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The industrial and professional organisation for Nurses, Midwives and Assistants in Nursing in Australia

Submission to the Australian Government Department of Health Consultation Paper on Specialist Dementia Care Units

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Introduction

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a national membership which now stands at 270,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

ANMF members work across all settings in which aged care is delivered, including approximately 30,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-home care), depending on their health needs. Being at the fore-front of aged care, and caring for elderly people over the twenty-four hour period in acute care and residential facilities, our members are in a prime position to witness the challenging behaviours of people with dementia as their condition progresses. ANMF members who practice in mental health are likewise cognisant of the effects of dementia progression on younger people, as dementia is not exclusively a condition of older people.

The ANMF welcomes the opportunity to provide feedback for consideration in the Government's decision-making on the proposed high-level model of care and funding, and administrative options, for Specialist Dementia Care Units (SDCUs). The ANMF

supports the concept of specialised units for the care of people with severe behavioural and psychological symptoms of dementia. There are clear benefits for the person with dementia, their families and/or carers, as well as for the nursing staff and other health care providers involved in their care. The ANMF contends that the opportunity should be taken to carefully consider the infrastructure requirements for effective care delivery to achieve optimal outcomes for the person with dementia. This includes staffing levels and skills mix for best practice safe and competent care, collaborative multidisciplinary health care professional teams, and, fit-for-purpose facility design.

General Comments

> *Looking after people with advanced dementia is one of the most ethically complex things I have done.*[1]

The ANMF supports the concept of the Specialist Dementia Care Units (SDCUs) for the care of people with severe behavioural and psychological symptoms of dementia. There are clear benefits in creating safer environments for people with dementia and for their carers (formal and informal), which may be achieved by well-staffed units with qualified and experienced staff competent to manage individuals with high levels of aggressive behaviours and psychological symptoms of dementia.

However, the ANMF raises several concerns from our reading of the consultation paper, *Specialised Dementia Care Units* (November 2017), as follows:

Staffing:

Locating SDCU's within existing Residential Aged Care Facilities (RACFs) will mean staffing requirements will fall under the *Aged Care Act* (1997), therefore there will be no effective and mandated staffing model. Nursing staff requirements, based on the acuity of the resident's assessed care needs, must be specified in any agreements for Government funding for the establishment of ongoing operation of SDCUs nationally.

[1] Australian Nursing and Midwifery Federation. 2016. *ANMF National Aged Care Survey: Final Report.* July 2016. p20. Available at: http://www.anmf.org.au/documents/ANMF_National_Aged_Care_Survey_Report.pdf

We seek such an obligation to maintain consistency with specialist mental health units within the public sector health services, which have agreed mechanisms to address nursing workloads and the safety of clinicians and the people for whom they are caring. The ANMF maintains all SDCUs will require mandated staffing levels and skills mix to equivalent standards, to protect the public and to enable the provision of effective, safe and competent delivery of assessed nursing care.

The ANMF notes the consultation paper (p16) states the Severe Behaviour Response Team's (SBRTs) view is that more could be done in the usual environment of RACFs to better manage behaviours of those with dementia. This view fails to take account that a contributing factor to the escalation of aberrant dementia behaviours is the current lack of safe staffing levels, required skills mix of nurses and care staff, and the quality of the training and experience of the latter. The ANMF has conducted research in this area and considers this situation is not likely to resolve unless there is a clear intent to mandate staffing profiles based on assessed care needs, in aged care and SDCUs.

With reference to the consultation paper (p39) which says that 'providers generally will be expected to demonstrate…' staffing of SDCUs which is at 'higher levels of appropriately trained staff (whether care workers or nurses) than typically seen in mainstream facilities'. The ANMF supports this concept and hopes that it is not just promising sounding rhetoric. Given the current staffing situation in many government funded RACFs, and without legislated mandates for safe staffing, there is no guarantee of staffing models within the SDCUs that is based on residents' assessed needs. Evidence of staffing according to assessed resident care needs and solutions for staffing and skills mix have been provided by a study commissioned by the ANMF in 2016[2], which should be used in the commissioning of SDCUs.

