ACCPA

Aged & Community Care Providers Association

Revised Aged Care Quality Standards

Consultation Paper

Submission

November 2022

About ACCPA

Aged and Community Care Providers Association (ACCPA) is the national Industry Association for aged care providers offering retirement living, seniors housing, residential care, home care, community care and related services.

ACCPA exists to unite aged care providers under a shared vision to enhance the wellbeing of older Australians through a high performing, trusted and sustainable aged care sector. We support our members to provide high quality care and services while amplifying their views and opinions through an authoritative and comprehensive voice to the government, community, and media.

Our sector serves to make better lives for older Australians, and so do we.

Background

In response to the Royal Commission into Aged Care Quality and Safety the Australian Government (the Government) is reviewing the Aged Care Quality Standards.

The review is focussing on improving governance, dementia care, diversity, food, and nutrition and strengthening clinical care.[1]

Government commissioned an independent evaluation tasked with focussing on whether the Standards are easily understandable; their relevance; whether they are achievable and measurable; the impact of the Standards on consumers and what are the barriers to achieving the Standards.[2] An evaluation of the current Standards was undertaken by KPMG with results released earlier this year.

The Department of Health and Aged Care (the Department) subsequently released a consultation paper on the Revised Aged Care Quality Standards

ACCPA is pleased to submit our response to this important consultation paper (the Paper).

[1] Independent Evaluation of the Aged Care Quality Standards, Department of Health and Aged Care, Australian Government 2022
[2] Consultation Paper: Aged Care Quality Standards Review Summary Consultation Paper, Department of Health and Aged Care, Australian Government 2022

Executive summary

ACCPA supports the introduction of new Aged Care Quality Standards that improve the quality of life of older Australians receiving Commonwealth funded aged care services.

They must be written in a way that makes them measurable and achievable and they must be clear in what they are expecting of providers[3].

They must also be written such that they allow for consistent interpretation and application by both the regulator[4] and providers.

The revised Aged Care Quality Standards (the Standards) will need to be introduced and used for a period before we will know whether they achieve these things.

Successful introduction of new Standards will occur only if they are supported by a transition plan for the sector, supported by good quality guidance / education / support materials that are available well ahead of implementation date, and with an adequate transition timeline (of at least 12 months).

Goals for the revised Quality Standards

The Summary Consultation Paper[5] includes the following goals in revising the Standards:

- *A stronger focus on the older person:*
  We are comfortable this has been achieved. *Standard 1: The Person* focuses on the individual, with Outcomes that include person centred care; dignity respect and privacy; choice and independence; and transparency. Additionally, the structure of the Standards has been changed with each Standard prefaced with an expectation statement that is framed from the perspective of the older person and written in the first-person.

- *Clearly communicates expectations and what actions providers can take to achieve the desired outcomes:*

  In the new structure each Standard comprises a statement of intent, an expectation statement (framed from the perspective of the older person), outcomes and actions.

  ACCPA is supportive of this approach.

  The independent review of the current Standards by KPMG included examination of the 'clarity of the wording' of the Standards.[6] On this front we have concerns with some of the wording of the revised Standards, including the following:

  - Use of words / phrases like '*with kindness,'* '*regularly reviewed*,' a '*healthy and resilient workforce*,' '*effectively communicated*' are open to varied and inconsistent interpretation. They are too broad and general. Phrases like '*optimise my wellbeing*' are motherhood statements. Clarity of language is paramount and is needed to enable those applying the Standards to have a common understanding of what they mean allowing for consistent application;

[3] An approved provider is an organisation that has been approved by the Commission to deliver Australian Government subsidised home, residential or flexible care services to eligible older Australians.
[4] The Aged Care Quality and Safety Commission
[5] IBID, p6
[6] Independent Evaluation of the Aged Care Quality Standards, Department of Health and Aged Care, Australian Government 2022

this applies equally to providers and Aged Care Quality and Safety Commission (the Commission) assessors.

- Maximum effort must be attended by the authors of the revised Standards to reduce subjective terms and language that are open to varied interpretation and application. This will be aided by the provision of clear guidance materials.

- The words '*regular*' or '*regularly*' are used in numerous Actions across various Standards. Guidance materials will need to explain what is meant by these terms and how providers would evidence they are achieving this requirement.

ACCPA recommends an audit of the revised Standards is undertaken to minimise the use of words that are subjective and open to varied interpretation and application. Doing this will improve the useability of the Standards.

- *Enables some Standards to be applied based on the types of service being delivered:*
  ACCPA recommends adopting an approach that applies individual Standards to relevant services, depending on what services the provider is registered to deliver. Currently the Aged Care Quality Standards apply to all Commonwealth-funded aged care services regardless of the risk profile of the provider or the service type.[7]

  Government is proposing to introduce an approach where providers register to deliver different service types. Under this approach Quality Standards would be applied depending on the types of services being delivered by the provider. This is vital in an environment that is moving to a more seamless aged care system that better aligns the spectrum of aged care services from non-complex service types (such as gardening or maintenance services – where providers are registered to deliver just these services – and who may not be subject to the Standards) through to complex and clinical care service delivery where a provider may be subject to all the Standards. We support this approach.

