



Catholic Health Australia – Residential Care Service List

January 2025

Catholic Health Australia

www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA members provide 20 per cent of home care provision, in addition to 12 per cent of all aged care facilities across Australia.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Executive Summary

Catholic Health Australia (CHA) welcomes the opportunity to provide input into the updated Residential Care Service List (Service List). Catholic aged care providers will continue to work with the Australian Government to ensure the sustainable provision of aged care and support services for older Australians meet community expectations of safe and quality of care. In our submission to the Senate Inquiry on the Aged Care Bill in October 2024, CHA noted our support of robust consultation on the subordinate legislation. We look forward to working with the Government during the consultation process to ensure the draft Rules achieve their intended outcomes. Our goal is to ensure that the new Act and subordinate legislation fully support a high-quality and safe aged care system for all Australians irrespective of their wealth or geography.

In the main, CHA is supportive of the proposed changes to the Service List, with some important qualifications outlined in this submission. As CHA noted in our submission on the draft Service List in October 2024, some of the current requirements under Residential everyday living and Residential clinical care are unduly homogenised and do not reflect the diversity of care recipient needs and wants and/or the capacity of current residential aged care homes to provide these services. Some language also needs to be amended for clarity.

The draft Service List includes changes to what is required to be delivered by providers in residential aged care settings. These changes, such as ironing services and specific furnishings, have cost implications and therefore, require consideration of appropriate funding amounts to be provided by Government under the Australian National Aged Care Classification (AN-ACC) funding model. It will be important for the Independent Health and Aged Care Pricing Authority (IHACPA) to review the finalised Service List and use this as the basis for future costing studies for residential aged care so that all items are adequately costed and therefore appropriately funded.

Key observations and issues relating to the revised Service List articulated in our submission include:

Everyday living services:

A brief summary of key issues pertaining to each consultation question and corresponding subsection are listed below:

1. **Operational services:** Some descriptions should refer to **services being provided where possible**, as the provision of these services may at times be outside of the control of aged care providers, such as internet and telephone access in some geographical areas.
2. **Personal and communal spaces:** Some descriptions should be **broader and less restrictive** to support providers to be responsive to individual needs and preferences, for example the provision of armchairs and shower chairs; periodic instead of regular outings; the provision of mouthwash; returning personal laundry to an older person's room rather than their wardrobe.
3. **Personal and communal spaces:** Some requirements should also be **subject to an assessed need by a health professional** such as the provision of a recliner or specialised chair; or need to be a **decision of the individual aged care home** following a risk assessment in consultation with the individual resident and other residents such as the use of a motorised wheelchair.

4. **Meals and refreshments:** Some requirements need to **better reflect the residential aged care setting**, such as amending the requirement for 'flexibility in mealtimes if requested by the individual' to 'a defined period of time in which cooked meals would be available', or 'as appropriate to a residential aged care setting,' given that residential aged care is not set up as a restaurant and there are food safety considerations.
5. **Mobility aids and equipment:** Some **language should be amended** so as not to infer clinical activities where these are not intended, for example 'assist the individual with' rather than 'fitting' sensory communication aids, hearing aids, artificial limbs and other personal mobility aids.

IHACPA would also need to adequately price the provision of ironing services if included.

Care and Care Services:

CHA believes that the proposed change to **care and care services**, which involves developing care and services plans in consultation with the individual and their family (as needed), aligns with the broader principle of delivering high-quality, person-centred care to older people. Specific issues in each subsection have been summarised below:

1. **Care planning and clinical care:** CHA is supportive of the proposed changes to involve an individual and their family (as needed) in the development of care and services plans. This section of the submission details the specific supports and considerations that would support the cohesive, consistent implementation of the Service List in residential aged care settings, including care minutes targets.
2. **Minor treatments:** If the concept of 'minor treatment' is incorporated in the Service List, a definition is required for it to act as practical guidance for providers. Supporting guidance should include means to facilitate training programs that support a reduction of minor treatments undertaken by non-clinical staff.
3. **Allied health and therapy programs:** CHA and its members are concerned about speech therapy being differentiated from allied health programs generally. This section of the submission outlines implications of the proposed change, and sets out the recommendation to reconsider the specific mention of speech therapy from the Service List as not to diminish the importance of other self-regulating allied health therapies.
4. **Maintenance therapy, restorative care therapy, therapy and support programs:** CHA believes that the language in this section broadly aligns with the Royal Commission recommendations as well as the Strengthened Aged Care Standards. Customisation of therapy and support programs for people with cognitive impairment will require specific supports in place, which is detailed in this section.
5. **Transport:** CHA is supportive of the exclusion of transport costs (including escort costs) as part of a providers' obligation to make arrangements for individuals to attend health professional appointments. The clarification of expectations around the provision of transport costs is important and welcomed in the context of the Service List. This section of the submission details the management of transport services for residents attending medical appointments, as well as the most common medical services that residents attend.