Regarding the staffing profile, our research referred to above,[3] found that the proportion of qualified nursing staff (registered nurses and enrolled nurses) to personal

[2] Australian Nursing and Midwifery Federation. 2016. *National Aged Care Staffing and Skills Mix Project Report - Meeting residents' care needs: A study of the requirement for nursing and personal care staff.* Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf
[3] Ibid. p15.

care workers, employed in residential aged care settings nationally, has decreased significantly over the past decade. In relation to caring for people with dementia the National Aged Care Staffing and Skills Mix Project[4] reports as follows:

> *It was again noted that staff with minimal education, such as PCWs, could not be expected to have the knowledge to understand the complexity of this type of resident profile, and may risk rushing showers or toileting, focusing on the completion of tasks, which increased the risk of falls. It was also noted that where nurses did not have dementia-specific training, their response to residents was often reactive leading to an escalation of resident behaviour and increasing care requirements.*

Another study, undertaken by the New South Wales Nurses and Midwives Association (NSWNMA – the NSW Branch of the ANMF), records the staffing concerns of a participant:

> *I worked in the acute secure dementia ward. Two AINs were responsible for 19 fully mobile [patients] who had a high level of aggression towards staff and other residents with incidents occurring daily. It was common to complete 7-10 incident reports on a shift. When we complained and asked for additional staff we were labelled troublemakers and given less shifts.*[5]

The ANMF contends it will be critical to ensure the care staff skills mix in SDCUs is appropriate for the models of care and management of people with high-risk dementia behaviours.

The ANMF is advised by our members employed in this sector of concerns that approved providers of RACFs would require care staff to be co-opted from the existing RACF if there are shortfalls in staffing numbers for the SDCUs - this could be due to unplanned vacancies (such as for sick leave). This would potentially leave the RACF critically under-staffed, and also highlights the issue of whether the staff re-deployed

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[4] Ibid. p61.

[5] NSWNMA: New South Wales Nurses and Midwives Association (NSWNMA). 2015. *Report: Who will keep me safe? Elder Abuse in Residential Aged Care.* Available from: http://www.nswnma.asn.au/wp-content/uploads/2016/02/Elder-Abuse-in-Residential-Aged-Care-FINAL.pdf

from the RACF had the necessary educational preparation to competently provide for the assessed care needs of the residents within the SDCU.

Education:

The language in the consultation paper is of concern. In particular, page 39 refers to 'appropriately trained staff (whether care workers or nurses)'. Given there is no mandated minimum training requirement in the *Aged Care Act* (1997) the ANMF seeks clarification as to how the providers of the SDCUs will ensure adequate numbers of qualified staff with education in dementia care. The care staff skills mix must have a high proportion of registered nurses with post-graduate qualifications in dementia care, to be able to provide essential assurance to residents' families and carers, of safe and competent care in the SDCUs.

Concern has been expressed by ANMF members that there will be a monopoly on training by Dementia Training Australia. Specifically, according to members, the content of this training appears to have a focus narrowly only on dementia, rather than more broadly encompassing de-escalation, evade and escape techniques, and aspects of mental health that may be required for the management of complex behaviours exhibited by the person with dementia.

The ANMF suggests expanding the availability of dementia care education.

Duration of residence in SDCU:

There is an underlying assumption that short-term (6-12months) admission to the SDCUs will be sufficient to reduce or stabilise symptoms in the majority of cases. According to the consultation paper (p37), if this cannot be achieved, there will be a referral to appropriate mainstream facilities. While admirable, this can only be a short-term measure, where the referral is to a mental health facility or (and less likely) to a Special Mental Health Program for Older People facility, due to the shortage of available beds in these facilities. Residents would then have to return to their usual RACF or to home – either of these seems most inappropriate if the person's symptoms are not stabilised.

