Review of services for older people
Brotherhood of St Laurence

Discussion Paper 2
Residential care: hostels and nursing homes

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BROTHERHOOD
BROTHERHOOD OF ST LAURENCE

CONTENTS

RESIDENTIAL CARE

Introduction

In 1946, the G K Tucker Settlement at Carrum Downs was converted into a settlement for elderly people. It was the first step towards the establishment of the Brotherhood's program of residential care, and of Fr Tucker's vision for older people of security, activity and the incentive to keep going. The accommodation was for active elderly people, able to care for themselves in independent units, and was duplicated at St Laurence Park, Lara (1958) and to some extent in the Keble Court flats, Brunswick (1961).

As the first groups of residents aged, supportive domestic services were developed in 1969 to help maintain residents in their units for as long as possible. Cox Court was the first of the residential care facilities established to house 30 people in serviced flats. Nursing units at Lara and Carrum Downs were available for temporary illness and convalescence following illness and permanent nursing home beds were only available at Carinya in Box Hill.

Today, in three regions, the Brotherhood runs a series of integrated aged care facilities, designed to ensure total care for its client group. Residential care now provides support, personal care and nursing services for people who require the various levels of support. These services have been targetted at the most needy of the aged population, especially those on pensions and without assets. However, the pattern of need is changing; there is an increase in some categories of need (i.e. dementia) and an increasing number of older people who are multi-disadvantaged and government policy changes have changed the continuity of care approach.

The purpose of this discussion paper is to describe the changes which have been and are occurring, discuss their implications for Brotherhood hostels and nursing homes and canvass options for future planning for these services.

The first section of the paper describes the key external policy changes for residential care of the past decade: the national aged care reform agenda; State government policies for health, geriatric centres and deinstitutionalisation; and the direction of other service providers.

The paper's second section examines issues of particular importance to Brotherhood hostels and nursing homes. These include:

- ways in which existing hostel and nursing home buildings could be modified to better provide for residents' needs;
- whether continuity of care is a concept the Brotherhood wishes to preserve;
- how hostels and nursing homes are best staffed;
- how the quality of life and service for residents could be improved;

- whether the Commonwealth's definition of financially disadvantaged person adequately reflects the circumstances of Brotherhood residents; and

- what progress has been made in the implementation of the Brotherhood's Quality of Life program.

The Review decided to produce a separate discussion paper on residential care (and then papers on community care and low-cost and supported housing), because the experience of living and working in and managing a hostel or nursing home raises many common issues. However it is important to stress that the Review is viewing each service as part of the Brotherhood's whole involvement in services for older people and is keen to discuss ways in which different types of services — day centres, Linkages, respite services, hostels, nursing homes, villages, flats, rooming house — can work more closely together and share good practice.

The external context

Federal Government policy

Following the Commonwealth Government's Nursing Homes and Hostels Review (Commonwealth Department of Community Services 1986), the Aged Care program has undergone major reform. This reform has seen the introduction of needs-based planning for residential care. The Aged Care Strategy has been to restrict nursing home entry to the most dependant, and to ensure that hostels provide a range of hostel and personal care services for the frail elderly who are assessed by Aged Care Assessment Teams as requiring personal care and support. The shift in resources between residential and community care has resulted in an expansion in Home and Community Care (HACC) services (which will be discussed in the paper on community care) and containment of residential care. To control what was seen as inappropriate admission, hostel places have increased whilst nursing home growth has been limited.

The ratio for nursing home beds is 40 beds per 1000, 70 years and over. Hostel and Community Aged Care packages provide 60 places per 1000, 70 years and over (5.2 places Community Aged Care Packages).

The gaps, or surplus in residential care will be discussed in the paper profiling the needs of low-income older people in each Brotherhood service region.

This arbitrary figure does not take into account the rapid ageing of the older population and the associated increases in frailty. There is anecdotal evidence that suggests that both nursing homes and hostels in some areas have long waiting lists.

Private hostels who receive recurrent funding from the Federal Government have entered the market and are beginning to offer people with means a way of buying themselves out of the queue. The people who are least likely to gain access to residential care when demand is high are those with multiple disabilities and financial disadvantage because of the higher level of resources required and the ability to pay only the minimum fee for service.

The Age Care Reform Strategy (Commonwealth Department of Health, Housing and Community Services 1991) has also involved major changes to the funding of residential care, particularly nursing homes.

Nursing homes

The Commonwealth Government provides financial assistance to Nursing Homes according to five categories of dependency. The funding is provided in two parts; the care aggregated module (CAM) which funds direct care; and the standard aggregated module (SAM) which funds cleaning, domestic duties, catering etc.

A review of the structure of nursing home funding (Commonwealth Department of Health, Housing and Community Services 1993) has recently been undertaken by Professor Bob Gregory to examine opportunities to enhance the viability and efficiency of Australia's nursing home industry while maintaining the quality of care received by residents. The first stage of the Review has proposed options for modifying the funding system in line with recent industrial relations changes and for maintaining and replenishing nursing home stock. It seems that there will be little change to the funding system and only minor impact on the industry. One modification may be a flexible fee structure, similar to hostels.

The second stage of the review will:

- examine the effectiveness of capital funding arrangements in providing incentives for infrastructure upgrading and replacement of nursing homes and consider options for the long-term financing of residential aged care in general; and

- examine the interaction of the nursing home funding system with the hostel capital funding system and the regulation of hostel resident charges.

Hostels

The Hostel Personal Care subsidy was restructured in 1992, to better target funding to residents with high levels of physical or mental frailty. The subsidy rates include funding for personal care services and for people with dementia. These rates will have replaced the old dementia grants by July 1994.

However, both nursing homes and hostels continue to argue that the funding for residents with dementia does not meet the cost of providing high quality services and resources required for people with dementia in either integrated or dementia specific facilities. Some dementia specific units are likely to close because of the lack of adequate funding

Stage two of the Gregory Review will examine the need for hostels to employ a registered nurse on their staff in recognition of the high frailty levels and increased dependency. The impact on the hostel funding system and the cost of this requirement to hostels will also be examined.