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Our list of recommendations

CHA makes the following recommendations to the Department:

Recommendation 1: In recognition of limitations to internet access in some geographical regions and to minimise the need for amendments in the Service List due to changes in technology, amend the description of telephone and internet services to read 'Access to telephone and internet services in the residential care home where possible (but not the cost . . .)'

Recommendation 2: To reflect what services are practicable and are currently provided and the preferences of residents, amend the descriptors so that:

- armchairs are to be provided in rooms where possible or required based on an assessed need;
- a shower chair is provided in showers should an aged care recipient want one or requires one based on an assessed need;
- armchairs and/or shower chairs are fit-for-purpose (meets residents' needs) and meet Australian safety standards and
- the provision of recliner chairs needs to be fit-for-purpose and part of an assessed need for the individual by a health professional such as a physiotherapist or occupational therapist.

Recommendation 3: Reflecting the residential aged care setting, refer to a 'defined period of time within which cooked meals would be available unless alternative arrangements are in place', or 'as appropriate to a residential aged care setting' rather than 'flexibility in meal times if requested by the individual.'

Recommendation 4:

Refer to 'assist the individual with' rather than 'fitting' sensory communication aids, hearing aids, artificial limbs and other personal mobility aids to avoid association with professional fitting services. Add that mouthwash is to be provided on request, to reflect individual choice and preferences. Reword to say 'return of personal laundry to the individual's room' so as to be responsive to individual needs and preferences.

Recommendation 5: Acknowledging their necessity for some people, CHA recommends that the use of motorised wheelchairs is at the discretion and decision of the individual aged care home once an individual has been assessed for the requirement, with the following also informing the decision-making process: staff training has occurred in how to assist; and the

aged care home has undertaken a risk assessment that supports its use, in consultation with the individual resident and other residents.

Recommendation 6: Under 'Recreational and social activities,' replace 'regular' with 'periodic' outings into the community in (b) to reflect that this may be what some residents prefer; it may reflect the availability of some activities, particularly in some seasons and in rural and remote areas; and it is more realistic in terms of what providers can manage given staffing and transport challenges for some providers.

Recommendation 7: Ensure that risks and unintended consequences of how Higher Everyday Living agreements can be entered into, is monitored, and that policy settings are adjusted accordingly.

Recommendation 8: CHA recommends the following:

- **Medication review:** Department to consider increasing the proportion of care minutes able to be delivered by enrolled nurses (ENs) to provide registered nurse capacity towards specialised tasks, such as delegation and/or supervision of medication reviews.
- **Provision of audio-visual equipment for telehealth appointments:** Department to amend the text to "capability to provide telehealth appointments" as a more reasonable expectation of services able to be provided in a residential care home.

Recommendation 9: If the concept of minor treatments is proposed to be included in the Service List, ensure that:

- A definition of 'minor treatment' is included in the Service List or in supporting guidance; and
- There is flexibility in supporting guidance to enable task-shifting within staff teams supporting a resident, where appropriate frameworks and/or training programs are in place and facilitated by clinical staff.

Recommendation 10: CHA recommends that the inclusion of speech therapy in the Service List is reconsidered, as to not diminish the importance of other self-regulating allied health therapies.

Recommendation 11: If customisation of therapy and support programs for people with cognitive impairment is proposed for inclusion in the Service List, ensure that the following supports are in place:

- Greater access to expertise needed to deliver tailored programs;
- Strengthening of relationships between aged care providers and health service clinical teams; and
- Greater funding to upgrade existing programs and facilities needed to deliver these programs.

