Due: 31 August 2023

Re: Consultation Paper on the Pricing Framework for Australian residential Aged Care Services 2024 - 2025

Submitted via Email: submissions.ihacpa@ihacpa.gov.au

The Public Sector Residential Aged Care Leadership Committee is thankful for the opportunity to present this submission, enabling feedback on the Pricing Framework for Australian Residential Aged Care Services 2024 – 2025.

About the Public Sector Residential Aged Care Leadership Committee (PSRAC LC)

Public Sector Residential Aged Care (PSRAC) is a priority service in Victoria, supporting approximately 5,500 residents in more than 180 Victorian government aged care facilities. To ensure older Victorians receive the best possible care, the Victorian Government established the PSRAC LC in 2012 - an advisory body comprised of Directors of Nursing (DON) from the 3 state-wide public sector Director of Nursing (DON) committees - metropolitan, regional, and small rural.

The purpose of the PSRAC Leadership Committee is to represent Victorian public sector Director of Nursing Groups and consumer interest while offering a mechanism for providing leadership, advocacy, promotion of quality care, influencing decision making and creating an avenue for information exchange with the Victorian Department of Health, Safer Care Victoria, Health sector unions, education institutions and consumers. We are a body who are positioned to advocate and voice matters specific to public sector aged care residents staff and providers.

About Victorian Public Sector Residential Aged Care (PSRAC)

The Victorian public health system operates 9% of residential aged care beds across Victoria, consisting of 174 facilities (54 low care facilities and 120 high care), totaling approximately 5,500 beds across the state. 9 of the 174 sites are multi-purpose services and approximately 80% of PSRACS are in rural and regional areas.

In several rural areas, PSRACS are often the only aged care provider in the town. And as such, have a significant community benefit and play an important economic role. In metropolitan areas, many PSRACS facilities are specialist aged person mental health units. This is unique to Victoria, and it is interesting to note that the specialty of aged persons mental health is not recognized in the AN-ACC specialties. Public Sector Residential Aged Care employs approximately 10,000 staff.

The cohorts in Victorian PSRACS are among the most complex and vulnerable people requiring care for older persons. This is a result of clients with complex and challenging comorbidity or social circumstances, finding it difficult to be accepted in the private sector. The acuity of Victorian aged care residents assessed as 'high' for Complex Health Care grew from 12.7% in 2008-09 to 90.4% in 2019-20, outlining the complex skill set of public sector residential aged care staff.

Feedback on the Consultation Paper - Pricing Framework for Australian residential Aged Care Services 2024 - 2025

Thank you for the opportunity to comment on the pricing framework 2024-2025. In the context of this engagement opportunity, we would like to start by returning to currently available financial performace data that outlines just over half (57.7 per cent) of residential aged care providers reported a net profit before tax in quarter two (based on isolated quarter 2 results), compared to 33.9 per cent of providers in quarter one[1]. This data indicates that current funding of aged care is moving in the right direction, yet many providers still operate at a loss of $12.66 per resident per day. The data may be suggestive that

[1] Quarterly Financial Snapshot of the Aged Care Sector – Quarter 2 2022-23 (health.gov.au)

operators in the profitable area are those positioned to utilize economies of scale. For example, large corporate entities. We would also like to point out that public sector residential aged care operates with additional costs due to the requirement to work within the Safe Patient Care Act and the defined nurse patient ratios. Whist this enables the public sector to outperform the private sector in staff metrics shown the QFR and 5 star ratings, this comes with considerably steeper operating wage cost. To meet the requirement of the Safe Patient Care Act, PSRACS employ nurses to provide many direct care activities, as well as having nurses in senior positions, as opposed to private and not for profit employing the unlicensed care worker as the primary workforce. This factor is not harmonized against contemporary staff minute mandates and the AN ACC funding.

As requested in the consultation paper, the PSRAC LC will focus our paper on the questions raised. We do not intend to answer each question. Please see our responses to question one, two, four and seven.