Dementia care

The needs of older people with dementia has been a particular priority of the Age Care Reform Strategy. The National Action Plan for Dementia Care (Commonwealth Department of Health, Housing and Community Services 1992) estimates that half of those with moderate to severe dementia are in residential care, with nursing homes accommodating one-third of this number. In the Dementia Hostels Study (Rosewarne & Bruce 1992) it was reported that some 20 per cent of residents in hostels have moderate to severe cognitive impairment.

Attention needs to be given to the development of dementia care in both mainstream and dementia specific residential services to respond to the continued increase in numbers of people with dementia.

The Inquiry into Mental Illness (Burdekin 1993) heard consistent evidence that people with dementia in institutional care should be separated from people who are not cognitively impaired. Burdekin recommends that residents with severe ambulant dementia should not be admitted to nursing homes, or hostels where the layout cannot accommodate their need to move around, and that purpose-designed dementia facilities should be built.

The Burdekin report and the Aged Care Reform Strategy have also both discussed the needs of older people with a psychiatric disability. The result of the State policy of mainstreaming and deinstitutionalisation is that an increasing number of older people who are multi-disadvantaged are seeking entry to residential care.

Implications for Brotherhood services

The net result of these national funding and program changes for Brotherhood services is that the Brotherhood's residential care facilities now give higher priority to residents with high dependency. In effect, financial disadvantage is considered only after sufficient funding levels are ensured through dependency levels.

This means that the continuity of care Brotherhood facilities were designed to provide can no longer be guaranteed. In particular, the nursing homes are less likely to admit residents from Brotherhood accommodation than in the past when beds could be 'reserved' for residents thought to be moving towards nursing home care. In the cases of Carinya and Flinders Lodge, many residents have now not had to pass the low assets test applied to other accommodation.

Staff who have worked in residential care for some time are very aware that residents today are frailer, more dependent and more confused: this was the Reform Strategy's intent. In the words of one staff member:

> The hostel today is more like the nursing home used to be and the nursing home is more like a hospice.

Over the last decade staff have therefore been challenged to re-define the length and nature of their relationships with residents and the care they provide. Many staff have worked for the Brotherhood for many years.

Table 1 Percentage of staff with 10 or more years service

Facility	**% of staff with 10 or more years service**
Nursing homes	
Flinders Lodge	32
Broughton	26
Carinya	15
Hostels	
Cox and Collins Courts	17
Hume Court	12
Sambell Lodge	8
Sumner House	N/A

For example, one-third of staff at Flinders Lodge have worked there for 10 or more years. The Brotherhood's training programs have aimed to assist these staff cope with residents' increased frailty and changing ideas about good practice.

The Brotherhood's Quality of Life project preceded the Commonwealth's introduction of user rights' initiatives and programs to ensure quality of care. The program changes and staff training which developed from that project have assisted the Brotherhood to meet the Commonwealth's outcome standards. The issue for the next decade is how the Brotherhood can consolidate this effort and improve standards which are now regarded as industry averages. This issue is discussed in a later section.

The Brotherhood does not provide any specific residential dementia care program, though the management of residents in general hostels and nursing homes with moderate to severe dementia is a pressing issue. For example, Sumner House, providing hostel accommodation for older people predominantly with few strong family ties, has 72 per cent of residents with some cognitive impairment. (The older person with dementia is more likely to be able to stay at home in the community if there is a carer who lives with them. Lack of family support could be one of the reasons for the higher than average number of residents with cognitive impairment at Sumner House.)

The Burdekin report on mental illness is also a timely reminder that dementia is not the only mental illness experienced by older people. Increasingly, older people seeking to live in Brotherhood accommodation in the Metropolitan region have a psychiatric disability. The management of residents with such disabilities requires appropriate staff training and considerable skill. Without specific staff development and a carefully designed and integrated program, the quality of life for all residents will be affected.

State Government policy

Health

There has been a great deal of concern about the likely impact on older people of the new case-mix funding of Victorian hospitals.

This concern centres on the funding formula which it is argued does not take adequate account of the fact that older people often develop multiple conditions and heal more slowly (Draper 1992). As a result, older people are likely to be discharged from hospital with high care needs. Nursing homes and hostels argue that they are not well equipped to deal with the higher level of care required.

The outcomes of the new funding system are not yet clear. However, older people have been vulnerable to poor discharge planning from hospitals for many years. All Brotherhood service managers have anecdotal evidence about residents returned from hospital without notice late on a Friday afternoon, with care needs which assume nursing staff will be on weekend duty.

Discharge planning and adequate post-hospital services are therefore critical elements in the new health policy for older people. Residents have requested that the Brotherhood provide convalescent facilities at Carrum Downs and Lara to meet their need for care during a brief illness or following hospitalisation. This request is discussed in a later section.

Geriatric Centres

The State Government's Aged Care policy, announced that Geriatric Centres would increasingly focus their activity on acute and rehabilitation services. The number of nursing home beds in these facilities will gradually be reduced.

The Government hopes that this new focus will reduce the number of older people awaiting elective surgery.

The back wards and nursing home beds of State Centres such as the Kingston Centre have traditionally been home to older people with disabilities and behavioural geriatric problems. The reduction in State nursing home beds from one-third of Victoria's beds to 10 per cent, will mean that more community providers will need to provide this care and will have a much reduced referral point for 'difficult' residents.

Deinstitutionalisation

A common theme in each of the Review's papers is the effects of the relocation of people with psychiatric and intellectual disabilities from large segregated state residential care to smaller facilities, nursing homes, boarding houses and family care. Now living out in the community, many are part of the Brotherhood's traditional target group: they approach later life with low incomes, few assets and limited family support.

As mentioned earlier, this is already providing a service delivery challenge, particularly to the Brotherhood's services in Fitzroy.