There is also a section, on page 33 of the consultation paper, in which it is proposed there be a negotiated 'take back' arrangement with a newly accepted resident's existing accommodation provider, in the event the person's behaviours are too severe for care to be provided in the SDCU. This somewhat bizarre arrangement effectively means that a high risk resident would return to their facility of origin, which would most probably not have the higher staffing levels and expertise required to manage the risks posed to themselves, other residents and staff.

Seven-tiered model of dementia:

In the consultation paper (p11) it is suggested that the SDCUs will primarily be for people with Tier 6 level associated behavioural and psychological symptoms of dementia. While further on in the document it is suggested that Tiers 5 and 7 residents **may** be admitted to a SDCU, this is not described as the aim of these units. The ANMF seeks clarification as to why categories for the SDCUs would not be Tiers 6 and 7. The pyramid at Figure 1 (p11) indicates that people with Tier 7 level dementia are cared for in an 'intensive specialist care unit' – is that not what a SDCU is?

In addition, there is no mention in the consultation paper, that a diagnosis of dementia at the Tier 6 level, could be on the trajectory for end of life, nor that dementia care progresses to end of life care and may result in the need for palliation and pain control – both of which require expert nursing intervention for symptom management.

SDCU Design:

The ANMF considers it problematic that there is no proposal for specific capital funding for the establishment and maintenance of SDCUs. Given that Tiers 6 and 7 level dementia includes high risk of violence, aggression and self-harm potential, this indicates why these types of residents are usually managed in psychogeriatric, neuro-behavioural or intensive specialist care mental health units. There are consequent implications for the design, layout, fixture and fittings necessary to protect these residents from the risk of self-harm. Initiatives that apply to this level of risk posed by Tier 6 and 7 residents include, for example, the removal of all points of ligature

attachment, break-away at 15 kg railings, CCTV monitoring, that will need to be considered and costed for the fit-out of these units.

Design planners may also need to consider incorporating the design principles of an acute unit because it has a high dependency unit incorporated within it separated by a 'quiet' room or area that can ensure the safety of a resident whose behaviour is temporarily uncontrolled and presenting a risk to staff and other clients. The *Work Health and Safety Act 2011* is clear on the requirements of a 'person conducting a business or undertaking' to control risk where it has been identified, in consultation with staff affected. Given the high-risk nature of people with dementia being admitted to these SDCUs, the units must meet contemporary standards and best practice for the 'worst case scenario'.[6],[7]

Additional to the built environment and design controls, other basic safeguards include the provision of duress alarms with person down and location finding capability, a duress response plan which includes internal or external assistance (especially in remote areas), identification of safe havens, safe access and egress points, entrapment areas and communication channels which are not compromised by 'blackspot' interference. These systems will obviously vary from unit to unit depending on its context and location and, should therefore, be developed in consultation with all stakeholders involved in the process, before commissioning.

Specific Comments

The ANMF provides the following comments against particular questions posed in the Consultation paper *Specialist Dementia Care Units* (November 2017).

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

[6] Pantzartzis, E et al.2016. A built environment response to the rising costs of dementia. *Journal of Financial Management of Property and Construction.* Vol 21 92), pp160-187.
[7] Mobley, C et al. 2017. Examining relationships between physical environments and behaviours of residents with dementia in a retrofit special care unit. *Journal of Interior Design*. Vol 42(2), pp42-69.

Other reforms conducted in the aged care sector include:

- Aged Care Reform Legislated Review;
- Review of the Aged Care Funding Instrument;
- Elder Abuse;
- Development of the NDIA/NDIS and linkages to aged care;
- Living Longer, Living Better strategies;
- Development of the My Aged Care website and portals;
- Single Aged Care Quality Framework; and
- Aged Care Workforce Strategy Taskforce

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?

