The Hon. Tony Pagone QC
Ms Lynelle Briggs AO
Royal Commission into Aged Care Quality and Safety

June 2nd 2020

Dear Commissioners

Thank you for the opportunity presented to community members to make a submission on the impact on aged care clients and services from the COVID 19 crisis.

Please do not hesitate to contact us if you require further elaboration on any of the points listed below.

Yours sincerely

[redacted]

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Submission into the impact on aged care clients and services from the COVID 19 Crisis

Reverence for Life: Valuing the Lives of Older People

Introduction

About OWN

OWN NSW is a community-based organisation that is run by older women, for older women. Established in 1987, OWN aims to promote the rights, dignity and wellbeing of older women. We encourage mutual support and friendship amongst our members and work to foster a positive attitude toward ageing. Members of our organisation are older women who have a strong interest in ensuring that aged care in this country is adequately funded, compassionately delivered and respectful of the needs of older people.

About the Submission

This submission is in response to the call by the Aged Care Commission for feedback from the public and organisations regarding the impact on the aged care sector of coronavirus (COVID-19).

OWN NSW is part of the sector delivering services to older people, specifically older women, to improve and maintain their wellbeing. OWN groups provide a wide range of wellness activities which delay and reduce the need for high level medical services and increasing dependency on aged care supports. This is borne out through the longitudinal study conducted by Professor Pat Bazeley into the impact of OWN's activities.

OWN made rapid changes to the delivery of its services and communication with its members and older women in the community in response to the coronavirus and subsequent lockdown (referred to in this submission as 'the lockdown'). The changes included the provision of:

- new online 'live' activities to counteract social isolation such as 'Cuppa & Chat', 'Film Club' and other discussion groups
- transferring as many face to face activities online as possible to ensure participants stayed physically active and maintain existing relationships. These activities are provided free of charge to all participants

- up to date links with online social resources
- telephone advice for technical support and referrals
- official government information and news items through the website and e-newsletters

As the lockdown continued, OWN witnessed a four-fold increase in participation in its online activities.

Through responses to these activities and social media items; members, friends and family receiving aged care services kept OWN informed of their experiences as the lockdown progressed. **This submission is based on individuals' comments gathered through our daily communications and supplemented by formal in-depth interviews with carers, where their experiences and recommendations are discussed in more detail below.**

Summary

The experience of carers and clients was mixed, rating the service providers' response to the lockdown from 'poor' to 'well done under the circumstances'. All described the current identified problems such as the existing staff ratios and skill mix, and reliance on casuals to exasperate conditions that decreased the quality of life of those receiving services during this time. The lockdown also highlighted other issues such as access to technology, design of buildings and community attitudes towards older people that inhibited a productive response to the crisis.

Some respondents considered the clinical arrangements to be inadequate, with a lack of use of PPE, no separation from residents who moved outside the centre from those who were under a lock down, and no standard procedures for visiting health professionals or other essential services to follow hygiene procedures.

The lockdowns led to clients missing contact not only with friends and relatives but with the outside world and activities, without much thought as to how they could be mitigated or replaced. There were reports of increased use of medication as residents complained or became unsettled due the restrictive practices.

The isolation became a significant issue as carers reported their parents becoming despondent with the lack of visitors and activities. When relatives died during the lockdown from other causes, some believed the isolation and loneliness contributed to their premature death (particularly when there was no obvious disease present).

Relatives made attempts to bridge the gap with increased phone calls and use of video visits but this was rarely supported by staff or the internet connections were unavailable. There was a very quick response in ending activities within centres regardless of whether they met government recommended guidelines, and there were very slow or non-existent attempts at providing alternatives.

The lockdown revealed a serious failure in access to technology that the rest of the community takes for granted. Internet was either not accessible or staff were not available to assist residents to use devices (for example online family meetings in the evenings).