- *Improves harmonisation across NDIS, aged care, and veteran's care:*

  Harmonisation across these three sectors is important. There is work currently occurring to harmonise key areas of commonality including in relation to the Standards, albeit this appears to be occurring slowly. Currently aged care providers who have residents that are also recipients of NDIS funding (referred to as dual participants) are experiencing all sorts of headaches due to having two regulators, two sets of Standards, and dual reporting requirements among other duplications. For many providers this is disincentivising the taking on of older Australians who need aged care but who also happen to be in receipt of NDIS funding. This is a poor outcome for those older Australians.

  Harmonisation work now occurring between the respective Commissions must address this as soon as practicable, including in relation to harmonisation between

[7] Consultation Paper: Aged Care Quality Standards Review Summary Consultation Paper, Department of Health and Aged Care, Australian Government 2022, p7

the Standards. We would like to avoid further changes to the Standards further down the road as a result of harmonisation lagging the introduction of new Standards.

Carve outs for the In-Home Care environment

Currently there is only one carve-out for the in-home aged care environment, and this is in *Standard 4 The Environment: Outcome 4.1a Environment and Equipment at home*.

ACCPA supports this carve out.

We believe there are other opportunities for in-home aged care carve-outs, including:

- *Standard 3 The Care and Services*. Outcome 3.4 addresses coordination of care and services. ACCPA recommends that a carve-out of a home care specific Outcome for in-home care service providers be attended that addresses the coordination of care and services in a multi provider environment, specifically:
    - Outcome 3.4a: Coordination of care and services at home
    - Outcome 3.4b: Coordination of care and services in a service environment

- *Standard 4 The Environment*. Outcome 4.2 reads as if it has been written primarily for a residential care setting. We recommend a carve-out is made for in-home aged care services with a stand-alone Outcome:
    - Outcome 4.2a Infection prevention and control at home; and
    - Outcome 4.2b Infection prevention and control in a service environment

  Infection Prevention and Control (IPC) in the home care context is different from that in the residential aged care setting and warrants its own Outcome. IPC leads are used in the residential care setting, the relevance of their use in the home care setting needs to be considered.

- *Standard 5 Clinical care*. The provision of clinical services in the older person's home is sufficiently different to the residential aged care environment and contains enough of its own challenges and requirements that it warrants a stand-alone Outcome written specifically for the in-home aged care environment. Such an Outcome must be co-designed with the people who deliver these services. See section below *Standard 5 Clinical Care* for more commentary.

- *Standard 6 Food and nutrition.* We understand that this new Standard, as currently written, is intended only for residential aged care. We recognise that in the future it may be considered appropriate for the Standards to cover food in the home and community care environment (for example in the in-home aged care program, in relation to delivered meals services, in day centres, and respite services). Should this be deemed necessary we recommend that a stand-alone Outcome be developed for the in-home aged care environment and co-designed with providers that deliver these services.

- *Standard 7 The Residential Community: Outcome 7.2 Planned transitions.* Again, we understand that this revised Standard as currently written is intended for residential aged care. We recognise that in the future it may be considered appropriate for the Standards to cover planned transitions in the in-home aged care environment particularly as this environment engages a range of primary health practitioners, community health providers, approved providers and in the future the potential for

multiple service providers to the older person. Should this be deemed appropriate we recommend that a stand-alone Outcome be developed for the in-home aged care environment and again co-designed with those providers that deliver these services.

Infection prevention and control

- Currently this is addressed in *Standard 4 The Environment: Outcome 4.2 Infection prevention and control*. Given the pandemic Australia has experienced over the last three years and the fact that COVID-19 is now endemic, plus the ongoing risk of other infectious outbreaks that periodically occur in residential aged care we recommend that infection prevention and control be given its own stand-alone Standard.

  Subsuming it into another Standard does not give it the prominence it requires. We will discuss this in more detail further down.

Planned transitions

Planned transitions are currently addressed in *Standard 7 The Residential Community: Outcome 7.2 Planned Transitions*. We support this Outcome.

ACCPA recommends Outcome 7.2 be transferred to *Standard 3 The Care and Services* as we believe it more naturally fits with that Standard. Standard 3 contains matters spanning assessment and planning; delivery of care; communicating safety and quality; and coordination of care, planned transitions fit naturally with these topics. We will discuss this in more detail further down.

Culturally safe, trauma aware and healing-informed care

There are references across multiple Actions to *'culturally safe, trauma aware and healing-informed care*' (for example see Action 2.9.6(b)). Whilst many in the sector will already be delivering on this, some providers will not be familiar with the concept.

Guidance materials will need to explain what it is, what is expected of providers and how providers will evidence it. The guidance materials should include references to sourcing information and training / education materials on this subject.

