The use of respite care in Australian nursing homes and hostels

WELFARE DIVISION

WORKING PAPER NO.12

The use of respite care in Australian nursing homes and hostels

Zhibin Liu
And
Ching Choi

November 1996

Australian Institute of Health and Welfare
Canberra

A complete list of the Institute's publications is available from the Publications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web site at http://www.aihw.gov.au.

Suggested citation

Zhibin Liu and Ching Choi November 1996 The use of respite care in Australian nursing homes and hostels Canberra Australian Institute of Health and Welfare (welfare Division Working Paper No.19)

Any enquiries about or comments on this publication should be directed to:

Zhibin Liu and Ching Choi
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Phone: (02) 6244 1174

WELFARE DIVISION WORKING PAPER No.12

THE USE OF RESPITE CARE IN AUSTRALIAN NURSING HOMES AND HOSTELS

Zhibin Liu and Ching Choi

November 1996

AUSTRALIAN INSTITUTE OF
HEALTH & WELFARE

This is the twelfth publication of the Australian Institute of Health and Welfare's Welfare Division Working Paper Series. A complete list of the Institute's publications is available from the Publications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601.

Suggested Citation:

Liu Z & Choi C 1996. The Use of Respite Care in Australian Nursing Homes and Hostels. Canberra. Australian Institute of Health and Welfare (Welfare Division Working Paper No. 12.)

Comments on this paper are welcome and should be forwarded to:

Zhibin Liu
Aged Care Unit
Welfare Division
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Australia

Telephone: (06) 244 1000 or (06) 244 1174
Facsimile: (06) 244 1299 or (06) 244 1199

Contents

The use of respite care in Australian nursing homes and hostels*

1 Introduction

1.1 Introduction

The Aged Care Reform Strategy, commencing in the mid 1980s, has been shifting the balance of aged care from residential care towards home and community care. As a result, more and more highly dependent older people are able to remain in the community instead of entering nursing homes or hostels. These older people, who would otherwise be cared for in residential settings, now stay at home and are mainly dependent on their relatives, friends and neighbours, some of whom have limited formal support. Research has shown that older people prefer to stay at home as long as possible and enjoy a better life style as a result; however, the enormous work involved in caring for a frail person at home for lengthy periods of time must be recognised (AIHW 1993; AIHW 1995; HHLGCS 1991). Respite care reflects such a recognition and provides relief services for carers as well as care recipients. The importance of respite care is highlighted by a major review currently being undertaken by the Commonwealth and by the 1996 Annual Conference of the Carers Association of Australia which focused on respite care.

This paper analyses the use of respite care in nursing homes and hostels, including length of stay, and examines the destinations of respite residents on the completion of their respite stay.

1.2 Residential respite care

Purpose

Respite care provides short-term care for people who need a 'break' away from their usual care arrangements. Residential respite care provides short term accommodation and care for people who may otherwise have to take up permanent residence in a nursing home or hostel should their support system break down (CSH 1990). It is designed for providing support for carers, and it is also important to care recipients. Persons caring for

---

* Helpful comments from Diane Gibson, Jane Halton, Richard Madden and Sid Sax are gratefully acknowledged. However, the authors are responsible for any remaining error. Views

expressed in this paper are not necessarily those of the Australian Institute of Health and Welfare.

themselves are also assisted by the availability of respite care. Residential respite is also valuable in temporary emergencies, for example when carers become ill or otherwise unable to continue their caring role for a short period of time. Respite residents are expected to return to the community at the end of their respite stay. One of the important goals of the respite care program is to prevent or delay institutionalisation by supporting people to stay at home as long as possible (HSH 1995; CSH 1990).

Hostel respite care

Hostel respite care is a compulsory program for hostel operators. The Hostel Recurrent Funding Agreement requires that hostels with 50 or fewer approved permanent places provide at least 1 approved respite place, and those with more than 50 approved permanent places provide at least 2 approved respite places. Hostels may apply to the Commonwealth Government for places which they anticipate needing for the year, in addition to the required minimum. A hostel must keep its approved respite places available for respite residents.

As at November 1995, a government subsidy of $11.20 per resident per day is payable for 'hostel level' respite care and $33.45 for 'personal level' respite care. These payments are up to $12 higher than subsidies for non-respite residents. (For details of subsidies see Gibson et al, 1996: chapter 5).

A person is entitled to a total of 63 days of respite care in the same hostel in any one financial year. This entitlement of 63 days may be used for any number of episodes.

There is no requirement for formal assessment for those people who are seeking respite care and need 'hostel care' services only. If 'personal care' services are sought, the applicant must be assessed for 'personal care' services by an Aged Care Assessment Team (ACAT) according to the same criteria applied to permanent residents. They must also be subsequently assessed by the use of the Personal Care Assessment Instrument and score at or above the threshold for the Personal Care Low Subsidy. But ACATs have no authority to admit a person to a hostel. The hostel maintains the right to choose its residents. This is also the case for nursing homes.

Nursing home respite care

Nursing homes are not required to provide respite care. It is up to nursing homes to participate in the respite care program and to apply to the Commonwealth Government for the number of bed-days which they anticipate using in a financial year. This system has been operating since 1 January 1991. At present, the number of bed-days approved for a nursing home for one financial year will automatically be approved for the following year regardless

of the utilisation rate of respite bed-days in that home, unless the home requests a variation.

The approved respite bed-days can be used at any time in the year, and there is no minimum number of bed-days required to be used for respite care. Any approved respite bed-days not used are not carried over into the next financial year. Approved respite beds, when used by a respite resident, attract an additional subsidy which is about $18 per bed-day as at January 1996 (Gibson et at, 1996: chapter 6).

