ACSA
Aged & Community Services Australia

ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

RESIDENTIAL CARE SUBMISSION

8 May 2019

ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting over 700 church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.[1]

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant $17.6 billion economic contribution to Australia, representing 1.1% of GDP by producing outputs, employing people and through buying goods and services. The direct economic component is akin to the contribution made by the residential building construction and sheep, grains, beef and dairy cattle industries.[2]

ACSA members are important to the community and the people they serve, and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

ACSA CONTACTS

Patricia Sparrow, Chief Executive Officer
Aged & Community Services Australia
Level 9, 440 Collins Street
Melbourne VIC 3000
(03) 9607 1395
Patricia.Sparrow@acsa.asn.au
www.acsa.asn.au

Derek Dittrich,
State Manager SA/NT
Policy and Member Advice Manager
Aged & Community Services Australia
Building 3, Level 1
32-56 Sir Donald Bradman Drive
Mile End, South Australia, 5031
(08) 8338 7111
Derek.Dittrich@acsa.asn.au
www.acsa.asn.au

[1] Australian Government, Department of Health, Report on the Operation of the *Aged Care Act 1997*, December 2016.
[2] Deloitte Access Economics, Australia's aged care sector: economic contribution and future directions, Aged Care Guild, June 2016, page 24.

INTRODUCTION

Residential aged care is an important service for older Australians and their loved ones. 'Care' has been described as a cultural necessity for life[3]. Aged Care also makes a significant economic and social capital contribution to local communities.

Residential aged care services began in the form we recognise today, in the 1950s, with the formation of several private nursing home facilities. In the early 1960s a direct public subsidy for each nursing home bed was introduced. Growth occurred in the aged care market through to the mid-1980s at which time regulation of the market occurred. At this time there was also a move to providing alternatives to residential care and from this grew community-based options along with the introduction of Aged Care Assessment Teams as the gatekeeper.

In the late 1990s the development and implementation of accreditation for residential care occurred.

Early in the current decade a significant review by the Productivity Commission occurred with the release of the Caring for Older Australians Report[4], subsequently followed by the Living Longer, Living Better reform program with its emphasis on consumer directed care. The sector responded mid-decade with the Aged Care Roadmap with its emphasis on a 'consumer directed, market driven approach[5]'.

Whereas early aged care beds were said to be provided by mostly private for-profit homes[6] there has been a progressive shift towards a higher proportion of subsidised not-for-profit (NFP) services. Not-for-profit service providers also tend to deliver a far greater proportion of services in regional, rural and remote locations.

The demographic makeup of people coming into aged care in Australia has changed across the past decade or more, with those entering today now older and more frail than ever before, with more complex health conditions, requiring palliative care or living with dementia. These residents are staying for shorter periods of time and require more broad ranging clinical care – along with access to the full breadth of health care services.

Residential care is also a social model of care and providers are concerned to ensure that each resident is treated as an individual, able to exercise their rights and make choices that give meaning to their lives. Residential care providers seek to do this within a system

[3] The marketisation of care: Global challenges and national response in Australia, Fine M. et al, Macquarie University, Australia, 2018, Abstract

[4] Caring for Older Australians, Productivity Commission Draft Report, Productivity Commission, Australian Government, January 2011

[5] Aged Care Roadmap, Aged Care Sector Committee, 2016

[6] The marketisation of care: Global challenges and national response in Australia, Fine M. et al, Macquarie University, Australia, 2018, p7

that is designed, funded and regulated by the Commonwealth Government - a system where funding has not kept pace with the cost of meeting resident needs and community expectations, and where regulation is yet not evidence or outcome based.

Currently there are approximately 210,000 operational residential aged care beds in Australia[7]. In 2016-17 239,000 older Australians received services through 902 residential care providers[8]. See Table One for sector profile by ownership type.

Table One: Providers by ownership type 2016-17[9]

Year	Not for Profit	For Profit	Government
2016-17	56%	33%	11%

Total Australian Government expenditure in 2016-17 for residential aged care was $11.9 billion. Residents contributed around $4.5 billion to their living expenses, care and accommodation[10].

Most people (95.4%) living in residential aged care were aged 65 years or more, though the split across age groups differed for men and women, with women living in residential aged care tending to be older than men. Around two-thirds (65.6%) of all women living in residential aged care were over the age of 85 years (compared with 45.0% of all men), whilst, proportionally, there were more men than women living in residential aged care in all other age groups[11].

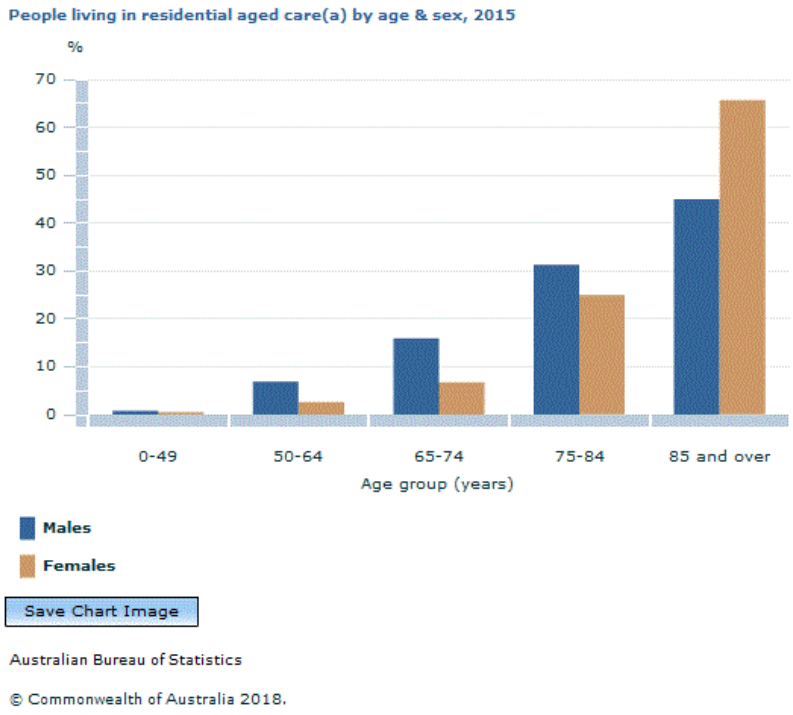
[7] Stocktake of Australian Government Subsidised Aged Care Places and Ratios as at 30 June 2018, Department of Health, Australian Government, 2018

[8] Sixth Short Form report on the Funding and Financing of the Aged Care Sector July 2018, Aged Care Financing Authority, Australian Government, pvii

[9] Ibid, p26

[10] Ibid, ppv-vii

[11] Australian Bureau of Statistics, Summary of Findings 2015, Residential Aged Care, Commonwealth Government of Australia, Nov 2018



Footnote(s): *(a) Includes people in nursing homes, aged care hostels and cared components of retirement villages.*

Source(s): *ABS Survey of Disability, Ageing and Carers: Summary of findings–2015*

In 2015, most people living in residential aged care had a disability. Disabilities can be broadly grouped depending on whether they relate to functioning of the mind or the senses, or to anatomy or physiology, and people may have one or more disabilities from different disability groups, see Table Two.

Table Two: Disability type experienced by people living in residential aged care in 2015[12]

Disability type	Percentage
Physical Disability	88%
Psychological Disability	73%
Dementia	50%

- 96.9% of men have a profound/severe disability
- 98.1% of women have a profound/severe disability

[12] Ibid

The only reason aged care providers exist is to deliver care and support services designed to help older Australians live a meaningful life regardless of where they live. Some not for profit providers also deliver a range of human services, including disability services.

Through this submission, ACSA aims to outline how residential care operates and outline examples of innovative practices in dementia care. This submission will also demonstrate to the Commission the challenges aged care providers face and how they expend the taxpayer funds entrusted to them to deliver care.

DELIVERING RESIDENTIAL AGED CARE

The Australian Government subsidises aged care facilities to deliver the care and services outlined in the Specified Care and Services Schedule (the Schedule)[13] and to keep costs reasonable and affordable for older Australians. The level of subsidy for each resident is based on their assessed individual care needs.

The care and services delivered to a resident are prescribed in the Schedule including (but not limited to):

1. Part 1: Hotel Services – administration, maintenance of building and grounds, furnishings and bedding, general laundry, toiletries goods, meals and refreshments, social activities (lifestyle program support, either 1:1 or group) and emergency assistance largely funded through the basic daily fee paid by residents[14] and set at (equivalent to) 85% of the single person age pension.

2. Part 2: Care and Services – daily living activities assistance, meals and refreshments (special diets not normally provided), emotional support, treatments and procedures, recreational therapy, rehabilitation support, assistance in obtaining health practitioner support and assistance in obtaining access to specialised therapy services funded through ACFI subsidies.

3. Part 3: Care and Services – bedding materials (including incontinence sheets, ripple mattresses, sheepskins etc.) goods to assist the resident to move themselves, goods to assist staff to move residents, goods to assist with toileting and incontinence management and nursing services, again largely funded through ACFI subsidies.

A person's care needs are assessed using the Aged Care Funding Instrument (ACFI), which incorporates an extensive assessment process. The cumulative score gained across

[13] Care and services in aged care homes, Information for Approved Providers, Department of Social Services, Australian Government

[14] Noting there are some residents that are not required to pay the basic daily fee – see 'steps to enter an aged care home', My Aged Care, Australian Government, June 2018, p12

three domains (Activities of Daily Living (ADLs), Behaviours (BEH) and Complex Health Care (CHC) is tallied and the total score determines the level of daily funding received. This component of funding is referred to as the basic subsidy rate[15].

Table Three: Daily (ACFI) basic subsidy rates*

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	$0.00	$0.00	$0.00
Low	$37.16	$8.49	$16.48
Medium	$80.92	$17.60	$46.95
High	$112.10	$36.70	$67.79

*In addition to the Daily ACFI subsidy rates above, a Quality Care Fund subsidy is being paid to providers to assist transition to new quality standards. Again, in addition to the daily ACFI rate a $320 million temporary general subsidy boost will be paid as an additional daily ACFI. As these two subsidies are temporary boosts to subsidy levels that both complete on 30 June 2019 they are not included in our funding examples provided below. To view the subsidy rates for these, see **Appendix A**.