Recommendation for IHACPA:

Should ironing be included in the service list, ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given that in many services this is not practicable or current practice.

Submission on the Residential Care Service List

Section 1: Accommodation and Administration

Accommodation

CHA and its members are supportive of the proposed change of “reinstatements” to “replacements” in the Accommodation subsection of the **Residential Accommodation** section. This change clearly outlines the intention of the Service List so that all stakeholders understand the obligation of providers in this section.

Should there be more detail about requirements and expectations for administrative activities?

CHA and its members do not consider it necessary for there to be more detail about requirements and expectations for administrative activities. The current list is sufficient to cover the administrative activities providers undertake.

Do references to emergency assistance need to be more specific about what counts as an emergency?

CHA and its members do not consider it necessary for the list to be more specific around what counts as an emergency as the list already categorises emergencies appropriately. Adding more specificity could have an adverse impact on the operations of aged care facilities in an emergency.

Facilities operate in their own unique environment that can greatly differ from each other. Responses to emergency situations need to be flexible to respond to the circumstances that each facility faces. For instance, the size of a facility may dictate whether it is safer for the provider to take action or instead to rely on emergency services to respond. Additionally, continually training staff in emergency procedures that are not aligned with best practices for their facility is unreasonably burdensome and risks creating confusion during actual emergency responses. Therefore, CHA does not consider more specificity necessary.

Section 2: Everyday living Services

Operational services

How do aged care homes currently offer residents internet access?

Internet access is important for resident connection to loved ones and the wider world and CHA is supportive of this being included in the Service List. However, there are geographical limitations to consistently reliable internet access for some residential aged care services so the words 'where possible' should be included in recognition that it may be beyond the control of some residential aged care providers whether they have internet access or not.

In addition, given that wireless networking technology (wifi) enables internet access; wifi can be expensive compared to alternatives such as broadband; and wifi technology may change. CHA suggests that the section about telephone and internet services does not need to reference wifi services as well as internet services.

CASE STUDY

ONE MEMBER HAS BEEN UNABLE TO PROVIDE RELIABLE PHONE AND INTERNET ACCESS IN A WING OF THE FACILITY DUE TO CONNECTIVITY ISSUES BY THE PROVIDER. TELSTRA IS CURRENTLY INSTALLING CABLES TO ADDRESS THIS ISSUE AFTER A 2 - 3 YEAR DELAY.

Recommendation 1:

In recognition of limitations to internet access in some geographical regions and to minimise the need for amendments in the Service List due to changes in technology, amend the description of telephone and internet services to read 'Access to telephone and internet services in the residential care home where possible (but not the cost . . .)'

Personal and communal spaces

CHA and its members believe that some qualifications could be added to improve the wording around the provision of furnishings in relation to personal and communal spaces. Importantly, these furnishings need to be fit-for-purpose for use by residents. CHA has already provided some feedback on this issue in our previous submission regarding the Aged Care Service List consultation in October 2024. This feedback has been restated below for clarity.

Some aged care recipients want to bring their own armchairs to the residential aged care home. Not all aged care rooms are able to accommodate the placement of armchairs alongside existing furnishings. Additionally, there is not always storage available onsite for excess armchairs if one is provided to every resident regardless of their wish or need for it. This would be the case if these qualifications or considerations are not incorporated into the Service List, as it is the understanding of CHA members that the Service List is intended to set the expectations for service offerings at each residential aged care home.

Some residents may want to bring their own shower chairs to the residential aged care home. Similar qualifications should also apply in this instance. It is important that regardless of whether the resident brings in their own armchair / shower chair, or that one is provided to

them based on an assessed need, it needs to be fit-for-purpose and meet Australian safety standards. This will ensure that staff are able to care for all residents, irrespective of whether they choose to bring their own furnishings or have them provided as based on assessed needs.

Furthermore, this section specifically refers to a recliner chair with arms being provided. The service offering of a recliner chair with these specifications should be fit-for-purpose. An additional qualification for this service offering could be that the provision of a recliner chair with arms is when it is deemed as an assessed need by a health professional, such as a physiotherapist or occupational therapist.