A significant finding in this submission is that aged care facilities need investment in technology to bring the centres into the 21st century to provide services that the rest of the community take for granted. The next generation of residents will have spent a significant proportion of their life 'online' and demand that they remain connected in this way in residential aged care facilities.

OWN is aware that a large part of these issues is based on the financial structure of the industry. OWN calls for a forensic accounting project to be undertaken to determine how the current funding from all sources are used by providers. Without knowledge of what services are provided at what cost, it is impossible for consumers to make an informed choice when deciding upon a service provider. The marketplace for aged care is extremely asymmetrical in favour of the provider, and until this is rectified there is no way for the marketplace to work effectively.

The mixed response highlights the reliance on 'good' or well-run operations against those that do not have satisfactory leadership. The current variation cannot be solely due to resources as all services receive the same government support and daily fees or equivalent from residents. It is not good enough for the standard of care to be based on the luck of selecting a facility with good staff and management.

All comments were from carers or consumers receiving low care services in not-for-profit services in Sydney or regional metropolitan centres in NSW.

Main Areas of Concern

Clinical management (hygiene controls)

All older people were concerned about contracting the virus and were alarmed about the lack of control of individuals moving within the facility and by the lack of PPE used

by staff. One resident described the positive outcome of no community transfer of infections within their facility as being due to "good luck rather than good management" - in that if someone was infected, the lack of controls would mean it would sweep through the facility.

The residents were heavily reliant on community control of the virus, that is, it not entering the facility, rather than in hygiene controls within the facility.

Services closed the doors to all non-essential visitors very quickly and ended most activities that would bring residents together or that took place outside of the centre. However, many facilities have mixed levels of care such as independent living units on the same property. One resident reported that nothing was done to restrict those from independent living units moving in and out of the facility, and moving within the centre to visit those in high care.

One carer also reported that residents in her father's facility ate meals together in the dining room. Her father requested to eat 30 minutes after everyone else and this was arranged, but staggering mealtimes was not standard practice.

Services also moved quickly to restrict who could enter the facility. Essential visitors would complete the visitors register (something which previously was not monitored in all services) and temperatures were taken. However, there was no insistence on the use of masks once inside the facility. One resident who received a consultation with a medical specialist had to ask the practitioner to wear a mask, which he did, but this was not the general policy of the service.

Residents also found that staff did not wear masks or other PPE consistently. Residents observed that staff found it too difficult to deliver personal care services with masks and gloves, and so abandoned it altogether.

Carers reported contradictions in rules. For example, staff and family were not allowed to gather in the resident's room due to physical distancing requirements. This meant when visiting was allowed, only one person could visit. Given this, one carer was surprised to find that this rule did not apply when her father died during the lockdown (not related to the virus), when several people were in his room at the same time after he died. She did not understand why, in this case, she and other staff could not have been with him in his final hours.

Many of the services' decisions were made quickly as a result of risk aversion, the lack of knowledge about the virus and fear of the spread of the disease. Lessons learnt from this experience should be instilled in a policy and procedure, with appropriate training, changes to staff ratios, and allocation of resources when needed. In this way, each facility will be prepared for any type of contamination and not react in ways that are detrimental to those in their care.

Recommendations

Develop an industry evidence-based standard for hygiene management for different levels of risk. The policy should include, but not limited to:

- Rigorous staff training required for all levels of staff (including professional refreshers)
- PPE – when and how to use, as well as stock that should always be on hand
- Movement and restrictions between services and within the residence for staff, visitors and residents within the site (eg where independent units are on the same site and have access to common facilities)
- Emphasis on good communication with residents, staff and visitors about changing arrangements
- Suitable arrangements which should be made within the facility for meals and activities
- Clear guidelines about gifts and other material which can be provided to residents
- Determination of what actions should continue as a daily routine and what is required if a higher risk is identified

Clinical management (use of chemical and restraints)

We were very concerned by the use of chemical and physical restraints on residents in aged care facilities prior to COVID 19, and the pandemic has underscored the need to ban the use of these restraints.