Question 1-

What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

The PSRACS LC feel that the following units of care need or activity fit several if not all elements within the residential aged care pricing principals:

- Administration costs relating to Quarterly Financial Reporting, (QFR).
- Management of Clinical Quality Indicator Data.
- The administration and governance of reform.
- Management of restrictive practice, frequent consultation and review process.
- Public care for bariatric, justice, severe behaviours older persons mental health.
- Re ablement – explore how sub-acute rehabilitation streams present opportunity for overall health care system efficiency in the aged care setting.
- The role of nurse practitioner models in aged care in efficient use of the health care system.
- The interface with the Victorian Public Sector Safe Patient Care Act and associated value and cost of operating this model that is not funded under AN ACC.
- The reccognition and importance of a holistic, person centered approach providing social and emotional care, not in AN ACC funding.

The above concepts are relevant to both the principals, care requirements and are opportunities to create value, harmonise, and provide efficient accessible quality care that it fair and equitable to all, including marginalised client cohorts.

Question 2 -

Do the current Australian National Aged Care Classification (AN-ACC) classes group residents in a manner that is relevant to both care and resource utilisation? (That is, require the same degree of resources to support their care delivery). What evidence is there to support your answer?

CARING FOR PEOPLE LIVING WITH COGNITIVE IMPAIRMENT

The PSRACS LC strongly suggest AN-ACC be revised to better reflect the complexity of caring for older persons with memory loss, confusion, and advanced deterioration of a cognitive state. Looking at the AN-ACC table, a non mobile client with pressure care risks and additional comorbidity are among the highest funding class (Class 13). Caring for immobilised and at risk clients in class 13 is valid and requires complex skill, resources and time. However the PSRACS LC advise that the complexitiy, the difficulty and the significant level of resource required to care for ambulatory persons with advanced and complex cognitive impairment, using a best practicve and evidenced based approach, is poorly understood in the context of cost, and highly under recconised in the AN-ACC funding model.

The Australian Institute of Health and Welfare (AIHW) reccognise the impact of dementia and complex care[2], and discuss the high rates of residential aged care clients living with dementia, along with other complex comorbidity and pallitave conditions.

[2] Dementia in Australia, Residential aged care - Australian Institute of Health and Welfare (aihw.gov.au)

The AIHW acknowledge the Royal Comision Report into Aged Care, stating caring for persons with dementia is becoming increasingly difficult and is overlayed in unmet needs via symptoms of aggression and agitation toward residents and staff. Dementia clients are commonly involved in incidents contributing to occupational violence and aggression and are predominant in a high incidence of the 'excessive use of force' reports category in serious incident response scheme (SIRS) involving people living with dementia[3].

Occupational violence in the aged care setting is widespread, yet largely unrecognised as an OHS problem. Staff believe that resident violence is an inevitable part of the job[4], and it is speculated that incident data does not reflect the volume of violence against health care workers when caring for persons with dementia[5]. It would be prudent for IHACPA to understand and consider the true impact and cost of caring for persons with complex dementia.

Whilst peak bodies are continuing to lobby for education of workforce to reduce OVA, it will be difficult to achieve desired outcomes with inadequate funding for staff numbers. In addition, more could be done to understand the sector by reporting on work health and safety data, work cover claims, absenteeism, moral, staff attitude toward work, and attrition, as a line of enquiry to quantify the impact and validate the indirect costs of caring for this cohort[6]. It is suggested that with adequate funding, staff would be less burnt out and increase staff capacity to work regularly caring for higher needs dementia clients.

Providing safe quality dementia care extends to prevent and manage verbal and physical harm to other residents [7]. By correctly funding and resourcing best practice dementia care, the PSRACS LC believe this could lead to a reduction in serious incident events, particularly the excessive use of force incidents, and an improvement in workforce factors as outlined above.

Adequate funding could provide safer, more person-centred rostering of appropriately trained staff to provide closer direct and specialised care[8]. It is suggested and advocated that appropriate resourcing and recognition of this speciality need will result in the reduction of SIRS incidents and will do more to protect vulnerable care community members in the residential setting.