Recommendation 2: To reflect what services are practicable and are currently provided and the preferences of residents, amend the descriptors so that:

- armchairs are to be provided in rooms where possible or required based on an assessed need;
- a shower chair is provided in showers should an aged care recipient want one or requires one based on an assessed need;
- armchairs and/or shower chairs are fit-for-purpose (meets residents' needs) and meet Australian safety standards and
- the provision of recliner chairs needs to be fit-for-purpose and part of an assessed need for the individual by a health professional such as a physiotherapist or occupational therapist.

What are the practical considerations for providing bedding to cater to such things as height and weight?

CHA is supportive of the current wording in relation to “(a) an adjustable bed (with a mattress) that is appropriate for the individual's height and weight.” It is the experience of CHA members that this is considered standard practice.

Meals and refreshments

What should aged care homes provide with regards to meals and refreshments?

CHA reiterates our comments and recommendation in the Aged Care Service List consultation in October 2024:

The current descriptor presents challenges regarding the stated flexibility that can practicably be provided. In (c), the descriptor should refer to a ‘defined period of time within which cooked meals would be available unless alternative arrangements are in place’, or ‘as appropriate to a residential aged care setting’ rather than ‘flexibility in meal times if requested by the individual.’ This recognises that while aged care homes are not staffed or set up like restaurants they still need to adhere to food safety requirements, including the requirement to keep hot food hot for an appropriate time period. CHA’s proposed amendments will support the implementation of the Service List in residential aged care homes. Importantly, these amendments account for the duty of care that providers have for their residents – in which all residents should receive proper food and nutrition that meets their care needs – while providing parameters that ensures service viability. These amendments will also build

the trust and confidence of individuals and their loved ones that the quality of care provided at these homes are consistent with Standard 6 of the Strengthened Quality Standards.¹ Additionally, these amendments will ensure that providers are able to readily demonstrate conformance with Standard 6.

Recommendation 3:

Reflecting the residential aged care setting, refer to a 'defined period of time within which cooked meals would be available unless alternative arrangements are in place', or 'as appropriate to a residential aged care setting' rather than 'flexibility in meal times if requested by the individual.'

Activities of daily living

What should aged care homes provide in regard to personal care assistance, continence management, toiletries, personal laundry and communication items?

In the main, CHA and its members agree that the draft list provided in regards to these concepts is appropriate. This section details some amendments to improve the language used in this section of the Service List and clarify the expectations from individuals and their loved ones regarding the extent of service provision.

- **Communication:** As CHA recommended in the consultation on the Service List in October 2024, when the word 'fit' is used in relation to fitting sensory communication aids, hearing aids, artificial limbs and other personal mobility aids, this should be 'assist the individual with' rather than 'fitting.' 'Fitting' has a specific meaning that typically associated with being 'professionally fitted'.
- **Toiletry goods:** The provision of mouthwash should be treated differently to toothpaste or denture care, and should be provided on request rather than as a standard item as not every older person wants or needs it. Exceptions should include supported residents with an assessed need.
- **Personal laundry:** The specification of 'return of personal laundry to the individual's wardrobe space' in (d) assumes that all clothes belong in wardrobes rather than drawers; is restrictive; and is not reflective of residents' choice, control or independence as to where they would like their clothes to go and whether they would want to put them away themselves. It should say 'return of personal laundry to the individual's room' instead.

¹ Department of Health and Aged Care, [Strengthened Quality Standard 6: Food and Nutrition](#)

Recommendation 4:

Refer to 'assist the individual with' rather than 'fitting' sensory communication aids, hearing aids, artificial limbs and other personal mobility aids to avoid association with professional fitting services.

Add that mouthwash is to be provided on request, to reflect individual choice and preferences.

Reword to say 'return of personal laundry to the individual's room' so as to be responsive to individual needs and preferences.

Additionally, CHA reiterates our recommendation that should ironing be included in the final Service List, then IHACPA would need to ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given that in many services this is not practicable or current practice. The draft Service List includes changes to what is required to be delivered by providers in residential aged care settings. These changes, such as ironing services, have cost implications and therefore, require consideration of funding amounts provided by Government under the Australian National Aged Care Classification (AN-ACC) funding model. It will be important for IHACPA to review the finalised Service List and use this as the basis for future costing studies for residential aged care so that all items are adequately costed and therefore appropriately funded.