A study into antipsychotic and benzodiazepine prescribed in residential aged care facilities found that 22% were on daily doses of these drugs. Over 10% were charted for these drugs on an 'as required' basis. (Breen, JW, Gee, P, Ling, T, Brown, DT, Franks, KH, Bindoff, I, Bindoff, A and Peterson, GM 2018, 'RedUSe: Reducing Antipsychotic and Benzodiazepine Prescribing in Residential Aged Care Facilities', *Med J Aust*, 208 (9), pp.398-403). We also know from a Human Rights Watch report that there is secretive use of chemical restraints (*'Fading Away': How Aged Care Facilities Chemically Restrain Older People with Dementia*).

The understaffing in aged care facilities means that aged care management can readily apply the 'last resort' excuse to medicate and/or physically restrain aged care residents in lockdown situations. We are very disturbed that Dementia Support Australia is recommending the use of restraints, including enforced isolation, in pandemic situations: "Locking a door is less restrictive than physically restraining someone to a bed. If this option is used, it is suggested that breakable items be removed from the person's room, and the person should be checked on at least every 15 minutes to ensure their ongoing safety, and provide access to personal care, food and fluids." (https://bit.ly/AgedCareRestraints) This advice is exceedingly dangerous, not only because it is a deliberate imprisonment of residents and an abuse of their human rights, but also because the facilities are already understaffed so there is no guarantee that the recommended step of checking in 'at least every 15 minutes' is practicable. An aged care resident in [redacted] was left to lie on the floor for two hours after falling [redacted] and this is AFTER staffing levels have been boosted following interventions from both the Federal and state governments.

More than 50% of residents in aged care facilities have dementia. Human Rights Watch has highlighted studies which showed that people with dementia treated with person-centred care without the use of drugs showed signs of improved quality of life, decreased agitation, improved sleep patterns, and improved self-esteem. If this level of care is available in all aged care facilities, then lockdown measures will be less traumatic, and diminishes the likelihood of residents being chemically or physically restrained.

Recommendations

- It is imperative that all aged care facilities bring staffing levels up to ensure that person-centred care can be given so that during times of lockdown, it will be much easier to manage resident care
- Staff should all be trained in how to manage residents with dementia
- Chemical and physical restraints should be banned. Older people are no different to other age groups in the community and should not be treated differently and have their human rights violated

Communicating New Arrangements

Standard communication of changes in visiting and other arrangements to residents and family carers was done through email and text. Family members were understanding of the rapid developments and need for standard communication of the main messages. In addition to the standard communication, carers appreciated:

- Nursing staff contacting them directly to discuss their parent's/partner's care
- Staff repeating the description of the arrangements in person when the opportunity arose, such as when the carer telephoned or visited the facility
- Carers receiving a contact number and name of staff member they could call if they had a question or if an issue arose

Carers complained that when they did raise an issue or had a question, staff did not always return their call. There were also reports of carers turning up to find a sign on the door that the facility was closed. It is not clear whether this was due to the carer not receiving messages.

Recommendations

- Standard communication with carers/family members through email and text should be mandatory. In periods of crisis, carers should receive daily bulletins
- Staff must also discuss arrangements with carers in person through meetings or telephone calls
- Audio visual links must be made available for staff, residents and family carers to conduct family meetings and visits

Staffing Ratios and Skill Base

Staffing ratios and professional staff mix have been identified as a serious issue in previous submissions. This became more evident during the lockdown. Our members are concerned that the lack of qualified medical staff (including Registered Nurses) in facilities deprives residents of the care they deserve and need, not only before COVID 19, but also during the lockdown. The outbreak in Newmarch House is a case in point. It indicates to us that management of aged care in that facility does not understand infection control measures, and do not have the systems in place to include medical expertise in their handling of the outbreak.

