

At What Cost?

Aged Care Industry Costs

Arising From

Resident Classification

Scheme Processes

Commissioned by
Aged Care Association Australia

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Dear Mr Young

**AT WHAT COST? Aged Care Industry costs arising from
Resident Classification Scheme processes**

Thank you for the opportunity to investigate and report on financial outlays by industry and government related to the operation of Resident Classification Scheme (RCS) processes. The report detailing findings of this study is attached.

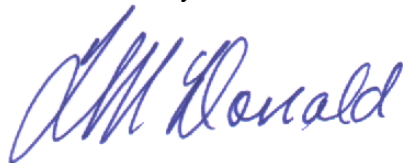
The findings identify time and costs associated with staff involved with RCS documentation as well as time spent in satisfying perceived requirements of Government validation processes. An estimate of resources applied to validation processes by commonwealth nursing officers and clerical support is also included.

The time allocated to satisfying RCS regulations is 5,844,449 aged care staff hours or 243,519 complete days per year. On this basis, industry expenditure arising from RCS processes is \$142,350,977 and of that, \$93,902,695.00 relates to aspects of the RCS that have little margin for discretionary decisions by approved providers. The costs to the Department for RCS processes was not able to be estimated based on the information received but is thought currently to amount to at least \$17,000,000.00 per annum.

I would like to acknowledge the assistance provided to this project by Mr Bill Bourne, Manager Financial Services, ACAA-NSW in accessing industry variables used in the calculations.

Please do not hesitate to contact me should you wish to discuss the contents of this report and issues related thereto.

Yours faithfully



Dr Tracey McDonald

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Resident Classification Scheme processes

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EXECUTIVE SUMMARY

There has been much discussion and debate across the Aged Care Industry as to the extent to which documentation associated with the Resident Classification Scheme (RCS) creates its own workload with consequent costs to the industry. Funding received through the RCS is primarily for resident care and accommodation services and the resources required to satisfy the workload associated with RCS are not factored into the funding formula.

It has been estimated that \$10,000,000.00 is spent by the Department of Health and Ageing on the existing RCS validation approach where approximately 90 validators are employed at Commonwealth Nursing Officer (CNO) level. The extent to which clerical support have been engaged to assist CNOs is not generally known. The 2004-2005 Australian Government budget allocated an additional \$29,000,000.00 over the next four years to enable the Department to increase validation intensity. This amounts to \$7,000,000.00 per year without the existing Departmental outlays for validation of RCS. Unfortunately access to details of government expenditure associated with CNO activities was not possible for this study.

The Aged Care Association Australia (ACAA) has also estimated that the national costs of documentation could amount to around \$90,000,000.00 at least, but ACAA realised the need to establish through independent research, the extent to which RCS imposed a cost burden on the industry.

Dr Tracey McDonald, Professor of Ageing with ACU National in the RSL Veterans' Retirement Village Chair of Ageing, was appointed to conduct the research.

The study

The survey that forms the basis of this study was developed in consultation with industry representatives and piloted prior to distribution via facsimile and email. Participants were asked to ensure that the survey be completed by staff who are normally involved with RCS activities. Completed survey sheets were then either emailed or faxed back to the researcher within 1-2 weeks of receipt.

Responses to this survey were received from 147 residential aged care providers involved with 237 facilities representing 13,250 approved and occupied beds, or 9.06% of the total approved beds across Australia. 129 high care and 108 low care facility responses were received. Within the sample some facilities are stand-alone high or low care and some are combined services. The average size of participant facilities is 89.53 beds (median 70) with a range of 30 – 390 overall.

Responses varied across different States and Territories. Jurisdictions have been aggregated as necessary to ensure de-identification of particular aged care facilities. These are Victoria and Tasmania (18% of responses) NSW and ACT (31%) and South Australia and Northern Territory (15%).

The data obtained provides estimates of time spent by different groups of aged care employees in five main areas of RCS activity:

1. Admission RCS assessment
2. Annual review of RCS
3. Ongoing RCS documentation monitoring, staff training and coaching
4. Validation of RCS claims
5. Appeals against RCS downgrades

The findings

Estimates based on the data collected put the total wages cost to the aged care industry of satisfying regulatory requirements associated with RCS funding at \$142,350,977.00 and taking up a total of 5,844,449 aged care staff hours or 243,519 complete days per year.

The cost of annual RCS reviews and RCS validation processes are directly attributable to regulatory requirements generating an aged care industry expenditure of \$93,902,695.00 per annum.

Other RCS related processes such as assessment, ongoing activities and appeals against RCS validation decisions, incorporate an element of discretion for approved providers who have control over their systems and approaches used to achieve RCS outcomes. These RCS activities amount to \$48,448,282.00 per annum.

The total finding of costs is based only on the wages expenditure for the staff categories listed below, and does not include any paper, copying, communication or computing resources that they use to complete and process RCS documentation. The breakdown of staff costs are as follows:

- Managers (not including approved providers or directors) = \$44,502,594.00
- Registered nurses (RNs) = \$61,620,086.00
- Care staff (Non-RN) = \$27,907,840.00
- Other staff including allied health = \$8,320,457.00

Implications

The totals shown above are conservative representations of the cost of wages for the categories of staff involved in processes set up either by government or by approved providers to satisfy the requirements of the RCS. Not included are the costs of equipment, training, computers, paper and travel which can add considerably to the overall burden on the aged care industry.

Despite the financial outlays made by industry to ensure successful connections with a very complicated funding system, the uncertainties of funding and the intricacies of interpretation of sub-regulation have not improved over time. Still, the industry contributes 243,519 full days to the support of a funding system that does little to acknowledge the impressive growth, change and quality commitment of approved providers in the contemporary aged care industry. Such acknowledgement would be evident if there were to be a reduction of mandated processes attached to local operations of aged care facilities, and this in turn would relieve the financial burden imposed by extensive micro-regulation.

Relieved of the financial burden of engaging with a complicated system of funding, aged care providers, managers and staff would be better able to extend the essential care and services that they are able now to deliver, to become a more innovative and effective environment for adding quality to the lives of residents. Having to outlay \$142,350,977.00 in order to satisfy RCS workload demands that are core to aged care industry participation, has meant that approved providers have faced severe handicaps in their efforts to meet standards for care and accommodation set down under the Aged Care Act 1997. If the cost burden associated with the RCS and the excessive documentation that this system drives could be lifted, approved providers would regain access to resources sorely needed to ensure ongoing sustainability of services, further development of professional level care, and treatment and support for innovative lifestyle options for older Australians.

TERMS of REFERENCE

Background

Of the many issues arising from processes set up under the Aged Care Act 1997 and Principles, none seem to have been so enveloped in concern as the extent to which approved providers have had to resource their operations in order to ensure adequate and stable funding for the care, treatment, support and protection provided to residents.

Against this background of widespread uncertainty around funding for resident care, aged care providers have been keen to have access to information that may assist them to estimate the outlays needed to ensure continuity of funding under the RCS and importantly, to reduce the incidence of RCS downgrades resulting from RCS validation audits of their care documentation.

In October 2005 the Aged Care Association of Australia requested that an independent study be undertaken to determine the level of staffing, time and other resources that have been set up to enable approved providers to work effectively with the Resident Classification Scheme (RCS). The study is aimed specifically at identifying only those staff and times applied to RCS activities. Activities which could be said to have a dual purpose and which would have been done if there had been no RCS process involved, have not been included. In other words, it is expected that every aged care facility will have systems in place to generate a thorough assessment and care plan for every resident on admission and throughout their stay. In this study, only those functions related to RCS requirements have been included. (Please see authorisation letter, Appendix 1)

Terms of reference

Specifically, the goals of the study are to:

1. estimate time spent by nurses in the residential care programme completing documentation associated with the Resident Classification Scale (RCS);
2. estimate time spent in satisfying the perceived requirements of the Government's RCS validation processes; and
3. calculate the financial cost of validation processes associated with the RCS

The remaining calculation related to expenditure by government for CNO activities, could not be achieved based on feedback from industry respondents who were in no position to provide accurate details of CNO time invested in RCS activities.

An estimate of the hours and resources allocated to CNO and clerical support involved with RCS validation and appeals processes would have added a further dimension to the overall resourcing of the RCS process. Based on Australian Government Budget announcements at least \$17,000,000.00 per year is allocated to this aspect of RCS validation. However an independent estimate would not have been possible without the direct involvement of the Department of Health and Ageing and is therefore omitted from calculations other than for average time spent in on site validation visits.

ETHICAL CONSIDERATIONS

Because the aged care industry is highly regulated and frequently scrutinised in terms of processes as well as outcomes of systems of care, treatment, support and protection, concern exists among many providers and managers that comment on government processes may attract even more attention than they might reasonably expect. Such perceptions were

received uncritically by the researcher and assurances given to participants that feedback would be treated confidentially regarding personal and organisational identities, and that only de-identified and aggregated information would be made public. Participant acceptance of this guarantee was deemed to exist on their return of completed surveys.

Ethical approval for this study was granted by the Human Research Ethics Committee (HREC) of the Australian Catholic University. (Please see ethics approval, Appendix 2)

METHODOLOGY

The focus of this quantitative study is on time spent by various classifications of employees of aged care facilities doing tasks directly associated with RCS assessment, validation and documentation in both low and high residential aged care contexts. It was also thought useful to calculate jurisdictional differences in financial outlays by aged care providers, caused by the wide variation in wages across different States.

Differing perceptions of the purpose of activities carried out in relation to documentation create some margin for variability which needs to be factored into any interpretation of results. The survey tool focused attention specifically on RCS activities and around times and processes allocated at the local level to RCS activities and where dual-purpose activities occurred these have not been included.

A pilot test of the survey tool occurred in October 2005 enabling the questions to be refined and ambiguity reduced. Despite variations between States and Territories regarding nomenclature used to describe staff classifications, and also differences between facilities regarding periods of assessment and review, the one-page survey format was able to be understood and answered confidently by the majority of facilities assisting in the pilot test.

The survey questions and participant information (Please see survey, Appendix 3) were distributed via facsimile and email through the national office of the Aged Care Association of Australia and a request was made that the survey be completed by a staff member who is normally involved with RCS activities. They were asked to fax or email their answers within 1-2 weeks of receipt. The researcher had no influence over the distribution of surveys, nor the total number of recipients. However a target of 300 or around 10% of residential aged care facilities was thought desirable. A contact telephone number was provided in the information sheets to assist anyone in doubt as to the meaning of any of the questions or time-frames and several participants availed themselves of this service.