Other service providers

Residential aged care has been substantially provided by non-profit organisations (mainly church based) and private for profit businesses.

Over the last decade many non-profit providers have become involved in community care. The Brotherhood has been part of this trend.

In Victoria, more local governments — major suppliers of community care — have built hostels and nursing homes, or supported local organisations to do so. There is clearly a trend to greater plurality of service provision (Wilson 1994).

However at the same time many service providers are targetting their services at older people with means. Only a few of the residential services operated by benevolent and charitable organisations specifically target financially disadvantaged people (e.g. St Vincent de Paul; Salvation Army; Wintringham).

ISSUES

The common themes in this section of the paper are standards of service and the need for more funding over and above that provided by the Commonwealth. Sometimes these themes are mutually inter-dependent, as in the discussion of the ways in which hostel and nursing homes could be re-developed to better meet the needs of residents. Often times however, the standard of service is much more a matter of the attitudes of staff and the model of care employed by a service. There are therefore a range of possible actions which would continue to improve life for residents in hostels and nursing homes without requiring a great deal of extra funding.

Hostels — buildings

The BSL hostels were all developed during a period of high building costs at a time when the majority of residents required hostel care services only. Although the facilities in the hostels at Carrum Downs and Lara included en suites, most residents in the Metro hostels share bathroom facilities. During the staff consultations it was commented by one long-term staff member that the difference in design was intentional as the Metro client group did not need private facilities. In 1992 a review of selected facilities was undertaken by Richard Oliver International (Oliver 1992) to assess the building life safety standards. Key risk exposures for residents in regard to fire and other emergency situations were identified. One of the strong recommendations of this report was that no disabled person is housed above the second floor in any residency. Access for residents who are wheelchair dependent is restricted in Sumner House even on the lower floors. Toilet doors have been replaced with curtains in some instances to enable wheelchair bound residents the dignity of using the toilet independently with an attempt to maintain some privacy.

Although care is taken with new admissions and placement of residents who may be at risk, if the guidelines were taken literally residents eligible for hostel care only would be housed above the second floor.

A consequence of the Richard Oliver recommendation is the added restriction on admission which affects income in terms of dependency levels.

Guidelines for building life fire purposes suggest a person with a disability would be a resident who cannot respond independently to an alarm or warning due to the following impairments:

- loss of hearing
- loss of sight
- loss of limbs
- loss of cognitive function
- being unable to move without appliances or assistance.

The hostels at Lara and Carrum Downs present different problems for people who are frail and have mobility problems. Both have been built with a central focus (dining room and lounge) at a considerable distance for many residents. The varying levels at Lara are an additional barrier to independence in mobility for the very frail.

The exposed balconies of Hume Court and Sumner House, though pleasant to look at or from, have very limited recreational use because of the cold in winter and heat in summer. Residents do not use these areas to socialise except in perfect weather conditions or to have a cigarette.

None of the hostels were built to securely house a resident with dementia who wanders. Whilst some protection may be afforded by the nature of the surroundings at Lara and Carrum Downs, this is not the case in Metro.

Nursing home — buildings

Flinders Lodge, at Lara, is the only purpose-designed nursing home, and was built during the period that suggested that shared wards and central facilities were best. Except for two single rooms, the accommodation is 4-bed ward style. The other two nursing homes are converted houses offering accommodation varying from single rooms to six-bed wards. Shared accommodation reflects and emphasises the medical model of care, instead of the personalised individual care that is more easily practiced within the confines of a single room. The size and style of the bathrooms at Carinya and at Flinders Lodge lends itself to abuses in the area of privacy, and structurally, is being, or has been addressed at all three facilities.

Carinya is unable to use the lifting machine in some of the bedrooms and during the consultation, staff at Broughton said they could not lift safely because of lack of space. The high level of staff injuries were reported to be caused by poor staff facilities, resources and restricted space.

Joint issues — buildings

None of the nursing homes or hostels are able to manage ambulant dementia residents separately from the very frail, and this obviously presents difficulties and causes tension to develop amongst residents, families and staff. As stated above, residents who wander are not able to be cared for safely and securely.

Choices and variety in areas for socialisation, activity or privacy is limited, though Cox and Collins Court has a good activities area, and Broughton has increased its communal and activity area in recent upgrading. However, the other facilities offer activity and dementia programs in corridors, disused staff accommodation, shared sitting rooms and occasionally dining rooms when a reasonable space is required. Such making-do restricts the range and type of activities offered, the numbers who may be involved and the satisfaction or enjoyment gained by residents and staff.

The design of residential care facilities has now moved away from the medical model that encouraged and emphasised the clinical environment. Today the building design creates a

home-like environment and enables residents as much as possible to maintain their individual identity.

New nursing homes and hostels are now being built as small cluster units. Personal accommodation is designed to provide for privacy and to support and encourage independence with access to communal space and social interaction.

All of the Brotherhood's residential facilities are limited in their design. They may not meet the standards required to provide private and personalised accommodation, nor promote social interaction. Work practices are in some instances affected by the design of the accommodation.

Should the Brotherhood bulldoze the lot and start again, or can we by using the design principles outlined above, modify the buildings to achieve these outcomes? For instance, all of the hostel programs could be developed by 'floor' or by 'wing' on the cluster model: particularly at the Courts at Lara and Carrum Downs. The 'wings' would enable frail residents to be cared for separately from residents who have moderate to severe dementia. Because of the shared bathroom facilities in the Metro hostels, the ideal situation would be to reduce resident numbers so that each bedroom would have its own private bathroom and sitting room — or large bed sitter. Another option for the Fitzroy site would be to develop Millott House as a dementia specific hostel (10 beds), maintain the ground and first floor at Sumner House as hostel beds providing personal care services to residents with varying degrees of frailty and develop the top two floors as rooming house accommodation. The independent living units (flats) in Palmer Street could be utilised as hostel beds under the Community Aged Care packages as these units were required or as this level of care was required.

