2/12/2025

The Australian Commission on Safety and Quality in Health Care
Level 5, 255 Elizabeth Street
Sydney NSW 2000

**Via email** pathology@safetyandquality.gov.au

Dear Point of Care Testing Working Group

**Draft Point of Care Testing Standards**

Thank you for the opportunity to comment on the draft Point of Care Testing (POCT) Standards.

Ageing Australia is the national peak body representing providers across the aged care sector, including retirement living, seniors housing, residential care, home care, community care and related services.

Ageing Australia strongly supports the development of POCT Standards, which we believe will strengthen governance and oversight of service providers and to address the safety and quality issues identified in POCT.

This submission has been prepared from an aged care perspective to highlight gaps as they relate to POCT services delivered in residential and home care settings.

## General Comments

Ageing Australia acknowledges that the proposed standard represents an important step toward improving the safety, quality, and consistency of POCT across the health and aged care sectors.

However, the draft document primarily reflects hospital and pathology laboratory contexts and does not sufficiently address the operational realities of residential aged care or home-based settings, where POCT is increasingly used to support timely, person-centred clinical care.

## 1. Does the draft POCT Standard clearly describe the purpose, scope and applicability of POCT within health service providers?

Ageing Australia notes the draft document clearly outlines the purpose of POCT, its benefits, risks, and the overarching governance requirements. The scope section appropriately distinguishes POCT from self-testing and pathology laboratory testing. Aged care is explicitly included as a health service provider, which is helpful for sector clarity.

However, there are areas where improvement could be made noting:

- Applicability to home care/Support at Home is unclear - many home care providers do not have on-site clinical governance structures comparable to residential aged care.

- Operational differences in aged care (e.g., staffing compositions, on-call clinicians, limited supervision, after-hours care) are not acknowledged.
- Care complexity and frailty of older people (e.g., higher prevalence of cognitive impairment, mobility limitations, increased need for consent support) should be recognised.

*Recommendation:*

- Add a short section describing (with examples/case studies) how POCT applies to residential aged care, home care, and subacute care models to support appropriate implementation by non-acute providers.

## 2. How could we improve the language and terminology used?

The draft standard is comprehensive and technically robust, but its language and terminology often reflect pathology laboratory environments and acute healthcare settings. This limits clarity and applicability for aged care, community care, and other non-laboratory contexts.

For example:

- Complex technical terminology (e.g., "metrological traceability", "analytical performance", "likelihood ratios") may be difficult for aged care staff without pathology backgrounds.
- Workforce terms (e.g., "clinician" and "workforce") should explicitly acknowledge enrolled nurses, personal care workers (PCWs), and assistants in nursing (AINs) as these roles are central in aged care.
- Reference to "patients**"** could be updated to reflect aged care terminology such as "residents" and "care participants" where appropriate.

*Recommendations:*

- Include a simplified language guide.
- Expand definitions to include common aged care roles permitted or not permitted to undertake POCT.
- Avoid using pathology-specific jargon without explanation in sections intended for broader audiences.

## 3. Are there actions that are not addressed appropriately or listed?

The draft is comprehensive but includes several gaps where key actions are either not listed, not addressed sufficiently, or not operationalised for real-world implementation in aged care and community settings.

In the context of residential aged care, for example, omissions include:

- Escalation pathways in aged care - aged care often relies on external GPs, virtual care, or after-hours services. Actions do not specify how urgent POCT findings should be escalated when an on-site clinician is unavailable.
- Medication safety and POCT use - in aged care, POCT frequently informs medication decisions (e.g., insulin, anticoagulation). There is no specific action linking POCT to medication management, dose change processes, or clinical review responsibilities.
- Clinical handover requirements - aged care has shift-based staffing; results must be handed over between shifts and to external prescribers.

- Integration with aged care digital systems - My Health Record is mentioned, but no reference to common aged care systems (Care Management Systems, progress notes, GP shared systems).