According to the most recent Aged Care Quality and Safety Commission Sector Performance Report, March 2023[9]; the category for unreasonable use of force (where resident to resident verbal and physical aggression is recorded) remains the single most repetitive and trending concern. Resident to resident aggression remains on the increase despite mandatory care minutes, 24 /7 Registered Nursing, and improved AN-ACC tariffs.

See illustrations and table below excerpted from the March 2023 ACQSC sector performance report. Attempts to support and protect residents from excessive use of force are articulated in the Weekly Source, making suggestions that staff should be doing more[10] however, when simply put, funding and appropriate staff numbers for this complex care area is insufficient[11].

[3] Regulator releases case study report to help providers manage 'unreasonable use of force' cases (theweeklysource.com.au)

[4] View of A protocol for responding to aggression risk in residential aged care facilities (ajan.com.au)
[5] Occupational violence in aged care - ScienceDirect
[6] Reduction of aggressive behavior and effects on improved wellbeing of health care workers and people with dementia: A review of reviews - ScienceDirect
[7] Resident-to-resident aggression in Norwegian nursing homes: a cross-sectional exploratory study | BMC Geriatrics | Full Text (biomedcentral.com)
[8] Best Practices in Dementia Care: A Review of the Grey Literature on Guidelines for Staffing and Physical Environment in Long-Term Care | Canadian Journal on Aging / La Revue canadienne du vieillissement | Cambridge Core
[9] Sector Performance January–March 2023 (agedcarequality.gov.au)
[10] Regulator releases case study report to help providers manage 'unreasonable use of force' cases (theweeklysource.com.au)
[11] Best Practices in Dementia Care: A Review of the Grey Literature on Guidelines for Staffing and Physical Environment in Long-Term Care | Canadian Journal on Aging / La Revue canadienne du vieillissement | Cambridge Core

January - March 2023
Total Resident to Resident Aggression incidents - 7704

Resident to resident aggression incidents per 10,000 occupied bed day
Jan – Dec 2022 - 3.90
April 22 – March 23 – 4.12

SIRS notified incident rate (per 10,000 occupied bed days)

Incident type	1 Jan 2022 – 31 Dec 2022	1 Apr 2022 – 31 Mar 2023
Unreasonable use of force	3.90	4.12

Reference: Sector Performance Report Aged Care Quality and Safety March 2023

BEST PRACTICE - RESTRAINT FREE ENVIRONMENTS

The PSRACS LC are pleased to have the restraint free guidleines[12] in place to ensure all persons living in residential aged care enjoy the least restricitve environment possible. But in doing so, the unintended consequence of such is confused and wandering residents in large and vast facilities, which places residents in a position of vulnerability, often triggering aggravated incidents. Hence the above data impact with resident to resident agression is further compounded.

To properly cater to persons living with dementia in a least restrictive way, means significant infustructure, and building design that is safe, secure, purpose built, with important home like features that are familiar. In an environment with the right ammount of correctly trained staff and leadership[13], [14]. This requires appropriate attention and pricing to be considered.

Question 4 –

Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry into or departure from a service.

The PSRACS LC would like to recommend.

- The need to include respite admissions in the ANACC one-off payment.
- The need to consider activity-based costs involved with managing resident departures.

Our rationale is detailed below.

CLIENT ENTRY

Many services operate preadmission meetings with the new resident, and their family that comprise of clinical engagement, welcome and a sense of community. The family and /or resident are free to talk at length, feel heard and reassured that the care needs are being shared and a partnership in care is being nurtured.

