Aged Care Reform Update for GPs: New Strengthened Aged Care Quality Standards

This webinar will start shortly.

Aged Care Reform Update for GPs: New Strengthened Aged Care Quality Standards

Zoom webinar – 28 October 2025

6.30 – 8 pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Identify changes to the new Strengthened Aged Care Quality Standards.
- Understand the role GPs play in the new Strengthened Aged Care Quality Standards.
- Demonstrate how to apply the new Strengthened Aged Care Quality Standards in practice.
- Identify how to guide older patients to the right entry point for aged care services.
- Explain the basics of the new Support at Home program and how it improves flexibility for patients compared to previous home care packages.
- Know the role of advocates and registered supporters and how GPs can work with them to ensure patient needs are met.

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Scan here to register for your next Primary Health Tasmania event

Presenters

Kim Ford

Aged Care Reform Unit

Dr Mandy Callary

Aged Care Quality & Safety Commission

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Australian Government
Aged Care Quality and Safety Commission

Aged Care Act 2024

Strengthened Quality Standards 2025

Dr Mandy Callary, Chief Clinical Advisor

Aged Care Quality and Safety Commission

29 October, 2025

Australian Government
Aged Care Quality and Safety Commission

What I will cover

- A little about me
- The role of the Aged Care Quality and Safety Commission
- New Aged Care Act - What is changing?
- What these changes mean for General Practitioners?
- Where are the potential rub points?
- What are the opportunities?

Dr Mandy Callary

BMBS FRACP Mst Gerontology Grad Dip Leadership GAICD

I am a clinician

With some aged care board experience

The Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission was created on **January 1, 2019**

It replaced the former Australian Aged Care Quality Agency and Aged Care Complaints Commission.

Its origin is directly linked to the **- 2018 Royal Commission into Aged Care Quality and Safety: Care, Dignity and Respect -** which investigated systemic failures and abuse in the sector - recommending a new national regulator to build confidence and ensure better care for older Australians.

The Aged Care Quality and Safety Commission:

To protect and enhance the safety, health, wellbeing and quality of life of older Australians receiving aged care services

Overview

The Commission is an independent statutory agency pursuant to the Commission Act and *Public Governance, Performance and Accountability Act 2013* (PGPA Act). The primary role of the Commission is to:

- **inform older people** in Australia accessing aged care and their supports about their right to quality and safe care and services
- **regulate aged care providers** and monitor the quality of care and services
- **educate providers** on their responsibilities to deliver safe and high-quality care
- **monitor compliance with the Aged Care Code of Conduct and Quality Standards**
- make and enforce financial and prudential standards
- deal with complaints or feedback given to the Complaints Commissioner
- deal with reportable incidents under the Serious Incident Response Scheme
- register providers of aged care, as well as renew and revoke registrations
- publish data and insights on sector and provider performance
- promote engagement with older persons about the quality of care and services, and
- promote confidence and trust in the provision of aged care.

Chief Clinical Advisor
Aged Care Quality and Safety Commission

"Assists the Commissioner in the performance of the Commissioner's functions"

Co-leads the Chief Clinical Advisor Division

Chief Clinical Advisor Division – compromises 65 staff – 50 of whom are clinically trained – nursing, pharmacy, speech pathology and dietetics

Small division – represent 4.5% of the Commission's workforce

Chief Clinical Advisor Division

Comprises 5 distinct clinical functions

1. Clinical Unit
2. Behaviour Support and Restrictive Practices Unit
3. Clinical Pharmacy Unit
4. Food Nutrition and Dining Unit
5. Clinical Education Unit

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Aged Care Quality and Safety Commission

New Aged Care Act 2024 will come into effect on 1st November 2025

Aged Care Act 1997 – Aged Care Act 2024

- Statement of Rights
- Statement of Principles

Aged Care Act 2024: Statement of Principles

- A person-centred aged care system
- An aged care system that values workers and carers.
- A transparent and sustainable aged care system that represents value for money
- An aged care system that continues to improve

Aged Care Act 2024: Statement of Rights

- The Statement of Rights is a key component of the new Aged Care Act 2024.

- The Statement of Rights consists of 13 rights an older person is entitled to have upheld when accessing or seeking to access funded aged care services.

- While not enforceable under law - registered providers delivering funded aged care services to individuals must take all reasonable and proportionate steps to act compatibly with the rights.

Rights under the new Aged Care Act

The 13 rights fall under the following 6 areas:

- independence, autonomy, empowerment, and freedom of choice
- equitable access
- quality and safe funded aged care services
- respect for privacy and information
- person-centred communication and ability to raise issues without reprisal
- advocates, significant persons, and social connections.

Statement of Rights

23 Statement of Rights

Independence, autonomy, empowerment and freedom of choice

(1) An individual has a right to:

(a) exercise choice and make decisions that affect the individual's life, including in relation to the following:

(i) the funded aged care services the individual has been approved to access;

(ii) how, when and by whom those services are delivered to the individual;

(iii) the individual's financial affairs and personal possessions; and

(b) be supported (if necessary) to make those decisions, and have those decisions respected; and

(c) take personal risks, including in pursuit of the individual's quality of life, social participation and intimate and sexual relationships.

Equitable access

(2) An individual has a right to equitable access to:

(a) have the individual's need for funded aged care services assessed, or reassessed, in a manner which is:

(i) culturally safe, culturally appropriate, trauma-aware and healing-informed; and

(ii) accessible and suitable for individuals living with dementia or other cognitive impairment; and

(b) palliative care and end-of-life care when required.

Quality and safe funded aged care services

(3) An individual has a right to:

(a) be treated with dignity and respect; and

(b) safe, fair, equitable and non-discriminatory treatment; and

(c) have the individual's identity, culture, spirituality and diversity valued and supported; and

(d) funded aged care services being delivered to the individual:

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Strengthened Quality Standards will also come into effect on 1st Nov 2025

Aged Care Quality Standards 2019 – Strengthened Quality Standards 2025

The Quality Standards 2019:

- Establish expectations of safe quality care as well as the outcomes which providers will be assessed against by the ACQSC
- Located in the Rules: subordinate legislation

Recommendation from the *Royal Commission into Aged Care Quality and Safety final report: Care, Dignity and Respect 2021* to strengthen the standards to be more comprehensive, simplified, objective and measurable

The Strengthened Aged Care Quality Standards 2025

- 8 Aged Care Quality Standards become 7 Strengthened Quality Standards comprising 33 outcomes (and 154 supporting actions) against which providers will be assessed
- The majority (87%) of actions expected of providers are similar, with only 13% considered new or significantly enhanced
- Strengthened **focus areas** – dementia care, governance, **food and nutrition**, diversity, and **clinical care**

Structure of the Standards

Each standard has:

- an **intent** and **expectation statement**
- **outcomes** and **actions**

Standard 3: The Care and Services

Intent of Standard 3

Standard 3 describes the way providers must deliver care and services for all types of services being delivered (noting that other standards describe requirements relevant to specific service types). Effective assessment and planning, communication and coordination relies on a strong and supported workforce as described in Standard 2 and is critical to the delivery of quality care and services that meet the older person's needs, are tailored to their preferences and support them to live their best lives.

In delivering care and services, providers and workers must draw on all relevant standards, with particular reference to Standard 1, including to ensure care is tailored to the individual and what's important to them. Family and carers are recognised as having an important role in assisting or providing care and services.

Standard 3 expectation statement for older people:

The care and services I receive:

- ***are safe and effective***
- ***optimise my quality of life, including through maximising independence and reablement***
- ***meet my current needs, goals and preferences***
- ***are well planned and coordinated***
- ***respect my right to take risks.***

Outcome 3.1 Assessment and planning

Outcome statement:

Older people, and others involved in their care, are actively engaged in developing and reviewing their care and services plans through ongoing communication.

Care and services plans describe the current needs, goals and preferences of older people, including risk management and preventative care strategies. Care and services plans are regularly reviewed and are used by workers to guide the delivery of care and services.

Actions:

3.1.1 The provider implements a system for assessment and planning that:

a) identifies and records the needs, goals and preferences of the older person

b) identifies risks to the older person's health, safety and wellbeing and, with the older person, identifies strategies for managing these risks

c) supports preventative care and optimises quality of life, reablement and maintenance of function

d) involves relevant health professionals where required

e) directs the delivery of quality care and services.

3.1.2 Assessment and planning is based on ongoing communication and partnership with the older person and others that the older person wishes to involve.

3.1.3 The outcomes of assessment and planning are effectively communicated to:

a) the older person, in a way they understand

b) the older person's family, carers and others involved in their care, with the older person's informed consent.

3.1.4 Care and services plans are individualised and:

a) describe the older person's needs, goals and preferences

b) are current and reflect the outcomes of assessments

c) include information about the risks associated with care and services delivery and how workers can support older people to manage these risks

d) are offered to, and able to be accessed by, the older person

e) are used and understood by workers to guide the delivery of care and services.

Standard 5 – Clinical Care

Increased Focus on Clinical Risk
Providers must proactively manage high prevalence and high impact clinical risks, including choking and swallowing, falls and mobility, oral health, continence, nutrition and hydration, mental health, pain, pressure injury and wounds, and sensory impairment through regular screenings using validated tools.

Multidisciplinary Approach
There's an increased expectation for holistic multidisciplinary collaboration with GPs, pharmacists, dietitians, and speech pathologists to plan and implement interventions for clinical care.

Enhanced Care Planning
Care plans must be clear, up-to-date, and effectively shared among relevant team members to ensure coordinated and safe clinical care.

Communication and Consent
Providers must communicate critical clinical information to other involved parties, with consent from the older person, ensuring timely and effective information sharing.

Standard 6 – Food and Nutrition

Dedicated Focus on Food and Dining:
The new dedicated standard places a strong emphasis on the importance of the food and dining experience for older people.

Nutritious and Appetising Meals:
Providers must deliver meals that are nutritious, flavourful, and appealing, meeting individual needs, including those with texture-modified diets.