Recipients were asked to estimate only the times spent by different groups of employees in five main areas of RCS activity:

1. Admission RCS assessment for each resident, setting up RCS documentation and lodgement of claim
2. Annual review of RCS classification for each resident, documentation and lodgement of claim
3. Ongoing RCS documentation monitoring, staff training and coaching and checking of entries to ensure that the care being delivered is appropriately documented
4. Validation of RCS claims by Commonwealth Nursing Officers (CNOs) who visit aged care facilities and scrutinise the documentation of care given against the RCS claim made for each resident's care and other services.

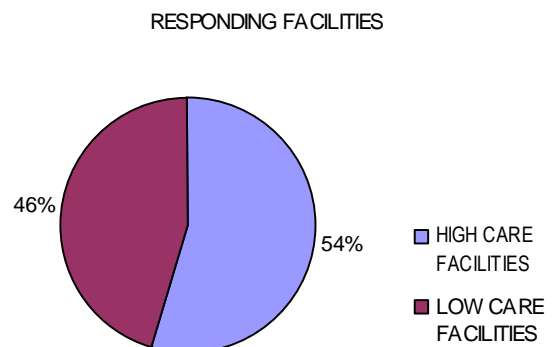
5. Appeals against RCS downgrades following a CNO validation visit, in order to retrieve funding that has been removed as a result of downgrades.

Staff and time allocated by approved providers to these RCS activities formed the basis of the survey.

SURVEY DISTRIBUTION

Responses to this survey were received from 147 residential aged care providers involved with 237 facilities and representing 13,250 approved and occupied beds, or 9.09% of the total approved beds across Australia.

The average size of participant facilities is 89.53 beds (median = 70) with a range of 30 – 390 overall. Within the sample some facilities are stand-alone high or low care and some are combined services. In all, counted separately, there are 129 high care and 108 low care facility responses.



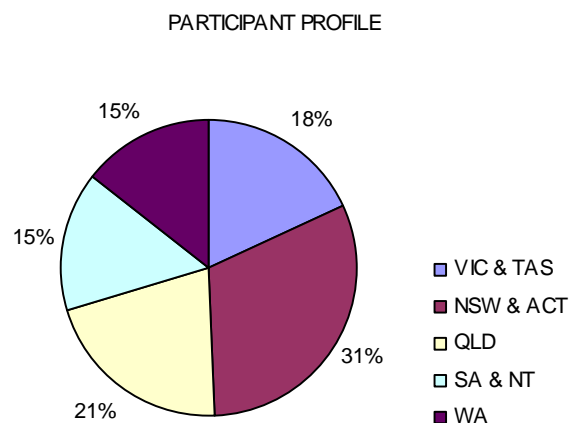
SAMPLE / RESPONSES

State and Territory participation

Across the different States and Territories responses varied and where few responses were received, these areas were combined to ensure de-identification of particular aged care facilities.

Consequently the profile chart (left) shows Victoria and Tasmania (18% of responses) NSW and ACT (31%) and South Australia and Northern Territory (15%).

Diagram 2. Participating aged care facilities



CONFIDENCE AND LIMITATIONS OF DATA

Statistics for each table in this document are based on all cases with valid data for all variables in each table. Data cleansing was undertaken in terms of obvious outliers which were removed from the statistical calculations of central tendency to ensure confidence in the stripped averages generated. The result is therefore a conservative estimate of final costs in each category. Statistical outliers are discussed under the survey result areas as they arise. In all, 147 facilities responded to the survey. While this is 50% of the target response, the short turn-around time of two weeks may have made it difficult for some facilities to find the time to participate. Even so, the response is sufficient to produce useful and reliable calculations.

The survey data were analysed in terms of the time, staff and wages costs involved across each State and Territory. Financial modelling of these data allowed for the generation of national totals of hours and financial outlays involved based on the average time spent by different categories of staff in the different jurisdictions. Sample averages were used to calculate population results. For instance, calculation of annual RCS validation appeals (Question 5) was the sample average hours spent by staff categories multiplied by the known number of annual appeals for each State and Territory.

In calculating Australia-wide results, certain assumptions are necessary and are as follows:

1. Rate of resident placement turnover

Admission rates to residential aged care facilities impact directly on the work associated with admitting a person to care and completing the RCS assessment and documentation necessary for accessing funding. From sources in the Aged Care Industry it was estimated that the average length of stay in high care is approximately 22 months and for low care, the average length of stay is estimated to be 34 months. Of course, length of stay varies across regions and depending on access to alternative providers of health and aged care services, but for the purposes of this study these estimates have been used.

Based on these estimates the resident turnover rates per year are 54.55% in high care 35.29% in low care. Residential turnover rates are critical to study outcomes in that hours and categories of staff involved would be altered significantly if these rates were to be altered.

2. Salary rates

To calculate the cost of financing RCS activities it is necessary to include different categories of staff and the diverse hourly rates of pay across different State and Territory industrial arrangements. The national total draws upon these differences.

Table 1. Hourly rates for staff categories across jurisdictions

	Queensland	New South Wales & Australian Capital Territory	Victoria & Tasmania	Western Australia	South Australia & Northern Territory
	\$	\$	\$	\$	\$
Manager	34.9039	38.0289	39.0000	36.7718	39.9539
Registered nurse	26.1566	27.0237	25.5579	24.8658	24.4954
Care staff	16.0395	15.1763	16.4750	15.7474	16.0739
Other	16.0395	15.1763	16.4750	15.7474	16.0739

3. Approved residential aged care places

Information available through Government agencies and industry bodies was used to establish a baseline for the number of approved residential aged care beds as well as the proportion of high and low care beds.

Table 2. Distribution of approved residential aged care beds or places

	QLD	NSW & ACT	VIC & TAS	WEST AUST	SA & NT	AUST
HIGH CARE BEDS:	14412	30229	21292	6443	8474	80850
LOW CARE BEDS:	12194	21340	19406	6103	6352	65395
TOTAL	26606	51569	40698	12546	14826	146245

4. RCS reviews and appeals

Information on the number of RCS appeals across Australia was taken from reports provided to industry by the Department of Health and Ageing. The work associated with appealing a decision by the Department in relation to the level of funding to be granted, is quite onerous and time consuming. It is not the purpose of this study to examine the patterns of reviews and appeals across jurisdictions however the frequency of this RCS activity has implications for approved providers who resource the activities.

Table 3. RCS reviews and appeals reported across jurisdictions

	QLD	NSW & ACT	VIC & TAS	WEST AUST	SA & NT	AVERAGE
REVIEWS:	352	676	832	192	252	460.8
APPEALS:	10	36	22	8	8	16.8
HIGH CARE FACILITIES:	240	503	355	107	141	1346
LOW CARE FACILITIES:	244	427	388	122	128	1309

Of interest is the low incidence of appeals reported within the sample group, no doubt an anomaly arising from a small sample. Only 26 of the 147 respondents, representing 237 facilities, reported experience of appealing decisions on RCS validations. Even so, when the number of RCS appeals reported by government is examined in relation to the number of reviews across each jurisdiction, the appeal rate is quite low and possibly indicates a level of approved provider reluctance to embark on this activity.

RESULTS

In this section the overall results of the survey are provided, followed by a more detailed presentation of results against each of the five survey areas.

OVERALL RESULTS

In calculating the overall national cost of RCS processes, all activities associated with the setting up, maintenance, operation and evaluation of documentation required to access funding for aged care placements are included.

On these estimates, the total wages cost to the aged care industry of satisfying regulatory requirements associated with RCS funding is \$142,350,977.00. The costs borne by the Government in relation to the activities of Commonwealth nursing officers in review and appeals processes were not able to be estimated with any degree of accuracy however it appears from Australian Government budget announcements that the allocation is at least \$17,000,000.00 per year.

Table 4 shows the overall distribution of finances allocated to RCS processes and draws on combined information gathered through the survey and its relationship to available information on wages, turnover and time allocated to RCS activities.

Activities directly attributable to regulatory requirements are the annual RCS reviews and RCS validation processes. When combined, these cost the aged care industry an estimated \$93,902,695.00 per annum. Other processes related to RCS such as assessment, ongoing activities and appeals against RCS validation decisions, incorporate an element of discretion for approved providers who may or may not choose to invest heavily at such resource intensive points.

Table 4. Overall results: Sample distribution of finances allocated to RCS processes

	QLD \$	NSW & ACT \$	VIC & TAS \$	WA \$	SA & NT \$	AUSTRALIA \$
RCS assessments	4,410,191.00	5,941,773.00	8,087,034.00	1,967,523.00	2,402,350.00	22,808,871.00
Annual RCS reviews	24,098,277.00	16,385,935.00	30,919,224.00	13,501,290.00	8,487,252.00	93,391,978.00
Ongoing RCS support activities	5,079,323.00	4,368,137.00	9,653,783.00	2,620,897.00	3,704,442.00	25,426,582.00
RCS validation processes	82,807.00	130,461.00	213,143.00	35,971.00	48,335.00	510,717.00
Appeals against RCS validations	767.00	2,139.00	212,829.00	0	0	212,829.00
TOTAL	33,671,365.00	26,828,445.00	49,086,013.00	18,125,681.00	14,642,379.00	142,350,977.00

Table 5 shows similar information to that above however it is segmented according to the category of staff involved across high and low care. By far the people most involved in RCS activities are registered nurses (Division one in Victoria). Managers also are very involved in RCS activities and they are likely to be in situations involving teams of staff who also assist.

Table 5. Overall results: Finances invested in RCS processes

	TOTAL HIGH CARE \$	TOTAL LOW CARE \$	TOTAL INVESTMENT \$
Managers	25,461,749.00	18,903,843.00	44,502,594.00
Registered Nurses	35,699,664.00	25,884,194.00	61,620,086.00
Care staff	14,412,138.00	13,476,410.00	27,907,840.00
Others (including Allied Health)	4,768,699.00	3,531,450.00	8,320,457.00
TOTAL	80,342,250.00	61,795,897.00	142,350,977.00

As can be seen in other tables in this section, registered nurses do most of the work associated with RCS processes (43.29% of the industry wages funding) and spend quite a large amount of time coaching and overseeing the work of multi-occupational teams.

Various aspects of RCS activity are performed by different categories of staff and are not directly concerned with the delivery of care. Decisions as to which staff to involve are guided by the requirements of the Aged Care Principles under the Aged Care Act 1997 and the documentation and assessment skills of staff.