*In addition to the basic subsidy rate government provides a range of supplements to providers for specific purposes, for example oxygen therapy and enteral feeds, for the rates for these supplements see **Appendix B**.

Accommodation costs and prudential arrangements

In addition to the requirement to contribute to the cost of care and services, consumers of residential aged care services may also be required (dependent on means testing assessment) to contribute to the cost of their accommodation[16]. The level of contribution broadly fits into the following:

- No accommodation costs, if assets are below a certain amount, in which case the Government pays;
- An 'accommodation contribution' where a resident needs to pay for part of their accommodation; and
- An 'accommodation contribution' where the resident needs to pay the full cost of their accommodation. A price is negotiated with the service provider.

The resident, where required to contribute to, or pay for, their accommodation has a choice as to how they will pay, with a variety of options available[17].

Accommodation contributions have been a cornerstone of the Government's approach to providing a mechanism for the sector to fund refurbishments and capital infrastructure developments. This approach is vital for the sector to be able to provide for the anticipated growth in demand for aged care places into the future, anticipated to

[15] Schedule of Fees and Charges for Residential and Home Care: From 20 March 2019, Australian Government Department of Health

[16] Steps to enter an aged care home, My Aged Care, Australian Government, June 2018

[17] Ibid, p15

be an additional 88,000 places over the next decade, with an investment required in the order of $54 billion[18].

These accommodation contributions are refundable to the resident or their estate when the resident leaves the service. In the mid 2000's the Government introduced a Prudential Guarantee Scheme to protect these refundable accommodation payments. Government guarantees the repayment of these monies should the approved provider default on their payment. Over the life of the Scheme, some thirteen years, the industry default rate has been approximately 0.2%, or $43 million out of a current Bond Pool of approximately $25 Billion[19]. The Government has always had the ability to impose a recovery levy on the sector for these default events, but to date has chosen not to do so. This is changing with a move to a mandatory levy imposition on the sector should certain criteria be met.

Recently the Government has undertaken a review of the Prudential Guarantee Scheme with a view to 'strengthening the protections' within the Scheme.

We believe there are some risks to the operations of providers associated with the recommendations outlined in the Government's discussion paper[20]. We outline these risks in our submission to the Department of Health, available here.

In this submission to the Commission we have limited our focus to care and services funding but ACSA will make a subsequent submission on the matter of Accommodation Charges and related prudential matters.

Care and services funding

On average the government subsidises each resident approximately $65,000[21] per annum. The maximum care funding is $79,000 per annum.

Residents are expected to contribute to the cost of their care if they are able to do so. Eligibility to contribute is determined through an assets and income assessment undertaken by either the Department of Human Services (DHS) or where appropriate the Department of Veterans Affairs (DVA). Where a person is deemed eligible to contribute they can be asked to do so:

- A Basic Daily Fee – this covers living costs such as meals, cleaning, power and laundry, heating and cooling. Everyone can be asked to pay this fee which is set at

[18] Sixth Report, Short Form Report, Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018

[19] Review of Refundable Accommodation Payments, Aged and Community Services Australia, Submission to Department of Health, March 2019

[20] Managing Prudential Risk in Residential Aged Care Discussion Paper, Department of Health, Australian Government, 2019

[21] steps to enter an aged care home, My Aged Care, Australian Government, June 2018

85% of the single person rate of the basic aged care pension. This currently equates to $51.21[22] per day.

- A Means Tested Care Fee – if a person's assets and income are over a certain amount they can be asked to contribute towards the cost of their care, determined by an assets and income assessment (there are provisions for certain categories of veterans). Those that meet thresholds will co-share this payment with government, with any consumer contribution commensurately reducing the level of government contribution.

- Fees for Extra and Additional Services – some residents may have to pay extra if they choose a higher standard of accommodation or additional services that are above assessed care needs or the care and services the home must provide to them.

People come in at a later stage of their life to residential aged care and are likely to require a greater level of support and care, we know for example that care needs have in fact increased over time as evidenced by the percentage of residents being funded at the highest level for Complex Health Care growing from 12.7% in 2008-09 to 53% in 2017-18[23]. Funding growth needs to match this changing level of acuity.

StewartBrown data for the first six months of the current financial year to December 2018 continues to highlight concerns for providers in relation to average care and services income and expenses per bed day, see Table Four.

Table Four: Care and services income[i] and expenses per bed day[24]

category	$ amount
Average Daily Care and services income	$229.63[ii]
Direct care staffing costs[iii]	-$144.69
Every Day living expenses[iv]	-$59.33
Administration expenses[v]	-$33.91
Outcome per resident per day	**= -$8.30**

[i]Table Four focusses on care and services income, 'accommodation' related income is not included

[22] Ibid

[23] Report on Government Services 2019, Chapter 14 Aged Care Services, Table 14A 12, Productivity Commission

[24]Aged Care Financial Performance Survey, Sector Report (2018 Financial Year), StewartBrown, February 2019

[ii]Consists of ACFI $175.56; Supplements (oxygen/enteral feeding) $1.74; Operational Grants $0.38; Basic Daily Fee $50.43; and Extra/Optional Services $1.52

[iii]Represents 63% of care and services revenue

[iv]Made up of catering/cleaning/laundry/utilities/maintenance (regular)

[v]Administration expenses are $33.91 per bed day

A member recently attended modelling to determine their average care and services income and expenses per resident per day (see Table Five below). Their results are broadly consistent with the StewartBrown data provided in Table Four.

Table Five: Member modelling of care and services income and expenses per resident per day

category	$ amount
Average Daily Income	$232.52[ii]
Care labour, other care related labour & allied health costs	-$142.18
Catering, cleaning and laundry	-$47.20
Other expenses[i]	-$57.65
Total loss per resident per day	**= -$14.51**

[i]Other expenses include items such as medical consumables, utilities costs, regulatory and compliance costs, property and maintenance expenses, HR payroll and rostering and other 'operational' expenses.

[ii]While care needs to be exercised in directly comparing figures from separate sources, the member income figure of $232.52 per resident per day aligns closely to the daily Care and Services income result of $229.63 described by StewartBrown in their December 2018[25] survey results, AND the member care staff costs (as a percentage of the care and services income) again closely mirror the StewartBrown results (being 61% and 63% respectively) which again provides confidence that our member example is 'representative' of what providers in the sector may be experiencing.

As Table Five shows this member experienced a deficit of $14.51 per resident per day, with this daily loss being cross-subsidised from accommodation and other parts of their business. This was because the provider was not prepared to reduce staffing costs to break even. Many ACSA Members are erring on the side of carrying deficits in the short to medium term to maintain staffing levels, critical to the quality of care.

The above daily deficit experienced by this member is consistent with commentary from StewartBrown which indicates that a significant proportion of their survey participants (42.3%, rising to 61% in outer regional, rural and remote facilities) have a negative operating result[26]. As highlighted in Table Four, StewartBrown data shows that the *EveryDay Living Revenue* does not cover the costs of delivering

[25] Aged Care Financial Performance Survey Sector Report (six months ended December 2018), StewartBrown, February 2019

[26] Ibid, p5

catering/cleaning/laundry/utilities/routine maintenance as required by the Specified Care and Services Schedule creating an $8.30 per bed day gap[27].

Sustainability of the services many older people rely on is under threat and action needs to be taken to ensure that the Australian community can enter residential care as and when they need to.

Service expectations and funding

We are experiencing a change in consumer expectations; older Australians want choice and flexibility[28] in the services they receive. Coming generations are likely to be both more health literate and more willing to articulate their expectations. The Aged Care Roadmap[29] articulates the transition to a consumer directed, market driven approach. However, we do not believe the current level of, or approach to, funding residential aged care services is going to be able to meet these changing expectations.

The sector is experiencing the effect of inadequate base level funding compounded by inadequate indexation[30]. Put simply annual growth in expenses is outstripping the indexation factor applied and as a consequence each year the sector is falling further behind[31]. The indexation factor used by Government needs to consider the major cost drivers for the sector and ensure the indexation figure applied keeps pace with real cost growth as experienced by providers.

"In the current year we will post a loss, with expenditure continually outstripping income."

ACSA Member

[27] Sector Update (FY18 and Q1) Survey Results, ACSA SA Finance Symposium, February 2018

[28] You don't know what you don't know: The current state of Australian aged care service literacy, National Seniors Australia, 2018

[29] Aged Care Roadmap, Aged Care Sector Committee, 2016

[30]Commonwealth subsidies and supplements are generally indexed either biannually (accommodation related) or annually (care related). The indexation applied to the basic subsidy for residential care is the Wage Cost Index 9 (WCI–9), which is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indices, the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI–9 is based on changes in the Consumer Price Index between March quarters each year. Accommodation related supplements are indexed using the Consumer Price Index (CPI). (Sixth Report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018)

[31] Aged Care Financial Performance Survey, Sector report (Six months ended December 2018), StewartBrown, 2019, p17

There is a lack of real income growth in the basic daily subsidy, see Table Six.

Table Six: Growth of ACFI July '17-August '17 to July '18-August '18

Average ACFI Category Subsidy	Jul 2017 to Aug 2017	Jul 2018 to Aug 2018	Real Growth Over Same Period in Previous Year
Activities of Daily Living	$91.48	$94.44	1.8%
Behaviours	$27.52	$28.33	1.5%
Complex Health Care	$52.59	$52.78	-0.3%
Actual growth of ACFI[32]			**1.1%***

*Real growth in ACFI Jul-Aug 2017 to Jul-Aug 2018

- in major cities = 1.1%
- in outer regional = 0.6%
- in remote Australia = -1.2%
- in very remote = -0.0%

In an attempt to manage the aged care budget Government implemented indexation freezes and adjusted ACFI claiming (generally making it harder to claim higher levels of funding needed to support higher needs) in the 2015 Mid-Year Economic and Fiscal Outlook (MYEFO) and in the 2016-17 Budget. The Aged Care Financing Authority in their Sixth Report[33] noted that these changes "appear to be reflected in reduced financial results in 2071-18, as reported by the sector and through financial surveys conducted by StewartBrown."

It is worth noting that even though ACFI income is remaining almost static, care hours per resident per day have risen in FY2018 by 0.15 hours to 3.06 hours, and have increased from 2.44 care hours per day in 2012.

