



## Australian College of Nursing

Australian College of Nursing (ACN) submission to the Australian Government Department of Health on *Specialist Dementia Care Units – Consultation Paper (November 2017)*

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## **ACN submission to the Australian Government Department of Health on Specialist Dementia Care Units – Consultation Paper (November 2017)**

### **General comments**

ACN supports the view that effective and high quality care and management of people presenting with severe behavioural and psychological/psychiatric symptoms of dementia (BPSD) can positively impact their quality of life and health outcomes. ACN recognises however that federal and state funding as well as effective oversight is lacking in BPSD where specialised care and services are often needed. Aged care facilities are often inadequately resourced in terms of clinical and management skills to meet the complex needs of residents with BPSD, which extend beyond high-level physical care, including lacking access to specialist nursing and medical services. BPSD symptoms are wide-ranging requiring an understanding by service managers that extends beyond lifestyle and basic care considerations. Nurses have the foundational skills to undertake skilled assessments, diagnosis, planning and regular review of care for people with BPSD. It is particularly crucial within BPSD service contexts that registered nursing roles not be substituted by unlicensed health workers (however titled) as occurs throughout general areas of residential aged care. Funding to support continuing professional development (CPD) education for nurse managers, registered nurses (RNs), enrolled nurses (ENs) and assistants in nursing (unlicensed health workers) is essential to the timely identification and appropriate management of residents presenting with severe BPSD. Such funding needs to be acquitted against the employment of skilled nurses rather than be added to the general revenue stream of service providers. Specialist education at a state and territory level is necessary to ensure a skilled workforce in the effective management of BPSD residents

As an overarching comment, ACN notes that greater consideration should be given to the duration of stay within the proposed 'Specialist Dementia Care Unit' (SDCU) model recognising that some people may not be able to transition back to their facility or to an alternative facility able to meet their care needs. The current model suggests a 12-month timeframe (Page 37; Section 4.4.3.1) for transitioning back into a long term/permanent aged care facility. ACN suggests the inclusion of assessment criteria that focus on the option of a person remaining within an SDCU facility beyond this timeframe if symptoms do not improve to obviate the possibility of their condition deteriorating following transition back into an aged care facility. Detailed procedures and clinical guidelines must be in place to provide an appropriate clinical pathway for these individuals.

### **Questions from the Consultation Paper**

#### **Q1) Are there are other system reforms that would impact on, or be impacted by, the establishment of Australian Government-funded SDCUs?**

Consideration should be given to the impact of SDCUs on the transition to end stage dementia (ESD) and palliative services; and how quality standards impact SDCU units as these accreditation standards may need to differ from those in mainstream aged care facilities where there is less emphasis on clinical and health services. In addition, outcomes of the current House of Representatives Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia may have an impact on the establishment of SDCUs.

#### **Q2) What other risks and issues need to be considered in introducing SDCUs into the existing service systems for people with very severe (tier 6) BPSD?**

The introduction of SDCUs is an essential initiative given the prevalence of people presenting with BPSD, anticipated increases in frequency, and the lack of appropriate facilities with the skills and resources needed to adequately cater for these special needs residents. Given there is limited evidence supporting the new SDCU operating model, a pilot study focused on clinical as well as quality of life outcomes would help identify any risks or issues. The Mental Health Aged Care Partnership Initiative (MHACPI) was a pilot of two special care units within a Residential Aged Care Facility (RACF) staffed with a multidisciplinary team of skilled professionals in managing severe BPSD. Evaluation of the initiative (completed in 2010) showed promising results in terms of outcomes for residents, staff, families, carers,

and demands made on acute hospitals. There were several critical success factors (organisational, environmental, educational, leadership, governance and partnership agreements).<sup>1</sup> The pilot had mechanisms in place for transitioning residents back into long-term care either through a complementary unit facilitating discharge of residents to permanent aged care facilities or the use of dedicated staff involved in a discharge program.<sup>2</sup> The evaluation provides a basis for the expansion of the MHACPI model and identifies areas for improvement particularly around operational and reporting arrangements.<sup>1</sup>