Approved providers are required to employ appropriately skilled staff for their facility, considering the resident category mix and their care, treatment, support and protection needs. However, not all staff are proficient in English language and literacy and few are capable of analysing text in terms of subtle meaning. This places greater onus on employers to undertake ongoing activities to compensate for the low levels of literacy that, if occurring in a particular region or facility, can compromise the success of RCS documentation and processes even if the care delivered is actually meeting all of the residents' needs.

ADMISSION RCS ASSESSMENT AND DOCUMENTATION

Question One of the survey asked respondents to estimate the total time per day that each of the staff categories listed are involved in resident RCS admission processes. While the admission period extends to several weeks, much of that time would normally have been allocated to conduct admission assessments even were there no RCS requirement; but the assessment of residents would not be so pressured in terms of time. Therefore, in consultation with managers and staff involved in the assessment of residents under the RCS, the component of the admission process related to satisfying RCS requirements was estimated to take up 5 days of that initial few weeks of assessment.

Survey responses demonstrate the time allocated for involvement in RCS-only elements of the resident admission assessment and documentation processes varies according to the category of staff involved.

The overall results of responses to Question One are shown in Table 6 below.

Table 6. Average time (hours) invested in RCS assessment across jurisdictions

	Managers		Registered Nurses		Care Staff		Other (Incl. Allied Health)	
	High care	Low care	High care	Low care	High care	Low care	High care	Low care
QLD	0.79	0.20	1.38	0.83	0.79	0.59	0.81	0.23
NSW/ACT	0.33	0.33	0.50	0.71	0.25	0.25	0.00	0.00
VIC/TAS	1.04	0.51	1.38	0.90	1.18	0.96	0.39	0.28
SA/NT	0.48	0.48	0.98	0.70	1.04	0.83	0.17	0.10
WA	0.70	0.77	1.06	0.70	1.16	1.05	0.17	0.09

The information provided in Table 6 can be more fully appreciated in the charts below which display the differences between categories of staff working in both high and low care.

Chart 1. Managers Q1.

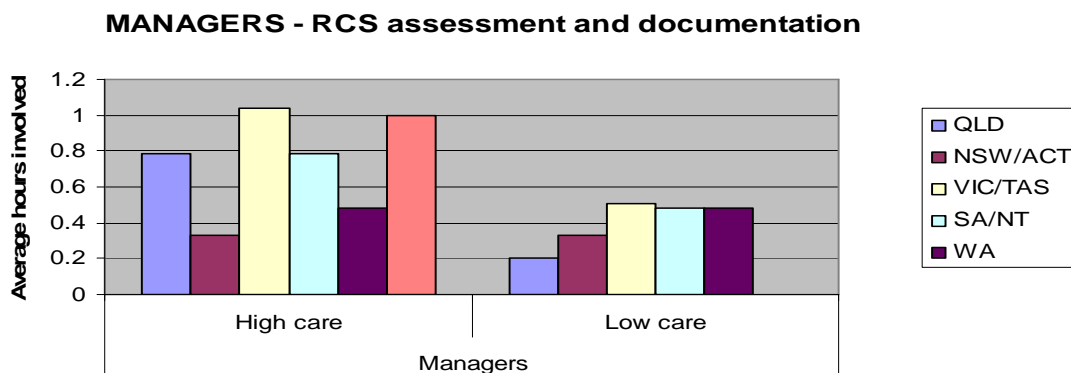


Chart 1 above shows managers in high care to be quite involved in RCS assessment and documentation ranging from 15 minutes to a little over an hour per day for at least five of the admission assessment days involved in this initial assessment. Much of this time is given to setting up the RCS documentation and checking that the documentation is accurate and complete despite this activity also requiring a large effort by registered nurses.

Registered nurses involved in this initial assessment period apply considerable time to making professional assessments which they would perform even if there were no RCS requirement. However certain aspects of the assessment process are driven by RCS requirements and would either be omitted if RCS were not operating, or spread out across more time than that specified for meeting regulations around resident admission.

Chart 2. Registered nurses Q1.

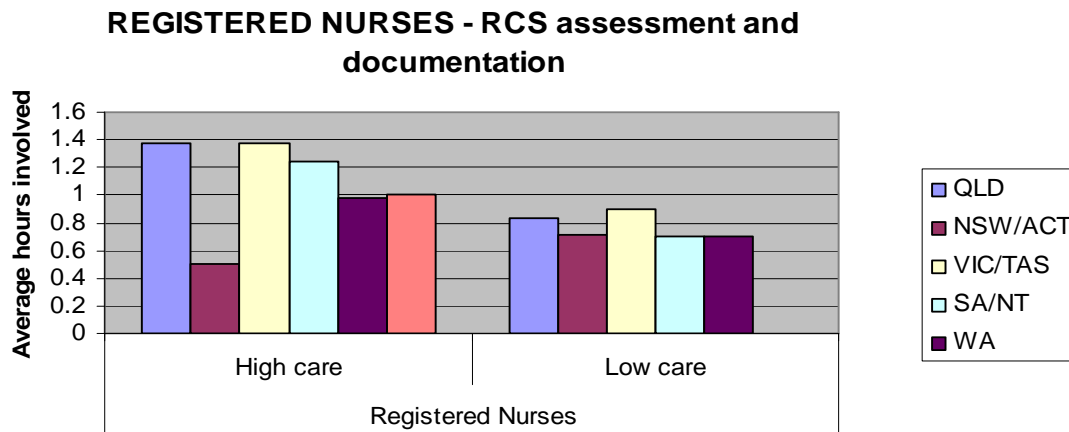
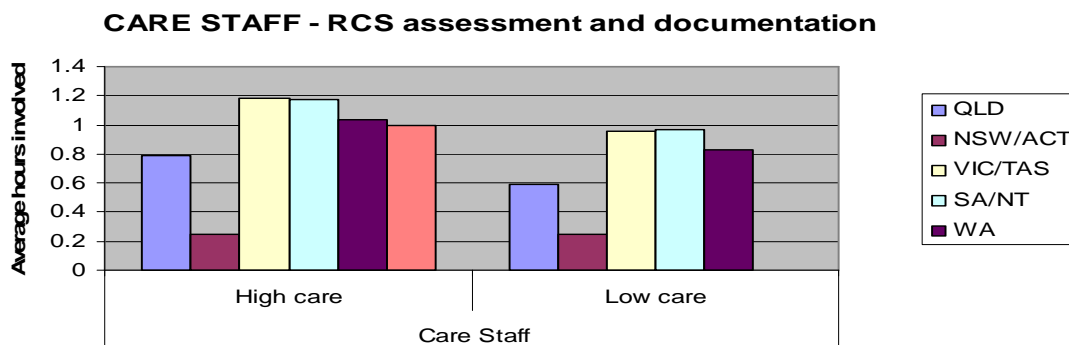


Chart 2 above represents the registered nurse time allocated to RCS-only activities around the assessment period and is most probably related to setting up RCS documentation, completing the required application forms and following up on different assessments required from other staff in order to access RCS funding. Registered nurses in high care spend from 30 minutes to 90 minutes per day over at least 5 days of the initial resident assessment period in RCS processes.

Chart 3. Care staff Q1

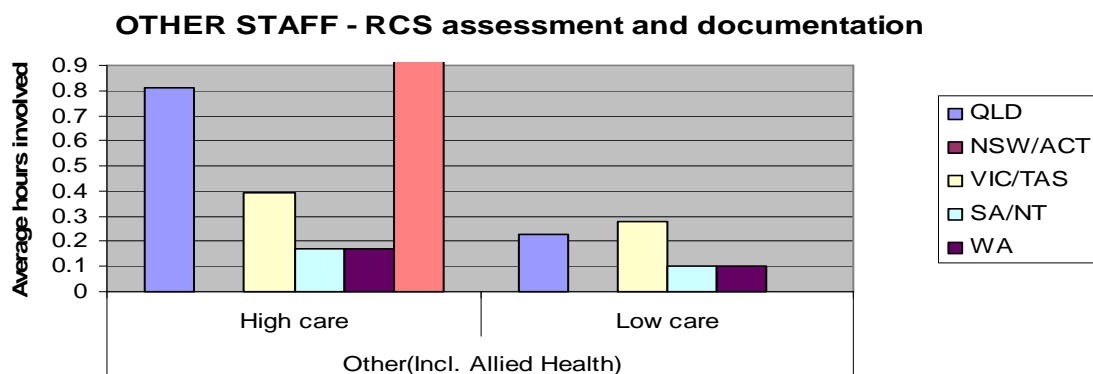


Care staff depicted in Chart 3 above generally assist registered nurses, especially in high care, to compile the information needed for RCS documentation and also to compile the documentation itself. In low care areas care assistants undertake a pivotal role in the administrative systems of the facility and in particular, the documentation needed to successfully access RCS funding.

Claims under the RCS cover a wide range of care and lifestyle elements and can involve non-registered nurse personnel during the initial assessment period of a resident's admission. Such personnel can include medical practitioners, physiotherapists, occupational therapists, psychologists, social workers, activity coordinators, recreational and other allied health aides.

The main purpose of engaging these staff in the admission process is to establish a range of professional assessments of the residents, as a basis for the formulation of a care plan. This process would occur even without the RCS requirements, however the survey asked for only that time allocated to RCS-specific tasks such as assessments that would not normally be performed or documentation under a process that would not normally occur. Chart 4 below shows times allocated for RCS-only activities only. The involvement of these other staff in assessment overall is much greater than occurs for RCS.

Chart 4. Other staff including allied health Q1



When the sample averages of time spent on RCS assessment and documentation are used as a basis for calculating time expended across the aged care industry, the extent to which time is allocated to RCS assessment and associated documentation on admission becomes apparent.

The times shown in Table 7 below are based on 5 days out of several weeks wherein residents are assessed following admission to residential aged care. In high care almost 4 hours per day of the 28 day assessment period are allocated across various staff and in low care it is around 3.5 hours per day.

Overall, RCS assessment and RCS documentation associated with resident admission to aged care accounts for 38,444 complete days per year financed by the aged care industry.

Some participants questioned the shortened time period stipulated for RCS assessment in this study, and indicated that they would prefer to allocate more time. However, the dual nature of assessment was discussed with them and they agreed that 5 days is a reasonable time to allocate for RCS-only assessment and documentation.