Cultural and Personal Choices:
Greater emphasis on respecting and documenting cultural, religious, and personal dietary needs and preferences.

Dignity of Risk:
Providers must support residents in exercising their "dignity of risk" in food choices, allowing them to make choices and eat as much and as often as they want.

Monitoring and Response:
Providers are expected to monitor for unintended weight loss, dehydration, or changes in appetite, and respond swiftly to concerns.

Strengthened Quality Standards 2025

Outcomes most relevant to GPs

2.7.1 Clarified requirement that providers have an accurate, current and secure information management system
3.2.1 Clarified requirement for the provider to deliver care that is culturally safe, trauma aware and healing informed, in accordance with contemporary, evidence-based practice, meeting their current goals, needs and preferences and optimise their quality of life
3.2.6 **New/enhanced** requirement to identify skills and strengths of people living with dementia and to encourage their use on a day-to-day basis
3.2.7 Aligned requirement for providers to minimise the use of restrictive practices
3.3.4 **New/enhanced** requirements to provide monthly care statements
5.1.4 **New/enhanced** requirement for the provider and health professionals to agree on their respective roles, responsibilities and protocols for providing clinical care
5.4.3 Aligned requirement for the provider to refer and facilitate access to relevant registered health practitioners and medical, rehabilitation, allied health, oral health, specialist nursing and behavioural advisory services to address the individual's clinical needs.
5.4.4 Clarified requirement for the provider to implement processes to: a) deliver coordinated, multidisciplinary and holistic comprehensive care and to d) provide timely notification to the individual's general practitioner, the individual's supporters, and other persons involved in the individual's care when clinical incidents or changes occur.
5.3.2 **New/enhanced** requirement for providers to have processes to ensure medication reviews are conducted appropriately.
6.3.2 **New requirement** for providers to provide food and drink at each meal, such that individuals can exercise choice about what, when, where and how they eat and drink.
7.2.2 Clarified requirements for providers to implement safe transitions to and from hospital, to facilitate access to external health professionals as required including maintaining connections with specialist services including dementia services

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What does the new Aged Care Act and Strengthened Quality Standards mean for General Practitioners ?

PLEASE NOTE:

The obligations of the aged care provider are not your obligations

The ACQSC does not regulate medical practitioners

Your obligations are those directed by AHPRA and the RACGP

However, aged care providers won't be able to fulfill their obligations and provide high-quality aged care without you

Intersection between rights and risks will be felt more keenly

- Risk assessment
- Informed consent
- Capacity

Prescribing will come increasingly under the spotlight

- Chemical restraint
- Antimicrobial stewardship
- Vaccinations

Increased opportunities for participation in Clinical Governance

Frailty management

Rights vs risks

A Coroner's Case

Mr G
Born 26th September 1946
Died 19th October 2023 – aged 77 years - possible healthcare related death

Past medical history: Parkinson's disease, vascular dementia, depression, bipolar disorder, obesity and chronic hip pain

Nursing home resident who was 'reasonably independent'
Mobilised with an 'assistive device'.
Able to shower himself
Able to call staff using a 'buzzer'
Described as quite stubborn – did not like to be disturbed overnight

Falls Risk Form – 26th May 2023 - moderate risk of falls: 'No reported falls had occurred that year'

Rights vs risks

The Fall
On 14th October 2023 at around 0630 – Mr G was found on the floor in his room
“legs underneath him while in a prone position”
He had been there since 2040 the previous night

Ambulance called
At 0830 – he became breathless and hypoxic.
He then became tachycardic, hypotensive and confused
Ambulance arrived at 0900 and transported him to hospital at 0940

At hospital – he was found to have multiorgan failure - likely secondary to rhabdomyolysis.
He then developed ischaemic colitis in the setting of AF and deteriorated
He transitioned to comfort care and died on day 5 of his admission

Death certificate: Ischaemic colitis due to AF, sepsis and a mechanical fall

Rights vs risks

Coroner's conclusion:

"It is accepted that Mr G was reasonably independent and that he was able to mobilise to the bathroom by himself using a walking stick or walking frame. He was also reported by his daughter to be very stubborn, and that he did not like to be disturbed after he went to bed. It was the practice of the RACF to respect Mr G's wishes and to not check on him during the night"

"In hindsight this was not appropriate. I would expect that when the night duty staff commenced their shift, they would do a round to check on all residents as a baseline and then with minimal invasiveness check on the residents intermittently through out the shift. How often would depend on a documented risk assessment"

"Had Mr G been found earlier in the night, it seems likely he would have survived"

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What do you think about the Coroner's conclusion?

Rights vs risks

Dignity of Risk

Dignity of Risk is the idea that people in aged care have the right to live the way they want to, even if it sometimes involves risk

Aged Care Act 2024
Statement of Rights

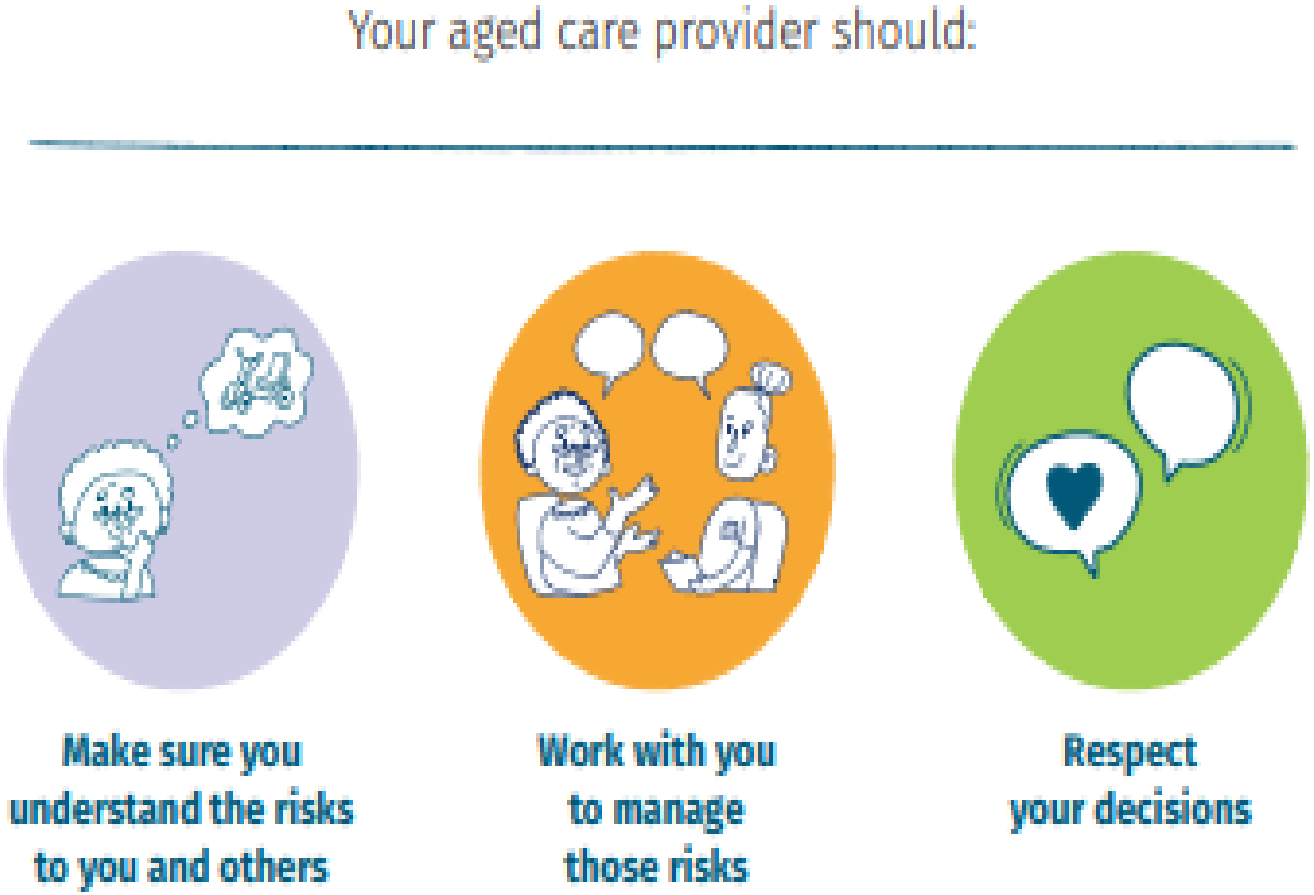
An individual has the right to take personal risks, including in the pursuit of the individual's quality of life, social participation and in intimate and sexual relationships

Rights vs risks

There is still a duty of care

Is the older person adequately informed

- Does the older person truly understand the size, nature and consequences of the risk?
- Has the older person been given adequate opportunity to work with the provider to **share** accountability for the risk?
- How has the aged care provider worked with the older person to reach agreement and/or compromise over the management of their shared risk(s)?