The lack of staffing highlighted:

- Staff Ratio
    - staff were not available for extra duties such as helping residents make phone calls or use online meeting apps
    - staff unavailable on weekends and at night when families wanted to meet online or via phone with the resident
    - lack of time to undertake personal care tasks while using PPE

- lack of time to assist with individual activities or deliver meals individually or in smaller groups
- tasks often done by family carers such as helping with meals meant residents were not fed and their condition worsened

- Casualisation of the workforce
  - Staff moving between facilities increased the spread of infection if a staff member was infected. This is an issue regardless of the nature of the infectious disease
  - Agency staff not aware or not following standard procedures for the facility. Other industries have 'white cards' ensuring basic safety accreditation. This is also accompanied by a safety briefing when they enter each worksite to ensure issues unique to the workplace are understood. When each facility has specific requirements, there should be a similar compulsory induction for each new agency member

- Skill mix
  - The undervaluing of the elderly leads to the undervaluing of the work to care for the elderly. The fact that over 90% of the workforce in the aged care sector is female is a contributing factor to the poor remuneration and conditions of the Personal Care Workers in nursing homes. There is a lack of training offered to PCW, and no recognition of the important role they play in ensuring the good care of residents.

    Also, as much as personal care workers must be valued and recognised for their delivery of care across all health sectors, they should not be asked to replace our registered and regulated clinical workforce. Aged care providers have been cutting these higher paid positions, and replacing them with less qualified workers. This is unacceptable.

Recommendations

The lockdown has demonstrated the need for:

- Staff ratios. There is a clear need for additional staff who are all trained to provide personal care to the standard required
- Staff with the right skills to interact with residents and decrease social isolation (for example to provide assistance with use of technology)
- Procedures are in place and actively monitored to ensure evidence-based hygiene practices

- Casual and agency staff are kept to a minimum and inductions take place on specific procedures for the facility each time a staff member new to the facility is engaged
- Additional vocational certification is required for each staff member on safety and hygiene practices
- Delivering COVID 19 stimulus packages for employment in the aged care sector to create jobs in metropolitan and regional areas where it is needed most, at the same time as saving lives of older people in care and waiting on home care packages

Visiting, activities and access to technology

All carers and residents reported that activities ceased immediately to comply with government rules about size of gatherings. Carers were concerned that this applied to all activities regardless of how many people usually attended and that there was generally a very slow response to provide alternative activities. One resident pointed out that it was rare for more than 10 people to attend the activities, and that the same space was used for unlimited numbers for dining.

One resident said they arranged to eat their meal half an hour after everyone else to avoid contact. This was arranged as a special request but was not offered to anyone else, nor was dining in small numbers with physical distancing arranged.

Alternative activities reported included 'corridor games', photocopied pages of puzzles, moving libraries of books and videos to accessible areas.

Access to internet and Wi-Fi services was not consistent across services. Where it was available, residents may not have access either due to cost or technical skills. Relatives reported that they would like to communicate with their parent using the computer or a portable device, but staff were either unavailable or not skilled to assist the resident. This was particularly the case in the evening and weekends when extended family were available to meet online. Extended family members could have helped alleviate the isolation experienced by residents during the lockdown through the use of technology but were left out of the solution due to the inability of the aged care facility to provide assistance to the residents to connect online.

Carers also advised OWN that services did not always offer options for visits in gardens, 'window visits', or virtual visits; or if they did, they failed to organise the visits. On other occasions, the families were advised that some activities would continue, but this also failed to occur. Family carers were left to try and fill the gap from a distance,

leaving books, stationery and stamps and telephones. It should be asked as to why the service could not have initiated these services. We can reasonably assume that residents without family were left with even less.

Carers also reported that activities were not designed for the interests of the individual, and made simple for the most cognitively challenged. This was a complaint of existing activities, and highlights the lack of person-centred care that continued through the lockdown.

