Submission by the Australian Nursing and Midwifery Federation to

The Independent Health and Aged Care Pricing Authority (IHACPA) Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 322,000 nurses, midwives, and carers across the country.

Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

The ANMF welcomes the opportunity to provide feedback to the Independent Health and Aged Care Pricing Authority's (IHACPA) Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25.

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities. With regard to the care of older people, ANMF members work across all settings in which aged care is delivered, including over 45,000 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, primary health care, in-home care), depending on their health needs. Being at the forefront of aged care and caring for older people around the clock, seven days per week in acute care, nursing homes, and out in the community, our members are optimally positioned to make clear recommendations to improve funding policies and processes that seek to enhance the quality and safety of Australia's aged care system.

PRINCIPLES FOR ACTIVITY BASED FUNDING IN AGED CARE

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

1.1 As per ANMF's previous submissions to the IHAPCA, the ANMF highlights the need for the inclusion of additional principles around accountability on the part of providers in the use of funds. While the principles articulated in the consultation paper, such as 'transparency', account for a proportion of this in the way funding is *distributed*, greater focus should be placed on the way the funding is *used* by providers and the methods of how this will be reported. It must be an obligation on the provider that the use of any funds received for the delivery of care be transparently and accountably used for the purposes it was provided, and if not for the surplus to be returned to the Government or paying aged care participants. It is of importance that issues of "commercial in confidence" are not allowed to get in the way of appropriate transparency and accountability regarding the use of funds. Funds should be used to provide evidence-based, safe, effective, and dignified care that where possible, is restorative and aims to bring about better outcomes to residents. Over-servicing and exploitation of aged care residents and government subsidies remain a concern. Transparent and up to date reporting and audits are a key component in the creation of an efficient, sustainable, and safe residential aged care system.

1.2 As noted in ANMF's previous submission the use of AN-ACC funding to provide additional/extra services as a means of profit generation by providers remains a concern. Providers will have varying capacities to provide additional/extra services with smaller providers and providers in 'thin markets' being less likely to have the capacity to provide the same level of additional/extra services in comparison to larger, wealthier providers. This could detrimentally impact the equitable provision of safe, effective, dignified care of residents. The ANMF also highlights that there have been several occasions where providers have charged for additional/extra services (e.g., internet access) by bundling unwanted or even inaccessible services. The use of ABF should bring about a reduction in provider discrepancy on staff expenditure. Principles on these offerings should be included and monitored for predatory provider behaviour such as price gouging.

1.3 As the ANMF has previously submitted, in activity-based costing methods there is a hierarchy of costs which allows for non-linear cost accumulation, i.e., costs not caused by providing care such as education/ training, marketing and research. These non-linear costs should be clearly identified and reported.

1.4 While the ANMF recognises that the principles do include 'promoting value' and promoting the use of 'ABF where practicable and appropriate', further efforts should occur to where possible adopt an outcome/value-based approach to funding and provision of care. This would help to incentivise better outcomes for residents where activity-based funding might not.

1.5 The ANMF highlights that overall, the principles do not account well for the aged care workforce that provides care. The cost of wages for the provision of direct care activities is the largest outlay of funding in the aged care sector. Here, more accurately, it is the *staff* that deliver aged care as opposed to the provider as an organisation or business entity. The ANMF strongly recommends that the principles should be revisited to include a clearer and more apparent focus on the aged care workforce.

THE AUSTRALIAN NATIONAL AGED CARE CLASSIFICATION FUNDING MODEL

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

Overall, the ANMF is concerned that the AN-ACC funding model doesn't adequately reflect the *actual* amount of nursing (registered and enrolled nurses) and unregulated care worker care time required to provide best practice care. For example, there is no robust empirical support that specifies the decision to land on the baseline of an average of 200 minutes of direct care time (including 40 mins of registered nurse time). Data from the QLD public sector RACFs suggest that average direct care time exceeds four hours per day (ranging from 4.11 to 5.18 hrs). Further, Palliative Care Australia reports that palliative care patients, who are comparable to AN-ACC class 1 residents, receive around 6.5 hours of RN/EN care per resident per day,[1(p. 33)] far exceeding the AN-ACC funding of 284 minutes. This suggests that AN-ACC classifications do not encapsulate the actual amount of care required for each class. Further, the ANMF is concerned with the lack of specific differentiation between enrolled nurse care time and that which is provided by PCWs. These two very different employee groups that should not be consolidated.