According to *The National framework for action on dementia 2015-2019*, SDCUs must have the ‘right mix of dementia friendly organisational policies, leadership, facility design, staff and resources’.<sup>3</sup> These factors must be taken into account when introducing SDCUs if risks to residents and others in the environment are to be mitigated against. ACN strongly endorses the need for an appropriately skilled workforce of adequate size, including appropriate access to specialist services to ensure safe and quality care is provided in RACFs.<sup>4</sup> In particular, RNs are highly trained and skilled health care professionals that are clinically “able to recognise and ensure early intervention and management in response to changes in an individual’s health, thus reducing the risk of deterioration and potentially reducing the need for unplanned admissions to acute facilities or transfer to emergency departments”.<sup>5</sup> The level of clinical judgement required on a 24 hours per day basis within SDCUs can only be delivered by RNs. Furthermore, RNs collaborate with a range of health professionals and service providers and are therefore well placed in the provision of collaborative, coordinated and integrated care within Residential Aged Care Facilities (RACFs).

To ensure quality and safe care is provided to people with BPSD, the need for appropriate professional nursing staffing levels and skill-mix must be identified within the proposed model. ACN recommends that regulation of RACFs should at a minimum mandate a requirement that an RN be on-site and available at all times to promote safety and well-being for residents and to oversee delegated tasks performed by unlicensed health workers (however titled). While this is our minimum expectation for RACFs, due to the complex care needs of SDCU residents, ACN anticipates that appropriate staffing of SDCUs would require more RNs in clinical roles to ensure the delivery of safe and effective clinical care. Furthermore, there is a need for unlicensed health workers (however titled) to be better prepared in terms of training and education, as well as regulation to ensure the safety of residents and to provide better support to RNs within RACFs.<sup>6</sup>

Maintaining appropriate numbers of registered and enrolled nurses in rural and remote areas may prove challenging even with government provided funding for the SDCU services. The establishment of expert professional teams within a stable and well-funded model could contribute to making such a career attractive to clinical nurses. Consideration should be given to attracting and retaining nurses who have a particular interest in specialisation in these areas. Noting the expectation that the proposed SDCU initiative will contribute to the international evidence-base, it is assumed that substantive and standardised monitoring and evaluation requirements will form part of implementation plans.

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<sup>1</sup> NSW Health. 2011, ‘Mental Health Aged Care Partnership Initiative Evaluation Summary Report’. Sydney, NSW. Accessed from: <http://www.health.nsw.gov.au/mentalhealth/Documents/mhacpi-evaluation.pdf>

<sup>2</sup> Sax Institute. 2017, ‘Specialist Dementia Care Units’. Ultimo, NSW. Accessed from: [https://www.saxinstitute.org.au/wp-content/uploads/Specialist-dementia-care-units\\_FINAL.pdf](https://www.saxinstitute.org.au/wp-content/uploads/Specialist-dementia-care-units_FINAL.pdf)

<sup>3</sup> Department of Health. 2015, ‘National framework for action on dementia 2015-2019’. Ageing and Aged Care. Canberra, ACT. Accessed from: [https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09\\_2015/national-framework-for-action-on-dementia-2015-2019.pdf](https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2015/national-framework-for-action-on-dementia-2015-2019.pdf)

<sup>4</sup> Australian College of Nursing. 2016, ‘The role of registered nurses in residential aged care facilities - Position statement’. Canberra, ACT. Accessed from: [https://www.acn.edu.au/sites/default/files/representation/position\\_statements/the\\_role\\_of\\_the\\_rn\\_in\\_residential\\_aged\\_care.pdf](https://www.acn.edu.au/sites/default/files/representation/position_statements/the_role_of_the_rn_in_residential_aged_care.pdf)

<sup>5</sup> Dwyer, R., Stoelwinder, J., Gabbe, B. & Lowthian, J. 2015, ‘Unplanned Transfer to Emergency Departments for Frail Elderly Residents of Aged Care Facilities: A Review of Patient and Organizational Factors’, *Journal of the American Medical Directors Association*, vol. 16, no. 7, pp. 551-562.