At the facility, this is a lengthy process that can take several hours. The nursing staff leading the meeting must have robust communication skills to effectively listen, act, lead and unpack personal and clinical information and do so with sensitivity, clinical reasoning, and risk mitigation skills. A key feature of such a meeting point in the care journey is an understanding that

[12] Minimising the use of restrictive practices | Aged Care Quality and Safety Commission
[13] Special Care Facility Compared with Traditional Environments for Dementia Care: A Longitudinal Study of Quality of Life - Reimer - 2004 - Journal of the American Geriatrics Society - Wiley Online Library
[14] Korongee Dementia Village | University of Tasmania (utas.edu.au)

consumers at the meeting are often always experiencing grief and loss. Often families are overwhelmed, feel guilt, or anxiety or information overload. This reiterates the requirement for clinical expertise, and dedicated time.

The preadmission meeting is a matter for experienced clinicians who are equipped to map care, practice advanced consumer engagement and communication and leadership skills in care planning and team handover; as well as educate clients and families about process, clinical support, and the facility. The nurse is highly experienced, with leadership qualities and has an in-depth knowledge of the aged care system, the local service and experience with nursing older persons.

The preadmission clinic supports care planning, timely referrals, ensuring all required specialised equipment is ready before arrival day, that the team have a safe handover and that medication management, medical practitioners, and pharmacy are organized before arrival. This time investment by the provider serves as family support and education with opportunity to answer complex questions. But is also an important safety and quality feature of the clinical journey.

The cost of operating a preadmission clinic is considered to some extent in the activity based funding (ABF) - one off payment. The PSRACS LC would strongly advocate that this funding also be available to respite clients. Respite clients are extremely vulnerable, may have been experiencing a social or safety crisis and families are often exhausted. This situation presents a risk of missed opportunity to provide high level of care due to potential lack of information. This is parallel to recommendations from the Victorian Institute of Forensic Medicine, who suggest a respite client's admission process and care planning should be no different to a permanent entry to care, and as such should attract the same one off payment as a permanent resident, to build therapeutic relationships, correctly identify and assess care needs, plan and manage clinical risk, and to promote a strong sense of person centered welcome and belonging.[15]

DEPARTURES

The PSRACS LC agree there are considerable unavoidable costs associated with departures. This can range from handover and medication management / liaison between pharmacy and patient or another service provider; to managing bereavement.

Occurring as foundation care, the process involved with bereavement and breaking bad news to relatives, answering questions, dealing with heightened emotional states requiring advanced emotional support skills including holding staff debriefing and support sessions is paramount. This area falls to the nurse in charge who is also handling routine care of others, performing supervisory duties and coordinating after death care and transfers for someone who has passed. Not all residents pass under the portfolio of a palliative admission at the class 1 tariff. This work will often be underfunded, under resourced and the value of this work diluted.

An acknowledgement by the work of IHACPA on the advanced skill set and complex workload associated with care of persons who have passed in the residential setting may inform better resourcing, support and have flow on improvements for workforce retention and attraction to the complex area of specialised bereavement practice[16],[17].

This essential care for the community and relatives is different to direct clinical care during the terminal phase where funding is reccognised. With aged care being predominately a nurse led environment, thoughtful consideration of the care of the person, and the family following death, may not be reccognised in the funding model and is worthy of review.

Question 7

What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?

[15] RCD.9999.0063.0145.pdf (royalcommission.gov.au)

[16] When someone dies in Residential Aged Care - Grief and Loss for Families (flinders.edu.au)

[17] rapid review of the literature on end-of care in aged care and community settings - final - word accessible - march 2023.docx (live.com)

The PSRACS LC see opportunity to develop understanding and efficiencies for the ethical and equitable care of persons from marginalised groups that require specialised services such as:

- Advanced dementia care
- Aged persons mental health
- Severe behaviour supportive care
- Bariatric care
- Care of persons from the judicial system

The PSRACS LC believe there is scope to acknowledge and properly cater to these marginalised groups in the same human rights approached way that we embrace diversity and humanity overall. These groups take greater resourcing weather this be in clinical therapeutic interactions, knowledge and expertise, and, safety and security or equipment.

