VincentCare
Victoria

A response from VincentCare Victoria to the Productivity Commission Issues Paper:

Caring for Older Australians

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July 2010

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Executive Summary

VincentCare's submission focuses predominantly on issues relevant to this Inquiry which relate specifically to a particularly marginalised and disadvantaged group of older people - the older homeless.

Homeless people over 55 years of age are the age group which has increased more than any other homeless age cohort between 2001 and 2006. While this group increases in size, there is a very limited pool of aged care beds and packages being made available to meet this special need. The submission details case studies to illustrate our particular concerns on behalf of this group. We highlight that traditionally, the aged care service system is premised on an assumption that many receiving care have family support. This is not the case for our special group and prompts our call for greater service flexibility in design and delivery.

Our submission discusses the experience of VincentCare through our aged care facilities and our community aged care program, which assists older people who, without these packages, would be at risk of homelessness. Vincent Care advocates for an integrated aged care system with each component well linked to enable ease of transition for all care recipients and a holistic and individualised response.

Issues addressed include:

- The considerable under-funding of the aged care sector which poses particular challenges for organisations wanting to remain in the business of providing aged care facilities.

- Inconsistencies and limits regarding what support needs are funded under the Aged Care Funding Instrument (ACFI) which result in under-funding in relation to older homeless people.

- The age eligibility for Aged Care Assessments is normally 65 and over. Our submission argues that this be extended to 50 years with discretion to assess people in their forties, due to the early ageing which people experience as a result of homelessness, associated hardship and isolation as well as often complex health issues.

- The need to address workforce limitations and the need for strengthened regulation of workers within the aged care sector, in order to ensure long term viability and a high level of care and support of older people.

- Dementia remains one of the most significant health issues confronting society. VincentCare believes that there should be a stronger focus on:

    - Early prevention through health promotion programs espousing dietary and recreational programs which research indicates may be effective, and

    - Incentives for creative programs to provide as much fulfilment as possible in the lives of people suffering from dementia.

- The shortage of appropriately skilled doctors with a vocation for aged care plus a lack of financial incentives results in patchy medical coverage across certain facilities. VincentCare considers ways to overcome this shortage including offering financial incentives and scholarships to Div 1 nurses to undertake further study in order to train as Nurse practitioners, specialising in aged care.

Our submission also highlights the valuable contribution of committed family members who are active contributors at facilities even after their loved one has died. This type of volunteer effort achieves mutual benefits and adds greatly to the life of the facility. A range of recreational and social activities that may not otherwise occur, are made possible which enhance well being. Considering the marginalisation and loneliness of the group we are focusing on in this submission, it is particularly valuable that every opportunity is offered to maximise the kinds of activities that can occur through valued volunteer effort. Current funding arrangements do not adequately support recreational activities within aged care and our experience is that they are very important in the lives of care recipients and residents.

The submission also discusses alternative models of care which could be better suited to this particular specialist group such as supported ILUs.

Recommendations

VincentCare makes a number of suggestions and recommendations to this Inquiry in relation to:

Cost of providing aged care services

That flexible funding arrangements be developed which better reflect the true cost of providing quality aged care services.

That subsidies and grants be available to address the additional legitimate need for services to specialist groups particularly older homeless people.

That pilot funding be available to explore innovative programs that can be offered from existing facilities to better meet needs of specialist groups of older people.

Facilities with a high proportion of concessional residents

That where facilities are meeting specialist needs such as providing care for older homeless people without assets and are therefore not receiving adequate revenue via bonds, that "top up" funds be available in accordance with set criteria.

Bed vacancies

That options for converting bed licences into other forms of care and support packages continue to be made available. These could include day care options, respite and home care support.

ACAR application process

That alternative ways of tendering, such as selective tendering for the small number of community care packages made available each round, be explored to minimise unnecessary effort and expense for services tendering and to better target these packages to disadvantaged groups.

ACFI

Productivity Commission recommendations in relation to ACFI be given due consideration in the impending outcome of the ACFI Review, given the key role ACFI holds in aged care funding.

That ACFI's existing categories be expanded to better reflect the true extent of care and support needs of extremely disadvantaged residents with complex behavioural and lifestyle needs.

ACAT assessment in relation to ACFI

Identify where ACFI and ACAT assessment methods work against each other, resulting in incompatible outcomes in relation to a resident's accommodation, care and support needs.

Age eligibility for ACAS assessment

That discretion be allowed in regard to age eligibility for assessments of people aged between 50 and 65 with further discretion in particular cases where a person in their 40s, displays concerning symptoms of early ageing.

Bonds

VincentCare supports the call for bonds to be applied to both high and low care.

Conversion of bed licences

That pilot government funding be available to explore innovative ways of "converting" bed licences into other forms of care and support to isolated and vulnerable members of local communities

Community care packages

Enable flexibility for community care providers to maximise individualised tailoring of services to meet recipients' needs. This is especially important for disadvantaged care recipients with little or no family support.

Workforce issues

That aged care be promoted as a valued career option for nurses and PCWs and that there be:

- Mandatory registration of all PCWs with annual renewal.
- Development of clear scope of practice, code of ethics and competencies for PCWs under the auspice of the Australian Nursing and Midwifery Council.
- Requirement for all PCWs to undertake continuing professional development and to submit a statement verifying this with their annual registration (setting a minimum number of hours to be achieved).
- Requirement for all RTOs to comply with minimum training standards, to submit course outlines, teaching methods, course learning objectives and outcomes to the regulatory body for verification. Auditing by regulatory body to ensure the submissions are accurate.
- Requirement for RTOs to assess their PCW staff against the set competencies prior to their certification to ensure standardised level of competency of graduates.
- Set minimum standard of literacy and numeracy for PCW students.
- Funding for all Registered Aged Care Facilities (RACFs), CACPs providers to undertake the initial administrative task of collating and verifying their PCW staff have registered e.g. a one off bonus payment based on staff numbers per provider.

- An increase in aged care funding to enable parity of wages across the health sector.
- Scholarships to enable RNs to complete a Master of Nursing – Nurse Practitioner Aged Care.
- Scholarships to enable ENs and RNs to complete post graduate training in areas such as gerontology, chronic disease management and dementia care.
- Clear framework of career structure between the three levels PCW – EN – RN.

Dementia

- That government commits to introducing early prevention programs across communities at risk which could potentially slow the onset and incidence of dementia and supports innovative dementia programs with an appropriate incentives scheme.

Access to doctors at facilities and intersection with hospitals

- That methods and incentives to attract appropriately skilled and vocationally committed general practitioners to service aged care facilities be reviewed
- That opportunities to provide financial support/scholarships for nurses to undertake study to become Nurse Practitioners be explored.
- That hourly coverage be increased for In-Reach and Out-Reach, the hospital medical advice programs.

Inappropriate placement of people with disabilities in aged care facilities

- That better accommodation and support options continue to be sought in order that young people with disabilities, including young onset dementia and people with degenerative neurological disorders are not inappropriately placed in aged care facilities.

Other models of care

- That innovative models be explored which allow flexibility in responding to the needs of particular communities such as the highly disadvantaged, homeless older people and the increasing numbers suffering forms of dementia.
- That options to better utilise existing facilities for the benefit of socially isolated older people in local communities be explored.
- In recognition of specialist skills within homelessness agencies, that transition options be strengthened for people who are supported by agencies offering both community programs and aged care.
- Supported ILU model be examined with a view to providing a further accommodation and care option which meets affordable housing and support needs and extends

capacity for independent living-therefore avoiding institutional care with associated increases in dependency.

