Submission to the Royal Commission into Aged Care Quality and Safety

Lessons of the COVID-19 crisis for Aged Care Reform

Submission 2

Prepared by

COTA Australia

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COTA Australia

COTA Australia is the national consumer peak body for older Australians. Its members include State and Territory COTAs (Councils on the Ageing) in each of the eight States and Territories of Australia. COTA Australia and the State and Territory COTAs have around 40,000 individual members and supporters and more than 1,000 seniors' organisation members, which jointly directly represent over 500,000 older Australians.

COTA Australia's focus is on national policy issues from the perspective of all older Australians as citizens and consumers and we seek to promote, improve and protect the circumstances and wellbeing of older people in Australia. Information about, and the views of, our constituents and members are gathered through a wide variety of consultative and engagement mechanisms and processes.

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Lessons of the COVID-19 crisis for Aged Care Reform

Introduction

COVID-19 has now had a devastating impact on parts of residential aged care in Australia, particularly in the state of Victoria. The 'second wave' of the disease expanded rapidly through greater Melbourne leading to outbreaks in over a hundred aged care facilities and substantial numbers of deaths in a number of them.

After the first wave of the pandemic, Australia could argue that it was the envy of the world with the relative number of cases and deaths low after high levels of testing. Aged care provider peak bodies were highlighting the alleged excellent infection control efforts and outbreaks in aged care were limited to a small number of facilities. As the preface in our first COVID-19 submission states, COTA's view was that the "jury was out" due to the low rate of community transmission at that time. Our caution at being too congratulatory has unfortunately and regrettably proven to be correct.

In our first submission to the Royal Commission on COVID-19 we indicated that it was likely that we would be writing a second submission. Recent events have highlighted the importance of clarifying and strengthening arguments addressed in the first submission as well as discussing new issues that have arisen during the second wave of the pandemic in Victoria.

The COVID-19 pandemic and its severe impact on aged care comes at a time when the Royal Commission is finalising its public hearings and is beginning to draft its final report with key recommendations for reform. The circumstances of COVID-19 do highlight some important reform issues, particularly inconsistent approaches by providers to residential care visits by families, vastly different success at infection control by aged care providers, variable implementation of communication strategies by providers, variable demonstrated preparedness for health emergencies, clinical decision making in residential aged care particularly related to potential hospitalisation, the relationship with state health systems, and workforce shortages, capacity and skills.

However, the pandemic experience should influence but not overshadow or dominate the final conclusions of the Royal Commission. It is possible that large scale public health emergencies will become more common in the future, but it is also true that this pandemic is unprecedented. In terms of the long-term reform challenges for aged care, these preceded COVID-19 and it should be placed into context.

It is also important to consider that older Australians are currently living with the physical health, emotional and psychological impacts of COVID-19, in both residential care and in the community, and will continue to do so long after the immediate severity of the pandemic has passed. While the deaths of older aged care residents is tragic (and many could have been prevented - but not all), there are thousands of older consumers of residential care and home care who are isolated and experiencing the emotional toll of experiencing current events, with many not receiving adequate ongoing health care. Older people are at the centre of this crisis and of reform of aged care in this country. The message that the voice of aged care consumers is critical to aged care reform seems to

require constant repetition as it is often being lost. The current public debate about aged care generated by the pandemic, combined with the hearings of the Royal Commission, needs to be reminded of this.

Older Australians, whether they are living in residential aged care, receiving home care packages or living in the community, bear among the largest burdens of this pandemic in various ways, both now and for many years after the severity of the disease has subsided.

Who is Responsible? Need for balance in contextualising reform

Residential aged care providers have a considerable level of responsibility for failures in aged care highlighted by the COVID-19 pandemic. Current evidence provided to the Royal Commission and public debate does not reflect this.

Initial reform priorities are for substantial resources for home care packages and the Aged Care Workforce strategies combined with abolishing the ACAR, increased powers for regulation and compliance and changes to place consumer engagement at the heart of organisational and systemic governance.

