Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
November 2022

Feedback on the Revised Aged Care Quality Standards

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

The College welcomes the opportunity to provide feedback on the Revised Aged Care Quality Standards (the Standards). Aged care is critically important for rural and remote communities and an integral part of rural and remote medical practice. Rural Generalist doctors are involved in the full spectrum of aged care – through general practice-based primary care, home visits, nursing home attendances, secondary care in the local hospital, coordination of team-based care and referrals, support for family and carers, and palliative care.

Over one in four Australians in the aged care target population live in rural or remote communities, and there are fewer aged care services in rural and remote Australia than in metropolitan regions.[1] Compared with rural areas, people who use residential aged care in remote areas tend to be younger and comprise a greater proportion of men and Aboriginal and Torres Strait Islander people.[2]

The Standards must therefore consider the perspectives of both rural and remote and younger Australians living in aged care facilities outside urban and/or regional centres. They must not increase an already complex system; add to the administrative imposts of rural and remote practitioners; or create additional impediments to the provision of services and operation of rural and remote facilities and practices.

General Comments

The College trains doctors to become specialist General Practitioners equipped to work in the Rural Generalist model of practice. As such they are purpose-trained through the ACRRM Fellowship (FACRRM) to provide comprehensive primary care, secondary care, population and public health services and emergency care within the clinical context of rural and remote locations, including residential aged care facilities (RACFs).

Rural Generalists are often the only provider of medical services in rural and remote areas, and in areas where health services do exist, are often the first point of contact for patients. They work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. These doctors are often the only readily available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to specialists, allied health professionals, or health care teams in larger areas.

The differing circumstances in rural and remote areas require practitioners to provide a varying and typically broader and more complex suite of services than their urban counterparts. These extended services are often delivered in ways that differ from typical urban practice models due to the limited resources and clinical teams in the local rural setting, and it is important that the Standards allow flexibility to reflect these circumstances.

Given the important role of Rural Generalists, particularly in rural and remote communities without access to specialist aged care services, it is important that their pivotal role in providing services to residents in RACFs is acknowledged within the Standards. Rural Generalists are often the only provider of aged care services in rural and remote areas, and in areas where other services do exist, are often the first point of contact for dementia patients and RACFs in need of assistance. These doctors are also often called upon to support patients in the case of health emergencies.

These practitioners are critical to the delivery of aged care services in rural and remote areas, as they provide continuity of care for patients at all stages and have the necessary skills and training to provide intervention to those in need.

One of ACRRM's concerns is that the Standards could be perceived to be designed to meet the needs of large, urban based RACFs. As such, there may be uncertainty associated with their applicability and scalability for smaller facilities, particularly those in rural and remote areas. As a consequence, these facilities may choose not to engage with the Standards, or (in the worst-case scenario) decide that compliance would be so onerous or expensive that they are unable or unwilling to continue to

[1] AIHW Factsheet Aged Care in Rural and Remote Areas Factsheet 2020 https://www.gen-agedcaredata.gov.au/www_aihwgen/media/2020-factsheets-and-infographics/Aged-care-in-rural-and-remote-areas-factsheet_2020.pdf?ext=.pdf
[2] Ibid.

operate their business. Either of these outcomes would significantly disadvantage rural patients and their communities, especially given the already limited access to a range of services in those areas.

We have commented on the Standards pertinent to the work of the College.

Standard 1: The Person

I have the right to be treated with dignity and respect and to live free from any form of discrimination. I make decisions about my care and services, with support when I want it. My identity, culture and diversity are valued and supported, and I have the right to live the life I choose. My provider understands who I am and what is important to me, and this determines the way my care and services are delivered.

- Outcome 1.1 Person-centred care
- Outcome 1.2 Dignity, respect, and privacy
- Outcome 1.3 Choice, independence, and quality of life
- Outcome 1.4 Transparency and agreements

Rural and remote aged care should be person-centred while being cognisant of the needs and circumstances of families, carers, and the wider community. It should be culturally appropriate and tailored to meet the specific needs of a diverse population, including Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds.

The place of death and dying is culturally and spiritually significant for many Aboriginal or Torres Strait Islander people in particular. With returning to Country being an important part of end-of-life decisions, service models must reflect preferred places of care, which will often be in rural and remote areas.

