# SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
# INQUIRY INTO AGED CARE

ACAS Victoria is the peak body for Aged Care Assessment Services (ACAS) in this state. A major responsibility of the group is to facilitate consistency of best practice and quality service across all 18 ACASs in Victoria. It has led the way with a proven track record of a systematic approach to comprehensive assessment. This is achieved through providing an independent, autonomous, client focused view, that identifies the needs of older people as well as gaps in available service provision. Our role affords us input into planning on both a regional and state-wide basis, and we welcome this opportunity to present this submission to the inquiry. Our submission will respond to parts (a), (c), (d) and (e) of the inquiry's terms of reference.

**(a) the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;**

**<u>Ageing in Place</u>**

Victorian ACAS's are concerned about the possible ramifications of the recent changes in the 2004 Budget, which allow Ageing in Place without the input of Aged Care Assessment Services. ACAS Victoria acknowledges the change will remove the stressful relationship between ACASs and aged care homes, resulting from funding for ageing-in-place residents being dependant on our approval of these residents as eligible for high level care.

However, ACAS input at the point of reclassification from low level to high level care gave the opportunity for an independent, client focussed, face to face, expert evaluation of the resident's care needs at a point when it was perceived that their care needs had increased. This approach enabled all restorative opportunities to be explored for every client before high level care approval could proceed. The new arrangements do not require this to occur unless the client plans to move to a different facility. A resident who is ageing in place may stay at the one facility for some time before moving to a different facility, by which time any possible scope for improvement will have passed.

ACAS services have been involved in recommending strategies to assist with behaviour & care management, have identified scope for changes to medication and have facilitated rehabilitation opportunities at this juncture in the past. High care approval has also been time limited on some occasions in recognition that the client may have increased care needs at the time of assessment, while acknowledging that there is scope for improvement.

While the Resident Classification Scale monitoring role will be expanded under the new arrangements, it is unclear if the care needs of every resident with a high care classification will be reviewed. This auditing role in its present format does not include a face to face assessment of the client and relies on a review of the documentation that supports the high level classification. The ACAS assessment process includes a face to face comprehensive assessment of the client and their care needs in conjunction with supporting documentation.

While ACAS's would welcome referrals for clients who may benefit from an ACAS assessment if there is scope for restorative options, it is no longer guaranteed that this will take place appropriately under the new arrangements. All residents of aged care facilities should continue to have the opportunity for an assessment that is independent of the needs, perceptions and funding pressures of the facility in which they live.

**(c) the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;**

**Younger People with Disabilities**

Victorian ACAS's are grappling with an increasing number of referrals for assessment of younger people (under 65) for both residential aged care, and also for Community Aged Care Packages (CACPs). The ACAS target population are people over the age of 65, but our operational guidelines allow for ACAS to assess younger people who are considered to have special needs. For younger people with disabilities the Commonwealth Aged Care Assessment Program Guidelines state:

"In assessing whether younger people with disabilities should enter aged care homes, delegates should be aware of the Commonwealth's view that residential aged care homes focusing on the needs of aged people rarely, if ever, enhance the quality of life or offer the least restrictive accommodation option for younger people with disabilities. Entry to this type of care should have been approved only after all other care alternatives have demonstrably been exhausted."(ACAP Guidelines 2002 p.35)

Regardless of this approach, younger people with disabilities including mental health problems, intellectual disabilities, Acquired Brain Injury, Multiple Sclerosis, Huntington's Chorea, Cerebral Palsy and other degenerative conditions are routinely referred to ACAS because of a significant lack of more age-appropriate accommodation and community support options. The state government policy of de-institutionalisation of psychiatric and intellectually disabled clients without adequate planning and provision of supports for these clients as they age has accentuated this problem. Victorian ACASs have met with key staff from the Department of Human Service's Disability Service's teams to endeavour to progress development of inter-agency protocols around working arrangements between our two agencies. So as ACAS and Disability Services do all they can to ensure that all other care alternatives for younger people have been demonstrably exhausted, the situation we face is a growing gap between the number of younger people with accommodation and care needs and the supply of suitable options for them. The end result is that in many cases ACAS staff are reluctantly approving younger people for entry into residential aged care, or for a CACP to support them in the community. These outcomes limit the availability of services for the ACAS target population and result in younger disabled clients accessing aged care services that are not appropriately designed or funded for these special needs groups. It is also worth mentioning that ACAS are funded on their catchment's population of people aged over 70, and this presents a concern for future planning for the Aged Care Assessment Program if numbers of referrals for under 65 year olds continue to grow.

**Dementia Care**

The availability of good dementia care is another area of concern to ACAS. The incidence of dementia in people referred to ACAS is increasing, and this condition often "tips the balance" where services are trying to support people living at home. Often it reaches a stage where the carer of a dementia sufferer is no longer able to provide the care essential to keeping them at home, or in the case where there is no carer dementia frequently causes the sufferer to no longer be safe to remain at home. In these situations ACAS then face the challenge of finding appropriate residential aged care options. The limited supply of dementia care facilities, especially in regional Victoria, has forced clients and families to accept vacancies outside their towns and communities causing further isolation for these clients and distress for their carers. The adequacy of funding for dementia care facilities must be reviewed, as ACAS have observed residential aged care providers

close dementia specific units on the grounds that it is not financially viable for them to cater for people with advanced dementia and challenging behaviours.