Rights vs risks

Understanding the risk

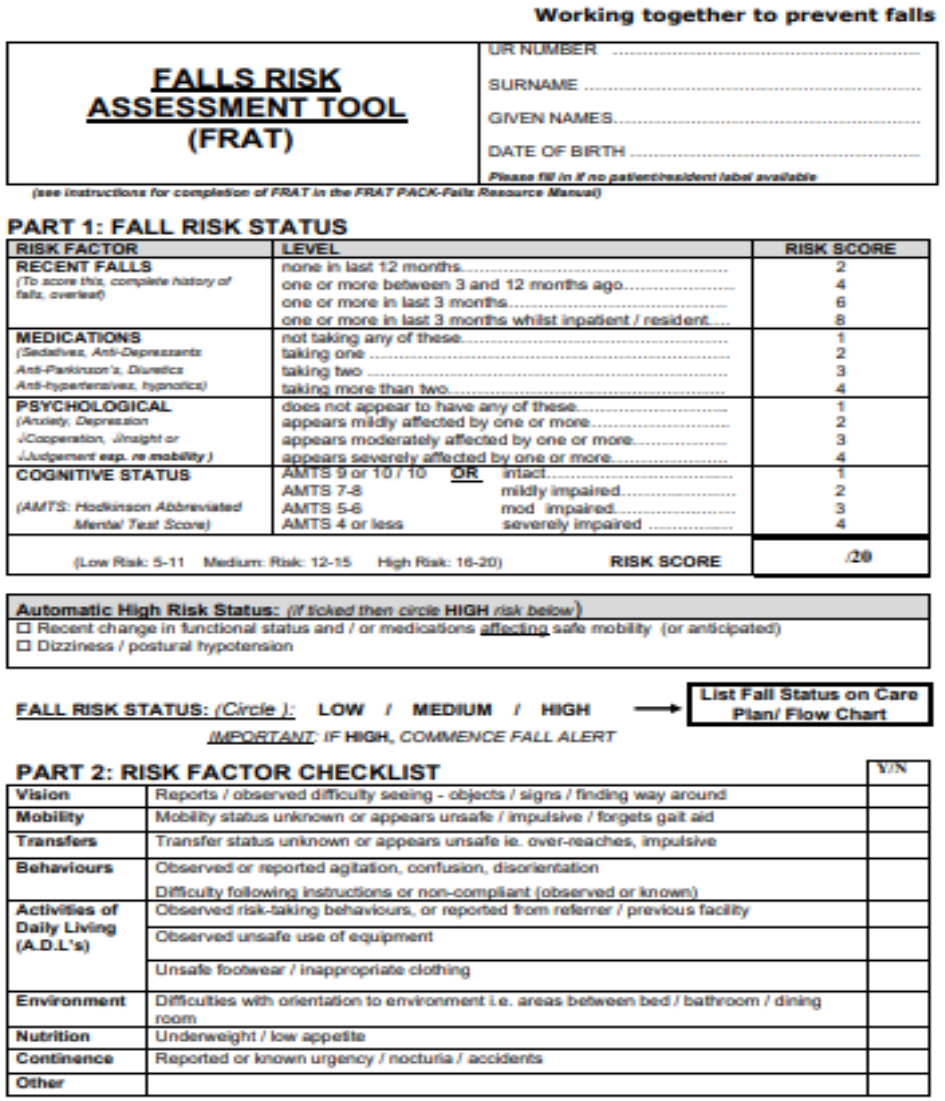
Mr G: Falls Risk Form – 26th May 2023 - moderate falls risk: 'No reported falls had occurred that year'

Sharing the risk

- Aged Care Nursing assessment
- Medical assessment
- Medication review
- Allied health assessment

Sharing and/or compromising on risk management

- When the older person does not accept initial clinical recommendations – alternative, less ideal approaches should be considered



Working together to prevent falls

FALLS RISK ASSESSMENT TOOL (FRAT)

UR NUMBER .....
SURNAME .....
GIVEN NAMES .....
DATE OF BIRTH .....
Please fill in if no patient/resident label available

(see instructions for completion of FRAT in the FRAT PACK-Falls Resource Manual)

PART 1: FALL RISK STATUS

RISK FACTOR	LEVEL		RISK SCORE
RECENT FALLS *(To score this, complete history of falls, overleaf)*	none in last 12 months		2
	one or more between 3 and 12 months ago		4
	one or more in last 3 months		6
	one or more in last 3 months whilst inpatient / resident		8
MEDICATIONS *(Sedatives, Anti-Depressants Anti-Parkinson's, Diuretics Anti-hypertensives, hypnotics)*	not taking any of these		1
	taking one		2
	taking two		3
	taking more than two		4
PSYCHOLOGICAL *(Anxiety, Depression √Cooperation, √Insight or √Judgement esp. re mobility)*	does not appear to have any of these		1
	appears mildly affected by one or more		2
	appears moderately affected by one or more		3
	appears severely affected by one or more		4
COGNITIVE STATUS *(AMTS: Hodkinson Abbreviated Mental Test Score)*	AMTS 9 or 10 / 10	**OR** intact	1
	AMTS 7-8	mildly impaired	2
	AMTS 5-6	mod impaired	3
	AMTS 4 or less	severely impaired	4
(Low Risk: 5-11 Medium: Risk: 12-15 High Risk: 16-20)		**RISK SCORE**	/20

Automatic High Risk Status: *(if ticked then circle* **HIGH** *risk below)*
☐ Recent change in functional status and / or medications affecting safe mobility (or anticipated)
☐ Dizziness / postural hypotension

FALL RISK STATUS: *(Circle):* **LOW / MEDIUM / HIGH** → **List Fall Status on Care Plan/ Flow Chart**

IMPORTANT: IF **HIGH**, *COMMENCE FALL ALERT*

PART 2: RISK FACTOR CHECKLIST

		Y/N
Vision	Reports / observed difficulty seeing - objects / signs / finding way around	
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid	
Transfers	Transfer status unknown or appears unsafe ie. over-reaches, impulsive	
Behaviours	Observed or reported agitation, confusion, disorientation	
	Difficulty following instructions or non-compliant (observed or known)	
Activities of Daily Living (A.D.L's)	Observed risk-taking behaviours, or reported from referrer / previous facility	
	Observed unsafe use of equipment	
	Unsafe footwear / inappropriate clothing	
Environment	Difficulties with orientation to environment i.e. areas between bed / bathroom / dining room	
Nutrition	Underweight / low appetite	
Continence	Reported or known urgency / nocturia / accidents	
Other		

But what happens when the decision still seems unsafe?

Need to determine:

- If more information is required
- Right to take a risk - Dignity of Risk
- Right to make a bad decision
- Impaired decision - making

Rights vs risks

I am loath to undertake formal capacity assessments

- No one appreciates their intellect being questioned
- Time consuming and of limited value

Establish if the older person

1. understands there to be an issue or a problem
2. understands that a decision needs to be made
3. understands the decision(s) which could be made
4. understands the consequences of each decision
5. can communicate their decision
6. is consistent in their decision
7. (actions their decision)

Restrictive Practices

Royal Commission into Aged Care Quality and Safety final report: Care, Dignity and Respect 2021

"Restrictive practices have been identified as a problem in aged care in Australia for more than 20 years. The inappropriate use of unsafe and inhumane restrictive practices in residential aged care has continued, despite multiple reviews and reports highlighting the problem. It must stop now".

This has led to a much stronger regulatory focus

- The ACQSC Behaviour Support and Restrictive Practices Unit
  - Has responsibility for supporting the Aged Care Quality and Safety Commission in regulating the care of older people living with changed and/or complex behaviours
- National Mandatory Quality Indicator data
  - Physical restraint (including environmental restraint) and antipsychotic use

Prescribing

Chemical restraint

A drug is considered a chemical restraint if it is “used for the primary purpose of influencing a care recipient’s behaviour”

For whose benefit is the drug being prescribed?

Many different types of medication may be used as chemical restraints – because many different drug classes have properties which affect behaviour

(2) ***Chemical restraint*** is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a care recipient’s behaviour, but does not include the use of medication prescribed for:

(a) the treatment of, or to enable treatment of, the care recipient for:

(i) a diagnosed mental disorder; or

(ii) a physical illness; or

(iii) a physical condition; or

(b) end of life care for the care recipient.

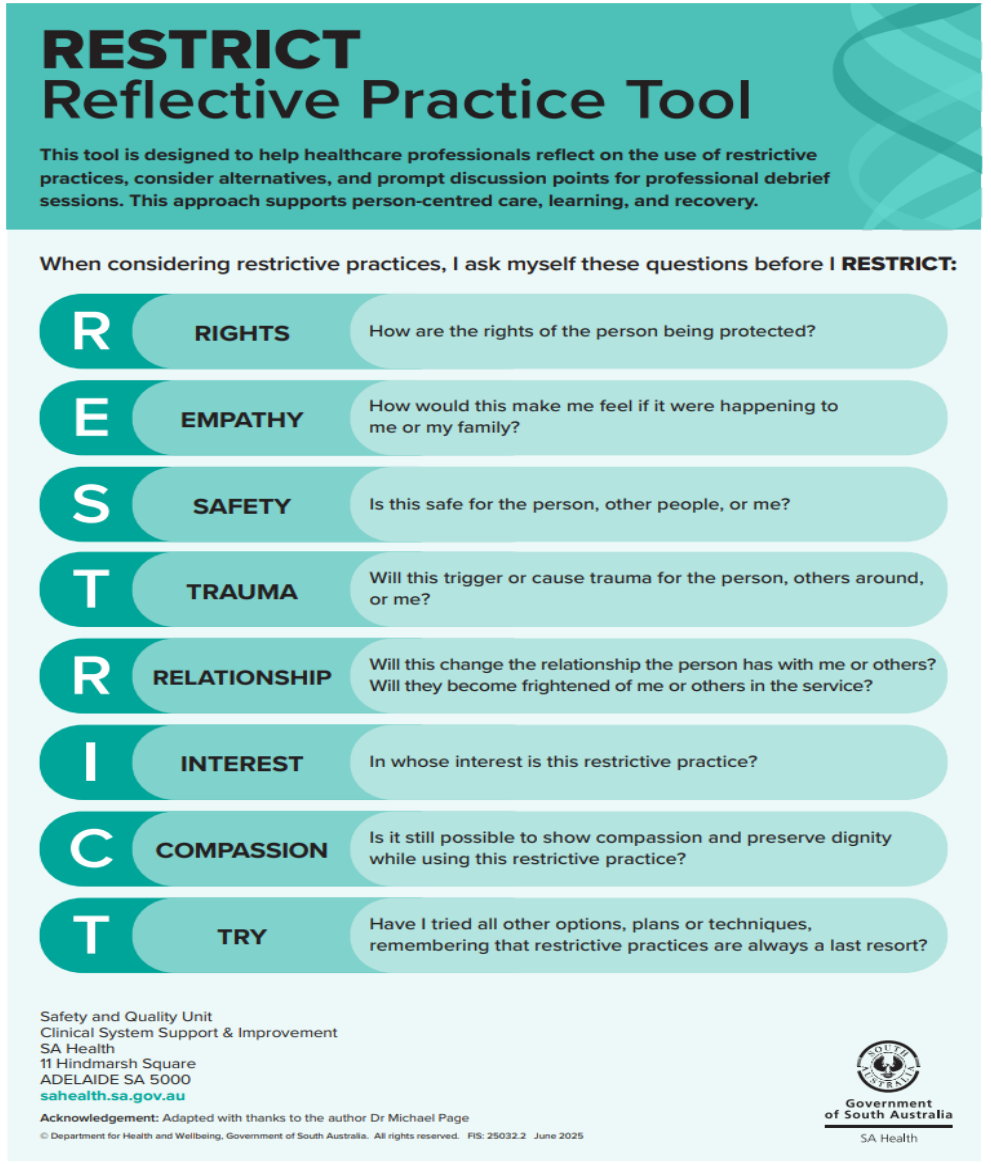
Quality of Care Principles 2014 Part 4A Division 2 Restrictive Practices

