FINAL REPORT

Uniting*Care* Wangaratta

Evaluation of 'Community Respite House' Model of Service Delivery

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INTRODUCTION

Background

Federal and State aged care and disability policy over the past two decades has placed increased emphasis on the development and expansion of services that support older people and people with disabilities to remain living in their communities. These support services aim to assist not only those in need of care, but just as importantly, the carers who look after them in their homes. By expanding these home care and support services, governments have been able to reduce provision and utilisation levels of institutional care (acute hospital and longer term residential care). An important part of the support system for carers has been the development of an expanded range of respite options, both institution-based and community-based.

One of the more recent respite options to emerge for carers is the Community Respite House model. In the case of older people, Community Respite Houses provide overnight emergency, unplanned and planned short-stay respite care in home-like settings that are not part of residential aged care complexes. Community Respite Houses usually offer homelike accommodation for four to six people and have either been specifically built or modified to meet the needs of older people. The clients accessing the respite houses have a variety of physical and cognitive impairments and often dementia; the model is particularly appropriate for people with dementia.

While the Community Respite House model of service appears to be delivered in a consistent format by numerous service providers, there are no industry wide written guidelines and it appears that no previous evaluation has been undertaken relating specifically to the model of care.

Terms of Reference

The defined aim of this project is to describe and review the operations, outcomes and cost effectiveness of the Community Respite House model of service delivery, and develop recommendations for future operations. The specific terms of reference are:

1. To fully describe the operation of the Services, including details of the service provided, cost structures, fee charging practices, client characteristics, usage patterns, utilisation, marketing, links with other services, staffing and management structures and processes, including quality standards that are used.

2. Identify from both a carer and client perspective the strengths and weaknesses of respite house care and make recommendations for improvement. Examine the success of the model in meeting carer and client needs.

3. Examine cost effectiveness and appropriateness of the service in relation to other forms of out-of-home respite care. Identify advantages/disadvantages of respite houses attached to larger aged-care complexes (eg nursing home, hostel).

4. Describe Best Practice elements of care that act as benchmarks and can be developed into guidelines and standards for service delivery in Community Respite Houses.

In reviewing the scope of the Community Respite House model, the project brief identified the following services as the sample study group (respite services in disability, mental health and children's sectors were specifically excluded):

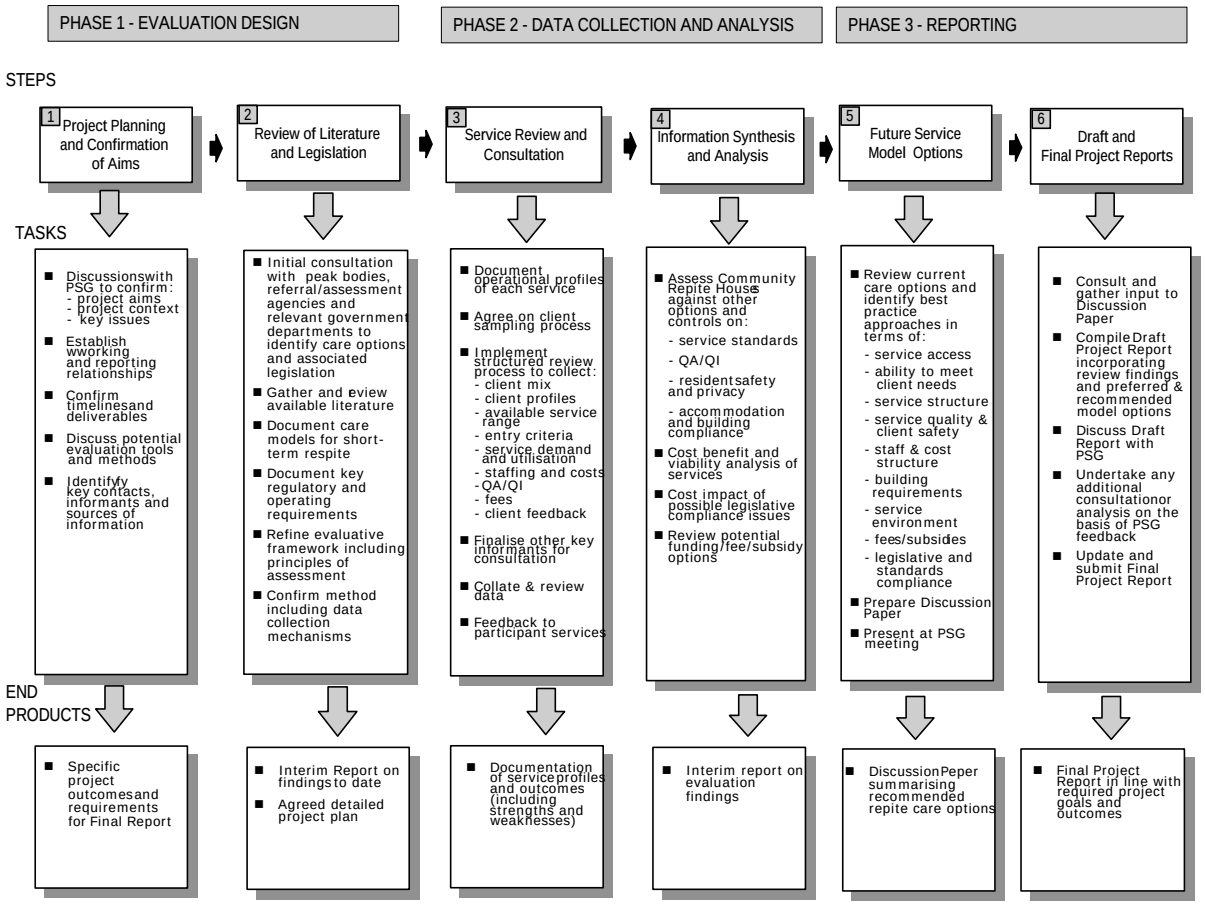
Service Provider	Respite House	Location
Villa Maria Society	Carinya House	Wantirna
St Laurence Community Services	St Laurence House	Geelong
Brotherhood of St Laurence	Banksia Centre	Frankston
Anglican Aged Care	Kilby House	Glenroy
Anglican Aged Care	Hurlingham	Brighton
UnitingCare Wangaratta	Neil Stewart House	Wangaratta
UnitingCare Wangaratta	Cornish Vale	Mooroopna
Ballarat Health Services	Eyers House	Ballarat
CoCare Gippsland	Brooke House	Traralgon

The project brief also prescribed a number of tasks that the methodology should include:

- Review and synthesise data and information about demand, waiting lists, occupancy rates, costs and clientele (demographics, cultural backgrounds etc).
- Carry out extensive consultation with key stakeholders.
- Review previous documentation relating to Community Respite Houses, cottage respite, home-like respite.
- Review of current literature on the provision of aged-care respite services.
- Discuss the differences and similarities between residential aged care facility respite and community house respite.
- Define and analyse the characteristics of Community Respite Houses, including building profiles, staff, target groups, needs of clients, philosophy of care, management structures, relevant legislation, staff qualifications and training.
- Identify funding issues related to current operations and future funding options.
- Identify areas of Best Practice and make recommendations for future operational guidelines and minimum standards of practice.

Methodology

The evaluation was undertaken in three main phases: (1) Evaluation Design, (2) Data Collection and Analysis, and (3) Reporting. The diagram below presents a summary of the activities that took place in each phase. As part of the process to describe the Community Respite House model, Phase 1 included an initial survey of all services in the sample group to establish the range of data that was collected and able to be uniformly reported. Phase 2 included the detailed collection and analysis of the data elements identified in Phase 1, to enable a detailed description of the client profile, service range and other features that have developed as the model of service delivery.



The project was overseen by a Steering Group comprising representatives from each service in the sample group, a representative from Social Sciences, La Trobe University (Albury/Wodonga), and representatives of the Department of Human Services, Hume Region, and the Commonwealth Department of Ageing, Aged & Community Care Branch. The Steering Group met regularly throughout the course of the project to discuss and provide advice in relation to project progress and direction, and to assist in the collection of data relevant to the project objectives.

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CONTEXT FOR THE DEVELOPMENT OF COMMUNITY RESPITE HOUSES

Background

In earlier generations, it was common for families to look after elderly relatives in their own homes until deterioration of the relatives' health required hospitalisation. This changed around the middle of the last century when governments expanded the residential aged care sector in Australia, resulting in a growing trend to place the elderly in need of care in institutions rather than the family home. Aged care became a large and growing cost (also affected by an increasing life expectancy) for government.

In the 1980's, partly to redress the escalating cost of aged care, the *Home and Community Care (HACC) Program* was introduced as a joint initiative of Federal and State/Territory governments to provide an extensive range of support services that would enable aged and disabled persons to remain living at home rather than residential institutions. Over the past 20 years, the continued expansion of HACC funding and services has contributed to the reduction in the planning guidelines for the provision of places in aged residential facilities as well as the reduction in acute hospital stays.

The success of the HACC program in reducing the dependence on Commonwealth funded aged care homes was based on the recognition of the central role of carers. Respite services accept that the role of the carer carries a 'burden' that can negatively impact on the carer's health. Thus, respite services can be broadly defined as services that alleviate some of the burden of care. They are more commonly referred to as services that give the carer a break from the role of caring (*refer The Respite Review Report, Commonwealth Department of Health and Family Services, 1996*).

Through HACC (and other respite programs), a range of services have been developed to assist and support people in need of care (i.e. the aged and disabled) and their carers to remain living in their homes and communities. A wide variety of respite options have been developed so that carers can avail themselves of the type of break they most desire.

In examining the requirements for respite care, it is important to realise that the services are being delivered to people who are capable of continued living in the community with home-based support. They do not have health-related problems with an immediate requirement for institutional care, however their continued ability to remain living in the community in many cases is very dependent on the continued availability of the carer(s). In these situations, the well being of the carer becomes of paramount importance if people in need of care are to remain

independent and stay out of residential care. Thus the range of available respite options should be tailored to the needs of both carers and the people they care for. Whilst there is evidence that for some individuals premature admission to residential care can result in a decline in health, this needs to be balanced by studies that report failure to provide adequate respite can have significant impacts on the health of carers.

Current Commonwealth aged care strategy aims to provide a flexible range of respite care options to support carers of aged persons. The Commonwealth *Aged Care Act 1997* describes respite care as residential care or flexible care as the case requires provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. However, Community Respite Houses have developed in response to local needs rather than specific government policy and program initiatives, and are a relatively new concept for providing respite care for aged persons in Australia. As a result, the services they deliver are funded through a range of program and brokerage funds rather than one specific funding program. Nevertheless at a time when government planning has identified substantial unmet community needs for aged respite care, Community Respite Houses provide an effective, albeit undefined, respite care option for some of those community needs.

Much of the literature on respite care development in Australia has occurred in the 1990's and has been summarised and reviewed in a number of publications (*The Respite Review Report, Commonwealth Department of Health and Family Services, 1996; The Respite Care Needs of Australians, Gibson, D et al., Australian Institute of Health and Welfare, 1996; Review of Respite Care Services provided in the Community, Rhys Hearn, C et al., AGPS, 1996; Targeting in the Home and Community Care Program, Commonwealth Department of Health and Aged Care, 1999; Dementia – Care and Support in Victoria 2000 and Beyond, Department of Human Services Victoria, 2000*). Most of the literature deals with the broad range of respite care policies, programs and services available to carers of people of all ages i.e. respite care for the aged, disabled and children. The remainder of this Chapter will focus on the program and service options for aged respite care that are either in place or emerging, in order to enable the position of the Community Respite House model of care to be established.

Aged Respite Care Programs in Australia

Respite services for the elderly over the past 20 years have been developed through three main government program streams. The *Aged Care Act 1997* regulates the provision of care for predominantly elderly people in Commonwealth funded aged care homes or in their own homes through Community Aged Care Packages (CACPs), and it includes a component of respite care in residential facilities. The *Home and Community Care (HACC) Program* includes a range of flexible programs for in-home and centre-based community day and overnight respite care and activities; it also provides funding for specific brokerage services (eg *Linkages* and *Community Options*) which can also assist in the purchasing of

community respite care services on behalf of those in need. More recently, the Commonwealth Government has introduced the *National Respite for Carers Program* which expands available support for carers, and this can extend to the purchasing, organising or managing the delivery of respite care assistance packages.

Respite Care in Commonwealth Funded Aged Care Homes

Respite care is available in Commonwealth funded aged care homes and its provision is tightly controlled under the *Aged Care Act 1997*. Under the Act, the respite care can be provided in both high care and low care facilities but the provider must have approved provider status from the Commonwealth Department of Health and Ageing. All recipients of respite care must be assessed as appropriate by the Aged Care Assessment Service (ACAS); eligible people will be classified as appropriate for either high care or low care facilities depending on their individual needs. The Commonwealth provides specific funding for the respite care through the Department of Health and Ageing in the form of daily subsidies and respite care supplements.

Community Aged Care Packages (CACPs) are available for older persons (usually over 65) who are frail or disabled, who are eligible for admission to low care Commonwealth funded aged care homes but elect to remain living at home with support, and who require coordination of their support services. Services similar to low care are delivered to clients at home, and HACC services may be purchased through CACPs.

Under the *Aged Care Act 1997*, the Commonwealth funding for aged care homes including respite care is only available for services that have been independently assessed by the Aged Care Standards Agency and met the prescribed quality standards for accreditation. The Act further requires that the services must be delivered in facilities that meet defined facility certification standards that deal with safety, privacy and space.

Commonwealth funded aged care homes are presently planned on the basis of guidelines that provide for 90 places (40 high care and 50 low care) per 1000 population aged 70 years and over in all local government areas. The planning guidelines also provide for a further 10 CACPs per 1000 population aged 70 years and over. As part of the guidelines, the Commonwealth endeavours to manage residential respite care to an upper limit of three places per 1000 population aged 70 years and over.

Respite care in Commonwealth funded aged care homes is presently capped at a maximum of 63 days of care per financial year for each care recipient. Below this ceiling, care may be received during a number of care episodes that meets the recipients' needs (subject to ACAS assessment). The average episodes of respite care is 23 days for high care facilities and 22 days for low care facilities (*The Respite Review Report, Commonwealth Department of Health and Family Services,*

1996) with bookings sometimes necessary up to 12 months in advance. Due to its planned nature, this respite care option is rarely responsive to emergency, short-term respite care requirements, and in this regard it has been reported as inflexible and unresponsive to the needs of many carers (leading many to search for services more suited to their requirements).

Home and Community Care (HACC) Program

The Home and Community Care (HACC) Program aims to provide basic maintenance and support services for frail older people, people with a disability, and their carers. The services are provided to assist people to live independently at home and in the community, and to assist carers in their caring role thereby preventing inappropriate or premature admission to long-term residential care with consequential enhancement of the recipient's quality of life.

Unlike the Commonwealth funded aged care sector, there are no mandatory quality assessment and accreditation requirements as a condition of funding although an Assessment Resource Kit has been developed by the former Department of Health and Aged Care to provide for comprehensive assessment in the HACC Program. In addition, many HACC services associated with hospitals and Commonwealth funded aged care homes are included as part of the accreditation programs for these service organizations (eg via ACHS EquIP, Aged Care Standards Agency etc).

Within HACC, there are both directly funded respite care services as well as some brokerage funding (through *Linkages* and *Community Options*) that can be used to purchase respite care services for elderly people with special and/or more complex needs. (Note however that brokerage pays for the client contributions rather than the service costs of overnight respite). Again, unlike Commonwealth funded aged care homes, HACC does not have a formally defined 'global' assessment process for eligibility and access to HACC services and as a result, entry into the HACC program generally involves a local assessment of needs, priorities and available resources by the specific agency involved in service delivery.

Services available through HACC include Planned Activity Groups (formerly known as Adult Day Activity Support Services or ADASS programs, and, more recently, Centre Based Social Support) that provide socialization and recreational opportunities for the frail aged and adults with a disability. Additional services, such as allied health services (eg balance clinics etc) can also be offered and client contribution fees normally apply for any optional extra service components. (It should be noted that Planned Activity Groups are not defined as a form of respite care although, in practice, carers often view respite as an important reason for using such services).

Overnight care and in-home respite care (also termed community respite), can also be secured through HACC. Access to centre-based programs can be by referral from local medical officers, family members, case managers, Commonwealth Carer Respite Centres or self-referral. Entry will depend on local assessment of client needs usually by the provider agency and the availability of resources. There are no prescribed minimum eligibility criteria. In-home respite provides an alternative to centre-based respite care services and is designed to provide carers with a break from the caring role by delivering services directly in the home environment. The scope of both in-home and centre-based services includes support for the carer role, provision of planned, unplanned and emergency respite care, holiday respite, and provision of a bridging service into other care and respite services such as day care.

Funding for agencies to deliver centre-based and in-home respite care, and Planned Activity Groups, is undertaken on the basis of annual funding and service agreements negotiated with the State authority responsible for HACC funding distribution. However other brokerage services such as providers of *Linkages*, *CACPs*, as well as the *Department of Veterans' Affairs, Community Care* and carers (privately) are all able to purchase additional respite care from the HACC-funded agencies.