Recommendation for IHACPA:

Should ironing be included in the service list, ensure pricing is adequate in relation to the requirement for residential aged care to offer ironing services given that in many services this is not practicable or current practice.

Mobility aids and equipment

What are the practical considerations around providing motorised wheelchairs in residential aged care, and how are the risks currently managed?

Motorised wheelchairs are necessary for some people, including those with neurological conditions. However, the decision to use them in an aged care home should be at the discretion of each residential aged care home and should depend on the following factors:

- the type, age and size of the aged care home;
- the circumstances of the aged care home;
- an assessment for the requirement;
- staff training in how to assist; and
- a risk assessment by the individual aged care home (including battery risks and risks to other residents) in discussion with the resident and other residents.

The type, age and size of an aged care home is a significant factor in determining how the motorised wheelchair can be stored when not in use by the resident. Not all aged care homes have the capacity to store a large motorised wheelchair onsite and in a safe space. There may be insufficient space in the residents' room to park the wheelchair while allowing staff to effectively provide care to the resident. In such instances, it would at the discretion of the aged care home to prioritise the provision of care to the resident over agreeing to the regular use of a motorised wheelchair.

CASE STUDY

ONE CHA MEMBER HAS SOME SITES THAT WOULDN'T BE ABLE TO HAVE MOTORISED WHEELCHAIRS AS THEY HAVE COURTYARDS WITHIN SMALL RESIDENTIAL AGED CARE HOUSES (CONGREGATE LIVING), WHILE OTHER, LARGER SITES CONSIST OF LARGER BUILDINGS WITH WIDE CORRIDORS THAT COULD ACCOMMODATE MOTORISED WHEELCHAIRS.

Furthermore, it is important to consider the additional costs that would be incurred should all aged care providers be obligated to provide motorised wheelchairs in the home. This means that costs of the motorised wheelchair are likely to be passed onto residents, as providers are not funded to cover the costs of these wheelchairs. This may result in unintended consequences, where some residents can afford the costs of a motorised wheelchair while others cannot, leading to disparities in access and quality of care.

There is no 'one size fits all.' It should ultimately remain up to the individual aged care home as to whether they can accommodate a motorised wheelchair, considering safety and the views of other residents at the home. Potential outcomes of the risk assessment may include restrictions on the use of motorised wheelchairs, including in dining rooms / crowded spaces, speed limits, designated areas of the home. Outcomes of the risk assessment will support discussions with the resident and other residents at the home, such as to balance potentially differing views of residents around the use of a motorised wheelchair.

Recommendation 5:

Acknowledging their necessity for some people, CHA recommends that the use of motorised wheelchairs is at the discretion and decision of the individual aged care home once an individual has been assessed for the requirement, with the following also informing the decision-making process: staff training has occurred in how to assist; and the aged care home has undertaken a risk assessment that supports its use, in consultation with the individual resident and other residents.

Social and emotional support

How can homes maintain and improve social interaction, and prevent loneliness and boredom?

CHA and its members acknowledge that social interaction and engagement in meaningful activities to prevent loneliness and boredom are important aspects of care. However CHA considers that more flexibility is needed in relation to the detailed requirement for outings as part of the Service List. CHA reiterates the recommendation we made in the Aged Care

Service List consultation in October 2024 to replace 'regular' with 'periodic' in relation to outings into the community, unless these may be funded through an additional wellbeing fee.

Outings responding to community events that are periodic rather than regular may be preferred by some residents, noting that loneliness and boredom thresholds vary from individual to individual. Residential aged care also has high and increasing levels of acuity.² Therefore, for some residents, stimulation able to be delivered inside the home may be more appropriate.

From the provider's perspective, staff are needed to be rostered at specific places in order to provide outings, and often require a minibus or other means of transport as well, which not all aged care homes have. Historically, costs of bus trips for some providers have been part of their Additional Wellbeing Fee. Accordingly, the term 'regular' causes some concern and is ambiguous. Given that lifestyle is not included in AN-ACC funding for Care Minutes, it is unclear where the funding required to deliver these services should come from.

Recommendation 6:

Under 'Recreational and social activities,' replace 'regular' with 'periodic' outings into the community in (b) to reflect that this may be what some residents prefer; it may reflect the availability of some activities, particularly in some seasons and in rural and remote areas; and it is more realistic in terms of what providers can manage given staffing and transport challenges for some providers.