The impact of the pandemic on older people in aged care and the failures of both government and providers to plan and respond should not be used as a rationale to prioritise the dismantling of the current aged care system governance architecture over policy, program and funding reform initiatives. This would be time-consuming and counterproductive for reform.

As outlined in our governance submission, COTA argues strongly that it would be time consuming, costly and counterproductive to the reform agenda if the Royal Commission recommended immediate changes to the systemic governance architecture of the current system. Substantial and urgent resources are required to address key reform issues including the provision of more home care packages to eliminate waiting times, implementing the Aged Care Workforce Strategy and strengthening the powers and resources of the ACQSC The abolition of the Aged Care Approvals Round (ACAR) and greater transparency of information about the fees and quality performance of providers is also critical. Prioritising the reform of system governance architecture would be misplaced.

Naturally, it is an important and necessary agenda for the Royal Commission, and for the general public, to understand how the current residential aged care outbreaks and resultant deaths occurred. We need to understand what work had been undertaken to both prevent and respond to this and who is responsible. Some of the suggested need for a new system governor seems to be based on assumptions about who is responsible for delivering aged care

COTA is concerned that much of the current framing of responsibility for dealing with COVID-10 outbreaks during recent hearings lacks appropriate balance and perspective. More specifically, we are concerned with the perception or proposition that aged care providers are passive, inert, inherently ill-equipped actors, incapable of making and implementing their own decisions, 'sitting

ducks' for the pandemic and should be micro-managed and rescued. This impression has been created, whether it is the intention of senior counsel at the Royal Commission or not.

Aged care providers are strong and powerful actors in this system. The current aged care system is not only the product of Federal Government decisions. It is the outcome of much 'push and pull' between providers and governments over many years. Aged care is delivered by providers, not by government or the regulator. Aged care providers are accountable for delivering support and care in accordance with the Aged Care Standards and the Charter of Rights. Some do so to a high standard, others perform acceptably but not at the level many of us would hope, and a minority scrape through, struggling with meeting the standards and often financially.

Providers have been reporting to the government and the regulator, in response to checking in the early stages of the pandemic, and indeed for many years, that they have infection control and emergency management plans in place and have staff that are trained to implement them. Providers have consistently opposed greater regulation and compliance measures on the grounds that they have the skills, capacity and expertise to provide quality care and meet the clinical needs of residents, during a public health emergency or otherwise. During this pandemic, many aged care providers have proved this to be true. Unfortunately, the lack of planning and preparedness of others has been tragically and devastatingly exposed. It is possible that other providers have been poorly prepared but have been lucky to not encounter an outbreak because they are not located in an area of high community transmission. It is this inconsistency and variability in provider preparedness that should be explored by the Royal Commission. We do not believe it has attracted the degree of attention and scrutiny it should.

The Aged Care Quality and Safety Commission (ACQSC) regulates aged care providers and their compliance with the Aged Care Quality Standards. The ACQSC can only act within the frame of its legislated powers and has a discrete and limited budget. As outlined in other submissions, particularly the governance submission, the relatively recent formation of the ACQSC as a body independent from government that regulates aged care providers, is a critical step towards improved quality and transparency leading to better outcomes for consumers. (We note that this was in fact a positive response to an earlier Review recommendation). We have repeatedly argued for increased powers for the ACQSC, the detail of which we will not repeat here.

To what extent can responsibility for the current COVID-19 crisis be laid at the feet of the ACQSC? It is true that the ACQSC does have a key role in advising providers on the necessary planning and actions to ensure they are compliant with the Standards, and obviously in assessing that compliance. However, it is the provider that develops, prepares for and implements plans to meet Standards and protect residents. The ACQSC is a regulator with the capacity to enforce sanctions and provide strong guidance on meeting standards. It is not a rescuer or 'hand holder'.

