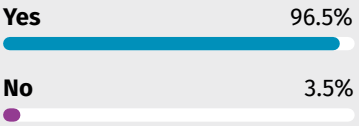
Although the rate of positive responses is very encouraging, the number of services monitoring residents' mental wellbeing during isolation (98.9%) is still slightly lower than those monitoring physical symptoms (99.4%).

Contact tracing for residents

The vast majority (96.5%) of services maintained records of resident movement outside the service, which may be used to support contact tracing in the event of an outbreak. The written responses to Question 4 indicate that the most common approach was to screen residents on their return to the service and record the locations they visited.

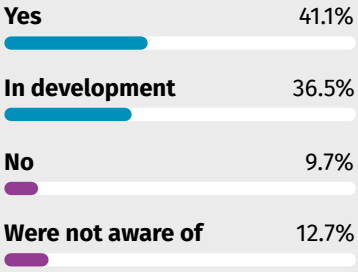
Question 17.

Do you have processes in place to assist public health authorities conduct contact tracing of residents travelling outside the service?



Question 18.

Have you implemented partner in care arrangements?



Partner in care arrangements

The number of services with partner in care arrangements in place increased throughout the survey period to a total of 41.4%, although many services (36.5%) were still developing such arrangements (see Question 18). Almost 10% of respondents did not have these arrangements in place and almost 13% were unaware of them before completing the survey. The Commission anticipated these results, having only released the Partnerships in care fact sheet on 3 December 2020.

Large services with 100 or more residents were more likely (44%) to have adopted partner in care arrangements than smaller services with 50 or fewer residents (39%). The discrepancy in uptake of these arrangements may indicate that smaller services have less staffing capacity to rapidly implement new arrangements.

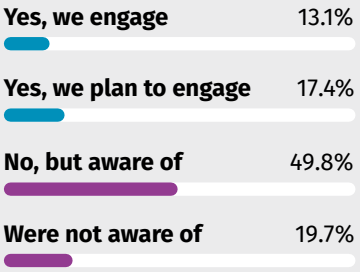
Use of visitation assistants

Only services in Victoria were able to respond to the question regarding residential aged care visitation assistants scheme which was only available in Victoria (until 31 December 2020). Of the services that responded to this question, 13.1.% had engaged visitation assistants. The visitor access survey was conducted quite soon after the introduction of the scheme, which explains this relatively low uptake rate and low awareness (19.7% of services were not aware of visitation assistants). However, 17.4% of services were already planning to engage visitation assistants when they completed the survey and it is anticipated that more services would have done so subsequently.

The Commission received written feedback from some services in regional Victoria that had applied for visitation assistants but found none were available in their location.

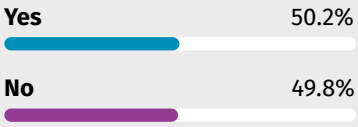
Question 19.

Have you engaged, or do you plan to engage, visitation assistants in your service?



Question 20.

Have you received complaints from residents or their families regarding lack of visitor access during the COVID-19 pandemic?



Complaints about lack of visitor access

There was an almost even split between the number of services receiving complaints related to visitor access (50.2%) and those that did not receive complaints (49.8%) (see Question 20). The majority of complaints related to visitor hours and visitors not being able to see residents at their preferred times. Other common complaints indicated uncertainty around screening processes and access requirements, and technical issues with technology-supported remote visits.

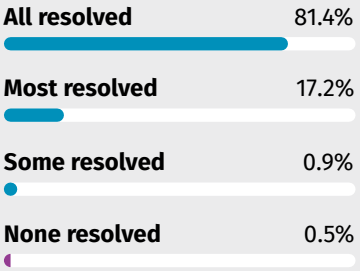
Services that imposed restrictions exceeding the Public Health Directions (see Question 3) were more likely to receive multiple complaints from families.

Complaints resolution

Of the services that did receive complaints about visiting, most were generally successful in resolving them (see Question 21). The majority of services (81.4%) were able to resolve all complaints, and a further 17.2% resolved most complaints. Less than 1% had resolved only some complaints, and only 0.5% had not resolved any complaints at all. This is likely due to the willingness of most services to negotiate with families and visitors to arrange visits, as indicated in the responses to Question 2.

Question 21.

Were the complaints resolved with mutual agreement between the service, the resident and the complainant (where the complainant was not the resident)?



Glossary

Approved provider: An organisation or person that has person been approved as is suitable to provide aged care under the Aged Care Quality and Safety Commission Act 2018.

The Code: The Industry Code for Visiting Residential Aged Care Homes during COVID-19

Contact tracing: The process of gathering and compiling information about where a person has been and who they have been in contact with, for the purposes of identifying potential COVID-19 exposure and/or transmission. These records can be used to promptly inform others who may have been exposed, so they can test and/or isolate to prevent further transmission.

COVID-normal: A situation in which there is some ongoing risk of COVID-19 transmission or outbreak, managed through social distancing, contact tracing, mask wearing, and other infection prevention and control precautions. Measures are also in place to support the health and wellbeing of individuals and communities affected by these restrictions.

Infection prevention and control (IPC) lead: A nurse appointed by the service as the lead person for infection prevention and control. See the Department of Health website for more information.

Partner in care: A person – such as a family member, loved one, friend or representative – who has a close and continuing relationship with a resident, and who frequently visits the resident to provide regular care and companionship. See the Partnerships in care fact sheet for more information.

Public health direction: A legally enforceable public health measure imposed by a state or territory for the protection of public health and safety.

Service: In this document, a residential aged care facility.

Visitation assistant: In Victoria, a person who assists residents with remote and in-person visits. This can include providing support with scheduling, technology, PPE and hygiene. See the Department of Health website for more information.

Visitor access campaign: A program of activities the Commission is implementing to support the transition of the aged care sector to a COVID-normal operating environment.

Visitor management plan: A formal plan, developed by a service preferably in consultation with residents and their families, to manage visitor access for the purposes of helping to minimise the risk of COVID-19 transmission within the service.

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, In Your Capital City