Ongoing contact between families and facility after resident dies

That opportunities to retain ongoing connection between committed families and the facility after family member dies be promoted through various incentives, given the contribution of such support and recreational activities to countering social isolation for many residents.

Introduction

VincentCare

Victoria welcomes the opportunity to submit to this critical Inquiry. VincentCare Victoria operates aged care, homeless, community care and housing and a disability employment program, all of which receive government funding. VincentCare is an incorporated company governed by a Board of directors under the auspices of St Vincent de Paul Society Victoria. The following short section provides some background to our organisation, the later part of our submission covers specific issues we wish to bring to the attention of this Inquiry. These are:

- Ongoing underfunding of aged care services continues to result in considerable shortfall
- The need for provision of special grants or subsidies to support the work of agencies accommodating and supporting special needs groups, particularly disadvantaged people with a history of homelessness.
- ACFI
- ACAR assessments
- Workforce and regulatory arrangements
- G.Ps servicing aged care facilities
- Families ongoing contact with facilities
- Inappropriateness of people with disabilities being placed in aged care facilities
- Models of care, appropriate to disadvantaged older people with special needs

Our submission captures the wisdom and experience of VincentCare's committed facility managers, CACP program manager and other staff who operate funded services for our aged care residents and clients. It has also been informed by the experience of other Catholic and not-for-profit aged care providers with whom we have a collegial relationship and with whom we have a shared mission to provide quality services for older men and women and those who are chronically disadvantaged. A number of agencies met together to discuss issues which we believe will be reflected in several submissions. We have included two case studies from another facility, Prague House, which has residents who have had former connection with VincentCare through our community services programs.

Background

While there is widespread concern about Australia's ageing population and shrinking tax payer base, there is less attention given to one of the most marginalised and needy, older groups which our submission wishes to focus attention on. This group is one with whom VincentCare has considerable contact throughout their young adult, adult and later years. We define this group as people who are homeless, either sleeping rough or living in precarious, sub-standard

housing arrangements. They are a significantly socially isolated and disadvantaged group. They are often prematurely aged as a result of their lifestyle and associated hardship and deprivation. Older homeless people usually have complex issues including chronic health conditions, mental health and behavioural issues; no or very limited family or community contact and/or support. It is important to clarify that this is the group we are discussing in the submission as often the term "disadvantaged" is used in a general way to cover low income groups who may still be well linked to community and family support and present with a lesser degree of chronic or complex issues.

The Department of Ageing identifies that there are currently 2000 residential aged care places for homeless people and the census data identifies that there are more than 18,000 homeless people over 55 years old. This particular homeless age group has increased more than any other age cohort between 2001 and 2006. It will therefore be essential to provide more places for this group of people in either specific homeless services or within the mainstream provision of aged care if the numbers of elderly homeless people are to be reduced. If services are not able to be financially viable, this will not be possible with significant consequences in being able to meet the Government target of reducing homelessness by half in 2020. While the overall Commonwealth funding system does not reflect or recognise the real cost of operations or capital required for all groups with aged care needs, we are particularly concerned about the substantial shortfall in facilities caring for older homeless people and the urgent need for subsidies or a special purpose "pool" for agencies which specifically cater to these older homeless people.

VincentCare Victoria

VincentCare's Aged Care programs provide care and accommodation for people who have undergone an assessment for eligibility into residential care services. We operate seven aged care facilities including residential care for residents with high and low care needs, with ageing in place and a Day Therapy Centre. These facilities are located across Victoria; one in inner Melbourne, three in metropolitan Melbourne, one in Geelong and two in regional areas. We also currently have 55 independent living units in four country locations, which provide another level of service to the aged in the community. We operate a 20 CACPs program from our community centre, detailed on page 12.

VincentCare also operates a Disability Employment Service, Ozanam Enterprises which is located in Mornington.

VincentCare also manages a range of programs which have a specific focus on addressing homelessness and demand for housing. We operate a housing service which is the Department of Human Services' identified primary housing provider for the northern and western region of Melbourne. Other services include Ozanam House, a short term residential program for men and Ozanam Community Centre, a day centre where our CACPs program operates. The program focuses on disadvantaged men and women who are at risk of homelessness. The Centre provides meals and a range of health and other services at no or minimal cost to socially isolated people, most of whom are either homeless, living in precarious accommodation such as rooming houses or in local public housing. Supports such as the Centre play a vital role in providing a sense of community and belonging to many people, who although housed in secure and affordable housing, are socially isolated and struggling financially. VincentCare also

operates Quin House, a residential drug and alcohol rehabilitation program for men whose lives are affected by substance issues and homelessness and two family violence programs - Marian Community in northern regional Victoria and Olive's Place in bayside Melbourne; as well as programs which support vulnerable youth and adults.

Profile of VincentCare's client group

This context illustrates that VincentCare provides a range of services, predominantly aimed at the most marginalised and disadvantaged members of society. The people we support often have little or no contact with family, are often homeless or live in precarious housing arrangements and are extremely isolated. Many display early signs of ageing, well before other members of society. Due to lives featuring impoverishment as well as often chronic physical and psychiatric health issues, alcohol and other drug misuse, we see people in their forties and fifties who present with limited capacities similar to people who may be ten or more years older. Working with this group of people requires a particular expertise that only specialist homelessness agencies possess and while this cohort does not currently represent the majority of our aged care residents, it is our stated Mission to maintain and explore expanding our commitment to this group of people as they grow older. This intention and how it can best be addressed is key to why we have chosen to focus on particular issues in our submission. A significant factor for this group is the lack of family contact and lack of informal support. This is significant because aged care programs have largely been developed in the main from a premise that older people usually have access to families for support.

VincentCare aged care facilities and CACPs program

VincentCare's seven aged care facilities provide 350 beds. They range from a two year old, state of the art facility at Geelong, (91 beds), a 1990s facility at Westmeadows (30beds) with the remainder in metropolitan Melbourne and country regions, built predominantly in the 1970s. A number are therefore what might be categorised as 'old and tired.' While the majority are classified as low care facilities, most have ageing in place and many have a large number of high care residents. Currently, close to 40% of residents pay bonds; individual amounts vary greatly. We have some residents paying as little as $9,000-$20,000 and the upper range is $245,000-$375,000. This equates to an overall average bond per bond-paying resident of approximately $105,483. This average is probably not particularly pertinent given the dramatic range in bonds paid however, what is apparent is that the average of $105,483 is well below the industry average of $ 159,494. (Stewart Brown Benchmarking)

The inadequacy of funding impacts greatly on VincentCare's capacity to upgrade and maintain facilities and limits our ability to admit highly disadvantaged residents. As we have a commitment to provide care and accommodation to disadvantaged men and women, this is an ongoing issue that agencies such as ours face.

The existing funding formula does not adequately provide for disadvantaged residents and capital improvements; bond payments are inadequate in our circumstances to meet capital costs. There needs to be an acknowledgement at a government policy level of the funding shortfall that most not for profit/faith-based facilities experience because, in many cases a significantly higher number of concessional residents come from low socio economic backgrounds. There will be a continuing need for Commonwealth Government support to

ensure that people with special needs and or/or fewer means continue to have access to high quality aged care services.

In the event that residents are in a position to make a contribution, VincentCare supports the call for bonds to be applied to both high and low care. This is one way of providing greater capital as well as having an allocation of Capital grants. It is increasingly difficult for agencies to consider building high care facilities and yet as people age and need high care, the funding is reliant on recurrent funding or bond retentions from those entering low care environment. Some of the low care facilities have not been built to cater for high care needs. In addition there are additional and more complex staffing and care issues.