Contemporary, evidence-based practice

There are several refences in the revised Standards to '*contemporary, evidence-based practice*' (see for example Action 5.1.2(c)).

There is potential for a wide variety of interpretations (by both the regulator and providers) of what constitutes a practice that is contemporary and evidence-based. Consistency of understanding of what this means will be needed by the regulator and by providers. Guidance materials must explain what is meant by the expression (including clear examples) and how providers would evidence they are meeting this requirement.

Transitioning to the new Standards

The Standards as outlined in the consultation paper are described as being 'revised.' Feedback we have received from many providers is that they are more than a revision and would be better described as new Standards. It is believed that significant effort will be required to transition to them.

There must be a transition plan for the sector to follow. We require a clear understanding of the transition timeline (to the new Standards) and the transition support that will be given to

the sector (for example guidance materials, education support, training support) to be able to understand the impact on providers to transition.

As we write we do not know how much effort and resources will be required to move from the current Standards to the new ones.

Sufficient and adequate notice will be needed by providers to plan for and then transition to the new Standards. At a minimum, twelve months will be needed, and all required resource and guidance materials (guidance manuals, education packages and training materials) must be available at the start of the twelve-month countdown.

Providers will require at least twelve months to update their systems, policies and processes and provide training to their staff.

An effective change management process, overseen by the Department of Health and Aged Care (the Department) will be needed to enable a smooth transition.

ACCPA recommends the Department attend a mapping exercise that shows the sector the changes from the current Quality Standards to the new ones and that this be available to the sector at the start of the planned transition period i.e. available at least a full twelve months out from the date the new Standards are slated to commence.

Aligning the revised Standards to the in-home aged care program

ACCPA is concerned that the design of the new Standards is occurring ahead of the design work for the in-home aged care program and that the requirements of the two may not be sufficiently aligned. That is, the design of the in-home aged care program will not fully align with the requirements of new Standards, requiring further changes to the Standards down the line. This is a risk for the sector.

The two should be designed, each with an eye on the other, and ideally, they should be slated to commence at the same time. The sector must continue to be consulted on both streams of work as it is providers who are the people responsible for both delivering in-home care and services and for implementing the Standards, who will be best placed to identify issues of (mis)alignment between the two.

The proposed in-home aged care program proposes several changes from the current arrangements including the ability for consumers to have multiple providers delivering their care and services. We need to carefully consider the impact on provider governance responsibilities in such an environment.

Governance

Standard 2 describes requirements for how organisations are to be run. The stated intent of this Standard is said to be to hold the governing body '*responsible for meeting the requirements of the Standards*.'[8]

Following the Royal Commission into Aged Care Quality and Safety the Australian Government introduced new legislation that addresses provider governance matters that commence on 1 December 2022 (the Principles).[9] These Principles cover matters spanning:

- Governing body
- Quality aged care advisory body

[8] Revised Aged Care Quality Standards Detailed version for public consultation, Department of Health and Aged Care, Australian Government, p11
[9] Aged Care Legislation Amendment (Governance and Reporting for Approved Providers) Principles 2022

- Consumer advisory body
- Staff qualifications, skills, and experience
- Provider constitutions, and
- Key personnel matters

These are now outlined in the Provider responsibilities relating to governance guidance document.

How the Commission interprets these and applies its approach to the legislated governance Principles will be important. Their approach must be consistent with the intent of the Principles. With the introduction of new Standards ACCPA would like to see an approach from the Commission that promotes good quality care provision, and that encourages a focus on education, quality, innovation, and that recognises excellence and partners with providers.

Feedback on the individual revised Standards

Standard One: The Person

ACCPA supports the intent and expectation statements for this Standard.

Outcome 1.1 Person-centred care

- Action 1.1.2(b) describes care that is '*trauma aware and healing informed*.' Whilst many in the sector will already be delivering on this, some providers will not be familiar with the concept. Guidance materials will need to explain what it is, what is expected of providers and how providers will evidence it (also see Action 3.2.1). Education and training support for the sector in this matter must be a part of the suite of supports provided.

- Action 1.1.2(c) makes references to delivering care that is '*right for people with specific needs and diverse backgrounds, including for Aboriginal and Torres Strait Islander peoples and those with dementia*.' It refers to culturally safe care.

  Application of the Standards must recognise the complexity that is present in delivering services to Aboriginal and Torres Strait Islander peoples, particularly in country and remote locations where the focus on service delivery must be about priorities and need.

  Providers must deliver care and services that are truly culturally sensitive, and we must guard against training that merely offers 'lip-service' to this subject.

  The Standards must recognise that each person's experience / situation and what is culturally safe for them is unique and different. Whist there are shared experiences, providers must respond to each person in an individualised way. The Standards must be written in a way that ensures that these matters are addressed adequately and overseen by the regulator. Clear guidance for providers on these matters will be essential.