From 1 April 1992 all respite residents automatically receive a default category of 3 on the Resident Classification Instrument (RCI) unless a higher level of care is assessed to be necessary. The default category recognises that additional staff time is required to settle and orient respite residents.

A person is entitled to a total of 63 days of respite care in the same nursing home in any 12 month period following his or her first respite admission. After 12 months, the entitlement to nursing home care returns to 63 days again. As in hostels, this entitlement of 63 days may be used for any number of episodes. Unlike hostels, no beds in nursing homes are set aside for respite purposes. Instead, respite residents fill the temporary gaps created by the discharge of permanent residents.

An assessment of eligibility by an Aged Care Assessment Team (ACAT) is required for admission to respite care in a nursing home. A person is automatically eligible for nursing home respite care if he or she has been assessed by an ACAT as eligible for permanent admission to a nursing home.

2. Provision and use

The Commonwealth Government sets its long-term planning target for respite care at 2 places in hostels and 2 beds in nursing homes per 1000 people aged 70 and over. These are equivalent to about 730 bed-days per annum per 1000 people aged 70 and over. (Bed-days will be used in this paper to refer to both bed-days in nursing homes and place-days in hostels.) Table 2.1 shows that there has been a large increase in the number of approved respite beds. Given the long term planning targets, it is likely that this number of approved bed-days would continue to increase. The increase in approved respite bed-days has been more rapid in nursing homes (146.1% in the period 1991-92 to 1994-95) than hostels (33.6%), although in absolute terms, the number in hostels is much larger than that in nursing homes.

Table 2.1: Approved nursing home and hostel bed-days, Australia, 1991-92 and 1994-95

	1991-92	1994-95	Increase (%)
		Hostels	
Respite bed-days	547,170	731,095	33.6
Respite bed-days per 1000 people aged 70+	420	508	21.0
Total bed-days	17,934,732	20,814,855	16.1
Total bed-days per 1000 people aged 70+	13,759	14,458	5.1
Respite bed-days as a proportion of total place-days (%)	3.1	3.5	15.1
		Nursing homes	
Respite bed-days	157,282	387,064	146.1
Respite bed-days per 1000 people aged 70+	121	269	122.8
Total bed-days	26,948,397	27,257,301	1.1
Total bed-days per 1000 people aged 70+	20,674	18,933	-8.4
Respite bed-days as a proportion of total bed-days (%)	0.6	1.4	143.3

Note: Bed-days=beds multiplied by the number of days in a year (366 and 365 days for 1991-92 and 1994-95 respectively).

Sources: ABS 1993: 32,38; ABS 1996: 9,15; AIHW 1995: 381; HSH 1995b: 139; 1995 ACCSIS unpublished data

In terms of the proportion of beds available, the approved level of respite care provision is considerably higher in hostels than in nursing homes. In 1994-95, about 1.4% of nursing home bed-days, compared with 3.5% of hostel bed-days, were approved for respite care.

The number of approved respite bed-days may be considered an indication of the number which the nursing homes and hostels expect will be needed in a year. In hostels, there is the additional need to satisfy the government requirement for a minimum number of respite bed-days to be provided.

The actual use of bed-days is determined by both demand and accessibility. In nursing homes, this is also affected by the number of bed-days vacated by permanent residents since there are no beds set aside for respite purposes only. Therefore, approved respite bed-days in nursing homes do not necessarily represent the availability or accessibility of respite care.

The utilisation rate of the approved respite bed-days is presented in Table 2.2. Utilisation rate of respite bed-days is defined in this paper as the proportion (%) of approved respite bed-days used for respite purposes. Table 2.2 also shows the occupancy rate of total bed-days, and this is defined as the proportion of total bed-days (respite and non-respite together) occupied whether or not for respite purposes.

Table 2.2: Utilisation of nursing homes and hostels, Australia, 1991-92 and 1994-95

	1991-92	1994-95	Increase (%)
		Hostels	
Bed-days used for respite care	331,083	506,653	53.0
Respite bed-days as a percentage of total bed-days used	2.0	2.6	27.8
Utilisation rate of approved respite bed-days (%)	61.4	69.3	12.9
Occupation rate of the total bed-days (%)	93.2	95.0	1.9
		Nursing homes	
Bed-days used for respite care	75,431	191775	154.2
Respite bed-days as a percentage of total bed-days used	0.3	0.7	156.1
Utilisation rate of approved respite bed-days	48.0	49.5	3.1
Occupation rate of the total bed-days (%)	97.7	97.0	-0.7

Notes: Bed-days = beds multiplied by the number of days in a year (366 and 365 days for 1991-92 and 1994-95 respectively). 979 and 259 leave respite bed-days are excluded from the analysis for 1991-92 and 1994-95 respectively.

Source: HSH 1995 ACCSIS unpublished data

The number of respite beds used in both hostels and nursing homes has increased markedly between 1991-92 to 1994-95 by 53.0% for hostels and 154.2% for nursing homes.

Utilisation rates (bed-days used per 100 approved respite bed-days), however, have not been high but have increased, although slowly. Hostels have a higher utilisation rate than nursing homes. In 1994-95, 69.3% of approved hostel respite bed-days were used compared with 49.5% for nursing homes. These rates were higher than the corresponding 1991-92 rates of 61.4% for hostels and 48.0% for nursing homes.

Ideally, one would expect high utilisation of the approved respite bed-days if the supply of respite places or beds matched the level of needs in the community, and there was no barrier to access. Full utilisation is not expected, as respite beds have a high level of turnover. The utilisation rates achieved in 1994-95 (69.3% for hostels and 49.5% for nursing homes), although higher than before, still seem low even after considering the effects of the potentially high levels of turnover. These relatively low utilisation rates may be caused by an over-estimation, by hostel and nursing home operators, of the actual level of and increase in demand but it is also affected by administrative arrangements required to admit residents for respite care. Some of the factors include the need for eligibility assessment for respite admission, and the co-ordination needed between the assessment authority (the ACATs) and the hostels and nursing homes. Other factors, including the lack of knowledge on the part of users of the existence of respite facilities and the relatively recent experience of nursing homes and hostels in providing respite care, also contribute to this relatively low level of usage of respite beds.

