COTA For older Australians
COTA AUSTRALIA
Suite 9, 16 National Circuit
Barton ACT 2600
P: (02) 6154 9740
www.cota.org.au
E: cota@cota.org.au
ABN 35 118 911 541

Australian Government Aged Care Reform

A New Residential Aged Care Accommodation Framework

COTA Australia Response

The Australian Department of Health has issued a consultation paper *A New Residential Aged Care Accommodation Framework.* This paper is part of the process by which the Department responds to the conclusions and recommendations included in the Final Report of the Royal Commission into Aged Care Quality and Safety that relate to aged care accommodation.[1]

The Council on the Ageing is pleased to respond to this consultation paper. This response as been prepared by Dr Stephen Judd AM, COTA Fellow 2021/22 and Ian Yates AM, Chief Executive.

Executive Summary

This short response to the paper follows earlier meetings with Departmental staff engaged in this initiative. The response advocates for an accommodation framework that:

- Is principle- based to encourage innovation, not a prescriptive approach that encourages 'cookie cutter' design. The framework should encourage innovation, consumer choice and control, and facilitate a variety of accommodation models responsive to consumer preferences.
- Is evidence based, which also actively enables innovation, and we provide a detailed but not comprehensive list of research literature.
- Recognises that even the best accommodation design alone does not produce good outcomes. They are a function of the whole approach – culture, workforce structure and support, training, models of care, clinical expertise, leadership, governance are all critical. The Accommodation Framework is interdependent with other aspects of reform, and it must say so and point to them, and not imply that good design produces results on its own. Institutional, non-relational and controlling approaches to care can operate in large and small, new and old built forms, even in in-home care.
- Does not consider the capital costs of different built forms from a short-term purely financial perspective but must be balanced with benefits to residents and to the long run interests of provider, taxpayer and community.
- Recognises the evidence of how design impacts on the prospect of better infection control, as demonstrated during the current pandemic, and on the implications for residents and staffing of different built forms when there is an outbreak.
- Does not add to complexity, duplication and inflexibility but encourages innovative approaches, within the proper requirements of building codes and accessibility guidelines.

COTA is happy to engage in further public and private discussion on our response to the Framework consultation paper.

[1] Final Report of the Royal Commission into Aged Care Quality and Safety, volume 3A pp. 221-236.

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1. Responding to the present not the past

While we can all identify areas in which aged care accommodation must be improved, it is worth noting the progress that has occurred over the past 25 years. The picture on the left of a multi-bed ward was from a well-reputed provider that continued to operate such wards until the late 1990s. At that time most residential aged care accommodation was modelled on a public hospital ward model with residents sharing their rooms with people who were hitherto strangers. There was little privacy; there was little opportunity to individualise surroundings; there was certainly no choice. The comparison with the picture on the right of a typical current residential care home's resident room is quite stark.

While there are still multi-bed wards in some services in Australia, the Aged Care Financing Authority FY21 report indicates that in FY20 82% of aged care residents were in single rooms with en-suite, up from 77% three years previously. Indeed, ACFA also indicated that only 10% of rooms could be considered 'ward style', down from 17% previously.[2] This is only one indicator of accommodation improvement but, given the life of buildings and the capital invested in them, it is no mean feat that this turnaround has occurred.

Nevertheless, there is more to be achieved as institutionalised, provider centric, non-relational models of care are often supported by a traditional cookie-cutter approach to the built form. Yet the future is already among us and has been for some time. While more innovation is needed and to be encouraged, the benchmarks for design that supports good quality approaches to care have already been set from within the industry and need to be encouraged and promoted.

2. A Principles-based approach encourages innovation

The Department's consultation paper says that the intention of the Framework is to encourage and enable innovative design for residential aged care that support high quality of life for those in care and meet consumer needs and preferences. COTA strongly affirms these objectives.

Importantly, for a regulatory framework to enable innovation, encourage consumer choice and facilitate variety of accommodation models it must, almost by definition, avoid prescription. Such a

[2] https://www.health.gov.au/resources/publications/ninth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2021, p77

framework should express Principles, not seek to manage details. In this context, COTA is encouraged that the Department's Framework paper included the Dementia Enabling Environment Principles which are an excellent example of what has already been developed. They focus on Principles such as a human scale, visual access, reduction of unhelpful stimulation (both noise and visual) as well as optimising helpful stimulation, familiarity, opportunities to be alone and socialise, and providing links to the community. What is telling is that there is no prescription as to how these Principles are implemented or expressed. Rather they indicate what the *effect* of the design is for the consumer.

While these Principles are cited as 'dementia-enabling' the Royal Commission noted that good dementia design is, simply, good design.[3] That is, people with full cognition also benefit from the application of these Principles to produce an environment that is both therapeutic and prosthetic. Given the significant proportion of residents in aged care services who have diminished cognition, we should not look to re-invent the wheel but use existing outcomes-focused Principles such as these in any Accommodation Framework.