2.1 It is also important to consider that the Resource Utilisation Classification Study's (RUCS) series of studies were undertaken at a time widely recognised to be marked by significant and systemic problems with the funding, delivery, and monitoring of aged care services including widespread poor staffing levels and skills mixes. This was most clearly demonstrated by the findings of the Royal Commission. While it is impossible to assess the nature and extent of the impact that this may have had on the analyses and results of the RUCS studies in relation to case mix classification and profiling, the funding model in relation to resident- and facility-level costs, and the rate and extent of changes to residents' care needs over time, the key issue is that the studies observed and assessed care that *was delivered* rather than care that *should be* delivered. For example, it is unknown how the staffing and skills mixes of participating nursing homes impacted upon the time observed to undertake care for residents. There is considerable evidence that staffing levels and skills mixes impact the delivery and outcomes of care, so it is important to be aware of this issue when determining the extent to which AN-ACC classes effectively group residents in a manner that is relevant to both care and resource utilisation. Ongoing work is required to ensure that the classification of residents in accordance with the AN-ACC continues to reflect emerging practices and cost structures and that there are important opportunities to measure and understand aged care quality and outcomes as the AN-ACC matures. The ANMF understands that over time, the care plans developed by residential aged care facilities will increasingly align to the AN-ACC model, and that this could enable improved accountability of providers and their ability to provide residents and stakeholders with transparent reporting regarding the real-world utilisation of received funds for care delivered.

2.2 While it is appropriate that the AN-ACC is uncoupled from care planning, over time, the funding model is expected to become more closely aligned with care planning as further insight is established regarding the types of care plans that are commonly delivered to residents classified into different classes. The risk here is that providers may base staffing and care planning around principles of cost saving and income maximisation rather than delivery of optimum care quality and safety to improve resident outcomes. Here, nationally standardised assessment, classification, and care planning, must be able to establish if providers are implementing suitable, evidence-based models of care delivered by an adequate number and skills mix of suitably trained staff. Further, the pricing of the AN-ACC be regularly reviewed by the IHACPA to ensure that the funding model supports the provision of this necessary care and staffing.

2.3 Given that best practice care is complex, AN-ACC classifications must support not only direct care activities but also indirect care (those actions that support the overall effectiveness of direct care interventions). Costing and funding of aged care should include consideration that staff must be able to spend sufficient time with residents to deliver safe, dignified, and appropriate care. Further, staff also need time with family/loved ones to respond to family's questions and to engage in other professional interactions that don't necessarily fall within an itemised 'care activity' for individual or groups of residents. If these types of things are not accounted for, then it is likely that the provision of safe, dignified care will suffer as staff would need to rush or minimise time with residents and families, particularly if staffing levels are low. There are often problems with itemised lists of care activities. Looking at the entirety of care (direct and indirect) in a more holistic fashion rather than a list of things is likely to be more reflective of care requirements and upholds the ambition of the provision of dignified, person-centred care. It is imperative that standards are applied to ensure that individual care plans reflect individual needs rather than cost.

2.4 The ANMF highlights that increasingly, the complex care residents require demand high-cost consumable items such as wound care/management and nutritional supplements. If these costs are not addressed appropriately in the AN-ACC, this care might not be well supported and drive otherwise avoidable hospital transfers which can be associated with poorer resident outcomes, and experiences, and cost-shifting to the public sector. Further, with the increasing acuity and comorbidity of older people, there is a greater requirement for nursing staff to coordinate interdisciplinary teams. These costs should be considered given the lack of funding for allied health professionals within AN-ACC.

3. What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

3.1 The ANMF has some concerns that despite the acknowledged benefits regarding incentivisation of reablement and restorative care within the model, there remains a risk that residents could be allowed to deteriorate, be reclassified, and attract greater funding. The ANMF also has some concern that the model may not adequately capture and support the complexity of care required in residential aged care, particularly for people affected by dementia, as level of independence assessed by mobility appears to be the major stratifying factor for the model. It is therefore unclear whether a resident with high dementia care needs but who is highly mobile would attract sufficient AN-ACC funding to support the delivery of safe, appropriate care. As the Royal Commission has highlighted, the management of dementia in Australian aged care is currently not at an acceptable standard. It is important to ensure the model rectifies this situation and does not inadvertently incentivise avoidable use of chemical or physical restraint.