Table Seven: Care hours per resident per day June 2012 to June 2018

	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018
Total*	2.44	2.69	2.74	2.86	2.90	2.93	3.06

*Care Management, Registered Nurses, Enrolled and Certified Nurses, PCA/Care Workers, Allied Health, Agency Care Hours

[32] ACFI Monitoring Report – August 2018, Australian Government Department of Health. August 2018

[33] Sixth Short Form report on the Funding and Financing of the Aged Care Sector July 2018, Aged Care Financing Authority, Australian Government, pvii

Sustainable funding

It is in the interest of the community, which has a growing number of older people, that there is a healthy, viable and sustainable residential aged care sector. It is in no-one's interest to have a sector where:

- Indexation does not keep pace with growth in expenses[34];
- Direct care costs in residential aged care are currently outstripping ACFI income, with this gap likely to increase as staff cost increases (averaging 3% annually) remain greater than ACFI indexation (at 1.1% - see Table Six). StewartBrown indicate that total labour costs for their survey participants have increased between 4.4% to 6.6% since June 2017[35] (understanding staff costs are the single largest cost component for providers). StewartBrown also indicate that approximately 69% of Operating Revenue relates to employee expenses[36]). This also has the effect on keeping downward pressure on wages growth.
- Long term trends over time (for example the ten-year period 2008 to 20018) show disturbing results on a per bed day basis[37]:
    - Routine Maintenance costs increasing by 74%
    - Hotel services costs increasing by 50%
    - Utilities costs increasing by 93%

  The above increases in costs outstrip gains in revenue. StewartBrown describe an increase in Everyday Living Revenue (over the same ten-year period) of only $13.83 (up from $38.12 to $51.95) for an increase of 36.3%, where the sector has experienced increases in Everyday Living Expenses by an average of $21.81 per bed day (up from $37.51 to $59.33) or a 58.1% increase[38].
- The overall effect of income and expenditure pressures result in 42.3% of residential aged care facilities operating at a loss, with this rising to 61% for regional, rural and remote facilities[39].

Government is currently examining the residential funding tool[40], within the existing funding envelope. The overall quantum of funds must also be considered to underpin investment in high quality services, as well as ensuring that providers have the resources to meet the needs of older Australians.

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[34] Aged Care Financial Sector Survey (Six months ended December 2018), StewartBrown, February 2019 p17

[35] Ibid, p16

[36] Ibid, p9

[37] Ibid, p19

[38] Ibid, p19

[39] Ibid, p5

[40] Australian Government Department of Health, Residential Aged Care Reform

Case studies

ACSA has constructed several scenarios to give an illustration of some of the challenges providers face within the current ACFI funding model. The cases show the struggle between delivering the type and level of care required by individuals within the current funding provisions.

Whilst the average 'pure[41]' ACFI is said to be $175/day[42], individual residents may receive more or less funding based on their assessed needs.

Low category funding:

- If a resident scores Low across all ACFI domains, they would receive $62.13 per day to support their needs. The provider would need to deliver all of the services to the individual required by the Specified Care and Services Schedule.

Table Eight: ACFI Funding for 'Low' category, per resident per day (prpd) and per resident per hour (prph)

ACFI Funding	Activities of Daily Living	Behaviours	Complex Health Care
Per resident per day	$37.16	$8.49	$16.48
Per resident per hour	$1.55	$0.35	$0.69

[41] The $175 average quoted here is the pure ACFI dollars received by providers, the average daily income per resident of $229 quoted in Table Four includes other income gained per resident, i.e. resident contributions; and additional government supplements for items such as oxygen and enteral feeding , these supplements are used to directly offset the cost of providing these.

[42] ACFI Monitoring Report – August 2018, Australian Government Department of Health. August 2018

Case Study: Mrs Claire Foster

Assessed Care Needs and Funding to Support Low (Low/Low/Low across the ACFI domains) at $62.13/day

Mrs Foster is an 82-year-old lady who lives in a retirement living unit that is owned by an organisation that also provides residential aged care services. The organisation facilitates the delivery of a level 2 Home Care Package to Claire. She requires some supports - including assistance with showering, basic gardening and cleaning services - to live successfully at home.

However, Claire is increasingly socially isolated from her neighbours and is becoming more anxious about living alone fearing something may happen to her, is cooking less for herself and whom her family feels is showing signs of generally not coping as well.

If Claire moved into residential care, she would receive low level funding of $62 per day which is unviable for the service provider. However, Claire and her family are keen for her to move somewhere where she would be around other people (less socially isolated) and better supported to manage her anxiety.

Through their approach to 'mission' the organisation willingly takes Claire into their residential service, understanding that Claire is likely to thrive in a supported social environment where she has regular social contacts with other residents and staff.

The current approach to funding simply does not adequately recognise the needs of older people who are socially isolated and / or who have anxiety or other issues related to living alone in the community and for whom the maximum amount of home care support is inadequate.

Social isolation, and conditions such as anxiety, should be recognised and supported in residential care.

A daily funding level of $62/day is largely seen as below the cost of delivering the services required through the Specified Care and Services Schedule (description page 3). We believe it would be increasingly uncommon for services to be able to support residents at this level of funding.

Medium category funding:

- If a resident scores Medium across all ACFI domains, they would receive $145.47 per day to support their needs. The provider would need to deliver all of the services to the individual required by the Specified Care and Services Schedule.

Table Nine: ACFI Funding for 'Medium' category, per resident per day (prpd) and per resident per hour (prph)

ACFI Funding	Activities of Daily Living	Behaviours	Complex Health Care
Per resident per day	$80.92	$17.60	$46.95
Per resident per hour	$3.37	$0.73	$1.95

Case Study: Mr Jim Smyth

Assessed Care Needs and Funding to Support Medium (Medium/Low/Medium across the ACFI domains) at $136.26/day

Jim is an 85-year-old gentleman who has been able to remain living at home with his beloved pets with support provided through a Level 4 (High Care) Home Care Package. Supports are provided to him five days a week.

Unfortunately, he recently tripped over one of his pet dogs and broke his hip, was transferred to hospital and underwent total hip replacement surgery. Whilst recovering in hospital it was felt that he was not rehabilitating to a sufficient degree to allow him to go back to his unit as the supports available were insufficient, Jim reluctantly acknowledged this was the case.

As his initial recovery was slow, due to other health issues his care needs were sufficient to gain him an ACAT assessment suitable for residential aged care. He was admitted to a residential aged care service and his care needs identified that he was suitable for Medium level care funding at $136.26/day.

The service, in consultation with Jim, developed a solid rehabilitation program overseen by their Physiotherapist, and implemented by a range of staff. Over time Jim settled into his new life, making new friends and rehabilitated well, once again walking independently and undertaking most of his activities of daily living himself with minimal staff intervention.

A requirement of the current funding process is where residents are admitted direct from hospital they must be reassessed at six months after admission. As Jim's home had supported him with a quality rehabilitation program and as he is now more independent on reassessment his funding level dropped from $136.26/day (M/L/M) to $101.71 (L/L/M) yet to keep Jim at this level the service needs to continue to provide him with support at the level they were previously.

A new funding tool, when being developed, needs to positively support services undertaking wellness or re-ablement approaches to their service delivery and acknowledge the ongoing nature of what's required to keep individuals as well as they can be.

High category funding

- If a resident scores High across all ACFI domains, they would receive $216.59 per day to support their needs. The provider would need to deliver all of the services to the individual required by the Specified Care and Services Schedule.

Table Ten: ACFI Funding for 'High' category, per resident per day (prpd) and per resident per hour (prph)

ACFI Funding	Activities of Daily Living	Behaviours	Complex Health Care
Per resident per day	$112.10	$36.70	$67.79
Per resident per hour	$4.67	$1.53	$2.82

Case Study: Mrs Filomena Gentile

Assessed Care Needs and Funding to Support (Medium/High/Medium across the ACFI domains) at $164.57/day

Filomena is a 92-year-old lady who emigrated to Australia with her husband Aldo as part of the post-world-war-two immigration wave into Australia. She lived with her husband at home up to the point when her husband was no longer able to care for her. She moved into Sunnybrook Nursing Home* in 2017. Unlike previous generations in her family, their daughters are both working and unable to care for Filomena at home. Filomena has care needs resulting from frailty and Parkinson's that require significant direct support from staff to attend all her Activities of Daily Living. She exhibits a range of behaviours as a result of her Dementia that require staff supports, and these are funded at a 'High' category through the ACFI instrument. And as with many people in their ninety's Filomena has a range of co-morbidity health conditions that require nursing interventions which are provided by nursing and allied health staff, to assist with managing her chronic pain, health monitoring activities etcetera.

The service receives $164.57/day (M/H/M categories) to provide complex health care services to Filomena. Prior to 2017 indexation freezes and ACFI adjustments Filomena would have received $216.59/day. The same level of care is being provided to Filomena, but the provider has $52/day less to do so.

Changes** over time to the funding instrument[43] have resulted in it now being far less common for residents to be classified at the highest level, regardless of their needs, impacting on the support available to an individual and/or to the services sustainability in the longer term.

*a fictional facility

**Changes to the Funding instrument were introduced with a view to contain greater than expected growth in ACFI expenditure, projected by government to be $3.8 billion over four years[44]

[43] Budget 2016 ACFI Modelling – Summary Findings, Ansell Strategic et al, June 2016, p3

[44] Ibid, p3

The instrument does not adequately recognise the true cost of delivering quality behaviour supports for residents with high level behaviours or palliative care services[45]. The following case studies demonstrate this.

Case Study Behaviour Support: Mr Stan Jones:

Assessed Care Needs and Funding to Support Low (Low/High/Low across the ACFI domains) at $90.34/day

Behaviour funding component = $36.70/day for the equivalent of $1.53/hour

Mr Jones is a 70-year-old gentleman with a cognitive impairment but who is otherwise physically active and mobile, with no other significant health issues. His cognitive impairment is severe, and he displays sexualised behaviours towards other residents and staff. He is often intrusive, wandering into other residents' rooms, requiring staff to frequently intervene and redirect him, and he can be verbally abusive. Due to his cognitive decline he has difficulty in taking direction and requires staff supervision and prompting with his daily activities such as showering/dressing, for toileting/hygiene and during meals.

With the structure of the current funding instrument he is funded to Low levels in the ADL and Complex Health Care Domains, predominantly due to the fact that he requires only supervision and prompting to perform tasks rather than staff 'doing for him'. Whilst staff do not have to actively assist him to wash for example, the time taken to supervise, and prompt can in fact take longer.