The respite utilisation rate for nursing homes is affected also by the voluntary nature of the service and, as already mentioned, the fact that no beds are set aside for respite. Since nursing homes are usually fully occupied and there are waiting lists for beds, the number of residents that can be admitted for respite is influenced by the number of beds vacated by permanent residents and made available for respite use. The higher rate of use of approved bed-days in hostels than in nursing homes lends support to this hypothesis.

3. Length of stay

3.1 Average and median length of stay

The length of stay of respite residents is affected by the number of approved respite bed-days and by the maximum limit of 63 days per resident in a hostel or nursing home in a year. Within these limits, however, the length of stay varies from resident to resident. The length of stay affects not only the level of use of respite care but also the number of people who can receive this care within the limits of the provision levels in a year. Longer stays mean fewer individual residents.

Because of the possible multiple use of respite service, the length of stay of individual episodes of respite care may be shorter than the length of stay for individual residents. By adding up the lengths of stay of all episodes for each resident, the distribution of length of respite stay can be generated. These measures are presented in Table 3.1. Hostels and nursing homes show a remarkable similarity in the average and median length of stay based on both episodic and total periods of respite care.

In 1993-94, 14,431 people shared 18,451 episodes of respite care in hostels, an average of 1.28 episodes per respite resident. In nursing homes, 4,806 people shared 6,039 episodes of respite care, or 1.26 episodes per resident. On average for both nursing homes and hostels, respite residents stayed for 24 days for each episode. Some of them used respite care more than once so that the average respite stay was about 30 days.

Table 3.1: Average and median length of stay (days) for respite care, Australia, 1993-94

Length of	Hostels		Nursing homes	
Stay (days)	Episodes	Residents	Episodes	Residents
Average	24	31	24	30
Median	19	24	19	25

Source: HSH 1995 ACCSIS unpublished data

The median length of stay is shorter than the average because there are some who stayed much longer than the average. One half of respite admissions (episodes) were discharged within 20 days. With regard to the individual total length of stay (ie including multiple admissions) one half stayed for less than 25 days in total.

3.2 Distribution of lengths of stay

Table 3.2 displays the length-of-stay distributions of hostel and nursing home respite admissions. Once again, both distributions show a similar pattern. Over 40% of respite admissions stayed for 2 weeks or less, over 70% stayed for no more than 4 weeks, and 98% stayed for no more than the maximum limit of 63 days (9 weeks). The predominance of short stays is expected as respite care is normally planned and is mainly for short periods of time.

Surprisingly, there were about 2% of admissions who stayed beyond the maximum limit allowable under the funding arrangements. This may be caused by data errors, but it is also possible that the extended stay was fully paid for by the residents.

Table 3.2: Length-of-stay distributions of respite care episodes, Australia, 1993-94 and 1994-95

Length of stay	Hostels (%)		Nursing homes (%)	
	1993-94	1994-95	1993-94	1994-95
0-2 weeks	41.1	42.8	42.8	43.5
2-4 weeks	33.2	31.2	31.2	na
4-9 weeks	23.7	24.3	24.3	na
9+ weeks	2.0	1.7	1.7	na
Total number (N)	**18,451**	**20,479**	**6,155**	**8,147**

'na' Data are not available due to 514 respite residents without record of date of discharge

Source: HSH 1995 ACCSIS unpublished data

The length-of-stay distributions shown in Table 3.2 are based on individual episodes (or admissions) rather than individual respite residents. Table 3.3 shows, for both nursing homes and hostels, the distributions of the length of stay of residents in the year 1993-94. Respite residents in hostels are approximately evenly divided into the three intervals of duration of stay, 0-2, 2-4 and 4-9 weeks. Respite residents in nursing homes show a somewhat longer stay compared with those in hostels. Of nursing home respite residents, 36% used between 4 and 9 weeks of respite care compared with 32% of hostel respite residents. A considerable number of respite residents in both hostels and nursing homes had total lengths of respite stay exceeding 63 days (9 weeks).

The 63 day limit does not apply to the total length of stay if the resident uses respite care in different hostels or nursing homes.

Table 3.3: Length-of-stay distributions of respite residents, Australia, 1993-94

Length of Stay	Hostels (%)	Nursing homes (%)
0-2 weeks	30.8	30.5
2-4 weeks	30.7	28.6
4-9 weeks	31.7	36.3
9+ weeks	6.8	4.6
Total number (N)	**14,431**	**4,806**

Source: HSH 1995 ACCSIS unpublished data

The statistics in Tables 3.2 and 3.3 show that the vast majority of respite admissions stayed for short periods. A more detailed analysis of the length of stay patterns based on the number of days rather than weeks, shows considerable clustering of particular lengths of stay. Figures 3.1 and 3.2 illustrate the day-by-day distribution (up to 91 days) of length of stay for both hostel and nursing home admissions in 1993-94. A pattern emerges from both figures. The number of respite admissions fluctuated as the length of stay increased and peaked at each exact number of weeks. The highest number was at 2 weeks. Of total respite admissions in hostels in 1993-94, 2,551 respite admissions, or 14%, stayed for 2 weeks exactly. The corresponding figures for nursing homes were 1,037 or 17%. Respite residents tend to stay for an exact number of weeks, in particular 1, 2, 3, and 4 weeks. The maximum entitlement of 9 weeks (63 days) is also a common length of stay. Among 18,085 hostel respite admissions with length of stay no more than 9 weeks, 6,649 or 37% of them had an exact number of weeks of stay. For nursing homes, among 5,933 respite admissions in 1993-94, 2,545 or 43% of them were discharged after an exact number of weeks of stay. These patterns reflect the fact that the use of respite care is often planned ahead of time and pre-arranged.