3.2 Other complex areas of care required in residential aged care which are not sufficiently recognised as key cost-drivers in the AN-ACC model include medication assessment, management, and a potentially limited definition and understanding of palliative and end of life care needs. There may be a risk that the costs of the provision of these aspects of care may not be sufficiently accounted for by the model. The ANMF is also concerned that the emotional and social care needs of residents may not have been clearly or comprehensively accounted for within the AN-ACC assessment.

3.3 While the ANMF understands that the AN-ACC model recognises technical nursing requirements as a cost driver, we are concerned that misinterpretation could arise that nursing may only be required to simply meet a limited array of high-level technical skills rather than the delivery of the broad, holistic, and comprehensive care which residents require, and which nursing specialises in. This could potentially result in some providers continuing to understaff their facilities regarding registered nurses (despite meeting the legislated requirements) thereby perpetuating poorer resident outcomes and unnecessary hospitalisation of residents who could have been cared for onsite.

3.4 More clearly incentivising rehabilitation and restorative care could occur through directly rewarding rehabilitation. For example, residents could be assessed using validated, evidence-based tools to establish the likelihood of successful rehabilitation (e.g., improved mobilisation). The costs of undertaking this assessment as well as rehabilitative interventions could then be funded and then successful/improved and maintained outcomes rewarded with further funding. This is partially integrated into the model as residents will not be reclassified if e.g., mobilisation is improved, however, there is limited incentive for providers to undertake rehabilitative interventions unless they are adequately remunerated.

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

4.1 Older people are entering permanent residential aged care with higher acuity needs and more complex care needs. This is likely to result in greater costs and need for staff when a new permanent resident enters a facility for the first time. When a new resident enters a facility, they will need timely assessment for both funding and care planning which are separate in the new AN-ACC system. Further, assessment of new residents should also include assessment of resident needs in terms of advanced care needs such as dementia, mental health, and allied health.

4.2 With the projected increase in the number of older residents with complex and more acute clinical needs including dementia and mental ill health, it is highly likely that there will be necessary increases to the number of direct care minutes required by more residents including those provided by registered nurses and enrolled nurses. Understanding that from 1 October 2024, there will be an increase to the mandatory care minutes to a sector-wide average of 215 minutes, including 44 minutes of registered nurse time it would also be expected that beyond this time, these care minutes will increase further in line with the needs of residents. This must be considered in advance, particularly in terms of the sector's ongoing viability, workforce, and funding requirements. Likewise, these increasing care needs will also necessitate a greater amount of care from medical specialists and allied health which ideally would be provided in place rather than following an otherwise avoidable transfer to an emergency department. This highlights the need for the sector to ensure a suitably sized and skilled workforce with effective and efficient interfaces with the wider healthcare system.[2]

4.3 The ANMF also highlights that unlike a hospital, on average, a 'permanent' aged care resident will stay in a nursing home for around two years and six months. There is a real intersection between quality of care and time delivered outside the more task-oriented care requirements (dressing wounds, administering medication, washing, showering, turning residents in bed). Time taken to make it feel like a home, to ensure there are daily interactions with each resident (that are recorded), getting them to walk slowly to the dining room etc. are as much about the care as the nursing tasks listed above. In hospital, most patients are there for short stays. There isn't as much focus on their social well-being and mental health, they eat in their bed, they are more mobile when they start to recover, there usually have multiple visitors etc. To a degree the AN-AAC classifications represent a medical/hospital model and is based on functional tasks. While that is part of the story of aged care, it isn't the whole story. These 'time to care' elements need to be valued in the elements that are included in the classifications and funding.

5. Are there any other legitimate or unavoidable costs associated with a respite resident's stage of care? What evidence is there to support your answer?

5.1 As above, the care needs of residents entering temporary respite care would also be expected to increase over time as people live longer and ultimately begin engaging with the residential care sector at older ages with a higher likelihood of complex and more acute clinical needs. This is likely to have flow on effects on the costs associated with respite residents' care with more residents likely to require higher levels of care from a suitably sized and skilled workforce. The ANMF highlights future refinements should also ensure that costing studies adequately support reablement of older people with a focus on effectively and safely transitioning recipients back to home/the community rather than into long term residential aged care. The future refinements should also ensure that the impact of changing resident demographics in terms of acuity and likely increasing complex care requirements be considered.