<sup>6</sup> Australian College of Nursing. 2016, ‘Assistants in Nursing (however titled) – Position Statement’. Canberra, ACT. Accessed from: [https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps\\_assistants\\_in\\_nursing\\_c5.pdf](https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps_assistants_in_nursing_c5.pdf)

ACN members have also identified several other risks and issues. These include:

- 1) Dementia as a progressive illness therefore the SDCUs will need to address the various transitions of dementia symptomology and identify the emergence of ESD and changes in clinical care required; and
- 2) Mobility issues and how SDCUs will address functional decline (e.g. immobile BPSD residents may be at risk by mobile BPSD residents) and safety issues.

**Q3) Are there alternatives to the establishment of SDCUs that would better address the current system issues, which should be considered by Government?**

Currently the needs of residents with severe BPSD are not adequately met within RACFs. Hospital services are also lacking in provision of effective responses to BPSD as residents with severe BPSD require specialised care for example, skilled assessment to identify behavioural triggers including hunger, pain, discomfort, environmental factors or overstimulation.<sup>3</sup>

Of the ACN members providing feedback to this consultation, there are those who believe there may be alternative approaches. These include:

- 1) Providing funding within existing RACFs to upskill RNs in identifying and managing BPSD and in the use of antipsychotics. Mandatory education and clinical skills assessment for RNs and ENs linked to accreditation could significantly reduce the number of residents requiring access to SDCUs.
- 2) Establishing specialist university and TAFE education and qualifications for care workers, ENs and RNs in dementia, BPSD and its impact on individuals and society.
- 3) Strong nurse led clinical leadership that can establish frameworks in BPSD care from assessing, planning and managing behaviours related to BPSD.
- 4) Attaching service specific to BPSD residents to residential and aged care facilities to be supported by a skilled multidisciplinary health care team.
- 5) Licensing of approved providers and key management personnel who have undertaken further qualifications in BPSD management issues, for clinical governance accountability associated with SDCUs, within the accreditation system.

**Q4) Do you consider 1,450 to be a reasonable estimate of the national demand for SDCU-like beds for people with very severe BPSD? If not what other factors and/or methodologies should be considered?**

Given the prevalence of very severe BPSD is estimated to range between 3550 to 4100 residents from the year 2017 to 2022<sup>7</sup>, and that 25-40% of tier 6 BPSD residents would likely benefit from a SDCU-like service<sup>8</sup>, then 1450 beds would be a reasonable estimate. The estimated demand is likely to increase by 2020 and consideration may need to be given to additional bed spaces or transferring residents between Primary Health Networks (PHN), particularly if waiting lists are long in one PHN and spaces are available in another PHN. Funding transferral should be an option, however transfers within PHNs may prove problematic due to distances within some PHNs.

ACN member comments on national demand include:

- 1) Consider the impact on numbers where residents become immobile or face ESD, and where family/carers may request removal from the SDCU.
- 2) Possible need to relocate residents to services distant from family if there are limited bed spaces locally.

**Q5) Are the proposed SDCU service principles appropriate? If not, how should they be amended?**

Yes, the proposed SDCU service principles are generally appropriate. ACN suggests specific inclusion of a statement recognising the special needs of Aboriginal and Torres Strait Islander (ATSI) People and the importance of fostering culturally competent services.<sup>9</sup> The inclusion of culturally and linguistically diverse (CALD) groups in these service

<sup>7</sup> Department of Health estimates using data in AIHW, Dementia in Australia, op. cit.

<sup>8</sup> SA Health, The Oakden response models of care project, op. cit., p. 33.

<sup>9</sup> Australian Government. 2013, 'National Aboriginal and Torres Strait Islander Health Plan 2013-2023'. Commonwealth of Australia. Canberra, ACT. Accessed from:

principles is also recommended. CALD older people are a special needs group within the Aged Care Act 1997 and CALD issues are a focus on the aged care agenda.<sup>10</sup> The New Aged Care Diversity Framework launched by the Minister of Aged Care, has highlighted the need to address specific challenges not only faced by CALD communities but also ATSI people, and people who identify as Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI).<sup>11</sup>

In addition, it may be appropriate to add a point on privacy in Principle 7 (page 25). According to HammondCare, Australia's leading dementia-specific service provider, privacy is closely linked to improved behavioural outcomes with BPSD residents.<sup>12</sup> Also consider adopting a "restorative" approach within Principle 1 and practices that "maintain dignity" within Principle 7 (page 25).