National Respite for Carers Program

The National Respite for Carers Program (NRCP) was established in 1996/97 to extend the availability of respite services to support carers with a high need for assistance in maintaining their caring role. It concentrates on providing increased opportunities for carers to exercise choice and control over respite care arrangements, and supports carers of people who are unable to care for themselves because of chronic illness, disability or frailty.

Through the NRCP, Commonwealth Carer Resource Centres have been established in each State and Territory as a single point of contact for carers seeking information on their caring role and advice about the full range of services and support. The NRCP has also established Commonwealth Carer Respite Centres in each DHS region in Victoria as a central point to help carers access available respite services, arrange individual carer-specific respite when needed and to stimulate more flexible and responsive local delivery of respite care. In response to community concerns about the inflexibility of respite care in Commonwealth funded aged care homes, more recently Commonwealth Carer Respite Centres are being requested to provide an expanding role in purchasing, organising and managing the delivery of respite care assistance packages tailored to individual carers' needs and those for whom they care. The Centres are receiving additional Commonwealth funding for a variety of uses including local purchasing of required respite care on behalf of carers. This brokerage role has included the purchase of short-stay respite care in Community Respite Houses.

Department of Veterans' Affairs (DVA) Community Care Program

This program has been recently introduced to directly assist veterans and war widows who wish to remain living at home with support services. It is very similar in service scope to the HACC program. DVA periodically tenders for the appointment of approved agencies to provide community-based services at contracted rates and quality standards to DVA clients following initial assessment. Services purchased under contract include community-based aged respite care, which can be short-term planned and emergency respite care. Where overnight respite care is funded, DVA is prepared to provide this care either at home or in a range of residential services including Community Respite Houses.

Community Respite Houses

Community Respite Houses have emerged (primarily in the last decade) from HACC-funded centre-based services, in line with the needs of carers for more flexible and responsive respite care options. Some of the early examples of the model appeared in Western Australia and were termed 'cottage respite', which provided respite care, including overnight accommodation, in a house typical of ordinary residential dwellings. Early evaluations of the cottage respite model suggested it might be more effective than hostel-based respite although it was also assessed as having a relatively high cost per place (*Gatter & Dolley, 1996*). It has been suggested that the model may be more capable than other residential respite options of responding to the unmet demand of carers for overnight or weekend respite (*The Respite Review Report, Commonwealth Department of Health and Family Services, 1996*).

The Community Respite House model has not emerged from a specific government program or initiative - it appears to have been community-driven and funded using overnight respite HACC funding and other brokerage funding through CACPs, Linkages Programs, the Department of Veterans' Affairs Community Care Program, and the National Respite for Carers Program (note however that some of these sources cover client contributions only and not service operating costs). Where Community Respite Houses have been established, they are generally providing planned or emergency overnight or short-term (i.e. less than five days) respite care in small groups, without the long booking times required by alternative aged residential facilities. Services are mostly delivered in residential-type accommodation or in facilities used for Planned Activity Groups, these sometimes being a precursor for overnight community respite.

Community Respite Houses often target services specifically to people with dementia as the care recipients, although services are also accessible more broadly including to adults and children with intellectual, physical or sensory disability and people with acquired brain injury. The service scope includes carer support, short-term planned, unplanned or emergency respite care, support for participation in community activities, and carer advocacy. Entry to the Community Respite House generally relies on local assessment of client needs, the ability of

the service to meet those needs and available resources, rather than prior assessment by an ACAS. This approach is one factor that enables greater flexibility and responsiveness, particularly in emergencies, than can be provided by the aged residential care respite model.

Private Sector Services

Apart from the government-funded services outlined above, the private sector also offers a number of short-term respite care services on a 'user pays' basis, often in 'special aged accommodation' facilities (including Supported Residential Services). Private sector operators of these services usually require a minimum stay of two days and charge at the rate of around $660 per week. Like the Community Respite House model, this private option also caters for episodes of unplanned respite care.

Overseas Trends

A recent international review of literature on innovations and best practice in respite care highlighted an urgent need for the development of high level care for both in-home and community settings to meet the global increase in growth of the frail and disabled relative to current levels of service development and availability. The international studies indicated that access to respite care can intervene and delay or decrease the likelihood of nursing home placement.

Some of the innovative respite models that are emerging internationally include the following (several are already in operation or under development in Australia):

- Brokerage of care services using electronic multimedia management systems. Carer resource centres fulfil brokerage roles that include 'one stop shop' access to information and services for respite care as well as access to emergency respite services through electronic information management mechanisms.

- Day care centres providing transport to and from centres which provide meals, personal care, allied health and health monitoring services, as well as social and cultural activities each day. Programs can run between 6.00 am and 6.00 pm.

- Adult foster homes that offer respite care for up to five individuals in one home. The respite care is provided on a 24-hour per day basis, and is generally short-term. This appears to be similar to the Community Respite House model.

Assessment of Needs for Respite Services

The 1998 *Disability, Ageing and Carers Survey* conducted by the Australian Bureau of Statistics estimated that there were 2.3 million carers in Australia, with approximately 450,900 of these being primary carers with significant, ongoing responsibilities (including for people with disabilities). Within the primary carer group, 49% were estimated to be receiving assistance for their caring role, with 25% indicating that they needed more assistance including respite care.

The 1996 review of *The Respite Care Needs of Australians* undertaken by the Australian Institute of Health and Welfare (AIHW) found that a core group of 4% of primary carers have an unmet need for aged respite care services. This review also identified a need for improved flexibility in the access and delivery of respite care with a requirement for more flexible, unplanned and emergency community respite care options in contrast to the more rigid, planned respite care services available in Commonwealth funded aged care homes.

In response to the AIHW study, the Commonwealth introduced the National Respite for Carers Program that as outlined earlier provided for the establishment of the Carer Resource Centres and Carer Respite Centres. Their predominant initial roles were to operate as a single point of contact for information and assistance to carers, and assist in organising and managing respite care. The AIHW findings were subsequently confirmed in the *Two Year Review of Aged Care Reforms* undertaken by Professor Len Gray. This study included recommendations for the expansion of Commonwealth Carer Respite Centres to provide more direct management of residential respite care such as purchasing respite care from providers on behalf of high-priority respite clients.

In response to the study by Professor Gray, the Commonwealth acknowledged that there was an over-dependency on respite care options though the aged residential care sector, and that these options were often inflexible and unresponsive, particularly for emergency respite requirements. To address this deficiency, the Commonwealth commenced providing brokerage funding to Commonwealth Carer Respite Centres to enable them to purchase services and support to meet the specific needs of individual carers. This approach enabled the Centres to offer more flexible and responsive respite care options, particularly for short-term emergency situations, in line with specific community needs. A proportion of available brokerage funding is used to purchase overnight care in Community Respite Houses.

In Victoria, the priority areas of unmet respite needs appear to be longer stay and regular weekend out-of-home respite, particularly in facilities close to home; additional, more responsive forms of day centre respite; more accessible in-home respite with longer hours; and increased availability of in-home weekend and overnight respite *(Carers Association of Victoria).*

Reports of unmet need for aged respite care however are largely anecdotal (*The Respite Review Report, DH&A 1996*). It appears indisputable though that a significant number of carers are looking after highly dependant people in difficult circumstances and are not utilising respite care services, many for reasons associated with the nature of current respite care service provision. For example, determination of need may be constrained by what is available (i.e. the experiences of carers). Utilisation may be damped by carers' sense of duty or responsibility, strong emotion, guilt or concern that the care recipient would be unhappy or improperly cared for.

In addition, carers often have difficulty in accessing relevant information, which may inhibit a carer's capacity to make informed choices about what services they would like to use or even if they want to use respite care services at all. Furthermore if a carer needs to find some form of care, in the absence of comprehensive information about what options they have, they may be more likely to turn to the most visible and recognisable source of alternative care. This may well be a nursing home or hostel that for many carers may be the least preferred respite care option.

Consultations have indicated that there appears to be insufficient suitable 'dementia specific' places, whether for permanent or respite care, and generic facilities that do accept older people with dementia often are not able to provide the additional supports necessary to cope with and care for them. The number of people living with dementia in Victoria is expected to increase by 61% from an estimated 40,719 in 2001 to 65,520 in 2021, although the increase is not uniform across the state (*Information Sheet June 2002, Alzheimer's Association Victoria*). The *Victorian Burden of Disease Study 1999* predicted that by 2016, in terms of burden, dementia will have become the 5th major disease causing ill health in men and the 1st major disease causing ill health in women.

The key theme that emerges from a review of relevant literature is that carers have a wide variety of respite needs. For carers to obtain temporary relief from the 'burden of care', it is apparent that a wide variety of flexible and responsive respite options must be available to ensure individual needs can be met. The range of available service models must be capable of providing conveniently accessible options for short-term and longer-term respite, planned and unplanned respite, in-home and out-of-home (including centre-based) respite, as well as day and overnight respite. Community Respite Houses represent an important option within this broad service range.

Current Legislation and Regulatory Instruments

Respite care in Commonwealth funded aged care homes is subject to extensive legislation and regulation. As mentioned earlier, aged residential care is subject to the *Aged Care Act 1997* which has formal controls for the approval of operators, resident classifications and payments for residential and respite care, service accreditation and facility certification. Non-compliance can result in financial sanctions or in extreme circumstances even service closure.

Respite services that are funded and operate as part of the HACC or National Respite for Carers Programs are not subject to the same restrictions. Where the House receives HACC funding, the HACC National Service Standards are recognised as a guide to service provision. The HACC standards are an important part of a broader quality assurance framework and provide a nationally consistent method for evaluating and monitoring the quality of service provision. Commonwealth Carer Respite Centres have no formal standards of their own but support the HACC standards. The Commonwealth, in respect of the use of NRCP brokerage funds at

facilities not approved under the Aged Care Act 1997, expects "centre coordinators to investigate the quality and safety of the physical environment including State and Local Government Licensing Regulations, as well as the suitability and training of care staff. It is imperative that, in the desire to meet the respite request of a distressed carer, the need for quality care for the care recipient is not overlooked."

CACPs must be provided according to Community Care Standards arising from the Quality of Care Principles of the Aged Care Act 1997.

In addition, in almost all instances, the Community Respite Houses included in the sample group are either developing their own standards or adapting the standards, policies and procedures of an auspice organization in order to guide administrative functions and meet individual needs. In most instances Houses have extended or are in process of extending surveys/audits to assess service adequacy, client satisfaction and best practice.

A source of formal regulatory control comes through the Building Code of Australia and, more significantly in Victoria, the Victorian Building Regulations that stipulate mandatory building features that must be complied with depending on the nature of the service operation. How these regulations apply to Community Respite Houses is a matter for interpretation that may have significant implications for some forms of respite care.

A number of Community Respite Houses commenced provision of respite services as extensions of day programs in response to expressed needs. Once overnight care is offered, different building regulations apply and therefore Houses should seek confirmation that they meet the Building Code of Australia 1996 and the Capital Development Guidelines (2001) of the Department of Human Services.

As it stands now, there appears to be no prescribed standards or process for building certification of Community Respite Houses (such as that required for Commonwealth funded aged care homes). The Building Code of Australia (BCA) 1996 and 1999 uses a classification system based on the intended purpose for buildings (classifications range from class 1 to class 10 to classify all buildings). Under this definition, it is unlikely that Community Respite Houses would be seen as residential aged care buildings with a requirement to comply with the certification standards under the Aged Care Act 1997.

However, the situation is clouded by the fact that State legislation is able to extend the provisions of the BCA. In Victoria, the Building (Amendment) Regulations 1997 have retained the BCA's prescriptive provisions and, in the case of aged residential facilities, extended requirements particularly in relation to fire risk management. For these facilities, the Department of Human Services has adopted a new classification system under Capital Development Guidelines released in 2001. Under these Guidelines, aged residential facilities (high care and low care) are included under the classification of 'Congregate Care Facility' or Capital Development Guideline 7.5 (CDG 7.5) and are required to provide a range of fire

safety measures including automatic sprinkler systems and fire compartmentalisation. The Capital Development Guidelines also include classifications of Community-Based Houses (CDG 7.7) and Supported Community-Based Houses (CDG 7.4). Under CDG 7.7, Community-Based Houses can be classified as BCA Class 1b buildings with the following features:

- One or two storey houses of typical domestic style construction and layout with a total floor area of not more than 350m^2; and
- A maximum of 12 persons ordinarily resident (including sleepover staff) where not more than one needs physical assistance in conducting their daily activities and to evacuate the building during and emergency; and
- 24-hour staffing.

Guidelines for Supported Community-Based Houses (CDG 7.4) have the following field of application:

- One or two storey houses of typical domestic style construction and layout with a total floor area of not more than 350m^2; and
- A maximum of six clients who need physical assistance in conducting their daily activities and to evacuate the building during and emergency; and
- 24-hour on-site support and care staffing.

It is possible that Community Respite Houses may fall into either classification CDG 7.4 or 7.7 depending on their client profiles. The two types of facilities have notable differences in terms of their requirements for fire services, and in particular automatic sprinkler systems.

Current and Future Policy Direction

Current national carers policy provides for the continued development of a flexible and responsive range of respite options. Whilst the residential care sector delivers Commonwealth-funded respite care, in practice this is limited to planned respite for fixed periods and with long waiting times. It's limitations have been well-documented with the major deficiencies being the lack of accessibility and responsiveness to emergency respite needs particularly for short stays overnight and on week-ends, and its lack of a home-like environment.

As a result, the main emphasis in current respite policy is to develop a wide range of flexible options that cater for the diverse needs of carers including:

- Planned, longer-term respite in residential care facilities.
- Planned and unplanned (emergency) day respite (short and long), both centre-based and home-based.

- Planned and unplanned (emergency) overnight and weekend respite, both centre-based and home-based.

- Information on locally available respite options.

Planning guidelines exist for the provision of respite care for older persons in Commonwealth funded aged care homes, however there are no planning guidelines at present that address the delivery of short-term respite facilities based on local needs. Also, planning guidelines do not address the special needs of people with dementia (while these needs include access to emergency respite, they importantly include the need for frequent ongoing respite in a familiar homelike environment with suitably experienced staff).

COMPARISON OF EXISTING OPERATIONS

This section provides a summary of Community Respite House service characteristics, activities and outcomes. It is based on detailed review of the operations of each of the Houses (see Attachment 1) included in the evaluation sample and, for the purposes of this project, serves to constitute a description of the service model.

Overview of Participating Houses

Banksia Services for Seniors in Frankston is auspiced by the Brotherhood of St Laurence. The Centre prides itself on providing a homelike setting and there is a security entrance to ensure the safety of clients who may wander. Disability access includes ramps and modified bathrooms, and there is a continuous pathway enabling all clients to access the external environment. Banksia commenced as a day centre providing ADASS programs. A large multipurpose room converts into two bedrooms by drawing ceiling mounted bi-fold partitions. Up to four heavy duty foldaway beds are set up at night for overnight respite and if necessary a fifth bed can be accessed by carers who are experiencing an emergency.

Brooke House is operated through the Gippsland Carer Respite Centre. Brooke House is a two bedroom domestic unit designed with facilities for the disabled by a local developer (who constructed a six-unit complex, the other five units having been privately sold). The complex backs on to a (permanently-staffed) Supported Residential Service (Glenwood), and an intercom in Brooke House is connected to Glenwood for assistance in emergencies. Brooke House was established following Commonwealth government funding (2001/02 only) to cover the lease and insurance costs and some other minor operating expenses. Carers and care recipients are able to book Brooke House for short-term respite; typically it is used to either break trips from Gippsland to Melbourne or to provide accommodation whilst the carer/care recipient undergoes treatment at the local hospital.

Carinya House is part of a large Villa Maria Society campus in Wantirna that, apart from respite services (day and overnight), also provides an extensive range of residential, rehabilitation and disability services. Carinya House is purpose-built for day programs (up to 15 places with planned activities) and overnight respite (six places operating on a seven days-per-week basis). Six single bedrooms are provided for overnight respite, which has been operational since the early 1990s. The admission policy provides for up to five nights respite per stay, most of which is planned respite with clients commonly having regular stays of 1-2 nights per week or month.

Eyers House is a unit of Ballarat Health Services, operating from a period home built in the early 1900's (which was a private home until the 1950's, later converted to a home for intellectually disabled women). For the past 14 years Eyers House has provided a Dementia Specific Day Centre; it has offered respite care for the past 11 years. Eyers House is of domestic construction with modifications for access for the disabled. Day programs are provided in two multipurpose rooms - one utilised for activities and the other as a dining and craft room. The house has four bedrooms and a day bed in the activity room is utilised for a seventh person if required. The house provides day care for 16 clients, overnight respite programs for a total of 6-7 people at a time and sometimes combined overnight respite and day respite for up to 10 clients.