DEVELOPING AGED CARE PRICING ADVICE

6. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

6.1 As previously raised by the ANMF, the ANMF is concerned that utilising Fair Work Commission wage movements alone, to adjust the cost component of Residential Aged Care Price will impede bargaining by not reflecting actual wage movements and impacting on wage negotiations within the sector. This has been a significant issue in the previous indexation method where previous government-imposed efficiency dividends which suppressed aged care wages. As further upward movement in aged care sector wages can be anticipated including possible Fair Work Commission recommendations, this likelihood must be considered.

6.2 The ANMF remains concerned regarding the weighting given to wage and non-wage costs. Previous residential aged care funding indexation incorporated a cost-of-living component, Consumer Price Index (CPI). The weighting was set to 75% wage component and 25% non-wage component. Under the new indexation method, no such information is provided to date. Given the COVID-19 pandemic, there has been significant downward pressure on wages and significant increases in non-wage costs. Under the previous indexation method, the set weighting method created unintended circumstances where aged care workers paid for the increased non-wage costs of providers through lower wage increases. If this situation is perpetuated, ongoing challenges with attracting and retaining high quality staff across the sector will persist.

6.3 Further, the ANMF considers it neither efficient nor acceptable that "… any adjustments to wages made by the Fair Work Commission could take multiple years to be reflected in the cost data utilised by the IHACPA in calculating prices". Given that wages are the major component of aged care costs, the pricing model must reflect the actual cost of care (at a best practice level). In the IHACPA's previous consultation report, feedback from stakeholders was acknowledged regarding concerns with the FWC and wages particularly in light of wage rises and weighting wage and non-wage costs. Overall, the IHACPA noted that feedback was mixed and that broadly stakeholders seek a methodology that adequately addresses growth in input costs, particularly wage costs, given that these are a significant component of provider costs. The IHACPA noted their intention to conduct regular costing studies to support indexation that reflects trends in the growth of reported costs over time which the ANMF is supportive of and until this cost data becomes available, the IHACPA will use a range of Australian Bureau of Statistics indexes to separately index each labour and non-labour component of the aged care price for application on 1 July 2023.

ADJUSTMENTS TO THE RECOMMENDED PRICE

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

7.1 The ANMF again highlights the need for further research, evaluation, and consideration of costing complex care which is needed by many aged care residents who have multiple complex, and evolving care needs. It will also be vital that sufficient funding be provided to ensure that care is, where possible, restorative/re-enabling and supports residents to both be healthier for longer and to regain health and wellbeing.

7.2 The ANMF also highlights the need for adjustments for residents presenting with complex mental health issues. Elderly adults are increasingly susceptible to mental ill health such as major depressive disorders, with Australian estimates between 4 – 10.3% in elderly women and 2.8-6.9% in elderly men aged 75+,[3] as compared to 3.9% in women and 2.4% in men aged 18-65.[4] In a study of 430,862 individuals Australians in permanent residential aged care, the overall prevalence of any mental health disorder was estimated at 57.8%, with depressive disorder accounting for a majority of presentations (46.2%).[5] A 2016/17 analysis from Flinders University and the South Australian Health and Medical Research Institute (SAHMRI) found that fewer than 3% of residents accessed government-subsidised mental health services.[6] Australian studies suggest that this is due to a lack of referrals by aged care staff,[7] which may be reflective of low staffing levels and skills mix, lack of education and training, and lack of resources and time to adequately screen residents for mental health issues. Low use of these services among aged care residents indicates a need for organisational and policy changes to improve access, including for residents with chronic and complex mental health diagnoses and care needs. These changes would only be enabled through adjustments in aged care funding.

8. What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?

8.1 The ANMF are supportive of the changes to the Specialised Base Care Tariff to include homeless people and Aboriginal and Torres Strait Islander people, however, would recommend that the specialised BCT be available for all Aboriginal and Torres Strait Islander people despite MMM classification of the provider. This will ensure that culturally sensitive care is able to be provided by skilled and trained staff, working within adequate skills mix. It will also afford greater accommodations to make residents comfortable in residential care.