Family carers are often aged themselves and in a high-risk category, and do not want to travel. Residents are also concerned about their family members and do not want them to be put at risk. In these circumstances, there should be a greater responsibility on the facility or other community services to facilitate activities and contact with others. This must be built into any lockdown plan.

Of significant concern to carers was the effect of this social isolation on their family members. One carer believed this isolation led to her father's premature death as without visits he disengaged, had difficulty understanding the circumstances that led to the isolation, stopped taking his medication, became depressed and was not responding to the family. This occurred when visits were still allowed but reduced to an hour per week. The family was devastated. There is substantial research on loneliness, which found that whether actual or perceived, social isolation is associated with increased risk for early mortality, with up to a 32 percent increase (Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, Julianne Holt-Lunstad, Timothy B. Smith, Mark Baker, Perspect Psychol Sci, 2015 Mar;10(2):227-37).

Recommendations

- Internet connections and Wi-Fi to be made available to all residents. An IT or AVL room should be set aside for residents to use, making it available to those that cannot afford their own connection
- Staff to be trained to assist older people and where practicable, outside service agencies funded to deliver training for staff and older people
- Cost of connection should be part of the residential service package and not an additional cost
- Activities should be tailored to meet individual needs and interests
- Rules and procedures must apply that do not include restricting an individual to their room. This could, for example, include an AVL room where meetings using

virtual meeting software could be permanently established. This would assist medical and legal professionals as well as family

Building Design

The economic imperative for residential service providers is to house as many people as possible in the smallest space. This economic model means common space is limited and makes maintaining social distance while still having some human contact exceedingly difficult.

It became apparent that the design of buildings around courtyards, often with a large common meeting room for the entire facility or rooms on multiple levels; did not assist in facilitating communication and visits with carers or activities for small groups. For example, 'window' visits were not possible in multi-level units. Access to smaller spaces or gardens could not be accessed without walking through and being in contact with other residents. Smaller rooms for visits and activities away from the main facility were not made available.

In buildings that included independent living units, there was no restriction on residents entering or leaving the building. In buildings with common entrances for all residents, for example, the same lift was used by all residents. This increased the risk of contact from the community.

In circumstances where the facility could have repurposed rooms, establishing spaces that could be 'protected areas' was not attempted in the facilities identified for this submission.

Recommendations

- Research projects on innovative designs that enhance communication and reduce the threat of infections should be funded. This should include retro- fitting as well as design for new buildings and rooms. Results should be incorporated into building standards
- Aged care facilities need to create safe spaces so that visits can take place without transmitting a disease. This can be used not only with this longer-term lockdown, but with flu and other contagious diseases that shut down facilities on a regular basis. Furniture and screens should also be designed for safe visits

Home Care Packages

Older people receiving home care packages have been affected in different ways. The most drastic is the removal of services. Consumers receiving personal care are a

priority and continue to receive services. Older people receiving low care packages, mainly consisting of cleaning services, have lost the service altogether in some cases.

One carer described the loss of her father's cleaning service as a lack of understanding of the benefits of this service. Her father is nearly blind and while living independently, had difficulty maintaining the house. For example, he would not be aware of spills on the kitchen floor. This would not be cleaned and the dust and mould on the floor was a slip and hygiene hazard. The weekly cleaning service was an essential part of keeping him safe and independent. Yet the service had ceased without any risk assessment or consideration of what safety controls could be put in place. There was no indication of when the service would recommence.