A number of our older facilities have recurring bed vacancies. This mainly relates to these facilities not providing ensuite bathrooms and having shared rooms. Potential residents and their families prefer to live in more up to date facilities which offer a higher level of comfort and amenity. VincentCare does not want a situation where these beds become the option of last resort and therefore could be allocated to those of our clients who have little "buying choice," that is the most chronically disadvantaged. These people's lives have been dominated by a lack of choice or empowerment. VincentCare is committed to equity of choice so that this group of people can enjoy the best quality of care.

These older facilities with recurring bed vacancies can conversely, present an opportunity in that existing facilities are well placed to support home care, day care options, respite and in the case of VincentCare, options could be explored that could support the older homeless. It seems clear that the increase in availability of home and community support services over the last decades has successfully and appropriately decreased the demand for low-care beds providing an opportunity to transfer resources for low-care beds to support ageing in place in the community. We believe we could build on the base these facilities provide to explore innovative ways of offering types of care and support to isolated older members of local communities. This is an area worthy of pilot funding by government.

As we seek greater flexibility in the range of services offered to older people, particularly the cohort of interest to VincentCare, we are aware there could also be implications for accreditation. We believe it would be prudent of the Government to consider offering greater flexibility in regards to accreditation for facilities providing accommodation and support for the elderly from specific disadvantaged groups such as homeless people. While many issues are similar for many elderly people, providing enhanced support for this group will require more variables and specific support needs such as potentially, specific building requirements and specialist staff for support of people with for example, drug dependence.

VincentCare has to date, been unsuccessful in applying for CACPs which would be administered from one of our aged care facilities. We are aware that there would be considerable benefit in what we could provide, utilising existing infrastructure and the expertise of facility staff as well as VincentCare personnel from other programs.

CACPs program

VincentCare operates its CACPs program from its day centre in North Melbourne, Ozanam Community Centre. The 20 programs have been allocated to people disengaged from

mainstream health and care services who live in public housing or substandard rooming houses. The program objectives under which this program operates require that the packages target people with a history of homelessness and those at risk of homelessness. The service delivery model maximises flexibility and the capacity for the program to meet the needs of people experiencing barriers with mainstream services, due to issues such as unstable housing, mental health conditions, alcohol or other drug dependency, living in squalor, isolation and disengagement from the community. We find this is an appropriate setting from which to operate the CACPs program for these care recipients who are usually homeless and disengaged from mainstream health services and are more comfortable with the "community" feel of this centre.

The program's flexibility is a key to its success. Being able to spend time working with care recipients and getting them to a point where their situation is sufficiently stable, and then putting in place brokerage services, allows a range of barriers to be overcome.

Although we have received very positive feedback on the success of our CACPs program through departmental audits, we have to date been unsuccessful in tendering for additional packages in successive rounds for either our existing program or for new services proposed to be based at one of our aged care facilities. . A significant amount of work and expense is incurred by providers in submitting applications. We query whether the CACPs program gives adequate priority to the care needs of our disadvantaged clients as there are very limited packages made available to this special group. There may be an easier way to apply for tenders through a preferred provider process. This could achieve a less wasteful and more targeted use of limited resources and a more targeted use of funds for priority needs.

Current configuration of Aged Care Services

VincentCare believes the aged care service system should be viewed and managed holistically as one rather than separated into silos as community care and residential care. This enables a more holistic response to the needs of individuals and would also allow for an easier transition between the different service sectors. As an example, in relation to the older homeless group, it would be far preferable if there was an assessment model that followed the care recipient across the continuum of various forms of care, matched by a funding model that supported the delivery of changing care needs in an individualised and responsive manner.

As mentioned earlier, VincentCare has pursued obtaining community packages which could be established at our existing facilities as we know this would be of great benefit to older residents in these local communities. To date, we have been unsuccessful and recognise it is a highly competitive market. We will continue to pursue this option as it is a very effective provision of aged care which is often more responsive to the needs of individual aged people. There are also economies of scale and potential benefits which can be shared across the diverse programs available through VincentCare.

Aged Care Funding Instrument (ACFI)

There was a recent review into ACFI which we welcomed. As the report has not yet been released, we would like to utilise the opportunity provided by this Inquiry to outline some of the complexities and limitations in gaining adequate funding which matches residents' complex care and support needs. Our experience is that ACFI fails to adequately account for the true extent of

care and support needs of extremely disadvantaged residents, especially those who were previously homeless and who have complex needs including mental health issues. As with most complex government funding systems, ACFI is inevitably subject to some “gaming” with services often employing ACFI experts to maximise their revenue. There are also specific limitations with ACFI in relation to behavioural issues, with many being unfunded, but which are common to the residents we see in our facilities who come from extreme disadvantage and present with complex issues. The issue of support needs of this group of residents is particularly important as most have lost contact with families and the facility becomes their only social support. In many cases, the support needs are more critical than the care needs. Some examples, which are illustrated in case studies which follow, relate to limitations of ACFI, which did not exist with the former tool, the Resident Classification Scale (RCS). While staff are pleased that paperwork has reduced under ACFI, many claims that could be made previously, can no longer be made. Examples of specific limitations raised by staff across our facilities include:

- Mobility - Unable to claim the time taken to assist and supervise the individual.

- Activities - Facilities cannot claim for Activities prepared and delivered to residents, although they were claimable under RCS. Yet activities for residents are an expected outcome in the accreditation process, (Standard 3.7.) Activity programs are essential to the wellbeing of our residents. They diminish boredom, bring enjoyment, stimulate the mind and exercise the body. Activities also provide an avenue for involving volunteers and families through for example, outings.

- Nutrition - Cannot claim for the extra high protein drinks needed for residents who are prone to losing weight.

- Behaviours - While we can claim on some, for example wandering and verbal and physical aggression again the time needed to put strategies in place to enable day to day life to occur with minimal complications is not claimable.

- Other - The hours spent on referrals for external services to come in is also not claimable. The time spent completing paperwork, following through with GPs, for example, dental services, Eyecare2 you, mental health services, optometrists is not claimable. Where residents do not have families supporting these tasks, the burden falls on facility staff.

- Medication preparation - We can claim for the time it takes for resident to be administered with medication but cannot claim for the preparation of medication. Schedule 8 drugs take considerable period of time to organise with two nurses checking. If this time allocation was funded, there would be considerable funding relief.

The following are case studies which highlight the difficulties which exist with present ACFI assessment.

Case Study One

Several residents at one low care facility have no contact with family. They have approximately thirty external appointments to medical and other agencies per month. Staff take time to escort them to these appointments. We do not receive funding to fully cover the cost of this support provided by the facility staff. Such is the commitment of many staff to residents that they are prepared to undertake some of these roles in their own time.

Case Study Two

One male resident with a diagnosed personality disorder is extremely difficult to distract. It can take staff ten to fifteen attempts to distract him in order to give him his medication. This can mean repeatedly attempting ways to distract him throughout the morning and evening. The time given to the distracting which is the only way to ensure he has his medication is not covered by ACFI. The actual time spent administering the medication is funded but that represents only a tiny proportion of the time the overall task requires to ensure this can be achieved successfully.

Case Study Three

A resident with significant mental health issues requires frequent prompting throughout the day to enable personal care such as showering, medication and meals. The prompting and guiding required to bring the resident to the point of receiving different types of personal care is what takes the time. Staff can spend several hours persuading this resident to have a shower. When they eventually have the resident's agreement to take a shower, he takes it, refusing assistance. Many of these residents have spent time in institutions where they experienced inhumane treatment with routines such as bathing. Their entitlement to privacy is one they hold onto dearly and which staff are deeply committed to uphold. It is the hands on act of assisting with the showering which is funded, but again, this is the tiny fraction of time expended out of a large component of time spent getting him to the point of taking a shower.