Prescribing

Chemical restraint

- Chemical restraint may be justified in the management of severe changed and/or complex behaviours – when such behaviours remain potentially harmful or very distressing – and non-pharmacological measures have been tried and not sufficient

- Because these medications are more likely to cause harm than benefit – GPs should obtain informed consent from the restrictive practice decision-maker



RESTRICT
Reflective Practice Tool

This tool is designed to help healthcare professionals reflect on the use of restrictive practices, consider alternatives, and prompt discussion points for professional debrief sessions. This approach supports person-centred care, learning, and recovery.

When considering restrictive practices, I ask myself these questions before I **RESTRICT:**

R	RIGHTS	How are the rights of the person being protected?
E	EMPATHY	How would this make me feel if it were happening to me or my family?
S	SAFETY	Is this safe for the person, other people, or me?
T	TRAUMA	Will this trigger or cause trauma for the person, others around, or me?
R	RELATIONSHIP	Will this change the relationship the person has with me or others? Will they become frightened of me or others in the service?
I	INTEREST	In whose interest is this restrictive practice?
C	COMPASSION	Is it still possible to show compassion and preserve dignity while using this restrictive practice?
T	TRY	Have I tried all other options, plans or techniques, remembering that restrictive practices are always a last resort?

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Acknowledgement: Adapted with thanks to the author Dr Michael Page

Government of South Australia
SA Health

Prescribing

Chemical restraint

Over time – the prevalence of physical restraint, antipsychotic use and environmental restraint has improved significantly

BestMed - between 2018 and 2022, the % residents administered antipsychotics has declined by 35%

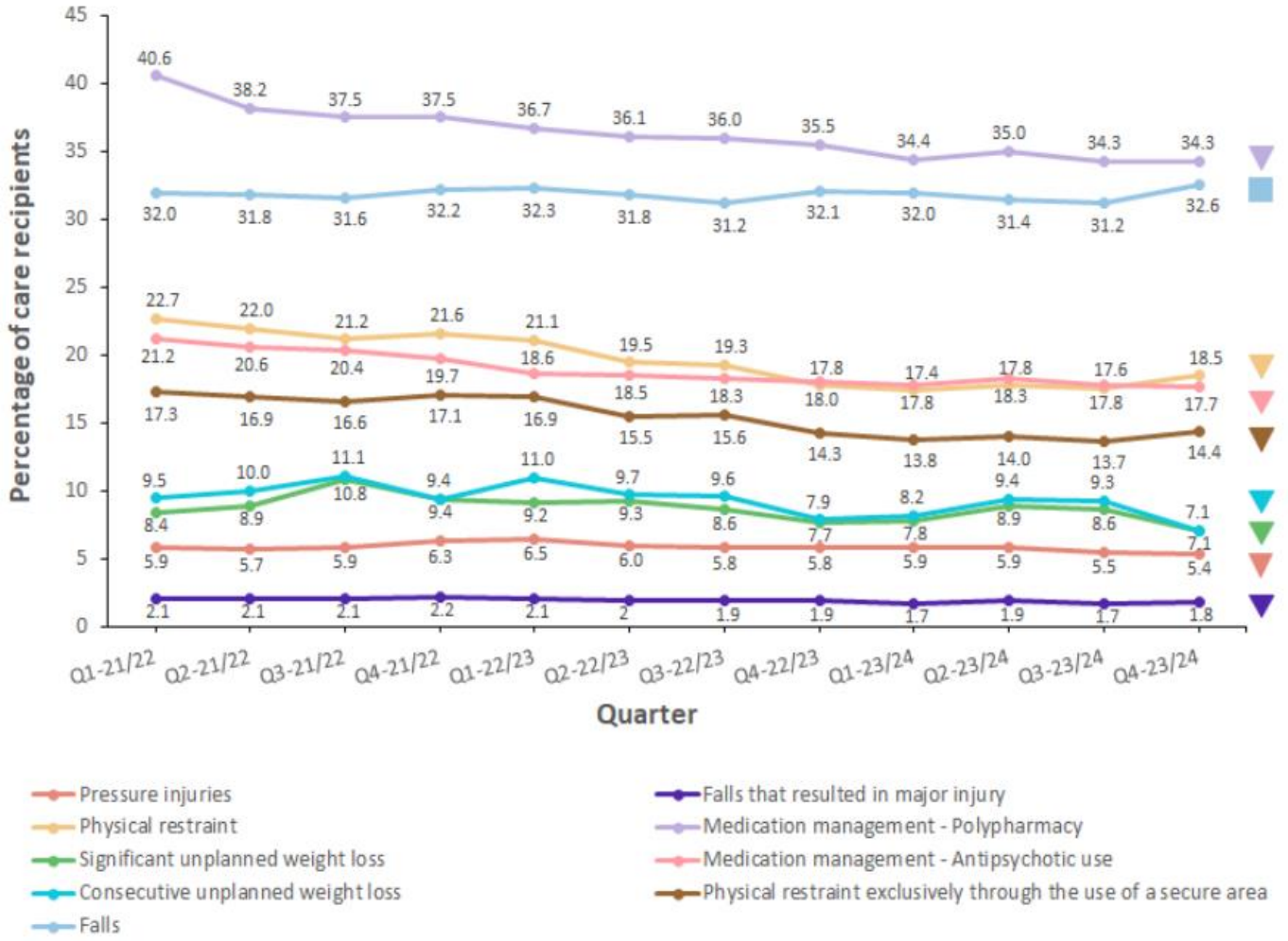


Figure 1: Prevalence proportion (%) of care recipients reported by RACS as meeting criteria for clinical quality indicators, Quarter 1 2021–22 to Quarter 4 2023–24

Prescribing

Antimicrobial stewardship

The Climate Change of Aged Care

Overuse of antimicrobials result in multiresistant organisms which reduce the effectiveness of antimicrobials

Outcome 5.2: Preventing and controlling infections in delivering clinical care services

Outcome statement:

The provider must ensure that individuals, aged care workers, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

The provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.

Actions:

5.2.1 The provider implements an antimicrobial stewardship system that complies with contemporary, evidence-based practice and is relevant to the service context.

5.2.2 The provider implements processes to minimise and manage infection when providing clinical care services that include, but are not limited to:

a) performing clean procedures and aseptic techniques

b) using, managing and reviewing invasive devices including urinary catheters

c) minimising the transmission of infections and complications from infections.

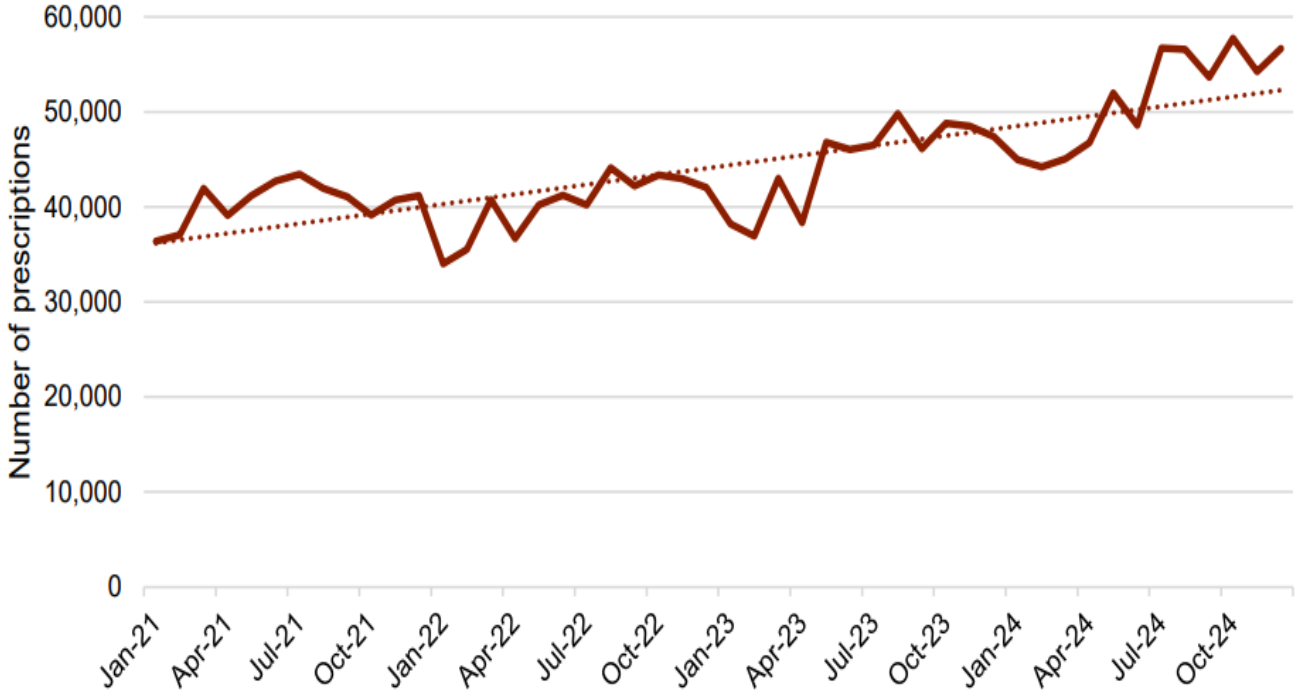
Prescribing

Antimicrobial stewardship

Rates of resistant organisms are higher in aged care than in hospitals

Aged care residents received more than double the number of antibacterial prescriptions per person compared to community living older people in 2024