Section 6.2 of the Final Report of the Royal Commission into Aged Care Quality and Safety calls for National Aged Care Design Principles and Guidelines but makes clear that they should not be mandated. Rather they should be voluntary.[4] If the Department is to accept Recommendation 45 of the Royal Commission then such an Accommodation Framework must be just that: principles-based. Further any Guidelines should not be prescriptive. Such an approach will enable different and innovative ways by which such outcomes can be achieved.

3. A Framework that is based on Evidence will enable innovation

COTA supports a Framework that is not only based on Principles which enable innovation and encourages consumer choice and preference but must also supported by evidence. Over the past 25 years there has been considerable Australian and international research into residential aged care environments and COTA strongly supports a Framework that is based on such evidence.[5]

Much research has shown the benefits of small domestic households, and clearly Commissioner Briggs supported the encouragement of small domestic households. By contrast Commissioner Pagone maintained that small-scale accommodation is not for everyone.[6] These different perspectives of the Commissioners shows that the regulatory framework must be enabling not ddisabling. It must be able, within that framework, to provide a diversity of accommodation options.

That is also why the design elements should not be 'one size fits all' as contemplated by the Department's paper on page 14.

COTA also believes that there are great opportunities to ensure that the accommodation options in which older Australians might receive aged care support should not be restricted to what is today regarded as residential aged care. For example, group homes and retirement villages are currently outside of the regulatory framework of residential aged care but are already, sometimes with the

[3] Royal Commission into Aged Care Quality and Safety. Final Report, Volume 3A p.224
[4] RC Final Report, volume 3A, p.225
[5] A detailed but not comprehensive list of the research literature is included in Appendix A
[6] RC Final Report, volume 3A, p.227

support of CHSP and Home Care Packages, providing a long-term, comfortable, and safe *home* for the person as well as facilitating the provision of appropriate health care. Such diversity of accommodation options is what COTA believes Australian consumers want and deserve. Such diversity of accommodation options cannot be achieved if consumer choices are constrained by a regulatory framework that is persistently prescriptive. It cannot be 'one size fits all'.

4. Accommodation alone does not produce good outcomes.

COTA is concerned that the Accommodation Framework paper focusses on accommodation design alone, exclusive of all of the other operational ingredients that are essential to producing quality care outcomes. (This concern is not restricted to this component of the reform package. We have a concern about many aspects of reform being considered on a stand-alone basis, when transformational reform will only come when they all operate in tandem.)

Certainly, physical design can facilitate or inhibit independence, connectedness and higher quality of life. But all of the Australian and international research shows that staffing, training, models of care, clinical expertise and leadership are essential to producing the quality of life outcomes that we all seek.[7] Having one without the others is a recipe for failure. Unfortunately an institutional, non-relational and controlling approach to care can exist in both small and large environments (indeed even in the delivery of in-home care).

COTA believes that the Accommodation Framework should incorporate these human and organisational considerations into any Principles and Guidelines. Put simply, while COTA supports a regulatory framework that actively encourages small households that provide aged care, COTA believes that "Accommodation Frameworks" cannot be promulgated in isolation from other initiatives such as workforce reforms. Rather the Department must ensure that the expression of accommodation design principles is closely integrated with other parts of the reform agenda.

For example, Flinders University research, cited by the Royal Commission, concluded that the workforce structure in small households was vital to their success: there were more personal care attendant hours per resident per day and registered nurses spent less time on administrative activities and more on clinical leadership.[8] Similar findings have been made in research of the GreenHouse model of aged care in the US.[9]

5. The Capital Costs of Small Households

The Framework paper cites a review of international models of aged care which was undertaken for the Royal Commission which concluded that the costs to build small domestic households were slightly higher than traditional care facilities and it is this higher capital cost that discourages

[7] For example, Smith R, Mathews RM, Gresham M 'Pre- and Post-occupancy Evaluation of New Dementia Care Cottages', American Journal of Alzheimer s Disease and Other Dementias, (2010) 35:265, 265-275; Harrison SL et al, Alternative staffing structures in a clustered domestic model of residential aged care in Australia. Australasian Journal on Ageing. 38, 52 (2019) Access. https://doi.orq/10.1111/aiaq 12674

[8] Harrison SL et al, Alternative staffing structures in a clustered domestic model of residential aged care in Australia. Australasian Journal on Ageing. 38, 52 (2019)

[9] For example, Robert Jenkens, Financial Implications of The Green House model, in Seniors Housing and Care Journal v19, no 1, pp3-22;

providers from building small households. Another reason cited elsewhere has been that it is not possible to build small households in densely populated areas because of the land cost.

The Royal Commission heard that a 'clustered domestic model' requires 17% more capital than a traditional care facility because of the higher floor area.[10] This accords with the financial analysis of the GreenHouse model in the US.[11]. However the research also shows that this additional cost for an investment that will operate for 25 or more years is more than offset by benefits to residents, providers and the funder in terms of increased quality of life, reduced hospitalisations and a lower annual cost of care for Government of more than $12,000 compared to comparable residents in a traditional nursing home.[12] Such a return on investment should give confidence to government to support this form of accommodation financially as recommended by the Royal Commission.

