

The delegate's dilemma: ACAT re-assessment in hostels

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Abstract

The provision for 'ageing in place' in the Aged Care Act of 1997 has provided an opportunity for hostel facilities to broaden their scope of care for older people. Aged Care Assessment Teams (ACATs) are required to provide assessments to give approval for high or low level entry to these facilities, and to provide approval for reclassification from low to high care. However, guidelines for ACAT assessments are contradictory with respect to the Resident Classification Scale (RCS) which provides the facility funding formula, thus creating gatekeeping compared with advocacy difficulties for the ACAT.

If the facility can support a claim of high care need for a resident via the RCS but the ACAT (using different and less in-depth criteria) does not agree with that claim, then the care of that resident might be compromised due to inadequate funding. Recommendations made to solve this dilemma include conferring the right of the hostel staff to reclassify residents when necessary, with the responsibility for confirmation of that classification to remain with the trained validation officers from the Commonwealth Department of Health and Family Services, not the ACAT.

The new conflicts in ACAT roles

The roles of Aged Care Assessment Teams (ACATs) are complex and subject to continual change. Recently there has been an increase in requests for ACAT teams to reclassify some residents of residential low care facilities or hostels, to the high care classification, in line with 'ageing in place' legislation. With no training in the administration of the Resident Classification Scale (RCS), which is a process that uses a numerical scale based on care needs to enable specific funding, and with only the Aged Care Application and Approval document (2624) and its accompanying brief guidelines to direct them, ACATs are sometimes placed in a difficult position. They may either refuse the reclassification (and thus disallow increased funding and possibly compromise the resident's care) or just accept the word of the facility staff. This creates a dilemma for the ACAT member - to act as a 'rubber stamp' for reclassification requests, or to attempt the time consuming job of unravelling the RCS complexities.

The ACAT's roles, according to the Commonwealth Guidelines for Assessment Services (1994) can be broadly summarised as follows:

- providing assessment of physical, social, psychological and medical needs of consumers to assist in choosing appropriate services to meet their needs;
- providing referral to those services and monitoring of consumer satisfaction;
- promoting community awareness and education about aged care issues and services.

An advocate is defined as '*one who pleads the cause of another*' (Forbes et al, 1984). It could therefore be inferred that the role of the ACAT in assessment, information, advice, referral and monitoring fulfills that advocacy

definition. In support of this, those Guidelines propose that ACAT strategies should have a 'consumer focus' aimed at meeting their needs and increasing awareness of the ACAT role in the general community (Commonwealth Department of Human Services and Health 1994).

At the 2nd National Conference of ACATs, Mary Murnane, then the Deputy Secretary for the Commonwealth Department of Human Services and Health, spoke about directions for aged care assessment, and noted that the roles of teams had shifted from '*gatekeeper of nursing home entry to assessor of care needs*'. In addition, initiatives were planned that would consolidate the role of assessment teams in '*assisting the individual older person to get the best form of care*' (Commonwealth Department of Human Services and Health 1994).

However, an examination of international literature and Australian policy documents shows that assessment can mean different things to different stakeholders, depending on their point of view. In particular, policy makers regard assessment as '*providing a gatekeeping role to ensure those in most need receive appropriate services*'. It is further pointed out that there remains competition and dichotomy between the needs of the individual and allocation of scarce resources (Butler et al. 1998).

It seems ethically difficult for a service to combine both advocacy and gatekeeping roles. Advocacy involves beneficence or 'doing good', and non-maleficence or doing no harm (Matteson and McConnell 1988). On the other hand, gatekeeping is concerned with utilitarianism and distributive justice by controlling access to scarce resources, with the possibility of detrimental outcomes to those who may not be deemed the most needy at that time.

The 2626 Form

A summary of the 1997 Aged Care Act states that '*... some members of ACATs will operate as delegates of the Secretary ... to provide approval for care recipients of residential, community and flexible care*' (Commonwealth Department of Health and Aged Care 1999). To this end, the 2624 Form was devised and the Aged Care Assessment Guidelines April 1999 were distributed to ACATs to provide '*instruction on the use of the Application and Approval form*'.

Whilst most of the form proved to be self-explanatory, Section B, which provides the necessary information for making a high or low care judgement, is rather non-specific and open to individual interpretation. The most instructive part, section 22, which asks for a Functional and Activity profile entered against a Low Level and High Level column of tick boxes, does not state how many tick boxes equates to which level of care. However, the High Level sector does note that during each activity the person '*requires hands on assistance with most of the activities or (is) unable to perform any part of the activity*'. Thus the assumption appears to be that assessment of a high care need is based on a need for '*hands on care*' (Commonwealth Department of Health and Aged Care 1999).