Figure 12 Number of PBS/RPBS prescriptions for J01 antibacterials for systemic use dispensed, aged care home residents, 2021–2024



PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Pharmaceutical Benefits Scheme

Source: Gadzhanova, Roughead[56]

Prescribing

Antimicrobial stewardship

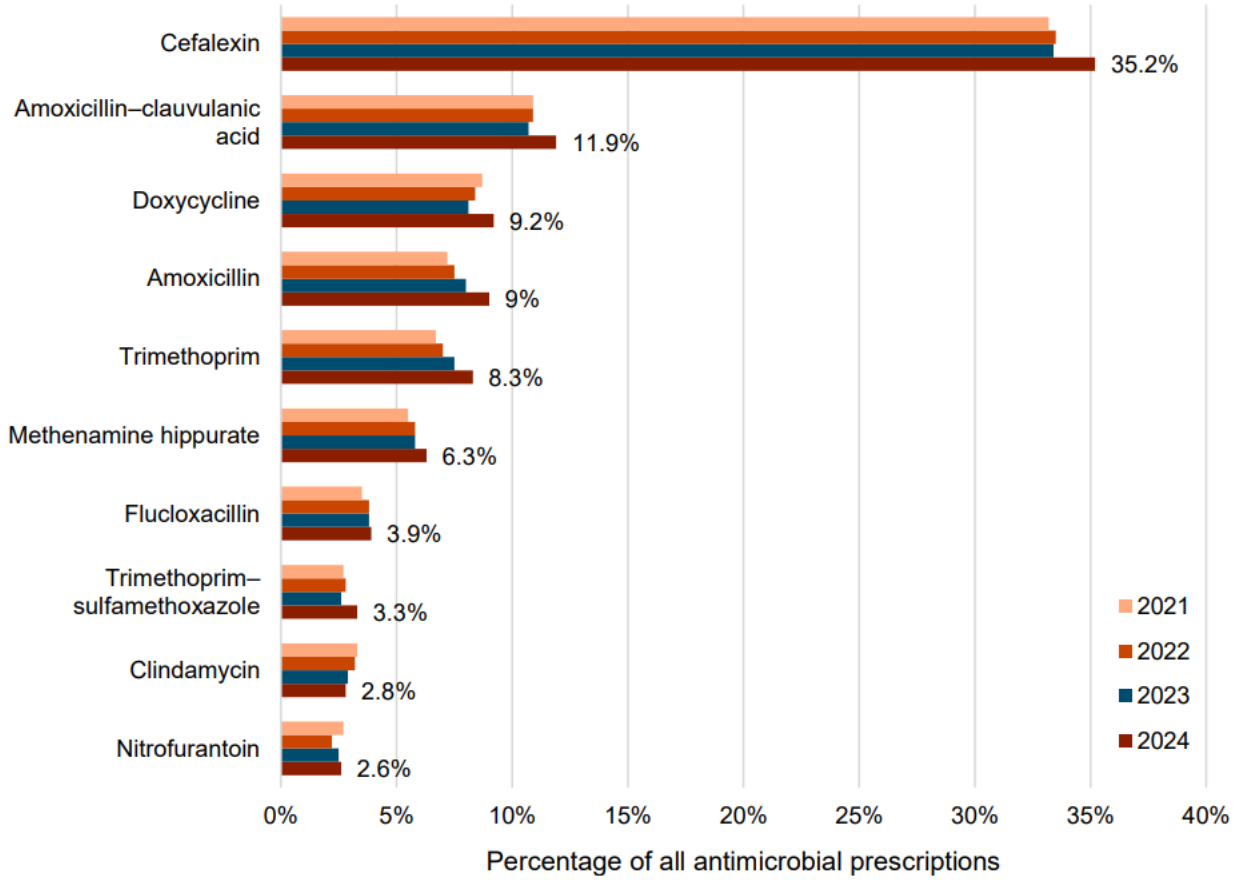
Majority of these antibiotics are broad spectrum

Often not first-line recommendations for common infections – urine, respiratory or skin

Sometimes used when not indicated

- When an infection has not been "confirmed"
- For more than 6 months
- When prescribed *prn*

Figure 14 The 10 most commonly dispensed PBS/RPBS antimicrobial prescriptions, aged care home residents, 2021–2024



PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Pharmaceutical Benefits Scheme

Note: Data labels for 2024 are shown.

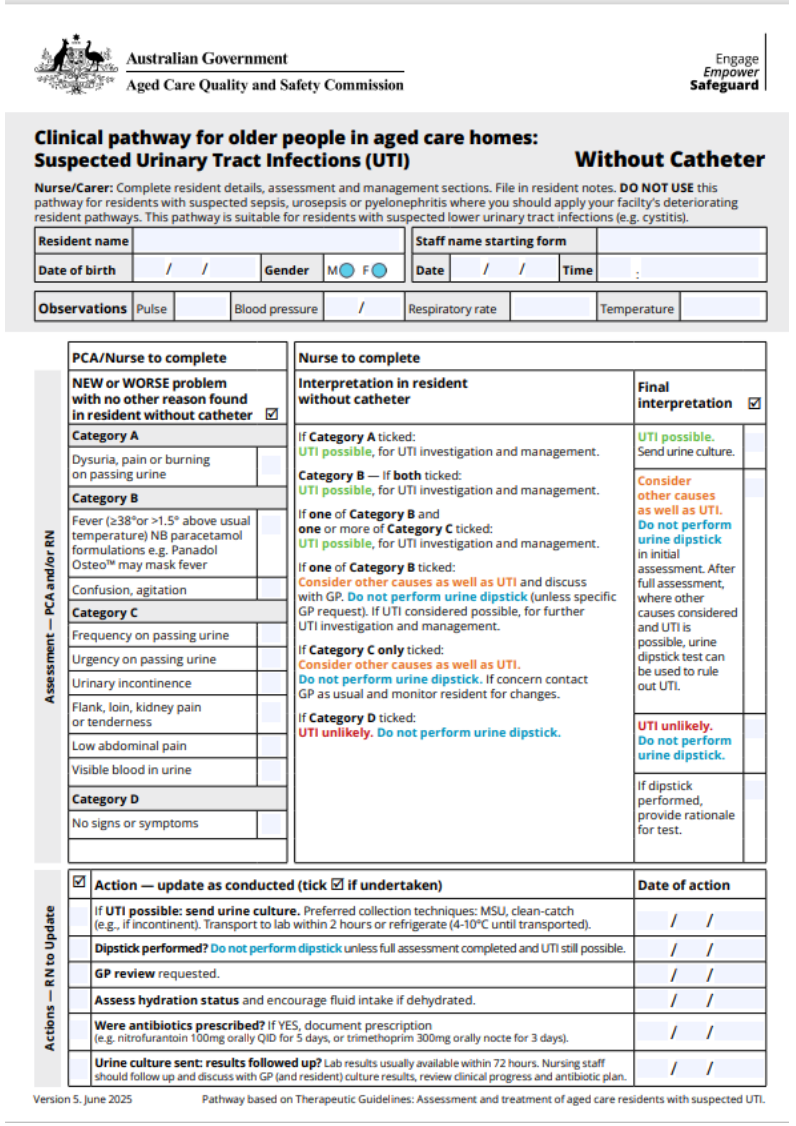
Prescribing

Antimicrobial stewardship

Rates of prescribing for UTIs are 3 times higher in nursing homes

To Dip or Not to Dip

Quality improvement activity to reduce low value urine dipstick testing in aged care homes



Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Clinical pathway for older people in aged care homes:
Suspected Urinary Tract Infections (UTI) **Without Catheter**

Nurse/Carer: Complete resident details, assessment and management sections. File in resident notes. **DO NOT USE** this pathway for residents with suspected sepsis, urosepsis or pyelonephritis where you should apply your facilty's deteriorating resident pathways. This pathway is suitable for residents with suspected lower urinary tract infections (e.g. cystitis).

Resident name			**Staff name starting form**		
Date of birth	/ /	**Gender** M F	**Date** / /	**Time** :	
Observations	Pulse	Blood pressure /	Respiratory rate	Temperature	

Assessment — PCA and/or RN

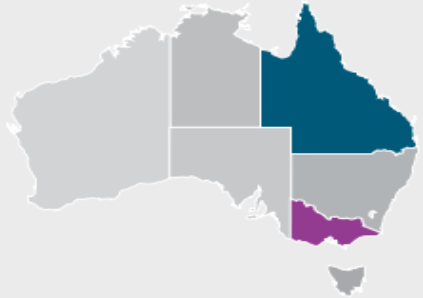
PCA/Nurse to complete		**Nurse to complete**	
NEW or WORSE problem with no other reason found in resident without catheter ☑		**Interpretation in resident without catheter**	**Final interpretation** ☑
Category A		If **Category A** ticked: **UTI possible**, for UTI investigation and management.	**UTI possible.** Send urine culture.
Dysuria, pain or burning on passing urine		**Category B** — If **both** ticked: **UTI possible**, for UTI investigation and management.	**Consider other causes as well as UTI. Do not perform urine dipstick** in initial assessment. After full assessment, where other causes considered and UTI is possible, urine dipstick test can be used to rule out UTI.
Category B		If **one** of **Category B** and **one** or more of **Category C** ticked: **UTI possible**, for UTI investigation and management.	
Fever (≥38°or >1.5° above usual temperature) NB paracetamol formulations e.g. Panadol Osteo™ may mask fever		If **one** of **Category B** ticked: **Consider other causes as well as UTI** and discuss with GP. **Do not perform urine dipstick** (unless specific GP request). If UTI considered possible, for further UTI investigation and management.	
Confusion, agitation		If **Category C only** ticked: **Consider other causes as well as UTI. Do not perform urine dipstick.** If concern contact GP as usual and monitor resident for changes.	**UTI unlikely. Do not perform urine dipstick.**
Category C		If **Category D** ticked: **UTI unlikely. Do not perform urine dipstick.**	
Frequency on passing urine			
Urgency on passing urine			
Urinary incontinence			
Flank, loin, kidney pain or tenderness			
Low abdominal pain			
Visible blood in urine			
Category D			
No signs or symptoms			If dipstick performed, provide rationale for test.