Table 7. Overall results: Time (hours) invested in RCS assessment and documentation

	Over 5 day period @ 54.55% turnover HIGH CARE	Over 5 day period @ 35.29% turnover LOW CARE	TOTAL TIME INVESTED per year
Managers	158,509	56,004	214,513
Registered Nurses	239,906	96,089	337,995
Care staff	181,055	96,484	277,539
Other (incl. Allied H'lth)	68,762	23,838	92,600
TOTAL	648,232	272,415	922,647

Participants also agreed that the time remaining beyond 5 days, would have been used for other assessments to establish professional care even though broad and ongoing professional assessment would not have been limited to the initial few weeks following admission.

In calculating the proportion of time allocated to RCS activities due consideration has been given to excluding those aspects of assessment which would have occurred and are expected to occur when a person is admitted to residential aged care. Resident assessments occur on admission and throughout the length of stay, and involve various professionals in constructing a plan of care that adequately addresses the care needs of the resident. However, staff activities in terms of including certain resident profile information and reporting in certain formats and in lodging RCS documentation within stipulated timeframes would not occur if the RCS were not driving them. It is only these activities that have been used to calculate the cost of RCS associated with resident admissions.

ANNUAL RCS REVIEW

Question Two focused on the annual review processes required under the RCS. The implications for approved providers in ensuring that reviews are timely and accurate lie in significant fluctuations in funding if they have not set their organisations up to interact successfully with the Government. Therefore emphasis is given by approved providers to documentation associated with the annual RCS review in an effort to ensure that it accurately reflects the level and extent of care being delivered to the resident; and there is written evidence that the care delivered is driven by the care plan which, in turn, is based on professional assessments of the full range of resident needs.

Table 8 shows the distribution of time, across staff categories, allocated to the annual RCS review of all aged care residents. All time associated with this activity is strictly attributable to RCS processes as it would not occur in the absence of the RCS. In such an environment, assessment would be ongoing rather than a concentrated period of time annually, and reporting of changes in condition would be incorporated throughout the residents' case files to support professional care and treatment decisions.

Table 8. Average time (hours) invested in annual RCS reviews across jurisdictions

	Managers		Registered Nurses		Care Staff		Other (Incl. Allied Health)	
	High care	Low care	High care	Low care	High care	Low care	High care	Low care
QLD	0.70	0.38	1.31	0.84	0.80	0.45	0.34	0.15
NSW/ACT	0.17	0.12	0.45	0.33	0.18	0.31	0.07	0.12
VIC/TAS	0.49	0.38	0.95	0.70	0.68	0.40	0.29	0.16
SA/NT	0.39	0.28	0.90	0.42	0.58	0.44	0.03	0.06
WA	0.45	0.55	1.27	1.26	0.69	1.33	0.26	0.19

Of interest are the differences between jurisdictions regarding staff involvement times associated with annual RCS review processes.

From the sample averages shown above the hours, the actual hours they represent are shown in Table 9 below. It again appears that registered nurses are very involved (37.11% of the total time for all staff). However, in some States care staff are heavily involved and in others, the majority of involvement rests with registered nurses. Much of the involvement of care staff probably relates to the implementation of assessment tools designed by registered nurses for gathering observed data on the condition of residents. Care staff then report to registered nurses who analyse the observations and evaluate residents' condition against evidence collected and reported to them through this process.

Many of the survey returns indicate that the hours allocated to 'other' for this question refer to allied health personnel who are involved in assessing residents in terms of their physical and mental abilities and their capacity for involvement in social and other activities. Because not all of the hours included in this category are allied health professionals, the salary rate for calculation of the national expenditure has been kept at the average for personal care staff.

Table 9 shows the hours allocated across the annual RCS review period based on the sample averages of time for each category of staff. In high care almost 3 hours per day of the total review period is allocated across the various staff and in low care it is, in fact, 3 hours per day.

Table 9. Overall results: Time invested in annual RCS reviews across staff categories

	Over 5 day period @ 54.55% turnover HIGH CARE	Over 5 day period @ 35.29% turnover LOW CARE	TOTAL TIME INVESTED per year
Managers	406,934	358,213	765,147
Registered Nurses	871,352	745,319	1,616,671
Care staff	521,407	560,462	1,081,869
Other (including Allied Health)	192,161	165,197	357,358
TOTAL	1,991,854	1,829,191	3,821,045

Sample average times of staff involvement, if applied across all jurisdictions, and when combined with the 28 day RCS review period for every resident, produce an estimated 159,210 complete days throughout Australia each year allocated to RCS reviews, funded by the aged care industry.

ONGOING RCS DOCUMENTATION MONITORING, TRAINING AND CHECKING

Question Three provides several insights into management decisions made at the local level which are no doubt driven by perceptions held by approved providers of the need for ongoing monitoring, staff training and internal RCS audits. In some facilities emphasis given to RCS documentation is significantly higher than in many others indicating the perception by approved providers of the importance of RCS documentation for funding stability. Because so much depends on care documentation reflecting the reality of care being delivered to each resident, and because an error in description of resident responses or an omission of care that was delivered can jeopardise ongoing funding, approved providers allocate differing levels of resources to training staff, monitoring documentation systems and checking that all care that has been delivered, is indeed recorded accurately. Much of this would not occur without the need to satisfy RCS requirements.

Survey feedback on this question highlights the wide variation of time and other resources allocated across the sample to ongoing upkeep of RCS documentation. In some facilities staff members, mostly registered nurses, are employed specifically to ensure that RCS documentation and reporting systems are in good order. In other facilities these responsibilities are shared among all staff or not given as great an emphasis. In such facilities documentation monitoring, staff training and checking of staff entries as well as the overall analysis of the documentation in terms of meeting RCS requirements may not be allocated to specific staff.

Table 10 shows the distribution of time invested in ongoing RCS activities across jurisdictions. It is interesting to note the differences in average time spent by high and low care managers and registered nurses on these activities.

Table 10. Average time (hours) invested in ongoing RCS activities across jurisdictions

	Managers		Registered Nurses		Care Staff		Other (Incl. Allied Health)	
	High care	Low care	High care	Low care	High care	Low care	High care	Low care
QLD	2.03	0.46	4.86	2.90	3.46	3.24	0.34	0.10
NSW/ACT	0.90	0.73	1.69	0.56	0.88	2.14	0.27	0.43
VIC/TAS	2.25	1.94	4.99	3.74	3.44	2.52	0.65	0.44
SA/NT	1.11	1.35	7.00	2.71	5.86	3.00	1.34	1.43
WA	1.47	2.17	3.61	2.80	4.12	4.84	0.02	0.27

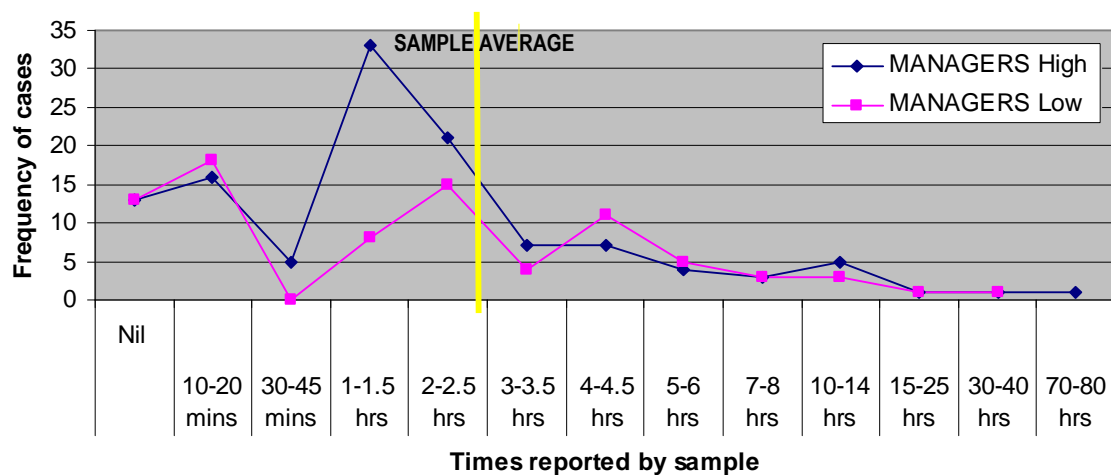
Widely differing allocations of time for staff categories across the sample created several data outliers which, when included in the sample average created significant distributional distortion. Despite the statistical difficulties with these unusually high cases, they do reflect the variability of RCS resourcing decisions that occur within the industry. The sample averages used in this instance have been calculated without the outliers so that the distribution is not skewed and a relatively accurate reflection of the population is generated. The result therefore is a conservative estimate of the total financial outlays for each variable.

The pattern of variability itself demonstrates a variety of approved provider interpretations of what may be required of staff in maintaining RCS documentation in ways that truly reflect the resident care being provided. Therefore outliers are included in the following sample distribution charts to provide the reader with an appreciation of the high variability of RCS process decisions being made at the local level.

The frequency distribution of these cases can be appreciated more clearly when shown graphic format provided below which is based on the sample data.

Chart 5 below illustrates the range of manager time allocated to ongoing RCS activities per week. Based on the overall sample average of 2.76 hours per week, managers on the whole tend to maintain involvement with these activities in terms of oversight and periodic intervention activity.

Chart 5. Managers Q3.



For a significant number of high care managers, time invested at a rate of 1.5 hours on average per week are demonstrated in this sample. It may be that this time does not occur on a regular pattern but would be determined by situations that may arise within a facility that require managers to be directly involved. The cases to the right of the chart indicate that some managers spend most of their time with RCS activities with a significant group spending 4 to 6 hours per week on them. Extreme outliers also appeared, indicating several managers being involved concurrently in accumulating 30, 40 and even 80 hours per week dedicated to RCS activity.