Bariatric equipment comes at a greater financial investment. Further, bariatric persons require up to 4 and sometimes five staff to safely support activities of basic living at any one time, in particular for mobility, hygiene or toilet care. Without funding and staffing, and entire team of staff are in one room for one client for an extended period, this is meaning other clients are otherwise waiting for care, or are left unsupervised, and places stress on staff.

Advanced Dementia care as discussed earlier requires proactive and specialised support in the right numbers to enable the safe environment for residents and staff alike. In order to effectively prevent and manage the behavioural symptoms of dementia, and the safety and security of other residents.

Mental health residents also require specialty approach, specialty staff education, and the right environment to minimize the impact of a symptomatic episode on other residents and to ensure staff are safe in the course of their work. This group would be similar to caring for persons aging out of the judicial system, where existing clients can become fearful, and concerned for the social and safety impact on their family friends and selves.

Residents with judicial, mental health or severe cognitive impairment backgrounds, at times require 1:1 supervision until acute concerns settle. According to the AIHW, the most common cause of incarceration for older prisoners is sexual assault [18]. Older prisoners find it very difficult to find supportive housing once their sentences are completed[19]. This adds significant strain to already stretched prison budgets. Further, these people are an easy target for discrimination balanced with a risk of re offending. And a such requires a robust support structure and funding model.

AN-ACC could consider weather 1:1 care for safety and security of others can be claimed as a supplement to support providers who provide care for marginalised groups, such as older persons from the judicial system, older persons mental health and serious behaviours arising from complex cognitive impairment. Providers already shoulder these care activities, to maintain a safe environment without appropriate recognition or financial support.

IHACPA could consider the above as opportunities to support flow in care provision for the wider health care environment, thus ensuring the right care for patients are occurring in the right place. If offered as additional needs-based subsidies and supplements could motivate providers to offer professional and high-quality specialised services. With appropriate funding and support frameworks these subspecialties could create interest and scope for workforce practice enhancement, workforce specialisation, greater career pathways and enhanced attraction to the sector.

Patients living with conditions requiring specialty support could be offered greater access to long-term care rather than remaining in acute services due to lack of staff, or suitable safe plant, equipment, or staff numbers.

[18] Older Australians, Justice and safety - Australian Institute of Health and Welfare (aihw.gov.au)
[19] Elderly sex offenders clog Australian jails, but struggle to find housing once released - ABC News

In close the following recommendations are made to strengthen the IHACPA review 2024-25

- Consider that slightly under half of Australian Providers continue to operate at a loss.
- Consider the operating costs of Victorian Public Sector Facilities that incur wage costs that exceed ANACC tariffs due to the Safe Patient Care Act.
- Be orientated to the clinical data sets collected by nurses for the purposes of QFR and Quality Indicators detract from care minutes and AN ACC funding, and whist are a requirement in the ever-growing reporting framework, are not reccognised as valuable and skilled quality activities in the funding.
- Review via the AN ACC tariffs, the complex and comprehensive paperwork required for caring with persons whom require least restrictive practice protocols and the associated paper work and consultation when nursing persons with complex wandering associated with memory loss.
- Consider efficiency and options for nurse practitioner roles in aged care, and associated subsidies of offering such a service.
- Consider efficiency and access in relation to offering funded re-ablement programs within aged care facilities.
- Reccognise the additional costs of caring for complex and marginalized groups that require greater staff to resident ratio such as complex cognitively impaired, bariatric, and judicial system clients.
- Improve and reccognise the needs of older person mental health under the AN ACC model.
- Acknowledge the opportunity that aged care providers could relieve pressure from acute facilities and the health care system overall if adequate funding supported providers to build capacity and broaden its scope.
- Review the weighting against the use of the behavior resource utilisation assessment (BRUA) to enable appropriate care for persons with cognitive impairment.

The PSRACS believes that our feedback is in line with the overarching consistency with the aged care pricing principals as outlined on page 13 of the consultation paper. Thank you for taking the time to read our thoughts and please feel welcome to be in touch if you would like to discuss our submission in more detail.

Yours sincerely,

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[redacted]