Proposals suggested early by a leading vocal critic of the government focused around putting members of the armed forces into every nursing home in Australia. What this would have achieved is quite unclear as most members of the armed forces are not, for example, trained in aged care or health care, do not daily use PPE or are skilled in training people to use it, and do not bring other skills that in a stand alone context would add value. They are a useful component of emergency teams and have been used as such, but to have deployed a minimum of 9,000 personnel, and it

would probably have required double that, around Australia would have been wasteful, compared to their concentrated use in emergency contexts.

COTA Australia notes the views of Senior Counsel that the Australian Government had no plan for dealing with COVID-19 in aged care. Without wanting to get involved in what constitutes a “plan” in the context of an unprecedented event, as an active participant in the processes of response to COVID-19 in Australia we would make the following observations:

- There was an early Commonwealth commitment, from the top, that the safety and well-being of older Australians would NOT be put at risk by taking the approach that “it mostly affects the old and they have already had a long life, so why sacrifice the livelihood of younger people for them?”
- The Commonwealth put border closures in place early and with the States put in place many lockdown measures with the intent of severely limiting community transmission, which is the greatest threat to older Australians, in or outside of residential aged care.
- In learning from the early experience at Dorothy Henderson Lodge the Commonwealth put in place the closest possible consultation with the sector, a review of that experience, guidelines for aged care facilities, developing a stockpile of PPE (depleted during the bushfires), putting surge workforce arrangements in place.
- Surveying all aged care facilities about their readiness for implementing preventive and responsive measures for infection outbreaks and providing advice and information about this
- A range of other measures in an ongoing way which we will not further document as they have been by others. We would note that many experts have observed that COVID-19 has behaved in ways that were not understood or expected in advance, or even fully understood during its early period overseas.

It is right for the Royal Commission to question the adequacy and foresight of the planning and the government has certainly partly been reactive. However it is inaccurate to say it has had no plan at all.

Visitor Code: Significant Policy Development Balancing Safety with Humanity

COTA played a pivotal role in the initiating the formation of the voluntary Visitor Code which has now been endorsed by most aged care providers enabling greater consistency and compassion to visits by families and friends to residential aged care and avoiding a protracted dispute between aged care providers and the Federal Government.

Notwithstanding the current crisis in Victoria, the formation and implementation of the Residential Aged Care Visitor Code has been one of the most important, reform-oriented developments during the time of the pandemic.

As our first COVID-19 submission outlined, back in March, at the beginning of the first wave of the pandemic, most aged care providers decided to implement a blanket 'no visitor' approach to visits by families and friends to residential facilities. In too many cases, this was combined with limited or no communication with families and friends, resulting in confusion, frustration and anxiety for residents and families alike. Scenes of confused and distressed family members standing outside residential facilities, attempting to find out more information on their mobile phones and staring through the gaps in fences became a feature on the television news.

Although we did not have the same media coverage within facilities, we did learn from some staff, some families and increasingly from GPs and other health professionals that the health and wellbeing of residents who were denied access to care and contact from family and friends began to decline rapidly. Examples of residents who were in the final days of their lives and denied visits from family were particularly distressing. As time went on so were the reports about residents who had been fed daily by family now dehydrated and starving because their family member was denied access and no compensatory measures put in place.

COTA and other consumer groups received thousands of calls from distraught relatives and directly from consumers regarding the inflexible visitor approach by providers. So did the Federal government and most State and Territory governments.

National Cabinet, through the Prime Minister, announced guidelines to enable restricted visits to aged care requiring providers to make exemptions on compassionate grounds when a lockdown was legitimately in place, and in areas without an outbreak to allow and orderly access to visits by families, while recognising that in the case of outbreaks, full lockdowns should occur for defined periods.

Despite this, most providers continued an inflexible approach to visits, publicly disagreeing with the Prime Minister and National Cabinet, to which threatened to legislate to ensure compliance if providers did not voluntarily follow the National Cabinet guidelines. The media correctly interpreted this as a standoff between the Federal Government and providers, which was not helpful to consumers.