8.2 The Base Care Tariff should also take into consideration the distance from the provider to other allied health services. While the ANMF advocates that transfers to emergency department should be avoided where possible, and the majority of health care should be enabled to be provided in the aged care facility, there are times this may be unavoidable. The BCT should support providers to hire skilled, multidisciplinary staff, who are able to provide care and care assessments, transferring residents only when necessary.

9. What, if any, evidence or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?

9.1 In our previous submission, the ANMF reported that the findings of the Royal Commission into Aged Care Quality and Safety highlighted a lack of transparency and accountability with profound consequences for the safety and quality of care for residents. We highlighted the needs of vulnerable community groups and that adjustments for quality and safety issues would need to complement and support the role and work of the Aged Care Quality and Safety Commission and avoid duplication or undue impact on aged care providers. We highlighted that as the AN-ACC system matures, it will be vital to monitor and evaluate its operation and impact on relevant stakeholder outcomes to ensure that safe, high-quality care is being appropriately funded and delivered. The ANMF understands that the IHACPA acknowledged that stakeholders were broadly supportive of price adjustments for quality and safety but noted significant variation in recommendations around the scope, nature, timing and phasing of such adjustments.

9.2 Adjustments for safety and quality through ABF can encourage good quality care, where payment captures not only the cost and complexity of care, but also the safety and quality of care delivered. The ANMF highlights the need to consider vulnerable populations that frequently require more expensive care due to their more complex needs. For example, people born in non-English speaking countries, people who have experienced homelessness, and people with mental illnesses. Further, the model must also be sensitive to regulatory requirements (including standards and accreditation), including in the safety and quality space. The ANMF agrees that adjustments for quality and safety issues would need to complement and support the role and work of the Aged Care Quality and Safety Commission and avoid duplication or undue impact on aged care providers. Furthermore, any pricing adjustments for safety and quality would need to consider a wide range of data, information, and perspectives, including clinicians, residents, carers and providers, along with considerations regarding occupational/workplace health and safety requirements and costs. As the AN-ACC system matures, it will be vital to monitor and evaluate its operation and impact on relevant stakeholder outcomes to ensure that safe, high-quality care is being appropriately funded and delivered.

9.3 The ANMF highlights that occupational health and safety should also be considered in future directions of IHACPA's aged care pricing advice particularly in terms of infection prevention and control and other workplace safety risks that impact both residents, staff, volunteers, and visitors. Additionally staffing costs need to be adjusted to meet quality care and compliance requirements which should be recorded and reported through sources such as the National Aged Care Mandatory Quality Indicated program.

PRIORITIES FOR FUTURE DEVELOPMENT

10. How could, or should the AN-ACC model be modified to be used for Multi-Purpose Services (MPS) and are there any factors that aren't accounted for under the AN-ACC model?

10.1 The ANMF highlights that as MPS providers are often conjoined with hospital facilities, staff are often 'borrowed' from the hospital to work in aged care and may not have appropriate training. Nurses working in MPS often don't have specialist knowledge in aged care,[8] and are therefore limited in their ability to provide high-quality, safe, and dignified care to aging residents. Funding for MPS should be supportive of hiring specialised carers or adequately training the nurses providing aged care.

10.2 As nurses may be required to work across aged care and the acute ward there may be instances when residents are left unattended (i.e., when called into the emergency department to assist with unexpected presentation). This creates health and security concerns, particularly for residents who suffer from dementia. Further this creates issues regarding AN-ACC funding, particularly in relation to the RN 24/7 supplement. If the AN-ACC funding is offered based on the assumption that a RN is present 24/7, however the on-duty RN assigned to the aged care ward is working in other areas of the hospital, issues arise in funding loopholes which may be exploited by providers, allowing them to claim the RN 24/7 benefit while not complying to the care requirements.

10.3 As MPS is jointly funded, fragmentation, and potential duplication, of funding received by MPS across services may make it difficult to determine what funding is being used for. Because of this, strict reporting requirements are required to ensure that AN-ACC funding is used exclusively for the provision of high quality and safe aged care.