Due to limited access to health care services in general, and limitations around public transport, rural patients are often reluctant to seek services outside their own community. This increases the importance of providing as many services as close to home as possible and supporting and retaining existing practices. This might, for example, involve providing aged care services for older Australians in rural and remote areas delivered in the home. ACRRM recommends that the way in which the Standards can be utilised and adapted recognises and accommodates the needs and circumstances of rural and remote patients and practitioners and facilitates equity of access despite their location.

Person-centred care should recognise the broader needs and circumstances of people living in rural and remote communities. This includes keeping those requiring care as close to home as possible, to minimise time and cost imposts of travel for families and the resultant dislocation from a community where many people would have spent a major part of their life.

The College welcomes that the Standards are cognisant of the diversity of older Australians and the acknowledgement that older people can come from a diverse range of backgrounds, including, but not limited to, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people living in rural or remote areas, people who are financially or socially disadvantaged, people who are veterans, people experiencing homelessness or at risk of becoming homeless, people who are care leavers (parents separated from their children by forced adoption or removal, people who are lesbian, gay, bisexual, transgender or intersex, people of various religions, people experiencing mental health problems and mental illness, people living with cognitive impairment including dementia, and people living with disability.

The Standards must consider the number of younger Australians living in RACFs, particularly in rural and remote communities where other specialist facilities do not exist. Although various government initiatives aim to reduce the number of people under the age of 65 living in aged care facilities by

2025[3], the reality for rural and remote areas is that there are still likely to be a proportion of younger people living in rural and remote RACFs.

In aiming to deliver person centred and culturally appropriate care, which is right for older people with specific needs and diverse backgrounds including Aboriginal and Torres Strait Islander peoples and people living with dementia, activities need to be tailored to the specific needs of the patient, and culturally safe and responsive. Translators should be available for those from linguistically diverse backgrounds, or those for whom English might be a second, third or fourth language. The role of Rural Generalists in rural and remote communities can be leveraged to ensure effective engagement with services and health practitioners.

Standard 2: The Organisation

The organisation is well run. I can contribute to improvements to care and services. My provider and workers listen and respond to my feedback and concerns. I receive care and services from workers who are knowledgeable, competent, capable, and caring.

- Outcome 2.1 Partnering with older people
- Outcome 2.2 Quality and safety culture
- Outcome 2.3 Accountability and quality systems
- Outcome 2.4 Risk management
- Outcome 2.5 Incident management
- Outcome 2.6 Feedback and complaints management
- Outcome 2.7 Information management
- Outcome 2.8 Workforce planning
- Outcome 2.9 Human resource management
- Outcome 2.10 Emergency and disaster management

Quality and Safety - Standards

As noted previously it is important that the Standards are appropriate for the needs and circumstances of smaller rural and remote primary care services and their clients, as well as for facilities in larger, more heavily populated centres. This does not mean that standards for quality and safety of services will be compromised in rural and remote settings, but rather that they may be applied differently to the way in which they are implemented in larger and more urban-based facilities.

ACRRM recommends that ongoing monitoring and evaluation be undertaken to identify any unintended consequences of application of the Standards and to monitor their impact on the compliance and other burdens of RACFs based in rural and remote locations. This process should be undertaken with input from rural and remote community members and health care practitioners.

Quality and Safety Culture - Cultural competence

Healthcare systems continue to face persistent challenges with health largely determined by many factors outside traditional healthcare settings. To serve the needs of a diverse population, it is

[3] 2019 Younger People in Residential Aged Care Action Plan https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-younger-people-with-disability-in-residential-aged-care-initiative/younger-people-in-residential-aged-care-action-plan

imperative that healthcare systems take measures to improve cultural competence.[4] The ability to collaborate effectively with individuals from different cultures to improve the patient healthcare experience and outcomes will play a pivotal role in the successful application of the Standards.

It is equally as important that providers consider diversity within their organisation/workplace. A diverse organisation is one that recognises that people with different backgrounds, beliefs, attitudes, and experiences can bring new ideas and perceptions to the team.

Lack of diversity in healthcare teams can lead to limited perspectives when providing people with care. Being responsive to diversity requires that services are universally accommodating as well as tailored to particular population groups[5].