Furthermore, ePAT Technologies recently collaborated with Dementia Support Australia on a pilot study to use a newly developed online application program able to better recognise and interpret pain experienced by dementia residents. The overall goal was to provide more efficient diagnosis and treatment of pain for dementia residents presenting with additional challenges including verbal communication.<sup>13</sup> Hence, consider including a principle on a SDCU service open to future informatics and information technology approaches.

**Q6) Are the above benefits what SDCUs should be aiming to deliver? If not, why?**

Yes, benefits presented at all levels are appropriate. At the client level, additional consideration may be given to carer needs and requests. In particular, those who wish to remain and support their family member or significant other within the facility. For example, the Specialised Dementia Care Unit at Villa Terenzio in Western Australia introduced a new room in mid-2016 to cater for a couple wishing to enter care together.<sup>14</sup> At the service level, include services providing access to tailored CPD. At the aged care and health system level, additional benefits include strengthening relationships and collaboration between service providers and research institutions.

ACN members believe SDCUs should be aiming to:

- 1) Meet the needs of individuals, families and carers around accommodation, particularly in the early and moderate stages of the illness.
- 2) Outline a purpose built palliative approach, given the progressive decline of residents to ESD in the late and severe stages of dementia.
- 3) Form affiliations with research institutions to advance understanding of BPSD and to test clinical efficacy of models of care and specific clinical interventions.

**Q7) What are the pros and cons of the SBRT performing the SDCU assessment service role? What other body (or bodies) might appropriately carry out this role?**

Regarding 4.4.1.2 Referral Pathway, it is unclear what role/s are being referred to by the "treating specialist" within the following sentence "Referrals will need to be supported by input from the treating specialist or GP". Aged Care Nurse Practitioners (NPs) would be suitably placed to support referrals and are likely to have a more regular and deeper engagement with aged care consumers. Figure 7: *SDCU proposed assessment elements* states GPs will have a key role in the referral process. ACN recommends NPs are included in the same capacity within the proposed

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Government [http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf)

<sup>10</sup> Australian Ageing Agenda. 2014, 'Time to move CALD to policy centre'. Accessed from: <https://www.australianageingagenda.com.au/2014/03/27/time-move-cald-policy-centre/>

<sup>11</sup> Department of Health. 2017, 'Aged Care Diversity Framework – Aged Care Sector Committee Diversity Sub-Group'. Canberra, ACT. Accessed from: [https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12\\_2017/aged\\_care\\_diversity\\_framework.pdf](https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2017/aged_care_diversity_framework.pdf)

<sup>12</sup> HammondCare. 2013, 'Dementia and BPSD: Submission to the Community Affairs References Committee'.

<sup>13</sup> Australian Ageing Agenda. October 2017, 'National aged care dementia service to trial facial recognition app'. Accessed from: <https://www.australianageingagenda.com.au/2017/10/20/national-aged-care-dementia-service-trial-facial-recognition-app/>

<sup>14</sup> Italian Aged Care. 2017, 'Villa Terenzio Specialised Dementia Care'. Marangaroo, Western Australia. Accessed from: <http://www.iaci.com.au/specialised-dementia-care.html>

pathway to potentially increase service access and timeliness, and to ensure NPs are appropriately consulted where they are the primary treating specialist.

In terms of pros, it is reported that the government funded SBRT consists of a mobile multidisciplinary workforce of staff, and should be easily accessible to provide “timely” advice to aged care staff with BPSD residents. In terms of cons, it is reported that the service is specific to Australian Government funded residential aged care providers and staff.<sup>15</sup> This role could potentially be carried out by the Dementia Behaviour Management Advisory Services (DBMAS), reported to provide assessments of persons with BPSD dementia.<sup>16</sup> According to Dementia support Australia, DBMAS have established procedures to decide when SBRT or DBMAS is the best service/support option. It is reported that DBMAS provides support in any setting (residential or community) and in acute care support, and support is available to residents, carers, family, aged care staff and other clinicians.<sup>15</sup>

**Q8) Might the requirement for evidence of a primary dementia diagnosis (as described above) impact on timely access to SDCU services for some people with BPSD?**

Yes, many residents with dementia who are living in RACFs do not have a formal diagnosis of what may be causing their dementia symptoms. Thus the requirement for a formal diagnosis may impact a GPs or geriatricians workload, which may already be strained by current health care demands. Access to a geriatrician in rural and remote areas may also be limited and GPs may be reluctant to provide this diagnosis. NPs must be included to optimise access and timeliness of these services.

