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EVALUATION OF THE DEMONSTRATION DAY RESPITE PILOT IN RESIDENTIAL AGED CARE FACILITIES INITIATIVE

FINAL REPORT

REPORT PREPARED FOR:

THE DEPARTMENT OF HEALTH AND AGEING

RESPITE FOR CARERS SECTION, OFFICE FOR AN AGEING AUSTRALIA, AGEING AND AGED CARE DIVISION

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ACCOMPANYING REPORTS

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Accompanying Report 2:	Monitoring and Evaluation Framework
Accompanying Report 3:	Case Study Overview Report and accompanying individual Case Study Reports
Accompanying Report 4:	Report of Surveys with CEOs/Service Directors, Care Coordinators/Managers, Care Workers, and Carers
Accompanying Report 5:	Report of the Analysis of Financial Accountability Report (FAR) data, 2008/09[1]
Accompanying Report 6:	Report of the Analysis of Service Activity Reports (SARs), 2007/08 & 2008/09[2]
Accompanying Report 7:	Report of the Analysis of Site Data for the period 1/7/09 to 31/12/09
Accompanying Report 8:	Final Site Data Collection Report – Operational changes in 2010
Accompanying Report 9:	Report of the Final Analysis of Service Activity Reports (SARs), 2008/09 (revised) and 2009/10
Accompanying Report 10:	Report of the Final Analysis of Financial Accountability Reports (FARs), 2008/09 to 2009/10
Accompanying Report 11:	Tools developed for the Evaluation of the Demonstration Sites in Day Respite in Residential Aged Care Facilities

[1] Note that report on FARs was a *preliminary* report, which has been superceded by **Report 10**.
[2] Note that this report on SARs was a *preliminary* report, which has been superceded by **Report 9**.

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SUMMARY OF KEY FINDINGS

FINDINGS ABOUT THE SERVICE MODEL

The location of day respite services in residential aged care facilities (RACFs) provides a valuable, and value-adding, component to the broader aged care system when certain conditions are met. Providing the following three factors are addressed, this model enables a synergistic sharing of resources across the organisation, and links service users to a wider range of supports and services than would normally be provided by a day respite program –

- ✓ its implementation is managed carefully
- ✓ it brings with it a design of physical infrastructure that is sensitive, user-friendly and supports flexible, consumer-centred service provision, and
- ✓ it is delivered by an organisation that provides a suite of service types.

Day respite that is located in a RACF setting can also reduce negative perceptions of residentially-delivered care through familiarisation of carers and care recipients with the services that can be available in RACFs, in particular, residential respite care. In such a context, day respite constitutes a bridge that seamlessly links community and residential services, smoothing the transition between both. However, the issue of stigmatisation of the DDR services because of their location can be a deterrent to consumers, albeit one which is overcome for most through familiarisation and satisfaction with services provided.

FINDINGS ABOUT APPROPRIATENESS

Appropriateness relates to a program's suitability in terms of achieving its desired effect and being used by its intended participants.

Administrative and Program Guidelines for the National Respite for Carers Program (2004) identify a number of target groups of which the following are relevant to the DDR initiative –

- people with dementia;
- people with dementia and challenging behaviour;
- frail older Australians (65 years or over, or 50 and over if Indigenous).

Consistent with the original intention of the day respite program, according to the SARs almost all of the care recipients attending the program over the past two years were aged over 65 (or over 50 if from an Aboriginal or Torres Strait Islander background). In terms of health and functioning, over half of all care recipients had dementia, around a quarter had dementia with challenging behaviours, and around a quarter had a disability. The characteristics of the carers and care recipients attending the program in 2008/09 and 2009/10 are summarised in Tables 14 and 16 of *SAR* Report **Accompanying Report 9**. The results show that –

- ➢ The proportion of carers and care recipients from *Aboriginal and/or Torres Strait Islander* backgrounds had remained constant at around 3 to 4%.
- ➢ The proportion of carers using the service who were living in *rural locations* appeared to increase slightly from 15.1% in 2008/09 to 21.6% in 2009/10, due to the increased service delivery of

some of the rural-based DDR projects. However the number of carers living in *remote locations* dropped slightly from 5.5% in 2008/09 to 3.0% in 2009/10.

- The proportion of carers from *financially or socially disadvantaged backgrounds* remained steady at 24.5% of carers assisted in 2008/09 and 2009/10.
- *Employed* carer numbers reduced slightly from 1 in 3 carers (33.3%) in 2008/09 to 27.5% of carers in 2009/10.

More detailed information on the health and functioning of care recipients was collected in the first round of our Site Data Collection (refer to **Accompanying Report 7**). That report illustrates that, at assessment –

- the *General health status* of nearly half (48.2%) of all care recipients was *Fair*,
- the *Level of care required* was assessed as *High* for 45.1% of care recipients,
- the *Priority level for entry* to the day respite service was assessed as *High* for nearly half (49.0%) of the care recipients, and
- *Special care needs* were reported for 67.6% of the 896 care recipients, of which the most common special care need was *Dementia* (27.2% of all care recipients).