6. Designing for infection control

COVID19 outbreaks in aged care homes have highlighted the importance of both active and passive infection control measures. The active measures should already be part of an effective clinical governance system. The 'passive' measures are those that can be reflected in the design of the care homes.

The experience of the past two years indicates that aged care facilities characterised by:

- a lack of adequate natural ventilation and reliance on mechanical ventilation
- congested communal dining and sitting areas
- long enclosed corridors and lacking ready access to outdoor areas

have been those that have been highly susceptible to COVID19 outbreaks, often with tragic outcomes.

By contrast the research done to date in Australia and overseas indicates that care homes that were small household models had fewer COVID19 outbreaks and their impacts were less severe.[13]

The issue of infection control will be one that will be of major importance for the foreseeable future and especially for existing residential aged care facilities. The Framework paper notes that the National Construction Code mandates that mechanical air-handling systems must control the circulation of pathogens and micro-organisms but observes that once installed there is no further testing of the building. In turn the Framework papers suggests consideration be given to other mechanical solutions such as negative pressure ventilation and air scrubbers. These solutions are similarly only as good and effective as the building maintenance regime.

COTA believes the approach to infection control will vary according to the physical design and operation of the service. Rather than incorporating specific requirements within a separate Accommodation Framework, COTA notes that aged care providers are obliged to demonstrate how they comply with Quality Standard 5 – to provide a safe environment – and anticipates that the

[10] Royal Commission into Aged Care Quality and Safety, Final Report, volume 3A p229
[11] Jenkins, R, op.cit
[12] Dyer SM et al, Clustered domestic residential aged care in Australia: few hospitalisation and better quality of life' the Medical Journal of Australia, 208, 10 (2018): Access. https.//doi orq/10.5694/mia17.00861
[13] Burton et al, Evolution and effects of COVID-19 outbreaks in care homes: a population analysis in 189 care homes in one geographical region of the UK, in the Lancet www.thelancet.com/healthy-longevity Vol 1 October 2020, pp. e21-31. See also Zimmerman S, Drummond-Stryker C, Tandan M, et al., Nontraditional Small House Nursing Homes Have Fewer COVID-19 cases and Deaths, JAM Med Dir Assoc. 2021.

Australian Aged Care Quality and Safety Commission will increasingly focus on how this Standard is met not simply by clinical practices but by the physical environment as well.

COTA notes that one of the major issues with COVID19 outbreaks in 2020 and 2021 was the impact on staffing, with at times whole workforces 'furloughed' and quarantined. One demonstrable benefit of small household models has been that if an outbreak occurred the number of staff needing to be 'furloughed' is far fewer. While Australian providers who had outbreaks in large institutional care homes with 100+ residents were forced to furlough as many as 100+ staff, thereby experiencing huge staff shortages, providers who had an outbreak in one household cottage or apartment of, say, 12 residents, isolated as few as 12 staff. This meant that the provider was able to function without resorting to a 'surge' workforce of agency staff.[14]

7. Design Standards must not limit innovation

COTA is pleased that the Accommodation Framework paper clearly states that any design standards must "work alongside existing accreditation standards and minimum building requirements such as the NCC…and would not replace them". It is important that these voluntary design standards do not take on a life of their own and introduce increased complexity.

Further, COTA does not necessarily agree with the opinion that NCC building specifications work against innovation, such as small household models of care. There are already multiple examples of small household models in Australia that have been built within the existing framework.

Certainly, Building Class 9c, which was introduced in 2004 and supported increased fire safety (such as sprinklers and compartmentation), resulted in enhanced resident safety but had the effect of a lack of diversity. COTA encourages the Department to work with building regulators to enhance the existing Building Codes, particularly Classes 1b and 3, and by means of 'performance solutions', rather than establishing a parallel and potentially conflicting set of standards.

The Framework paper also raises the question of accessibility. COTA clearly supports all aged care homes being required to be accessible to those with a disability and notes that accessibility criteria are addressed in the NCC, and a decision has been made to incorporate Livable Housing Design Silver Level, although policy positions vary between jurisdictions. The Framework paper references the excellent Livable Housing Design Guidelines[15] although COTA notes these Guidelines are focussed primarily on Building Classes 1, 1a, 1b, 2 and 3.

The tiered structure as described in the LHD guidelines is not applicable for the aged care sector. While COTA is encouraged that a minimum standard is being developed by the Australian Building Codes Board which will be incorporated within the existing building code regime, we believe all aged care providers should be building to Gold or Platinum standards, and that most are now doing so.

23 December 2021

Appendix A attached – Some relevant research literature

[14] This was the experience of HammondCare – Caulfield which had two 'outbreaks' in May 2020 in two separate cottages (where a single positive PCR test constituted an outbreak as defined by the Department.

[15] COTA Australia is a founding Member of Livable Housing Australia (LHA) and Ian Yates is a Director of LHA.

APPENDIX A

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