ACN members believe that early detection and diagnosis of dementia is essential in ensuring successful care planning and outcomes for residents and their carers/families. Diagnosis can often be difficult due to existing comorbidities affecting patient behaviours, as well as patient (or family and carers) denial or refusal for assessment. To ensure timely access to SDCU services, RNs within the community and RACFs should be supported by additional training in the clinical screening of patient symptoms/behaviours using validated cognitive assessment tools. This would allow efficient referral to a specialist geriatric nurse practitioner or general medical practitioner for a primary diagnosis of dementia as well as investigations and follow-up.

**Q9) Are the proposed assessment arrangements appropriate? If not, why not?**

ACN believes that RNs are “the key personnel qualified to assess, plan, implement, monitor and evaluate nursing services. They are well placed to collaborate with other health professionals and service providers in the coordination, management and delivery of care. They are the health professional best able to lead new models of care in the context of residential aged care”.<sup>4</sup> For this reason ACN recommends RNs be appropriately engaged in the work of developing assessment processes and placement arrangements for SDCU services.

Consistency in assessment arrangements provided by the person’s current service provider and/or health provider is essential for SDCU entry. Within a RACF, a RN led team is required to review and address patient behaviours and symptoms through existing recording systems (e.g. ABC chart, wandering chart). Within the community, consistency in reporting and assessment from case managers, clinical advisers and family would be required.

Regarding point 4 (page 32) on “the likelihood ... (to) transition back to a mainstream care setting...”, greater consideration needs to be given to situations where this is not feasible. If residents cannot return to a mainstream service a plan on how to meet the needs of these special care residents needs to be addressed.

**Q10) What other factors should the SDCU assessment service consider in deciding whether to recommend a person for a SDCU placement?**

<sup>15</sup> Dementia Support Australia. 2017. ‘Frequently Asked Questions’. Accessed from: <https://www.dementia.com.au/faqs>

<sup>16</sup> Dementia Behaviour Management Advisory Services (DBMAS). 2013, ‘Information Sheet for Referral Partners’. Greenwich, NSW. Accessed from: <http://www.mhcc.org.au/media/27375/dbmas-info-sheet-referral-partners-010813.pdf>

ACN members believe that SDCU placements should take into account the mobility of residents, particularly those presenting with high care needs for activities of daily living (ADLs) as this would require a staff and skills density sufficient to ensure quality patient care is provided. Residents would then need to be moved back into nursing home general care for end of life care pathways (EOL).

The SDCU assessment service may need to consider procedures and approaches for managing repeated requests for an SDCU placement by residents or carers in the event of not being able to satisfactorily meet the criteria.

**Q11) Is an 8–12 bed unit (within a larger residential aged care facility) the appropriate care setting for SDCUs? Are there circumstances in which larger or smaller units would be more appropriate?**

SDCU beds attached to a larger RACF would be appropriate for continuity of care for residents and carers. Residents and carers would benefit with the familiarity of the environment and limited disruption in moving across to the SDCU bed, which could exacerbate a person's symptoms and behaviours. Similarly, these benefits would also apply when transitioning residents back to a RACF from an SDCU bed within the proposed 12-month duration of stay timeframe.