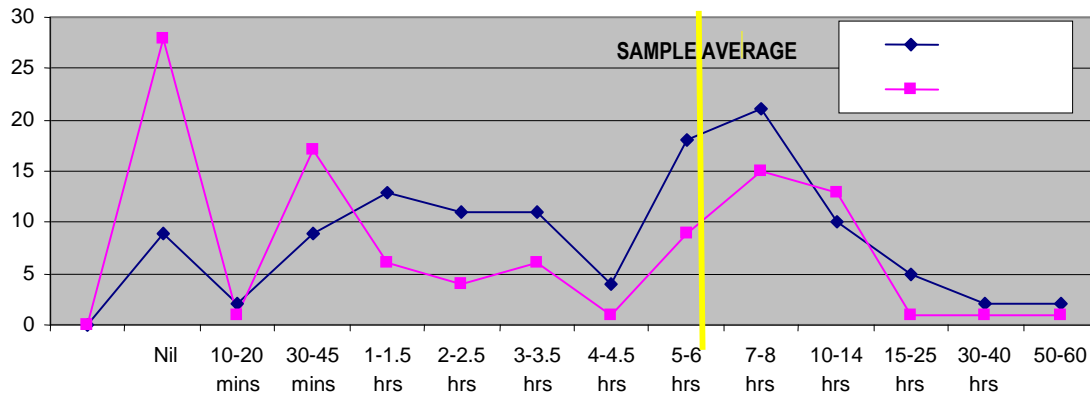
It would be interesting to discover any relationships between manager involvement and whether they have access to registered nurses who could accept delegated responsibility for ongoing RCS activities. However it is not the purpose of this study to pursue the links between managers and registered nurses in terms of allocation of time to ongoing RCS activities.

Across the sample illustrated in previous charts, high involvement by low care facility managers and registered nurses when compared with high care facilities, seems to reflect different workplace arrangements established by approved providers in these contexts.

Chart 6 below displays patterns of registered nurse involvement in ongoing RCS activities. In the chart it is clear that registered nurses, spend considerable time per week in ensuring that documentation is completed to standard, on average 5.95 hours. This overall time per week

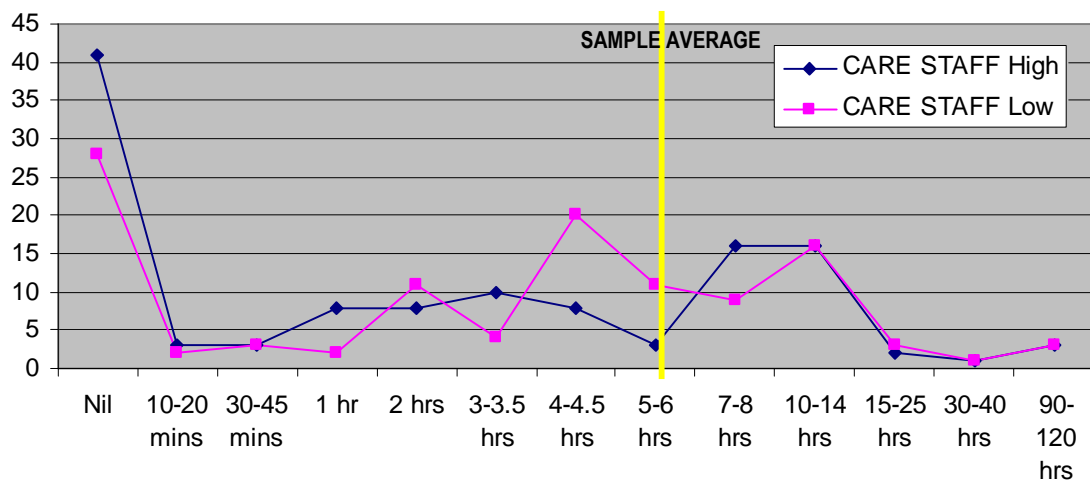
may vary according to daily requirements and it would also be determined by the level of confidence held by registered nurses that care staff and others involved in documentation, are performing capably.

Chart 6. Registered nurses Q3.



It is interesting to note the outliers in the above chart which shows a significant number of registered nurses engaged from 2 to 3 hours per week, and a few unusual instances of 15, 20 and 40 hours per week with one facility reporting over 70 hours per week expended by registered nurses on ongoing RCS activities. It is possible that these registered nurses have been employed specifically to focus on ongoing RCS documentation, staff coaching and oversight or, it may be that many registered nurses are involved extensively in ongoing RCS activity in those same facilities.

Chart 7. Care staff Q3.



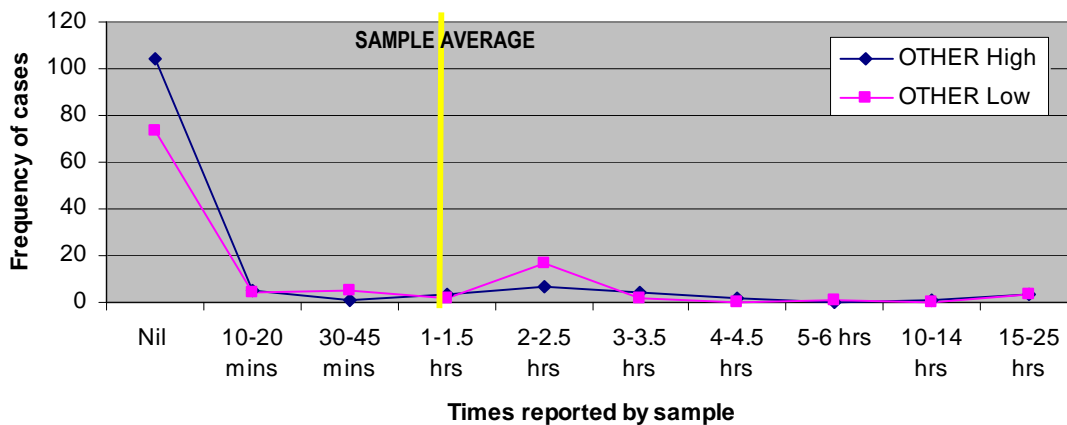
Care staff activities related to RCS range from attending training to assessing, observing and reporting to registered nurses on any changes in resident circumstances. Chart 7. above shows the overall sample average at 6.61 hours per week for care worker involvement in RCS documentation and other ongoing activities. As such it represents their role in observing,

collecting and reporting data on the condition of all residents, under the direction of registered nurses in high care and care managers in low care.

While it is clear from Chart 7 that a large group of care workers in high and low care areas are not involved with ongoing RCS activities, many are and especially in low care facilities. Wide variability within this sample can be taken to reflect local decisions by approved providers as to the emphasis to be given by staff and managers to ongoing RCS activities.

Chart 8. below reveals a skewed distribution of time committed by staff other than nursing, management or care staff, to ongoing RCS activities throughout the year. Again the combined sample average of 0.99 is affected by the large number of other staff such as clerical, activities officers, allied health professionals, medical practitioners, transport drivers who contribute to ongoing observations of resident capabilities and assessment of needs against the RCS.

Chart 8. Other staff including allied health Q3.



Most of those included in this category of staff are allied health personnel who regularly spend up to 15 minutes per week documenting for RCS funding as well as documenting for professional care and treatment. Some take longer and in some cases, up to 10 to 25 hours per week. In such cases, it may be that these staff are employed to be responsible for RCS assessment and documentation, staff training and other RCS-driven activities.

Differences between high care and low care allocations of time become apparent in Table 11 (below) which draws upon adjusted sample averages for both high and low care and, based on these reliable averages, an estimate of the total industry hours expended over a 12 month period.

Care staff spend the second highest amount of time (34.42%) on ongoing RCS activities but it is important to understand that many more hours are contributed by this category of staff in high care than in low care. It is registered nurses who spend most time on this aspect (38.25%) and predictably, high care registered nurses (62.57% of registered nurse industry time) are deeply involved in ongoing RCS activities.

Table 11. Overall results: Time (hours) invested in ongoing RCS documentation activities

	Over 5 day period	Over 5 day period	TOTAL TIME
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	@ 54.55% turnover HIGH CARE	@ 35.29% turnover LOW CARE	INVESTED per year
Managers	106,655	83,826	190,480
Registered Nurses	268,418	160,544	428,971
Care staff	195,683	190,239	385,923
Other (including Allied Health)	33,345	30,965	64,310
TOTAL	604,101	465,574	1,069,684

The total time invested per year in activities related to maintaining the RCS system at the local level equates to 44,570 complete days across the aged care industry. This includes all activities deemed by the respondents to be driven by the requirements of the RCS and its associated validation processes as well as ensuring that all staff understand and comply with the RCS requirements so that funding for residents is not compromised by errors or omissions.

RCS VALIDATION PROCESSES

Question Four relates to processes that are exclusively generated by mandated RCS requirements. There is no element of duality in these activities. Validation visits are initiated by the government and approved providers are compelled to be involved in the reviews and any subsequent follow-up that may be recommended by Commonwealth nursing officers (CNOs) who conduct all RCS reviews.

The RCS review visit may involve two to three CNOs over several days, on site and requiring informed staff to be available to answer questions and to assist the CNOs to access files and other information. Throughout these review visits considerable disruption can impact on the normal flow of operations within a facility even though every effort is made by CNOs and facility managers to minimise disruption. The consequent demands on staff and manager time are directly attributable to RCS processes.

The review visit is primarily a matter of concern to approved providers and facility managers because of the potential impact on future funding. However in this study the time expended by approved providers has not been included. Much depends on the size and location of the facility and also on the background of the approved providers, but it is fair to say that some approved providers take an oversight role in such processes and delegate to managers, while others adopt a more hands-on approach. Table 12 Shows the average time expended by different categories of staff across the jurisdictions and between high and low care areas.

Table 12. Average time (hours) invested in RCS validation processes across jurisdictions

	Managers		Registered Nurses		Care Staff		CNOs & Advisers		Clerical		Other (Incl. Allied Health)	
	High care	Low care	High care	Low care	High care	Low care	High care	Low care	High care	Low care	High care	Low care
QLD	4.07	1.66	5.00	1.19	0.84	0.78	6.96	3.46	1.38	1.38	1.03	0.34
NSW/ACT	4.45	2.59	1.67	0.62	0.18	0.15	6.19	5.30	0.75	0.74	0.34	0.41
VIC/TAS	4.80	1.78	2.62	2.67	0.26	0.30	7.39	3.80	1.41	1.41	1.98	1.64
SA/NT	3.43	2.63	3.83	0.61	0.28	0.48	7.30	3.83	0.09	0.09	0.09	0.04
WA	3.26	3.83	2.90	0.55	0.15	0.52	5.36	0.52	0.36	5.50	0.23	0.00

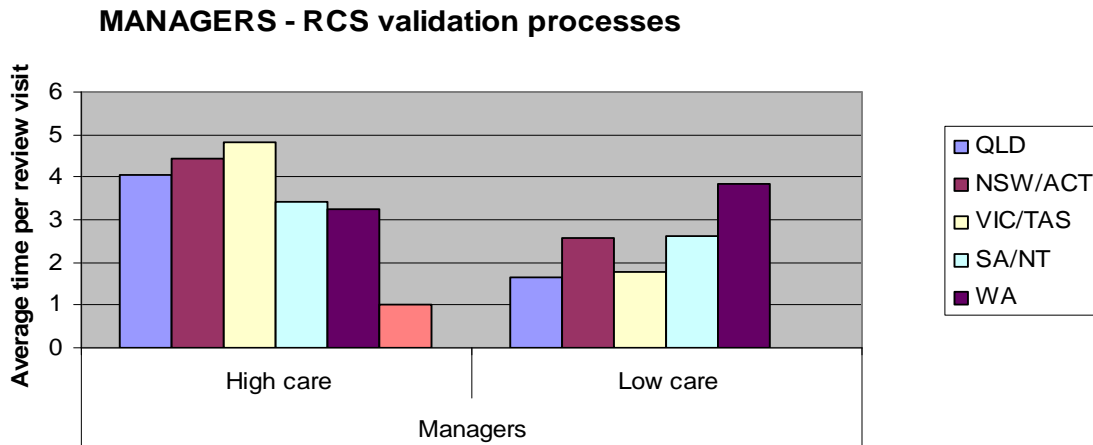
Estimations of average time by CNOs (Table 12) are based on reported time spent by CNOs during visits to the respondent facilities. These estimations are included in Table 12 to provide a comparative point of reference for time spent in RCS validation activities by facility managers and registered nurses.

