Royal Australian College of General Practitioners (RACGP) response to the Department of Health consultation on Specialist Dementia Care Units (SDCUs) – February 2018

2. What risks and issues need to be considered in introducing SDCUs into the existing service systems for people with very severe (tier 6) BPSD?

The RACGP has identified a number of risks and issues for consideration by the Australian Government prior to the introduction of SDCUs, including:

- population need
- staff turnover
- skill development

Population need

The RACGP notes that the Australian Government has committed to establishing at least one SDCU in each of the 31 Primary Health Networks (PHNs).

The RACGP suggests that prior to the implementation of the SDCU service delivery model, the needs of the population within each PHN must be considered.

Staff turnover

The RACGP notes that there is a high turnover of staff in some Residential Aged Care Facilities (RACFs), particularly nursing personnel, resulting in a dependence on locum staff. Members have reported that this is potentially a result of the challenges posed by high demand for services and complex patient needs in an under-resourced environment.

As a result of this high turnover, staff working in RACFs may have little background knowledge of the patients they are caring for. This not only poses challenges in the RACF context, but could also cause issues within SDCU-style settings, where skilled staff with knowledge of their patient's complex needs are required on an ongoing basis.

Skill development

Many patients with very severe BPSD require one-on-one care. However, RACGP members have noted that, in some cases, the RACF staff have not been adequately trained or resourced to care for patients with dementia.

The RACGP is concerned that, as a result of the establishment of specialised units to manage patients with BPSD, RACF staff development will not be prioritised. This could potentially lead to a reduction in the number of professionals trained to support patients with any level of BPSD within mainstream aged care facilities.

3. Are there alternatives to the establishment of SDCUs that would better address the current system issues, which should be considered by Government?

As stated in the consultation paper, there is limited evidence to inform a detailed SDCU operating model. However, the RACGP acknowledges the need for specialist services to support patients with severe BPSD.

The RACGP considers that patients with severe BPSD should be treated within their RACF or usual residential setting for as long as possible. Appropriately trained professionals should be readily available to the patients in these settings, to support RACF staff and the patient's usual GPs to assist the patient and manage the dementia symptoms.

RACGP members working in RACFs have noted that they are not fully informed of the Level 1 and Level 2 supports currently available to people living with BPSD, aged care workers, health professionals and family carers.

The RACGP recommends that there should be a focus on raising awareness of the Level 1 and Level 2 supports, such as the Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRTs).

17. Should there be any additional requirements for SDCU providers caring for people from Aboriginal and Torres Strait Islander, CALD or other diverse backgournds?

Staff working within in any model of care for people with BPSD should be able to work effectively in a cross-cultural context.

The RACGP considers that all staff providing care to patients should have a competent-level understanding of Aboriginal and Torres Strait Islander culture, history and health. These staff should also be trained in caring for people from CALD or other diverse backgrounds, and provided with the resources they require, including access to qualified medical translators and interpreters.

18. Would it be feasible to establish SDCUs in rural and remote locations? How can SDCUs (or alternative intitiatives) best support people with very severe BPSD living in rural and remote areas?

As there are issues concerning the proportion of need for SDCUs in different locations, the RACGP recommends that prior to the establishment of an SDCU or a similar service in each PHN, a needs analysis be undertaken. This is of particular importance for rural and remote locations, where it will be vital to ensure that the clinical expertise is available prior to the establishment of specialist units.

The RACGP also considers that raising awareness of the Level 1 and Level 2 supports currently available for patients with BPSD in rural and remote areas is vital.

Further comments

Supporting GPs

The RACGP acknowledges that the Australian Government provides a number of dementia specific supports to people with dementia, their carers, families and health professionals.

However, the RACGP considers that the Government could consider the implementation of additional resources for GPs and other staff who currently support patients with dementia in the community setting. This could include:

- programs that provide new GPs working with patients with dementia in the community access to experienced senior GP mentors

- consideration of the uptake of the Level 1 and 2 supports available to the aged care workforce, and whether further resourcing is required in order to prevent patient relocation where possible
- a phone service for health professionals and other staff working in RACFs that can provide guidance on appropriate dementia specific supports for patients

The RACGP notes that GPs will have a central role in referring patients for assessment for entry to SCDU's when established. GPs will also be responsible for:

- confirming that a patient has a primary dementia diagnosis
- assisting in the development of a care plan, as well as review
- assisting in post-discharge care once the patient has been discharged
- outreach support to the mainstream aged care provider

GPs face challenges when working within the RACF context as a result of a number of the previously mentioned issues, including turnover of highly skilled staff and complex patient needs. In addition, working within an RACF can account for a significant amount of a GP's clinical time. This not only involves scheduled visits to RACFs, but also being on call and available for regular telephone consults with other RACF staff. The RACGP notes that any work that a GP undertakes outside of a consultation with a patient is unremunerated.

The RACGP is therefore concerned that the removal of the GP Aged Care Access Incentive (ACAI) will create a barrier to GPs providing care to patients in RACFs. The ACAI is a vital resource for supporting GPs to remain involved in the aged care sector. Removal or consolidation of this incentive will therefore pose further issues to GPs providing care to aged care patients, including those with dementia.

Given the proposed involvement of GPs in a SDCU care model, the RACGP considers that they must be appropriately supported to undertake this work.

The SDCU referral pathway

With regard to the referral pathway for an SDCU assessment, the RACGP recommends that any guidelines or forms for GPs preparing a patient referral to SDCU-like services are succinct. Integration with existing practice systems to facilitate input of information from the patient health record would minimise the time involved in preparing referral documentation.