Hurlingham is a house situated next door to a high care Commonwealth funded aged care home in suburban Brighton. The property was originally purchased by the auspice of both services (Anglican Aged Care) to allow expansion of the high care facility. However, when this did not proceed, an alternative use for the house was proposed – as an aged day program with ADASS funding. The house is of 'normal' suburban design of three bedrooms, one of which is equipped with two beds in order to cater for couples. House capacity is therefore 3-4 clients at a time. Hurlingham's programs provide many stimulating and interesting activities, including activities based on individual preference, for older people. Respite for carers is provided to reduce the pressure of caring for an elderly relative or friend, to share information and provide carers with emotional support.

Kilby House is also a house situated next door to a 60-bed high care Commonwealth funded aged care home, purchased by Anglican Aged Care to allow expansion of the high care facility. Similar to the evolution of Hurlingham, when the development did not proceed, an aged day program was initiated with ADASS funding. The house has two bedrooms, with capacity of two clients at a time. The aim of Kilby House is to provide care and maintain the well being of older people living in the community and to provide respite and support for carers. This is achieved by providing a planned program of activities that enhances or maintains skills of clients for daily living.

Neil Stewart House in Wangaratta and ***Cornish Vale*** in Mooroopna, auspiced by Uniting Care Wangaratta, are both five-bedroom houses with pleasant garden settings. They are specially designed respite facilities providing day and overnight care on regularly scheduled weekends. Staff provide all levels of care, from minimal assistance to intensive support. Staff are trained and experienced in the special needs of people with memory loss. Activities are individually planned, with input from the participant and the carer.

St Laurence House is operated through St Laurence Community Services and was established following a special pilot program. It is a domestic (four bedroom) period house with modifications for disabled access, external security, garden areas for clients to work and walk in.

Need Identification and Service Establishment

Around the early to middle 1990's service providers began to react to an emerging demand for short stay and overnight respite care, both planned and unplanned and as an emergency measure. The need for such services was recognised in a variety of ways including requests from local nursing homes, other aged care services and carers (particularly carers of ADASS clients seeking extensions to day programs as a different form of break). In some areas more organised initiatives were carried out, such as regional consultations with service providers and carers; generally, demand was not quantified. In very few areas did short-term respite services exist – mostly there were high and low care Commonwealth funded aged care homes providing respite care but this was generally booked for weeks at a time, must be booked months in advance and not available for short stays. There was a clear requirement for facilities offering community-based, short-term and emergency respite care, particularly for clients with dementia.

Initial funding to establish most Community Respite Houses appears to have come from one of two main sources – either through HACC via a submission based grant process involving regional offices of the Victorian Department of Human Services, or through an allocation of discretionary funds from an auspice organisation (e.g. Villa Maria, Anglican Aged Care, UnitingCare Wangaratta). Ongoing operating funds (sometimes conditional upon successful trials) are usually derived from both the above sources, plus client contributions. More recently, funding has also been available through the National Respite for Carers Program, an initiative of the Commonwealth Department of Health and Ageing. Sometimes, the acquisition of government funding appears to have occurred only after the service was well established. Funding is generally subject to a Funding and Service Agreement, which often stipulates service targets (e.g. number of bed nights or 'blocks' of care) and caps on access for individual clients. During the days, clients often attend Planned Activity Groups in the same house (although this is not defined by the funding body as respite care).

Current Service Range, Demand & Utilisation

Community Respite Houses have been most innovative in providing services that will meet the needs of clients and carers alike. Services include overnight, weekend and emergency respite, day care, in-home respite, host home respite and carer support groups (which aim to provide information and resources to carers, initiate and support social activities, provide opportunities to share experiences and encourage carers to consider their own needs and self care). Feedback from carers and other services is positive, supporting the appropriateness of current programs.

While there is not a specifically defined client group for services delivered by Community Respite Houses, the care recipients at Houses under review are typically elderly people with varying degrees of dementia who need short-term (overnight) accommodation for respite purposes. Clients are generally

independently mobile, able to weight-bear and not in need of nursing care (eg insulin-dependent diabetes – where a person's care needs are such that technical procedures are required, a District Nurse will usually be asked to attend). Care recipients also include some people with strokes, age-related disabilities and frailty, but some Houses may exclude clients who require lifting or who exhibit aggressive or violent behaviours. A small number of Houses do not provide personal care however they can be arranged using brokerage funding if required.

Usually, an ACAS assessment is not required - Houses complete their own assessment in conjunction with the carer or family (the Care Plan), and external expertise is sought as required (e.g. district nurse, psycho-geriatric or other specialist assessment). House assessments or referral forms are usually quite detailed and include information about medications, continence, diet and eating skills, behaviour, communication, sleeping routine, mobility, dexterity and personal care requirements. All Houses endeavour to identify and meet the special care needs of clients within safety limitations and skill levels of staff.

When reviewing client profile data, the most immediate observation is that data collected and reported for the HACC Minimum Data Set (MDS) and National Respite for Carers Program is not standardised. As a result, the profile data from the two programs is not directly comparable. While many of the sample Houses did not provide complete MDS client profile information for review, the available data indicated that the profile of the client group is predominantly aged over 80 years and female (although at Neil Stewart House and Cornish Vale care recipients are predominantly male). The majority of care recipients are on pensions and reside locally in homes with their carers, although a proportion appear to live alone without a carer. Over 70% of carers are either spouses or immediate family members. While carer respite was almost entirely the reason for admission, the sources of referrals were fairly evenly spread across family, aged/disability/HACC assessment teams, health service providers (including GPs) and self-referral. Available overnight respite at the sample Houses ranged from weekend only to seven days per week. All Houses reported full occupancy levels (i.e. 100%), although in many cases data was unavailable to support the calculation of actual utilisation levels.

Current services appear more or less sufficient for the presenting client mix – most are fully booked (or able to fill vacancies) and some have a short waiting list. There are some periods of peak demand when demand clearly exceeds supply however these do not generally appear to be the norm. However, there has been little 'marketing' and therefore community need may be greater than current service provision. Although no statistics are kept, anecdotally there appears to be 'hidden' demand expressed through requests from existing clients for extra availability, from Commonwealth Carers Respite Centres, via enquiries from hospitals, nursing homes and GPs.

The lack of accurate waiting list data at most Houses also obfuscates the issue of demand, although all Houses report that they have small numbers of clients waiting for admission for short-term respite care and generally short waiting times. All Houses appear to effectively manage requests for services, although none heavily market their services which may generate additional demand leading to increased numbers of clients waiting for admission and longer waiting times.

Although Houses had not formally assessed levels of unmet demand for services, many are unable to cater for people with aggressive or violent behaviours, high nursing loads and, in some cases, high levels of dementia. Some Houses also reported that a significant proportion of clients would prefer longer stays, ranging from four or five nights up to two weeks consecutive stay that would facilitate a holiday for the family or carer. Within the communities that Houses serve, there appeared to be a general lack of emergency options, places that take couples and financially realistic options.

Standards and Quality

Community Respite Houses reviewed as part of this project tend to be used for both overnight respite and day programs, although some are purpose built and operated and a number of others use the facility to run other programs and activities as well. Most Houses are converted residential dwellings built within the local government administered standards applicable at the time of construction; since acquisition, most have been modified in some way (either structurally or with specially tailored fixtures and fittings) to meet the needs of the client group. (Where building works exceeded a defined amount, local government would have needed to grant a further certificate of occupancy). Special features typically include measures to promote access for the disabled, fire/smoke detectors and sometimes Fire Indicator Panels, and, in some cases, internal and external security for wandering residents with dementia. Most Houses have regular fire and evacuation drills and retain an independent auditor to inspect food preparation areas every six months (as required under the Food Act 1998). However, as noted earlier, very few of the Houses would fully meet fire and safety requirements under the Aged Care Act 1997 (i.e. few have residential sprinkler systems, fire compartmentalisation, emergency exit lighting etc) and there are no prescribed standards or process for building certification.

Where the House receives HACC funding, the HACC National Service Standards are recognised as a guide to service provision. DHS regional HACC project officers can conduct assessments against the HACC standards once per annum. Other funding sources may also carry standards compliance requirements (eg Disability Services Standards and a range of other guidelines and requirements stipulated by the State Government in some FASAs; Community Care Packages must be provided according to Community Care Standards arising from the Quality of Care Principles of the Aged Care Act 1997) although some do not (eg Commonwealth Carer

Respite Centres accept and support the HACC standards and do not require or provide their own set of regulations).

Also as discussed earlier, beyond formal external requirements, in almost all instances, Houses are also either developing their own standards or adapting the standards, policies and procedures of an auspice organization in order to guide service delivery and meet individual needs.

Some Houses have formal or adapted systems to facilitate quality assurance and continuous quality improvement (eg a number of Houses are in the process of undertaking audits to address service adequacy, client satisfaction and best practice in service delivery); however, others do not. At most Houses, staff are provided with appropriate, comprehensive training at orientation. No specific staff training is provided in relation to quality management or quality assurance, although each facility is committed to ongoing staff development and pursues opportunities to achieve this. Feedback and discussion about process changes are not generally communicated comprehensively across all staff at a facility. Usually, all staff have detailed job descriptions including objectives and key tasks and regular performance appraisals are carried out.

All Houses have a variety of mechanisms in place to ensure continuity of care. Each House has in place a detailed admission form or uses HACC or NRCP documentation that details client profile in relation to medication, dietary requirements, languages, likes and dislikes and other factors relevant to the provision of care. A process for administering medications is in place, which at some houses is very detailed. A perceived major strength of Community Respite Houses is the ability to provide a home like environment and integration with an existing day activities program (in all but one of the facilities). A format (whether it be formal of informal) for dealing with complaints exists in all facilities.

Service Costs and Funding Structures

Instead of the fixed schedule of subsidies and fees that applies to Commonwealth funded aged care homes, funding for Community Respite Houses is generally addressed though funding and service agreements with State-based managers of the HACC program and/or brokerage funding (eg via the NRCP, sometimes direct or usually via a Carers Respite Centre). Each source of funding generally has a separate agreement and reporting requirements, which can increase the administrative load. Under some funding agreements, Houses enjoy a 'guaranteed' level of recurrent funding (in return for meeting service targets) that appears to provide some certainty year on year; however others do not convey this advantage. Not all Houses appear to access the two most common funding programs, HACC and NRCP; very few Houses receive funding from outside these sources, either government or private.

In high care facilities, respite care receives Commonwealth funding equivalent to the Resident Classification Scale (RCS) 3 daily subsidy (currently $88.54 per day in

Victoria) and a respite supplement ($28.99 per day), while in low care facilities the daily supplement is based on RCS 6 ($30.35 per day) plus the respite supplement ($18.26 per day). Other supplements normally paid by the Commonwealth for residential aged care also apply depending on the clients' financial assessment and care needs, and respite care recipients may also be charged the normal daily care fees prescribed for residential care but not accommodation charges or bonds.

There is a range of brokerage funding programs available for different groups requiring respite care in Community Respite Houses. CACPs are available for older persons (usually over 65 years) who are frail or disabled, who are eligible for admission to low care residential services but elect to remain living at home with support, and who require coordination of their support services. Services similar to low care are delivered to clients at home, and all HACC services may be purchased through CACPs. The Commonwealth presently funds approved providers of CACPs at the rate of $29.12 per client per day, and service recipients are required to pay a client contribution of 17.5% of the single pension rate. Recipients of services through CACPs must be initially assessed by ACAS for eligibility.

Linkages on the other hand is available for people of any age with a disability, elderly people requiring additional support to remain living at home, as well as the carers of these people. Brokerage funding available through Linkages forms part of the HACC program and can be used to purchase any of the HACC services as part of a client's required package of care. HACC funds up to $10,700 per client per annum; clients can be requested to pay a contribution fee in excess of 17.5% of the single pension rate if above-average levels of service are provided to clients. Care recipients must have an appointed case manager to coordinate services, and unlike CACPs, Linkages can be used to purchase services for eligible clients who have separately assessed by ACAS as requiring high care.

In-home respite is a fully funded HACC service with no client contribution fees. Originally funded in hourly units, in-home respite care is now also funded for overnight 10-hour blocks of care ($109.28 per 10-hour block).

Community Respite Houses attract HACC funding under one or more of three sub-categories: (1) Respite (Overnight), funded as ten hour blocks of care; (2) Respite (Home and Community), funded per hour provided at the defined hourly rate; and (3) Planned Activity Group (either core or high), again, funded per hour provided. Respite (Home and Community) funding can be used to provide care in or out of home including centre-based care.

In addition to government funding, most Houses also charge a client fee. Fees range from $23 per overnight stay through to around the level of the applicable HACC payment for overnight respite (10 hour block), which is presently $109.28. Most Houses charge at the lower end of this scale; in addition, most will discount or waive fees where the capacity to pay is limited or for disadvantaged members of the local community.

Community Respite Houses are generally staffed with Personal Care Assistants and/or program and support workers; minimum qualifications are usually Level 2 First Aid and TAFE Certificate Three Personal Care (although there are a range of appropriate TAFE certificates). Staff are usually employed on a permanent part-time basis although a few are casuals. In a number of Houses it was found that there was a member of staff qualified at RN Div 1 level, although this was not a requirement and they were generally not paid at that rate. However, some Houses noted a gradual increase over time in the level of needs that care recipients appeared to be presenting, and were concerned that this may require more RNs on the roster.

Usually, there is no specific budget allocated for staff training although there is general support and encouragement for staff to pursue skill development. Most training undertaken appeared to be through the HACC centrally funded and provided program.

Not all Houses were able to provide financial data. Where data was provided, it could not be segmented to allow analysis of the overnight respite component alone. Thus, this evaluation was unable to accurately review service costs. Some Houses, however, expressed the view that their costs compared favourably with the costs of in-home respite (on the basis of a more efficient staff to client ratio).

Service Needs & Outcomes

There is a great diversity of caring relationships amongst older people, and their circumstances can vary widely. Carers may be spouses, children, relatives or just good friends; sometimes carers might not be friends at all. They may or may not live in the same residence or even suburb or town as the care recipient. All of them however will have their own lives and interests, and responsibilities and problems to deal with, as well as trying to meet the needs of the person for whom they are caring. The needs of the care recipient will often vary widely from individual to individual; in addition the particular needs of an individual can change from week to week. This multiplicity of circumstances and relationships means that services that aim to provide respite for carers of older people must be very flexible if they are to meet the wide range of presenting needs. It is also very important that in order to contribute to the maintenance of the caring relationship, the needs of the care recipient as well as the carer must be catered to.

Consultation with groups of carers currently using the Community Respite Houses included in this study tended to confirm published findings from recent surveys. Carers consulted in the present study expressed a high degree of satisfaction with the services provided by Community Respite Houses; most said the services were critical to their ability to continue to support their spouse or relative to remain living in their normal community environment.

Carers reported they are often very tired, uptight and frustrated; in addition, their caring role for a particular family member often impacted on other family

relationships. Caring can be an unrelenting task and carers said they often felt helpless and that their situation was hopeless (particularly where the person being cared for had dementia). Carers reported that access to respite care has helped them in a variety of ways: examples include staying 'connected' to family, friends and community (particularly important for their quality of life when, later, they may be alone); taking a holiday for the first time in ten years; some space and freedom, time to be on one's own; time to go somewhere together with their partner; and for the first time in months being able to keep a Doctor's appointment (because the Doctor is always running late and the carer couldn't make anything other than quite short alternative care arrangements!). Short breaks also encouraged commitment in their role as carer, reinvigorating them and helping to recharge their batteries.

All carers consulted indicated that in order to maintain their spouse/relative, they needed access to a wide range of respite services in order to meet their needs. There was uniform agreement that sole reliance on residential respite care would not provide the required support for their continuation in the role of carer. Flexible and locally accessible short-term relief options become essential. For the carers interviewed, who generally cared for elderly people with various levels of dementia, the usual pattern of respite needs involved combined use of overnight/weekend respite services in Community Respite Houses to provide regular opportunities for uninterrupted sleep (and sometimes work or holidays), access to day respite through day care or Planned Activity Groups to enable carers to plan regular social, shopping, relaxation and sometimes work activities, and finally in-home respite (day and overnight) usually for short-term, irregular relief for special appointments and activities. These were the key services for carers that enabled them to fulfil the carer role and still maintain a basic lifestyle.

A key feature of the services provided by Community Respite Houses is the capacity to provide respite care at short notice. Often carers will wait until a crisis point has been reached before seeking assistance; thus, because the lead-time for most other forms of respite care is long, when the need is greatest the fewest services are available. A proportion of caring relationships break down permanently for want of a short term, temporary placement that can act as a kind of 'circuit breaker'. This need is emphasised in cases where the person being cared for has dementia. The behaviour of some people with dementia is characterised by unpredictability, perhaps including physical and verbal aggression, making it all the more difficult for the carer to cope in situations that may be new to them.

A case study has been prepared to illustrate the needs and amplify the outcomes achieved by both carer and care recipient from short stay respite in a Community Respite House:

Ms S is principal carer for Mr W, her father, who now lives at home with Ms S, her husband and their three teenage children. Mr W has Alzheimer's disease, a chronic and progressive condition that has severely impaired his orientation, comprehension, language and judgement.