His high-level Behaviour funding equates to $36.70 per day, or $1.53/hour, for staff to support and manage his exhibited behaviours.

[45] The Resource Utilisation and Classification study undertaken and recently completed by Professor Kathy Eagar identifies that palliative care is a 'clinically discrete' need in residential care, that requires 'significant levels of additional resources'. The study's findings include the proposal for a discrete funding class for this category of resident. (Report One, The Australian National Aged Care Classification (AN-ACC), University of Wollongong, February 2019).

Case Study Palliative Care: Mrs Mabel Smith

Assessed Care Needs and Funding to Support High (High/Medium/Medium across the ACFI domains) at $176.65/day

Mrs Smith is an 85-year-old lady who has been living in the Sunnybrook Nursing Home* for several years and is an active participant in the life of the residential home. She has a range of health needs that require interventions from the nursing and allied health staff to help her manage her arthritis and the pain it causes her. Due to her physical frailty and incapacity she requires staff to directly assist her with cutting up her food and eating her meals. Staff directly assist her with her showering and dressing and support her with her continence needs. Her arthritis and poor balance impacts on her ability to walk unaided and staff assist her to mobilise around the facility. Mrs Smith also has cognitive impairment due to having Alzheimer's type dementia and associated depression requiring a range of assistance from staff to support her needs. She needs staff to help her with her medications.

Her care needs attract funding of $176.65/day.

Unfortunately, Mrs Smith has declined over recent months and in discussion with her family and her GP the service has implemented a palliative care approach. Staff now believe she is approaching an end of life stage, she no longer mobilises and is no longer eating, she is interacting less with other residents and staff.

To provide a quality palliative care approach to Mrs Smith and her family they are providing:

* Active palliative nursing interventions, including complex pain management;
*Increased supports to the family through their senior nursing staff;
*Active spiritual care services; and
*Increased liaison with Mrs Smith's GP and external palliative care services.

The service considers claiming for end of life care under the Complex Health Care Domain, this will increase the Complex Health Care Domain from a Medium to a High, increasing her funding from the current $176.65/day (H/M/M) to $197.49 (H/M/H).

An increase of $21/day to provide ALL the short-term end of life supports described above. But the service has a dilemma, as to apply for the palliative care component the service has to resubmit her ACFI claim, and as Mrs Smith is now close to the end of her life and her condition has deteriorated some of the supports previously claimed for across the ADL and Behaviour domains may no longer apply, so where a $21/day gain may be made in relation to the CHC domain funding may be lost across the other domains. This is a very real dilemma which impacts on the care able to be provided for the resident and is financially challenging for service providers.

*a fictional facility

These case studies illustrate several issues or limitations with the current (ACFI) funding instrument that are proving challenging:

- It is not a funding instrument that provides funding certainty for either the sector or government, it is generally considered no longer 'fit-for-purpose';

- The instrument does not promote resident independence. It does not for example recognise the additional time it takes to allow people to do for themselves (therefore supporting the resident to be independent) rather than staff 'doing for' residents. In effect it does not promote true person-centred care;

- The instrument does not adequately account for, and fund, time spent by staff providing general 'social' supports to residents and their families. Significant supports are periodically delivered by providers to residents and their families at various stages of a resident's stay including as they settle into a facility, during periods of health crises, for periodic care reviews and family conferences and at end of life. These supports may be provided through a range of mechanisms and staff (nursing staff, facility management, spiritual or chaplaincy services, lifestyle staff).
  Service providers also willingly provide support to residents who do not have visitors (they may have no family or geographically distant family or family who doesn't visit), noting the Hon Ken Wyatt's comments that 'up to 40% of aged care residents receive no visitors[46]'. The support and time given to these residents is not well recognised or valued by the current approach to funding. A common comment from residents, families and staff is the lack of time available to simply spend time with residents.

  Loneliness, social isolation and boredom are recognised as characteristics experienced by many older people. It is recognised that residential facilities can contribute to people not achieving their full potential[47]. The current funding approach does not acknowledge the importance in addressing these issues. While funding of $46 million[48] has been provided to fund community visitors which is a useful initiative, service providers need to be funded to provide ongoing support to address these 'quality of life' outcomes on a daily basis.

- It is resource intensive for providers with a significant focus on administrative inputs, process and documentation in excess of what it required to evidence care

[46] $46.1 Million to Combat Loneliness in Local Communities, Media Release, The Hon Ken Wyatt AM, MP, Minister for Aged Care, 6 May 2018

[47] Creating the conditions for self-fulfillment for aged care residents, Brownie S. et al, 2012,

https://journals.sagepub.com/doi/abs/10.1177/0969733011423292

[48] ($46.1 Million to Combat Loneliness in Local Communities, Media Release, The Hon Ken Wyatt AM, MP, Minister for Aged Care, 6 May 2018)

funding. Time spent on this level of administration is time that could be better spent providing direct resident care.

"The requirement of the regulator to support every element of care provision with documentation is time consuming and reduces the time that staff have available to spend with residents. There is a documentation burden on the providers to constantly confirm care and services delivered, rather than the presumption that care and service is delivered as reflected in the care plan. "

ACSA Member

Supporting increasing needs in residential aged care

The acuity of residents has increased over time and as the Community Care programs successfully enable older Australians to remain living in their own homes for longer it means that people come into residential aged care later, frailer and with more (co)morbidities.

Productivity Commission data supports the changing nature of residents and shows the increased high need across all ACFI domains but particularly in the percentage of people in residential aged care funded at the highest level for Complex Health Care, this group having grown from 12.7% in 2008-09 to 53% in 2017-18[49], see Table Sixteen.

Table Sixteen: Proportion of residents funded as High ACFI Need Level

Year	Activities of Daily Living	Behaviours	Complex Health Care
2008-09	34%	37.1%	12.7%
2017-18	58.9%	64.1%	53%

On average providers receive $269 per day for all care and services provided to a resident. This is considerably less than daily funding received by other services supporting frail older Australians.

Table Seventeen: Separation data from Round 19 NHCDC Cost Report, Financial Year 2014-15

Type	Average cost of separation	Average length of stay	Average cost per day
Acute	$5,026	2.64 days	$1,901
Sub-acute & non-acute*	$13,193	13 days	$1,011
Geriatric Evaluation and Management	$15,649	17.74	$882**
Psychogeriatric	$36,878	26.3 days	$1,400***

[49] Report on Government Services 2019, Chapter 14 Aged Care Services, Table 14A 12, Productivity Commission

*sub-acute and non-acute includes the following separation types: rehabilitation care, palliative care, geriatric evaluation and management (GEM), psychogeriatric care or maintenance care

**derived at by dividing the average cost of separation by the average length of stay

*** derived at by dividing the average cost of separation by the average length of stay

While caution needs to be taken when comparing across sectors, we believe that reasonable comparisons are possible when looking at average per day figures across residential aged care (funded at $269/day) as compared to the average cost per day figures in Table Seventeen above.

The best comparison with aged care (although there are still some differences) are the sub and non-acute service types.

Separating out two components from the Sub-acute category, specifically Geriatric Evaluation & Management (GEM) at $882/day and Psychogeriatric at $1,400/day may be useful as well, as the patients receiving these types of services in hospitals may more closely align with the resident cohort that reside in residential aged care.

GEM patients stay in hospital for longer (double the national average length of stay) at a cost that is three times the national average. This potentially reflects the complexity associated with providing services for these people of who would be similar in care needs to the residential aged care population.

So, the funding range from $882/day for GEM patients through to $1,400 for Psychogeriatric patients is substantively greater than that received for older Australians (average $269/day) residing in residential aged care.

Even allowing for some difference in service provision the disparity of funding is stark.

Challenges faced by regional, rural and remote services

The current approach to funding does not serve regional, rural and remote service providers well. These service providers generally have lower income levels, due to receiving less income per resident per annum[50] than their metropolitan counterparts (most likely due to characteristics of the funding instrument) and higher expenses than their metropolitan counterparts particularly labour costs[51].

In residential care in the rural and remote sector 64 per cent of service providers are not-for-profit and 32 per cent are state / territory operated, leaving approximately 4 per cent operated by the for-profit sector[52].

[50] Financial Issues Affecting Rural and Remote Aged Care Providers Part 1, Aged Care Financing Authority, Australian Government, 2016, pv

[51] Ibid, pv

[52] Ibid, pviii

- ACFI funding per resident that is on average less than that received by metropolitan providers, reportedly $6,660 per annum, see Table Eleven.

Table Eleven: Government funding Rural/Remote verses Non-Rural/Remote per resident per annum (prpa)[53]

ACFI	Rural/Remote $ prpa	Non-Rural/Remote $ prpa
Base care subsidy (ACFI)	$48,348	$55,006

It is generally accepted that regional, rural and remote service providers are unable to receive the same amount of ACFI funding to support residents as they are often unable to attract allied health staff to attend complex health care management. This is despite their residents having the same care needs as those who live in metropolitan areas.

Additionally, ACFI growth has been demonstrated to be lower in outer regional, remote and very remote locales than in major cities, further disadvantaging these providers, see Table Twelve.

Table Twelve: Growth of ACFI July '17-August '17 to July '18-August '18[54]

ACFI	Major cities	Outer regional, remote and very-remote
ACFI Growth	1.1%	0.6%*

*This percentage rate is an average of the growth rate of these three region types

Occupancy levels are progressively lower the more remote the location of the service, see Table Thirteen. ACFA report that 'the greatest variation in occupancy continues to be by remoteness of location. A clear trend is that more populous areas generally have higher occupancy rates than less populous areas'[55].

[53] Ibid, pxi

[54] ACFI Monitoring Report – August 2018, Australian Government Department of Health. August 2018

[55] Sixth Short Form report on the Funding and Financing of the Aged Care Sector July 2018, Aged Care Financing Authority, Australian Government, p17

Table Thirteen: Residential aged care occupancy, by remoteness area, 2016-17[56]

Remoteness location	Occupancy 2016-17
Major cities	91.4%
Very remote	77.4%

Professor Kathy Eagar in her Resource Utilisation and Classification Study (RUCS) also recognised that remoteness is closely associated with small size and low occupancy[57].