Other issues

The ability to discuss Higher Everyday Living Fees prior to entry to residential aged care

CHA and its members are supportive of the principle that providers must inform residents of all possible fees before entering care, including the options that may be available with a HELF.³ CHA believes that this principle promotes transparency and consumer choice around the additional services available that individuals may wish to pay for. CHA and its members also believe that this principle should be incorporated into the draft Rules to enhance clarity

² The proportion of people assessed as having high care needs when they first enter permanent residential care has increased over time. Trends over time for the 10 years from 2012–13 to 2021–22 indicate that:

- High care ratings when first entering permanent residential care have become more common for *activities of daily living* (from 36% to 58% of people) and *cognition and behaviour* (from 35% to 55% of people).
- Low and nil care need ratings became less common, with the largest decrease in nil care ratings for *complex health care* (from 11% to less than 1% of people), and the largest decrease in low care ratings for *activities of daily living* (from 32% to 8.9%). Source: [People's care needs in aged care - AIHW Gen](#)

³ Department of Health and Aged Care, [Higher Everyday Living Fee fact sheet](#), December 2024

of the current provisions in the Clause 284 of the Act and mitigate potential misinterpretations of this Clause.⁴

Additionally, providers are likely to continue to face the issue of uncertainty regarding income from HELF due to the changes being introduced under the Act. There are also likely to be unintended consequences from these changes. For example, there is potential for some providers to admit all potential permanent residents on a respite basis and, depending on whether the resident agrees to pay the HELF fees during respite, determine whether to admit the person as a permanent resident. It will be important to understand and monitor the risks to both consumers and providers and adjust policy settings as required to support the effectiveness of these changes.

Recommendation 7:

Ensure that risks and unintended consequences of how Higher Everyday Living agreements can be entered into, is monitored, and that policy settings are adjusted accordingly.

Section 3: Care and Services

CHA supports the additional text regarding service type care and services plan oversight. CHA believes that the proposed change, which involves developing care and services plans in consultation with the individual and their family (as needed), aligns with the broader principle of delivering high-quality, person-centred care to older people.

Care Planning and Clinical Care

CHA welcomes the proposed changes in the service types: **medication management** and **general access to medical services**. Specific observations and issues with these sections of the Service List are as follows:

- **Medication review:** CHA is supportive of the review of medication under the delegation and clinical supervision of a registered nurse (RN), or other appropriate health professional, as it promotes safeguards around the delivery of quality care under appropriate supervision. A similar approach could be adopted for additional tasks beyond medication administration, such as wound care and vital sign checks. It is important to consider how this could also be aligned with other requirements of RNs, such as the care minutes target. For example, the proportion of care minutes able to be delivered by enrolled nurses (ENs) could be increased so that RNs are able to work to their full scope of practice. This means that RNs will have greater capacity to be delegating or supervising medication reviews. Furthermore, to ensure that administrative burden around the distribution are minimised, the department could look to incorporate a proportionate percentage of time, as opposed to discrete minute targets.

⁴ Clause 284 - Fees for higher everyday living, *Aged Care Act* (2024).

- **Provision of audio-visual equipment:** CHA believes that there should be a focus on the capability of the residential aged care provider to provide telehealth appointments, as opposed to providing the older person with the audio-visual equipment for the appointment. As it is currently written, some providers may be required and/or expected to buy specialised audio-visual equipment for telehealth appointments (such as television screens with video-conferencing functionalities). This may not be the best use of technology resources. CHA recommends that the text is amended to 'capability to provide telehealth appointments,' which would reflect the scope of what could be reasonably expected and provided at a residential care home.

Recommendation 8: CHA recommends the following:

- **Medication review:** Department to consider increasing the proportion of care minutes able to be delivered by enrolled nurses (ENs) to provide registered nurse capacity towards specialised tasks, such as delegation and/or supervision of medication reviews.
- **Provision of audio-visual equipment for telehealth appointments:** Department to amend the text to "capability to provide telehealth appointments" as a more reasonable expectation of services able to be provided in a residential care home.

What minor treatments are undertaken by non-clinical staff at the moment?