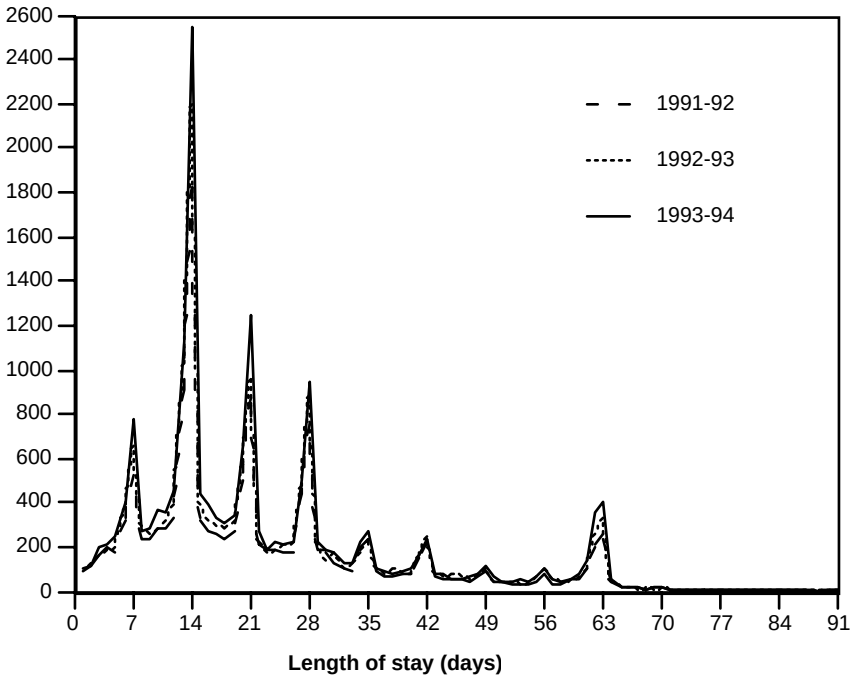

Figure 3.1: Length of stay of respite admissions in hostels, Australia, 1991-92, 1992-93 and 1993-94

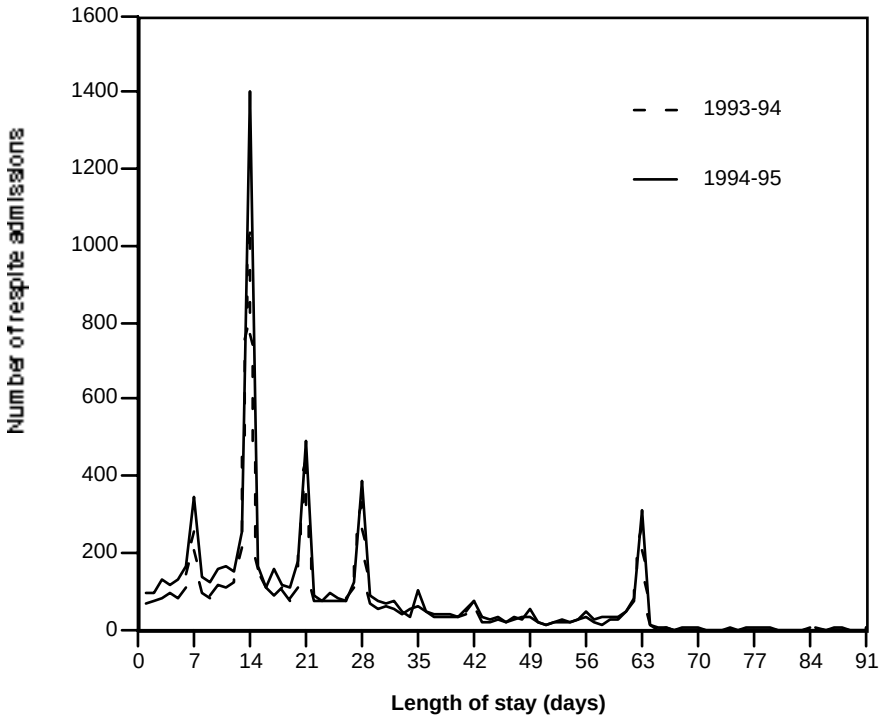

Figure 3.2: Length of stay of respite admissions in nursing homes, Australia, 1993-94 and 1994-95

4. Resident movement

4.1 Destination of respite separations

Respite residents move frequently in and out of hostels and nursing homes. In principle, they are expected to return to the community after a short period of stay. In reality, some may die while they are in respite care, or be transferred to another institution such as to a hostel, a nursing home or a hospital. More importantly, they may enter another episode of respite care without first leaving the hostel or nursing home; and they may also become permanent residents. This section looks at the outcomes of respite care in terms of destinations of separations from the hostels and nursing homes and changes to permanent status.

Hostels

Indicators of the outcomes of hostel respite care are obtained from information on the status of care (permanent or respite) provided to residents at first admission and at subsequent admissions together with information on the destinations of residents on discharge from hostels. These outcomes are presented in Table 4.1 by length of stay.