Re-designing the nursing homes on a similar model is not so straightforward. Carinya has more potential than Broughton or Flinders Lodge to establish separate 'wings' or clusters.

Hostel services

All residential facilities need to maintain a balance in the degree of frailty and personal care needs of clients. Staffing levels are maintained to ensure a good quality of life for all residents. Hostels will tend to admit clients whose care needs are low whilst maintaining the resident who is becoming more frail and whose needs are more extensive. They will also maintain a person with moderate and often severe dementia who may wander, but is managed well because they have lived in the hostel for some time; the environment is familiar, and the other residents are often willing to offer their support because the person is known to them. A new resident suffering from dementia who may have behavioural and wandering problems is less likely to be admitted to any of the hostels.

To maintain good standards of care within the constraints of a budget determined by government-set subsidies and fees, and a few low ingoing donations, most facilities will admit residents who will not stretch the resources of staff and budget any further.

Nursing home services

The impact of the Brotherhood's policy to admit only residents who are categorised 1-3 on the Resident Classification Instrument, has resulted in a reduction of admission from existing BSL clients, or from the traditional BSL client group. Broughton is the only nursing home still giving priority to settlement residents with a focus on low income **and** low assets. At Lara, few residents from the 'Park' or hostel move into Flinders Lodge, though according to staff, the nursing home attempts to give priority to Lara residents who have been long-term supporters of the Brotherhood. Carinya may accept a BSL client if a vacancy coincides with the need for a placement and the dependency needs are high enough.

As with hostels, preference is given to residents with high dependency needs which attract a higher subsidy rate, and this criteria takes precedence over levels of income and assets.

Joint issues — services

A gap in service provision that has been identified in consultations in all of the regions is a program that will admit clients who have high personal care needs, or who otherwise may be categorised under the RCI as 4 or 5. Although all hostels have residents who are eligible for nursing home care, they are usually residents who have deteriorated over a period of time in the hostel, rather than residents admitted at the higher dependency level. Hostels tend not to admit clients whose care needs are high, and nursing homes also reject admissions from people in these categories because they do not attract sufficient funding. Similarly, older people suffering from dementia with behaviour and wandering problems are hard to place in BSL nursing homes and hostels.

Hostels should not be caring for older people who are in need of continuous nursing care unless this is of a temporary nature such as short-term illness, waiting placement in a nursing home or providing palliative care for a resident who is dying. Comments from staff working in dementia care suggested that people who have dementia and are ambulant frequently score 4 or 5 on the RCI and were consistently not being placed. The industry acknowledges that this group is falling between the gaps and is not funded sufficiently in hostels, and has lobbied for change in this area. To shift the cut-off between nursing homes and hostels and actually admitting residents who are now nursing home eligible would mean committing more resources to hostels to increase levels of care provided. At this point this does not seem a likely initiative from government.

Residents at Carrum Downs and Lara identified the need for convalescent or post-acute care. Although this gap was most strongly expressed by the residents at Carrum Downs, it was echoed by residents at Lara. Older people are fearful that case-mix funding will result in early discharge with less than adequate support in the community. Should the Brotherhood provide this service for their clients who live in independent living units? Convalescent care could be offered in hostels in addition to respite care but discussion is needed as to whether such a service response is practical and strategic. A service response suggested by residents during the consultation was the establishment of 1-2 convalescent beds in each hostel to offer temporary support services following acute care. Whether this is a role the Brotherhood should assume, or one that belongs in the area of health care, needs to be discussed. It raises the question of the Brotherhood's primary role in the care of

older people — is it health care or accommodation and support? Advocacy to ensure better post-hospital services in each Brotherhood region would be an alternative response.
In this area the Brotherhood needs to ensure that good discharge planning is occurring, and early or inappropriate discharge of older people from health services without suitable support must be monitored and responded to.

The Brotherhood nursing homes do not provide respite care and only three hostel respite beds are available; two at Hume Court at Lara, and one bed at Cox and Collins Court at Carrum Downs. The two Metro hostels do not provide respite care. One reason for Metro's exemption was that clients who were referrals for respite care were unable to afford the fee for respite care and the rental costs of their accommodation. During the consultations, staff from the community care areas and the dementia specific programs commented on the limitations of respite care by both the level of care and the number of rooms available. There is a need for emergency respite and respite care for people requiring high levels of care either because of severe frailty or severe dementia in all areas, but how to fund this service in Metro would need to be resolved. Funding does not seem to be an issue at Barwon or on the Peninsula.

The regional geriatric centres are usually able to be more responsive to the needs of emergency respite. The day centres caring for people with dementia are particularly concerned that the needs of their clients and their carers are not able to be met sufficiently. It would seem that St Laurence House and the Banksia Centre have the better resources and the environment to respond to the need for respite for people with dementia. The hostels are in a better position to offer respite for frail aged whose care needs are high. None of the regions have the infrastructure to be responsive to emergency respite. This service may be better left in the health system.

Continuity of care

Since the early days of the involvement by the Brotherhood in aged care, there has been a need and a promise to provide continuity of care. Resident agreements, including those for independent living units have stated that:

> The Brotherhood will accept moral responsibility for the welfare of the resident and that every reasonable effort will be made to find alternative accommodation.

The Brotherhood developed its own accommodation to provide this care.

This responsibility has usually meant that a resident is able to move from independent living units to hostel to nursing home within the Brotherhood as their care needs have changed. This has certainly been the expectation of residents with some encouragement from staff. Support services followed accommodation; nursing units provided for temporary illness and eventually nursing homes were established to enable residents to move from self-care to supported and total care as their needs changed.

Community Aged Care packages provide funding for older people to have hostel and personal care services provided in their own home. As many of the Brotherhood residents become more frail and require personal care services, we should be offering residents an alternative to moving into the hostels by providing hostel services in the independent living

units enabling people to have the service and care package brought to them. Currently no community aged-care packages are managed by the Brotherhood.

A further development of care packaging would be taking a care package to people who require nursing home care to them in their own homes. This model is being developed in South Australia.