ACN members commented that consideration should be given to 'butterfly' models of SDCU service delivery for early and moderate stages of dementia to preserve community connections and support functional care, and end stage accommodation for ESD and palliative approaches. Dementia care in residential contexts has traditionally been task oriented and institutionalised in nature however the 'butterfly' model aims to transform the way people with dementia are cared for with a focus on "their emotions, and replicating home-like environments and everyday activities they enjoyed earlier in life" to increase quality of life.<sup>17</sup> A 'butterfly' model introduced in Australia (Barunga Village) saw the "complete refurbishment of the interior spaces where they live, to ensure the rooms are colourful, highly engaging and emulating a home environment....a key aspect of the model is developing small households to create family-like environments. The residents are grouped in the houses with their fellow residents who are at similar levels of dementia to give them the best chance to thrive and have a sense of wellbeing, while enabling our staff to provide specialist skills in focused groups".<sup>18</sup>

**Q12) Should there be a maximum limit on the duration of an individual's residence within a SDCU? If not, why not? If so, how long?**

No, time limiting is a blunt instrument with little to no relevance for patient needs and clinical goals. Without a specified pathway to suitable care facilities there should not be a limited time. While a "restorative" approach to symptom management is recommended, a primary focus should not be on a specified duration of stay. Residents may continue to present with BPSD symptoms at the suggested 12-month timeframe for transitioning back into a RACF, which may not be an appropriate facility to address high care BPSD needs.

In specific cases, duration of an individual's residence may be dependent on the identification of end stage dementia and the mobility of the patient, and would require well-coordinated and dedicated case management through multidisciplinary health care teams. Consideration should also be given to how changes to the individuals' residence might impact their behavior and symptoms.

**Q13) What is a reasonable period for transitional support from a SDCU to the new accommodation provider?**

Setting what is "a reasonable period" for transitional support from a SDCU should be determined following assessment of service need. Ideally, this would occur once the services have been operational for a period and service demand and usage patterns evaluated.

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<sup>17</sup> Aged Care Insite. 2017, 'For a new approach to dementia care, explore the Butterfly effect'. Accessed from: <https://www.agedcareinsite.com.au/2017/07/for-a-new-approach-to-dementia-care-explore-the-butterfly-effect/>

<sup>18</sup> Barunga Village Inc. 2017, 'Butterfly Household Model of Care launches at Barunga Village' Port Broughton, South Australia. Accessed from: <http://barungavillage.com.au/butterfly-household-model-of-care-launches-at-barunga-village/>

Some ACN members suggest that residents should remain in the SDCU service until the need for a palliative approach emerges because environmental changes accompanying transition may contribute to further deterioration in the residents' symptoms.

**Q14) Might existing security of tenure arrangements pose a significant issue for the 'transitional' operation of SDCUs? If so, how?**

ACN is advised that some services cannot meet the needs of a challenging and complex client. ACN has been advised that current entry and exit clauses are unlikely to present issues and that residents' rights addressed under the legislative provisions. Proficient case management and partnerships with families allows for transparent discussions around transitions between services when needed.

**Q15) What strategies could be used to facilitate SDCU 'throughput' within existing security of tenure provisions?**

ACN is advised that once the person has been accepted for care within a facility the security of tenure rules apply. The issue of whether a facility has the capacity to meet the needs of any patient is determined on admission through professional nursing assessment in collaboration with medical advice. Facilities that fail to accurately assess the needs of applicants against their capacity to provide effective and appropriate services is a dereliction of approved provider responsibilities. The variable nature of BPSD symptoms and the aetiology of the behaviours requires more time than in general admissions so that the person can be closely observed and possible causative factors identified and tested. It is possible that errors of clinical judgement could occur and (a) the patient's condition resolves within a few weeks of admission; or (b) the patient's BPSD further deteriorates. ACN members suggested that a trial period following admission, within which further assessment and validation of clinical judgement can occur, is justified for BPSD residents. There may be scope for the current security of tenure provisions to be confirmed at, for example, 8 weeks post-admission providing a safeguard for both residents and service providers against risks to safety.

**Q16) What mechanisms should be used to support partnerships between SDCUs and acute services?**

Aged Care Nurse Practitioners are well positioned to optimise timely access to services and this should be emphasised at the end of Section 4.4.4.3. NPs within PHNs could be appointed to work across the interface between aged care, community home care and hospital services to lead the assessment care planning and transitional requirements of residents with PBS conditions. These NPs could be funded as part of the SDCU allocation as well as the hospital and health services funding. This would legitimise these specialist NPs within both sectors and provide them with access to specialists and systems needed to be activated to provide appropriate services.