CHA and its members believe that a definition of minor treatment is needed, alongside specific examples of what and/or what does not constitute minor treatment. This would support providers to better understand the intent of the policy proposed, and therefore align their practices towards achieving these policy goals.

It is the experience of CHA members that there has been progress made by providers to reduce the number of non-clinical staff undertaking clinical treatment on residents. It is important to recognise that this progress may be hindered by ongoing workforce challenges.⁵ For instance, low-level tasks perceived as 'minor treatments' may be delegated by a RN to a non-clinical staff member, such as a personal care worker, so that the RN's capacity can be allocated towards more specialised tasks.

CHA and its members believe that there should be flexibility in how non-clinical staff are upskilled or trained to undertake specific tasks (which may constitute 'minor treatment'). For example, if a multi-skilled certificate IV personal care worker is capable of changing a resident's dressing, there needs to be a training program in place (involving clinical staff) for the provider to assess the capability and skills of the personal care worker to do so. Fundamentally, if a non-clinical staff member has demonstrated their training, regular accreditation and/or assessment to undertake a specific task as part of the broader team supporting a resident, they should be able to perform these tasks.

⁵ There is a workforce shortage of aged and disability workers nationally. Source: [Jobs and Skills Atlas | Jobs and Skills Australia](#).

Recommendation 9: If the concept of minor treatments is proposed to be included in the Service List, ensure that:

- A definition of 'minor treatment' is included in the Service List or in supporting guidance; and
- There is flexibility in supporting guidance to enable task-shifting within staff teams supporting a resident, where appropriate frameworks and/or training programs are in place and facilitated by clinical staff.

Allied health and therapy programs

CHA and its members are concerned about the specific inclusion of speech therapy in this section of the Service List diluting the importance of other allied health therapies. This may be particularly the case for allied health professions that are self-regulated by their own professional association, such as dieticians.⁶ While it is the experience of CHA members that speech therapy is one of the most used services in aged care,⁷ it is unclear why speech therapy is being singled out from other self-regulating allied health professions. CHA requires greater clarity on the feedback that was provided to the Department to result in this proposed change. Implications of the proposed change include:

- Community expectations are placed on providers to have arrangements in place to deliver speech therapy, which may not be necessary or feasible in certain circumstances;
- Dilution of community sentiment towards other allied health professions, especially other self-regulating allied health professions; and
- Disproportionate emphasis on the relative importance of speech therapy for healthy ageing and functioning, in comparison to other allied health professions.

Given the above, CHA and its members are concerned that the importance of speech therapy could be overstated in comparison other allied health therapies. Clarification around the intent of this inclusion of speech therapy in the Service List would address this concern.

Recommendation 10:

CHA recommends that the inclusion of speech therapy in the Service List is reconsidered, as to not diminish the importance of other self-regulating allied health therapies.

⁶ [Self-regulation by a professional association](#) that certifies qualifications, sets and maintains standards and oversees professional development.

⁷ Of all people with a disability in 2015, approximately 41.9% of them were older people with a communication disability as noted in the [ABS 2015 Survey of Disability, Ageing and Carers](#) (SDAC).

Is the proposed wording on maintenance therapy and restorative care therapy clear?

CHA and its members agree that the proposed wording on maintenance therapy and restorative care therapy is clear and consistent with the Royal Commission recommendations. Section 4.12 of the final report, titled "Care, Dignity and Respect," addresses the use of language on restorative care and maintenance therapy. The report emphasises the importance of these therapies in improving the quality of life for aged care residents. It highlights the need for a shift from a purely medical model to one that includes restorative and maintenance approaches to care. Additionally, Standard 3 of the strengthened Aged Care Quality Standards sets out the provision of 'services aimed at getting back or improving a consumer's independence or daily living activities.'⁸ Given the references to maintenance therapy and restorative care therapy are consistent with Royal Commission recommendations and the description set out in Standard 3, CHA and its members are supportive of this proposed wording for inclusion in the final Service List.

Do therapy and support programs need to be customised for people with cognitive impairment?