Outcome 1.4 Transparency and agreements

- Action 1.4.3 addresses providers allowing the older person sufficient time to review and consider their options. Guidance materials will need to define what is '*sufficient time*' for a person to '*consider and review*' a contract and how a provider would evidence it. There needs to be an acknowledgement of the basic legal concepts of acceptance of contract terms, including that if people do not reply, they are deemed to accept the terms of the contract.

Standard Two: The Organisation

ACCPA supports the intent and expectation statements for this Standard.

Outcome 2.1 Partnering with older people

- Action 2.1.1 states the 'The *governing body partners with older people to set priorities and strategic directions*…' The guidance materials must explain what level of engagement with older persons will be expected of providers (including providing practical examples) and how this engagement will be evidenced.

In the proposed in-home aged care aged care program, it is proposed consumers can self-manage their package and should they choose to do so, they can select multiple providers to deliver services to them (with no lead provider in place). How will Action 2.1.1 take account of this scenario?

More broadly, legislation that is being enacted now[10] addresses provider governance matters, including in relation to consumer advisory bodies. The revised Standards must be written with an eye to this new legislation, ensuring alignment.

Outcome 2.4 Risk management

- Action 2.4.2 states the provider is to '*control, minimise or eliminate identified risks.'* Whilst this is an important principle, it needs to be balanced against the older person's right to self-determination and to make an informed choice to take risks. Being older does not negate this right. Guidance materials must describe how providers are to balance these matters, including explaining the approach to be taken by the regulator in relation to the 'dignity of risk' and what providers will need to do to evidence they have achieved a sound balance.

  It is important to understand the difference between home care and residential care environments when it comes to a provider identifying environmental risks and then managing or mitigating those risks.

  In the home care environment, the provider is an invited visitor into the client's home and whilst they can advise the client on identified risks, and how to reduce these, they cannot require the client to comply.

  Having said this, the client's home is also the home care worker's workplace, and the provider may need to make decisions about whether the environment (the older person's home) is safe for their workers to enter.

  These matters are likely to be further complicated where (under the proposed In-Home Care program) the older person can select their own workers and engage multiple providers (with no lead provider in place) to deliver their care and services.

  Guidance materials will need to provide clear guidance for providers on their level of responsibility and accountability in relation to these complex matters.

Outcome 2.8 Workforce planning

- Action 2.8.2 states the provider is to '*implement strategies for supporting and maintaining a healthy and resilient workforce*.' This is a 'motherhood' level statement that is too general, too broad, and whilst aspirational, what does it mean? What is expected of providers and how would these things be evidenced?

  ACCPA recommends the wording be changed to better articulate an Action that can be objectively measured and assessed (allowing for inter-assessor reliability) and that results in a common and consistent understanding and application by providers. Again, clear guidance must be provided.

[10] https://www.health.gov.au/resources/publications/exposure-draft-and-explanatory-statement-aged-care-legislation-amendment-governance-and-reporting-for-approved-providers-principles-2022

Outcome 2.9 Human resource management

- Action 2.9.6 (d). In relation to workers being regularly trained, the Action requires '*all workers to be regularly trained*' to '*respond to medical emergencies.*' What is the expectation on providers? Will the expectation of the level of training required be, for example, commensurate with the worker's function and position?

  Guidance materials must be clear on what is expected of providers and should include examples.

  ACCPA recommends that the requirement for training to manage medical emergencies is commensurate with the worker's role, for example the level of expectation for a registered nurse is different to the expectation on an administration role. The wording for Action 2.9.6 should be changed to reflect the proportionate expectation.

- Action 2.9.6 (e) indicates that workers are to be regularly trained in the '*requirements of the Code of Conduct*.' What is the expectation on providers on how this is to be attended by providers and to what depth of training? And again, as mentioned earlier, how is '*regular*' to be interpreted by assessors and applied by providers? Guidance / education materials will need to be clear on this.

Standard 3 The Care and Services

ACCPA supports the intent and expectation statements for this Standard.

Expectation statement

This statement describes care services that are '*safe and effective*.' We support this principle.

We would however like to explore what 'safe' means in the context of an older person's right to exercise choice and control, including the right to take informed risks. How will the regulator approach (and articulate to the sector) this principle and balance competing interests of keeping the older person 'safe' against their right to self-determination?

The principle of being 'safe' also needs to be understood in the context of an in-home aged care environment. In this context any reference to care and services being 'safe' must be limited to the actual care and services being delivered by providers to the older person and not be expanded to be interpreted as meaning the older person being generally 'safe' in their own home, as this would be beyond the responsibility of providers.

What is expected of providers on this matter and how would these things be evidenced? Clear guidance is required for the sector.

Outcome 3.1 Assessment and planning

- Action 3.1.3 states the outcomes of assessment and planning are to be '*effectively communicated*.' What does this mean and how would this be objectively assessed and consistently applied by the Commission's assessors and how is it to be evidenced by providers? Guidance materials must address this and provide practical examples of Actions that could be undertaken to meet this requirement.