**Q17) Should there be any additional requirements for SDCU providers caring for people from Aboriginal and Torres Strait Islander, CALD or other diverse backgrounds?**

Yes. It is now recognised that a large proportion of older people are from CALD backgrounds and numbers are expected to rise in Australia. There is also a growing community of older refugees accepted as Australian residents who also require unique and sensitive assessment and service provision. Culturally appropriate care provided by SDCUs would be required to overcome barriers that exist for people from these backgrounds.<sup>19</sup> Similarly, aged care can present unique challenges to people from Aboriginal and/or Torres Strait Islander communities who tend to hold strong connections with their families and land.<sup>9</sup> These should also be addressed within the SDCU framework.

**Q18) Would it be feasible to establish SDCUs in rural and remote locations? How can SDCUs (or alternative initiatives) best support people with very severe BPSD living in rural and remote areas?**

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<sup>19</sup> Department of Health. 2016. 'National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds'. Ageing and Aged Care. Canberra, ACT. Accessed from: <https://agedcare.health.gov.au/older-people-their-families-and-carers/people-from-diverse-backgrounds/national-ageing-and-aged-care-strategy-for-people-from-culturally-and-linguistically-diverse-cald-backgrounds>

Yes, and they should be attached to rural and remote nursing homes as well as the local health services and PHN networks. Flexible service compliance arrangements may be required that incorporate telehealth strategies and plans to enable greater specialist engagement with rural and remote communities.

**Q19) What specific costs would contribute to the ‘top up’ amount?**

In order to provide an effective service, sufficient resourcing is needed to attract specialised nursing clinicians as well as engaging local medical practitioners. Administratively, these units will need sufficient resourcing in order to liaise with PHNS, medical networks and hospital services to build a care plan around the needs of the person experiencing BPSD. It is essential that funding must be stable and continuous and not determined by bed occupancy if expert teams and services are to be established and maintained. ACN members commented that a minimum of \$300 per day was necessary to facilitate specific assessment and care planning; higher volumes of staff education; specialised case management; and individual intervention and therapy plans.

**Q20) To what extent might these costs vary across SDCUs, for example in response to geographic location or local mix of people with BPSD?**

ACN members commented that the bulk of expenses in metropolitan areas are generally associated with costs to accommodate, whilst in rural areas isolation is another cost incurred. In both contexts the costs of travel can be extensive and particularly if family members are trying to maintain close contact and engagement with the person’s care and treatment.

**Q21) Which ‘top up’ funding option do you prefer? Why?**

ACN members provided differing views on funding options, which include:

- 1) Providing a daily top up allowance (e.g. \$300/day) to the approved unit per person diagnosed with severe BPSD. This allowance would reduce or cease at the end stage of care to reflect standard palliative care funding.
- 2) Grant funding linked to specific outcomes to be achieved in the management of persons with severe BPSD in SDCUs. SDCUs would be provided with a lump sum and funding managed within a pre-planned budget with itemised services. This would also allow budget flexibility when more funding is needed for a particular service and make monitoring of spending more visible. Renewal of grant funding would be ensured if the facility meets the criteria for achieving specific outcomes.

The stability and reliability of option (2) offers a greater opportunity to attract and retain specialised nurses who commit to a particular professional pathway. The administration of these units would also benefit from being protected from funding fluctuations associated with bed occupancy which then translates to reduction of staff work hours offered each week.

**Q22) Are there other funding mechanisms that should be considered?**

ACN members have identified several other funding mechanisms that may also be considered. These include:

- 1) Medicare funding through Chronic Disease Management to allow fees and services from MDHT
- 2) Care team arrangements
- 3) GP and NP interventions and case management
- 4) Funding instrument for above HHH in the Aged Care Funding Instrument (ACFI) and fee for service from consumer.