An examination of the Commonwealth Guidelines for ACATs (1999) shows less than half a page of instructions for low care and possibly two thirds of a page devoted to high care. Low level care can be summarised as the provision of general accommodation services, and possibly includes the following:

- daily assistance with bathing, showering, personal hygiene
- organising, supervising, administering medication
- toileting, continence management
- meal assistance
- fitting of sensory aids
- transfer, mobility, dressing, undressing
- assessment and referral for appropriate support
- communication assistance
- special diets
- emotional support.

There are no further clarifying instructions about the intricacies or quantification of these tasks. Certainly there are no instructions about the time required for behaviour management, such as, personal attention, distraction, stimulation etc. Does informed intuition and experience provide the answers?

To these tasks is added the instruction that *'a person receiving low level care must be re-assessed by an ACAT to gain approval for high level care. ACATs are not expected to classify people into the specific classifications as outlined under the RCS but to limit approval in terms of the level of care required (i.e. at low or high level).* However, the notion that that care might mainly be supervision, not hands on care or behaviour management, is lost in the 2624 tick boxes. This is a different notion from the instructions in the RCS.

In examining the documentation available to foster the ACAT member's understanding of the requirements for high care, the Commonwealth Guidelines (1999) state that, as well as providing the care as stated for the low level, the following care needs must also be considered:

- intense/ ongoing medical and/or nursing services
- access to 24hr care by a RN or supervision of a RN
- functionally very dependent
- complete or almost complete assistance with ADLs
- continence needs and cognition deficits.

However, concern has been expressed by ACAT staff about the additional statement that *'... other factors that should be considered in determining high care include the person's continence, the person's level of cognitive impairment and the ability/adequacy of low level residential services to meet the needs of the individual successfully'.* This would require an in-depth, and possibly judgmental, knowledge of all staffing levels and service provision in all local aged care facilities providing low level care.

Further problems are noted with some changes from low care to high care classification, when it results in a transfer of the resident out of the original facility to another, usually a nursing home. Whilst, Section C requires notation of the specific level of required care, it also requires notation of the name of the facility to which the client is referred for that care. Often ACAT staff are reassured that the resident will stay in their present facility and that facility name is then entered on the form. However, transfers after reclassification, to another facility not so named in the 2624, are reported. Therefore, there is no protection for the resident to maintain their place in their chosen residence, once their classification is changed to high level. The danger is that full advocacy for that resident who does not want to move, may not have taken place.

The Resident Classification Scale (RCS)

In an attempt to understand the intricacies of the Resident Classification Scale (RCS), the Training Workbook was examined (Commonwealth Department of Health and Family Services 1998). It states that the RCS is a relative resource allocation instrument (not a care plan), includes 20 questions each having 4 ratings, provides a nationally consistent score, and consists of levels 1-4 indicating high care and 5-8 indicating low care.

In addition, the allocation of categories is based on the assessment of resident care needs, a clearly defined and documented care plan, and the allocation of time and effort. It does not cover occasional needs. Further, it requires a plan, interventions and PROOF that the interventions are being applied. The proof is left up to the documentary insight of individual facilities and there is not an easily assimilated set of criteria for ACATs to assess.

Education to apply the RCS is stated to be provided via a manual made up of 8 modules with the recommendation that these be used at work sessions for 1-2 hours per week, over an 8-week period. Each module provides activities to test the user's growing knowledge. It is suggested that new residential aged care facility staff members should be introduced to the manual for orientation purposes. In all, this equates to possibly 16 hours of training. ACATs have not been offered this training nor has it been considered to be necessary.

A point of particular interest is that different weightings are attached to each RCS category. These are said to be aimed at reflecting supervision, observation, support, prompting and encouragement. Staff of a local facility

advised me that care is aimed at preventing problems. Therefore, if those problems are not evident to the short-term observer, it means that the plan is working. Types of interventions might include a special place for a resident to sit that meets their needs or special methods of careful communication or special time set aside for one-to-one care. Neither of these interventions would necessarily appear unusual if the entire context of the intervention were not evident to an uninformed observer.