Outcome 3.2 Delivery of care and services

- Action 3.2.1 describes an older person receiving '*contemporary, evidence-based practice.*' There is potential for a wide variety of interpretations (by the Commission's assessors and providers alike) of what constitutes a practice that is contemporary, and evidence based. Consistency of understanding of what this means will be needed by the regulator and by providers. Guidance materials must explain what is meant by the expression (including clear examples) and how providers would evidence they are meeting this requirement.

- Action 3.2.5 references minimising the use of restrictive practices. ACCPA is pleased to see the use of '*minimises*' rather than 'eliminates' as it acknowledges there are legitimate circumstances where the use of a restrictive practice is appropriate, understanding that the guiding principles must be adhered to.

- Action 3.2.6 references the provider taking '*reasonable efforts to involve the older person in selecting their workers*.' What does this mean and how is this to be interpreted and evidenced by providers?

  Clarity will be needed regarding to what extent providers are expected to involve the older person in staff selection processes. Care will be needed to ensure their engagement on selection panels is appropriate and their input meaningful. We are unclear if the expectation to involve the older person in selection processes is dependent on the roles being recruited to.

  We have some concern about how this would work in practice in country and remote communities where it may be difficult to avoid conscious or unconscious biases or conflicts of interest. These will need to be managed carefully. Clear and consistent guidance will be required.

Outcome 3.3 Communicating for quality and safety

- Action 3.3.1. In this Action, the expression '*communicating structured information*' is used, what does this mean? We are unclear what it is, does it mean for example communicating transfer or hand-over information using proforma templates? Further explanation is required.

Outcome 3.4 Coordination of care and services

- Outcome Statement 3.4 states that '*older people receive planned and coordinated care and services, including where multiple health and aged care providers…are involved in the delivery of care*.' The proposed in-home aged care program[11] states that people are to have '*real choices about who provides their services*.'[12] Under the proposed program older people will be able to choose to have multiple service providers and workers deliver care and services to them. This supports the principle of increased consumer choice including the right to self-manage their care and services and funding should they choose to do so.

[11] A New Program for In-Home Aged Care Discussion Paper Department of Health and Aged Care, Australian Government, October 2022
[12] IBID, p5

Delivering on the requirement to provide planned and coordinated care and services in a multi-provider environment, where there may be no lead provider, and which may include contract or platform workers that have been contracted individually by the older person and in which brokering of services is likely to be more commonplace, is going to be a very real challenge for providers.

We highlight the following:

- Communication between service providers will be paramount and providers must have the ability to understand which other service providers are involved in the delivery of care and services to the older person, including where they have a Care Partner coordinating care management.

- Service fragmentation in a multi-provider environment is a significant risk and the in-home aged care program must address this risk.

- Failures in communication at transition points of care is another risk that will need to be managed in an environment of multiple providers.

- Privacy and confidentiality matters will need to be addressed and managed when there are multiple providers/workers involved in delivering care and services to the older person to ensure comprehensive and coordinated care in an environment of multiple service providers.

- Where there is a significant change in the older person's health status or where there is significant change in circumstance identified when a service is delivered by a provider, it will likely be the responsibility of that service provider to pass the information on the Care Partner (where there is one in place) or other relevant providers of services to the client.

As can be seen in these illustrative examples, the delivery of planned and coordinated care and services will be a challenge in a multi-service provider environment where there is no lead provider.

ACCPA recommends that a carve-out of a home care specific Outcome for in-home aged care service providers be attended that addresses the coordination of care and services in a multi provider environment, specifically that there be the following:

- Outcome 3.4a: Coordination of care and services at home
- Outcome 3.4b: Coordination of care and services in a service environment

Again, and as we have noted elsewhere, the in-home aged care program and the revised Standards should each be developed with an eye on the other.

Comprehensive guidance materials will be needed that provide clarity for the regulator and providers alike.

Standard 4 The Environment

ACCPA supports the intent and expectation statements for this Standard.

Outcome 4.1a: Environment and equipment at home

- Outcome 4.1a: Environment and equipment at home. This is currently the only Outcome in the revised Standards that carves out a specific reference to the home care environment. We believe having home care carve-outs is positive.

  This Outcome addresses environmental risks in the home. This Outcome needs to strengthen its wording around environmental risks to workers and the provision of a safe working environment for workers in the older person's home (acknowledging the older person's home is not under the control of the provider). It must be clear that the older person and their family have a responsibility to manage the identified risks in their home making the environment safer for in-home workers.

  Action 4.1.2 uses the word 'unobtrusively' when describing reducing risks in a service environment. The same principle could apply for the reduction of risks in the older person's home.

  In the home care setting providers can assess risks and make recommendations to the older person and their family to reduce these, but the older person still has the right to make their own determination as to whether they will address the identified risks. This must be recognised by the Standards and the regulator. The provider must be able to make their own determination as to whether the environment is safe for their staff.