Below, are two case studies which compare the classification and consequent funding which results when a resident's medical and care history are reviewed using both an RCS assessment and an ACFI assessment. Both cases reveal that ACFI has had a negative funding impact on these residents who have special emotional, mental and social health needs in comparison with the previous RCS instrument. The comprehensive medical and social histories of these two cases are attached in Appendices.

Case Study Four

Resident:	54 year old male
Primary Health Issues:	Chronic Alcohol Abuse
Past History:	Schizophrenia Epilepsy L CVA (Severe haemorrhage) 1990 Peripheral Neuropathy Tobacco Abuse Pancreatitis 2000
Current History:	Intermittent acute psychoses Tobacco withdrawal Depression, (related to self blame when occasionally consumes alcohol) Intermittent agitation, (often on weekends – boredom, unable to occupy self)
Social History:	Admitted to hostel in 2002 as unable to care for self in the community Brother is NOK, not in regular contact and works 5 days per week

Under RCS, this resident is assessed for a RCS 6 rate of $36.38 per day.

Under ACFI, this resident is classified as Nil/Med/Nil which is $14.11 per day. This is a shortfall of @22.27 per day or over $8,000 per annum and is a 60% reduction.

Case Study Five	
Resident:	78 year old male
Primary Health Issues	Alcohol abuse
Past History:	Intracerebral haemorrhage Wernickes encephalopathy Cerebrovascular disease Myocardia infarction Malnutrition
Current History	Stress/urinary incontinence Abnormalities of gait & mobility Mild cognitive impairment
Social History:	Admitted to Bailly House Jan/10 Unable to care for self in the community Has no family. Previously lived in rooming house.

Under RCS, this resident is assessed for a RCS 6 rate of $113.55 per day.

Under ACFI, this resident is classified as Nil/Med/Nil which is $57.29 per day. This is a shortfall of @56.26 per day or over $20,000 per annum or a 50% reduction.

The above two case studies reveal a significant gap when RCS and ACFI are compared. VincentCare has a commitment to providing a high level of care that respects the dignity of each resident. This means that staff extend themselves to deliver beyond what the funding allows. This is the only way presently that we can continue to honour our commitment to our Mission which states that:

" VincentCare's responsibility is:-

- To provide quality services for men and women struggling with complex needs including substance abuse and mental health needs "

Facilities that specialise in accommodating the specific group mentioned above, such as Prague House charge lower fees than generic aged care facilities but in effect, offer more to their residents in order to service their overall needs beyond what is funded through government contributions. Prague House is a facility to which a number of homeless clients of VincentCare have been referred in their later years. The shared experience of such facilities is that by providing support which caters to needs of people with complex needs, challenging behaviours are minimised and there is a greater chance of responding in a way that respects the dignity of

the residents. Prague House is not providing a submission but gave permission for the following case studies to be included in the VincentCare submission, in order to demonstrate the limitations of ACFI in relation to the residents for whom they care. Prague House estimates that the limitations with ACFI result in a $10,000 shortfall per resident per annum in meeting care costs.

Prague House, which comes under the auspice of St Vincent's Hospital, is a low care aged care facility in Melbourne, which provides accommodation and care for both men and women who are socially and financially disadvantaged and who could otherwise be homeless. It receives most referrals from two psychiatric wards within St Vincent's Health, the Community Mental Health teams and the RDNS homeless persons program.

We believe there is a need to devise a funding instrument that better reflects the true cost of supporting people who are homeless, extremely disadvantaged and have a range of complex care and support issues. The experience of specialist agencies that support this group of older people identifies that psychosocial support including mental health and behavioural issues is often the key component of care for this group. These issues require a reasonable degree of flexibility not available in ACFI.

Case Study Six

One resident with complex psychiatric health issues including schizophrenia, experiences delusional thoughts. She is convinced that the kitchen staff are attempting to poison her. Every effort has been made to work through options that she accepts as ways of safeguarding this from happening. She trusts the facility manager and is happy if her meal is prepared by her and is then covered in glad wrap and sealed on the bottom with cellotape to show that no one has tampered with it. The extent of time and care taken to facilitate this arrangement is not funded through ACFI. The time taken to respectfully find a solution that the resident accepts has ensured she receives appropriate nutrition and has allayed her anxieties.

Most of the residents at a facility like Prague House would not fit a "generic" aged care facility as they are unable to conform to normal social expectations.

Mismatch between ACAT and ACFI

This mismatch between ACAT assessment and ACFI classifications is common in VincentCare facilities, when a person is admitted to a facility. This does not relate specifically to significantly disadvantaged residents. It relates instead to many issues where ACAT and ACFI's assessment methods are incompatible and work against achieving a funding level outcome that matches the resident's care and support needs.

This is most often demonstrated when a resident receives a low level assessment from ACAT but the ACFI assessment is for high care. This causes problems when the facility submits to the

department for high care funding which defaults to low care. The reality is that ACAT may not see the true extent of an older person's care needs as for example, the family may shield the assessors from the true extent of care needs for a range of reasons. The facility has up to 56 days to perform ACFI assessment and submit to the department. There is settling in time, a chance to monitor trends in behaviour and overall, to gain a more holistic view of the resident's care and support needs. This is therefore where there is often a significant mismatch between the two assessments.

CACP programs

In relation to community aged care for this group, we have found that CACP and HACC are beneficial in supporting the lives of the homeless or disadvantaged. But CACPs are extremely limited and difficult to secure. The success of VincentCare's CACP program specialising in working with significantly disadvantaged people at risk of homelessness reinforces the considerable capacity of a package to turn around the life of an older person who is in need of a range of community supports in order to remain living in the home. Our reputation for working with homeless agencies has lead to agencies seeking us out when other agencies may have failed to engage with the client. For example:

Case Study Seven

North West ACAS (NWACAS) approached VincentCare CACPs team to provide a CACP service to an individual at high risk who was refusing to engage with other services. The care recipient had a long history of self harm and distrust of services. The care recipient had been diagnosed with a syndrome which is characterised by self neglect and hoarding behaviour. The care recipient sleeps on the front verandah due to the house being filled with hoarded items and rubbish and also being unsafe. The care recipient conducts limited personal care from a local public toilet block and obtains food from soup vans and drop in centres.

The care recipient had also neglected to seek medical attention for a large carcinoma on her hand. VincentCare attempted contact which was initially refused but over several months the care recipient began accepting a lift with the care manager to Ozanam Community Centre for lunch. A condition of accepting the lift was that there be no discussion about support needs. These conditions were accepted and some months later the care recipient was agreeable to discuss her circumstances, provided there was no expectation of engaging with a health care provider. Case conferences with previous service providers and NWACAS resolved that the preferred strategy was to focus on not jeopardising the relationship so that VincentCare CACPs program could remain in a position to monitor presentation and health. After approximately 18 months of monitoring and transportation of meals, the care recipient was agreeable to having the carcinoma removed and remains a regular visitor to the Ozanam Community Centre for meals.

Similar to the experience outlined with aged care facilities funding model, within our CACPS program, there are many real needs to meet that are not covered by instrumental care costs

such as personal care and domestic support. Instead, the people we support may require shelter, white goods, clothing and recreation. Fee payment is not a key feature of this group which also needs to be factored into the funding equation. Unlike residential care, neither CACPs nor HACC derive a Commonwealth supplement in lieu of people's inability to pay a fee. Case management is complex, there are other material needs for which people need support, yet no means to offset increased costs and decreased revenue.