Mr W has recently undergone an ACAS assessment and the carer has been informed about residential respite programs but has not accessed a service yet. The carer is very apprehensive about relinquishing care, even for short periods, and has very high levels of stress. Contributing to her concerns is the issue that at present, the children are studying for important exams and are finding it difficult to concentrate and make any progress given the disruption to normal household function caused by Mr W.

On the basis of information provided by the ACAS, Ms S contacted five aged residential services in the area; several she visited, in order to get a better feel for the facilities. Four of the services said they were unable to assist because of Mr W's advanced dementia - their premises were not secure and, in any case, they felt that Mr W's presence would disrupt other residents. The fifth service did provide a couple of 'dementia-specific' places although there would be a wait of 11 weeks before Mr W could be admitted and the minimum stay would be two weeks. Ms S was unsure if the family could afford this and felt that she didn't want to be away from Mr W for that length of time. There was no Supported Residential Service in the area that could handle Mr W's needs; even if there was, fees would be expensive and they also required two week minimum stays.

When Ms S contacted the ACAS again to report her frustration, it was suggested that Ms S also contact the regional Commonwealth Carers Respite Centre. After an appointment was made, the CRC assessed Ms S as requiring 'emergency' respite. They arranged for Mr W to spend four nights at Willowbank, a local Community Respite House. The CRC handles most of the paperwork and seemed to smooth the process - Ms S was extremely anxious and unfamiliar with what should happen. Ms S was able to go straight over to Willowbank to have a look. The staff welcomed her and made a pot of tea. The house looked like most other houses in the street, inside and out. It had three small bedrooms (just like home) that Ms S felt would create a sense of comfort and familiarity for her father. The staff offered to have Mr W join in a day activity in the House for a few hours so that Ms S might better guage how he might react and get a feeling for the way the House worked. All this contributed to a sense of ease for Ms S and she agreed that it would be good for everyone if Mr W could stay a few nights. The House provided Ms S with a list of things that Mr W would require during his stay. She went home to pack and arranged to drop Mr W off later that day when she could fit it in around work commitments.

When Ms S came to pick up Mr W, he was a little confused but staff advised Ms S that he was generally happy throughout the break. They discussed the activities that he had engaged in, how he slept and other aspects of Mr W's stay (including that he insisted on an early breakfast seated at the kitchen table!). They were even able to give a helpful hint to Ms S about how to encourage a particular routine for Mr W.

Ms S was able to find some space to take care of other things in her life – the residential respite allowed her to "get things back together" at home and "steel herself again for battle". Last night was the first full nights sleep Ms S had enjoyed for nearly a year.

Willowbank offered a shorter residential option than alternatives, even had they been available, flexible admission and no waiting in an emergency. Mr W was cared for in a safe environment, specifically created to meet his needs. The staff at the House were able to pay Mr W special attention. When Ms S got home, she thought "why wait" and rang the House to plan another weekend for Mr W, this time to coincide with the next school holidays.

Source: Compiled from information provided by Commonwealth Carers Respite Centre Southern Region

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FINDINGS & RECOMMENDATIONS

Strengths and Weaknesses

Based on a review of relevant literature, consultations with carers, program administrators and service providers, and detailed analysis of the operations of Community Respite Houses, the model of care has the following strengths:

- Smaller scale community residential facilities are often more capable of responding to demand for short periods of out of home respite care than alternative options and can often address emergency requests immediately. Community Respite Houses are available at the times that they are most likely to be required (ie overnight and at weekends).

- Community Respite Houses also respond to other inflexibilities in alternative aged residential respite care services (eg can only be provided in approved homes; persons seeking admission as a respite resident need to satisfy admission criteria; limit of 63 days for which additional subsidies may be paid).

- Community Respite Houses are more affordable for carers, and are less difficult to maintain as a planned option, than private respite options and Supported Residential Services.

- Community Respite Houses are effective in maintaining people in their own homes and can prevent or assist in delaying admission to more costly and less preferred residential options. (By providing relief to carers, Community Respite Houses can support the overall shift in balance from residential to community care by helping to prevent the premature or inappropriate admission into long term residential care).

- Community Respite Houses are a vital component of flexible respite packages (that might also include in-home respite and a range of out of home respite including day care, recreational activities and other short stay residential options) designed to meet the specific needs of individual carers.

- Community Respite Houses can allow couples to stay overnight, thereby meeting the emotional need of the couple not to be separated. This may particularly alleviate anxiety associated with separation for first time residential respite users, and lead to a wider array of options being utilised in the future.

- The smaller homelike environment of Community Respite Services allows for increased familiarity with the staff and setting and minimises disorientation for the care recipient. It can adhere to home patterns and contribute to resident routines.

- Community Respite Houses provide flexible admission/discharge times that can contribute to more individual tailoring of the respite experience, enabling carers to arrange their commitments, transport and extended family support.

- The smaller staff to resident ratio at Community Respite Houses ensures more immediate staff accessibility and personalised support. It ensures familiarity between staff (who can become very skilled at meeting the specific needs of particular people) and care recipients.

- The smaller staff pool promotes continuity of care and facilitates more informed, detailed feedback to carers.

- Where Community Respite Houses utilise the services of volunteers, 1:1 support may be possible and a high level of monitoring for the care recipient is assured.

- Access to and integration with an existing centre-based day program promotes interaction and ensures activity throughout the day.

- Relationships with Commonwealth funded aged care homes (i.e. high and low care facilities) can influence staff training and introduce carers to another service that promotes future planning and discussion about alternative care.

- Community Respite Houses also generally have strong links to other community services (eg hospitals and transport) that can assist carers to access the services they most need. They may even operate other services themselves that carers may find useful (eg host family respite, attendant care).

- The program can target carers looking after people with dementia and more complex care needs, who often cannot find suitable services. Structurally and programmatically, Community Respite Houses can be finely tuned to the particular needs of people with dementia.

- Some Houses have trained nursing staff to manage and coordinate respite bookings, to facilitate appropriate admission and liaison with GPs. They can also ensure help to ensure appropriate coordination and/or provide any specialised nursing needs.

- Community Respite Houses are able to appropriately and simultaneously address the needs of both the carer and care recipient. Most Community Respite Houses also provide a range of ancillary carer support services (eg emotional support; stress management).

- Community Respite Houses effectively understand informal supports and can link them carefully with formal services (Houses have assessment approaches that assist carers to identify what would be most effective for them).

- Community Respite Houses are aware of what carers see as important. In many cases carers may not use a service unless they believe that it will be positive for the person they care for and for themselves. Houses are sensitive to a range of concerns that carer's may have including loss, guilt, resentment and anger.

- The service experience within Community Respite Houses can be tailored to the specific activity needs of individuals.

- The Community Respite House model is a specialised respite service that is easily replicable; it provides a planned, supervised and safe option.

The Community Respite House model of care may also have some weaknesses:

- Not all Community Respite Houses have well-organised and promoted activities programs that cater to the specific needs of care recipients.

- Not all Community Respite Houses provide feedback so that carers are aware of what the person they care for has been doing during the respite period; this would also assist with conversation at home and future care planning.

- Not all Houses have occupational health and safety plans in place.

- Infrequently, in order to meet 'emergency' situations, the usual standards of care within a Community Respite House may be compromised.

- Some staff at Community Respite Houses may not be accessing a range and level of training that will help to maximise their effectiveness.

- Regular rotation of staff at some Community Respite Houses can make it difficult for carers to develop relationships with the staff who regularly look after the person they care for.

- Whilst an issue in respite and residential care services generally, more formalised and better-promoted processes for medication management may help to eliminate potential medication problems and errors and ensure that medication administration continues in the usual way.

- There may be a requirement for a more formalised and better-defined process for dietary control in some Houses, to eliminate the chances of care recipients eating inappropriately during respite periods.

- Some Houses require more standardised bedroom accommodation so that carers (often the elderly spouses) feel confident that dignity and safety is being maintained (in keeping with the standards of their era).

- Community Respite Houses should have more formal and consistent programs to improve community information about respite care options.

- Some Houses would benefit from improved communications, with carers, internally amongst staff and with the sector and community in general (including both formal and informal mechanisms, and complaints systems).

- Not all Community Respite Houses have a formal process to secure back up and/or additional professional expertise in case of emergency.

- There are no defined, consistent policies and standards to assist in formalising the Community Respite House service model and to provide a basis for future service benchmarking.

- There is a lack of prescribed standards for the structure and certification of the physical facilities at Community Respite Houses. Some Houses may not comply with the BCA 1996 and Victorian Capital Development Guidelines.

- Funding for Community Respite Houses is not coordinated or provided through a specific government policy or program; two Houses providing the same level of service may be funded at different amounts. For some Houses, there is no assured ongoing funding for the service.

- There is a lack of consistency between Community Respite Houses in relation to defined assessment and eligibility criteria for care recipients.

- There is a lack of stipulations as to required minimum staffing structures.

- There is a lack of coverage by specific regulations (in comparison to Commonwealth funded aged care home and their incorporated respite care component) and by prescribed standards for the accreditation of services (instead of the various sets of standards applying piecemeal eg HACC standards, the Community Care Standards arising from the Quality of Care Principles of the Aged Care Act 1997, Houses' own standards or adapted policies and procedures of an auspice organization).

Aspects of Best Practice

At present, as reference points for best practice in respite care services, there are mandatory standards that all respite care providers must meet. These include standards prescribed under the *Building Code of Australia (BCA)*, and State-based standards covering food safety (*The Food Act*), occupational health and safety (*Occupational Health and Safety Act 1985*), and additional building standards for Victorian health sector facilities (*Capital Development Guidelines*).

In the provision of overnight respite care for older people, the services provided by Community Respite Houses fit somewhere between the HACC National Service Standards and the standards for Commonwealth funded aged care homes prescribed under the *Aged Care Act 1997*. The HACC Standards were developed to promote a nationally consistent approach to the delivery and quality of all HACC funded services (but are not prescriptive as a condition of funding). The HACC Standards deal with service standards but not standards for the buildings from which services are delivered. On the other hand, standards for Commonwealth funded aged care homes, including those providing respite care in addition to residential care, are mandatory (for approved provider status and funding from the Commonwealth) and cover both services and facilities.

These latter standards are designed for permanent residents in Commonwealth funded aged care homes, extended to cover respite care when the facility offers respite. However, as indicated earlier, the nature of respite in residential care is different, being for planned longer-term episodes of respite. Community Respite Houses, on the other hand, cater for carers needing short-term, often unplanned or emergency, respite. The Community Respite House model targets a different set of carer needs and therefore needs a different set of best-practice standards (to those applicable in permanent residential aged care). Standards for the Community Respite House model need to be appropriate for respite stays of up to seven days in duration.

At present, Community Respite Houses have generally developed their own internal standards based on HACC Standards. There is little commonality in the standards in use across Community Respite Houses, and to some extent this reflects the arbitrary nature of the emergence of the model over the last decade. However, feedback from carers has established the need for the short-term (unplanned) centre-based respite option, and the adoption of uniform and specific best practice standards for Community Respite Houses will assist in defining, formalising and legitimising this respite model for both consumers (ie carers) and funding bodies.

The following table therefore summarises some suggested and recommended standards for uniform adoption as part of the Community Respite House model.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
SERVICE ROLE DEFINITION	Flexible definition (i.e. overnight and weekend respite with/without staff services; stand alone/integrated with day care).	• Single purpose model. • Flexible service model based on tangible identified needs. • Rigid service model tightly defined for funding eligibility. • Multi-purpose/integrated service model (eg integrated overnight/day respite services).	Research indicates that carers seek access to a range of locally available respite services. If needs can be identified and quantified, funding programs should be sufficiently flexible to provide services through a variety of models in line with carers' needs. From Community Respite Houses, carers are seeking short-term overnight care for care recipients who normally live at home, some with the assistance of visiting nursing care but not permanent nursing care. Community Respite Houses need to replicate this environment. This influences the type of staffing structure required i.e. predominantly personal carers with the possibility of some nursing care (preferably arranged through brokerage) but not permanent nursing care. Where substantial nursing care is required throughout the respite episode, this will most economically be delivered through high care facilities with respite services where trained nurses are permanently rostered. The service role for Community Respite Houses should therefore be short-stay overnight or weekend respite (including unplanned and emergency respite) to 'low care' level. The respite care would be delivered by staff trained in personal care; some visiting nursing (Division 1) services could be provided where appropriate, but people requiring substantial nursing care would be referred to 'high care' services.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
BUILDING **Structure**	• Not defined; possible that some buildings used for overnight/weekend respite do not meet current BCA and State Capital Development Guidelines. • In a number of cases, the need for overnight respite has been identified by providers of day programs for clients in Planned Activity Groups, and the day facility has been adapted for overnight respite.	• Buildings used for overnight/weekend respite should comply with prevailing BCA and State Capital Development Guidelines (likely to mean that all facilities will require sprinkler systems unless there are six or less clients accommodated in the facility with no more that one requiring assistance to evacuate in the event of a fire). • Mandatory compliance with all other fire and building services required by BCA/CDG and Local Authorities (i.e. fire detection and separation; evacuation plans etc). • Carers have expressed a strong preference for single bedroom accommodation similar to the home environment for dignity and privacy. • Audit built environment to ensure tailored for people with dementia (eg thermostats, window rails or locks, safety glass, contrasting colours, as homelike as possible inc. smell, etc). • Given the nature and implication of the CDG and the large numbers of clients with dementia, the optimal structure for Community Respite Houses is likely to be a facility of less than 350 m^2, accommodating six residents, that can be evacuated in less than three minutes (with no more than one resident requiring significant assistance to evacuate). The CDG require such facilities to include a range of fire safety features including smoke detectors/alarms, automatic fire sprinkler systems, primary exit paths, fire separation compliance, 'fire safe' construction, fire extinguishers and annual fire drills.	Under the State Capital Development Guidelines (CDG), facilities used for Planned Activity Groups are deemed non-residential and are therefore not covered. The CDG at present regulate residential facilities. Where an ADASS facility has been adapted for overnight/weekend respite, different standards would apply under the CDG. Whilst the CDG do not have a category named 'Community Respite House', they do have categories of Community-Based Houses (CDG 7.7) and Supported Community-Based Houses (CDG 7.4) which would cover the Community Respite House model. Under the CDG, both types of facilities must be less that 350 m^2 (with new facilities being only single storey). Community-Based Houses can accommodate up to 12 residents while Supported Community-Based Houses can accommodate up to six residents, but in both cases there must be no more than one resident (or 10% of residents) who requires significant (or physical) assistance to evacuate the facility in an emergency; in essence, the CDG require the facility to be capable of being completely evacuated within three minutes. If the guidelines on facility size or evacuation capability are exceeded, the facility must then comply with the additional requirements of the Congregate Care Facility classification (CDG 7.5) which includes aged residential facilities.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Location	• Various structures presently exist, from standalone buildings to buildings integrated with other aged care services on a single campus.	• Flexible models as at present. • Multi-service 'campuses' where there is the possibility of emergency professional backup if needed. • Where ready campus access to backup is not available, then formal processes need to be established for summoning assistance in emergency situations.	Consultation with carers confirmed that many using Community Respite Houses also have high need for day respite/planned activity groups. Given that overnight respite providers are likely to incorporate activity programs as part of the service, provision of Community Respite House services co-located with Planned Activity Groups/day care programs is probably a desirable association for planning purposes. Some Community Respite Houses felt co-location of the service with aged residential services enabled better back-up support. Whilst establishing arrangements for emergency medical or nursing care is recommended, this does not necessarily rely on co-location with other services.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
FUNDING			
Structure	• Presently a mixture of HACC and NRCP funding as well as components of brokerage funding (eg CACPs) and 'user pays'.	Combination of: ▪ Single FASA covering all sources of government program funding. ▪ Contracted funding agreements with 'brokerage' agencies (eg CACPs, DVA). ▪ User pays at fixed industry rates. ▪ 'Purchaser provider' models.	Current funding is ad hoc; whilst there can be various funding sources, the quantum of funding ideally needs to be negotiated and provided through a single agreement so that all parties are aware of the extent of available funded services.
Levels	• Ad hoc through negotiation; sometimes based on HACC overnight respite rates.	Funding levels could be based on a range of industry norms such as: • HACC overnight respite rates. • Respite care rates in low care facilities plus margin in recognition of small unit size. • Respite care rates in high care facilities. • Market rates in private facilities.	Small Houses will need higher levels of daily funding than alternative, larger residential care providers. They cannot be expected to achieve the same economies as larger units. Community Respite Houses are providing a different type of respite service (including unplanned and emergency) to that in aged residential care facilities, in smaller-sized facilities. The smaller units will not enable the same economies of scale seen in residential services, and hence the need for higher daily funding levels. Nevertheless, there is a need for Community Respite Houses to be funded on a uniform formula, whether this is based on a time-based unit or a standard staffing profile.
Fees	• Community Respite Houses establish their own fee scales for different client groups.	• Ensure equity in fees scale, consistently applied.	Fee scales should be uniform and based on the Guidelines for HACC National Service Standards.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
SERVICE STANDARDS	• Houses presently adopt practices consistent with HACC standards. Some agencies are working towards ISO accreditation whilst others are undergoing accreditation as part of a parent organisation's accreditation process.	• An amalgam of industry standards could be adopted based on relevant aspects of the HACC Standards, Aged Care Accreditation Standards plus a combination of sources (especially in the areas of OH&S and privacy/dignity). • The HACC National Service Standards (alone) could provide best practice principles for personal care and these could be used as the basis for developing improved self-assessment. • Community Respite Houses must be aware and compliant with all applicable regulations.	To legitimise the Community Respite House model the sector needs to define and adopt a uniform set of service standards so that consumers and funders are aware of achievement of at least the basic level of service in all funded facilities. Typically the development of such standards should include some 'over-arching principles' that apply across broad service components. Within the human services sector, 'broad service components' typically involve the areas of management and organisation; service/care provision; client lifestyle; and client safety. The 'over-arching principles' typically deal with regulatory compliance, continuous quality improvement, and staff education and development. This categorisation has been broadly applied in the options and recommendations that follow.
Regulatory Compliance	• Community Respite Houses comply with a number of mandatory regulations, but there are some areas where regulatory requirements are unclear.	• To publicly demonstrate adherence to defined standards, Community Respite Houses could undergo some form of quality accreditation (either through ISO or some sector-specific accreditation process eg CHASP, ACHS etc).	At present, Community Respite Houses must comply with all regulations pertaining to relevant Federal and State Building codes, food safety regulations, and occupational health and safety regulations.
Continuous Quality Improvement	• Quality improvement processes are followed to various extents in the different Community Respite Houses at their discretion. • Most agencies have developed in-house quality management programs. • No enforced quality management or accreditation program.	• There needs to be a defined uniform process for quality improvement adopted in the sector. This should incorporate uniform statements of residents' rights and responsibilities, as well as defined processes for dealing with client complaints. • Undertake annual evaluations of service. • Undertake satisfaction survey of a proportion of all carers three months after service experience.	Demonstrating a commitment to ongoing quality improvement is an essential component of standards implementation and monitoring. Quality improvement should be outcome-based evaluation emerging from areas including policy/procedure reviews and updates, staff appraisals and competencies reviews, and staff orientation and training.