Actions — RN to Update

☑	**Action — update as conducted (tick ☑ if undertaken)**	**Date of action**
	If **UTI possible: send urine culture.** Preferred collection techniques: MSU, clean-catch (e.g., if incontinent). Transport to lab within 2 hours or refrigerate (4-10°C until transported).	/ /
	Dipstick performed? **Do not perform dipstick** unless full assessment completed and UTI still possible.	/ /
	GP review requested.	/ /
	Assess hydration status and encourage fluid intake if dehydrated.	/ /
	Were antibiotics prescribed? If YES, document prescription (e.g. nitrofurantoin 100mg orally QID for 5 days, or trimethoprim 300mg orally nocte for 3 days).	/ /
	Urine culture sent: results followed up? Lab results usually available within 72 hours. Nursing staff should follow up and discuss with GP (and resident) culture results, review clinical progress and antibiotic plan.	/ /

Version 5. June 2025 Pathway based on Therapeutic Guidelines: Assessment and treatment of aged care residents with suspected UTI.

To Dip or Not to Dip in Australian residential aged care services: Key outcomes



- **12 services**
  - 8 Queensland
  - 4 Victoria
- **1,074 residents**
- **Project from Nov 2021 – Jul 2023**

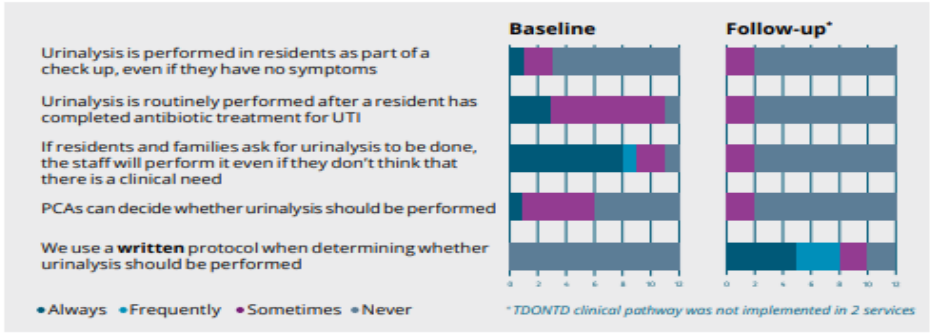
Implementation of a quality improvement activity to reduce low value urine dipstick testing in residential aged care by:
- case-based education to nurses and personal carers
- use of a clinical pathway to identify suspected UTI

"Before we always had to do dipstick testing after residents completed antibiotic courses for UTI. Now we have been told it is OK not to do it.

It has changed our staff thought processes. Instead of dipstick and antibiotics, we are doing more promoting hygiene, toileting regularly, changing pads regularly, encouraging fluids." *(Nurse)*

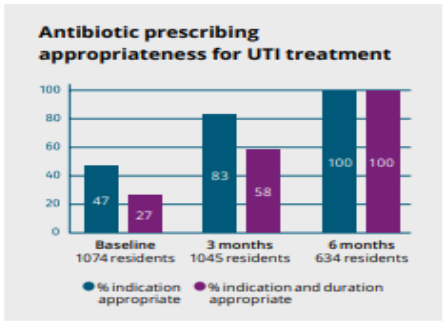
Findings

Survey of dipstick practice at baseline and 3 to 6 months

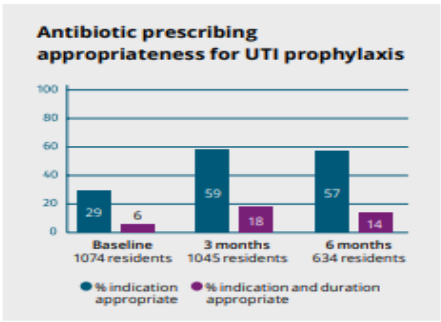


*TDONTD clinical pathway was not implemented in 2 services

Antibiotic audits



Prescribing for these indications was considered inappropriate: ASB, charted prn, urinary tract indication uncertain and no signs or symptoms at antibiotic commencement. Accepted prescribing durations for cystitis were up to 7 days, for pyelonephritis up to 14 days.



Prescribing for ASB or where indication was unknown or not documented was considered inappropriate. Prescribing durations over 180 days were considered inappropriate.

Prescribing

Vaccinations

The new Aged Care Act requires Aged Care Providers – to support access to vaccinations for older people in keeping with the National Immunisation Programme

- Influenza, Pneumococcal, Shingles
- * Not Covid
- Ongoing access to free vaccinations for aged care workers is also under a cloud

Elements of a successful immunisation programme

- Establish immunisation status upon entry – use Australian Immunisation Register
- Trusted health care worker promotion
- Dedicated immunisation lead
- Verbal consent is sufficient – if recorded in the resident's clinical record
- Consider co-administer of Influenza and Covid vaccinations

Frailty

The primary focus of a doctor working in aged care is often in managing clinical risk

Another name for clinical risk is “FRAILTY”

Australian Clinical Frailty Guidelines

1. An individualised, balanced, protein-rich diet is likely to be effective in delaying onset of frailty. Protein-energy malnutrition and nutritional deficiencies should be identified and treated. A nutrition care plan that considers relaxation of dietary restrictions aligned with goals of care should be planned to maximise quality of life for older adults with severe frailty.

2. Progressive, individualised and ongoing exercise involving a combination of aerobic and resistance exercise, balance and functional training tailored to frailty level and supervised by professionals can help prevent or delay frailty progression.

3. Social prescribing for older adults should be co-designed to support meaningful, accessible, and culturally appropriate activities that foster social engagement, with plans tailored to the individual's frailty level, health needs, preferences, and support systems, and regularly reviewed to ensure continued participation and well-being.

4. A comprehensive, multidisciplinary medication review tailored to the older adult’s health status, preferences, and frailty degree helps optimise medication use, minimise harm and support functional independence across all stages of frailty.

5. Older adults with severe frailty need a regularly reviewed, personalised care plan that respects their values and goals, involves carers in decision-making, supports advance care planning, and ensures high-quality end-of-life care.

Increased opportunities for participation in clinical governance

➢ Governing body membership requirements

Providers need the right mix of people to drive the continuous improvement processes that deliver the high quality of care and services that older Australians deserve.
Under the changes to the Aged Care Act and the Aged Care Quality and Safety Commission Act, providers must ensure their governing body meets two requirements:

- it has a majority of independent non-executive members
- at least one member with experience in providing clinical care.

➢ Quality Care Advisory Body membership requirements

Providers are also required to establish a Quality Care Advisory Body (= Clinical/Care Governance Committee)
Membership must include at least one person involved in the provision of clinical care
Reports to the governing body at least once every 6 months

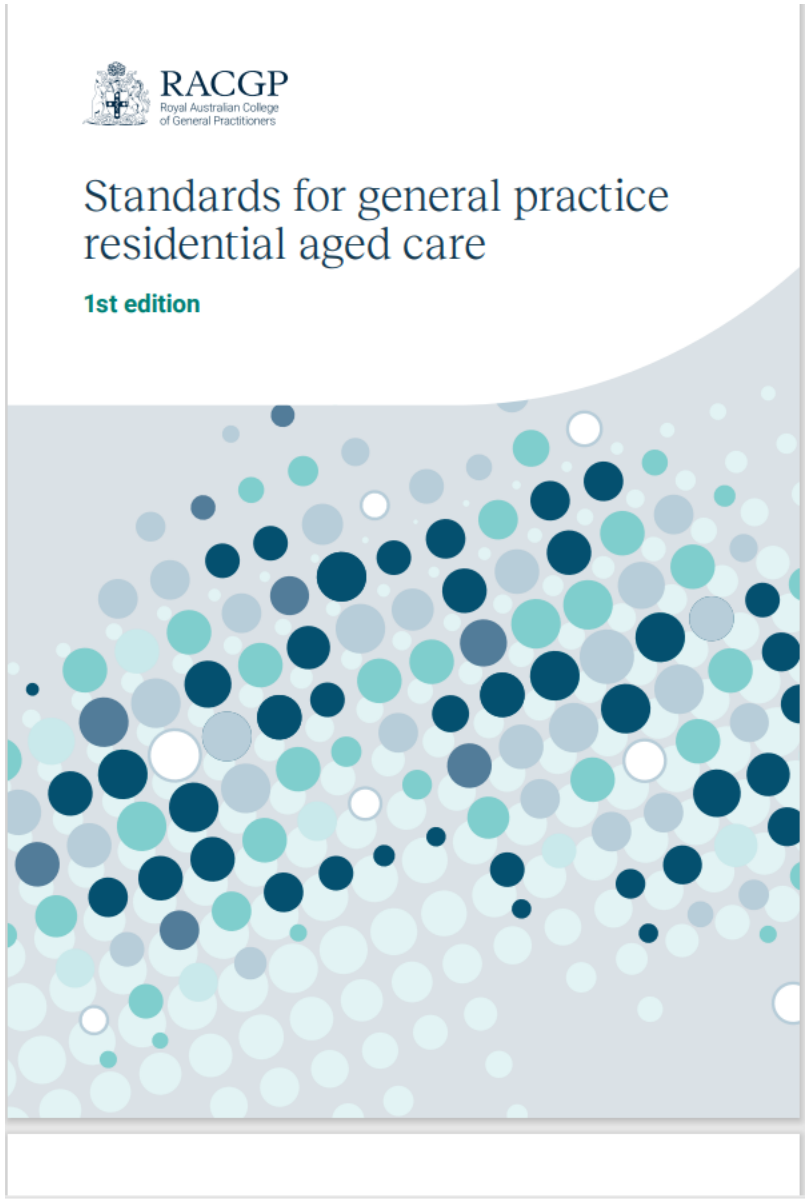
➢ Medication Advisory Committee membership

New/enhanced requirements under Outcome 5.3.6 for providers to have effective organization-wide governance systems which regularly review and improve the effectiveness of the system for the safe and quality use of medicines

GP Quality Standards 2023

RACGP have outlined ‘Standards’ for residential aged care settings

Expectations of how Aged Care providers can support GPs in providing best care for their residents



Resources the ACQSC provides

Many educational resources

Webinars

Fact sheets

ALIS Learning modules e.g.