Information management

Members report positive experiences with the use of electronic drug charts in RACFs, and welcome technologies which integrate with existing systems and processes.

Member Feedback

"Electronic systems have intrinsic safeguards to reduce prescribing errors and are intrinsically legible. However, like all designed products, not all are created equal. There are some very good systems out there and there are some poorly designed systems"

"In principle, electronic systems are the way forward, but they should by default be good systems that integrate with other things we already use, and there needs to be engagement from the end user during the acquisition and roll out, and recognition and remuneration for training."

Workforce planning

The workforce crisis facing the rural and remote aged care sector has been well-documented, and the problems faced by a sector in crisis have been exacerbated by the impact of COVID-19. Better pay and conditions for aged care workers, and nation-wide strategies to retain and attract staff are required.

A well-trained and appropriately remunerated aged care workforce is essential in providing timely access to care and delivering quality services which cater for older people's physical, emotional, functional, and psychosocial needs. In rural and remote areas, one of the most effective workforce strategies is to recruit and train local people who are most likely to remain within the community. This can be facilitated through a wider range of training mechanisms to allow local people to undertake training remotely; and promoting access to and incentivising ongoing training and professional development opportunities.

The pivotal role played by rural doctors needs to be better recognised and supported through a range of strategies including:

- Providing appropriate remuneration for a full range of services provided, both face-to-face and via telephone/telehealth; and including consultations with relatives, carers, specialist consultants and other members of the health care team
- Increasing the range of rural and remote incentives and loadings to support GPs in providing aged care
- Streamlining administrative requirements and reducing red tape

[4] Cultural competence and ethnic diversity in healthcare, Nair and Adetayo, May 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6571328/
[5] https://www.health.vic.gov.au/populations/designing-for-diversity

- Better coordination and communication between aged care facilities, practices, and practitioners to improve the quality of patient care; increase collaboration and communication; and reduce GP workloads.

A healthy and resilient workforce

Many of the factors which make rural communities attractive and rewarding places to live and work, are also those that can present the biggest challenges for health professionals

Rural and remote health professionals are affected by the social and economic issues which impact on the communities in which they live and work. Like their counterparts in the wider community, they feel the economic and social impacts of vagrancies of climate and a reduced range of services.

In addition to their professional capacity, these people and their families are also community members who have several other roles within their community. They will meet their patients in a range of other capacities and the separation of roles can be difficult for both patient and practitioner and create another barrier to seeking treatment.

The College recognises the importance of practitioner health and wellbeing and is committed to caring for and supporting a rural and remote workforce which is geographically dispersed and often working in more challenging circumstances than their urban counterparts. It will continue to take a lead role in setting quality standards and develop innovative models of care to support practitioners at all stages of their career and enable them to 'thrive' in rural and remote practice.

We must ensure the rural and remote aged care workforce has access to personal mentoring and support structures to assist them maintain their physical and mental safety and wellbeing.

Standard 3: The Care and Services

The care and services I receive are safe and effective; optimise my well-being and quality of life; meet my current needs, goals, and preferences; are well planned and coordinated.

- Outcome 3.1 Assessment and planning
- Outcome 3.2 Delivery of care and services
- Outcome 3.3 Communicating for safety and quality
- Outcome 3.4 Coordination of care and services

ACRRM believes all Australians, irrespective of where they live, should have access to excellent healthcare. While the best model of care may change in differing rural and remote contexts, all Australians should have access to a continuing care relationship with a medical practitioner.

Rural and remote healthcare is best served through team-based models with appropriate collaborative arrangements in place. Wherever possible, the general practitioner should be the first point of contact for patients and regarded as the key person in the continuum of care.

The College supports models of care that involve a collaborative and team-based approach where possible. This includes adopting a distinctive, flexible, and broad scope of practice within each practitioners' safe scope to deliver the fullest and best possible local care in rural and remote areas. It is noted that there is already a broad range of excellent rural and remote nursing and allied heath models involving remote area nurses, midwives, Aboriginal and Torres Strait Islander health professionals and others which reflect this rural generalist approach to rural healthcare.