The differences between high and low care time allocated to RCS review visits in Table 12, are illustrated even more clearly in the charts below.

Chart 9 below demonstrates differences in time (hours) occurring between high and low care manager involvement in RCS validation visits. Managers in high care appear to be particularly engaged throughout the review visit however it is not clear whether they are directly involved or involved in unusual activities because of the visit.

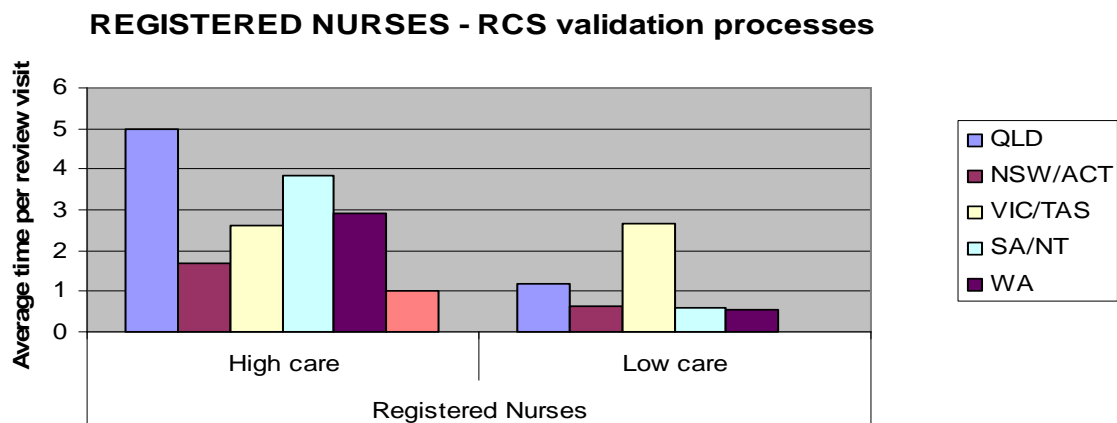
In smaller facilities often it is the manager who conducts in-house training sessions to ensure that care staff are following the RCS documentation protocols and systems in place, and that they understand the purpose of RCS validation visits and can assist as needed.

Chart 9. Managers Q4.



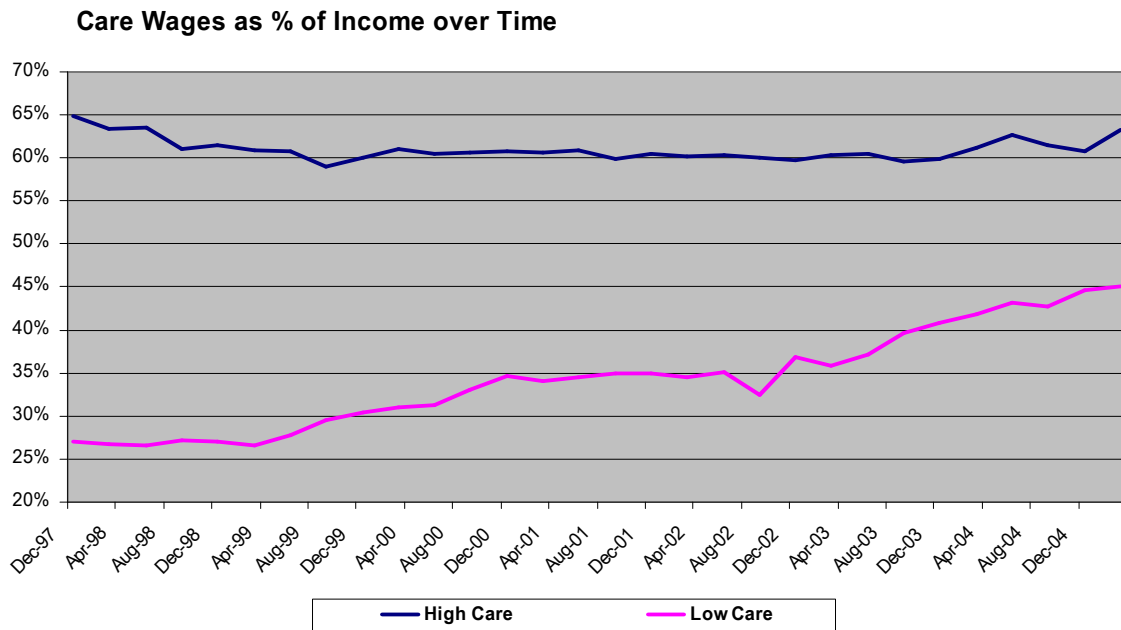
Registered nurses' involvement is similar to that for managers except that low care has a much reduced time involvement for this category of staff than high care, as shown in Chart 10 below. From the responses, it appears that managers of low care facilities are more likely to be involved in RCS validation visits than are registered nurses. This result is not surprising in view of the difference in staffing patterns across both contexts which also differ in terms of service focus.

Chart 10. Registered nurses Q4.



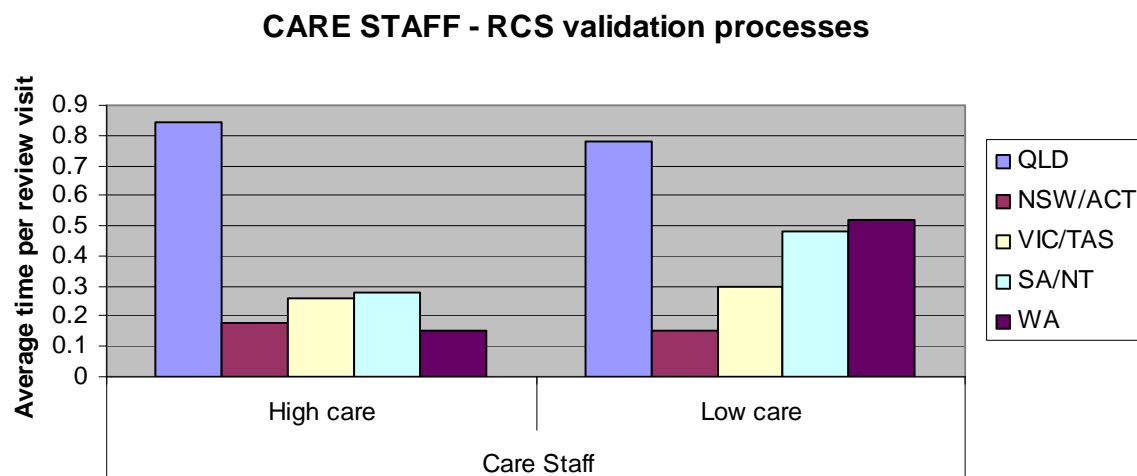
In low care, a growing proportion of residents are 'ageing in place' and registered nurses are being employed in increasing numbers in low care facilities as is demonstrated by the chart below constructed by Stewart Brown ACFPS (2006). The time series data collected between December 1997 and December 2004 shows a steady high care wages expenditure trend and an increasing wages expenditure within low care.

Chart 11. Wages expenditure over time. Stewart Brown (2006)



Average time across different jurisdictions and care contexts is less than an hour per visit for care staff as their involvement in RCS is mainly to do with ongoing activities between review visits. Still, it is interesting in Chart 12 below, to note differences between contexts where care staff in low care facilities appear to be much more involved in RCS validation visits (except for Queensland) than they are in high care.

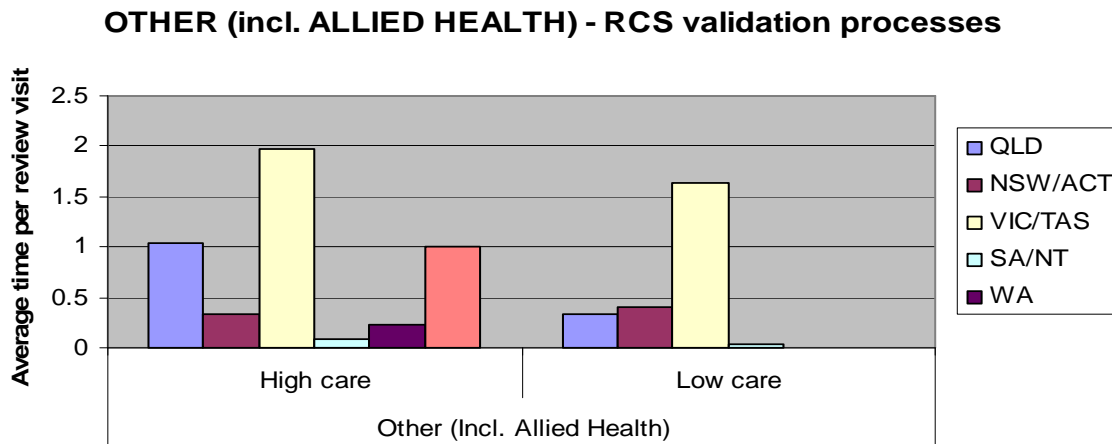
Chart 12. Care staff Q4.



Other staff who may be involved during RCS review visits include medical practitioners, physiotherapists, occupational therapists, diversional therapists and a range of recreational officers and allied health aides. Their involvement is especially important in low care areas where efforts to promote engagement in social and physical activities are emphasised among

a population of residents who tend to be more physically capable of participating in such programs.