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Staff Education and Development	• Community Respite Houses are actively involved in staff education.	• A formal program and evidence of active staff education across all areas of service operations based on the defined standards.	An effective staff education process typically involves the existence of a policy and procedure manual covering all defined service standards, and a staff induction and in-service education program based on the standards and manuals. It should also include regular assessment (eg annual) of staff training needs as part of quality improvement.
Management and Organisation			
Client assessment for service eligibility	• *Most agencies determine target clientele and conduct their own client assessments for admission.* • *Generally, agencies are targeting aged clients with dementia, able to weight bear and with uncomplicated medical conditions.*	• *In-house assessment of clients for admission as at present.* • *Independent assessment of clients for eligibility where government funding is meeting the full cost of service.* • *In-house assessment for full-fee paying clients.*	*Community Respite Houses need to have a defined client group with minimum admission eligibility criteria, as well as criteria which set the upper limit of client needs that can be met. This will ensure Community Respite Houses are appropriately utilised.* *The assessment process would include review of ADL capacity, as well as cognitive assessment and assessments in psycho-social and cultural risk areas.* *Under best practice, all Houses would adopt uniform standards. All would be able to service clients with "low end" needs, but different capabilities may exist for "high end" needs.*
Service Access	• *Most overnight stays are pre-booked by a broad cross section of the community.* • *Emergency beds exist in some Houses.*	• *Single emergency contact number (24 hours/seven days).* • *Extended bookings up to 12 months out.* • *Access determined upon basis of need.* • *Ensure transport can be provided to and from the House.*	*Access needs to be based upon principles of equity. It also needs to reflect key features of the service model i.e. available on an emergency basis, as and when needed.*

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Communication	• *Houses have developed individual communication mechanisms to carers. Feedback from carers indicated many are seeking more detailed communication about daily activities and procedures.* • *Currently there is often minimum handover when clients enter or are discharged from respite.* • *Most facilities do not have formal feedback loops for dealing with suggestions, concerns and complaints.*	• *Produce and distribute information sheets, fact sheets and brochures).* • *Formal exit meeting (eg three monthly) with carer to discuss ongoing care plan and services that may assist this.* • *Review complaints handling procedures to ensure equity, timeliness and responsiveness.* • *Provide culturally specific workers or alternative formats where required (eg should adopt guidelines and assessments developed through the Partners in Culturally Appropriate Aged Care Project).* • *Supply written information about practical details of respite (what to bring with you; who to talk to; how to organise finances).* • *Try to ensure one member of staff has counselling experience to assist distressed carers (as well as through transition if it is a new experience) or have access to same through co-location/agreements with other services.*	*Carers require detailed communications about services at the facility and daily programs.*
Documentation	• *Documentation kept is basically at the discretion of service provider; there do not appear to be any mandatory requirements.* • *Most services have adopted systems based on HACC service standards.*	• *Industry standards should be adopted.* • *Consult with carer and care recipient in development of service plan.* • *Formal client records need to be maintained particularly in the areas of personal care provision and risk management. These records should maintain details of clients' general condition, Activities for Daily Living risk management and interventions.*	*Proper client records are needed as a routine communication tool between staff and carers; monitoring subtle changes in client service needs improves the quality of client care.*

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Procedures	• *Although not rigidly stipulated or enforced, most service providers have adopted procedures and systems for client management based on HACC service standards.*	• *Better defined and more uniform operating procedures and systems.* • *Industry standards could be adopted.*	*Industry practices should be defined so that people are aware of what to expect before, after and during admission to the service.*
Administration	• *Administrative and financial reporting systems are very variable, partly a reflection of the different funding processes and associated reporting requirements.*	• *Clear financial management system that accurately reports costs and core services.* • *Monitor and control funds and provide ease of oversight.* • *Establish links with key regional service providers.*	*High levels of interaction between CRCs, the carer and the service provider in the initial respite experience have been shown to impact on whether the carer will accept respite on a regular basis.*
Data collection and reporting	• *Presently agencies can complete Data Returns for both HACC and NCRP funding programs. HACC and NRCP Data Returns are inconsistent (HACC data focuses on the care recipient and NRCP data focuses on the carer).*	• *Mandatory uniform data collection by all agencies.* • *HACC and NRCP adopt a consistent Minimum Data Set.*	*A uniform dataset for short-stay respite care would enhance administrative efficiency.*

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Health/Personal Care *Staffing*	• *Most agencies have adopted appropriate staffing structures based on PCA-level qualifications.* • *In some higher care facilities, Div 1 or Div 2 Nurses are employed.* • *Carers are generally very satisfied with staffing at Respite Houses; when issues arise they are usually related to matters of staff identification and staff rotation and its impact on care continuity.*	• *Staffing standards that ensure appropriate staff qualifications for the defined clientele.* • *Pay and conditions including allowances referenced against appropriate Award.* • *Develop annual agency training plan and ask staff to report achievements.* • *Staff experienced in caring for and communicating with people with dementia.* • *Minimum training requirements for personal care staff should be at least Certificate III level.* • *Staff should undergo training courses in food handling at least once every two years.* • *All staff should receive regular training in OH&S, back care/safe lift, infection control (especially hand washing) and waste disposal.* • *Policies should be in place to ensure staff work within their training/experience abilities and to monitor training needs so that staff skills are kept up to date.*	*Staffing structures should reflect the defined Community Respite House service model. Given that clients normally reside at home with support, staffing structures could largely comprise trained Personal Care Workers. Where a client normally receives visiting nursing services, this could be maintained using visiting nursing services to the House where appropriate. If clients require ongoing access to trained nursing staff, they should be referred to other facilities with permanent nursing staff (trying to staff 6-bed units with full-time nursing staff would be uneconomic).* *For 6-bed units, there should be 1 PCA rostered on overnight, as well as one rostered on during the morning and afternoon shifts, but preferably working with other staff involved in co-located day care activities. This generally reflects current staffing practices. In certain circumstances, it can be unsafe if less than two staff are available during waking hours.*

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Medication Management	• *Houses generally act in accordance with HACC Standards.* • *However, there have been instances where documentation of medication regimes, as well as the handling and administration of medication has been inadequate.*	• *Uniform medication standards adopted and enforced.* • *Medication management needs to be undertaken in accordance with the Best Practice in Medication Management in Residential Care Guidelines (second edition) which advocate the adoption of unit dose administration aids.*	*For best practice, recommended standards in aged care need to be adopted and this will involve unit dose administration which may be based on either blister packs or compartmentalised boxes. The latter may be more suitable for use in overnight services if the client is not already using the blister pack system. This approach would reduce any risks of medication errors.*
Dietary Management	• *All Houses required to comply with standards for food handling and preparation under the Food Act.* • *Separate from this however, sometimes clients have received inappropriate diets due to breakdowns in current systems.*	• *Regulatory regime appropriate as is.* • *Broad menu choice.* • *Capacity to meet special dietary or cultural requirements.* • *As a minimum, Houses are recommended to implement the HACC guidelines for dietary intakes and recommended food services.*	
Client Lifestyle *Physical facilities (see also above)*	• *Current shared accommodation and bathroom facilities in some Houses do not permit clients to undertake Activities for Daily Living in private eg dressing.*	• *Physical facilities provided by Houses not only need to be compliant with all building regulations and codes, but also need to provide accommodation standards that promote privacy and dignity.*	
Dignity	• *Every effort is made to respect the dignity of clients.* • *Same carers however have a strong preference for single room accommodation to multi-bed accommodation that exists in some facilities.*	• *Review procedures and evaluate outcomes to ensure they maximise independence.* • *Adopt privacy principles especially in the area of confidential security of client and care recipient records.* • *Introduce a confidentiality agreement for staff to sign as part of employment process.*	
Activities	• *All facilities have comprehensive programs of activities.*	• *There should be a comprehensive program of diverse activities for residents (carers like to have regular, detailed communication about these activities).*	

SERVICE COMPONENT	CURRENT PRACTICE	BEST PRACTICE OPTIONS	UNDERLYING PRINCIPLES
Cultural diversity	• *As small service providers, agencies endeavour to meet cultural needs of clients where practical.*	• *As practical, the cultural diversity of clients needs to be accommodated.*	
Resident Security	• *Community Respite Houses provide secure environments for residents, particularly given the high incidence of dementia within the client group.*	• *Appropriate security systems for residents need to be provided without undue restraint.*	
Client Safety			
Safety management	• *Facilities have generally provided a level of fire safety and security, however some Houses are unaware if these are fully compliant with required standards and regulations.* • *Although not enforced by required standards, Houses have generally adopted practices involving regular fire training for staff but not all Houses have undertaken evacuation training and drills annually.*	• *Complete compliance with prevailing building standards.* • *Industry standards should be adopted.* • *Annual fire training and drills for all staff should be compulsory.*	
ACCREDITATION	• There is no stipulated accreditation process at present. • Some Houses voluntarily participate in accreditation process such as ISO etc.	• Practice a range of accreditation process. • Develop a required industry accreditation process to enhance professional standing of Community Respite Houses and to enforce minimum service standards.	As part on an accreditation process, components might include a self-assessment element, monitoring against a minimum set of Key Performance Indicators, and a Quality Improvement plan.

Recommendations

Service Recognition

1. That Community Respite Houses be acknowledged as a legitimate model of care, one that assists people to remain living at home in the community through satisfying the needs of carers and care recipients in ways that alternative services often cannot.

2. That Community Respite Houses be recognised as a particularly effective model of care for people with dementia, providing and expanding the choices available to carers in an area where appropriate services have traditionally been extremely difficult to access.

3. That Community Respite Houses be promoted within local communities and to other local and regional services, as a mechanism to inform carers of the choices that exist.

Defined Service Roles

4. Although there is a need to preserve flexibility in responding to the respite needs of carers, Community Respite Houses should define an agreed service role indicating the range of needs to be serviced through the Community Respite House model.

5. That the target clientele for Community Respite Houses comprise carers and care recipients who may require personal care and possibly some visiting nursing services normally delivered in the home environment. The target group would not include clients requiring full-time nursing care.

6. That a formal study of demand for Community Respite House services be conducted in order to quantify the level of community need.

Service Funding and Reporting

7. Based on a defined, uniform service model, that a model of funding be identified that promotes flexibility and ensures ongoing viability.

8. That to simplify present administrative effort and to make workload reporting more manageable, the HACC and NRCP programs endeavour to agree on a common set of client data for reporting.

Service Guidelines

9. That the Community Respite House sector define and agree on an initial set of uniform service guidelines covering regulatory compliance, continuous quality improvement, staff education and development, management and organisation, health and personal care, client lifestyle, and client safety.

10. That all Community Respite Houses agree to uniformly adopt the defined guidelines to minimise the present variations in service approach and delivery between services and to present more consistent service standards across the field to clients and funding bodies.

Service Accreditation

11. That with the adoption of uniform service guidelines, Community Respite Houses agree on a single (or limited range of) service accreditation process to enable independent assessment and confirmation of service standards to publicly occur.

Buildings

12. Given the history of the establishment of the various Community Respite Houses in Victoria, all facilities should seek re-assessment by a building surveyor for compliance with the BCA 1996 and Victorian Capital Development Guidelines and to ensure Certificates of Occupancy are valid.

13. That Community Respite Houses standardise on an operating unit of up to six beds in facilities that are compliant with CDG 7.7 of Community-Based Houses, taking into account the specifications for a maximum size of 350 m^2 and no more than one resident requiring significant (physical) assistance for evacuation in the event of an emergency.

14. That opportunities for co-location of Planned Activity Groups within Community Respite Houses be explored as an appropriate means of maximising limited resources.

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ATTACHMENT A - DETAILED DESCRIPTION OF HOUSE OPERATIONS

Need Identification and Service Establishment

How were needs identified?	
Banksia	The need for short-term overnight respite care was identified in the early 1990s from requests from carers of family members who were already accessing Banksia's ADASS programs. The carers had formed a support group, affiliated with the Alzheimer's Association, and urged Banksia to seek funding from the Department of Human Services to commence an overnight respite service. Other demand for overnight respite came from local service providers including Mornington Peninsula Hospital, the Community Health Centre and Mt Eliza Geriatric Centre.
Brooke House	Brooke House in Traralgon commenced in July 2001 in a purpose-built retirement unit for the elderly and disabled. The original need for the service was identified through feedback from carers and service providers, seeking a facility for Gippsland residents who need a place to either break trips to Melbourne where care recipients are booked for medical treatment, or to stay in close proximity to Latrobe Regional Hospital where either the carer recipient or carer may be undergoing treatment.
Carinya House	The original need at Carinya is thought to have been identified in earlier regional consultation with service providers and carers. This lead to the establishment of the HACC-funded day program and subsequently the overnight respite program based on feedback from the original regional consultation and from the carers of early clients in the day program. Feedback identified needs for short-term overnight relief for carers as well as day relief. The centre-based overnight respite was established as an alternative to existing home-based respite, thereby offering a different form of break for carers.
Eyers House	Eyers House commenced operations 14 years ago in response to a need identified from many distressed carers of clients attending the dementia specific day program.
Hurlingham	The need at Hurlingham was initially identified from informal polling of families and carers of people attending the ADASS about desired extensions to the day program, and through feedback to the Carers Respite Centre (Southern Region) from it's Residential Respite Program and CareLine. The need detected related to emergency overnight or short stay respite care.
Kilby House	In 1998, under the National Carers Initiative, Moreland Community Health Service developed a joint submission and approached Kilby to become a member of the consortium through the provision of weekend and emergency overnight respite (in addition to existing programs operated from the House). Moreland conducted a preliminary needs analysis that sought qualitative information from ACAS, local ADASS coordinators, support services and advocacy groups, culminating in a meeting involving interested parties. The need was for emergency overnight or short stay respite care.
Neil Stewart House & Cornish Vale	In the early 1990s, families and carers of people attending the Wangaratta ADASS were informally polled about desired extensions to the day program. There was also latent demand evidenced through links with other aged care services, professional knowledge and local information. The need detected related to emergency overnight or short stay respite care. Demand was not quantified. At Cornish Vale in Mooroopna, although only open for less than a year (commenced 16 October 2001), the need was defined as an extension of Neil Stewart House and so the target group is similar.
St Laurence House	The initial need for overnight respite at St Laurence House was identified through approaches and requests from distressed carers associated with clients attending the dementia-specific day program at the time. These carers felt there was no service available to provide them with support. St Laurence 'spear-headed' preparation of documentation for a funding submission that resulted in a pilot program. At the time there were no short-term respite services in Geelong - there were a number of high and low care residential facilities providing respite care but this was generally booked for weeks at a time and not available for short stays. There was a requirement for facilities offering community-based, short-term respite for dementia-specific clients.