10.4 Registered nurse movement from RAC wards to ED is of particular concern considering current nursing shortages that are prevalent Australia-wide. Often time a rural hospital will be staffed, particularly in evenings and nights, with only one RN who is supported by an EN. This means that in the circumstance of an emergency presentation all resources are moved there, leaving the RAC ward under/unstaffed. This issue is compounded by the evaluation and performance measures used in MPS as the Emergency Treatment Performance (ETP) which places prioritisation of other sectors over RAC. Ring-fenced direct care minutes established through AN-ACC has the potential to ensure the skill mix in respect of RAC beds and will by default, require additional staffing resources for the remainder of the MPS if this requirement is built into the funding conditions. It would also ensure the ACQSC had a benchmark from which to measure compliance.

10.5 An unintended consequence of introducing AN-ACC for MPS is that it may reduce overall staffing and skills mix per aged care bed. MPS are often considered to be able to provide greater staffing and skills mix then residential aged care facailites,[9] notwithstanding issues regarding RN movement. The AN-ACC determined DCM target may be less than is currently provided and therefore many disincentivise providing care beyond the requirements. The ANMF suggests that funding must seek to raise the staffing numbers and skill mix in MPS aged care, and ring-fenced workforce to ensure they are not used in respect of other services provided at the MPS, such as ED.

10.6 The ANMF is overall, supportive of the adaptation of the AN-ACC model to support MPS, as funding is often reported as a sustainability issue for the use of MPS in rural Australia.[10,11] The flexibility to meet community needs that is enabled by MPS programs is often indicative of high quality aged care,[9,12] however, appropriate funding is required to ensure that staff working under this model are adequately trained and working in appropriate skills mixes.

11. How could, or should the AN-ACC model be modified to be used for National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?

11.1 The ANMF is pleased that the IHACPA has plans to consult with Aboriginal and Torres Strait Islander stakeholders to inform considerations, data collection and analysis relevant to the potential use of AN-ACC, or a model based on AN-ACC, for NATSIFACP services in the medium-to long-term. Here, the ANMF recommends that the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the peak national body that represents, advocates for and supports Aboriginal and Torres Strait Islander nurses and midwives in Australia, be consulted closely.

REFERENCES

1. Palliative Care Australia. Palliative Care Service Development Guidelines. Canberra: Palliative Care Australia; 2018.
2. Morphet J, Innes K, Griffiths DL, Crawford K, Williams A. Resident transfers from aged care facilities to emergency departments: can they be avoided? *Emerg Med Australas*. 2015;27(5):412-8.
3. Kiely KM, Brady B, Byles J. Gender, mental health and ageing. *Maturitas*. 2019;129:76-84.
4. Wilhelm K, Mitchell P, Slade T, Brownhill S, Andrews G. Prevalence and correlates of DSM-IV major depression in an Australian national survey. J *Affect Disord*. 2003;75(2):155-62.
5. Amare AT, Caughey GE, Whitehead C, et al. The prevalence, trends and determinants of mental health disorders in older Australians living in permanent residential aged care: Implications for policy and quality of aged care services. *Aust N Z J Psychiatry*. 2020; 54(12): 1200-11.
6. Cations M, Collier LR, Caughey G, et al. Government-subsidised mental health services are underused in Australian residential aged care facilities. *Aust Health Rev*. 2022;46(4):432-41.
7. Stargatt J, Bhar SS, Davison TE, et al. The availability of psychological services for aged care residents in australia: A survey of facility staff. *Aust Psychol*. 2017;52(6):406-13.
8. Henderson J, Willis E, Xiao L, Toffoli L, Verrall C. Nurses' perceptions of the impact of the aged care reform on services for residents in multi-purpose services and residential aged care facilities in rural Australia. *Australas J Ageing*. 2016;35(4):E18-E23.
9. Neumayer B, Chapman J, Whiteford G. Role of multi-purpose service programs providing residential aged care in rural Australia: a discussion paper. *Aust J Rural Health*. 2003;11(6):287-91.
10. Anderson J, Malone L. Suitability of the multi-purpose service model for rural and remote communities of Australia. *Asia Pac J Health Manag*. 2014;9(3):14-8.
11. Malone L, Anderson JK. Understanding the need for the introduction of the multi-purpose service model in rural Australia. *Asia Pac J Health Manag*. 2015;10(3):GS3.
12. IBID [9].