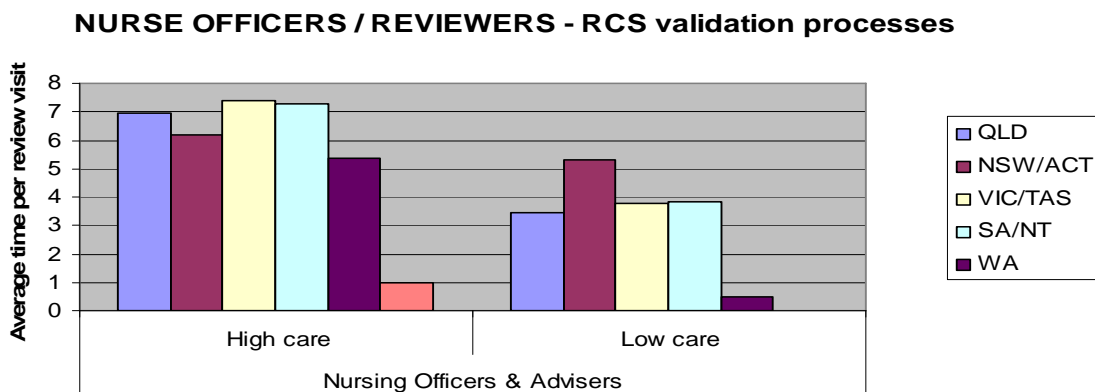
Chart 13. Other staff including allied health Q4.



Non-registered nurse or manager categories of staff are not usually engaged in any regular employment pattern across the aged care industry however in some instances, where RCS claims in their areas of expertise are being questioned by reviewers, they do make themselves available should RCS reviewers require explanations or need to access specific evidence.

According to respondents, the usual review visit time spent by Commonwealth nursing officers is from 1 to 3 days depending on the number of CNOs and the size of the residential aged care facility. Review visits to low care are usually shorter and with fewer CNOs than in high care and this difference is illustrated in Chart 14 below. The data provided by participating facilities was based on estimates of CNO time rather than it being provided by CNOs themselves. Therefore it does not include any time expended on travel, pre-reading for the visit or internal discussions following the review.

Chart 14. Commonwealth nursing officers Q4.



In terms of time expended by different staff categories on RCS validation visits, Table 13 below presents the time expended by manager and registered nurses in relation to that taken by CNO review officers per year.

Table 13. Overall results: Time (hours) invested in RCS validation activities

	Over 5 day period @ 54.55% turnover HIGH CARE	Over 5 day period @ 35.29% turnover LOW CARE	TOTAL TIME INVESTED per year
Managers	5,444	2,339	7,783
Registered Nurses	3,593	1,543	5,136
Care staff	400	388	789
Other (including Allied Health)	2,449	1,867	4,316
TOTAL	11,886	6,137	18,024

During the visit, assistance is given by staff to the CNO reviewers in accessing files, copying documents, finding people, ensuring their physical needs are met and re-directing confused residents who may inadvertently disrupt their concentration. And no doubt there are many other tasks that arise directly from the review team being present on-site.

At least 751 complete days at a wages cost to industry of \$212,829.00 are expended each year on wages related to RCS review visits in residential aged care facilities which would not occur if the RCS were not in operation. The wages costs for CNOs who conduct the visits and reviews, have not been included in this figure.

RCS APPEALS PROCESSES

Question Five referred to the use by providers of the appeals processes available should they disagree with the findings of the RCS review. CNOs who review RCS documentation seek to establish whether the documentation of care and treatment in individual resident files is consistent with claims being made by the approved provider for funding of care for each resident. The approved provider is then faced with the choice of appealing a decision arising from the RCS review, or accepting the resultant loss of funding which can prompt further decisions as to the feasibility of maintaining current levels of staff employment.

Very few of the respondent facilities reported experience of RCS appeals (17.68%) and those provided are quite varied. All are included in the calculations for national figures however these need to be interpreted with some caution. Still some useful information can be gained from the responses received.

Table 14 shows the average time expended by those who reported on their RCS appeals experiences. Most of the participants who reported RCS appeals are from Victoria and Tasmania and in this survey, no reports of RCS appeals were received from South Australia, Northern Territory and Western Australia.

Table 14. Average time (hours) invested in RCS appeals processes across jurisdictions

	Managers	Registered Nurses	Care Staff	Clerical	Other (Incl. Allied Health)
QLD	1.45	1.00	0.00	0.00	0.14
NSW/ACT	1.19	0.46	0.08	0.04	0.85
VIC/TAS	4.22	1.70	1.41	1.41	0.07
SA/NT	0.00	0.00	0.00	0.00	0.00
WA	0.00	0.00	0.00	0.00	0.00

Nevertheless, while respondents in this study did not include evidence of appeals for South Australia, Western Australia or Northern Territory, appeals do occur in these jurisdictions. Information obtained from industry peak association sources indicates that over the last year, 2,304 RCS reviews have been conducted and 84 appeals lodged across Australia. This equates to a rate of 3.65% overall.

- Victoria and Tasmania combined, experienced the highest number of RCS reviews at 832 for the year and lodged appeals at a rate of 2.64% which falls well below the overall rate. A similar experience occurred in South Australia with an appeal rate of 3.17% against a total of 352 RCS reviews.
- NSW and ACT combined, had 676 RCS reviews and the highest appeal rate at 5.35%.
- The second highest rate of 4.17% occurred in Western Australia which had the lowest number of RCS reviews per State.
- The lowest rate of RCS appeals was in Queensland with 2.84% where they had 352 RCS reviews.

It follows that survey responses may not reflect the full national experience of appealing RCS reviews however for the purposes of this report, all feedback on industry personnel costs was used in the calculation of a national estimate of costs (see Table 15 below) which errs on the conservative side of what may be occurring across Australia.

Table 15. Overall results: Financial outlays in appealing RCS validation decisions

	High & Low Care (Average hours per RCS appeal)	Costs (\$) based on frequency of appeals per State/Territory (all residents)
Managers	7.62	137,003.00
Registered Nurses	3.52	36,228.00
Care staff	1.61	19,292.00
Other (incl Allied Health)	0.58	20,307.00
TOTAL		\$212,830.00

Throughout the aged care industry, appeals against decisions by CNOs regarding changes to resident category status are not commonplace. There are many reasons underlying this observation including approved provider attitudes ranging from an acceptance that their documentation simply was not adequate to sustain the claims made, to a desire to avoid possible confrontation with those providing funding.

It is important also to understand that approved providers rely on managers and registered nurses for advice on appeals and are unlikely to initiate an appeal without the full support of nurses and managers involved. The quality of nursing advice received will determine a provider's estimate of the likelihood of recovering funding lost through a validation decision, or whether the cost and stress associated with an appeal is justified when the resources that would be used in appeals could be better allocated to ongoing support of staff learning to improve the potential for future RCS compliance.

DISCUSSION OF RESULTS

The results presented in this report represent a conservative estimate of financial outlays by the aged care industry and the Australian government in supporting the Resident Classification Scheme through which the industry gains access to funding for care being delivered to residents of aged care facilities. Approved providers across the industry have an interest in ensuring that their connections with government are robust and successful because the levels of funding provided fluctuate significantly as different elements of the RCS become active.

Government of course has a responsibility to ensure that funding is distributed fairly and that it is used for the purposes for which it was distributed. Consequently, certain aspects of the RCS are tightly mandated and impose a cost burden on approved providers in meeting the requirements. Other aspects of the RCS allow for a certain level of discretion by approved providers who make internal resourcing decisions based on their perceptions of what is necessary or desirable. However that having been said, not resourcing such activities would undermine their own financial sustainability.

Both the aged care industry and government expect that administrative choices made at the local level will not jeopardise the essential care, treatment, support and protection services to residents. However it is also expected that aged care organisations will be run efficiently and that government will not impose undue burdens on managers, staff and employers as they undertake their regulatory roles. Unfortunately, the results of this study reveal that in both of these areas, the cost of satisfying the documentary intricacies, review uncertainties and personally stressful requirements of different aspects of the RCS, is excessive.

The overall RCS burden on industry

Conservative calculations of time spent by different aged care staff categories on admission of residents to aged care reveal that they spend \$142,350,977.00 per annum for 5,831,400 hours spent carrying out work associated with the RCS. In other words, based on a 24 hour day, the RCS takes up 243,579 full days per year across Australia, resourced by approved providers.

These calculations are based on certain assumptions around the different wage rates for staff categories and within different industrial relations areas; and also that the through-rate of residents in high and low care areas is at 54.55% and 35.29% respectively. These rates have been established with key informants and consultants to the study and as such, could be varied should more certain data become available. The turnover rate is important in that so many RCS requirements are linked to individual residents at different times throughout their length of stay with an aged care facility. Overall, the cost to industry per annum, for RCS-only activities associated with resident admission is \$22,808,871.00 or 922,647 hours which equates to 38,444 full days dedicated to RCS aspects of the admission process.

Activities directly attributable to regulatory requirements are the annual RCS reviews of residents and RCS validation processes. When combined, these cost the aged care industry an estimated \$93,902,695.00 per annum. Both of these elements of the system are initiated only by government and conducted exclusively for the purpose of ensuring that costs of aged care are kept to a minimum. Perceptions by approved providers across the aged care industry vary as to whether the funding retrieved by government through these processes is fair or not. There is widespread cynicism within the industry that the RCS fails to recognise that care and accommodation may have been given at a satisfactory standard, yet on the basis of a documentation technicality, funding penalties can be applied against what has already been expended in delivering services to residents.

Quality of care is not an issue considered in annual RCS reviews or RCS validation visits. Rather, the focus is on determining whether claims by approved providers can be substantiated from the documentation in each resident's case file. It is not surprising therefore that approved providers go to some effort to ensure that their approach and systems for documenting the care given is accurate and complete. Not to do so would result in lost funding for care that has indeed occurred, but which could not be proven within the documentation.

The full cost per annum of annual RCS reviews conducted on all residents across Australia is \$93,391,978.00 or 3,821,045 hours (159,210 full days). A small proportion of these totals is borne by the government but the major burden is placed upon aged care industry providers. The other unavoidable RCS process is that of the review audits. These are also initiated by government and result in considerable workloads, particularly for registered nurses and care managers, in trying to ensure that funding is not removed because a reviewer is not satisfied with the documented evidence.