Table 4.1: Per cent of hostel respite admissions by separate destination at different length of stay, Australia, 1993-94,

Discharged to	Length of stay (weeks)										Total
	0-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	9+	
Community	71.9	82.6	77.7	70.4	63.8	56.9	49.9	38.5	47.6	39.7	71.1
Same or different hostel-permanent	9.1	8.6	12.3	19.0	22.6	28.5	34.4	43.2	33.2	41.8	16.5
Same or different hostel-respite	1.6	2.0	3.2	3.5	4.3	5.0	7.0	9.5	12.0	8.5	3.8
Nursing home	2.3	0.8	1.1	1.0	1.9	2.8	1.4	1.6	1.4	2.0	1.3
Hospital	13.3	4.8	4.4	4.4	5.5	4.7	4.7	3.9	3.2	3.9	5.5
Deceased	0.6	0.4	0.5	0.5	0.3	0.3	0.2	0.6	0.0	1.0	0.4
Unspecified	1.3	0.8	0.8	1.2	1.7	1.7	2.4	2.7	2.7	3.2	1.3
Total number (%)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
(N)	**2,056**	**5,425**	**3,707**	**2,575**	**1,352**	**877**	**540**	**440**	**1,113**	**366**	**18,451**

Source: HSH 1995 ACCSIS unpublished data.

Over all lengths of stay, 71% of all hostel admissions returned to the community at the end of their stay, 17% remained as permanent residents in the same hostel or a different hostel, 4% started another episode of respite care, and 6% were

discharged to a hospital. Transfers to nursing homes (262 cases) accounted for slightly more than 1% of all discharges from hostels. Only a few hostel respite residents died while residing in the hostel.

The rate of hospitalisation is relatively high in the first week of stay but low and flat over the remaining periods of stay. The rates of discharge to all other destinations are low and stable throughout the duration of stay.

The destination of hostel separations is closely associated with the length of stay. As Figure 4.1 illustrates, the longer a respite resident stays, the more likely he or she is to remain in a hostel, and the less likely to return to the community. About 42% of respite admissions with 9 or more weeks of stay became permanent, while only 40% returned to the community. This contrasts with about 80% of short stayers (under 2 weeks) returning to the community and 9% becoming permanent after their respite stay.

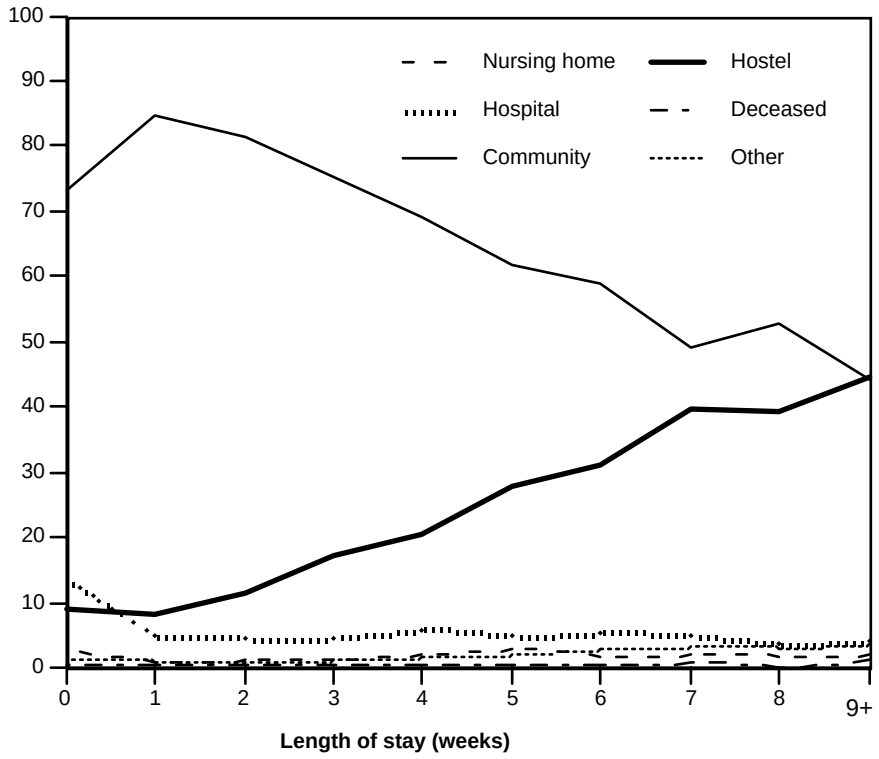

Figure 4.1: Destination of respite separations at different length of stay in hostels, Australia, 1993-94

Nursing homes

Nursing home data for 1993-94 on the destination of separations do not allow the separate identification of hospital admissions or transfers to hostels. These are combined with 'returned to the community' as one group. Table 4.2 summarises the identifiable outcomes of nursing home respite admissions in 1993-94 by length of stay.

The proportion of respite admissions who left the nursing home (returned to the community, discharged to hospitals, etc.) was about 71% and was lower than the corresponding proportion for hostels (79.2%).

It is likely that the proportion of nursing home respite separations which were discharged to hospitals is higher than that the corresponding proportion for hostels, although data on nursing home discharges are not available to show this. If this is the case, the proportion of nursing homes respite separations discharged to the community would be considerably lower than the proportion for hostels. This can be expected as nursing home residents are more frail and it is expected that a lower proportion than hostel residents are able to return to the community.

Nearly one in four nursing home respite admissions in 1993-94 became permanent after completing their respite stay. This proportion is considerably higher than that for hostel residents (16%). As is the case with hostel respite admissions, the longer the length of stay in the nursing home, the more likely it is for that admission to become permanent. For admissions in 1993-94 lasting more than 9 weeks, almost 68% became permanent. A discernible proportion (3.4%) of nursing home admissions died while in respite care; this compares with 0.4% among hostel respite admissions.