**Q23) Is block funding, occupancy-based funding or a combination of both most appropriate for SDCUs? Why?**

SDUs will require the construction of a service provision environment that ensures safety of residents as well as others within the environment. The investment required in these units will be considerable and would require some capital funding. Once established, block funding is most likely preferable as it is not dependent upon bed occupancy for funding to be maintained. ACN members advised that if the funding minimum is set at mid level 3 with an option of increasing the daily top-up according to increased behavioural symptoms and health care needs then it is possible to have a funding system calibrated to meeting residents’ needs that also enables the specialised unit and expert teams to be maintained.

**Q24) Are the proposed uses of 'top up' funding appropriate or should there be other costs included or excluded?**

Building upon the basic raft of funding required to maintain this care and treatment service, the funding required to engage professional clinicians to commit to the service will be greater than for ordinary aged care services. ACN members suggested that this funding can be part of a top up model or it could be a percentage based on the higher salaries of medical and nursing specialist clinicians. This further funding could be monitored through an acquittal system where the funding can only be expended on professional salaries and not converted to general revenue or pay for substitutional staff. The funding level could also be contingent on manager/administrator licencing based on attainment of further qualifications in BPSD management e.g. Graduate Certificates or Certificate IV level qualifications. This clinical governance requirement would ensure that fund managers understand the nature of BPSD units and appreciate the need for resourcing required to achieve clinical and safety outcomes.

**Q25) With no specific capital funding for SDCUs proposed – is there a minimum funding period to justify an operator investing to establish a SDCU?**

The cost of conversion of existing residential services to SDCUs includes the loss of general aged care beds as well as approved providers meeting their duty of care towards residents and staff. The possibility of poor return on investment in costly conversions to create SDCUs could act as deterrents to many providers who are experiencing constraints through ACFI funding overall.

**Q26) Do the proposed provider funding arrangements pose any financial sustainability risks?**

Yes, risks are apparent in terms of being able to set up the units; attract highly skilled professionals; establish intersectoral links with PHNs and health services; and also to meet high standards of care and services for a complex resident group. In the event of discovering that the SDCU is unsustainable, the security of tenure arrangements would force the approved provider into a regulatory risk area that seems to have few options for resolution other than transfer BPSD residents to the nearest hospital with potentially no means to accept them back.

**Q27) Should any special resident fees and payments arrangements apply to people receiving care in a SDCU?**

Any fees and payment arrangements must rigorously support equity in access to SDCU services. Access to the full extent of SDCU service provision must be on the basis of need, not a person's financial circumstances. Approved providers must not, however, be expected to subsidise residents who cannot contribute to their own care costs, government provision in terms of a special classification for extended financial assistance will be required.

**Q28) Are the proposed provider selection criteria appropriate? Do you consider some selection criteria mandatory?**

In terms of mandatory selection criteria, it is essential that providers are required to meet SDCU minimum workforce stipulations that ensure SDCUs are staffed by appropriately skilled nurses at all times. Further criteria need to be applied to approved providers and executive teams to ensure that they understand their clinical governance responsibilities in adequately resourcing the units and supporting intersectoral links. Ideally this would mean setting up criteria for licencing approved providers and key personnel who wish to be eligible to undertake SDCU service provision.

**Q29) Which factors should be prioritised in determining the regional rollout schedule and why?**

ACN members recommended that this should be on a national basis and subject to the number of inquiries to an area and substantiated locality, access to other services, and what is currently available in local areas. Regionally, most of the residents requiring SDCU services would already be known to local PHNs and hospitals and they could be canvassed for evidence of frequency of demand for such services.

**Q30) What factors should be considered in evaluating the SDCU program?**

Factors for consideration in evaluating the SDCU program include:

- 1) As a specialist clinical service, the criteria for success needs to be established at the outset and incorporate clinical outcomes as well as monitoring referral patterns incoming and outgoing from the SDCUs.

- 2) Levels of professional staffing against the increased funding for professional salaries could be an indicator of management capacity for running the SDCUs.
- 3) Engagement of the unit in making training opportunities available for medical and nursing personnel in surrounding aged care, community and hospital services could indicate the unit's commitment to workforce sustainability.

The SDCU program should be evaluated based on feedback from residents, family and carers (e.g. satisfaction of services); patient outcomes (e.g. reduction of behaviours); staff feedback (e.g. staff satisfaction, perceptions of service performance); and education provided (e.g. staff training and CPD requirements).