There are increased costs in providing the services in RRR locales[58], including staffing costs which are $16,360 more per resident per annum, see Table Fourteen.

Table Fourteen: comparison of staffing costs between rural/remote and non-rural/remote facilities

(ACFA Feb 2016)

Expense type	Rural/Remote $per resident per annum	Non-Rural/Remote $per resident per annum
Care management	$8,629	$2,453
Registered Nurses	$12,317	$6,752
Enrolled Nurses	$7,400	$3,696
Hotel Services – labour costs	$8,427	$7,267
Maintenance – labour costs	$3,152	$872

- Overall financial results[59] indicate a significantly different EBITDA result for providers in rural and remote locations, see Table Fifteen.

[56] Ibid

[57] Australian National Aged Care Classification (AN-ACC) Version 1.0, Senior Professor Kathy Eagar, Director AHSRI, March 2019

[58] Sixth Short Form report on the Funding and Financing of the Aged Care Sector July 2018, Aged Care Financing Authority, Australian Government, pxii

[59] Financial Issues Affecting Rural and Remote Aged Care Providers Part 1, Aged Care Financing Authority, Australian Government, 2016, pxii

Table Fifteen: Overall Financial Results[60]

EBITDA	Rural/Remote $ prpa	Non-Rural/Remote $ prpa
Facility EBITDA	$2,070	$9,267

The pressures on rural and remote services are mounting and putting their ongoing availability at risk. With 63.5% of facilities currently operating at a loss according to the StewartBrown Aged Care Sector Report[61], this speaks more to the overall inadequacy of funding than it does to factors operating at an individual provider level.

An alternate funding tool

It is important these concerns are addressed with any consideration of an alternate funding model. Any new funding model should:

- Address equity including recognising and supporting services that provide specialist services (homelessness, ATSI, CALD etc.);
- Be outcome focused, supporting residents to achieve self-fulfilment thus alleviating conditions such as loneliness, boredom and isolation;
- Ensure the aged care system is financially sustainable and not prone to financial volatility;
- Actively promote a re-ablement or wellness approach to service delivery and that promotes an approach that supports independence;
- Actively recognise that simply spending time with residents is a valid activity;
- Reduce the focus on administrative burden on providers;
- More accurately predict care inputs and adequately fund these;
- Recognise the additional resources required to support new residents as they settle into their new home, and fund this initial higher staff input, as recommended by the Resource Utilisation & Classification Study[62] (RUCS), recommendation 18; and
- Recognise and address (through appropriate weightings) the challenges experienced by regional, rural and remote (RRR) providers as described above.

Find here a copy of the not-for-profit Principles for Aged Care Services Funding developed in response to Governments announcement that it would review residential care funding arrangements.

[60] Ibid, xiv

[61] Aged Care Financial Performance Survey, Sector Report (2018 Financial Year), StewartBrown, p4

[62] Report 6, AN-ACC A National Classification and Funding Model for Residential Aged Care: Synthesis and Consolidated Recommendations, University of Wollongong, Australia, February 2019

Any new funding instrument should have built within it an ability for government to routinely, regularly (annually for example) and objectively review the 'cost' of providing services and allow for these to be adjusted as required.

The Financial context of ageing

It is important to recognise and celebrate our ageing population and increased longevity over the past century, primarily derived through improvements to public health measures, housing, education and medical advances. Our life expectancy in Australia has increased by around 30 years since the late 1800's, by 2009 a male was expected to live to 79.3 years and a female 83.9 years[63].

Whilst celebrating our ageing population it is important to understand the impact of the baby boomer generation moving into older age. It is believed that the 'effects of ageing on the budget will be felt more over the coming decade[64]' due to the effects of this generation entering retirement and subsequently ageing.

A greater proportion of the population will be retired with a decreasing proportion being in prime working age. This will decrease government revenue (through reduced taxes for example) and increase spending (for example on health and aged pensions) along with an accompanying increased demand on services for older Australians, when people are in their 70s and 80s. This will peak in the early 2030s, with people in this age group likely to be high users of aged care services (longevity generally bringing increasing morbidity and dependency).

For Australia to meet this demand we need to work together to find solutions that acknowledge:

- The true cost of providing the care to older Australians that we as a society expect, noting that the current funding level does not support this;
- That funding services for aged care are predominantly through taxes and individuals contributing to the cost of their care; and
- That providers need to generate surpluses to deliver quality care. Not-for-profit providers reinvest these funds into the delivery of care (it is used for example to provide training, building maintenance and regeneration and a range of other important service elements).

[63] Australian Bureau of Statistics, 4102.0 – Australian Social Trends, March 2011

[64] Australia's Ageing Population, understanding the fiscal impacts over the next decade, Report No. 02/2019, Parliamentary Budget Office

ACSA believes that the Legislated Review[65] recommendations that address sustainability, demand and supply and means testing should be implemented.

Younger people in nursing homes

In Australia people who have a disability and are under 65 years of age are supported through the disability sector, and people who are older and require supports are supported through the aged care sector.

There are approximately 6,243 people[66] under 65 years of age living in residential aged care in Australia comprising approximately five per cent of residential aged care residents[67].

This may be due to a lack of housing and housing options for people with complex disability. Also, often they enter RACF's because they are often faced with having 'no time, no knowledge, and no choice'[68] in sourcing appropriate accommodation.

As we outlined in our Witness Statement there is a significant disparity of funding between what is available to recipients of NDIS packages, with a small number of NDIS clients receiving support funding in excess of $200,000 per annum, as compared to the maximum funding available to residential aged care providers of $79,000 per annum. While aged care may incorporate some economies of scale, it is clear that the same level of care and services cannot be provided on this level of funding as can be provided with a high level NDIS package.

Various government policy initiatives have aimed to reduce the incidence of younger people living in residential aged care facilities[69] including the *Younger People in Residential Aged Care – Action Plan*[70]. We support positive actions being identified in this action plan that address the issues relevant to younger people in residential aged care, including:

- That younger people with disabilities, who do move into aged care facilities are not disadvantaged by doing so in terms of the support services they are funded to receive;

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[65] Legislated Review of Aged Care 2017, David Tune, Commonwealth of Australia, Department of Health

[66] Younger People in Residential Aged Care – Action Plan, Australian Government

[67] Young People in Nursing Homes National Alliance website. https://www.ypinh.org.au/about/our-members

[68]Barry, S, Knox, L & Douglas, J.M 2018 '"Time's Up": The Experience of Entering Residential Aged Care for Young People with Acquired Neurological Disorders and Their Families', *Brain Impairment*, vol. 20, no. 1, pg. 41.

[69] Young People in Nursing Homes National Alliance website, https://www.ypinh.org.au/key-reforms-and-initiatives/ypirac, Council of Australian Governments (COAG) 2011, *2010 – 2020 National Disability Strategy*, Commonwealth of Australia, p. 9, Community Affairs References Committee June 2015 *Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia*.

[70] Department of Social Services 2019, *Younger People in Residential Aged Care – Action Plan* https://www.dss.gov.au/sites/default/files/documents/03_2019/younger-people-aged-care-infographic.pdf.

- That improved supports are provided to younger people currently residing in aged care facilities ensuring they receive the breadth of services available to all recipients of NDIS funding;
- Access to appropriate assessment and planning pathways;
- Identifying and addressing appropriate alternate housing needs, whereby age appropriate housing options are developed;
- Funding of assistive technology that addresses function and independence, including ensuring these are available to younger people who reside in residential aged care services; and
- That funding aimed at enabling connection to the broader community continues.

When addressing the provision of services for younger people with disabilities we recommend:

- Consultation occurs with aged care providers to identify issues and involve the sector in the development of action strategies;
- Actions or recommendations developed should also benefit those younger people currently living in residential aged care;
- That any actions developed include strategies to 'build capacity' within the sector to be able to provide quality services;
- Support levels and funding match; and
- That duplication of legislative and regulatory requirements are addressed to remove disincentives for aged care providers to continue to be available to support younger people, even when this is a last resort.

The funding and administrative arrangements for the disability and aged care sectors seem to assume that people either have a disability or are ageing, but not both.

People with disabilities age, but aged care service providers are generally not able to meet the specialist needs of people with particular disability needs. For example, a person who has lived with quadriplegia or an intellectual disability throughout their life, will continue to have specific disability requirements as they age, but may also become more frail as they age. Also, a person may not acquire their disability until after the age of 65 years, making them ineligible for NDIS supports. A combination of disability and aged care supports would ideally and more effectively support ageing people who have disabilities.

The Aged Care Quality and Safety Commission

The new Aged Care Quality and Safety Commission (the Quality Commission) came into effect on the 1 January 2019. The Quality Commission is led by an independent Commissioner who reports directly to the Minister for Senior Australians and Aged Care. The stated role of the Quality Commission is to 'protect and enhance the safety, health, well-being and quality of life of people receiving aged care funded by the Australian Government[71]' and it replaces the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

The formation of the new Aged Care Quality and Safety Commission was announced by the Hon Ken Wyatt MP in April 2018 following the release of the Carnell/Paterson review[72] that stated, 'the need for improvements in the rigour of the accreditation system was a persistent theme in submissions to this review[73]'. This review recognised that the failings of the Makk and McLeay wards at the Oakden mental health service in South Australia highlighted the inadequacies of an accreditation process which awarded the Oakden service full accreditation[74].

It is in the interest of society and aged care providers that everyone is able to have confidence in the regulator and the accreditation process. We welcome the formation of the new Quality Commission including the incorporation into the Quality Commission the regulatory branch of the Department of Health from 2020. ACSA and its membership are committed to providing high quality care and support a firm but fair regulatory system which protects older people while allowing service innovation to flourish.

The performance of the Quality Commission in discharging its duties is critical to the effectiveness of aged services and for the community to have trust and confidence in the services provided. The new Commission must be ready and skilled to assess and guide implementation of the new streamlined standards from 1 July 2019, just as it is expecting of aged care providers. There are some concerns, based on experience of the Commission to date, as to whether this will be the case. Measures must be taken to ensure that Quality Commission staff and Surveyors/Auditors are appropriately and fully:

- trained in the new Quality Standards, including the focus on the consumer; and
- Are skilled across the breadth of components that they will be required to audit against in the new Standards, including but not limited to:
    - Governance principles;
    - Open Disclosure principles;
    - Clinical Governance frameworks; and
    - Antimicrobial stewardship.