Coordination across all levels of the health system is imperative, and especially important for rural and remote communities who rely on cross-sector collaboration to maximise local capacity. A systematic, proactive approach to ensuring all rural and remote communities are supported by adequate funding and resourcing should be adopted, alongside a commitment to cross-sector collaboration to maximise local capacity.

Standard 5: Clinical Care

I receive safe, effective, and person-centred clinical care which meets my needs.

- Outcome 5.1 Clinical governance
- Outcome 5.2 Preventing and controlling infections in clinical care
- Outcome 5.3 Medication safety
- Outcome 5.4 Comprehensive care
- Outcome 5.5 Care at the end of life

Rural Generalists and other General Practitioners are often the only provider of aged care services in rural and remote areas, and in areas where other services do exist, are often the first point of contact for dementia patients and Residential Aged Care Facilities (RACFs) in need of assistance. These doctors are also often called upon to support patients in the case of health emergencies.

Rural and remote general practitioners work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. These doctors are often the only readily available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to psychiatrists, allied health professionals, or health care teams in larger areas. These doctors work in local healthcare teams that are small in number and supported by minimal resources.

The distinctions of these rural and remote contexts have important implications for what represents the safest and best clinical care.

Medication Safety

Whilst care for people living with dementia and changed behaviours should cater for their specific needs and provide non-pharmalogical strategies to assist, the reality is that the aged care sector in rural and remote Australia faces many challenges compared to city counterparts.

There is generally poorer access to and availability of a range of services, including psychiatry and allied health services. Recruiting and retaining a skilled aged care workforce becomes increasingly difficult with remoteness. The distribution of mental health professionals rapidly decreases with remoteness. Psychiatrists are six times less prevalent; psychologists five times less prevalent and mental health nurses three times less prevalent in rural and remote areas.[6]

Rural and remote clinicians are generally unable to access psychiatric services in their area, with our members indicating that wait times to see a psychiatrist can be as much as two years. Testimony by a representative of RANZCP to the New South Wales Senate Inquiry into rural healthcare services,

[6] CRANA Plus (2020) Remote Health Workforce Safety and Security Position Statement

suggested that access decreases rapidly with remoteness, with psychiatrists being seven times less prevalent in rural areas.[7]

Urgent problems often require an immediate response, including prescribing psychotropic medicines. Dementia or Alzheimer's patients can often become disturbed or agitated at night, which is a common consequence of brain deterioration in these diseases. Caring for hyperactive patients with dementia carries with it risks for the safety of the patient, other residents, and staff. It is therefore important that the Standards take cognisance of these issues, particularly with reference to Action items numbered 5.3.2 (medicine reviews) and 5.3.5 (processes to identify, monitor and mitigate risks).

For example, the Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications for People Living with Dementia in Aged Care were issued in draft format in April of this year, with the consultation process closing in early May 2022.

Our College Submission[8] stressed the importance of being able to have the option of prescribing antipsychotic medication in the treatment of psychotic and agitated elderly patients, which often avoids transferring patients to busy emergency departments or acute medical wards. Members report that antipsychotics are often used for nausea control, comfort and in some instance's sedation. The consequences for patients who have no reversible causes for their unsafe behaviour and for whom one-on-one nursing is not an option would be increased personal distress and risks to the safety of healthcare staff, other residents, and patient carers. This is important in all contexts but especially pertinent in rural contexts of geographic isolation and generally low levels of in situ staff and resources including local police and emergency services.

We see need for a more considered analysis of the implications of Outcome 5.3 of the Standards when applied in small, geographically isolated communities with access to only minimal staff and resources in situ.

Where a specialist psychiatrist is not available, allowances must be made for the specialist GPs and Rural Generalists providing regular care to manage patients to keep them safe and well.

Polices and protocols must be developed to either facilitate swift access to consult services or to include alternative sufficiently expeditious mechanisms for enabling use as required, including facilitating access to telehealth Psychiatry services.

Care at the end of life

As Rural Generalists, ACRRM doctors are trained to work in the limited resource contexts of rural and remote communities. They are trained to be able to deliver a broad scope of services to allow them to fill service gaps which arise due to the lack of access to consultant specialists, allied health practitioners and other specialised services and resources in their areas. Their scope extends to working in GP clinics, hospitals, retrieval services, and other clinical settings. All doctors that attain ACRRM Fellowship are assessed as having attained strong skills in Palliative Care. The ACRRM Fellowship training program provides the option to complete a full year of assessed, Advanced Specialised Training (AST) in Palliative Care.