Perceived additional risks in introducing SDCUs include:

- Cherry-picking of potential residents by facilities that do not have SDCU capability, in not taking on individuals already exhibiting dementia, and who could potentially develop to the stage of needing to be in a SDCU.
- If additional (and adequate) funding is not provided by the Government to support an all-qualified staff profile for these specialised units, providers may staff with unqualified or low qualified staff, leading to great risk of inappropriate and unsafe care delivery.
- Potentially long waiting lists for admission to SDCUs.
- Specific clinician education, recruitment and retention of qualified staff;
- Access and equity in the supply of human resources nationally.

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?

The estimate provided in the consultation paper is based on South Australia's statistics, which may or may not be reflective of aged care profiles across the country.

It is estimated there are 354,000 people with dementia across Australia (page 11 of the consultation paper), and that there is a suggested prevalence level for Tier 6 of <1% of the dementia population. For simplicity sake, if we use 1%, then 1% of 354,000 equals 3,540 people with Tier 6 or above dementia, with the population of people with dementia growing each year.

The ANMF considers it is critical the Australian Government is flexible, therefore, on the initial proposed number of beds for SDCUs, with the ability to increase when the need indicates more funded beds are required. When the sums are done on the proposed 12 beds per SDCU per each of the 31 Primary Health Networks (PHNs), there's already a substantial shortfall in the planning of bed numbers, according to the estimated number of people with Tier 6 or above dementia.

Furthermore, a balance between high population density PHNs and those PHNs with less population, will need to be achieved, to ensure all PHNs are adequately covered and access is available for all people in Australia who meet the criteria for admission. Whilst 1,450 places may seem a reasonable first step, addressing the national demand will require close monitoring and regular reviews of data.

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

The proposed SDCU service principles listed appear adequate, except that there is no mention of cultural safety[8] or culturally appropriateness. The ANMF sees this to be a major omission, and having conferred with our colleagues at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), urge that 'cultural safety' should be embedded within the principles.

With regard to point 6, we request that more detail be included about 'adequate numbers of appropriate skilled and trained staff'. This means clearly defining the staff

[8] Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. *Cultural Safety Position Statement*. Endorsed March 2014. Available at: http://catsinam.org.au/static/uploads/files/cultural-safety-endorsed-march-2014-wfginzphsxbz.pdf

numbers and skills mix to be dedicated for each SDCU, to meet required assessed needs, according to an evidence-based mechanism.[9]

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

Yes. Highlights of the listed benefits pages 25-26 of the consultation paper are:

- The person with BPSD feels safe and supported, although again there is no mention of culturally appropriate care
- Families are reassured of appropriate care (again the above comment applies)
- The element of stabilising the condition with a possibility of return to a lower level of care
- Appropriately qualified staff – although does not specify adequate numbers of staff to meet needs
- Minimising use of restrictive practices
- Well-managed transition from other services
- Evidence-based care
- Education for staff – this must be on-going; centre of excellence – this should include for training as well as care delivery; education for all staff across care sectors to recognise signs and symptoms of BPSD for early intervention.

The ANMF supports these benefits.

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?

The single central entry point for accepting SDCU referrals has merit in terms of streamlining processes and simplicity for referees. Using existing SBRT to perform the SDCU assessments also makes sense, given their current role.

ANMF members have raised a couple of points for consideration:

[9] Australian Nursing and Midwifery Federation. 2016. *National Aged Care Staffing and Skills Mix Project Report - Meeting residents' care needs: A study of the requirement for nursing and personal care staff.* Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

- For people living in rural and remote areas, will there be ease of travel for SBRT to all reaches of the country in a timely manner.
- A concern for possible further privatisation of services within the aged care sector. That is, would the centralised referral intake service become privatised? If the contract for this service is awarded to a company that runs a SDCU, would they ensure admissions are based on residents' need or the need to fill beds and keep them full?

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, this is a potential risk, and timeliness is of the essence here primarily for the safety of the person with BPSD, but also for other people in their environment, especially those involved in their care.