In late April, COTA acted decisively to initiate an Industry Code for Visitors. Intense negotiations with provider peak bodies, and consultation with the government, the Commission and other stakeholders took place and after 72 hours of multiple drafts a Consultation Draft was prepared for review by the sector and by the Australian Health Protection Principal Committee (AHPPC) and National Cabinet. The later two endorsed it immediately.

After consultation over the following week and a bit, all aged care provider peak bodies endorsed the Code which was supported by the Australian Government. Since then, the Code has been reviewed by the major stakeholders with various changes predominantly reflecting changes in State Directives, which have now tended to align with the Code, with some variances

At this point we should address the suggestion put to the Commission's Hearing that the Code was development with reference to workforce representatives. This is incorrect. The initial DRAFT of the Code was negotiated between COTA and other Consumer Peaks, and Provider Peaks. That was

because it was providers who were imposing the unreasonable visitor exclusion policies. At the same time other providers were not doing so. Therefore, the issue was with providers. However we then consulted on the Draft Code for a week and in that period workforce representatives (unions) had every opportunity to provide input. COTA specifically reached out to the ANMF at national level and received a written submission on the Draft Code from the ANMF. That was considered in the finalisation of the Code, but in response to a question of whether the ANMF wanted to be as signatory part we received a negative response, because the ANMF advised it had developed its own requirements/Code.

While it is our understanding that the Code has been adopted in principle by the vast majority of providers, led by the peak bodies, nevertheless it is clear today that too many providers are not following the Code in full, or are adhering it to by exception when challenged but not proactively; or are using the existence of a COVID-10 'hot spot' even a substantial distance from them to lock down outside the provisions of the Code.

The worst examples we are hearing from families, and from our colleagues in Dementia Australia, relate to the refusal of some providers to allow family members who had pre-COVID-19 been directly involved in the support of care of a resident, to continue to do so. Also, instances in which the family member may not have been involved in care, but was now willing to do so in the context that the facility now has staff shortages, and/or has "surge staff" who do not know and understand the needs of dementia residents or just don't have time. However they are prohibited from doing so by the provider. As a result, residents are experiencing serious issues such as dehydration, malnutrition, being left long periods in full continence pads, emotional distress and death.

Both the above concerns raise the question of why the Visitor Code is not mandatory? When we originally conceived the Code we proposed it be mandatory. However it became clear provider peaks would not support this, which would at worst have scuttled the idea and at best delayed it significantly. It was also clear that this was not a government preference. So we compromised and got a reasonably effective Code in record time. We later approached the ACQSC about how to give the Code teeth and in due course they published A Fact Sheet on the Code – see https://www.agedcarequality.gov.au/resources/fact-sheet-industry-code-visiting-residential-aged-care-homes-during-covid-19 which inter alia advised that in considering complaints about visitor access the Commission would, in addition to the Standards and Charter, "also give consideration to the provider's application of the Code." We have used this to exert pressure on quite a few providers.

However COTA does believe the Code should be mandatory and is disappointed that the aged care industry leadership does not. Other industries have enforceable Codes. Once again aged care industry leaders have declined to demonstrate best practice and transformative leadership.

If continued non-compliance increases, we will again approach the Federal Government to make the Code a Principle under the Aged Care Act, which would make it enforceable.

Whilst a future review of the Code's value and adherence will be required, it has been successful in:

- providing greater consistency in the overall provider approach to visits, compared to the situation before the Code
- empowering consumers, families and friends and residential aged care staff by providing a clear reference point for enabling visits
- drastically reducing complaints
- supporting some allied health professionals to access residential care facilities to provide essential care for residents
- demonstrating that key stakeholders in the aged care system including government can work together to rapidly introduce a critical policy and practice initiative.

COTA is aware that many providers experience implementation challenges with the Code. These are less to do with the Code itself but more related to other issues including staffing, availability of technology and building design.