Assessment and dependency criteria have meant we no longer guarantee continuity of care despite a strong expectation from residents that we should do so. There is a tension for staff between wanting to provide care to all individuals whose needs are high and the reality of a limited service. Directors of Nursing would interview a number of prospective clients, or their families for one successful admission. They turn away many people who may or may not fit the Brotherhood's criteria for admission.

As their services increasingly provide palliative care, staff are also questioning why they do not provide hospice care for all age groups, rather than focus on nursing home care for older people. This tension has developed because of the nature of the service that nursing homes now provide — nursing care for people in the last stages of life. Palliative care is provided within existing services to residents of hostels and nursing homes who choose to die in their 'home' instead of moving to a health care service if staff are able to provide the care required. Palliative care for people of all ages who are dying from an incurable disease such as cancer or AIDS is a separate issue and one which the Brotherhood is currently being asked to consider. A service response to identified local needs will shift the focus from what has predominantly been an accommodation service with support and care to health care with the focus on easing the pain and suffering associated with terminal illness. Ageing is not a terminal illness.

Staffing

A necessary component of a quality service is a competent and skilled staff team. The quality of staff will affect the service much more than the state of the facility itself, and attitudes may be more important than experience and qualifications. No matter how constrained we are by less than satisfactory buildings, the attitude of staff will affect the quality of life for residents more significantly.

Quality service is achievable, and it must be acknowledged that in all facilities practice is good and many staff strive to achieve a high quality service. Many changes have been made since the introduction of Quality of Life and Outcome Standards imposed by the Brotherhood and the Commonwealth. However, we need to keep in mind that these are minimum standards to be achieved — not optimum.

There is continued evidence of lack of quality service in all facilities. A major concern would be the lack of awareness that staff have of the control they exercise over all aspects of the residents lives. Most facilities have an established resident committee but some are disempowered through practice (control by staff; minutes not distributed prior to meeting; insufficient time for meaningful discussion; action not followed through to resolve issues).

- Few residents are consulted and involved in decisions about their care needs.

- Value judgments are made about what is best for an individual (alcohol watered down, or substituted for cordial).

Residents spoke about feeling rushed through their care by staff with one or more staff being involved in providing personal care (one to toilet; one to wash; one to dress; etc.). Instead of feeling like an individual, one felt just part of a process. Why the rush — is it to meet roster and staffing needs — the outcome being that many residents just sit around for the rest of the day.

How do we enrich the lives of residents in nursing homes and hostels?

It is important that we continue to focus on staff development and support to achieve high quality care, and not lose sight of the fact that practice and attitudes in the end are more important than the bricks and mortar.

Hostels have the flexibility to employ who they wish as currently there is no requirement to employ registered nurses or a specific ratio of staff to residents. Although many hostels employ Registered Nurses, they are frequently employed in a management position, and are less able to provide direct nursing care. The Review of the Structure of Nursing Home Funding Arrangements Stage Two (Commonwealth Department of Health, Housing & Community Services 1993) is considering the issue of registered nurses in hostels and the preferred position in the industry and one that should be supported by the BSL is that management should have the flexibility to decide how nursing care is provided, so long as the needs of the residents are met.

On the other hand, staffing in nursing homes is highly regulated and funded accordingly.

The very nature of nursing care and the institutional focus of the medical model is perhaps one of the greatest constraints in the provision of aged care. Nursing, as a profession has spread throughout aged care, yet nursing care is only one component of the support or services that older people may require. Nursing care may be essential, as is physiotherapy, occupational therapy and medical services at specific points in time, and when required must be met by appropriately qualified and skilled personnel. However it can be argued that older people are in the main not in need of nursing care full-time, whether they are in a nursing home or not, but may be in need of care that can be provided equally competently by staff with suitable expertise. It would seem that the medical model, including nursing care, tends to focus on ill-health rather than well-being; dependence rather than independence.

An alternative staffing model in all residential facilities. may be the attendant care model, where staff are multi-skilled and able to assist residents to maintain levels of independence, and provide only the care and support that each individual requires.

The largest number of staff employed in residential care are those that provide personal care. Whether it is nursing staff in nursing homes or personal care staff in hostels, the emphasis on personal care results in almost neglect of the psycho-social needs of residents. Activity programs and leisure activities have a low priority instead of being an integral part of the abundant life that residents should be enabled to maintain in residential care.

Staff who are multi-skilled would balance the different needs of residents, ensuring that the psycho-social needs are given the attention they deserve. Staff would work in small groups of residents:

- to involve residents with dementia in activities (personal care, leisure, domestic) that maintain their skills; and

- ensure that the quality of life for frail residents is enhanced by pursuing interests wherever possible.

The variety of tasks undertaken by staff and the greater involvement in the life of the resident would surely give staff greater job satisfaction if there was this shift from task orientation.

Nursing care would be provided only when it was necessary to meet the specific needs of the individual. This model has been successfully introduced in some nursing home facilities in South Australia, and by the MS Society in a small nursing home in Greensborough.

Volunteers are increasingly involved in service delivery and are an invaluable resource to enhance and extend services that are provided in residential care. In many facilities, paid and unpaid staff assume the role of family, particularly where there is limited, or no social support from the family or community.

Paid staff in excess of funding levels cannot be maintained, however the residential facility that is not able to rely on family support must provide additional services and resources to ensure that the quality of life is maintained, i.e.:

- assistance with recreation and leisure,

- accompany and transport to appointments (medical or social),

- shopping for clothes and essentials, and

- banking, or assistance with financial management.

However the staffing model as it exists, does not acknowledge these differences, and facilities are frequently compared with one another (often unfavourably) without taking these factors into account.

Dementia care is provided in hostels and nursing homes operated by the BSL. It is increasingly obvious that higher staff levels than those funded by government is required from time to time, depending on the needs of a particular client or group of clients. In a nursing home a person who is ambulant requires more resources and staff time than one who is bed-bound. These differences are not acknowledged through funding, and so are not usually responded to in practice. In hostels, a resident who wanders also makes more demand on staff time than one who is content to be involved in a daily program or activity within the hostel.