Table 4.2: Nursing home respite admissions by discharge destination (per cent)at different length of stay, Australia, 1993-94

Discharged to	Length of stay (weeks)										Total
	0-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	9+	
Permanent	21.5	11.5	17.3	19.5	29.3	38.4	39.3	50.7	62.2	67.9	24.1
Respite	2.0	1.6	1.5	1.7	2.8	4.4	2.8	3.4	2.1	0.9	2.0
Deceased	6.8	2.0	3.2	2.8	4.3	4.4	7.9	4.7	1.1	4.7	3.4
Community & Other(a)	69.8	84.9	78.1	75.9	63.6	52.7	50.0	41.2	34.6	26.4	70.6
Total (%)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
number(b)	**764**	**1,776**	**1,100**	**809**	**396**	**294**	**178**	**148**	**468**	**106**	**6,039**

(a) Includes discharges to hospitals and hostels
(b) 116 admissions are excluded from the table due to coding errors.
Source: HSH 1995 ACCSIS unpublished data.

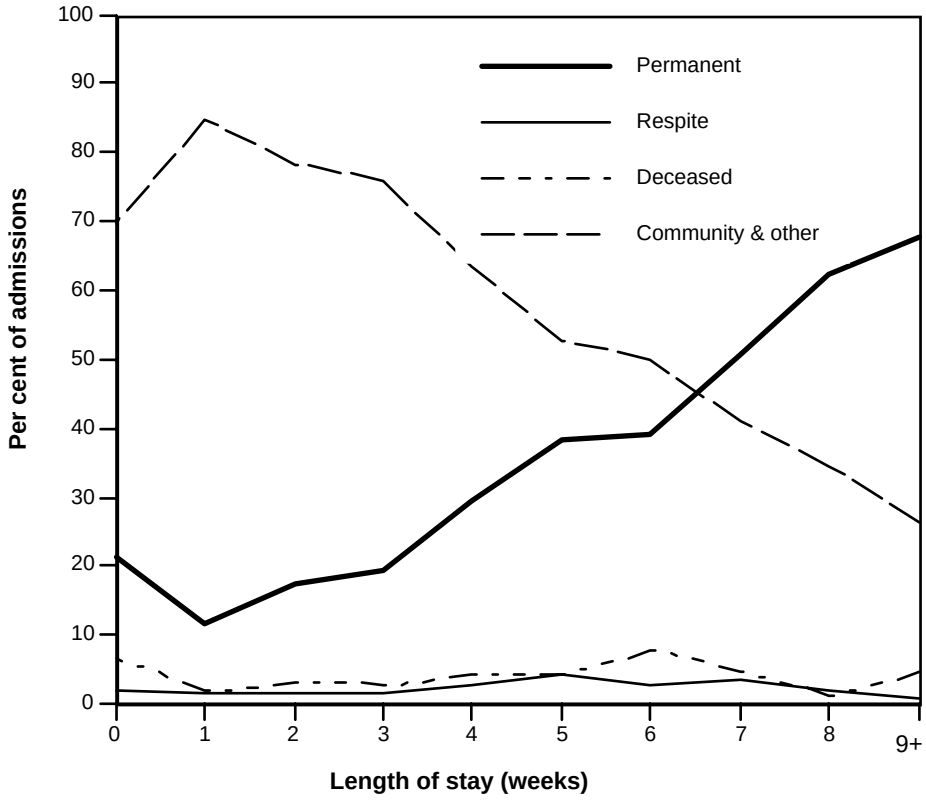

Figure 4.2: Destination of respite separations at different length of stay in nursing homes, Australia, 1993-94

4.2 Movement of respite residents

The above analyses of the destinations of separations are based on episodes of admissions and separations. The movements of individual residents are more complex. A resident may be admitted more than once in a year, and may move from one type of care to another. An important question is the extent to which individual respite residents (rather than admissions) become permanent residents.

Table 4.3 presents a movement model for those respite residents admitted to hostels in 1992-93 and those to nursing homes in 1993-94. Three categories of movement destinations within a 12-month period following admission were identified for both hostels and nursing homes residents. They are: became a permanent resident; returned to the community with no change of status; and died. For hostels, there is a fourth category: transferred to a nursing home.

Over half (57%) of hostel respite residents and about 39% of nursing home respite residents returned to the community within 12 months. These movements represent a usage of residential facilities consistent with the purposes of the respite program, one of which is to provide a break from the usual care arrangements. They also may represent a successful delaying of

permanent admission into a nursing home or hostel. Respite residents have been assessed as suitable for hostel or nursing home care and would qualify for a permanent place in a hostel or a nursing home.

About 30% of respite residents in hostels in 1992-93 became permanent residents in the same or another hostel after their first episode of respite stay. Another 7.8% and 3% became permanent residents respectively after the second and the third (and subsequent) episodes of respite stay.

Nursing home respite residents were more likely than hostel respite residents to become permanent residents. Over 40% became permanent after their first episode of respite stay, and 9.7% and 4.5% respectively became permanent after the second and the third and subsequent episodes of respite stay.

Table 4.3: Movement of respite residents within 12 months of first admission (per cent), hostels 1992-93 and nursing homes 1993-94

	Hostel 1992-93	Nursing homes 1993-94
Became permanent after 1st respite admission	30.0	42.3
Became permanent after 2nd respite admission	7.7	9.7
Became permanent after 3rd respite admission	3.0	4.5
Became permanent : Total	40.7	56.5
Returned to community, and others (a)	57.0	38.6
Died as a respite resident	0.8	4.9
Transferred to nursing homes	1.4	na
Total respite residents	**12,932**	**4,579**

Notes:

(a) Others including those discharged to a hospital and transferred to other institutions.

"na"=not applicable.

74% and 77% of the transfers from respite to permanent care occurred after having the first episode of respite care in hostels and nursing homes respectively.