Inadequate, confusing or limited communication and information provided by aged care facilities and services to consumers, families and friends and even the general public remains a significant issue. The experience of the pandemic and the development of the Visitor Code has highlighted the vast gap between providers who have effective, consistent communication strategies and those who do not. Communication with consumers and families and friends should become a key criterion in measuring the performance of aged care providers.

The spread of COVID-19 in residential aged care facilities has not come from visitors but from staff. Yet provider's default reaction is to ban visitors, when it should be to redouble and triple efforts and infection control through better staff procedures, training and supervision. Poor balancing the rights of aged care consumers with safety and infection control has been part of the aged care pandemic experience in Australia. The development of the Visitor Code shows that when genuine compassion for, engagement with and understanding of aged care consumers and their families is central to policy making then better outcomes are achieved. But there is much more to be done.

Hospitalisation: Individual Clinical Need not a Blanket Policy

The rights of older people in residential aged care should be the same as all citizens. The experience of the pandemic has reflected existing institutionalised and paternalistic attitudes to this group of older people among parts of the acute health system. The design of the system needs to change, and human rights embedded in new legislation for aged care.

The current rapid increase in COVID-19 outbreaks and deaths in Victorian residential aged care facilities has drawn attention to the issue of whether older residents who contract COVID-19 should automatically be transferred to hospital. Aged care provider peak bodies and some others have argued for this.

COTA argues that the decision of whether to transfer an older person to hospital should be based on clinical need and judgement. It should also consider the views of the older person about their care and be informed by Advanced Care Directives. This decision-making process must happen quickly

and effectively. The resource capacity of aged care facilities and hospitals, whether they be public or private, should not be part of this assessment. Many residential aged care facilities do have the capacity to isolate (or cohort) residents and provide the required clinical care. Transferring residents to hospitals is not always in the best interests of patient health. The process of transfer can lead to further health complications, emotional and physical distress.

COTA is aware that some residential aged care facilities have had a culture, before the pandemic period, of transferring slightly ill older people to hospital based on transferring risk rather than assessing individual clinical need. The situation of older people transferred to hospitals from residential aged care waiting in hospital corridors for treatment has been well documented. In principle, policy and decision-making processes regarding hospital transfers should be consistent regardless of whether they are occurring during a pandemic or public health emergency or not.

There is currently no national consistency in approach to COVID-19 hospital transfers. In South Australia there is a current agreement that all aged care residents who test positive are sent to hospital. We note that this has not been tested in a situation of high levels of community transmission. It is understood that Queensland is considering moving to this approach. The publicly stated positions in Victoria and New South Wales largely align with the COTA view.

The argument for automatic hospital transfers is understandable, particularly during the current demands on aged care facilities and their residents. The assumptions of the argument are that hospitals can provide specialist treatment, have better infection control measures (i.e. most aged care facilities are not designed like hospitals) and have nurses more highly trained in infection control. Whilst these assumptions are often true, individual clinical need and assessment should still be the key driver of decisions to transfer. Many residential facilities have demonstrated excellent infection control measures, do have adequately trained nursing staff and can isolate residents who test positive. In Victoria at this current time, the additional workforce resources and improved coordination provided by the Aged Care Response Centre should enable more residents who test positive to remain in their facility.

Some of the advantages of undertaking an individual clinical need approach are that:

- older people benefit from carers who know them, and they have a relationship with. For example, it can be detrimental to move people with dementia away from a familiar environment and established carers can be aware of issues that trigger behaviours that are difficult to manage. The assessment could therefore be that optimum care can be provided by remaining at the facility.
- respect for the autonomy and wishes of the older person and their families. For example, older people may have stated in an Advance Care Directive that they do not want to be transferred to hospital regardless of whether they have a life-threatening illness. Alternatively, older people may wish to be transferred to hospital regardless of the capacity and expertise at the residential aged care facility.