The packaged care service system tends to define outputs narrowly. This definition includes items such as domestic support, personal care, shopping, outings or a meal as valid care that can be purchased. These are defined in the Community Care Subsidy principles or HACC Service Outputs. Providers try to work flexibly on the ground, yet the system does not automatically acknowledge or validate its value. Building rapport and relationship to slowly make changes in people's lives takes time and again, the system does not necessarily place a high value on this engagement approach. We know through the experience of our day centre, Ozanam Community Centre where our CACPs program resides, that recreation support can be a very useful way to enable avenues for social participation and activity. The Commonwealth Department of Health and Ageing funds Planned Activity Groups and there are leisure interests and activities reflected in the Aged Care standards, however we believe with more funding support of recreational opportunities, more could be achieved at an individual level for older people to achieve a more satisfying existence.

Many reforms in the way departments conceptualise program delivery is, over time, extended to other jurisdictions. The challenge is that sometimes the extension of an idea that works well in disability will not necessarily translate well into aged care or across all cohorts of clients. An example that VincentCare is aware of where this difficulty exists is with Consumer Directed Care (CDC). For some of the clients we work with, for example, men and women who have experienced institutionalisation and may have brain injury, substance or mental health issues, the concept of CDC is not particularly relevant. For some clients, the role of a worker or advocate to control support resources and finances on the clients' behalf is critical to keeping other aspects of their life running smoothly. VincentCare welcomes that the Commonwealth Government acknowledged these concerns when it decided to make a provision in the CACPs for representatives or interested organisations to be the recipient of an individual's CACPs funds.

Aged Care Assessment Services (ACAS) assessments of people aged 50-65

Many people we support through our programs present with signs of age-related conditions even though they may be as young as their late forties. Currently, most ACAS' will not carry out an aged care assessment if a person is under 65 years of age, regardless of whether they present with concerning age-related symptoms. We believe it is essential for services to be encouraged to have discretion to perform an assessment where a health, community or aged care provider believes it is warranted. As a guide, an extension to 50 years and over is appropriate with discretion to assess people in their forties if sufficient symptoms present. For some special groups such as Indigenous Australians and people who have experienced poverty, homelessness, drug and alcohol misuse, mental health issues, it is relatively common for early onset of some age-related conditions which should enable them to access age related care services.

If the Government's commitment to homelessness is to be effective, then a fair and equitable assessment process should be in place addressing age related issues without regard to age itself. Recognition that many people with mental health issues need support in various and complex ways should be addressed. Facilities which meet set criteria should be recognised as a "specialist facility" and be eligible for "top up "funding in recognition that the ACFI does not fund these facilities sufficiently.

An experienced and well trained workforce and regulatory arrangements

A consistent message across many of VincentCare facilities is that it is difficult to attract and retain good staff. This is particularly the case with enrolled nurses (previously Div. 2) and personal care workers (PCWs). In relation to enrolled nurses, once they are qualified to do medications and intravenous medications, they are able to gain better paid positions in the acute sector. Equitable pay rates are central to retaining these nurses in aged care. There is a damaging perception that aged care is neither a career of first choice for a nurse, nor a job with particularly high value or status. In reality, nurses who work in aged care are usually required to provide care for residents with multiple health problems, without the benefit of onsite medical practitioners. They also carry out the critically important care of both residents and relatives in the end stage of life. In part, the issues with PCWs relate to the inadequate quality control of the registered training organisations (RTOs) who deliver PCW courses. The implementation of such measures would ensure recipients of these courses receive adequate training to enable them to fulfil the necessary requirements of working in aged care. The length of the courses (both classroom contact time and practical placement hours) between RTOs is variable; ranging from an extremely short course of a couple of weeks with no clinical placement through to course over a period of months with participants completing 60 – 100 hours of practical aged care experience. Facility staff are often frustrated at the low literacy levels of these recently trained PCWs This usually serves to cause extra pressure and frustration on staff as they make time to guide them in simple procedures such as bed making, and setting up prior to bathing.

A related issue is that the people who undertake these courses do not necessarily have a vocation to work in aged care. For some, it may be a stepping stone towards achieving citizenship in Australia, and as more newly arrived migrant groups undertake these courses, there are associated literacy and communication issues. For others, attending the course may be the difference between continuing Centrelink benefits or not.

VincentCare believes that it is appropriate for an overarching regulatory body to have responsibility for personal care workers (PCWs). This is a highly unregulated part of our industry and as seen in other aspects of the aged care industry, regulation is a way to raise standards and ensure adequate monitoring occurs.

We suggest that this category could come under the auspices of the Nursing and Midwifery Board of Australia. This body approves codes and guidelines to provide guidance to the professions and a flow on effect is that this helps clarify community views and expectations on a range of issues in relation to aged care.

The United Kingdom has a robust health professional structure which includes vocational and university based courses, all regulated by the one sector. It also provides a framework for the review and ongoing assessment of Assistant in Nursing or Personal Care Worker level,

demonstrating how the regulation and monitoring of this level not only maintains the overall level of competency of these staff, but also links them to further training and development. The United Kingdom College of Nursing incorporates into its charter, regulation of PCWs (UK equivalents), providing an ongoing framework of professional competence, education and ethics, rather than just quick isolated courses, thus ensuring higher standards of care. There may be elements within the United Kingdom model which would be worth considering as ways of enhancing regulation and standards.

As an industry we need to find an effective way to promote aged care as a valued career path. VincentCare actively promotes work experience opportunities for school students in many of our facilities and ensures the experience is a rewarding one for the student. We also support and encourage our facilities as suitable places for health professional students to undertake clinical placement, both the vocational and university/higher education sectors. We recognise that more could be done to forge relationships between nursing and related training institutions to forge relationships and promote that we are an Employer of Choice and to spell out the benefits of employment with VincentCare. The lack of wage parity is an issue. A fair wage commensurate with the skills necessary to look after the physical and emotional needs of older people requiring care and the regulatory demands of aged care is critical. Staff should not be paid less than their counterparts employed in other parts of the healthcare sector. This would also assist in raising the perception of aged care workers as equal to their acute care counterparts; from a social perspective it is difficult to promote equality when remuneration is not equal.

Access to doctors at facilities and intersection with hospital care

The ability to obtain the services of doctors to visit aged care facilities is difficult. While it is desirable for many people to maintain contact with their own doctor, after moving into an aged care facility, this is not always practicable. Some of the more disadvantaged older people we accommodate may not have had regular contact with one doctor for many years. Having a doctor with a commitment to aged care who is the regular contact at an aged care facility and remains in contact with residents can provide the best service. Aged care is however, not the most sought after area of medicine for general practitioners. This is partly because it is not seen as highly profitable as the amount of time given to communication with both the facility and the family and tasks such as organising prescriptions and driving between the surgery and facility is largely unremunerated. It is unlikely that general practitioners will allocate the time to aged care casework unless the remuneration levels improve.

In the past, semi retired general practitioners have often fulfilled this role, however as the paperwork increases and aged care embraces more sophisticated I.T programs, this area is of less interest to them. ICare is relatively easy to log onto and displays all relevant information on residents so is relatively easy to use. However the automated system does require doctors who are able to adapt to these tools. Again, aged care should be seen as a vocation as personnel working in this area are performing significant work in often supporting and caring for an older person at the end of their life.

VincentCare believes that having Aged Care Nurse Practitioners within facilities would assist in alleviating the workload carried out by doctors. Nurses undertaking Masters degrees and intending to go on to complete the requisite units of study to gain qualifications as Nurse

Practitioners could be attracted to consider working in aged care facilities if appropriate financial support/scholarships were offered by organisations such as VincentCare. This is an area where with adequate government resourcing, better outcomes could be achieved for resident care.