Recommendations

- The home care package program requires an extensive review, including the disproportionate amount of funding that goes to residential care compared with home care. Included in the review should be the need for a code that does not simply cut off a service but undertakes a risk assessment and considers what controls can be put in place to continue to deliver the service

Response of Federal Government to the Crisis

We would like to bring the attention of the Commissioners to a report prepared for the government by the Defence Department regarding a forecast of Australia's vulnerabilities in a global crisis. A landmark review of Defence planning was commissioned to prepare for what the Department had concluded was an increasingly likely global crisis. One of the scenarios outlined is of a global pandemic of a scale worse than the current novel coronavirus. We are concerned that the government has not appeared to take the findings of the Department seriously enough to take the necessary steps to prepare the country for these eventualities (https://bit.ly/DefForce). Australia's systems were clearly unprepared and therefore unable to put in measures to deal with the outbreak quickly enough. The shortage of PPEs, for instance, impacted aged care facilities. We know that aged care nurses were concerned by the lack of PPE. It is by sheer luck that Covid-19 did not spread through aged care facilities in the way that it did in other countries. If it had done so in the early stages of the outbreak, it was clear that the stock of PPEs would not be sufficient.

We are also very concerned that the Federal Government's response to Newmarch House was very slow and inadequate. The case highlighted the reality of the way aged care is experienced on the ground with regulations and legislations from both State and Federal governments impacting the delivery of care. For instance, the State

Government is responsible for the health responses in the facility, but the Federal Government is responsible for regulating other aspects of the facility. There was clearly no pandemic plan and process which outlines clearly all the steps to be taken in concert by both the State and the Federal governments in dealing with outbreaks like the one which happened in Newmarch House.

We are also very concerned that the response of the NSW State Government to the pandemic in relation to aged care facilities was not clear. There were mixed messages being relayed with regards to what to do in cases of residents testing positive to Covid-19 – whether to keep the residents on the premises, or moving them to hospitals. This is probably one of the contributing factors leading to the continuing infection and death rates in Newmarch House.

We would also like to refer the Commissioners to the article in The Saturday Paper which outlines the way in which the Federal Government has contracted a "surge workforce" to deal with the pandemic in aged care facilities. The relevant parts of the article are quoted below:

- "The federal government awarded a $5.77 million contract to an aged-care staffing app that claims to have no "duty of care" for the quality of its workforce or liability for the care provided.... It went out as a limited tender on the grounds it was "to protect human health" and is therefore exempt from the Commonwealth's own procurement rules."
- "The Department of Health announced it would pay wage costs for any crisis workers employed via the Mable app. It does not appear that the government would subsidise workers who were not employed through the app."
- "Mable is not a direct employer of support workers or nurses. It functions much like Uber, or other gig economy-style platforms. The app explicitly states in its terms that any person hired through its platform is "not a partner, employee, independent contractor or agent" of the company."
- "Mable states that it "has no control over and is not responsible for the acts or omissions of any Users on or off the site"."
- "The app "makes no representation or warranty regarding the quality of any Home Care Services or any other services provided by any Member; is not responsible for the accuracy or reliability of any information provided by any Member on the Site; and takes no responsibility and has no obligation in contract or duty of care to manage or involve itself in any interactions between Users or in respect of any Support Worker Contract"."

We find it extraordinary that the Federal Government took this step to award a contract under these terms for an app which reduces recruitment options for aged care providers, and which does not have a duty of care for the quality of its workforce. This is completely unacceptable.

We remain concerned that the aged care sector is seen as a milking cow for private operators and times of crisis are exploited for profit without accountability and transparency.

Recommendations

- That the Federal and State government work together to have a coordinated response to pandemics and any other vulnerabilities which may impact on aged care facilities
- That private contractors hired to deal with problems in the aged care sector during the pandemic be subject to the same procurement rules as other contractors, and that all contractors are responsible for the quality of the services provided

Conclusion: Community and media discussion on value of older people

We are very concerned by the ageist attitudes expressed in the community and media regarding the value of older people, and the divisive narrative which pitches the young against the old. This has come to the forefront during this pandemic. The rhetoric of the "young" bearing "the burden" of this health crisis, and having to "pay the price" of keeping the elderly alive destroys inter-generational community building.

Most alarming to older people and their families was the Australian and international discussion about how to manage infection control, particularly the approach of 'herd immunity' and what death rates among the aged was acceptable to achieve this result. The public discussion presented a section of the community undervaluing human life, particularly that of older people. Older people were discussed as expendable in getting the economy operating again.