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[71] Aged Care Quality and Safety Commission website: https://www.agedcarequality.gov.au/about-us

[72] Review of National Aged Care Quality Regulatory Processes, Carnell K. et al, October 2017, Australian Government, October 2017

[73] Ibid, pix

[74] Ibid, pix

It is also important that the new Commission engages with the community and the sector in an open and transparent manner on their own performance including on implementation of new practice and methodologies, feedback received and indicators achieved.

Additionally, we request that measures are taken to address the concerns raised through the important and well received Peak Body and Australian Aged Care Quality Agency Roundtable events[75] that occurred in 2018 where the following key issues were **addressed**:

1. The Agency's risk based approach;
2. Consistency in application of the Standards and of approach;
3. Complaints about the Agency's practices and services;
4. Communication and information; and
5. Future reforms.

For a copy of the Aged Care Providers Roundtables Discussion Paper, see here.

Interface across health sectors and equity of access

The COAG Health Council meeting in October 2018 indicated a preparedness to address the interface between health and aged care. The Federal, state and territory Health Ministers met in Adelaide to discuss a range of national health issues. The COAG Health Council Communiqué 12 October 2018 stated:

Aged care and ageing matters Ministers discussed how best to address the interface between health care and aged care matters, particularly those which would benefit from collaborative effort and combined leadership across jurisdictions. Consideration of access to care particularly in rural and remote communities, sustainability of services, the development of interim arrangements for vulnerable clients awaiting care and better monitoring of issues were key concerns. Ministers agreed to immediately initiate work to conduct a census of long stay older patients and development of a suite of system indicators that will enable monitoring of key interface issues.

This report identified five enabling themes and associated actions to achieve this shift. Themes like "Empowering Consumers" and "Supporting integrated and precision health solutions" are particularly relevant to aged care. Both industries will undergo significant change and shifts over the next fifteen years and strengthening the interface between them will be crucial to successfully navigating this. Building on this report the government funded CSIRO Futures to work with Health and Aged Care to design a path to strengthen the interface that has both national, state and local enabling themes and action and aligns respective change agendas.

[75] Aged Care Provider Roundtables, Executive Summary, Published July 2019, AACQA, ACSA, Aged Care Guild, LASA, 2018

There are examples of ACSA members proactively working to address some of these interface points, we have provided one illustrative example.

Case Study: Collaboration with Primary Health Networks

An ACSA member is collaborating with a Primary Health Network to reduce acute presentations to hospital emergency departments by its residents. This service believes that older people should be able to receive the care they need where they live and 'truly age in place'.

The service seeks to build the capacity and expertise of its nurses to enable them to manage the clinical care of residents through all stages of ageing through to end of life care. They have implemented a clinical program that includes:

* Upskilling of Registered and Enrolled Nurses in extended clinical care;

* Providing a Nurse Practitioner to provide advanced clinical care and clinical training programs;

* The introduction of protocols to guide extended clinical care;

* An emphasis on advanced care planning, including the 7-step resuscitation pathway; and

* Building on collaborative relationships with visiting GPs, Extended Care Paramedics (ECPs) and Emergency Departments (EDs).

Over an 18-month period of the trial, 26 per cent of all acute clinical events (89 episodes) have been treated at the service that would otherwise have presented to an ED. The remaining 74 per cent were transferred to an ED.

Over a twelve-month period, January 2018 to December 2018 it was calculated, using an averaged length of stay (LOS), that the total hospital bed days saved equalled 218 bed days. (ACSA notes that the national average cost per bed day in acute care in Australia is $1,901[76]. Extrapolated out this was a saving of $414,418 in acute care bed days).

This pilot trial provides an example of mutually beneficial programs (both cost saving and direct benefits to the residents themselves - as they can remain in their own familiar surroundings cared for by nurses that are familiar with their needs) that address the aged care / acute care / primary care interface.

[76] Report on Government Services 2019, Chapter 14 Aged Care Services, Table 14A 12, Productivity Commission

Equity of access to health services for all Australians is a cornerstone of Australia's healthcare system and a basic tenet of Australian's belief in a 'fair go for all'. It is critical that care recipients, especially in residential care, have the same access to primary care, mental health, hospital services and oral health as they would in the community. ACSA supports reforms that ensure this occurs, whether this occur through the health system or increased residential care funding.

ACSA has consistently argued for equity of access for older Australians living in residential aged care to primary care, mental health, hospital services and oral health.

- Access to mental health and psychological services:

  Until recently, older Australians living in residential aged care have not been eligible to access mental health and psychological services available under the Better Access Initiative. The Better Access Initiative increases community access to mental health professionals and team-based mental health care, with general practitioners encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists. However, ACSA acknowledges a recent measure to provide for mental health and psychological services for aged care residents with funding through the national Primary Health Networks (PHN) being rolled out over a four-year period. While any funding and acknowledgement of this lack of access is welcomed there is concern that funding it through the PHNs will be an expensive model which won't be as effective as the introduction of a Medicare item to support equal access for aged care residents. It will be important that the PHN initiative provides equitable access for residents as received by older persons still living in their own homes. Time will determine whether the level of funding and the distribution method is adequate to ensure equity of access. This measure should be monitored for effectiveness and modified should it not work the way it was intended.

- Access to oral health services:

  Poor oral health is linked to poor health outcomes across a range of areas including poor nutrition, cardiovascular disease, and stroke among others[77]. older people are identified as a special health needs group[78]. ACSA supports positive plans to address access of Older Australians to dental health services. We acknowledge positive announcements that improve availability of subsidised dental health services for Older Australians, (for example as recently announced during the 2019 election campaign by the ALP) but more needs to be done. In our 2019 Pre-Budget Submission we recommended that the establishment of a Federal, State and Territory 'Aged Care Oral Health Taskforce' to develop a ten-year plan including consideration of:

[77] Oral health and dental care in Australia, Australian Institute of Health and Welfare, Australian Government, Cat No: DEN 231, March 2019

[78] Ibid

- MBS Provider Numbers for Oral Hygienists attending residential aged care or providing services to clients of Commonwealth subsidised home care;
- Incentives for dentists to visit residential and home care consumers; and
- Establishing a 4-year $10 million Aged Care Oral Health Best Practice Program to support innovative workforce development programs, use of technology and infrastructure development such as mobile services across regions.

- Access to general practitioners (GPs):

  Is vital for residents and service providers alike. ACSA has sought equality of access for residents for some time. It is pleasing to see that the Australian Medical Association (AMA) concurs and recently stated that 'older Australians all too frequently do not have the same level of access to medical care as other age groups – a longstanding result of inadequate funding and coordination in the aged care and health systems[79].

  We note the measures in the 2018 MYEFO and the recent 2018 Budget to retain the Aged Care Access Initiative designed to improve residents' access to GPs. The AMA has outlined what it believes is required to ensure GP access for residents through Medicare rebates. ACSA supports GPs being appropriately remunerated to visit their patients who reside in residential aged care services. But while increased Medicare remuneration may be a cornerstone of GP access this approach leaves the funding on an individual level and limits an aged care providers ability to ensure consistent, quality visits for all the residents in their care. Residential aged care providers facilitate and coordinate GPs for residents as well as to ensure the provider's clinical leaders and Registered Nurses receive appropriate support and direction in caring for the GP's patient. The relationship between a GP and a residential aged care provider (and the workforce) is crucial to delivering quality clinical and primary health care. However, the individualised incentive approach for GPs means that aged care providers have no ability to motivate and encourage consistent quality visitations for all residents under their care. Consideration should be given to a scheme that enables the residential aged care provider to offer whole of facility/system incentives for building quality GP visits and strong effective relationships and systems with their workforce. This could also include funding for on-site infrastructure as required.

[79] Key Health Issues for the 2019 Federal Election, Australian Medical Association, 2019

Case Study: Interface with Primary Health Care

Numbers of providers are seeking to establish models that improve access of residents to GPs.

One example of this is an ACSA member undertaking a program with a GP service that specialises in providing medical services to older people living in residential aged care facilities. The relationship is based on mutual benefits for both parties.

The focus of the collaboration is on providing an environment that supports the visiting GPs service a significant number (critical mass) of residents within the facility (whilst still promoting individual resident personal choice regarding their GP) creating efficiencies for the clinic and the service provider. The service provides the visiting GPs with:

* Nursing support, including access to Nurse Practitioners;

* A single point of contact with a senior Registered Nurse who case manages the GP's patients;

* Clinic space;

* Treatment/examination facility;

* Priority access to private Geriatricians who also operate a regular clinic in the Aged Care Facility;

* Education and professional development sessions (e.g. advanced care planning); and

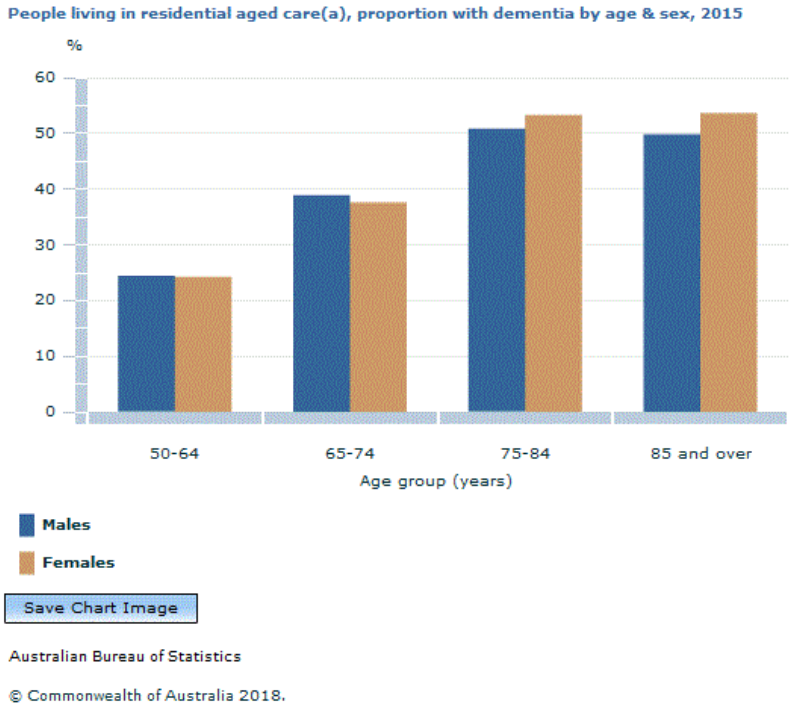
* ICT capacity that is compatible with the GP clinics ICT system.