Intersection with acute care

In relation to possible hospital admissions, we have found a particular pilot program which has now received ongoing funding, to be of benefit. "In-Reach" covering inner Melbourne and "Out-Reach" covering outer metropolitan region is a program which provides a specialised medical advice service which has assisted facilities by minimising the transfer of residents into hospital. This is due to the quality back up received by qualified staff who work in this program. Unfortunately it does not provide 24 hour coverage. In reality, the majority of assistance is required after 6pm and coverage is until 9pm weekdays and 6pm on weekends. Nonetheless, without a program such as this, these situations would normally be managed by locum doctors who are not familiar with the residents or facilities. The advantage of In-Reach is that their team are familiar with our residents, individual records are well maintained in an ongoing manner and are easily accessible. It also makes it relatively stress-free as the program can fast-track a resident being transferred to public hospital. This avoids the unwanted situation of residents being left unattended on uncomfortable stretches in unfamiliar territory. If there is then a need for further treatment, The Hospital in the Home receives a referral from In-Reach to provide service back at the facility, again minimising trauma for the resident and potentially, their family. Hospital in the Home is an excellent resource to our facilities, providing coverage for procedures such as intravenous medication, where facilities may not have an appropriately trained nurse available every day to administer I.V.

The In-Reach/Out-Reach model has eradicated previous issues such as residents being discharged without a phone call to the facility, being returned without transfer information and requiring the facility to spend considerable time chasing up relevant information on behalf of the resident.

Families ongoing involvement with facilities

Our facilities remain in contact with families after loved ones have died. This is an important part of the bereavement process for the families and the ongoing relationship is valued by both the facility and the family. Equally if not more significant, residents have access to activities and social engagement they may otherwise not enjoy. These benefits are particularly important for our disadvantaged group. ACFI does not give a high funding priority to these activities. It would also be beneficial if there was seed funding via grants available which facilities could access in support of establishing these kinds of activities, rather than entirely relying on the goodwill of former families and volunteers.

Examples of ongoing connection include, a family member spending one day per week running activities such as bingo for residents and helping with meals; a couple have for a number of years, committed themselves to doing the garden including establishing a vegetable patch. One facility has established a regular social evening for former families and a good number of people regularly turn up and enjoy the connection with others who have also had a loved one spend time in the aged care facility. The experience is that these family members report getting a great deal of satisfaction from this ongoing connection. We wanted to include mention of this in our

submission as we believe enabling this kind of ongoing connection achieves mutual benefit and adds a great deal to the life of the facility. This is another example of an activity that does not attract funding under ACFI although it did attract funding under RCS.

Inappropriate placement of people with disabilities into aged care facilities

VincentCare is aware that many people with for example, an Intellectual Disability or neurological disorder can end up being placed in an aged care facility because their personal care needs go beyond what can be managed in traditional disability housing settings. We are also, along with many in the community, concerned about the trend that has seen many young people with disabilities languishing in aged care facilities. The skill set and the recreational and other needs required to support people with disabilities, other than mental health, differs substantially to what is available in the aged care system. This kind of inappropriate placement usually leads to the person being inadequately supported, receiving a poor quality of care and has inadequate regard for the person's social needs, rights and dignity. It is more appropriate for purpose-built accommodation with on-site support be made available. Examples of this are where organisations such as MS Society have designed units for MS sufferers as their condition advances to a level where they require intensive care and support.

Other models of care appropriate to extremely disadvantaged older group.

The aged care and support needs of many people who fall into the homeless or disadvantaged category do not always easily fit into existing care programs such as HACC, CACPs or residential care. They require a much broader mix of accommodation and support options. It is important that government funding enable opportunities to explore innovative models which are better tailored to particular populations or communities. Where specialist agencies have capacity to respond to respond flexibly and innovatively to an individual's needs, far better outcomes can be achieved. VincentCare is committed to seeing provision of holistic care to specialist groups of older people.

There is value in exploring the continuum of care for people who are clients of agencies such as VincentCare in the early to middle years of their lives and how they could then transition into services designed to meet their needs in their older years. The benefit of this approach is that agencies such as ours are attuned to working flexibly with clients who are chronically disadvantaged, in a person-centred way. Other innovative programs worth exploring further include the Home Share Program where vulnerable Victorians who need help with household tasks are matched with younger people looking for accommodation in home environment.

It is also open to debate whether the needs of older homeless/at risk of homeless people would be better served within a broader social care system rather than the aged care system. This is because many of the issues faced by older homeless and disadvantaged people are the same as those faced by other age cohorts of homeless people. Specialist homeless services cannot continue to take on more cases unless an expansion of services is funded. Otherwise, an uptake needs to occur elsewhere, provided the other service area has specialist, skilled and competent personnel working with this vulnerable client group.

We believe there is capacity to explore utilising existing facilities for a range of additional services such as day centre activities for non-residents who would benefit from recreational

programs, psychosocial support and a sense of belonging. A level of supervision could also be provided that many frail people miss out on, when living alone. Facilities kitchens could be better utilised to provide additional meals to isolated, older community members and vacant beds could be utilised in a range of short term ways that could assist older people requiring for example, respite.

VincentCare sees great opportunity in a supported ILUs model, where frail and socially isolated people can be supported to remain living independently with a range of services provided to them in their homes. There is also then a link with our aged care facilities if this need arises.

In conclusion

We have chosen to focus on a particularly marginalised and disadvantaged group of older people in this submission. We are aware that this cohort is increasing in numbers and that policies which cater specifically to this group lag behind what is happening across mainstream aged care. This group deserves special attention and a particular commitment, especially given the little or no family support available to them.

Appendices

Case Study: Comparison Funding RCS Vs ACFI

Abstract:

The aim of this case study is to demonstrate that the current method of resident classification and thus care funding the Aged Care Classification Scale
(ACFI) has had a negative funding impact especially for residents with special emotional, mental and social health needs in comparison to the previous Resident Classification Scale (RCS).

The method included the review of the resident's medical and care history and completing both an RCS assessment and an ACFI assessment based on his current healthcare needs, with consideration where able (within the parameters of the funding scale in use) his past history and health issues.

Findings:

Resident:	78 year old male
Primary Health Issues :	Alcohol abuse
Past History:	Intracerebral hemorrhage Wernickes encephalopathy Cerebrovascular disease Myocardia infarction Malnutrition
Current History	Stress/urinary incontinence Abnormalities of gait & mobility Mild cognitive impairment
Social History	Admitted to Bailly House Jan/10 Unable to care for self in the community Has nil family

Using the Resident Classification Scale (RCS) to assess and classify this resident:
RCS Assessment (based on current condition and care needs)

Q1 Communication

Major difficulty *C*
Staff are required to speak in a clear elevated voice, spend additional time listening and allowing resident time to process information. This is especially important for complex communication where the resident is required to process multiple pieces of information and then make a decision based on this information.

Q2 Mobility

Major Assistance *B*
Resident requires assistance for staff for transfers and accompanied or supervised when walking

Q3 Meals and Drinks

Some Assistance *B*
Resident requires limited assistance

Q4 Personal Hygiene

Extensive assistance *D*
Staff encourage or persuade resident to optimize self care function daily

Q5 Toileting

Some assistance *B*
Resident needs prompting and reminding to attend to post toilet hygiene. Staff set up toilet for ease of in/egress

Q6 Bladder Management

Major Assistance *C*

Q7 Bowel Management

Major Support *C*
Resident is continent of faeces but requires a bowel management plan to prevent constipation.