Source: HSH 1995 ACCSIS unpublished data

4.3. Age and sex profiles of residents

This section presents an analysis of the age and sex profile of those residents who were admitted as respite residents and compares these with those who were admitted as permanent residents.

Table 4.4 relates to hostel residents. The majority of hostel residents were aged 75 and over for both sexes and for the four resident groups. There were also more females than males. There is no marked difference in age and sex profile between those admitted as respite residents and those admitted as permanent

residents. Those residents who changed from respite to permanent were slightly older while those who changed from permanent to respite (a very small number) were slightly younger.

Table 4.4 Age distribution (at first admission) of hostel residents by age by sex and change in resident status, Australia, 1993-94

	<65	65-74	75-84	85+	Total number
			Females		
From respite to permanent	2.7	11.2	49.6	36.5	**3,929**
Permanent without changing status	3.3	11.9	49.3	35.4	**8,671**
From respite to community and others (a)	5.2	13.5	45.8	35.4	**5,188**
From permanent to respite	5.5	20.0	41.8	32.7	**55**
			Males		
From respite to permanent	6.2	18.3	46.6	28.9	**1,338**
Permanent without changing status	9.4	19.3	43.9	27.4	**4,070**
From respite to community and others (a)	8.9	24.6	42.8	23.7	**2,477**
From permanent to respite	7.7	17.9	56.4	17.9	**39**
			Persons		
From respite to permanent	3.6	13.0	48.8	34.6	**5,267**
Permanent without changing status	5.3	14.3	47.6	32.9	**12,741**
From respite to community and others (a)	6.4	17.1	44.9	31.6	**7,665**
From permanent to respite	6.4	19.1	47.9	26.6	**94**

Note: (a) Others including those discharged to a hospital and transferred to other institutions.
Source: HSH 1995 ACCSIS unpublished data.

There are, however, some differences in age and sex profile between two groups of nursing home residents. These two groups are:

(1) those who, at the end of the 12 months period, were permanent residents, ie who were first admitted as permanent residents and did not change their status within 12 months, and those who were first admitted as respite residents but changed their status to permanent within 12 months, and

(2) those who, at the end of the 12 month period, were respite residents, ie. those who were first admitted as respite residents and returned to the community with no change of status within the 12 months, and those who were first admitted as permanent residents but changed their status to respite within the period.

The first group of nursing home residents, that of permanent residents, is older; and the second, that of respite resident, is younger. There is a higher proportion of females in the second group (respite) than the first. The similarity of the age

structure between those who changed from respite to permanent care and those who remained as permanent residents may suggest that they are from the same population and that the transfer from respite to permanent may not be unexpected.

Table 4.5 Age distribution (at first admission) of nursing home residents by sex and change in resident status, Australia, 1993-94

	<65	65-74	75-84	85+	Total number
			Females		
From respite to permanent	3.1	15.4	41.3	40.2	**1,574**
Permanent without changing status	3.5	12.6	40.1	43.8	**20,863**
From respite to community and others (a)	8.2	16.0	39.4	36.4	**1,116**
From permanent to respite	4.9	21.2	38.4	35.5	**203**
			Males		
From respite to permanent	7.6	20.2	48.0	24.2	**1,014**
Permanent without changing status	8.5	20.6	42.8	28.1	**12,282**
From respite to community and others (a)	10.5	29.7	40.3	19.4	**875**
From permanent to respite	8.2	25.1	43.7	23.0	**183**
			Persons		
From respite to permanent	4.9	17.3	43.9	33.9	**2,588**
Permanent without changing status	5.4	15.5	41.1	38.0	**33,145**
From respite to community and others (a)	9.2	22.0	39.8	28.9	**1,991**
From permanent to respite	6.5	23.1	40.9	29.5	**386**

Note: (a) Others including those discharged to a hospital and transferred to other institutions.
Source: HSH 1995 ACCSIS unpublished data.

The available data can also be analysed to show the probability of respite residents becoming a permanent resident at the end of the 12-month period. This is shown by age and sex in Table 4.6.

The probability of respite residents becoming permanent residents within 12 months is lower for hostels than for nursing homes - 40.7% compared with 56.5%. For both hostels and nursing homes, females are more likely than males to become permanent residents, and the difference is larger for hostels than for nursing homes. As can be expected, older residents are more likely than younger residents to become permanent residents. For females aged 85 years and over, 60.9% of those admitted as respite residents became permanent residents within 12 months.

Table 4.6 **Per cent of residents who were first admitted for respite care and became permanent residents within 12 months, by age and sex, Australia, 1993-94**

	<65	65-74	75-84	85+	Total
			Hostels		
Females	28.4	38.5	45.0	43.8	**43.1**
Males	27.4	28.7	37.0	39.8	**35.1**
Persons	*27.9*	*34.3*	*42.8*	*42.9*	*40.7*
Total number	**680**	**1,997**	**6,010**	**4,245**	**12,932**
			Nursing homes		
Females	35.0	57.5	59.6	60.9	**58.5**
Males	45.6	44.1	58.0	59.0	**53.7**
Persons	*40.8*	*50.5*	*58.9*	*60.4*	*56.5*
Total number	**309**	**886**	**1930**	**1454**	**4579**

Source: HSH 1995 ACCSIS unpublished data.

5. Summary and discussion

5.1 Provision and use

The recent increase in the provision and the use of respite care in both hostels and nursing homes is consistent with the Government's long-term planning targets. The approved number of bed-days in nursing homes (269 bed-days per 1000 people aged 70 and over in 1994-95) is low compared with those in hostels (508).