What was the initial approval and funding process?	
Banksia	Initial funding was through a HACC Service Development Grant from the Department of Human Services (DHS) Southern Metropolitan Region – the grant fully met staff and consumables costs for overnight respite care for four clients (plus one additional client if emergencies arose) on one night per week (each Tuesday night). Usually the care recipient had attended the ADASS program during the day. Demand for overnight respite exceeded expectations; an additional night opened with funding from the Brotherhood of St Laurence Linkages Program. In 1995 Banksia undertook a review that resulted in carers and service providers expressing a need for weekend respite. The program was expanding rapidly and it was recognised that Banksia needed to extend its activities area as well as incorporate bedrooms in the new structure. A combined fundraising effort involving carers, service clubs, Banksia staff and Committee, and with support from DHS, allowed the development to proceed. In 1997, Saturday and Sunday night respite began with funding from the DHS Carer's Initiative Program (now known as the Support for Carers Program). In 2000, funding was secured via the Commonwealth's National Respite for Carers Program (NRCP) to provide Friday overnight respite linking in with day programs over the weekend, thereby giving carers a 48-hour break (4 PM Friday to 4 PM Sunday).
Brooke House	The initial funding is for one year to enable coverage of the lease, insurance and cleaning costs of the unit. The funding is subject to a FASA with the Commonwealth Department of Health and Ageing (DH&A) through the NRCP.
Carinya House	Funding for the overnight respite care program is thought to have initially been through the Villa Maria Society from within discretionary funds, together with a carer fee contribution, in the early 1990's. Application for government funding appears to have occurred after the service was well established. This occurred through the NRCP through which flexible respite funding packages are now received under a FASA. The service has always been dementia-specific.
Eyers House	Initial approval and funding was provided through Linkages (HACC) with some additional support from private trust funds available to the Queen Elizabeth Centre in Ballarat. This was provided on the basis of a maximum of six or seven places being available every second weekend if warranted by client numbers and demand. Additional funding was subsequently received through the NRCP in 1999/2000, based on respite services being made available on weekends and offered to individual clients no more often than once every two months.
Hurlingham	Following a successful submission to DHS, HACC funding was initially used to establish the service. HACC does not fund weekend overnight respite as such, however it does fund 'extended care' which at Hurlingham is interpreted as overnight care from 9.00 AM Saturday through to 5.00 PM Sunday (every second week). HACC funding for Hurlingham is provided as 32-hour blocks of care (for the times noted) for one to three clients; care targets are expressed as a specified number of hours per quarter. Funding is also received through a pilot program (Dec 2001 – June 2002) with the Carers Respite Centre Southern Region (CRCSR). Under this agreement, the CRCSR books six night blocks of care (within which it might fill the bed with different clients although most are occupied by a single client). During the days, clients attend the Planned Activity Group in the same house. In practice, clients are able to stay a seventh night, being the HACC funded Saturday night. CRCSR applies a cap of 18 nights respite per client in each six-month period. Most are emergency, often same day, bookings.
Kilby House	Moreland Community Health Service funding for Kilby House was negotiated at $30 per hour (now plus GST) including day and overnight respite using the funding available through a successful tender under the National Carers Initiative. The charge is the same whether one or two clients are resident.
Neil Stewart House & Cornish Vale	Neil Stewart House was funded under a block grant, of which part was later allocated to operating costs at Cornish Vale. The property at Mooroopna was purchased and modified by DHS and is leased to UnitingCare Wangaratta. Original grant conditions specified that residents at Neil Stewart House should have dementia. This has applied for seven years; over the last three years the target clientele has broadened. The submission and conditions of grant for Neil Stewart House stipulate five places.
St Laurence	Initial funding for St Laurence House was via HACC (Linkages) for 6-7 places, as a pilot program.

Current Service Range

What direct services are currently provided?	
Banksia	Services provided by Banksia include centre-based long day care (incorporating activity programs, meals and personal care), evening overnight and weekend respite, a carer's support group and educational programs (affiliated with the Alzheimer's Association). Community-based programs include in-home and host home respite (incorporating care for up to three people with dementia in a paid and trained worker's home based on the model of family day care).
Brooke House	Carers and care recipients are able to book Brooke House for short-term respite services. Brooke House is designed for the elderly and disabled, and these have become the predominant target client groups. No direct care services are provided but can be arranged using brokerage funding if required.
Carinya House	Carinya House is able to provide respite services to dementia-specific clients who are mostly elderly. Admission criteria include that clients must be independently mobile with no high nursing needs; the service therefore does not accept clients with insulin-dependent diabetes, double incontinence, colostomies etc. Clients are internally assessed by Carinya, and may also undergo either ACAS, psycho-geriatric or other specialist assessment. The service scope includes short-term overnight respite, day programs and flexible respite programs (day activities and in-home).
Eyers House	The purpose of the facility is primarily to support the carers of elderly people suffering from dementia, some (manageable) psychiatric disabilities and some stroke patients. Clients are generally 65 years and older and have had an ACAS assessment (if unsure of suitability, clients can stay one or two nights prior to coming on a weekend). Day activities operate five days per week - programs include activities, personal care and meals. A District Nurse attends if technical procedures are required. Weekend respite operates 24 weekends per year (with 17 booked and seven remaining flexible). Clients attending weekend respite also attend the Planned Activity Group during the day in the same house. Carer support is also offered by providing a range of information about other services to assist the frail aged to remain in their own home and be as independent as possible; afternoon teas and sometimes outings are conducted for spouses of clients on monthly basis.
Hurlingham	Hurlingham provides overnight respite care to anyone aged over 65 years of age defined as requiring high-level care under HACC. Most clients have dementia, often profound. Although no specific assessment is undertaken by Hurlingham, a number of referrals have had an ACAS assessment or overview written by the referring General Practitioner. Hurlingham also provides a general referral service to older people and their families – it provides a range of information about other services to assist older people to remain as independent as possible. Planned Activity Groups provide activities five week days, commencing at 9.00 AM and concluding at 4.00 PM. Overnight respite is funded by both HACC and the Carers Respite Centre Southern Region and offered in conjunction with the day program in the same house. Hurlingham also provides a Coffee Club (that arranges for groups of up to three lonely and isolated people in the community to get together for a social outing that lasts up to three hours. There are five outings per week - a total of 15 clients, and the program is HACC funded under the existing FASA), an unfunded pilot Dinner Club (that involves a chef coming into the house and cooking dinner for a small number of people with serious depression - all are holocaust survivors and are referred through by their Case Manager at Bayside Community Options) and a Carer Support Group (that provides information and resources to carers, initiates and supports social activities, provides opportunities to share experiences and encourages carers to consider their own needs and self care. The group meets one day per month and is lead by a facilitator who may also arrange guest speakers as required).

Kilby House	Kilby provides services to two client groups: Moreland Community Health Service refers clients living in the local government areas of Moreland and Hume (high and low care assessed); the Carer Respite Centre refers in anyone living outside Moreland and Hume (high and low care assessed). Clients usually present with strokes, dementia and aged related disabilities. The House possesses an electronic hoist capable of being operated by a single person so no restrictions apply because of lifting and transfer requirements. No specific assessment is undertaken by Kilby, although the referral form which is completed by the family prior to admission is quite detailed and seeks information about medical diagnostic group, continence, diet and eating skills, behaviour, communication, sleeping routine, use of limbs and personal care requirements. Medication information is also sought. There is two 'types' of overnight respite provided - weekend planned respite (between the hours of noon Friday and 5 PM Sunday) and flexible/emergency respite (up to a maximum of 24 hours any time during a week or weekend). Kilby also operates a Carer Support Group that provides information and resources to carers, initiates and supports social activities and encourages careers to consider their own needs and self care. The group is lead by a facilitator who may also arrange guest speakers as required; the group meets one day per month.
Neil Stewart House & Cornish Vale	Both facilities are able to provide respite services to any adult who requires care that is not violent and who does not have care needs that cannot be met within the House (includes anyone who may need two people to lift and transfer). An ACAS assessment is not required - Houses complete their own assessment in conjunction with the carer or family (the Care Plan), and external expertise is sought as required (e.g. district nurse, the person's own specialists or professionals). Centre based respite operates four nights per week (Thurs – Sun) and five days per week. Host based respite (which takes place in the home of a qualified carer and may be planned, emergency, occasional or overnight in nature) is arranged as required. In addition, outings (a Men's Group and an ABI Getting Out Group) operate fortnightly. A Carers Support Group in Wangaratta and a trial drop-in group at Mooroopna operate monthly and weekly (for three months) respectively.
St Laurence House	St Laurence House provide a comprehensive range of respite services to people with dementia. An initial assessment is completed on referral to the service; an ACAS assessment is not required for admission. The St Laurence House admission form, which is completed by the carer, is quite detailed. There are two types of overnight respite provided - weekend planned respite (between the hours of 4.00 PM Friday and 10.00 AM Monday) and emergency respite one to two nights during the week or at the weekend. Planned Activity Group day care operates seven days per week. Programs implemented include meal preparation, ironing, gardening and music therapy. A Carer Support Group also operates out of the house Tuesday and Thursday evenings, where light tea is prepared and shared with carers and clients. These sessions provide a format for information exchange, opportunities to share experiences and encourage carers to consider their own needs. One session per fortnightly if for carers from a CALD background.
Are local needs being met?	
Banksia	A carer survey conducted by Banksia in 1999 indicated that there was a need for Banksia to expand its range of programs. Carers expressed their appreciation for day care, overnight and weekend respite, however they also wanted services to be provided in their homes for their family member with dementia. Funding was acquired and now Banksia is able to provide carers with a choice of respite services. Referrals to Banksia are able to be processed immediately as Banksia has just opened a second facility at Carrum Downs (providing HACC funded Planned Activity Groups for people who are socially isolated). The (original) Frankston program is reported to be booked out months ahead; however, due to the complex needs of service users, it is common to have cancellations at short notice. When this occurs, the service views it as another opportunity to provide short notice or emergency overnight care, thus providing the flexibility many carers seek.
Brooke House	This service only commenced operating recently so it is a little premature; however, at this stage, it does appear to be meeting needs. Utilisation is now high (after slow start) and bookings for next couple of months are solid. Note however that the service does not cater for clients with challenging behaviours and/or high levels of dementia.

Carinya House	Current services appear adequate – they are fully booked with a short waiting list. This has occurred with little marketing, therefore community need may be greater than current workload - although not researched, Carinya believes community needs are probably appreciably higher than the current service level. Feedback from CACPs, CRCs and carers is positive, supporting the appropriateness of current programs. For the presenting client mix, services are basically meeting needs. The only comment that arises from time to time is the different activity needs of the very elderly and the 'younger' client groups (e.g. 60 – 70 years).
Eyers House	Eyers House is unable to take clients that require a two-person transfer or who have behavioural problems that interfere with or threaten others, or who have high care level needs. Outside these groups, current services appear adequate. Feedback from carers and other services is positive, supporting the appropriateness of current programs. The house is fully booked with regular enquires - community need is unquantified but may be greater than the current services.
Hurlingham	Although no statistics are kept, there appears to be substantial demand expressed through requests from existing clients for extra availability, from the Commonwealth Carers Respite Centre Southern Region (CRCSR), via enquiries from hospitals and GPs. No waiting list is kept (as Hurlingham caters to emergency care and as such, 'booked emergencies' will not occur). The CRCSR is now beginning to receive requests for assistance at Hurlingham from outside its area; CRCSR reports across the region a general lack of emergency options, lack of places that take couples and a lack of options for dementia clients. HACC funded clients report that they would prefer longer stays, ranging from four or five nights up to two weeks consecutive stay that would facilitate a holiday for the family or carer.
Kilby House	Kilby can cater for wandering residents but is unable to accept people that exhibit aggressive behaviours. No statistics are kept however there is more capacity than can be filled (seven night basis) although most weekends of the year are booked (even though sometimes just one resident may be attending). There are some periods of peak demand when demand exceeds supply however these are infrequent. (All enquiries directed to the House from families, RDNS, councils, people/organizations with care packages etc are directed to contact either Moreland CHS or the Commonwealth Carers Respite Centre depending upon where they live. These two services then determine eligibility and availability of their funding and 'refer' back to Kilby. The two agencies also provide their 'own' referrals).
Neil Stewart House & Cornish Vale	Existing services need further development particularly in the areas of day respite and, most critically, overnight respite. No statistics regarding unmet need are kept however anecdotally there appears to be substantial demand expressed through requests from existing clients and external services. Across the Region there appears a general lack of emergency options, a lack of places that take couples, a lack of options for dementia clients and a lack of financially realistic options.
St Laurence House	St Laurence House has a strong partnership with the local Commonwealth Carer Respite Centre and works closely with Care Management Services in the region. The service currently meets all service requirements under the funding agreement, although a formal quality assurance process is not in place. The service reports that extra funding is required when emergency respite clients are not able to access day programs. A need for programs that address the needs of younger men with dementia has become apparent. A waiting list exists which may indicate community need is greater than the service is able to meet.

What is the target group?

Banksia	Banksia is primarily looking to help the older carers through the provision of respite, support, education and friendship. Care recipients include people with dementia, stroke, acquired brain injury, psychiatric illness, Multiple Sclerosis and frailty. Many care recipients use mobility aids such as wheelchairs, frames and scooters, but must be able to 'weight-bear' because the size of the facility cannot safely accommodate lifting devices.
Brooke House	Brooke House caters for carers needing a break during trips to Melbourne for specialist medical treatment and for carers/care recipients for short periods when their carer or care recipient is undergoing treatment at Latrobe Regional Hospital. The target group is primarily carers of people with low care needs.
Carinya House	The target group for short-term overnight respite care is carers for elderly clients with dementia who are independently mobile and without high nursing care loads (i.e. not clients with insulin-dependent diabetes, double incontinence, colostomies etc).
Eyers House	The target group are predominantly aged clients with varying degrees of dementia (moderate to severe) as well as stroke patients with changed personality. The service does not accommodate clients requiring lifting, or clients with behaviour that interferes or threatens other clients.
Hurlingham	Hurlingham provides overnight respite care to anyone aged over 65 years of age defined as requiring high-level care under HACC. Most clients have dementia, often profound. Hurlingham will not accept people that exhibit aggressive behaviours or people that require a two-person lift or transfer (which under the current staffing roster can only occur at shift overlap).
Kilby House	The target client group at Kilby is generally derived from two sources: Moreland CHS refers in clients living in Moreland and Hume (high and low care assessed) and the Commonwealth Carer Respite Centre refers in anyone living outside these municipalities (high and low care assessed). Clients usually present with strokes, dementia and other age related disabilities. Kilby can cater for wandering residents but won't accept people that exhibit aggressive behaviours. The House has an electronic hoist capable of being operated by a single person so no restrictions apply due to lifting and transfer requirements.
Neil Stewart House & Cornish Vale	The target group for both Houses includes any adult who requires care during periods of respite for their normal carers. The Houses are unable to care for people who are violent or whose care needs are beyond the service capability (includes anyone who may need two people to lift and transfer).
St Laurence House	The target group are predominantly aged clients with varying degrees of dementia. The service does not accommodate clients requiring lifting or clients with behaviour that threatens other clients.

What is the client profile? (Tables incomplete where Houses were unable to supply requisite data)

Banksia

Clients are predominantly residents of the Frankston and Mornington Peninsula LGAs (as well as a limited number from Casey and Kingston). Banksia classifies the client group as a high needs group. Summary client profile information from the HACC Minimum Data Set (MDS) shows:

BANKSIA HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: 9%; 70-89: 83%; 90+yrs: 9%
Sex	Female: 41%; Male: 59%
LGA of Residence	
Main Language at Home	English: 92 %; Italian: 8%
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: 61%; Disability Pension: 16%; DVA: 10%; Other Pension/Unclear: 13%
Accommodation Setting	Private Home: 89%; ILU: 1%; Boarding House/Hotel: 0%; SRS: 8%; Other: 2%
Carer Existence	Has a Carer: 100%; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %; Other: 5%
Carer's Relationship	Spouse/Partner: 47%; Daughter/Son: 33%; Other: 20%
Source of Referral	Family: 23%; Aged/Disabil/HACC Assess Team: 27%; Health Service Provider: 34%; Self: 9%; Other: 7%;
Reason for Admission	Carer Respite: 100 %; Other: %

Brooke House

Given the very short period of operation (nine months) and a facility that offers only a single respite place, there is insufficient data available at present to reasonably define the client profile. However, summary client profile information from utilisation statistics provided is as follows:

BROOKE HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: %; 70-89: %; 90+yrs: %
Sex	Female: 75%; Male: 25%
LGA of Residence	
Main Language at Home	English: %;
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: %; Disability Pension: %; DVA: %; Other Pension/Unclear: %; No Pension: %
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: %; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: %; Daughter/Son: %; Father/Mother: %; Other: %
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: %; Other: %

Carinya House

Carinya declined to provide client profile information for "commercial in-confidence reasons".