A significant proportion of older Australians in aged care require behavioural support due to conditions like dementia, which affects around 54% of aged care residents.⁹ As 'dementia is a shared responsibility,'¹⁰ CHA and its members agree that therapy and support programs in residential aged care should ideally be tailored for people with cognitive impairments. CHA believes that customisation of therapy and support programs is consistent with the policy intent of other initiatives, including the strengthened Aged Care Quality Standards, and the National Design Principles and Guidelines. In practice, providers are required to consider how they can ensure that care and services are 'adapted and responsive to the individual needs of older people living with dementia' as well as how their 'workers are trained and supported to manage these situations.'¹¹ This is related to Standard 3, in which personal and clinical care services can include 'support for consumers living with cognitive impairment.'¹²

However, given the practical constraints around the delivery of these tailored programs, CHA does not recommend that this degree of specificity is captured in the Service List. It is the experience of CHA and its members that there is a lack of expertise in residential aged care staff to deliver programs tailored to people with cognitive impairment. Given financial viability issues in the sector, not all aged care providers are able to employ a specific person with dementia expertise to lead staff to deliver these tailored programs. Other factors that constrain the supply of tailored therapy and support programs for people with cognitive impairment include:

- Availability of trainers with specific expertise (i.e., dementia) to upskill staff at a residential aged care service;

⁸ Department of Health and Aged Care, [Standard 3 - Personal care and clinical care](#).

⁹ Australian Institute of Health and Welfare, [Dementia in Australia](#).

¹⁰ Department of Health and Aged Care, [National Dementia Action Plan 2024 – 2034](#).

¹¹ Aged Care Quality and Safety Commission, [Draft evidence mapping framework – guidance material for the strengthened Aged Care Quality Standards](#) (page 76).

¹² Department of Health and Aged Care, [Standard 3 - Personal care and clinical care](#).

- Long wait times for education and training to deliver tailored programs that reflect best-practical models of care;
- Limited established networks with local health services to promote knowledge-sharing and to work alongside an older person's care team to deliver a tailored program and provide continuity of care; and
- Limitations with the AN-ACC funding model to cater towards cohorts of older people with specific care needs, such as dementia care.

CASE STUDY

ONE CHA MEMBER NOTED THAT THEY HAVE BEEN WAITING FOR 4 MONTHS FOR STAFF FROM DEMENTIA SERVICES AUSTRALIA TO DELIVER TRAINING TO SUPPORT PROGRAM DELIVERY SPECIFIC TO RESIDENTS WITH DEMENTIA CARE NEEDS.

Recommendation 11: If customisation of therapy and support programs for people with cognitive impairment is proposed for inclusion in the Service List, ensure that the following supports are in place:

- Greater access to expertise needed to deliver tailored programs;
- Strengthening of relationships between aged care providers and health service clinical teams; and
- Greater funding to upgrade existing programs and facilities needed to deliver these programs.

Transport

In the main, CHA is supportive of the exclusion of transport costs (including escort costs) as part of a provider's obligation to make arrangements for individuals to attend health professional appointments. It is the experience of CHA and its members that health professionals, such as general practitioners, are increasingly expecting residents to travel to them for appointments. This would impact the cost to providers to facilitate these services for all residents. These costs would be significant for smaller providers in rural and remote areas where the cost of transportation is significantly higher than in metropolitan or regional areas. As such, CHA and its members are supportive of this additional text to clarify the expectations around the provision of transport costs for residents attending health professional appointments.

How are transport services for medical appointments currently managed at your service? What are the most common medical services that residents go to?

It is the experience of CHA and its members that common medical services attended by residents include: optometrist appointments, general practitioners, and specialist appointments.

During the COVID-19 pandemic, CHA members typically organised staff members to take residents to medical appointments without charging a fee for transportation services. Post-

COVID-19, many providers have transitioned back to charging residents a fee for transport to and from medical appointments.

Transport arrangements vary between providers. Some providers have 'care cars' that transport residents to and from their appointments. These cars are owned and operated by community members. Other providers have allied health cars that specifically visit the home, which are covered by the residents' daily fee.

Some providers have a small number of provider-owned vehicles that help transport residents to their appointments. However, given the small number of vehicles available and the irregularity of residents' appointments, where residents are able to travel by taxi, the residential care staff of some providers organise a taxi and pay the taxi fee for the resident to attend their appointment. This is also dependent on the resident's preference and existing arrangements. For example, it is the experience of CHA and its members that veterans will tend to organise and pay for their own transportation.