- Restrictive practices
- Food Nutrition and Dining
- Antimicrobial stewardship Infection Prevention and Control
- Telehealth

I can be contacted on mandy.callary@agedcarequality.gov.au

Australian Government
Department of Health, Disability and Ageing

Support at Home

Aged Care Reform-Overview for General Practitioners

Presented by the Local Network – Tasmania

Tas.office@health.gov.au

The Department of Health, Disability and Ageing acknowledges the palawa and pakana people as the Traditional Owners of lutruwita - the lands on which we meet today.

We acknowledge and respect Aboriginal elders and their community – past, present and still to come, whom have lived on and loved this land through the fullness of time.

We also pay respect to any Aboriginal persons in the meeting with us today.

Who are we?

- We are representatives of the Department of Health, Disability and Ageing.
- Our roles were developed as part of Recommendation 8 from the Royal Commission into Aged Care Quality and Safety.
- We are referred to as "the Local Network" with our local team dispersed right across Tasmania.
- **Our role – ensuring the older person is central to all that we do** to improve access to care, quality, choice, and safe transitions of care in the aged care system.

What are we talking about today?

- **Key features of the new Aged Care Act 2024 that affect a GP**
  - **Single point of access to the Aged Care System for an older consumer**
  - **Single Assessment Process for an older consumer**
  - **Reformed Support at Home Program - the improvement to what you have known as "packages" or "home care packages"**
  - **Co-contributions and how these might impact an older consumer**
  - **Advocates or Registered Supporters.**
- **Questions**

New Aged Care Act

Key features of reform:

New Aged Care Act

- Rights-based approach
- Older people at the centre

A Single Entry Point to the age care system

- My Aged Care

A Single Assessment System

- Integrated assessment tool for the continuum of care needs
- Single assessment workforce

A new Support at Home program

- Prioritising supported ageing at home

Fair and equitable funding arrangements

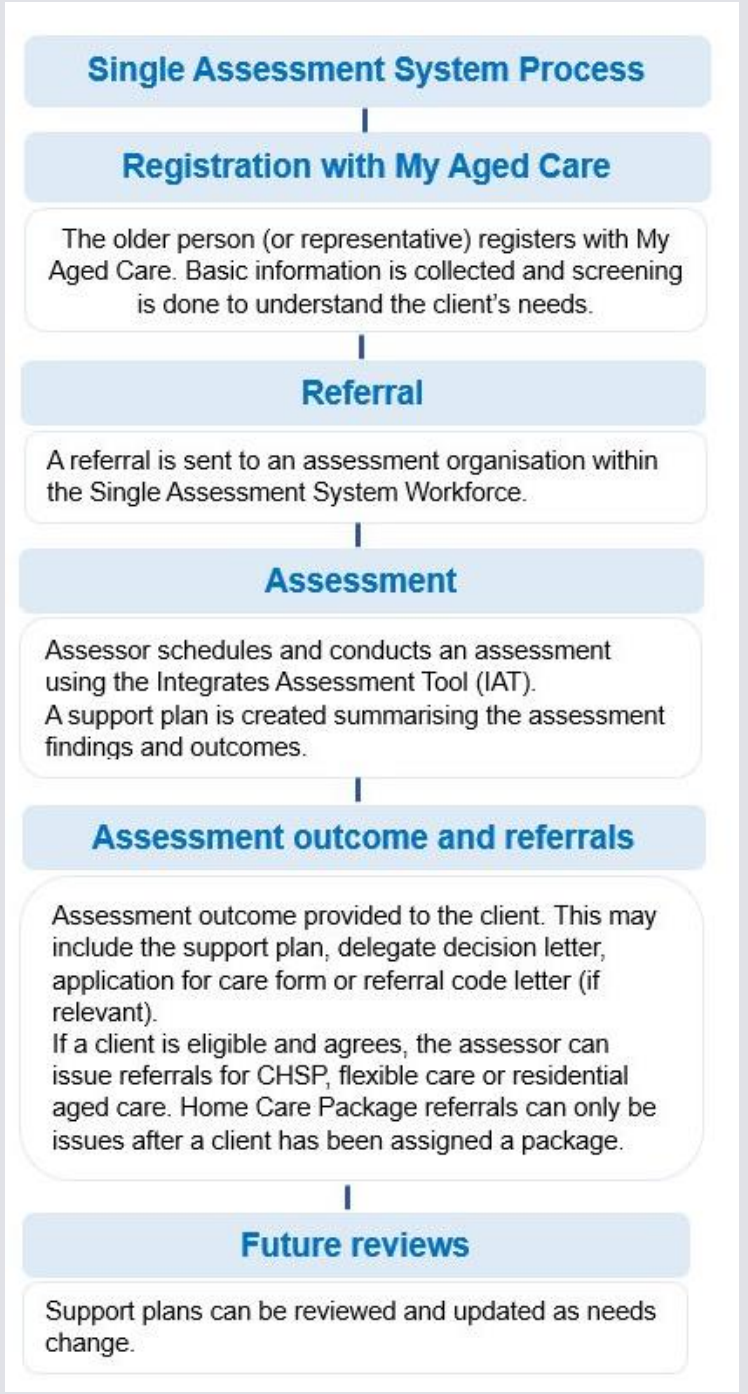
- Changes to contributions
- No Worse Off principle

Single point of entry – My Aged Care

- My Aged Care launched in 2013
- My Aged Care is the central point of access for aged care services for consumers and providers
- Registration through My Aged Care is the **only** way to access aged care services
- Registration is accessible **online** or by **phone**
- Registration is available through:
    - **Self-registration** – for older people who are capable, they can register themselves online or by phone.
    - **Family-assisted registration** – where an older person may require support, a family member can register and create a profile on their behalf.
    - **In-person registration** – for those needing more support, a face-to-face appointment can be made with an Aged Care Specialist Officer (ACSO) at Services Australia who will assist the older person to register online or by phone.

Single Assessment System

- Launched on **9 December 2024**, replacing ACAT and RAS.
- Provides a **single, simplified pathway** for older Australians to access care as their needs evolve.
- GPs may be involved in providing **clinical input** or **supporting patients** through this new process



Overview of Support at Home

From 1 November 2025, the new Support at Home program will replace the Home Care Packages Program and the Short-Term Restorative Care Programme.

Under Support at Home, there will be improved access to services, products, equipment and home modifications to help older people to remain healthy, active and socially connected to their community.

Ongoing services

Those older persons within the original 1-4 classifications – transitioned.

8 classifications for ongoing services. Each classification will have a quarterly budget.

Three new funding streams

1. Assistive Technology and Home Modifications (AT-HM) scheme

2. Restorative Care Pathway

3. End-of-Life Pathway

Participant contributions

Participants will pay contributions based on:

- an assessment of their income and assets, **and**
- the type of services they receive

Service pricing

Prices must include the entire cost of delivering a service.

Providers will initially set their own prices. From 1 July 2026, government-set price caps will apply.

Care management

Care management services will be delivered by a "care partner"

10% of a participant's ongoing budget allocated for care management.

Service List

The Support at Home service list has 3 service categories:

- **Clinical supports**
- **Independence**
- **Everyday living**

Participants will have access to an approved list of services, based on the outcome of their aged care assessment.

A care partner will help participants choose a mix of approved services based on the participants aged care needs, goals, preferences and existing supports.

Access the full service list here

Service categories	Service Type
Clinical supports	Nursing care
	Allied health and other therapeutic services
	Nutrition
	Care Management
	Restorative care management
Independence	Personal care
	Social support and community engagement
	Therapeutic service for independent living
	Respite
	Transport
	Assistive technology and home modifications
Everyday living	Domestic assistance
	Home maintenance and repairs
	Meals

Support at Home Participant Contributions

What's changing?

- Participants will only **pay an individual contribution rates for services received** instead of having to pay income tested care fees and basic daily fees regardless of what services they receive under the HCP program.

- The individual contribution rate participants need to pay will be dependent on their **pension status** and the **service category** of the services they have received.
  - There is no individual contribution rates for services in the clinical supports category.
  - Participants will make a percentage contribution to the cost of the services they use in the independence and everyday living category and depending on their pension status.

	Clinical supports	Independence	Everyday living
Full pensioner	0%	5%	17.5%
Part pensioner and Commonwealth Seniors Health Care (CSHC) holder	0%	5%– 50% depending on income and assets	17.5% - 80% depending on income and assets
Self-funded non CSHC holder and means not disclosed	0%	50%	80%

- The **no worse off principle will apply for existing HCP participants approved on or before 12 September 2024** (Support at Home announcement) and will pay the same or lower contribution rate and retain their lifetime cap. For HCP participants approved post announcement, they will pay the Support at Home individual contribution rate.