Approved providers are placed in a position of deciding what RCS documentation approaches are needed considering the size of the facility, the calibre of staff, their English language

competency levels, and their ability to be astute in reviewing their own and other staff's documentation. All of this takes time and depending on the situation facing each aged care facility, it can impose a range of financial burdens.

The consequences of inadequate RCS evidence in the residents' case files prompts providers and managers to undertake ongoing processes related to RCS such as staff training in RCS, allocation of time by registered nurses and supervisors to check for example, that the documentation does not mistakenly undermine any RCS claims simply because of a lack of English language skills by some of the staff involved; or a paucity of understanding of the implications of documentation wording that can be misinterpreted or dismissed by reviewers. These costs to industry are ongoing and amount to a national total of \$25,426,582.00 based on a conservative estimate of staff time at 1,069,685 hours or 44,570 full days spent on ongoing RCS activities.

The figures quoted above are conservative. Several participants indicated that staff allocated to these activities spend all of their time focused on RCS rather than any other activity within the facility. These unusual cases were regarded as outliers in the dataset and removed to enable a more reliable, albeit conservative, average times to be calculated. With these outliers included the end total reached \$46,313,080.00. The truth lies somewhere between these two figures however it was not possible to refine the data sufficiently to include outliers and maintain statistical reliability. The amount expended in ongoing RCS activities will vary across the industry according to each provider's approach to the issue. Still, for providers in diligent pursuit of efficiency in their operations, it is not possible to avoid most of the activities in this category if they hope to ensure they will not lose funding if case documentation is reviewed.

When approved providers have delivered appropriate care services to residents only then to have their funding cut following an RCS review, they do have a right under the Aged Care Act 1997 to appeal that decision and have their case investigated. Unfortunately, in exercising that right providers face further costs associated with staff time and possibly the stress of confronting the government which is the source of overall funding.

The power differential between approved providers and their managers and the Department of Health and Ageing is immense and this could possibly explain why there are so few appeals initiated by providers when their claims are refuted and downgraded. Of the 147 respondents who participated in this study, only 26 reported any experience within the 237 facilities they represent, of appealing an RCS review decision. The small sample may be the main reason for this low result, however when national figures released regularly by the Department are examined, the spread of appeal activity is still quite low at 3.65%. Only Western Australia and New South Wales exceed the national rate and even then, the NSW/ACT rate is still only 5.35%. Interpretations of this outcome could be that providers consider either the review is a fair assessment of documentation which they have poorly managed; or that the bother and cost burden associated with appealing is simply not cost effective. Either way, industry bears the resultant costs.

Future options

It would be easy to say that if the RCS claims were to be removed and replaced by a system that did not require annual reviews on every resident or audits of documentation as a basis for confirming or removing funding, then fewer staff would be needed in the aged care industry. Such a view would be based on a limited understanding of what actually occurs in aged care facilities.

Currently much of the work directly caused by RCS processes is done by staff and managers who donate much of their own personal time to its completion. They do this so that the care of residents is given priority over documentation and burdensome regulation. But personally compensating for cumbersome RCS processes will not be able to be continued, even in the short term. Unlike the public acute care system, only occupied beds are funded and only at the level of care that can be proven rather than needed. Managers and registered nurses understand the implications of not having several consistent pieces of documented evidence for each of the RCS question areas in each resident's file, that is, they know that care staff will have work hours cut and that residents overall will have their care maintained at essential requirements rather than reach optimum levels.

The needs of residents are assessed professionally by registered practitioners and, were RCS activities to be removed from the residential aged care environment, professional approaches to care, rehabilitation and palliation that now have to compete for priority with RCS processes, would be able to flourish and more capably serve residents and families who depend so heavily on the aged care industry for their quality of life.

A positive outcome of nearly a decade of dealing with the RCS approach to care and funding is that large numbers of registered nurses, care managers and care staff have developed an appreciation of the cost implications of their care and treatment activities. Equally, those whose activities include auditing case notes and coaching staff on literacy and responsible documentation have developed a skill set that is highly transferable to quality enhancement activities and to management. Also, if the RCS is removed, and provided is not replaced by an equally burdensome system, the paucity of potential managers in aged care will be alleviated as senior and talented nurses and managers become available to take up more broadly focused aged care work.

The aged care industry has developed strongly as a result of the quality and accreditation movements. It now remains necessary for government funding bodies to recognise the professionalism and extensive commitment throughout the aged care industry to the achievement of quality outcomes. Such recognition could occur with the building of a closer working relationship between industry and government which would then relieve any need for excessive scrutiny of local operational detail. Industry has responded to every call by government to adopt change and now government is urged to respond to a call from industry to lift the burden of 'red tape' imposed by regulation under the Aged Care Act 1997 and the Aged Care Principles. Such an outcome would allow industry to get on and do what it does best – to deliver quality care, treatment, support and protection to older, vulnerable Australians.



Dr. T. McDonald

Professor of Ageing

APPENDICES

1. Authorisation letter for the project
2. ACU National ethics approval for the study
3. Participant information
4. Survey form

Appendix 1. Authority for the project

20 October 2005

Dr Tracey McDonald
Professor of Ageing
ACU National University
Faculty of Health Science
PO Box 968
NORTH SYDNEY NSW 2059

Dear Tracey,

RE: Research Project

I wish to confirm that Aged Care Association Australia (ACAA) has sought your assistance to complete a piece of work which will assess the estimated time spent by nurses in the residential care programme completing documentation associated with the Resident Classification Scale (RCS)

To then assess how much of this effort residential care staff in purely satisfying the perceived requirements of the Government's validation processes.

If possible, to also assess the resources applied to the validation process by Commonwealth Nurses and Departmental Managers.

Finally, to quantify these resource assessments in dollars applied needlessly to the validation process and the number of wasted hours of time applied by residential care staff to this task.

Thank you for your assistance with the project.

Yours sincerely



Rod Young
CEO

Appendix 2. Ethics approval

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Professor Tracey McDonald
Nth Sydney Campus
Co-Investigators:
Student Researcher:

Ethics approval has been granted for the following project:
Assessment of RCS validation costs 2005 **for the period:** 17 November 2005 to 10
September 2006
Human Research Ethics Committee (HREC) Register Number: N200506 20

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (1999)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.



Signed:

(Research Services Officer, McAuley Campus)

.....

Date: 17 November 2005

(Committee Approval.dot @ 28.06.2002)

Appendix 3. Information to participants

Dear Participant

You are invited to participate in a survey authorised by Aged Care Australia (ACAA) of costs associated with the current aged care funding arrangement, the Resident Classification Scheme (RCS). With the approaching changes to the ways in which aged care will be funded through the Aged Care Funding Instrument (ACFI) it is imperative that we establish a basis for comparison of future costs compared with the current model of funding and its validation.

If you agree to participate in this study, you will be asked to provide information concerning the resources that you believe are required to comply with the current RCS funding model and its validation processes including any appeals that may have been necessary.

The questions to be answered are provided below and can be filled out in your 'reply' email and then returned to tracey.mcdonald@acu.edu.au

OR

You may prefer to print out this email, complete the answers in writing and return it by fax to (02) 9739 2009 or fax to your State office of the Aged Care Association Australia (ACAA).

In order to meet policy review timelines we would appreciate receiving your answers by Thursday 24th November 2005.

The information you provide will be combined with that collected from other providers of aged care across Australia, and analysed to construct a financial model associated with RCS validation processes to inform the aged care industry as well as guiding aged care policy review. By completing and returning the survey you will be taken to have consented to having your survey included in the study.

The survey questions relate to single site facilities, and are limited to:

1. Resources (time and staffing) associated with documentation related to RCS compliance, validation and appeals processes
2. Your State and Territory (to allow for calculation of staff wages) and the number of beds (to the nearest 10 to preserve confidentiality) you have at your facility

All information shared with the researcher will be treated confidentially. At no time will your identity or that of your organisation be obtainable from any publication of the data from this project. Any publications based on the de-identified information will be accessible to the aged care industry and government agencies.

At any time through the process you are free to withdraw from the survey without having to justify your decision. Should you choose to withdraw please be assured that your decision will have no effect whatever on you, your organisation or anyone connected with your organisation.

Any questions regarding the project should be directed to:-

Dr Tracey McDonald Telephone (02) 9739 2280

or through your State office of the Aged Care Association Australia (ACAA)

Appendix 4. Survey form

SURVEY QUESTIONS: (In answering these questions, please involve staff who take an active role in RCS processes)

1. ADMISSION RCS ASSESSMENT & DOCUMENTATION

Please provide an estimate of the TOTAL TIME PER DAY (hours or minutes) involved in the 5-day resident RCS admission processes for each of the staff categories shown:

(a) High Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE other () Other? ()

(b) Low Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE other () Other? ()

2. ANNUAL RCS REVIEW

Please provide an estimate of the TOTAL TIME PER DAY (hours or minutes) involved in the 28 day annual review of RCS activities for each of the staff categories shown:

(a) High Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE other () Other? ()

(b) Low Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE other () Other? ()

3. ONGOING RCS DOCUMENTATION MONITORING, TRAINING AND CHECKING etc

Please provide an estimate of the TOTAL TIME ON AVERAGE PER WEEK (hours or minutes) involved in this activity for each of the staff categories shown:

(a) High Care resident:

Manager (/wk) RN/Div 1 (/wk) Care Staff: AIN/PCA/CSE other (/wk) Other? (/wk)
CNO (/wk) Other? (/wk)

(b) Low Care resident:

Manager (/wk) RN/Div 1 (/wk) Care Staff: AIN/PCA/CSE other (/wk) Other? (/wk)
CNO (/wk) Other? (/wk)

4. RCS VALIDATION PROCESSES

Please provide an estimate of the total time (hours or minutes) involved in RCS validation activities for each of the staff categories shown:

(a) High Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE/other () Other? ()
CNO () Clerical () Other? ()

(b) Low Care resident:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE/other () Other? ()
CNO () Clerical () Other? ()

5. RCS APPEALS PROCESSES

Please provide an estimate of the TOTAL TIME PER CASE (hours or minutes) involved in RCS appeals against downgrades for each of the staff categories shown:

Manager () RN/Div 1 () Care Staff: AIN/PCA/CSE/other () Other? ()
CNO () Clerical () Other? ()

6. AND SOME BASIC INFORMATION TO ENABLE COSTS TO BE CALCULATED

Please provide the following information:

State or Territory of your facility () Bed numbers to nearest 10 ()

Thank you for taking the time to fill out this survey. If you have any further comments that you think could assist in calculating the costs associated with RCS processes, please do not hesitate to provide them to the survey team.