Utilisation rates of approved respite beds were low (70% for hostels and 50% for nursing homes in 1994-95) compared with the nearly full occupancy rates (for both respite and permanent beds) in hostels and nursing homes (95% and 97%). The reasons for the low levels of utilisation of respite beds are not clear but they are unlikely to have been caused by a "low demand" because both provision and utilisation levels increased simultaneously. For nursing homes, although beds are approved for respite use, the actual availability of beds for respite use is affected by the high level of need for beds for permanent occupancy. For hostels, it was considered that better coordination between hostel operators, carers and the assessment authorities might improve the use of approved respite beds (HHLGCS 1991).

While the data show that about half of nursing home respite beds are used by permanent residents, the data also show that there were some permanent residents who in fact used nursing homes for short periods of time. Of the 41,563 nursing home permanent admissions in 1993-94, 5,563 (13%) of them were discharged within 63 days and did not return within a week of discharge. This short stay group was nearly as large as the total respite admissions (6,115) in that year. If they were included as respite admissions or respite residents, the total number of respite residents would have been doubled.

The use of permanent places for short-term purposes is much lower in hostels than in nursing homes. There were only 437 permanent hostel admissions who were reported as having returned to the community. This was 2% of all permanent admissions (18,451) in 1993-94.

5.2 Length of stay

On average, each respite admission to either hostels and nursing homes stayed for 24 days. About 98% of respite admissions stayed within the 63 day limit. Taking into account multiple admissions of individual residents, the average stay by respite residents was about 30 days per resident in 1993-94. For 93% of hostel residents and 98% of nursing home residents, the total respite stay did not exceed 63 days. Only a minority used more than 63 days of respite care in a year.

People tend to stay for an exact number of weeks each time for respite care. Two weeks is the most common length of stay for respite admissions.

5.3 From respite to permanent care

The data show that a significant proportion of respite residents returned to the community within twelve months of admission (57% for hostels and 39% for nursing homes), indicating that respite beds were used as expected for short periods of stay, thus providing for both the carers and the care recipients, a 'break' from the usual care arrangements.

However, there is also a considerable proportion of respite residents who become permanent after the first episode of respite stay (30% for hostels and 40% for nursing homes). The data also show that the longer a respite resident stays in a hostel or a nursing home, the more he or she is likely to remain there on a permanent basis. Women and older people are slightly more likely to transfer from respite to permanent care. These patterns are worthy of further investigation.

There should be no dispute over the appropriateness of transfers from respite to permanent care in terms of care needs, because all applications for respite residence are subject to the same assessment procedures and criteria as application for permanent residence. However, it may still be argued that transfers from respite to permanent care represent an inappropriate use of residential facilities for respite care because these residents could and should have been allocated a place in the waiting list for permanent admission. Their use of hostel and of nursing home facilities was eventually not for respite purposes. For example, there have been concerns overseas that some families may use respite services as a transition stage from home to institution care (Scharlach & Frenzel 1986). The issue of whether the experience of a short period of respite care may encourage or deter the carer and/or the person being cared for to consider a permanent placement in institutions is a subject worth studying.

An important issue which has not been addressed in this paper is the part played by emergency or crisis admissions in the use of respite care. Emergency or crisis use of hostels and nursing homes represents an important use of residential facilities, and may become even more important as the ageing of the population means that both care recipients and carers will become older and more frail (Hancock, Jaques and Lamb 1995). There will always be some emergency admissions becoming permanent because the crisis situations which precipitate the emergency admissions may not improve. Transfers from respite to permanent care under such circumstances may be considered a normal part of the administration of residential aged care facilities.

Data needed to answer the questions raised above are, however, not available. The circumstances which result in the transfer from respite to permanent care are not known in any systematic way. There is a need to develop better data to

enable more thorough analyses of the use of respite care in nursing homes and hostels. Such data will help to inform discussions on the extent the objectives of residential respite programs are met and more generally the performance of residential aged care programs in Australia.

References

Australian Bureau of Statistics (ABS) 1993. Estimated Resident Population by Sex and Age, States and Territories of Australia, June 1987 to June 1992, Cat No. 3201.0

Australian Bureau of Statistics (ABS) 1996. Estimated Resident Population by Sex and Age, States and Territories of Australia, June 1994 and preliminary June 1995, cat. no. 3201.0

Australian Institute of Health and Welfare (AIHW) 1993. Australia's welfare 1993: services and assistance. Canberra: AGPS, 200-265.

Australian Institute of Health and Welfare (AIHW) 1996. Australia's welfare 1995: services and assistance. Canberra: AGPS, 174-238.

(Department of) Community Services and Health (CSH) 1990. Annual report 1989-90. Canberra: CSH, AGPS, 73-74.

(Department of) Health, Housing, Local Government and Community Services (HHLGCS) 1991. Aged care reform strategy: mid term review 1990-91 (report). Canberra: HHLGCS, AGPS, 67-71 & 119-121.

(Department of) Health, Housing and Community Services (HHCS) 1992. Care choices for older Australians, a guide to services provided by Commonwealth Government through the Department of Health, Housing and Community Services. Canberra: HHCS. AGPS.

(Department of) Human Services and Health (HSH) 1995a. The nursing home manual. Canberra: HSH, AGPS, p 1-14 to p 1-16.

(Department of) Human Services and Health (HSH) 1995b. Annual report. Canberra: HSH, AGPS.

Gibson D, Jenkins A, Butkus E, Liu Z, and Mathur S 1996. The respite needs of Australians. Canberra: Australian Institute of Health and Welfare (Aged Care Series no. 3). Canberra: AGPS.

Hancock A, Jaques K and Lamb A. Burrangiri Review, July 1995. ACT Departmnet of Health and Community Care.

Liu Z 1996. Length of stay in Australian nursing homes. Canberra: Australian Institute of Health and Welfare (Aged Care Series no. 1). Canberra: AGPS.

Scharlach A and Frenzel C 1986. An evaluation of institution-based respite care. The Gerontologist 26(1):77-82.