Q8 Understanding and undertaking living activities

Major Difficulty C
Resident requires prompts and reminders to remember, understand, plan and initiate activities

Q9 Problem Wandering or intrusive behaviour

Not Applicable A

Q10 Verbally disruptive or noisy behaviour

Extensively D
Observation and interventions are required daily.

Q11 Physically aggressive behaviour

Extensively D
Requires observation for reoccurrence and intervention daily

Q12 Emotional Dependence

Extensively D
Resident has no family or friends and relies on staff and work colleagues for emotional support.

Q13 Danger to self or others

Extensively D
Resident is a heavy smoker

Q14 Other behaviour

Extensively D
Resident exhibits inappropriate behaviour requiring staff to observe for the behaviour and remind resident of social etiquette to manage the issue in a more socially acceptable manner.

Q15 Social and Human needs – care recipient

Major Support C
Resident does not have nil family or friends and relies heavily on staff for socialization.

Q16 Social and Human needs – families and friends

Major Support C

Q17 Medication

Major assistance *C*

Resident requires assistance with the administration of regular and prn (when required) medications

Q18 Technical and Complex nursing procedures

Major assistance *C*

The resident requires technical procedures at this time

Q19 Therapy

Extensive support *D*

Resident has a physiotherapy directed exercise plan and is reviewed by the physiotherapist as required. Staff prompt and encourage resident to undertake the exercise plan to maintain his current level of function.

Q20 Other Services

No Support *A*

The resident requires no other services at this time.

Question	**Level of Support**	**Score**
1	C	0.36
2	B	1.19
3	B	0.67
4	D	14.61
5	B	5.98
6	C	3.82
7	C	5.72
8	C	1.11
9	A	0.00
10	D	4.60
11	D	3.05
12	D	3.84
13	D	1.98
14	D	2.61
15	C	1.98
16	C	0.55
17	C	8.55
18	C	5.54
19	D	7.01
20	A	0.00
	Total score	**73.17**

ACFI Question	Score	Value
1	B	0
2	B	0
3	C	7.89
4	C	6.11
5	C	0
ADL total	**LOW**	**14**
6	B	6.98
7	A	0.00
8	C	14.10
9	C	15.40
10	A	0
Behaviour total	**MED**	**36.48**
11	B	0
12	B	1
CHC total	**LOW**	**0**

The ACFI classification for this resident would be Low/ Med / Low, the per diem funding for this assessment is $57.29.

Thus for this resident, based on their current care needs the difference in funding between the RCS of $113.55 and ACFI of $57.29 is **$56.26 per day** or over $20,000 per annum. This amounts to a 50% reduction in funding.

The impact of this on resident care and lifestyle is extensive and potentially detrimental. The extra funding could be used for example: in the development of a 1:1 activity plan to assist provide the resident with socialization and interests outside work which would in turn improve the behaviours that have a negative impact on others and serve to further isolate this resident from the resident community.

Case Study: Comparison Funding RCS Vs ACFI

Abstract:

The aim of this case study is to demonstrate that the current method of resident classification and thus care funding the Aged Care Classification Scale
(ACFI) has had a negative funding impact especially for residents with special emotional, mental and social health needs in comparison to the previous Resident Classification Scale (RCS).

The method included the review of the resident's medical and care history and completing both an RCS assessment and an ACFI assessment based on his current healthcare needs, with consideration where able (within the parameters of the funding scale in use) his past history and health issues.

Findings:

Resident:	54 year old male
Primary Health Issues :	Chronic Alcohol Abuse
Past History:	Schizophrenia Epilepsy L CVA (Severe haemorrhage) 1990 Peripheral Neuropathy Tobacco Abuse Pancreatitis 2000
Current History	Intermittent acute psychoses Tobacco withdrawal Depression, (related to self blame when occasionally consumes alcohol) Intermittent agitation, (often on weekends – boredom, unable to occupy self)
Social History	Admitted to RACF (Hostel) in **2002** as unable to Care for self in the community Brother is NOK, not in regular contact Works 5 days per week in a disability supported workplace

Initial symptoms and self care deficits when admitted to the Hostel:

- Ataxia, mild (R) hemiplegia
- CNS disturbances – impaired alertness, extrapyramidal reactions, tardive dyskinesia
- On going intoxication (frequent falls, malnutrition)
- Refusal to comply with physiotherapy (non use of mobility aid)
- Constipation (poor nutrition and hydration status)

Under RCS, the resident is classified as a RCS 6 and receives $36.38 per day.
Under ACFI, the resident is classified as a Nil/Med/Nil and receives $14.11 per day. This amounts to a gap of @22.27 per day or over $8,000 per annum.

Commentary:

2007:

Alcohol abuse escalated to severe intoxication each afternoon with resultant antisocial behaviours, faecal incontinence and frequent falls. He had very little insight into his destructive lifestyle or how his behaviours impacted on others.

With support of his brother, staff attempted to discuss with the resident his alcohol abuse and ways of preventing subsequent issues. Resident decided his drinking could not continue therefore together with staff began exploring ways of preventing him drinking alcohol. A plan was developed with the manager whereby he agreed not to purchase or consume alcohol nor procure it from other residents. Staff would provide him with 2 glasses per day. Other avoidance strategies were also decided upon.

2008 - 2009:

Doctor discussed a residential detox program with the resident; he was therefore referred to Psych Services for assessment. Blood alcohol levels (BAL) were to be taken daily to establish pattern and thus clearer picture of alcohol consumption. Neuro-psych assessment undertaken and psych nurse continued daily BAL and counseling, discovering repetitive themes of unhappiness. Intermittent episodes of intoxication were reported during this time.

Management plan for detox developed with psych nurse and resident for inpatient detox program admission at de Paul House (St Vincent's Hospital). He then received an admission date for inpatient detox. When he returned from the detox program he said it had gone well.

Relapse prevention strategies were developed with the Psych Nurse. He subsequently was referred through community services to a local Acute Brain Injury (ABI) support group and commenced at the ABI men's group. Physiotherapy review was organized to assess his need for mobility aid and to assess his walking in general since giving up the alcohol. The Physiotherapist reported improved mobilization and recommended resident trial using his mobility aid at his discretion. He continued at men's group 2 days per week and began exercising with a personal trainer 2 days per week to assist with regaining muscle strength and mobility.

Doctor reviewed and made changes to the resident's medications e.g. ceasing vitamin supplements as resident's nutritional intake improved since ceasing alcohol consumption. Ceased anti-epileptic meds as no fits for many years. Some problems with insomnia though this had been an occurrence pre detox also. Some behavioural challenges continued at times but these are attributed to cognitive changes post CVA rather than intoxication.

Resident's brother organized an interview at a local disability supported workplace which resident attended and was given a position 3 days per week. Staff facilitated this by organizing a packed lunch to be supplied from the kitchen and modified his care plan to ensure staff assisted him get up and ready in time for work.

Some inappropriate behaviour (verbal) continued but no alcohol consumption. He then commenced working 5 days per week and he reports that he now feels as though he is some value to society. On all but a few occasions he was polite and responsive to the needs of others. He developed friendships with other residents that were not based on the acquisition and consumption of alcohol. Instead he often runs errands for other residents on the way home from work which has increased his feelings of belonging and usefulness.

2010:

Resident has suffered episodes of acute psychoses triggered by feelings of guilt when he occasionally has a drink which escalates to excessive consumption of alcohol, depression evidenced when he occasionally opens up and talks about – feeling of guilt for 'wasting his life'. He also decided that as he had obtained new teeth (partial plate) and could finally smile without embarrassment that he should give up smoking. While this was a positive health outcome his mental health has been affected detrimentally due to an increase in stress and anxiety.