The relationship, which requires input and commitment from the provider and the GP is based on mutual gain, with the ultimate winner being the residents themselves.

DEMENTIA CARE

The provision of quality dementia services is core business to the provision of contemporary residential aged care. Almost half (49%)[80] of all people in residential aged care in 2015 had dementia (incl. Alzheimer's type). We know prevalence increases with age:

- In the 50-64-year age bracket – approximately 24% of residents have dementia;
- In the 85+ age bracket – approximately half of all residents have dementia; and
- In residential aged care facilities those with dementia are twice as likely as those without to have 9+ impairments, which suggests care needs of this group may be high.



Footnote(s): *(a) Includes people in nursing homes, aged care hostels and cared components of retirement villages.*

Source(s): *ABS Survey of Disability, Ageing and Carers: Summary of findings–2015*

[80] Australian Bureau of Statistics, Survey of Disability, Ageing and Carers, Summary of Findings 2015, Commonwealth Government of Australia

Dementia Australia[81] indicates that:

- Dementia is the **second leading cause of death** of Australians contributing to 5.8% of all deaths in males and 11.3% of all deaths in females each year;
- In 2016 dementia became the leading cause of death among Australian females, surpassing heart disease which has been the leading cause of death for both males and females since the early 20th century. In 2017, dementia remained the first leading cause of death in females, and the third leading cause of death in males. Overall, accounting for 13,729 deaths;
- In 2019, there is an estimated 447,115 Australians living with dementia. Without a medical breakthrough, the number of people with dementia is expected to increase to 589,807 by 2028 and 1,076,129 by 2058;
- Currently an estimated 250 people are joining the population with dementia each day. The number of new cases of dementia will increase to **318 people per day** by 2025 and more than 650 people by 2056; and
- In 2019, there is an estimated 27,247 people with younger onset dementia, expected to rise to 29,353 people by 2028 and 41,249 people by 2058.

The impact of dementia in Australia

- **In 2018, dementia is estimated to cost Australia more than $15 billion**. By 2025, the total cost of dementia is predicted to increase to more than $18.7 billion in today's dollars, and by 2056, to more than $36.8 billion; and
- Dementia is the single greatest cause of disability in older Australians (aged 65 years or older) and the third leading cause of disability burden overall.

Dementia support services

Currently there is a tiered approach[82] to providing supports to service providers in caring for people with dementia:

- The first tier being the Dementia Behaviour Management Advisory Service (DBMAS) which provides advice and service to service providers;
- The second tier is the Severe Behaviour Response Team (SBRT) which are a team of mobile experts that provide support to service providers in relation to people who are exhibiting severe behavioural and psychological symptoms of dementia (BPSD); and
- The third tier is to be the Specialist Dementia Care Program (SDCP) which it is said will provide specialist accommodation for people with very severe BPSD who are unable to be cared for in mainstream aged care services. The stated position being to stabilise symptoms with a view of transitioning care recipients back to less intensive care settings (p23). It is believed this will account for around 1 per cent of all people living with dementia.

[81] https://www.dementia.org.au/statistics

[82] Navigating the Maze: An overview of Australia's current aged care system, Background Paper 1, Royal Commission into Aged Care Quality and Safety, 2019

This tiered approach with external supports to providers has merit and providers use these services as and when they need to. However, given the growing numbers of people with dementia, providers also need to be properly resourced to provide the level of care and support required. This requires an approach which builds capacity rather than just outsourcing the problem. A combination of increased provider capacity and calling on specialist support only when required will support a better level of care for residents with dementia.

Special Care Dementia Units, as a third level of specialist support assisting people with BPSD, is relatively new. Successful implementation will require admission criteria and practices that enable individuals to move through the system (from residential care to the Units and back again) to ensure the system can meet the demand. It is unclear whether the 31 planned Units will be adequate to meet the demand overall.

ACSA's Submission of February 2019 on Specialist Care Dementia Units can be found here.

Security of tenure

Managing behaviours sometimes associated with dementia can be very difficult as the needs of the individual, other residents and staff all need to be respected and be balanced. The Aged Care Act includes Security of Tenure (SoT) provisions designed rightly to protect individual residents.

ACSA supports the principle of Security of Tenure[83] for residents, it is important that residents feel safe and secure in their choice of accommodation.

However, concerns can arise where there are aggressive, intrusive, abusive or violets behaviours exhibited by residents with BPSD towards other residents, staff and others.

"The incidence of unpredictable episodes of physical aggression is increasing in residents with dementia and presents as the most challenging aspect of care. Equally challenging is the impact to staff managing these behaviours and the impact to those who are not adequately trained or skilled in managing these behaviours. Available support services are short term and insufficient to manage these residents. They also have a waiting period and are difficult to access quickly when needed."

ACSA Member

[83] User Rights Principles 2014, https://www.legislation.gov.au/Details/F2014L00808

Case Study: Mr Alfred James:

Alfred is in his early 70's, and is still physically active and mobile. Apart from his diagnosis of dementia he remains relatively healthy. Alfred, like many people with dementia displays BPSD, in his case this is manifest in regular bouts of verbally and physically aggressive behaviours. Other residents fear Alfred, as do many staff. The families of some other residents who are impacted by Alfred's behaviour are demanding the service remove Alfred from the facility. The service has enlisted the support of external dementia supports services, his GP and has had him assessed by a psychogeriatrician. He is currently in hospital following another recent outburst. Alfred's GP does not believe the current facility is suitable and recommends transfer to one that is in another regional town, but the family is refusing to agree to the transfer. In this case the resident will remain in the original facility through the Security of Tenure provisions.

The challenge is for government, the sector and consumer bodies to consider this important principle to address the needs and concerns of ALL concerned. The solution may in part be ensuring 'capability' at individual facilities as well as having appropriate levels of external dementia support services available (including SDCUs); whether 31 SCDUs spread across Australia will be enough to meet need is at this stage unknown.

Restraint practices

ACSA supports the appropriate use of restraints in residential aged care and encourages a proactive approach to restraint minimisation practices. ACSA has produced two guidance documents for members; which incorporate recent legislative changes[84] to the management of physical and chemical restraints. In summary:

1. Physical Restraint in Residential Aged Care, available here
    - Physical restraint should always be a last resort;
    - Be seen as a temporary solution and reviewed regularly;
    - Where used, the least restrictive form should be used;
    - Comprehensive resident assessment should occur, supported by documentation; and
    - Consent is an integral part of restraint implementation.
2. Psychotropic Medication use in Residential Aged Care, available here
    - The first line of response to BPSD should be psychosocial in nature;
    - When the use of psychotropic medication is considered, a thorough physical assessment should be undertaken by the treating medical officer;
    - Informed consent needs to be obtained by the prescriber; and
    - Regular review of the resident who is on a psychotropic medication should occur.

[84] The Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

ACSA is largely supportive of the new legislation which requires:

- Assessment by an approved health practitioner for physical restraint;
- Assessment by a medical practitioner or nurse practitioner who has prescribed the medication (for chemical restraint);
- Providers keeping comprehensive documentation relating to the use of restraints for individual residents including:
    - The behaviours that are relevant to the need for restraint;
    - The alternatives to restraint that have been used/considered; and
    - The reasons restraint is necessary.
- Allowing for restraint to be implemented without consent in 'emergency' situations.

In relation to the seeking of consent for physical restraint, approved providers are specifically listed in the Amendment (S15F) as having responsibility for gaining consumer (or their representatives) consent. However, in relation to chemical restraint, (S15G) the proposed legislation is silent on the requirement for consent. It is our expectation that it is the responsibility of the medical practitioner, as the prescriber to gain consent[85], but this is not explicitly stated. We believe, the legislation being silent on this point has the potential to create conflict on this important and fundamental responsibility. It is important that legislation is clear on this point so there is no confusion whatsoever. ACSA intends to pursue this apparent omission during the disallowance period for the legislation, which is still in force as a result of the Federal Election being called invoking caretaker provisions.
The subordinate legislation, introducing the changes, will come into effect from 1 July 2019 tying in with the commencement of the new quality standards. The parliamentary process means this legislation is adopted unless a politician proposes an amendment within 15 sitting days (the disallowance period) of its introduction.

Contemporary dementia practices

ACSA members provide a range of innovative dementia services that seek to provide contemporary, evidence-based approaches to better practice dementia services.

<u>The Household Model</u>

The model recognises that both the built environment of the care-setting, as well as the relationships within that setting, are critical and complementary parts of this model of care, which seeks to recognise the individuality of each resident, and encourages them to exercise independence.

[85] Both the Australian Medical Association in their *Position Statement: Restraint in the Care of People in Residential Aged Care facilities, (Revised 2015)* and the Royal Australian & New Zealand College of Psychiatrists in their *Professional Practice Guideline 10: Antipsychotic medications as a treatment of behavioural and psychological symptoms of dementia* indicate that gaining consent when prescribing medicines is essential for prescribers.

Under this approach, care homes are built as a series of small, domestic households typically with between eight to 15 residents each.

The built environment compensates for physical and cognitive limitations in an unobtrusive manner, while quality of life is promoted through a focus on dignity, independence, safety and family/carer participation in the person's care.

Staff are empowered to use both the physical and social environment *in concert* to promote the comfort and wellbeing of residents. Both environments can play important roles in supporting dignity; maximising independence and autonomy and promoting feelings of comfort, safety and security.

Case Study: HammondCare

HammondCare's small-scale domestic model of residential care for people living with dementia.

HammondCare operates a model of residential care for people living with dementia that recognises that both the 'built' environment of the care-setting, as well as the 'relationships' within that setting are critical and complementary parts of this model of care.

This model seeks to recognise the individuality of each resident and encourage them to exercise independence within a small 'household', domestic setting. Features of HammondCare's domestic households:

Built environment:

- Small households of 8-15 residents each;
- Single rooms and ensuites opening to a central open-plan;
- Residents have use of kitchen facilities and help with meal preparation as much as they are able;
- Households operate as much like a 'home' as possible (all 'back-of-house' activities which may disrupt or distress residents, including waste disposal, food and laundry deliveries, are performed out of sight and earshot of residents); and
- The objective of the household model is for residents to continue to engage in the familiar routines and rhythms of everyday life.