Decisions about hospital transfers from residential aged care, highlighted by COVID-19 outbreaks, should be based on individual clinical need and assessment and not a blanket policy approach. In addition to clinical issues, the rights and intentions of older people, sometimes

provided in Advance Care Directives, should be respected unless they would constitute a clinical threat to other residents.

Aged Care and State Health Interface

The COVID-19 pandemic has exposed the policy and decision-making challenges of our Federal system reflected in impractical demarcated roles and responsibilities between jurisdictions on how to provide the best health outcomes for older people living in aged care settings. Confusion, poor communication and information, false assumptions seem to hamper important decision making and development of a collaborative approach between Federal and State regarding COVID-19 outbreaks in aged care facilities. Perhaps, in hindsight, the Aged Care Response Centre currently operating in Victoria should have been planned implemented in all major state jurisdictions to improve coordination and effective decision making. We welcome the fact that this has now occurred and will be a model into the future.

The Royal Commission explored this issue before the onset of the pandemic back in late 2019. The responsibility for the management and funding of aged care sits with the Federal Government whereas responsibility for various levels of health care is complex but largely managed by State Government departments or a function of independent health practitioners such as GPs. Before its hearings, the Royal Commission rightly concluded that there is considerable regional variation in services available on the ground, and little evidence of a systematic approach to providing health care to people in the aged care, particularly residents in facilities.

Coordination and communication difficulties between jurisdictions and systems regarding aged care and health care are not new. Many practical improvements have been implemented including in-reach services to residential facilities. However, barriers remain and have been extenuated during the pandemic period. Residents in aged care facilities have been denied access to regular health care from allied health professionals who have had difficulties entering facilities. Older people living at home have been unable or reluctant, frightened and afraid to attend important health care appointments.

Despite some confusion in information and policy between the Federal and State Government Health departments, residential aged care providers should have effective infection control and public health emergency plans that have been trialled and tested and be able to demonstrate the implementation of these plans. Governance and management of aged care providers should have adequate expertise and experience to make decisions whilst being aware of the broader government jurisdictional overlap.

Access to health care is a fundamental human right regardless of where you live. COTA has been concerned for a long time by a policy mindset that seeks to apply a different set of rights for older people living in residential aged care to the rest of the community able to access mainstream health services. Since the start of the pandemic there have been panicked and inflexible decision-making processes (e.g. the provider approach to visits, provider approach to health care professionals calling on their resident patients, confusion about hospital transfer during outbreaks, conflict in decision-

making about sending all staff of a facility home at once) that seem to reinforce this. It reflects an institutional and paternalistic pattern of thinking rather than a consistent, individual focused approach based on respect and dignity. Federal and State policy and communication protocols should reflect the fundamental human right of access to health care regardless of living circumstances.

In working to improve and optimise infection control and safety, the rights of all older people, regardless of living circumstances or whether they have tested positive to COVID-19, should not be discarded or downgraded. When they are genuinely placed at the centre of policy and decision making, better outcomes are achieved.

Workforce Shortages and Planning

Deep and long-term flaws and gaps in aged care workforce planning and resources have been painfully exposed by the second wave of the pandemic. This has had a devastating impact on the quality and effectiveness of care for many older Australians. Investment in the Aged Care Workforce strategy is truly a matter of urgency.

The pandemic has highlighted, particularly the second wave in Victoria, the substantive workforce issues in the aged care industry. The story of disease spread in residential aged care is now familiar. Workers, often employed by multiple providers, have unknowingly contracted the virus in the community and brought it into a facility. Residents and other staff are tested and found to have contracted the virus. The facility has urgent care and management decisions to make. Large numbers of staff who tested positive must self-isolate and not come to work. Others may not return to work as they do not want to contract the virus. The results in substantial workforce shortages, increasingly the possibility/probability that many older people are denied regular care. It is interesting to note that most outbreaks in residential aged care have originated from staff and not family and friends visiting facilities.