Different, or flexible staffing models need to be developed in these situations to reflect the different care needs and higher staff input than the levels that are currently funded.

The tasks undertaken by staff in residential care have changed enormously as government policy takes effect. At one level accountability to funding bodies requires that considerable time is spent on documentation. At another level the workload is much heavier. Directors of Nursing and Hostel Administrators are required to be good managers with no funded administrative support and with much the same resources as they had when times were good and residents' needs were less. The staffing model needs to address the residents needs, as outlined above, but must better resource staff too.
Some options are:

- Reduction in administrative tasks with increased clerical support for managers.
- Higher staff levels in facilities where family support is limited.
- Flexible and higher staff levels where residents who are particularly frail, or who have behavioural difficulties are to be maintained in the facility.
- Recognition and resourcing for the range and extent of staff supervision and staff development.
- Higher staff levels and specific staff development in services for people with mental illness.
- Greater use of non-nursing staff and more use of attendant care type staff.

FUNDING

The Brotherhood has a long history of commitment to providing residential care for low-income and disadvantaged older people. The stated policy is to give preference to people receiving a full Age Pension, who do not own a house and have few assets or family supports (Brotherhood of St Laurence 1993). A maximum of one in four applicants owning assets to a maximum level of $85,000 (couples $90,000) may be accepted into hostel accommodation in the three regions providing services to older people, and into independent accommodation on the two settlements, on the basis that they make an entry contribution. Nursing home residents do not pay an entry contribution no matter what assets the person may have. Although preference is still given to applicants on low incomes, dependency levels are also considered.

The Aged or Disabled Persons Care Act 1954 defines a financially disadvantaged person (FDP) as a person who at the time of entry receives the basic rate of pension and has not owned a home for two years prior to their entry to the hostel. Under this definition a FDP may have assets in excess of twice the maximum level set by the Brotherhood.

When the Brotherhood talks of giving priority to financially disadvantaged persons in Aged Services, we are generally referring to people who have no other incomes and who are unable to pay any entry contribution, not those defined by the Act.

Table 2 Percentage of residents paying minimum fees in hostels

Facility	% of residents
Cox and Collins Court	44
Hume Court	26
Sambell Lodge	45
Sumner House	59

Rent receipts in March 1994 indicate that 42 per cent of hostel residents throughout the three regions providing aged services have **no** other income except the aged pension. However a relatively high percentage of residents in Brotherhood hostels have cash investments less than $10,000, and Sumner House in Fitzroy has the highest percentage of residents whose cash investments are less than $5,000.

The tables below show the percentages in each hostel.

Table 3 Percentage of residents with cash investments less than $5,000

Facility	% of residents
Cox and Collins Court	60
Hume Court	44
Sambell Lodge	57
Sumner House	74

Table 4 Percentage of residents with cash investments less than $10,000

Facility	% of residents
Cox and Collins Court	77
Hume Court	60
Sambell Lodge	62
Sumner House	77

'Financially Disadvantaged' is very broad and encompasses people with considerably different levels of assets.

It would seem that the Commonwealth definition does not adequately measure assets, and that the Brotherhood should have a definition that better describes the client groups served by the Brotherhood. In this way arguments may be put to the Government to fund differently or more adequately services provided to the most poor.

Many of the general issues in relation to funding of residential care, both recurrent and capital care are being considered in the Review of the Structure of Nursing Home Funding Arrangements. Whatever the outcome of this Review, it is unlikely that funding arrangements will change substantially and the Brotherhood will need to look at alternative means of generating income to adequately fund services; programs, maintenance of buildings and replenishment of stock.

The funding and regional focus of the Brotherhood means that some facilities are less able to generate income than others. To finance changes suggested in this paper costs may need to be shared between facilities and between regions. For instance, the development of services in Fitzroy could be financed to some extent by a shift to residents who are able to pay higher entry contributions at Sambell Lodge. A program working with high levels of dementia and multi-disability would be funded at a higher level than those who did not. This could be flexible and determined in a similar manner to the categories used now in nursing homes and hostels — an internal subsidy in recognition of the particular work load and client need.

The policy of the BSL to pare funding of aged care and depend largely on Commonwealth Government funding has seen good management practice and improved budget control in most facilities. The method of achieving an improved financial performance largely relates to the high levels of dependency of residents in both nursing homes and hostels. Funding of both types of facility is based on good financial management, and in hostels of maintaining a balance between residents who pay an ingoing entry contribution and those who do not (FDP). Although the government expects a minimum ratio of 80:20, many of the charitable and benevolent homes maintain an approximate 50:50 ratio, as opposed to the BSL ratio of 20:80. It can be argued that staff and managers focus on financial management has been at the expense of innovative programs and high quality service.

A quality service, whilst still maintaining residents with high dependency needs requires a focus on individual needs, a comprehensive recreational and leisure program and sufficient resources to ensure that the quality of life for residents is maintained at the highest possible level.

Capital works priorities are currently determined in each region. If capital works' priorities were determined on an organisation basis, those programs most in need could be given priority and standards that were acceptable to the organisation could be maintained or

achieved. On the other hand, major capital works can generate income through fundraising activities more successfully on a regional basis.

QUALITY OF LIFE PROGRAM

The Quality of Life education program was developed as an integral part of the Quality of Life Project which the Brotherhood instigated in 1988 (Ryan & Joyce 1993 2nd edn). All staff who work more than half-time in Aged Care are expected to have participated in the program within two years. In addition, staff employed in areas that have regular contact with clients of aged services (administration, maintenance) are expected to participate in the programs that focus on attitudes to ageing (i.e. simulation exercise) and information of ageing (i.e. physiology of ageing). Records of attendance show a broad variability in compliance with this expectation. In nursing homes for instance, attendance at the simulation exercise varies from 4 per cent at Broughton to 56 per cent at Flinders Lodge. Attendance from hostel staff ranges from 43 per cent at Sambell Lodge to 80 per cent from Hume Court. During the period of the Quality of Life Project (1989-91) staff replacement costs could be met by the project rather than the individual facility or regional budget but attendance figures were much the same in this period as they have been since June 1991. There seems to have been no apparent correlation between cost and attendance.