This lack of reverence for life in the community leads to devaluing all older people, including those receiving care. If the community does not value life, it is very difficult to argue for better distribution of funding, more and better trained staff and so on.

While this may seem out of the scope of this inquiry, it is hoped that through the Commission, there will be a greater appreciation of human life and the value of older people and this can then be reflected in the services they receive.

Complete List of Recommendations

1. Undertake a forensic accounting project to determine how the current funding from all sources are used by both non-profit and for-profit providers
2. Develop an industry evidence-based standard for hygiene management for different levels of risk. The policy should include, but is not limited to:
    - Rigorous staff training required for all levels of staff (including professional refreshers)
    - PPE – when and how to use, as well as stock that should always be on hand
    - Movement and restrictions between services and within the residence for staff, visitors and residents within the site (eg where independent units are on the same site and have access to common facilities)
    - Emphasis on good communication with residents, staff and visitors about changing arrangements
    - Suitable arrangements which should be made within the facility for meals and activities
    - Clear guidelines about gifts and other material which can be provided to residents
    - Determination of what actions should continue as a daily routine and what is required if a higher risk is identified
3. It is imperative that all aged care facilities bring staffing levels up to ensure that person-centred care can be given so that during times of lockdown, it will be much easier to manage resident care
4. Staff should all be trained in how to manage residents with dementia
5. Chemical and physical restraints should be banned. Older people are no different to other age groups in the community and should not be treated differently through having their human rights violated in this manner
6. Standard communication with carers/family members through email and text should be mandatory. In periods of crisis, carers should receive daily bulletins.
7. Staff must also discuss arrangements with carers in person through meetings or telephone calls
8. Audio visual links must be made available for staff, residents and family carers to conduct family meetings and visits

9. Additional staff who are all trained to provide personal care to the standard required
10. Staff with the right skills to interact with residents and decrease social isolation (for example to provide assistance with use of technology)
11. Procedures are in place and actively monitored to ensure evidence-based hygiene practices
12. Casual and agency staff are kept to a minimum and inductions take place on specific procedures for the facility each time a staff member new to the facility is engaged
13. Additional vocational certification is required for each staff member on safety and hygiene practices
14. Delivering COVID 19 stimulus packages for employment in the aged care sector to create jobs in metropolitan and regional areas where it is needed most, at the same time as saving lives of older people in care and waiting on home care packages
15. Internet connections and Wi-Fi to be made available to all residents. An IT or AVL room should be set aside for residents to use, making it available to those that cannot afford their own connection
16. Staff to be trained to assist older people and where practicable, outside service agencies funded to deliver training for staff and older people
17. Cost of connection should be part of the residential service package and not an additional cost
18. Activities should be tailored to meet individual needs and interests
19. Rules and procedures must apply that do not include restricting an individual to their room. This could, for example, include an AVL room where meetings using virtual meeting software could be permanently established. This would assist medical and legal professionals as well as family
20. Research projects on innovative designs that enhance communication and reduce the threat of infections should be funded. This should include retro-fitting as well as design for new buildings and rooms. Results should be incorporated into building standards
21. Aged care facilities need to create safe spaces so that visits can take place without transmitting a disease. This can be used not only with this longer-term lockdown, but with flu and other contagious diseases that shut down facilities on a regular basis. Furniture and screens should also be designed for safe visits
22. The home care package program requires an extensive review, including the disproportionate amount of funding that goes to residential care compared with home care. Included in the review should be the need for a code that does not

simply cut off a service but undertakes a risk assessment and considers what controls can be put in place to continue to deliver the service

23. That the Federal and State government work together to have a coordinated response to pandemics and any other vulnerabilities which may impact on aged care facilities
24. That private contractors hired to deal with problems in the aged care sector during the pandemic be subject to the same procurement rules as other contractors, and that all contractors are responsible for the quality of the services provided