Support at Home and General Practitioners

For older people considering access to government-funded aged care services

- Suggest and/or support referrals to access an aged care assessment

For participants accessing the Support at Home program

- Work with the Support at Home provider to develop or update care plans

For participants accessing the Assistive Technology and Home Modifications (AT-HM) scheme

- Support referrals for an aged care assessment to access the assistive technology or home modifications scheme

For older people who may access the End-of-Life Pathway

- Referrals to the End-of-Life Pathway for those eligible

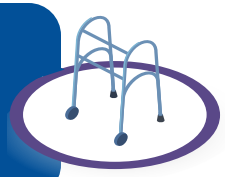
For older people wanting to know more about in-home care options

- Understand the Support at Home program, available pathways and eligibility and provide education on available options

Support at Home resources

Scan here to access our Resources page

Support at Home Program	Read the **Support at Home program manual** and the **Support at Home Service List**
Support at Home Training	Complete the **Learning package 1 - Program overview modules** and the **Module 3: Short-term Pathways**
Restorative Care Pathway	Read the Restorative Care Pathway Factsheet and the Restorative Care Pathway clinical guidelines
End-of-Life Pathway	Read the End-of-Life Pathway Factsheet
Assistive Technology and Home Modifications scheme	Read the **Assistive Technology and Home Modifications list** and the **Assistive technology and home modifications scheme Factsheet**



Registered Supporters and Advocates

Australian Government | myagedcare

What is a registered supporter?

The registered supporter role is one of the changes in the Aged Care Act designed to promote the older persons rights to make decisions and help them stay in control of their life.

Who can be a registered supporter?

A registered supporter can be anyone you trust, like a close friend or family member. You can have more than one registered supporter. Not every older person will want or need a registered supporter.

Older Persons Advocacy Network (OPAN)

Older people and their families can contact OPAN's Aged Care Advocacy Line for free, confidential, and independent advocacy support regarding government-funded aged care.

1800 700 600

enquiries@opan.org.au

Support

Aged Care Specialist Officer (ACSO)

- Aged care matters
- Test for eligibilities
- Refer for assessment organisations
- Financial services
- Connect with local support services
- Aged Care Specialist Officer in My Aged Care face-to-face services - My Aged Care face-to-face services - Services Australia

Financial Information Service Officer (FISO)

- Informed decisions about your finances
- Free impartial confidential service
- Provision of info, tools and resources
- 132 300

Care finder Program

- Offer face to face support and referral for vulnerable older people
- Support continued engagement and connection to services
- Support My Aged Care assessment application and connection with services.
- Help from a care finder | My Aged Care

Elder care support

- for older Aboriginal and Torres Strait Islander people
- to support to understand and navigate the aged care services
- Can assist with other types of health needs, including disability supports
- Elder Care Support | Australian Government Department of Health, Disability and Ageing

health.gov.au

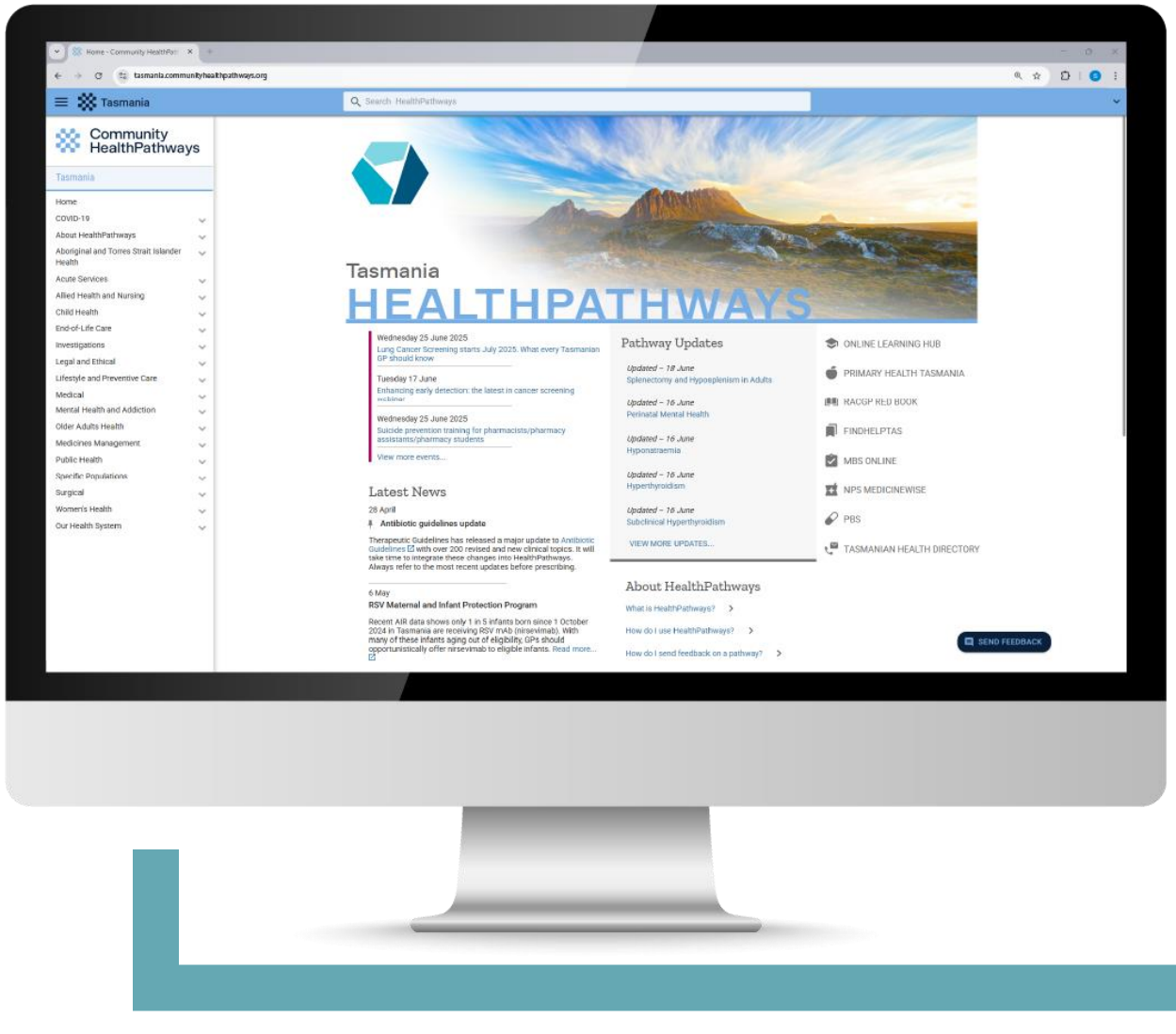
Phone **1800 200 422**
(My Aged Care's free call phone line)

Tasmanian HealthPathways

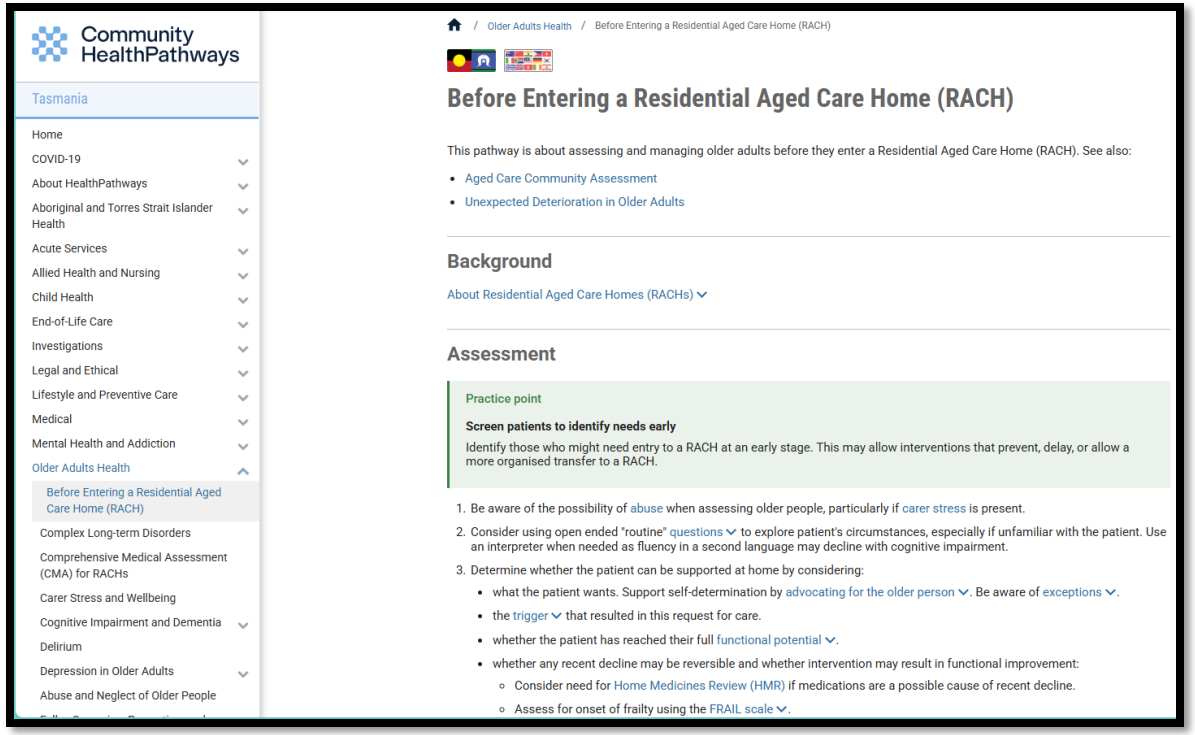
Tasmanian HealthPathways

is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

tasmania.communityhealthpathways.org



Tasmanian HealthPathways



To gain access to HealthPathways, please email
healthpathways@primaryhealthtas.com.au

Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact events@primaryhealthtas.com.au

Thank you

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