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

Yes. A comprehensive clinical assessment, conducted by an appropriately qualified and experienced assessment workforce, supported as being essential. This may reveal underlying health issues, for example, pain (such as the scenario with the dental problem, p34) being the primary cause of behaviour problems. This assessment, whilst comprehensive, must also be timely and be able to be fast-tracked when the person needs immediate care.

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

Other factors to be considered include:

- The personal circumstances of the family/carer.
- Staff skills mix, if the person with dementia is a resident of a RACF. Changing staff profiles[10] mean the staff may not be qualified to undertake clinical

[10] Australian Nursing and Midwifery Federation. 2016. *National Aged Care Staffing and Skills Mix Project Report - Meeting residents' care needs: A study of the requirement for nursing and personal care staff.* Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

assessment, or to understand behaviour management and appropriate interventions. ANMF members advise this is an emerging issue as the staff profile changes to one of fewer qualified nursing staff and assistants in nursing, to an increase in personal care workers. Unqualified staff can exacerbate problem behaviours leading to extreme agitation exhibiting as BPSD-like behaviour, but which may be due to staff not managing the person's condition appropriately.

- It seems that a waiting list is expected (not surprising given the figures demonstrated earlier showing the number of proposed places is severely under-estimated). This begs the question as to how people will be cared for while waiting for their place in a SDCU. This is critical, given that they would have been assessed as a risk to themselves and others to even have been considered for a place. What measures will there be to ensure their unmet needs are catered for and how long is an acceptable wait? Will this result in cost-shifting? Will public hospital beds be provided long term for those on the waiting list whilst Commonwealth funds are still keeping their bed open in the RACF?

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?

The siting of a SDCU within a RACF is appropriate as this aids transition for the person with dementia and their family, between facilities within a familiar environment. There would be less stress adapting to their changed location. Whether the move is to the co-located facility or another location, the essential element here is, the transition must be seamless.

The size of the unit is probably less important than the appropriateness and expertness of care delivered by qualified nursing staff.

The co-location aspect provides the benefit of giving a support infrastructure for the SDCU staff.

With regard to people from rural or remote locations requiring care in a SDCU, ANMF members are concerned as to how family contact will be maintained where provision of RACFs is already scarce. Being apart from family may escalate the severe dementia behaviours even further.

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. Applying a maximum timeframe would seem to negate the philosophy of person-centred care. There will be obvious differences in the time it takes for each Tier 6 dementia person to settle and stabilise such that they can be re-located back into either a RACF or the community. If an artificial timeframe is applied we could see people being transitioned out of the SDCU prematurely, and then needing to be brought back into the unit when it becomes evident they really were not stabilised. This 'bouncing' between facilities would have deleterious effects for the person with dementia and their family/carers, as well as for the nursing staff involved in their care.

ANMF members have also voiced their concern over the proposed short term nature of provision of SDCU care. The transient nature of the care could mean more escalation of behaviours during the settling in period, and anxiety for the family if the person is not exhibiting stabilisation as the maximum time for discharge approaches. Premature discharge back to the usual RACF can also escalate behaviours as the person is expected to make another environment change when not ready to do so, risking potentially disruptive and dangerous behaviours to be dealt with by staff in the regular RACF.

Applying the person-centred approach would mean that if the person is assessed by the multidisciplinary team as not improving, they must be able to stay in the SDCU for a longer period of treatment, for their own safety and that of others. This aspect would need to be included in the evaluation of effectiveness of the SDCU program.

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

Transitional support from a SDCU to new accommodation, or to a previous environment (such as home), is going to be a crucial element given the potential for escalation of behaviours during the settling in period on moving.

The transitional support needs to be determined to some extent by the assessment of the person involved. Clear communication channels between staff and education of staff, across facilities, will aid and reduce transitional support from a SDCU.

The ANMF contends that staffing of the SDCU must take account of this outreach support role by staff, for transitioned individuals, in addition to their time required within the unit.