Outcome 4.2: Infection prevention and control

- We make two key comments about this outcome:
  1. Given the pandemic Australia has experienced over the last three years and the fact that COVID-19 is now endemic, plus the ongoing risk of other infectious outbreaks that periodically occur (influenza, gastro-enteritis, etcetera), we recommend infection prevention and control be made a standalone Standard.

  2. Outcome 4.2 reads as if it has been written primarily for a residential care setting. ACCPA recommends a carve-out is made for an in-home aged care services stand-alone Outcome (as has been done for Outcome 4.1), specifically creating a part (a) and a part (b):
     - Outcome 4.2a Infection prevention and control at home; and
     - Outcome 4.2b Infection prevention and control in a service environment

  In doing this, consultation and engagement should then be had with recognised expert bodies in Infection Prevention and Control (IPC), for example the Australasian College for Infection and Prevention Control et al, the Aged Care Quality and Safety Commission and the sector to develop guidelines and guidance materials specifically geared for the in-home aged care environment. We believe this will give PC the gravitas it deserves. As it is, having it subsumed into Standard 4 does not lend it the weight and prominence it needs.

Standard 5 Clinical Care

ACCPA supports the intent and expectation statements for this standard.

Carve out for in-home aged care

Provision of clinical care in the home and community care environment requires a dedicated standalone Outcome.

The provision of clinical care in people's homes has enough of its own characteristics and requirements to warrant this.

ACCPA recommends a standalone Outcome be co-designed with key stakeholders and designed to ensure quality and safe clinical practices in the in-home aged care environment. Key stakeholders could include the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, providers, relevant peak bodies, and any others deemed relevant.

A 'carved-out' clinical Outcome for the in-home aged care environment should contain its own home care context specific Outcomes and Actions that address:

- Clinical governance
- Preventing and controlling infections in clinical care
- Medication safety, and
- Comprehensive care

As a general principle home care providers should only be responsible for the services that the older person is assessed as needing and that the provider is engaged and funded to deliver. Providers cannot be expected to be responsible for all aspects of clinical support that the older person may need. A carved-out home care Outcome must be written with this understanding.

Clinical matters such as continence, falls management, hydration, etcetera have specific requirements in the revised Standards that are relevant to a residential care setting (and that are covered in Outcome 5.4 Comprehensive care in the revised Standards consultation paper). These matters have a very different meaning in the home care setting where a provider can only be responsible for services they deliver at the times they deliver them.

In relation to medication safety, antimicrobial stewardship (as covered in *Standard 5 Clinical Care: Outcome 5.2 - Action 5.2.1*) will need to be considered in the context of a home care setting and what level of responsibility a provider has in this setting, we expect that the level of responsibility may be different to that in the residential aged care setting.

Standard 5 Clinical Care: Outcome 5.3 Medicine Safety - Actions 5.3.2 and 5.3.6 both talk about accessing medicine reviews. In considering the proposed in-home aged care program where older people are assessed by independent assessors (and their service plan identified) the matter of medicines reviews and meeting this requirement needs to be considered in the context of the level of support the older person is assessed as needing and whether medicines support is identified as one of those supports. As previously stated, providers can only be responsible for the services they are funded to deliver. We note access to the Home Care Reviews program is required to enable a review to occur and currently a referral is required for a review to occur.

A home care clinical Outcome would need to address communication and information transfer to ensure appropriate provisions are in place to ensure there is timely exchange of clinical information ensuring safe and quality care for the older person. This requires

mechanisms to exchange information between the aged care provider, primary health practitioners, community health services (such as pharmacists, hospitals) and others. Privacy and confidentiality provisions will need to be addressed.

Clinical skills in the in-home aged care setting would need to be considered and planned for. Workforce training and education requirements would need to be part of these considerations.

The relationship between clinical care provided in an older person's home by a provider and the coordination support to be provided by *Care Managers* to older Australians (as proposed in the in-home aged care program) will also need to be considered.

In a home care environment providers must only be held responsible for the clinical care delivered directly by them, they cannot be responsible for care delivered by other health practitioners or other providers or from care delivered in other health settings.

The revised Standards:

Outcome 5.1 Clinical Governance

- Action 5.1.3 references providers working towards implementing a digital clinical information system that:
    - *'a) enables clinical information to be integrated into nationally agreed electronic health and aged care digital records*
    - *b) supports interoperability by the use of national healthcare and aged care unique identifier and standard national terminology'*

  This Action raises several questions and challenges for the sector that will need to be addressed, and we note the following:
    - What specifically is being referred to when talking about *'nationally agreed to electronic health and aged care digital records'*, is this referring to My Health Record and / or other records?

    - What are the software and platform requirements to access these? There is significant variability in digital maturity across the sector that will need to be addressed. What level of support is Government planning to give to providers to assist them to achieve a technology related requirement that is to be enshrined in the Standards and subject to regulatory oversight?

    - What transition timeline will be provided to the sector to comply with this Outcome?