The issues with the adequacy, competency, skills, training and remuneration of the aged care workforce have been well documented and discussed including at hearings of the Royal Commission. It is not the intention of this submission to explore these. COTA argues, in a range of submissions, that it is critical and urgent for the Aged Care Workforce Strategy recommendations to be implemented. This is one of the top priorities for aged care reform and the experience of the pandemic also make this abundantly clear.

To what extent could the need for a surge or replacement aged care workforce be better predicted or planned for? It is possible that with more comprehensive testing of aged care workers as part of a broader mandatory health worker testing strategy or blitz, some outbreaks could have been prevented? Perhaps, the lull between the first wave of the pandemic that had a substantive impact on a small number of facilities mostly in New South Wales and the second wave concentrated in Victoria, may have provided an opportunity for this. Our understanding is that there was no appetite for this in health circles. The COVID-19 testing of the aged care workforce should have been as much a priority as the mainstream health care workforce.

A surge workforce has been required and was organised early by the Commonwealth. Funding is available and the Federal Government is working with State and Territory Governments and aged care providers to support Victoria. This is utilising resources mostly from state health systems and coordinated through the Aged Care Response Centre.

In hindsight, this is reactive but also responsive. There is more to be learnt about the challenges in making high level decisions to respond to the pandemic. In a Federal system like Australia, decisions and actions by the Federal Government can be interpreted as national leadership or interference. The creation of the National Cabinet has provided a mechanism for important decisions to be made, endorsed by both Federal and State governments. The National Cabinet did not exist before the pandemic and was created because of it. COVID-19 has had a disproportionate impact on aged care but has had fundamental implications for all our society that may not have been foreseen.

Key Messages

- Older Australians, whether they are living in residential aged care, receiving home care packages or living in the community, bear among the largest burden of this pandemic, both now and for many years after the clinical severity of the disease has subsided.

- Residential aged care providers have a considerable level of responsibility for failures in aged care highlighted by the COVID-19 pandemic. Current evidence provided to the Royal Commission, media coverage and public debate does not reflect this.

- The impact of the pandemic on older people in aged care and the failures of both government and providers to plan and respond should not be used as a rationale to prioritise the dismantling of the current aged care system governance architecture. This would be time-consuming and counterproductive for reform.

- Initial reform priorities are for substantial resources for ending home care packages wait times and implementing the Aged Care Workforce Strategy combined with abolishing the ACAR, increased powers for regulation and compliance, and changes to place consumer engagement at the heart of organisational and systemic governance.

- COTA played a pivotal role in the initiating the formation of the voluntary Visitor Code which has now been endorsed by most aged care providers enabling greater consistency and compassion to visits by families and friends to residential aged care and avoiding a protracted dispute between aged care providers and the Federal Government. COTA agreed to the Code being voluntary in or=der to get it accepted rapidly, but COTA believes it should be mandatory and the resistance to this by providers demonstrates once again a lack of transformative leadership.

- Decisions about hospital transfers from residential aged care, highlighted by COVID-19 outbreaks, should be based on individual clinical need and assessment and not a blanket policy approach. In addition to clinical issues, the rights and intentions of older people, sometimes provided in Advance Care Directives, should be respected.

- The rights of older people in residential aged care should be the same as all citizens. The experience of the pandemic has reflected an existing institutionalised and paternalistic attitude to this group of older people among parts of the acute health system, The design of the system needs to change, and human rights embedded in new legislation for aged care.

- Deep and long-term flaws and gaps in aged care workforce planning and resources have been painfully exposed by the second wave of the pandemic. This has a devastating impact on the quality and effectiveness of care for many older Australians. Investment in the Aged Care Workforce strategy is truly a matter of urgency.

- In working to improve and optimise infection control and safety, the rights of all older people, regardless of living circumstances or whether they have tested positive to COVID-19, should not be discarded or downgraded. When they are genuinely placed at the centre of policy and decision making, better outcomes are achieved.