Eyers House

All clients have different levels of dementia with approximately 30% having high-level dementia. Specific needs able to be accommodated at Eyers House include Parkinson's Disease, Diabetes, Osteoarthritis, vision impairment, hearing impairment, Osteoporosis, general frailty, incontinence and colostomy. Carers are aged one-third 45 – 65 years, one-third 66 - 79 years, and one-third 80 years and over. Two-thirds of carers are female, and one-third is male. Summary client profile information from the NRCP Quarterly Returns indicates:

EYERS HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<65 yrs: 0%; 66-79: 45%; 80+yrs: 55%
Sex	Female: 79%; Male: 21%
LGA of Residence	Ballarat City: 76%; Golden Plains Shire: 17%; Hepburn Shire: 7%
Main Language at Home	English: 100%
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: 97%; Disability Pension: 0%; DVA: 3%; Other Pension/Unclear: 0%; No Pension: 0%
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: %; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: 28%; Daughter/Son: 52%; Father/Mother: %; Other: %
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: %; Other: %

Hurlingham

Hurlingham provides overnight respite care to anyone aged over 65 years of age defined as requiring high-level care under HACC; most clients have dementia. Any special care needs are collected in a Client Profile completed at service entry - this covers not only medical and care requirements (such as mobility, communications and physical care needs) but also interests and likes (e.g. pets, travel etc). The Client Profile also contains progress notes so that changing requirements may be recognized.

HURLINGHAM	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: %; 70-89: %; 90+yrs: %
Sex	Female: %; Male: %
LGA of Residence	Kingston 29%; Bayside 33%; Glen Eira 30%; Casey 6% and Stonnington 2%
Main Language at Home	English: %;
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: %; Disability Pension: %; DVA: %; Other Pension/Unclear: %; No Pension: %
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: %; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: %; Daughter/Son: %; Father/Mother: %; Other: %
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: %; Other: %

Kilby House

Any special care needs are collected in a Client Profile completed at service entry - this covers not only medical and care requirements (such as mobility, communications and physical care needs) but also interests and likes (e.g. pets, travel etc). Summary information indicates:

KILBY HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: 13%; 70-89: 75%; 90+yrs: 12%
Sex	Female: 65%; Male: 35%
LGA of Residence	
Main Language at Home	English: 65%; Italian: 21%; Other: 14%
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: %; Disability Pension: %; DVA: %; Other Pension/Unclear: %; No Pension: %
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: 100 %; Has No Carer: %; Other:
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: 38%; Daughter/Son: 48%; Father/Mother: 0%; Other: 14%
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: 100%; Other: 0%

Neil Stewart House & Cornish Vale

The major client diagnosis is stroke (30%) or dementia (65%), although a few present with ABI, Parkinson's Disease etc. Many would have an ACAS assessment but this is not required. Any special care needs are collected in a Care Plan completed at service entry, covering mobility, toileting, nutrition, hygiene, communications and mental and physical care needs as well as night routine and safety risk assessment. Client profile data for Neil Stewart House shows:

NEIL STEWART HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: 23%; 70-89: 69%; 90+yrs: 8%
Sex	Female: 46%; Male: 54%
LGA of Residence	
Main Language at Home	English: 84%; Italian: 4%; Ukraine: 4%; Other: 8%
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: %; Disability Pension: %; DVA: %; Other Pension/Unclear: %; No Pension: %
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: %; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: %; Daughter/Son: %; Father/Mother: %; Other: %
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: 93% (planned & emergency); Other: 7% (crisis accommodation).

For Cornish Vale, the available summary client profile data indicates:

CORNISH VALE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: 30%; 70-89: 65%; 90+yrs: 5%
Sex	Female: 42%; Male: 58 %
LGA of Residence	
Main Language at Home	English: 96%; Other: 4%.
Client Living Arrangement	Lives Alone: %; Lives with Family: %; Lives with Others: %
Pension Status	Aged Pension: 61%; Disability Pension: 10%; DVA: 10%; Other Pension/Unclear: 3%; No Pension: 16%
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: %; Has No Carer: %; Other: %
Carer Residency Status	Co-resident Carer: %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: 44%; Daughter/Son: 36%; Father/Mother: 4%; Other: 16%
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: %; Other: %

St Laurence House

The client group is generally aged 70 years and over. All have different levels of dementia:

ST LAURENCE HOUSE	
DATA ITEM	**SUMMARY CLIENT PROFILE**
Age Group	<70 yrs: 8%; 70-89: 92%; 90+yrs: 0%
Sex	Female: 41 %; Male: 59 %
LGA of Residence	Greater Geelong (58%), Bellarine (20%), Corio (13%), Colac Oyways, Surgcoast and Golden Plains
Main Language at Home	English: 88 %
Client Living Arrangement	Lives Alone: 1 %; Lives with Family: 98%; Lives with Others: 1%
Pension Status	Aged Pension: 84 %; Disability Pension: 6%; DVA: %; Other Pension/Unclear: %; No Pension: %
Accommodation Setting	Private Home: %; ILU: %; Boarding House/Hotel: %; SRS: %; Other: %
Carer Existence	Has a Carer: 100 %; Has No Carer: %; Other:
Carer Residency Status	Co-resident Carer: 99 %; Non-resident Carer: %; No Carer: %
Carer's Relationship	Spouse/Partner: 68 %; Daughter/Son: 28 %; Father/Mother: %; Other: 4%
Source of Referral	Family: %; Aged/Disabil/HACC Assess Team: %; Health Service Provider: %; Self: %; Other: %;
Reason for Admission	Carer Respite: 100 %; Other:

What is the current service utilisation? (Tables incomplete where Houses unable to supply data)

Banksia

Utilisation is 88% with a waiting list of usually between 10 to 50 clients.

BANKSIA HOUSE	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	2001/02
Number of Clients	34
Number of Stays/Admissions	
Average Stay Time	<2days
Occupancy of Available Facilities	88%

Brooke House

For the first six months of operation, there was a low level of utilisation due to lack of community awareness of the new facility. With more recent marketing to the community and service providers, utilisation over the past two months (Feb and March) has increased to 73%.

Carinya House

Carinya operates seven days per week and provides short-term respite care for stays of up to five days. Utilisation/occupancy rate is reported to be virtually 100%.

Eyers House

Current occupancy/utilisation level is reported to be approximately 90%. The House has a service target of 144 client admissions over a two-year period; at present, utilisation stands at 105 admissions for the 18 months YTD.

Hurlingham

Service utilisation for the year ended March 2002 has been calculated as follows:

HURLINGHAM	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	12 Months to Mar 2002
Number of Clients	66
Number of Stays/Admissions	84
Average Stay Time	4.7 nights
Occupancy of Available Facilities	103%

Kilby House

Occupancy of available overnight respite beds at Kilby was 45% during the year to March 2002. Utilisation appears low because Kilby is technically open for business every night of the year but only rosters staff when a booking is made (and funding from the Commonwealth Carers Respite Centre is limited). Kilby has met or exceeded related internal targets.

KILBY HOUSE	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	12 Months to Mar 2002
Number of Clients	52
Number of Stays/Admissions	95
Average Stay Time	1.8 nights
Occupancy of Available Facilities	45%

Neil Stewart House & Cornish Vale

For the year ending April 2002, care recipients were accommodated for a total of 759 nights:

NEIL STEWART	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	12 Months to April 2002
Number of Clients	58
Number of Stays/Admissions	210
Average Stay Time	3.6 nights
Occupancy of Available Facilities	88%

	For Cornish Vale, the utilisation statistics are as follows:

CORNISH VALE	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	12 Months to April 2002
Number of Clients	50
Number of Stays/Admissions	133
Average Stay Time	3.2 nights
Occupancy of Available Facilities	74%

St Laurence House — For St Laurence House, the utilisation statistics are as follows (current utilisation/occupancy is reported to be around 100%):

ST LAURENCE	
DATA ITEM	**SUMMARY UTILISATION**
Survey Period	12 Months to March 02
Number of Clients	90
Number of Stays/Admissions	280
Average Stay Time	3.6 nights
Occupancy of Available Facilities	N/A

Is there a waiting list?

Banksia	A waiting list is kept and it usually contains between 10 – 50 clients. Carers are encouraged to initially access day activity programs for their family members before accessing overnight and weekend respite. This enables clients to become familiar with Banksia services before staying overnight, and for Banksia staff to fully assess client care needs. The day care and activity programs are used by over 150 clients each week, approximately two thirds of whom have a carer and are potential clients for overnight and weekend respite.
Brooke House	Bookings for the facility are solid, but there is no waiting list.
Carinya House	There is presently a short waiting list for admission to the short-term respite care program.
Eyers House	A formal waiting list is not maintained. Existing clients are able to book places for specific weekend respite and then other community members seeking services are offered opportunities to fill any vacancies. At present, the House offers sufficient flexibility in terms of new admissions to avoid the need to maintain a waiting list.
Hurlingham	No waiting list is kept. Services are presently limited by numbers of available places, funding and an internal policy that does not provide the capacity to book in advance (i.e. take only emergencies).
Kilby House	No waiting list is kept. If the time someone is after is already booked then the Manager will discuss an alternative time with the family. Informal notes may be kept in case of cancellation but generally if there is a cancellation, the time will be left unfilled. Bookings are taken up to 12 months in advance. Length of stay is limited to three nights if over a weekend and no more than five nights if during the week.
Neil Stewart House & Cornish Vale	No waiting list is kept. People can only book once every six weeks (unless they are in crisis when an exception may be made). Both Houses are basically fully booked (bookings are four months out – it used to be six months but it was felt this was contributing to a high rate of cancellations. Only three bookings from the one person will be accepted in advance).
St Laurence House	St Laurence House has a waiting list. Usually, within a two-month period, all clients are provided with a service.

Is there an unmet demand?	
Banksia	Banksia is not aware of unmet local demand, although (with full occupancy) there has been little marketing to develop community awareness of the available service to assist in identifying potential unmet demand.
Brooke House	This service is still new with a low level of community awareness. Partly for this reason, any assessment of unmet demand is premature at this stage.
Carinya House	Carinya is fully booked with a short waiting list, which may indicate a low level of unmet demand. However, although not researched, Carinya believes that community needs are probably appreciably higher than the current service level.
Eyers House	Only ad hoc assessment of unmet demand has been undertaken in response to instances of inability to provide services. Through this process, the most apparent service gaps are in the areas of services for clients with high care needs and clients with some psychiatric conditions that could be assisted through early intervention and acceptance into the program.
Hurlingham	No formal assessment of unmet demand has been carried out however anecdotal evidence suggests that there are limitations on service brought about by caps on places and available funding, as well as Hurlingham's internal policy of not taking bookings. (At the time of writing this report, the Carers Respite Centre Southern Region is conducting a review of its trial service at Hurlingham that includes a survey of carers and analysis of unmet demand).
Kilby House	No formal assessment of unmet demand has been undertaken. Anecdotally however, there appears to exist a level of unmet demand - factors limiting current service are numbers of places, available funding, and lack of specialist skills (i.e. no nursing staff work at Kilby). Weekend stays are limited to once every eight-week period (unless crisis). Length of stay is limited by available brokerage funding via the Commonwealth Carers Respite Centre.
Neil Stewart House & Cornish Vale	An 'Unmet Demand' book is kept - often particular weekends are fully booked and details are kept of people who could not be accommodated in case of cancellations.
St Laurence House	In most circumstances respire requests can be accommodated. A need for a service for younger men with dementia has been identified.

Facility Standards	
Banksia	Banksia House is basically a facility of domestic dwelling standards but with special features to provide secure and safe short-term respite care for older clients. The single-level facility is used for both overnight respite as well as ADASS day programs. The special features include disabled bathroom facilities, fire/smoke detectors (although there is no fire compartmentalisation or sprinklers), and internal security for wandering residents with dementia including a secure circular path with lockable gates. The working areas of the House also allow full view of anyone outside thereby ensuring safety at all times. Through use of ceiling-mounted bi-fold walls, the ADASS activities room can be partitioned for separate overnight bedrooms with folding beds.
Brooke House	Brooke House has been built as a retirement unit. It is primarily a residential dwelling specially fitted out with facilities for people with physical disabilities, which for a period of 12 months is being leased by the Carer Respite Centre Gippsland for trial provision of a short-term respite facility. Facilities provided include disabled bathroom, cooking and dining facilities, smoke detectors and an intercom link to the adjoining Glenwood Supported Residential Service from where nursing assistance can be summoned in emergencies. Having been constructed as a residential dwelling, there are no sprinkler or fire compartmentalisation facilities.
Carinya House	Carinya House is a single-level multi-purpose building. It has separate areas for activities/dining (i.e. ADASS), kitchen, bathrooms, and office administration as well as six single bedrooms for overnight respite care. Carinya has been built to the same standards/regulations that apply to the other aged residential facilities (high and low care) of the Villa Maria Society. As a result, features include disabled access and egress, disabled bathroom facilities, emergency exit lighting, fire extinguishers, smoke and heat detectors as well as sprinklers and compartmentalisation. Outside, there is also security gates and fencing for the safety of clientele with dementia.
Eyers House	Eyers House is operated from a period home built in the early 1900's – until the 1950s it was a private home. Over the next 30 years, it was used as a home for intellectually disabled women. ADASS commenced 14 years ago with overnight respite care commencing 11 years ago. The building has smoke detectors and disabled facilities (rails, coded doors, showers chairs etc), but no sprinklers or fire compartmentalisation.
Hurlingham	The facility was originally a regular residential house and so the usual standards (local government administered) applied at the time of construction. Minor renovations were commissioned upon acquisition of the house to allow it to function as a day centre - these included wheelchair access and rails in toilets. A Fire Indicator Panel has been installed (but no sprinklering or compartmentalization) that is tested monthly by an independent contractor. Regular fire and evacuation drills are practiced. Doors to the house and gates to the property are fitted with a chime that sounds when doors/gates are opened (gates are of the type commonly fitted to swimming pools). The house is not included in any accreditation or certification processes underway at the nursing home next door.
Kilby House	Again, the facility was a regular residential house and so local government needed to grant a certificate of occupancy on construction. The house is not included in any accreditation or certification processes underway at the nursing home next door. Minor renovations were commissioned upon acquisition of the house to allow it to function as a day centre. These included wheelchair access and rails in toilets, full access to the bathroom for the disabled, sensor lights, ramps etc. Smoke detectors are installed (but no sprinklering or compartmentalization) that is tested monthly by an independent contractor. Regular fire and evacuation drills are practiced.
Neil Stewart House & Cornish Vale	Neil Stewart House in Wangaratta and Cornish Vale in Mooroopna are both five-bedroom houses with pleasant garden settings. The initial facility, Neil Stewart House, was built within the usual local government administered standards that applied at the time of construction (1991). The houses are not included in any accreditation or certification processes (although there is a requirement to comply with the Food Services Act). Both houses have wheelchair access and rails in toilets, and gardens are specially designed to cater for people with dementia. The working areas of the house (e.g. kitchen) are sited to facilitate full views of interior spaces as well as much of the surrounds. Other aspects of fixtures and fittings are also specially tailored for

	people with dementia (e.g. see through doors on cupboards). Doors to the houses and gates to the properties are secured. The houses are sprinklered and have fire compartmentalization and emergency lighting. Regular fire and evacuation drills are practiced. An independent auditor inspects the food preparation areas every 12 months (a condition of the Food Act). A Fire Safety Auditor appointed by DHS visits the facility annually and prepares a report. The houses also comply with OHS regulations and must also comply, by virtue of part funding, with the Victorian Disability Services Standards. Neil Stewart House has three bathrooms at present but ideally would like to increase the size of existing bathrooms and add another. At Neil Stewart, there are two two-bed rooms and three one-bed rooms (frequently the couples' rooms are occupied by only a single person). One bed is maintained as an emergency bed. Cornish Vale has one two-bed room and four single bedrooms. One bedroom is isolated so that if a disturbance occurs, other residents are not inconvenienced.
St Laurence House	St Laurence House is a domestic four-bedroom period home with modifications for disabled access, external security, and garden areas for clients to work and walk in. The building is fitted with smoke detectors, hose reel, fire extinguishers and fire blanket. A sprinkler system is currently being installed. Facilities for the disabled are provided (rails, bed poles, coded doors, shower chairs and secure gates).
Service Standards	
Banksia	The HACC National Service Standards apply at Banksia; in addition, Banksia has developed it's own internal service standards. No specific standards or accreditation framework applies to DH&A funding under the NRCP. HACC funded services generally conduct self-assessments against the HACC standards at appropriate intervals; DHS may conduct annual external reviews of funded service against HACC standards. Continuity of care at Banksia is facilitated in part by the stable part-time workforce. Other strengths include the practice of identification of individual staff education needs and the provision of targeted training to ensure that clients' needs are met. Another strength of the facility is that most of their referrals (70%) come from the community, which shows the high profile and standing the house enjoys.
Brooke House	Not applicable.
Carinya House	No external care standards are prescribed under the NRCP; however, Carinya uses the Villa Maria campus-wide CQI programs (which is also working towards ISO certification) and therefore adheres to the care standards that apply to aged residential services. Carinya also undergoes assessment and complies with the required food safety standards. A strength of Carinya is the service back up available as required from co-located Villa Maria services – this helps to ensure continuity of service and provides a broader range of assistance available during attendance at day programs and overnight respite.
Eyers House	Eyers House follows HACC standards and guidelines and EQuIP. There are collaborative process are in place to support continuity of care. Standards are maintained through a variety of measures including by ensuring each client has had an ACAS assessment, that there is a handover between day and night respite staff to ensure minimal disruptions to clients, and through the use of detailed client profile forms completed prior to admission to reveal medication, dietary requirements, languages, likes and dislikes and other factors relevant to the provision of care. Strengths of the current service include the bond of trust that exists between carers and clients and their being familiar with the house/staff.
Hurlingham	Care is provided under the HACC standards (the Commonwealth Carers Respite Centre accepts and supports the HACC standards and does not require its own set of regulations). A DHS regional officer conducts an annual assessment against the HACC standards. There are service agreements with Bayside Community Options, HACC and the Commonwealth Carers Respite Centre Southern Region. Hurlingham has a detailed client profile form that reveals medication, dietary requirements, languages, likes and dislikes and other factors relevant to the provision of care. Medications will be checked with the GP (prior to making arrangements with RDNS to administer if necessary). All medications must be Webster packed. There is a handover between day and night respite staff and back again in the morning to ensure minimal disruption to clients. The major strength seen by Manager is the cosy home like environment offered and integration with an existing day activities program; the major weaknesses are the need for better physical standards and OHS standards.