ACAS are also of situations where an aged care home has gained status as a provider of Commonwealth funded services on the basis that they will offer dementia specific care, but in fact does not provide the level and type of care expected. There seems to be few guidelines about how this care should be offered, what additional training should be in place for staff and what environmental considerations should be made when planning a new building apart from providing a locked entrance. It raises the question as to what monitoring arrangements are in place to establish if the kind of care advertised is in fact offered to an appropriate standard. There can be wide discrepancies regarding the commitment to dementia specific care ranging from having a secure wing, to appropriately managing difficult and challenging behaviours in a supportive environment with a commitment to true ageing in place. It also appears that despite all the evidence of an increase in the number of elderly people with dementia, new facilities continue to be built without provision or consideration for the problems of managing clients with dementia.

**Extra Service Facilities**

Although not normally identified as a special needs group, the problems of accessing residential care faced by people on low incomes needs to be addressed. Across Victoria there appears to be an increase in the number of Extra Services places offered at Commonwealth funded aged care facilities. In these facilities accommodation bonds can be charged for low and high care plus additional weekly costs. The concern is that for those with lower incomes or those whose sole income is the pension these facilities are not accessible due to cost. This results in greater demand for those facilities that have a higher proportion of concessional places and increases the waiting time for residential care for those in the lower income bracket.

The share of beds in each region that are offered as Extra Service places needs to be carefully monitored and targeted to suit the socio-economic status of the region concerned to ensure that those without financial resources are still able to access care, and are not required to move outside their community or region to do so.

**(d) the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly;**

The Home and Community Care (HACC) Program continues to provide essential support to frail aged and disabled clients living at home. ACAS frequently receive referrals from, refer to and collaborate with HACC agencies, and are able to provide some observations of this important service network.

ACASs have observed a progressive reduction of flexibility in the provision of generic HACC services as provider agencies move towards setting limits on the number of hours of service clients can expect from the HACC system. This has meant there are now limits to HACC services for high needs clients that prevent them from remaining at home. These service limits are based on the funding constraints of the provider agencies and do not allow for the actual needs of the person. A current dilemma is that as HACC limit their service provision to older people there are gaps created in the service network. People needing high levels of service cannot access these beyond the set limit forcing them to consider residential care or other options such as a CACP or an Extended Aged Care in the Home (EACH) package. However availability of and eligibility for these packages is limited and so clients are inevitably forced towards the residential care option.

Decisions made by HACC agencies and government departments that limit the level of service available to older people who are eligible for CACP or EACH is also of concern. The strict

implementation by HACC providers of a full cost recovery policy for all clients on a Commonwealth funded package has severely reduced the value of being on a CACP or EACH package. Providers of packages are now paying full cost recovery for HACC services such as Planned Activity Group and Meals on Wheels that had previously been allowed to continue to be accessed by clients at HACC subsidised rates. This change from a flexible client focused approach to a fiscal focus has resulted in a loss of collaboration between agencies working together for the best client outcomes. This is also producing additional burdens on carers trying to cope with progressive disorders that do not match up with the criteria for a package or with the service limit available from HACC. It would seem that CACPs and EACH packages are now seen as a way of HACC providers offloading high user clients that in the past managed very well with HACC supports. The other side of this dilemma is that Commonwealth funded packages are not adequately resourced to afford all the services and equipment that clients need. Once admitted to a package the State versus Commonwealth argument over responsibility begins and clients are caught in the middle as they become ineligible for HACC or state funded programs like Aids and Equipment Program.

The increasing availability of EACH packages to maintain support for those with higher complex needs is a positive step to provide the option of remaining at home however this would need to increase significantly. The community is becoming more aware of this option and the expectation is that packages will be readily available to support their needs and provide real choices.

**(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.**

**Hostel staffing**

Of major concern is the availability of Division 1 Registered Nurses in Hostel or low care accommodation. Presentations of older people at Emergency Departments in public hospitals continue due to limited nursing expertise available to manage the situation at the low care facility or influence the decision to transfer and admit to hospital. There are also duty of care issues that impact on the decision to return a client with high care needs to a low care facility that may not have the appropriate staff skill mix to manage the care. An accommodation model that provides for access to Division 1 Registered Nurses would address this concern.

**Convalescent Care**

The pressures on the acute hospital sector to reduce length of stay for older people have become problematic. Those patients requiring recuperative or convalescent care until rehabilitative therapies can commence, after orthopaedic surgery for example, become temporary placement issues particularly where the client is non-weight bearing. It is not appropriate to use aged care respite to support convalescence as the client, when returning to the community still needs to have the option of respite care to be available. Flexibility in providing transitional accommodation needs to be explored. Patients who can afford it are placed in Supported Residential Services, while others without available financial resources continue in the acute system or may even be discharged home despite considerable risks if carers are convinced to accept this.

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