Our doctors commonly provide palliative care services and the requirement to provide these services going forward is likely to increase. As growth in older populations continues to rise, the prevalence of death from diseases with a palliative phase will rise accordingly. The demand for end-of-life care services is increasing and the current specialist-based palliative care system does not have the

[7] NSW Legislative Council (2022) Health Coucomes and access to health and hospital services in rural, regional, and remote New South Wales: Report 57: May 2022. (page 117)

[8] https://www.acrrm.org.au/docs/default-source/all-files/college-submission---clinical-practice-guidelines-psychotropics-in-residential-aged-care.pdf?sfvrsn=e7480400_4

capacity to manage all end-of-life care, and therefore the responsibility of care must be borne by all healthcare practitioners, particularly those in primary care. This situation is exacerbated in the rural and remote areas where our doctors work, as most specialist-based palliative care services are based in large urban areas.

In rural and remote areas, strong collaboration between providers and Rural Generalists will be vital to ensuring care at the end of life can be delivered in the manner outlined in Outcome 5.5.

Standard 7: The Residential Community

I am supported to do the things I want and to maintain my relationships and connections with my community. I am confident in the continuity of my care and security of my accommodation.

- Outcome 7.1 Daily living
- Outcome 7.2 Planned transitions

Physical and psychological safety

Action 7.1.2 states that the provider must implement strategies to protect both the physical and psychological safety of older people. Mental health is a key component of the College's primary curriculum, and the AST in mental health is one of the twelve AST options which are compulsory as part of the College Fellowship training program.

Mental health conditions such as depression often remain undetected and untreated in residential aged care facilities, with less than 1% of aged care residents receiving any kind of psychological treatment.[9] However, there is gathering evidence to suggest that psychological interventions can be effective in treating late-life depression, anxiety, and dementia.[10]

Rural Generalists and General Practitioners are in a unique position to provide holistic care, crossing the siloes of mental health care and providing care across the illness spectrum and the lifespan, and work with an extended scope of practice. They are well placed to assist patients in aged care with psychological strategies for wellness but must be supported and adequately funded to do so.

As previously outlined, Rural Generalist practitioners and especially those with advanced skills in mental health, will be in the best position to deliver and coordinate a range of services, especially in those communities which lack the critical mass to employ a full health care team, including psychiatrists and mental health workers. The College believes that key to improving access to mental health services is through recruiting and retaining a skilled and supported medical workforce which can provide as many services as possible, as close to home as possible.

[9] APS Innovative psychological support in aged care facilities: Preliminary research and future directions https://psychology.org.au/inpsych/2016/december/bhar1

[10] Wells, Y., Bhar, S. S., Kinsella, G., Kowalski, C., Merkes, M., Patchett, A..,Holsteyn, V. (2014). *What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings*. Melbourne: beyondblue

Planned transitions

Rural Generalist doctors are involved in the full spectrum of aged care – through general practice-based primary care, home visits, nursing home attendances, secondary care in the local hospital, coordination of team-based care and referrals, support for family and carers, and palliative care.

ACRRM views the optimum model of care as enabling patients to continue to live within their community where they can be supported by family and their wider networks and receive ongoing, coordinated, and collaborative care from a well-trained, skilled, and supported health care team led by their local medical practitioner. Patients benefit the most from a lifelong relationship with a "usual GP".

In recognition of the desire of most people to remain in their homes and communities, service models should be based on meeting as many of the needs of clients as close to home as possible. This will require flexibility in service delivery models, utilising team-based care and providing additional support for facilities and carers.

Member Feedback

"The complexities of some situations must really be a hurdle for some people to get the care and support that they need which compounds even more so when the help just isn't available where you live and would like to remain living"

The Standards must recognise that the provision of aged care services in rural and remote areas requires a broad, outcomes-focused definition which incorporates the Rural Generalist scope of practice. In aiming to create a person-centred system which takes a holistic approach to health and wellbeing, the Standards needs to be cognisant that the delivery of support and treatment and who is best placed to deliver it, can be different in the rural and remote context.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.