The Quality of Life education program is designed to focus on the three areas:

- Attitudes to Ageing,
- Education, and
- Practical Skills.

The graphs below show that the lowest participation in all three areas of Quality of Life education is from nursing homes (Fig. 1-3).

Figure 1 Attendance by staff at Quality of Life Program — Attitudinal section

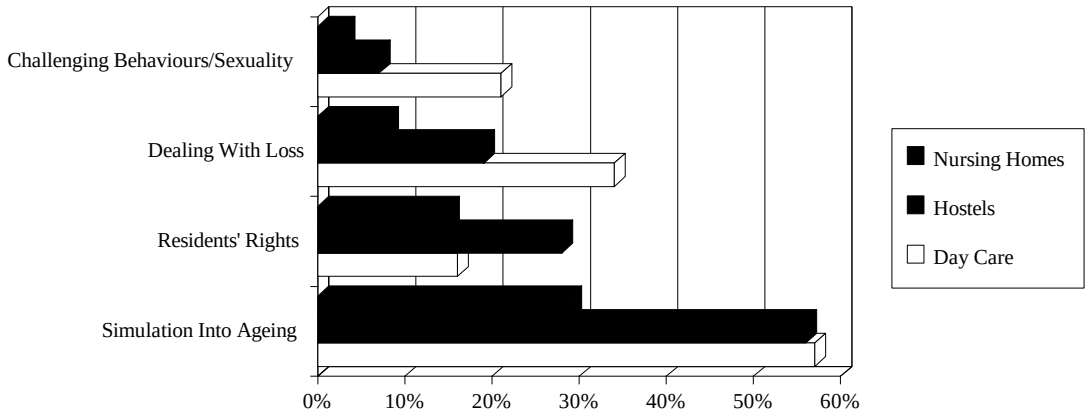


Figure 2 Attendance by staff at Quality of Life Program — Education section

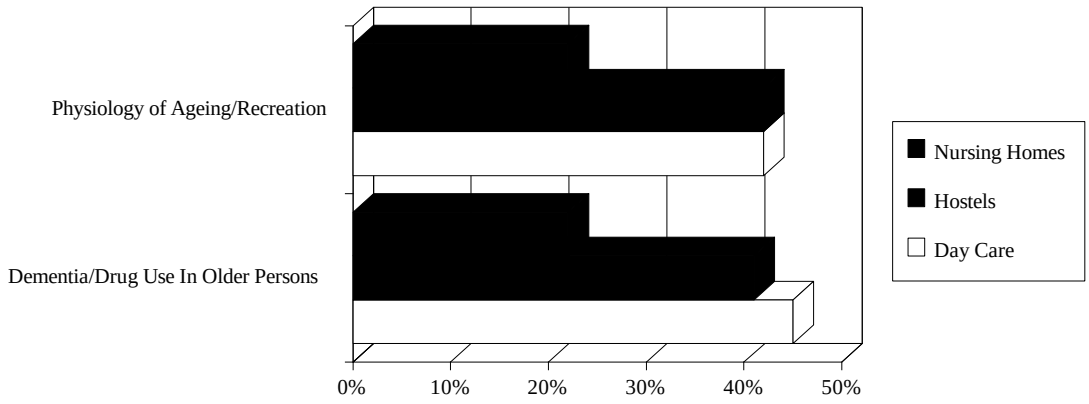
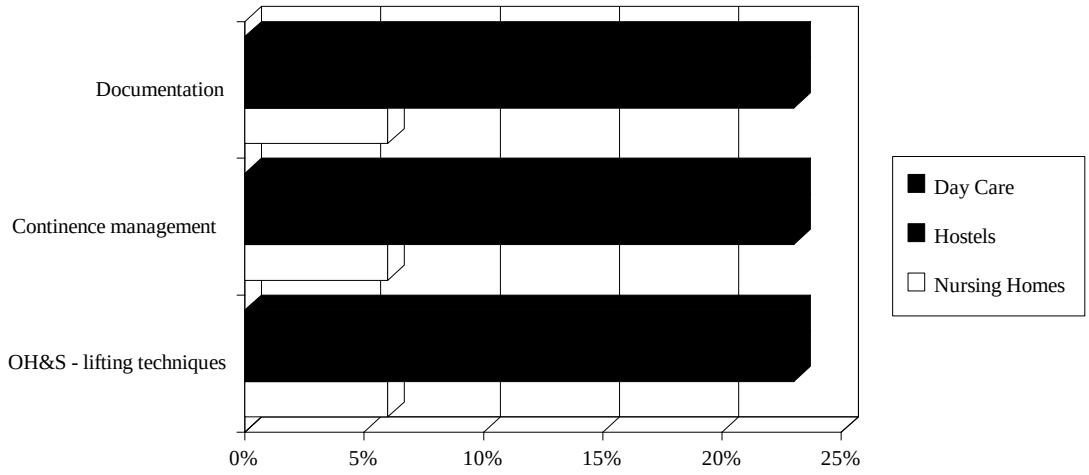
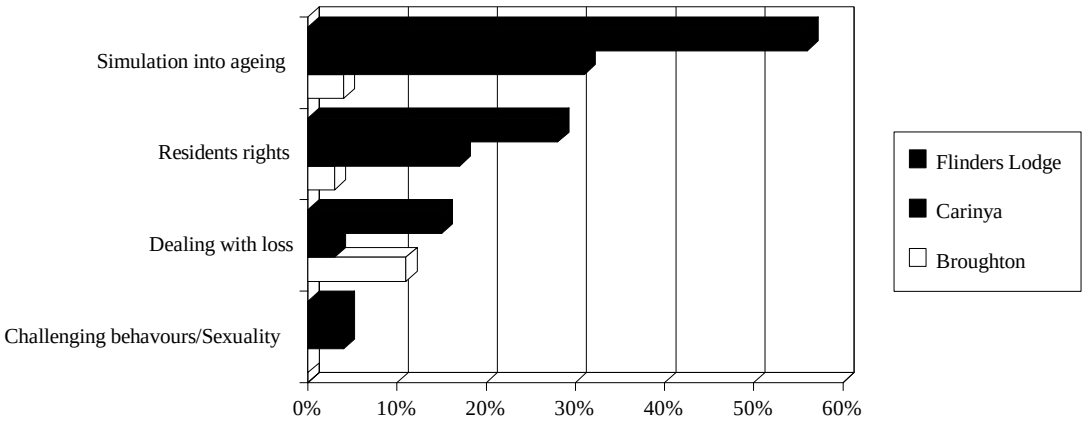