The heavy weighting of question 4 (Personal Hygiene) was also discussed at this facility, and it was pointed out that the requirement to *'encourage and persuade the care recipient on a one-to-one basis to optimise self-care function'* enabled a D classification. This could be as apparently simple as standing by to encourage and supervise but would attract 14.61 points. All other questions attracted lower and very variable points. This is quite contradictory to the 2624 Part B requirement for high level care, that is described as, *'hands on assistance or unable to perform any part of the activity'* and for low level care- *'able to perform activity without assistance or part of activity but requires some assistance'*.

The scores that denote each RCS category are definitive and should be of particular importance to the ACAT in defining the difference between categories 4 (high care or 50 to 56 points) and 5 (denoting low care or 39.81 to 50 points).

The assessment for completion of the RCS was noted to require the following:

- a minimum of 21 days (continuous for new residents)
- that behaviour can only be assessed after a 7-day settling-in period from admission
- a dated and signed assessment of needs
- a dated and signed care plan (actions)
- ongoing dated/signed notes showing changes and significant events
- a periodic evaluation and update.

An ACAT delegate would therefore need to have a high level of understanding of the RCS requirements and several hours of time available to be able to read and understand all this documentation. This is already the task of specially trained officers from the Commonwealth Department of Health.

Review and validation of RSC scores is carried out on a yearly basis but sometimes more often as a result of a 'special alert' when a number of changed categories have been noted. The process involves the checking of care plans, notes and other documents for written evidence of assessed needs and interventions, the checking of ACAT assessments, the observation of and interviews with the appropriate resident, consultation with staff and the completion of a special work sheet (Commonwealth Department of Health and Family Services 1998). For the facility, the risk and tempering factor of an unacceptable reclassification claim is loss of funding from the time of reclassification.

Additional information provided by the interviewed facility, included the opinion that there is a recognised inconsistency of approach by validators and that review often provides on-going informal education regarding acceptable interventions. For example, it was stated that if a resident received a regular aperient, then that would enable a C classification. However, if it was documented that to maintain bowel regularity and continence the resident required special exercise, encouragement with extra fluids and a toileting schedule, then a D could be claimed. These appear to be complicated instructions for fairly routine measures that only thorough training could master. What hope could an ACAT member with no training and a restricted visiting schedule have of providing an informed reclassification view?

The RCS review

In July 1998, a Review of the RCS was published. One of the recommendations was that *'... it would be highly desirable for ACATs to make their assessments as consistent with the RCS. ACAT approval should not be required to endorse a change in classification after the resident is admitted. This particularly applies to classification changes from low level care to high level care'* (Cuthbertson et al. 1998). These recommendations have not been implemented.

At present, ACAT members are frequently being requested to perform 2624 re-assessments for residents in low care facilities with care needs that the facility staff consider can be documented to support a high care classification via the RCS mechanisms.

The evidence shows that ACATs are not in a position to provide validation of an RCS classification. This is particularly problematic when the RCS gradings are close, as between low care (5 or 6) and high care (3 or 4). In addition, the following issues arise:

- As the 2624 classification must reflect the care that the facility can provide, to what degree should ACAT staff also be conversant with required care standards?
- If an ACAT member can not accept the hostel's justification for reclassification, what mechanisms are in place to protect the resident's right to demand appropriate care within the low-level classification?
- What procedures are in place to monitor the standard of high care provided in low care facilities?

Conclusion and recommendations

The ACAT is in a difficult position due to the contradictory criteria for judgement of care needs as posed by the 2624 and the RCS. Whilst the issues of monitoring care standards can not be addressed in this paper, the following four recommendations can be made regarding ACAT 2624 approvals.

First, low care facilities (or hostels) should have the right to reclassify residents to high care, without ACAT approval - but only for care in that hostel. This reference to the specific facility must be recognised and supported by the Department of Health and Aged Care. Validation of that reclassification should be the responsibility of trained validators.

Second, ACATs should be involved in re-assessment if transfer to another facility (either in the same or a different campus) is required, whether or not reclassification is required.

Third, as transfer to another facility (particularly a nursing home) is always very disturbing and disruptive for the resident, compulsory referral for professional multidisciplinary, medical, behavioural, social and functional advice provided by the ACAT is highly desirable.

Fourth, attempts should be made at least to synchronise the two assessment systems. Time and relationships are being eroded to the detriment of our older consumers whilst ACATs and residential facility staff grapple with the differences.

The Aged Care Act of 1997 has changed the structure of standards monitoring in aged care facilities. It seems prudent to now recognise and modify those parts which have proved to be least useful and to reinforce those that can be most helpful in providing optimum advocacy for aged people.

References

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