Kilby House	The Anglican Aged Care QMS applies although much of this is irrelevant given the nature and circumstances of Community Respite Houses – Kilby and Hurlingham are developing their own abridged, more relevant version. It would not appear that there are any standards to be met in order to attain funding. Kilby has a detailed client profile form which reveals medication, dietary requirements, languages, likes and dislikes and other factors relevant to the care that needs to be provided. Also like Hurlingham, medications are checked with the GP (prior to making arrangements with RDNS to administer if necessary) and all are Webster packed. Perceived weaknesses include that the Manager requires more administrative assistance and more living space for residents (although a garage has recently been converted to a separate living area (with funding from NCRP) for residents who do not want to join in with the ADASS. Another ensuite and better garden design and development would also complement the activities of the house. The major strengths seen by the Manager include the home like environment, integration with an existing day activities program and proximity to a nursing home for specialized advice, support and assistance.
Neil Stewart House & Cornish Vale	Care is provided under the HACC standards. The HACC project officer (DHS regional) conducts an assessment against the HACC standards once per annum. Disability Services Standards also apply, as well as a range of other guidelines and requirements stipulated by the State Government in the FASA. A detailed client profile reveals medication, dietary requirements, languages, likes and dislikes and other factors relevant to the care that needs to be provided. There is a handover between day and night respite staff and back again in the morning to ensure minimal disruptions to clients. All families are followed up after their stay. Transport can be arranged and referral/connection with other relevant services is arranged where required. All staff have detailed job descriptions including objectives and key tasks. Regular performance appraisals are carried out.
St Laurence House	Care is provided under the HACC standards. A detailed client profile is completed prior to admission which details medication, dietary requirements, languages, likes and dislikes and other factors relevant to the provision of care. There is a handover between day and night respite staff to ensure information transfer and minimal disruption to clients. Medications are administered from Webster Packs and Dossettes. All staff have detailed job descriptions and there are regular staff meetings to address care issues and care provision. Strengths of the current service include the capacity to meet the needs of current clients. Reviewing current services and programs and the changing needs of clients is part of St Laurence policy for all programs.
Quality Improvement	
Banksia	Banksia is currently reviewing its QA management systems to bring it in line with Brotherhood of St Laurence Services. Organisational and site-specific policy and procedures are available at the House. Feedback, processes and changes are communicated during staff meetings, carers support group meetings and management meetings. Complaints and issues raised by carers are documented and identify required actions and outcomes. A survey of carers and clients was undertaken in 1999 resulting in a second facility being opened in Carrum Downs. A DHS funded review of Banksia services and future directions is about to occur. This review will involve clients, carers, local service providers, Brotherhood of St Laurence management and government representatives. Staff and volunteers are given regular opportunities for on -going training e.g. dementia, ageing processes, personal care, Level 11 First aid and food handling.
Brooke House	Not Applicable.
Carinya House	No quality improvement system is prescribed. However, Carinya participates in campus-wide Villa Maria programs and is working towards ISO certification, including and Internal CQI program. Food safety standards are assessed under a regulated process.
Eyers House	EQuIP processes are employed to facilitate continuous quality improvement. This includes surveys, OH & S reviews, food services reviews, and a review of the appropriateness of activities (imputed via a carer survey from the Carer Respite Centre). Eyers House also follows the Ballarat Health Services complaints procedures, which is set out in a handbook and featured during staff orientation. Eyers House is also currently reviewing their care plan format to include a mechanism for follow up contact with carers following weekend respite.

Hurlingham	Hurlingham (and Kilby) are developing their own QA management system based on an abridged version of the Anglican Aged Care system (developed under the Aged Care Act 1997). The House Manager suggests that much of the organizational system will be irrelevant to the operations of the House, and she will select and adapt as appropriate. The House currently possesses it's own Policy & Procedures Manual to guide administrative functions, house upkeep and maintenance, and multicultural planning. Feedback/process changes are communicated during staff meetings although this does not ensure that a comprehensive transfer of knowledge occurs and not all staff attend the same meetings (i.e. some will miss out). A formal complaints procedure exists which establishes the steps, processes and expected outcomes. No specific staff training is provided in relation to quality management or quality assurance; however, the House Manager has been trained in aged residential policies and procedures as they apply elsewhere in the group, including the group QMS. The House Manager also participated in accreditation for the neighbouring high care facility and advises that she has taken parts of this process to apply at the Community House. Staff are provided with training on commencement dealing with orientation to the HACC standards.
Kilby House	Along with Hurlingham, the service is developing its own QA management system based on an abridged version of the Anglican Aged Care system. The House currently possesses it's own Policy & Procedures Manual to guide administrative functions, house upkeep and maintenance, and multicultural planning (many Italians attend the day activity program). Feedback/process changes are communicated during staff meetings although this does not ensure that a comprehensive transfer of knowledge occurs and not all staff attend the same meetings (i.e. some will miss out). A formal complaints procedure exists which establishes the steps, processes and expected outcomes. No specific staff training is provided in relation to quality management or quality assurance.
Neil Stewart House & Cornish Vale	At these services quality assurance is managed through a detailed Policy and Procedures Manual that is regularly reviewed and updated. Feedback/process changes are communicated during staff meetings. A formal complaints procedure exists which establishes the steps, processes and expected outcomes.
St Laurence House	The service is currently reviewing its QA management system to bring it in line with St Laurence Community Services overall program. Organizational and site specific policy and procedures are available on site. Feedback/process changes are communicated during staff meetings and management meetings. Complaints and issues raised by carers are documented identifying required actions and outcomes. A tea group survey was carried out in 2002. Audits are undertaken in the areas of food safety, OH & S, environmental, chemical hazards, fire evacuation, medication and manual handling.

Financial Performance (Note, not all Houses were able to provide financial data; of those that did, data could not be segmented to allow analysis of the overnight respite component alone)	
Banksia	Banksia has separate funding for all services provided and budgets are prepared for each funding source. However, it has advised that costs are not specifically broken down by individual service and no detailed information could be provided.
Brooke House	Not provided.
Carinya House	Deemed "commercial on confidence" and not provided.
Eyers House	Not provided.
Hurlingham	Not provided.
Kilby House	Not provided.
Neil Stewart House & Cornish Vale	UnitingCare Wangaratta does not segment financial data for the overnight respite component of service at either Neil Stewart House or Cornish Vale. Performance is reported at the 'Respite Program' level that consolidates Community Respite House financial data with Planned Activity Groups and a number of other activities. Whilst attributable income (via government grants, fees, donations etc) can be separated, expenses and other costs cannot.
St Laurence House	Not provided.
Service Staffing	
Banksia	Banksia is staffed with Personal Care Assistants (PCAs) and activities staff (including some with Certificate IV Diversional Therapy). A fixed roster of (exclusively) permanent part-time employees ensures continuity of care. No agency staff are utilised. Staff to client ratios comply with HACC guidelines (i.e. one staff per five clients). Most staff training is undertaken via DHS-funded programs, with staff paid to attend. The manager of the House holds tertiary qualifications in welfare and management. The staffing arrangements are seen by Banksia as sufficient for the present service. Banksia also enlists over 40 volunteers who attend on a weekly basis to help with various programs (and are assisted to access training as opportunities arise.
Brooke House	Not applicable - cleaners are the only staff funded directly at Brooke House; any other services are arranged using brokerage funding.
Carinya House	Carinya is staffed with one PCA overnight, rostered seven nights a week (two PCAs are rostered for day programs). Staff to resident ratios are 1:6 overnight. All staff are employed on a permanent part-time or permanent casual basis. Staff training is undertaken in conjunction with Villa Maria Society, including orientation, ongoing in-service and external training programs as required. Carinya has a House Coordinator and PCA staff; at weekends, a PCA is nominated as team leader. Staffing arrangements are seen as sufficient.
Eyers House	The facility is staffed with PCAs and activities staff. Staff are mainly employed on a permanent part-time basis although a few are casuals. Staff training is undertaken through the HACC funded and provided program. Orientation and certain other specific topics are provided in conjunction with the auspice, Ballarat Health Services. The House Manager reports to the Director Community Services. The House Manager is a Registered Nurse Div 1. The most senior member of the clinical/care staff holds a TAFE Certificate 3 qualification. It is felt that more RNs are required at Eyers House in order to cater for high care clients.
Hurlingham	Overnight stays at Hurlingham are staffed in two shifts - 5.00 PM to 10.30 PM and 10.30 PM to 9.00 AM – by one person who is either an RN Div 2 or a PCA level 3. If the care load is too high, the roster might be topped up during peak times with an additional PCA or student nurse. If RN Div 1 level care is required then RDNS is booked to attend and provide the necessary care (e.g. insulin dependant needs injection twice daily). The manager is hands-on. The staff: resident ratio is 1:3 or 4, depending upon the number of residents. The Manager is a permanent employee working 38 hours per week; in addition there are two Community Development

	Workers who are permanent part time (one kitchen and hands on, 30 hours per week; and the other Coffee Club and hands on 26 hours per week). Overnight staff are mainly permanent part time but occasionally casuals are required to fill roster gaps. House staff piggyback on training being provided at the nursing home next door (e.g. dementia, behavioural management) or take advantage of training provided via the HACC program. Hurlingham operates as a stand alone service with its own manager who has substantial delegation in relation to day-to-day operations. Finances and budgeting are overseen by head office and the manager reports through to head office once per month. The manager is a Div 1 Nurse, but registration has lapsed; the most senior member of the clinical/care staff are RN Div 2.
Kilby House	At Kilby, overnight stays are staffed in two shifts - 8.00 AM to 8.00 PM and 8.00 PM to 8.00 AM – by one who will hold the qualification of PCA level 3 (maximum). If RN Div 1 level care is required then RDNS is booked to attend and provide the necessary care. Staff to resident ratios are 1:1 or 2, depending upon the number of residents. The Manager is a permanent employee (38 hours per week); respite staff are all casuals. Staff piggyback on training being provided at the nursing home next door and also participate in HACC training. Like Hurlingham, Kilby operates as a stand-alone service with its own manager who has substantial delegation; finances and budgeting are overseen by head office and the manager reports through to head office once every three weeks. The nursing home alongside provides assistance with IT, admin, petty cash and receives the time sheets/rosters etc for processing. The Manager of the house holds a Bachelor of Social Sciences and a Welfare Certificate, and is currently undertaking front line management training at TAFE. The qualifications of the most senior member of the clinical/care staff would be PCA Level 3.
Neil Stewart House & Cornish Vale	There are two permanent staff positions within the House for the five days and four nights of operation. The first position works over three shifts 7 AM - 3 PM; 3-11 PM and 11 PM –7 AM. The second position works over two shifts: 8 AM 4 PM and 4 PM - 9 PM. These positions are supplemented by casuals where required. Staff are categorized as Program & Support Workers with minimum qualifications being Level 2 First Aid and TAFE Certificate 3 Personal Care (although there are a range of appropriate TAFE certificates). At the present time some of these workers are qualified as Div 1 and 2 Nurses, although they are not employed as nurses. Conditions are negotiated based on the H&CS Industry Sector Minimum Wages (as per the relevant classifications). One shift every day that a House is open would be worked by the Respite Supervisor who at Neil Stewart is a Div 1 Nurse and at Cornish Vale is a Div 2 Nurse. Respite Supervisors are permanent part time positions; all other positions within the House are casual. The staff to resident ratios are 1:3 during peak times and 1:6 overnight. House staff take advantage of training being provided externally (e.g. HACC) where courses include incontinence, Alzheimer's etc - relevant topics are identified and courses (and refreshers) located and arranged as required. There is no specific budget allocated for training although there is general support and encouragement to pursue skill development. The Program Manager is a member of the Board of Governance at Uniting Care Wangaratta and reports to the Respite Committee. Cornish Vale provides a local member to the Respite Committee. The Program Manager is a permanent full time appointment who holds a nursing qualification and assists workers in the Houses with some supervision. The most senior member of the clinical/care staff will be qualified at RN Div 1 level although this is not a requirement.
St Laurence House	Staff to resident ratios for day care and overnight respite is 1:4 with on-call via Vita-Link. There is two, 11 part-time and four casual staff members at St Laurence House. Performance and training needs are documented in annual performance plans. Staff have access to internal training including personal care, manual handling, risk assessment and stress management; and external training in occupational health and safety, first aid and food safety. Staff performance is reviewed annually against personal care capabilities for direct care staff and coordinator and management capabilities for management staff. The organisation has a recruitment policy that documents policy and procedures for staff selection. The procedures include selection criteria based on the documented job description, induction and orientation.

Funding Arrangements	
Banksia	Banksia receives government funding from both DHS and DH&A - separate FASAs exist for each and each has their own reporting requirements. DHS funds day activity programs, overnight respite on Tuesday and Saturday nights and Sunday respite. The Commonwealth funds overnight respite on Fridays, and host home and in-home respite within the community.
Brooke House	A FASA exists stipulating funding to essentially cover full rental and insurance costs. No service targets are provided under the FASA and there are no other contractual or funding arrangements with external parties.
Carinya House	A FASA exists with DH&A under the NRCP. No base level of recurrent funding and service targets are identified in the FASA. In addition, there are contractual arrangements with third party insurers. Client's fees are a flat $23 per night for all clients.
Eyers House	Eyers House receives government funding from both DHS (HACC) and DH&A (NRCP) - separate FASAs exist for each and each has their own reporting requirements. Client fee are $90 per weekend, although depending upon circumstances there is scope to waive or negotiate a reduced fee. Eyers House also accesses additional state funding through Carers Choice.
Hurlingham	There are service agreements with Bayside Community Options, DHS (HACC) and the Carers Respite Centre, but no contractual arrangements with third party insurers such as DVA. HACC funding is provided as 32-hour blocks of care for one to three clients; care targets are expressed as a specified number of hours per quarter. Funding from the CRC is provided through a pilot program (Dec 2001 – June 2002) - under this agreement, the CRC will book six night blocks of care (within which it might fill the bed with different clients although most are occupied by a single client). In practice, clients are able to stay a seventh night, being the HACC funded Saturday night. The CRC applies a cap of 18 nights respite per client in each six-month period. Client contributions are $25 per night and $7 per day of respite care. Clients using a HACC funded block of care (32 hours over the weekend) are charged $45. If a client cannot afford fees at this level then an exemption may be offered.
Kilby House	Kilby holds service agreements with Moreland Community Health Service and the Carers Respite Centre. These do not specify a base level of recurrent funding or service targets. There are no other contractual arrangements with third party insurers. Client contributions are $25 per 24-hour period.
Neil Stewart House & Cornish Vale	A FASA exists that specifies a base level of recurrent funding and service targets. DHS (HACC) grants are received in two main categories, each having a particular quarterly target and each split across the LGAs in the Region. The 'Overnight Grant' specifies 521 10 hour blocks be provided quarterly. The 'Home and Community Grant' specifies 6301 hours be provided quarterly. One-off contracts exist with several organisations to fund respite weekends. Client contributions are normally $105 per weekend stay although if an invoice is not required the fee is reduced to $90. Where there is bed capacity over and above the hours funded through the DHS grants, and away from weekends, fee for service clients may be accepted. Charges are roughly calculated on the basis of approximate costs plus a share of overheads. People with Community Care Packages are required to pay full cost recovery (approx $800 per weekend stay); however, in practice, it is felt that this is too expensive and a fee of $140 only is levied.
St Laurence House	St Laurence House has a funding and service agreement with the Department of Human Services (Home and Community Care) and the Department of Health and Ageing. Funding includes overnight respite (468 ten hour blocks), respite (1,040 hours), Planned Activity Groups (16,493 hours), Carers Initiative (564 hours), and flexible respite (1,440 hours). St Laurence House also has a brokerage arrangement with the Carer Respite Centre.