Figure 3 Attendance by staff at Quality of Life Program — Practical skills section



The comparison between nursing homes and the particularly low attendance from Broughton is shown in Figure 4.

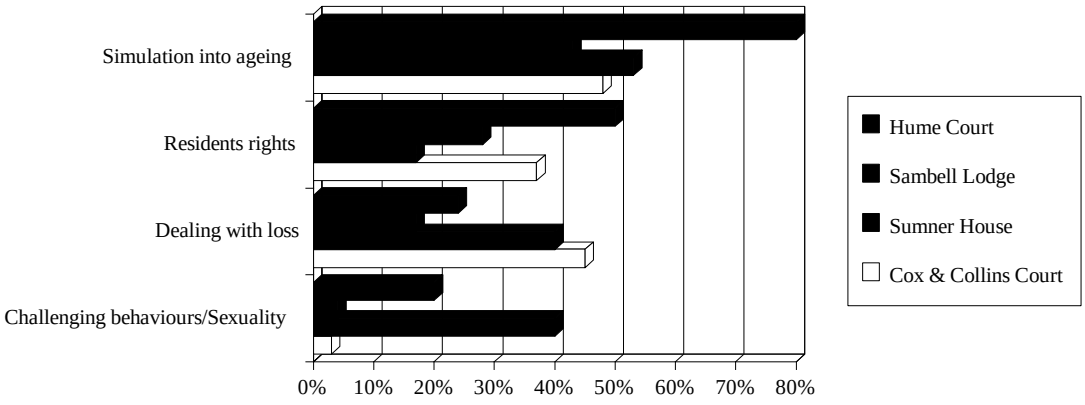
Figure 4 Attendance by staff at Quality of Life Program — Nursing Homes



The low participation from Broughton is not reflected in the attendance from other facilities from the Peninsula Region. Is it only budget constraints which underly the low attendance of staff at the Quality of Life education program?

Figure 5 shows attendance from hostels indicating a high participation over all.

Figure 5 Attendance by staff at Quality of Life Program — Hostels



As all of the residential facilities would need to employ replacement staff, the reasons for such variation between individual nursing homes and hostels is not one of replacement costs and the trends have not altered since the project ceased.

Of concern must be the participation in the two-day program on residential rights (15 per cent nursing home — 28 per cent hostel). These sessions underpin government policy on Outcome Standards and reinforce the Brotherhood's philosophy of care of the aged. The whole program was designed to build on the vocation, skills and knowledge that staff in Aged Care put into practice, and to emphasise the need for older people to maintain independence and control over all aspects of their lives.

Many staff have had difficulty moving from the model that is disempowering, not empowering, and have been defensive of their practice.

We need to ask what has changed for the residents since the introduction of the Quality of Life program. Staff are more conscious of residents' rights and are willing to involve residents in some decisions affecting the day-to-day life of the facility. All the facilities are more home-like using furnishings that are less institutional. Staff are out of uniform and for the most part do not wear name tags.

Is the attitude to residents any different and are they treated with dignity and respect as individuals? Labels are still applied to residents, and major decisions, and decisions about care are still taken on their behalf without consultation.

The impacts for achieving change and a system that monitored and implemented high quality service was diminished when the Quality of Life Project was no longer funded. The recently established Quality Assurance Committees will introduce systems that work towards high quality service and the participation of all staff in the Quality of Life Education programs is essential to achieve this.

SUMMARY OF QUESTIONS FOR DISCUSSION

1. Can we maintain and modify building stock to meet design principles and to meet the care needs of different client groups?

2. Should the BSL continue to give priority to residents with high dependency levels in preference to existing residents whose accommodation and support needs change?

3. Should the BSL develop a residential care service that meets the care needs of older people whose needs are too high for hostel admission but do not ensure adequate subsidy levels in nursing homes, despite meeting the financially disadvantaged criteria?

4. Should the BSL offer convalescent care as a service response or advocacy for better post-acute care for older people in the community?

5. Is the Brotherhood able to respond to community needs by providing emergency respite and respite for older people who require high levels of care?

6. Should palliative care be extended beyond aged services to respond to regional and local needs in the provision of care for people with an incurable disease?

7. What benchmark of service quality should the Brotherhood aim to achieve; the minimum outcome standards set by the Commonwealth; average industry standards; best practice; innovation; standards determined by residents/consumers?

8. What staffing model does the Brotherhood wish to adopt and what flexibility in staffing needs to be developed to reflect different care needs?

9. Should the Brotherhood re-define 'financially disadvantaged person' that would better describe the client group it serves?

10. Should the Brotherhood review the asset level and maximum entry contribution in response to local and regional needs and allow for cross-subsidy of services in areas such as South Fitzroy?

11. Should the Brotherhood continue to determine capital works priorities in each region or should organisational priorities be set?

12. What level of funding and resources is the Brotherhood prepared to dedicate to the development of best practice in its services for older people?

13. What strategies and resources are required for all staff in aged care to participate in staff development that will assure service quality?

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