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

The issue of funding will needs to be clearly identified in the planning for SDCUs. Care providers and families of the person with dementia will need a clear understanding as to whether security of tenure means two consecutive places will need to be funded (that is, the RACF bed, which is still their home, and the transient SDCU bed) either by the Government or by the privately funding person.

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

This is an excellent role for nurse practitioners who specialise in aged care, to act as liaison/co-ordinator of care roles across facilities. Where these nurses are currently employed, in either aged care or emergency care facilities, they are already undertaking an effective liaison role. Of importance to funders, these nurse practitioners are demonstrating huge savings on unnecessary transfers from aged care to acute care, by early diagnosis and intervention, leading to implementation of appropriate treatments.

The ANMF expresses strong concerns about the indication on page 39 of the consultation paper that SDCUs could be staffed by 'care workers'. The ANMF

maintains SDCUs will require qualified registered nurses who have dementia specific educational preparation. Care workers do not have education in assessment skills to recognise clinical changes of significance; medicines management; or de-escalation of behaviours. The staffing requirement we maintain as appropriate is for both the safety of the person with BPSD and the staff involved. Care workers should not be put into positions beyond their level of educational preparation. As outlined on page 41 – a "…higher level of staff skills and greater intensity of care [is] required to appropriately meet the needs of SDCU clients". If the correct levels of qualified staff are not employed for these units, they will be set up to fail, and we will witness inappropriate care such as was given in evidence to the various reviews on aged care in recent times (for example, the Australian Law Reform Commission Elder Abuse Inquiry, 2016/17).

Due to the parlous situation of there currently being no guidelines in relation to staffing or skills mix for RACFs, the ANMF commissioned the national study referred to previously[11]. This study found that 'data suggests a movement away from employment of registered nursing staff towards personal care workers'. The study resulted in a report which provides clear recommendations for staffing of RACFs, in order to meet the increasingly complex care needs of elderly residents. Mandatory staffing profiles must be instituted across aged care facilities to assure elderly people and their families of safe, competent care. Given that SDCUs will be required to provide an even higher level of care than for residents in a RACF, it is even more imperative that there be clear mandates for qualified nursing staff in these units.

The consultation paper (p40) discusses clinical governance and partnerships between the SDCU staff and liaising health care professionals and facilities. If staffing profiles of the SDCUs reflect those in some RACFs where there are no registered nurses on a shift, then effective partnerships with external parties will be compromised. There can be no guarantee that treatment instructions will be safely interpreted, carried out, or relayed accurately across facilities. Medicines management will be compromised, as

[11] Australian Nursing and Midwifery Federation. 2016. *National Aged Care Staffing and Skills Mix Project Report - Meeting residents' care needs: A study of the requirement for nursing and personal care staff.* Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

aged care staff other than registered nurses and enrolled nurses, can only give assistance to a resident to self-administer their own medicines.

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

The ANMF supports the planning for SDCUs to be inclusive of specific needs of groups within the community – such as, people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander peoples, and, lesbian, gay, bisexual, transgender, intersex (LGBTI) people.

SDCU providers will need to incorporate specific education relating to the needs of people from these groups who have dementia. Our colleagues at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives have provided the following advice in relation to dementia care education:[12]

> *Research to date indicates that Aboriginal and Torres Strait Islander people experience dementia at a rate 3 to 5 times higher than the general Australian population.[13] This means an aged care workforce that is trained and able to appropriately care for Aboriginal and Torres Strait Islander people living with dementia is essential.*

Another issue for consideration with Aboriginal and Torres Strait Islander peoples is connectedness to country, 'a critical component of wellbeing and quality of life'.[14] It is difficult to perceive how SDCUs could be structured to enable Aboriginal or Torres Strait Islander peoples to stay on country. However, this highlights the importance for SDCU providers to be inclusive of representatives of Aboriginal and Torres Strait