    - Government will also need to consider how to support providers of remote services that do not have reliable access to the internet and who may therefore struggle to implement some of these requirements.

    - We also need to recognise and respect that some people will choose not to engage with My Health Record, and this must be respected.

    - They will also need to collaborate with vendors to address interoperability requirements (including addressing access to and exchange of information) as providers across Australia use a variety of software platforms to enter and access an older person's clinical information.

  - Technology and software are expensive, and many providers will require financial support to move from where they are now to where they need to be to meet this Outcome.

- Action 5.1.5 prescribes the gaining of consent prior to clinical care being provided. We support this principle. We do need to consider though how consent is to be managed in the home care setting, this could include for example gaining consent from the older person to speak to their treating health practitioner/s and how the provision of care is to be managed where consent is not provided by the older person.

Outcome 5.3 Medication Safety

- Action 5.3.6(a) describes the provider implementing systems for the safe use of medicines that includes '*reviewing and improving the effectiveness of medicines review and reconciliation*.' We note as a point of interest the separate Department of Health and Aged Care work that is currently underway on the 'embedding pharmacists in residential aged care facilities' program. This program must be developed with an eye on the revised Aged Care Quality Standards.

  Medicines safety will need to be considered in the in-home aged care context in an environment where the older person may choose to manage their own package, where there may be multiple providers engaged by the older person and where there may be no lead provider and where there may or may not be a Care Partner in place. The older person may change GPs without informing the home care provider and they may choose to not consent to the provider contacting their GP.

  All these factors compound safety risks. As stated elsewhere, we recommend a carved-out home care specific Outcome for clinical care that can specifically address these challenges.

Outcome 5.4 Comprehensive care

This outcome lists a range of areas that providers must address spanning technical nursing; advance care planning; changed behaviours; choking and swallowing etcetera.

- Action 5.4.3 states providers are to '*facilitate access to expert advice and support, and referral when clinical care needs are beyond the service context.*' This can be a challenge for country and remote providers where equity of access is not achievable (relative to metropolitan providers). Access to allied health practitioners outside of metropolitan areas is an ongoing challenge. Unreliable or limited access to internet support for country and remote providers can make achieving this requirement a challenge. These challenges need to be accounted for in how this requirement is approached.

- Action 5.4.10 pertains to falls and mobility. ACCPA recommends changing the order of the three subpoints listed, raising the current point (c) '*maximises mobility to prevent functional decline*' to be point (a) to reflect this being the primary focus.

Outcome 5.4 has two Actions specifically addressing cognitive issues (5.4.6 *Changed behaviours* and 5.4.8 *Cognitive impairment, including dementia and delirium*). This seems a little 'underdone.'

The Royal Commission into Aged Care Quality and Safety spent considerable time on the matter of the quality of dementia care and *Recommendation 19: Urgent review of the Aged Care Quality Standards*[13] part (c) proposed reviewing the Quality Standards to ensure they sufficiently reflect the needs of people living with dementia and providing high quality dementia care.

The Summary Consultation Paper itself notes that the goals for revising the Quality Standards includes addressing issues raised by the royal Commission and '*strengthening requirements in relation to dementia*.'[14]

ACCPA recommends a stand-alone Outcome for dementia care, like what has been proposed in Outcome 5.5 for care at the end of life.

General comments

Negative health outcomes that result from care delivered in settings outside of the care and services delivered by aged care providers (for example deriving from care delivered in a hospital) should not result in compliance actions by the regulator on the aged care provider. Providers should only be responsible for care outcomes that are the direct result of care delivered by them.

In relation to the proposed in-home aged care program and *Care Partners,* we suggest consideration be given to requiring that where an older person is assessed as needing clinical care that there is then an automatic approval of a Care Partner being funded to coordinate that care.

Standard 6 Food and Nutrition

ACCPA supports the intent and expectation statements for this Standard.

We understand this Standard is intended to only apply to residential aged care services.

ACCPA recommends that this Standard be limited to concerning itself with food quality and the dining experience, and not cover clinical areas such as malnourishment, unexpected weight loss etcetera. We expand on this below.

Should it be determined in the future that food in the home and community care environment (this could include for example the in-home aged care program, delivered meals services, day centres, respite services etcetera) is to be included in the Standards we recommend it be addressed via a separate carved-out Outcome specifically designed for the in-home aged care environment. This must be co-designed with the sector utilising the expertise of those providers who are delivering these services.

In a home and community care environment a provider's level of responsibility would need to be commensurate with the services they are registered and funded to deliver.

[13] https://agedcare.royalcommission.gov.au/publications/final-report
[14] Consultation paper: Aged Care Quality Standards Review, Summary Consultation Paper, Department of Health and Aged Care, Australian Government, p6

As the design of the proposed in-home aged care program is not as far progressed in its design as are the revised Standards there is a risk of misalignment between the two streams. This creates a risk of yet again further revisions being needed to the Standards in the future. This should be guarded against.