Social environment:

- Each home has a non-institutional, universal staffing model;
- Specialised Dementia Carers (SDC) work with the same residents on a regular basis, getting to know them over time;
- Each SDC works as a case manager for a small number of residents with a relationship focus;
- SDCs build strong relationships with their families and key health professionals outside the home, such as GPs;
- SDCs work flexibly to perform a range of domestic duties, such as preparing freshly cooked meals and cleaning, as well as providing personal care;
- SDCs structure their work around resident needs, rather than tasks, as well as participating in day-to-day decisions about the running of the cottage; and
- A team of registered nurses called Specialist Dementia Advisers (SDAs) work alongside SDCs providing clinical care and oversight, mentoring and advice.

Case Study: Life Care's "house model" incorporating best-practice dementia design

Life Care's Gaynes Park Manor in South Australia is based on the "house model" of people living in small communities within residential care.

Gaynes Park Manor is based on more intimate model than the traditional nursing home, attempting to minimize or eliminate institutional features – long corridors, standard nurse-call buttons in rooms, set breakfast times, etc.) in favour of a more calming, home-like environment catering specifically for those with dementia.

The building's dementia-friendly design won it the Gold Standard Accreditation from the Dementia Services Development Centre (DSDC) in the UK – the first residential aged care facility in the Southern Hemisphere to receive the award.

The building was designed with the experience of residents with dementia at the fore of the design with residents living in six 'houses' across three floors.

"Rather than building modern nursing homes that look very much like the ones we were building 15-20 years ago we tried to build something a little bit different that is aligned with dementia training and staffing model and align that with technology to give people a much better experience," said Life Care CEO Allen Candy.

Evidence supporting the "household" model

Recent research has demonstrated that this model of care produces significant improvements in care outcomes for aged care residents, particularly people living with dementia. A 2010 evaluation study showed the positive impact on residents when they moved from a conventional nursing home built in the 1970s to a smaller, domestic environment. The study found that the new, more appropriate environment and model of care contributed to both increased engagement and reduced distress among residents.[86]

In 2018, an Australian study compared the outcomes and costs of small home-like models with conventional models of residential aged care. It found that residents living in the clustered, domestic models, experienced significantly higher quality of life, were 68 per cent less likely to be admitted to hospital, had a 73 per cent lower chance of presenting to an emergency department[87] and were 52 per cent less likely to be prescribed a potentially inappropriate medication than residents living in standard facilities.[88] The study also estimated that if the people who lived in clustered models of

[86] Am J Alzheimer's Dis Other Demen. 2010 May;25(3):265-75. doi: 10.1177/1533317509357735. Epub 2010 Feb 11.

[87] Dyer, SM et al, 2018, 'Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life', *Medical Journal of Australia*, 208(10):433-438.

[88] Harrison SL et al, 2018, 'Costs of potentially inappropriate medication use in residential aged care facilities', BMC Geriatrics, 18(9).

domestic care were in more traditional aged care environments, it would cost approximately $13,000 more to support each resident per annum.[89]

Social environment – relationship focus in the "household" model

The household model recognises that the built environment alone cannot produce quality care outcomes for people living with dementia. The combination of the built environment with a model of care that promotes a relationship approach to care, that focuses on knowing residents as individuals and that empowers care workers is necessary for the full functioning of this model.

Innovative Dementia Programs

As well as different models of care there are a range of programs being implemented to improve support for residents living with dementia. Most providers employ a range of therapeutic interventions in place to support people with dementia. Therapies can include art, music, humour and performance.

There are numerous examples of innovative dementia programs that are provided by ACSA members, the following provided as illustrative examples of what is being attended across numerous parts of the sector.

Art Therapy

Engaging with art and arts practice in a residential setting to enhance quality of life

The work of an Art Therapist at has drawn out some positive changes in residents struggling with the transition to residential aged care.

Art therapy helped Reg* realise entering aged care didn't mean he had to give up the things that made him happy.

With the help of Art Therapist John, Reg was able to apply his artistic and theatrical interests to new pursuits within his home setting, and begun acting in short films directed by another resident. He has also started painting, contributing to many of the large murals painted by residents.

"I can't speak highly enough about coming here. I'm so grateful to John and the people in charge for looking after me. From a bloke who thought 'this is all over for me' when I first got here, it's been marvellous," says Reg.

*Not the resident's real name

[89] Dyer, SM et al, 2018, 'Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life', *Medical Journal of Australia*, 208(10):433-438.

Sensory Gardens are also a popular dementia program in homes. These are designed to stimulate the senses of residents in the form of sight, sound, smell, taste and touch. Dementia sufferers, in particular, benefit from the extra exercise, increased use of motor skills, improved levels of stress and a heightened sense of wellbeing the garden provides.

Sensory Gardens

Scented roses, succulents, lavender, thyme and Lamb's Ear feature prominently in the garden. The choice of these plants and flowers was based on their colours, texture and smell; and also, on the strong sense of memory and reminiscence that they provide for residents suffering from dementia.

It has been met with much delight from residents and staff who have enjoyed the mental and physical health benefits of the sensory garden.

"The residents love it. They go for a walk on the pathway and then have their morning tea in the seated area. Residents living with dementia don't produce new memories, however their old memories are still there and recoverable," says a carer at ABC Aged Care*

*Name of facility has been changed.

'Door Project'

Memory recognition is an important component of dementia care and there are a range of approaches to support memory. A number of ACSA members have introduced personalised doors for aged care residents to 'make them feel more at home.'

A personalised door, based on a memory of a first or more favourite home, is a great support tool. Most people, despite losing memories over the years, often never lose the memory of their first or most favourite home.

Mary Rose*, Residential Care Manager of Sunset Village is now bringing those memories to the forefront of her resident's minds, by changing the interface of their bedroom doors to reflect their original homes or personal preferences.

'We've tried other initiatives for our dementia residents, like lines on the floors directing them to their rooms – but studies have shown this can just lead to confusion," says Mary.

"Since the installation of the doors, we've seen a dramatic increase in the lack of confusion our residents experience. We've also had so many positive responses from the residents, some have even cried when they first saw their new doors."

*Name of staff member and facility have been changed

‘Nurturing past passions’

Social and activity programs are also designed to connect with and pursue their passions and past friendships.

One member recently supported a resident from a rural residential aged care facility to visit the High Country in Victoria, as part of nurturing his past passion for cross country skiing, and reconnecting with friends and associates.

This approach can be particularly important for residents located in isolated rural facilities.

The following account of the experience is in the resident’s own words:

“I am still a member of the local Nordic (cross country) Ski Club based at Mount Beauty close to Falls Creek. I joined the club many years ago. Firstly, I would like to thank my service provider and my facility manager for giving me the chance to visit my beloved snow country. I would especially like to thank my care worker for driving me there and back. I kept my promise to my facility manager and did NOT try to ski.”

CONCLUDING STATEMENT

ACSA welcomes the commitment of the of the Royal Commission into Aged Care and Safety to address growing community concern about the quality of the care provided and as an opportunity to have a national discussion about the care we want to provide older Australians, as well as what must be done to make that possible.

ACSA believes that the majority of care provided by approved providers and delivered by more than 300,000 passionate and committed workers around the country, is of a good standard. However, where problems occur in the delivery of care and services it is important these are recognised and addressed. We are a sector committed to continuous improvement and addressing problems where they occur. We have zero tolerance for criminal abuse, assault or negligence. Poor or inattentive care leading to needless suffering has no place in our sector.

There are many positive examples of innovation and quality service provision to residents across the country, a very small sample highlighted in this submission.

Government, and society must ensure that there is no discrimination against older people living in residential care in terms of societal standards and access to services that any human has a right to access. As part of ensuring this fundamental right the current design, regulation and financial underpinnings of the system need to be reviewed. This includes ensuring that the costs to deliver quality services to a standard that we all expect is understood, identified and supported through financing arrangements. ACSA contests that this requires additional funding as the needs of residents continues to escalate and as length of stay shortens, fundamentally changing the nature of the service provided. Other systems, providing shorter term more clinical supports receive significantly higher per day per resident funding. Even allowing for the differences in service delivery the disparity is stark. Much of the funding debate to date has required the overall funding envelope to remain the same as it currently is.

To paraphrase Professor Hal Swerissen, in his statement from Hearing 2 of the Commission 'unless we have additional money, we will be here again at some point in time discussing quality of care[90].'

We are pleased that this Royal Commission is providing an opportunity to generate such a discussion within the broader community and look forward to the positive opportunities that will come out of its findings and recommendations.

[90]Adelaide Hearing 2, 21 March 2019, Royal Commission into Aged Care Quality and Safety.

Appendix A:

In addition to the Daily ACFI subsidy rates above, the Quality Care Fund will be paid to assist provider to transition to new quality standards will be paid as an additional daily ACFI subsidy amount for the period 20 September 2018 to 30 June 2019.

Additional Daily ACFI subsidy rates – Quality Care Fund (20 September 2018 to 30 June 2019)

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	$0.00	$0.00	$0.00
Low	$0.20	$0.05	$0.09
Medium	$0.44	$0.10	$0.25
High	$0.61	$0.20	$0.37

In addition to the Daily ACFI subsidy rates and the additional daily ACFI subsidy amount for the Quality Care Fund, the $320 million temporary general subsidy boost will be paid as an additional daily ACFI subsidy amount for the period 20 March 2019 to 30 June 2019.

Additional Daily ACFI subsidy rates–Temporary Subsidy Increase (20 March 2019 to 30 June 2019)

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	$0.00	$0.00	$0.00
Low	$3.54	$0.81	$1.57
Medium	$7.71	$1.68	$4.47
High	$10.68	$3.50	$6.46

Appendix B

Residential Aged Care Supplements

These rates are applicable from 20 March 2018 to 30 June 2019.

Supplement	Amount of Supplement
Oxygen Supplement	$11.57
Enteral Feeding Supplement – Bolus	$18.33
Enteral Feeding Supplement – Non-bolus	$20.59
Adjusted Subsidy Reduction	$13.21
Conditional Adjustment Payment	Rolled into subsidy rates
Veterans' Supplement	$7.08
Homeless Supplement	$21.01