*Recommendations:*

- Specify how urgent POCT findings should be escalated when an on-site clinician is unavailable.
- Identify specific action linking POCT to medication management, dose change processes, or clinical review responsibilities.
- Clarify clinical handover requirements for shift-based staffing where results must be handed over between shifts and to external prescribers.
- Clarify the role of common aged care systems in POCT.

## 4. Are there any gaps in the content to support safe, effective and consistent POCT in health service providers? If so, how should this be addressed?

Overall, the draft POCT Standard is thorough, well-structured and clinically robust. However, and as previously described, aged care providers differ significantly from hospitals and pathology-supervised environments.

The following table outlines some of the aged Care–specific gaps and proposed additions:

| **Gap** | **Why it matters in aged care** | **Proposed addition** |
|---|---|---|
| Consent and cognitive impairment | High prevalence of dementia; POCT may cause distress or confusion | Include a subsection on consent for people with impaired capacity & involving substitute decision-makers. This is aligned with the Strengthened Quality Standards, specifically Outcome 1.3.3. |
| Environmental constraints | POCT may be conducted at bedside, in small rooms, or during home visits | Add operational guidance on safe set-up in constrained environments |
| Infection prevention and control (IPC) limitations | POCT devices used in communal areas; staff vary in IPC training | Include IPC scenarios relevant to shared living environments |
| Workforce variability | Aged care staffing includes RNs (sometimes only one per site), ENs, PCWs, allied health | Provide guidance on minimum competency requirements for each role |
| Clinical review after POCT | GPs often off-site; delays can affect resident safety | Include requirements for timely GP/NP review and telehealth-enabled escalation |
| Emergency response | POCT results may require urgent action, but aged care settings lack immediate medical teams | Include guidance for emergency escalation and deescalation pathways and when to call ambulance services |

## 5. Are there any actions that need further clarification to reduce ambiguity?

Ageing Australia has identified a number of areas that would benefit from clarification, including:

- *1.04 – POCT Supervisor requirements*
    - The supervisor must be "authorised" and responsible for governance, training, interpretation, advisory services, etc. In aged care, there may be only one RN on shift—or none in home care.
    - Clarify whether the supervisor can be off-site (e.g., central clinical governance unit).
- *2.01 – Clinician competence*
    - Define which job roles *can* and *cannot* perform POCT.
    - Clarify minimum levels of education and training required for ENs, PCWs, and home care staff.
- *3.02 – Informed consent and financial consent*
    - In aged care, chargeable POCT is uncommon; financial consent processes may need special guidance.
    - Clarify how consent is managed for residents with impaired capacity.
- *4.01 & 4.02 – Medical device selection and use*
    - Specify whether aged care providers need to perform independent validation or can rely on manufacturer and pathology-endorsed validation.
- *5.02 – Patient identification requirements*
    - Using *three* unique identifiers can be difficult with residents with cognitive impairment or home care clients lacking documentation.
    - Clarify acceptable identifiers and what constitutes a "unique identifier" in aged care (e.g., Medicare card, AC number, facility ID).
- *6.02 – Quality control requirements*
    - Monthly QC for all devices may not be feasible for low-volume POCT sites; consider risk-based frequency.
    - Clarify expectations for low-volume aged care facilities.
- *7.03 – Critical results*
    - "Immediate notification" is ambiguous where no on-site clinician is present.
    - Add examples and escalation timeframes relevant to aged care settings.

## Conclusion

While the draft POCT Standard provides a strong foundation for improving safety and quality, further refinement is needed to ensure it is practical, proportionate and fully applicable across the diverse settings in which POCT is now delivered, including residential aged care, home care and other sub-acute environments.

Addressing the identified gaps—particularly those relating to governance in off-site or low-resource settings, workforce role clarity and competency requirements, consent and communication for people with impaired capacity, escalation pathways, digital integration, and risk-based quality assurance—will strengthen the Standard's ability to support safe, effective and consistent POCT implementation.

These enhancements will ensure the Standard is both clinically robust and operationally feasible, ultimately improving consumer outcomes and supporting providers to deliver high-quality, person-centred care.

Yours sincerely,

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