[12] Australian Indigenous Doctors' Association, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Indigenous Allied Health Australia, and National Aboriginal and Torres Strait Islander Health Worker Association. March 2016. *Joint submission to the Senate inquiry into the future of Australia's aged care workforce.* Available at: https://www.aida.org.au/wp-content/uploads/2015/03/AIDA_CATSINaM_IAHA_NATSIHWA-Joint-Submission-Aged-Care-Workforce.pdf

[13] Ibid. p.6. from Flicker, L. & Holdsworth, K. 2014. Aboriginal and Torres Strait Islander People and Dementia: A Review of the Research. A Report for Alzheimer's Australia. Available at: https://www.dementia.org.au/files/Alzheimers_Australia_Numbered_Publication_41.pdf

[14] Ibid. p.4.

Islander peoples, as well as people from culturally, linguistically and gender diverse groups, to enable creativity in planning flexible models of care.

Q19) What specific costs would contribute to the 'top up' amount?

Employment of additional nursing staff - that is, additional hours of nursing staff time required per person per day than that required for people fitting into Tiers 1-5; all nursing staff employed to be qualified, with a skills mix of registered nurses and enrolled nurses (noting that the enrolled nurses must always work under the supervision of a registered nurse); and, continuing professional development specific to dementia care.

The ANMF has concerns around the top-up funding proposed for SDCUs. It is already widely acknowledged that the Aged Care Funding Instrument (ACFI) model does not provide adequate funding for aged care in the behaviours domain. The funding provided for the total ACFI component already falls short for the requirements of the resident, leading to sub-optimal hours of care provided and poor staff skills mix. ANMF members question how the proposed 'top-up' funding will address this deficit and what assurances there will be that the 'top-up' funding will actually be applied to resident care requirements in the SDCU.

Q22 Are there other funding mechanisms that should be considered?

The ANMF suggests that an activity-based funding model be used for SDCUs. Activity-based funding studies the cost and mix of resources used to deliver patient care and would suit the SDCU model of care. This funding model would see SDCUs paid for the number and mix of patients they have. As the Federal Government is currently undertaking work in the development of an activity based funding model for aged care, SDCU may be a useful starting point for this model.

Whichever funding model is developed for SDCUs, the ANMF recommends that all such funding should be transparent, with public reporting, and that providers are held accountable for ensuring all SDCU funding is used for the provision of care only within the SDCU.

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

The Government should provide extra funding required for all specialised, qualified staffing requirements. The person with BPSD should not have to pay more for their care, otherwise there's the potential for inequity in that only those who can afford the extra care will get into SDCU's.

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

Yes. There should be a mandatory criteria and a commitment in writing to providing qualified nursing staff for the SDCU, and the right numbers of nursing staff to meet the needs of the people being cared for in the unit. Other criteria to be included: past history of compliance with aged care standards, having the right continuing education in place, the ability for self-governance, demonstrated high quality care, and, purpose-built facilities.

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

- Identified need for service
- Demonstration of appropriate facility
- Demonstrated collaboration of local partners.

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

- Evidence of staffing profile appropriate to qualifications and skills required for this level of specialised care
- Model of care and ability to meet staffing requirements for this type of unit
- Consumer feedback
- Incident reporting
- Complaints reporting
- Evidence of cost-shifting

- Re-entry rates
- Use of anti-psychotics medicines
- Medicines errors
- Development of standards for best practice, safety and quality

Conclusion

The ANMF is supportive of the development of specialised units for the care of people with severe behavioural and psychological symptoms of dementia. We perceive clear benefits of targeted care, for the person with dementia, their families and/or carers, as well as for the nursing staff and other health care providers involved in their care.

Our submission contains concerns to be considered in the design and implementation of the proposed specialised units and advice for best practice to facilitate optimal outcomes for dementia specific care. Essentially, our members want to be able to care for people exhibiting severe symptoms of dementia, in an environment which is conducive to de-escalation of those symptoms and provides safety for all people involved.