Using the Resident Classification Scale (RCS) to assess and classify this resident:

RCS Assessment (based on current condition and care needs)

Q1 Communication

Major difficulty C
Staff are required to spend additional time listening and allowing resident time to process information. This is especially important for complex communication where the resident is required to process multiple pieces of information and then make a decision based on this information.

Q2 Mobility

No Assistance A
Resident usually requires no assistance, though occasional supervision due to ataxic gait.

Q3 Meals and Drinks

No Assistance A
Resident eats and drinks independently when meals are provided.

Q4 Personal Hygiene

Some assistance B
Resident requires some assistance with grooming and shoe laces.

Q5 Toileting

Some assistance B
Resident needs prompting and reminding to attend to post toilet hygiene. Staff set up toilet for ease of in/egress

Q6 Bladder Management

No Assistance A
Resident is continent of urine

Q7 Bowel Management

Major Support C
Resident is continent of faeces but requires a bowel management plan to prevent constipation – encouraging fluids, pear juice and prunes, ensuring a high fibre diet and regular exercise. Resident is prescribed the aperient Movicol on a when required basis. Staff monitor and record bowel movements daily and continence advisor reviews care plan annually / when required.

Q8 Understanding and undertaking living activities

Some Difficulty B
Resident requires prompts and reminders to remember, understand, plan and initiate activities especially of the social interaction nature but including to a lesser extend personal hygiene.

Q9 Problem Wandering or intrusive behaviour

Occasionally B
Resident occasionally requires cues and prompts to remember social boundaries and etiquette.

Q10 Verbally disruptive or noisy behaviour

Extensively D
Resident is frequently verbally disruptive, especially at meal times and when he has to wait is very impatient. Observation and interventions are required daily.

Q11 Physically aggressive behaviour

Occasionally B
Resident has a history of recent intermittent psychotic episodes where his behaviour has been physically threatening towards staff

Q12 Emotional Dependence

Regularly C
Resident has few family or friends and relies on staff and work colleagues for emotional support. On the weekends when he is not working he can become attention seeking and manipulative to gain staff time and interaction or can become withdrawn and start drinking alcohol.

Q13 Danger to self or others

Occasionally B
Resident has experienced psychotic episodes triggered by binge drinking. Though he denies alcohol consumption to staff, when breathalysed shows highly positive readings. Resident has expressed suicidal ideation on these occasions.

Q14 Other behaviour

Regularly C
Resident exhibits inappropriate sexual behaviour requiring staff to observe for the behaviour and remind resident of social etiquette to manage the issue in a more socially acceptable manner.

Q15 Social and Human needs – care recipient

Major Support C
Resident does not have many family or friends and relies heavily on staff for socialization especially on the weekends. Resident requires social activities which do not trigger his addictions – alcohol, tobacco and gambling.

Q16 Social and Human needs – families and friends

No Support A
Resident's brother infrequently contacts staff and does not require support.

Q17 Medication

Some assistance B
Resident requires assistance with the administration of regular and prn (when required) medications

Q18 Technical and Complex nursing procedures

No Assistance A
The resident requires no technical procedures at this time

Q19 Therapy

Some support B
Resident has a physiotherapy directed exercise plan and is reviewed by the physiotherapist as required. Staff prompt and encourage resident to undertake the exercise plan to maintain his current level of function.

Q20 Other Services

No Support A
The resident requires no other services at this time.

Question	Level of Support	Score
1	C	0.36
2	A	0.00
3	A	0.00
4	B	5.34
5	B	5.98
6	A	0.00
7	C	5.72
8	B	0.79
9	B	0.80
10	D	4.60
11	B	2.34
12	C	1.50
13	B	1.11
14	C	1.82
15	C	1.98
16	A	0.00
17	B	0.79
18	A	0.00
19	B	3.64
20	A	0.00
	Total score	**36.77**

Thus according to Schedule 2, Classification levels, (section 9.17) Classification Principles 1997 this resident would be classified as RCS level six, aggregate figure range of (28.91 – 39.80).

The per diem funding for a RCS 6 saved rate is $ 36.38

Using the Aged Care Funding Instrument (ACFI) to assess and classify this resident the following is established:

ACFI Based on current condition and care needs:

Mental and Behavioural disorders checklist:

550B Psychoses e.g. schizophrenia, paranoid states
580 Other mental and behavioural disorders e.g. due to alcohol or psychoactive substances (includes alcoholism, Korsakov's psychosis, adult personality and behaviour disorders.

Medical Diagnosis Checklist:

0915 CVA – ataxia, visual disturbances
0606 Degeneration of CNS due to alcohol
1714 Abnormalities of gait

ACFI 1 Nutrition

1. Readiness to eat 0 independent
2. Eating 0 independent

ACFI 1 Rating A

ACFI 2 Mobility

1. Transfers 0 independent
2. Locomotion 0 independent

ACFI 2 rating A

ACFI 3 Personal Hygiene

1. Dressing and Undressing 0 independent
2. Washing and drying 0 independent
3. Grooming 1 supervision

ACFI 3 rating B

ACFI 4 Toileting

1. Use of toilet 0 Independent
2. Toilet Completion 1 supervision

ACFI 4 rating B

ACFI 5 Continence

Continence assessment summary
3-day Urine Continence record ☑
7-day Bowel Continence record ☑
Continence Checklist
1 No episodes of urinary incontinence
5 No episodes of faecal incontinence

ACFI 5 rating A

ACFI 6 Cognitive Skills

Psychogeriatric Assessment Scales – Cognitive Impairment scale: 6.8 ⇨ score 4
Cognitive skills checklist:
2 Mild impairment PAS = 4-9 including a decimal fraction below 4
ACFI 6 rating B

ACFI 7 Wandering

Trying to get into inappropriate places ☑ 7.3
Item 2 problem wandering occurs at least once in a week.
ACFI 7 rating B

ACFI 8 Verbal behaviour

Verbal disruption of others ☑ 8.3
Item 3 verbal behaviour occurs at least six days in a week
ACFI 8 rating C

ACFI 9 Physical Behaviour

Physically threatening or doing harm to self, others or property ☑ 9.2
Socially inappropriate behaviour impacts on other residents ☑ 9.3
Item 2 Physical behaviour occurs at least once in a week
ACFI 9 rating B

ACFI 10 Depression

Cornell scale for depression ☑ 10.2 score = 8
Symptoms of depression checklist item 1 CSD 0-8 minimal symptoms
ACFI 10 rating A

ACFI 11 Medication

Medication checklist item 4 needs assistance for less than 6 minutes per 24 hr period with daily medications
ACFI 11 rating B

ACFI 12 Complex health care

ACFI 12 rating A score of 0

ACFI Scores and Categories:

ACFI Question	Score	Value
1	A	0
2	A	0
3	B	7.89
4	B	6.11
5	A	0
ADL total	**NIL**	**14**
6	B	6.98
7	B	5.91
8	C	14.1
9	B	7.70
10	A	0
Behaviour total	**MED**	**34.69**
11	B	
12	A	
CHC total	**NIL**	**0**

The ACFI classification for this resident would be Nil / Med / Nil, the per diem funding for this assessment is $14.11.

Thus for this resident, based on their current care needs the difference in funding between the RCS of $36.38 and ACFI of $14.11 is **$22.27 per day**. This amounts to a shortfall of $8,000 per annum or a 60% reduction in funding.

The impact of this on resident care and lifestyle is extensive and potentially detrimental. The extra funding could be used for example: in the development of a 1:1 activity plan to assist provide the resident with socialization and interests outside work which would in turn improve the behaviours that have a negative impact on others and serve to further isolate this resident from the resident community.