Outcome 6.1 Partnering with older people on food and nutrition

Outcome statement. This statement uses several descriptors such as '*appealing*,' '*varied*' and '*enjoyable*,' these are open to wide and varied interpretation by the regulator, providers, and the older person themselves, so how is this to be managed?

To be able to apply and interpret Standards consistently, Outcomes and Actions need to be measurable and objective. Clear guidance will need to be provided by the Commission and its interpretation and application of this Outcome consistent.

- Action 6.1.2 (b), (c) and (d) states:
  'The provider implements a system to monitor and continuously improve the food service in response to:
  b) older people's intake of food and drink to ensure it meets their needs (including review of quality Indicator data on unplanned weight loss)
  c) the impact of food and drink on the health outcomes of older people
  d) contemporary evidence-based practice regarding food and drink.'

  We believe these subpoints (b, c, and d) are better suited to sitting in *Standard 5 Clinical Care* as they cover matters such as the nutritional adequacy of food, unplanned weight loss, Quality Indicators, the impact of food and drink on health outcomes and refer to contemporary and evidence-based practice.

  Matters like unplanned weight loss, nutritional adequacy etcetera are better managed through a clinical lens.

  These matters relate to health outcomes rather than the experience of quality food and the dining experience.

  ACCPA recommends Standard 6 focus solely on the food and dining experience of the older person and that Outcome Action items 6.1.2 (b), (c) and (d) be transferred to *Standard 5 Clinical Care*.

- Action 6.1.2(c) states providers are to monitor and improve the food service in response to '*the impact of food and drink on the health outcomes of older people*.' What does this mean? Guidance will be needed on how this statement is to be interpreted, including what is being expected of providers in meeting this requirement (what is being asked of providers here?).

- Little recognition has been given to food safety requirements (acknowledging that food safety regulations are generally state/territory based). We recommend inserting an Action that addresses food safety requirements. This could be as simple as indicating that providers are compliant with jurisdictional legislation and Acts.

Outcome 6.3 Provision of food and drink

- Action 6.3.3(b) references food being served at the '*correct temperature*.' This seems to be a reference to food safety requirements. If so, see our point immediately above regarding food safety requirements.

Outcome 6.4 Dining experience

- Action 6.4.1 refers to '*sufficient workers*' being available to support older people to eat and drink. Guidance is required on what is meant by 'sufficient' and how providers might evidence this.

  Separately, we believe the Standard should reference the importance of partnerships with family members and significant others in relation to supporting older people.

- Action 6.4.2 refers to workers '*physically supporting*' older people to eat and drink. Clarity is required on what this means, and how it is to be interpreted by the regulator. Guidance will be required on what is meant by sufficient and how providers might evidence this.

  Regarding guidance materials for this Standard when the Commission is developing the guidance materials we suggest that they review the NDIS Practice Standards – Mealtime management and severe dysphagia management as this addresses safety for those people requiring support for mealtimes and to manage severe dysphagia.

  ACCPA recommends Actions 6.4.1 and 6.4.2 be combined into one Action.

Standard 7 The Residential Community

ACCPA supports the intent and expectation statements for this Standard.

We understand this Standard is intended to only apply to residential aged care services.

Outcome 7.1 Daily living

- Action 7.1.1 uses terms like '*minimise boredom*,' '*maintain connections*,' '*contribute to their community*.' Like our earlier comment in Outcome 6.1, these descriptors are open to wide and varied interpretation by the regulator, providers, and the older person themselves, so how is this to be managed? To be able to apply and interpret Standards consistently, requirements and Actions need to be measurable and objective. Clear guidance will need to be provided by the Commission and its interpretation and application of this Outcome consistent.

- Action 7.1.3 refers to older people having control over who '*goes into their room*.' We support this principle; however, this can be challenging to meet in memory support units or similar environments where older people living with dementia may not understand the impact of their entering another resident's rooms uninvited. Clarity will be needed in any guidance materials that are produced that address this, including what is expected of providers.

- Action 7.1.5 references intimate and sexual relationships. This is an unnecessary repeat of *Standard 1 The Person: Outcome 1.1 Person-centred care - Action 1.1.3*. We think it better sits in that outcome and should be removed from Standard 7.

Outcome 7.2 Planned transitions

ACCPA supports this outcome.

We recommend this Outcome be transferred to *Standard 3 The Care and Services* as we believe it more naturally fits with that Standard as it contains matters covering:

- assessment and planning;
- delivery of care and services;
- communicating for safety and quality; and
- coordination of care and services;

and we believe 'Planned transitions' is a natural fit with those.

Whilst this Standard is described in the consultation paper as pertaining only to residential care, we wonder whether over time it would also reasonably apply to the home and community care environment, and maybe also to the retirement village environment.

If it were subsequently determined to apply to home and community care settings, we recommend a carved-out home care specific Outcome be co-designed with stakeholders, which would include primary health service providers, aged care providers and older people.