The Final Site Data Collection identified a change in the profile of carers and recipients by 12 of the 31 sites (38.7%) that included *a trend in 2010 towards increasing high care needs and clients from diverse cultural and linguistic backgrounds.* Some sites also noted an increase in the number of carers presenting with stress or health issues – see **Accompanying Report 8.**

In 2009 the most common reasons cited for *ineligibility or exclusion of applicants* to the DDR service were *High-level care needs* (i.e. requiring two staff), cited by almost half of all projects, and *High-level challenging behaviours* (i.e. abusive, intrusive or inappropriate behaviours), cited by more than a third of projects – see **Accompanying Report 7.** The final Site Data Collection showed that little had changed in 2010 – the most commonly cited reason for rejecting applicants was an inability to accommodate care recipients with complex and high level care needs, particularly arising from behavioural issues, mobility issues and other health issues requiring one-on-one support. Furthermore, most sites reported that they were rejecting around the same proportion of applicants as they had in the previous 12 months – see **Accompanying Report 8. This is a concern as this is one of the NRCP's key target groups and the burden for their carers is significant.**

It is important to note that assessment practices and care recipient characteristics may vary greatly between DDR projects as there is an absence of uniform, nationally consistent assessment (such as would be provided by an ACAT) informing the overall client profile. **The evaluators believe that a nationally consistent and recognised assessment process, as is provided by ACAT services, should be required to achieve entry to DDR services. Standardised assessment would allow more reliable quantification of the characteristics of carers, and promote a better understanding the impact of DDR services on entry to permanent residential care** (discussed below).

The *overall exit rate* for the day respite program appears to have remained between 28% and 39% so far, with an exit rate of 27.9% calculated for the period July-December 2009 (first Site Data Collection), and exit rates of 37.3% and 38.9% for the full 2008/09 and 2009/10 financial years respectively (SARs). Consistent with the reported difficulty in accommodating clients with high care needs, data on *exit destination* from the first Site Data Collection and from the 2009/10 SARs indicated that approximately one third of all care recipients leaving the day respite service entered *high level full time residential care*

(35.2% from the Site Data and 33.7% from the 2009/10 SARs). According to the SARs, this proportion had increased since 2008/09 (up from 27.4%), with a corresponding decrease in the proportion of care recipients entering *low level full time residential care* (18.0% in 2008/09 and 13.9% in 2009/10). However the ageing of the care recipients enrolled in the first year of the program may explain this apparent trend.

It will be important to continue to track exit destination as the DDR program matures and moves towards capacity, in order to determine its true impact on entry to high level residential care**. Therefore we recommend that the Department begins to include the exit destination section of the SAR in the usual subset of items that are *entered electronically by the Department from the paper SAR forms.*** (That the Evaluators undertook to enter this data for 2008/09 and 2009/10 specifically to address this issue).

A range of services that are appropriate to day respite care are being provided, with the value-add of access to additional services being provided by the RACF that are not normally available in a day respite service. These include nursing, health monitoring and hygiene supports, as well as residential respite.

Both the literature review and evaluation survey feedback (*Accompanying Reports 1* and *4*) identify *flexibility* of day respite delivery as the most important critical success factor for carers, closely followed by *responsiveness to consumer need,* and the evaluation has found the DDR services as a group to be addressing both of these requirements. Feedback from carers indicates that what they sought from the day respite services (for themselves and the person in their care) has been provided (see following section on 'Effectiveness').

Services have also rated well for their *accessibility*, with the provision of transport, subsidisation of fees and services designed for specific cultural groups - including Indigenous people or those from specific culturally and linguistically diverse (CALD) backgrounds, as well as people living in rural or remote locations - being essential to this outcome. On the whole, carers are satisfied with the amount of respite (88.6% of carers surveyed) and the hours of its delivery (82.5% of carers surveyed), but there are some (3.7%) who are not satisfied with the days or hours provided, often seeking more weekend and public holiday provision (refer to *Accompanying Report 4*). However, few DDR services offer specialist services for employed carers, and SAR data indicates that the proportion of these carers has reduced slightly from 33.3% in 2008/09 to 27.5% in 2009/10. Some but not all sites offer hours of operation that support carers' employment.

The research literature is clear in finding that transport plays a key role in making day respite services accessible. Findings from the evaluation confirm that *transport* is a critical success factor for the DDR service model. According to the most recent Site Data Collection (2010), only three projects do not currently offer any type of transport to their care recipients. It was evident from the Surveys and the Site Data Collections (see **Accompanying Reports 4, 7 and 8**) that services are tailoring their transport provision to user need, and to local conditions. Transport costs tended to be subsidised by the day respite service to minimise any financial burden on clients, however some sites have experienced difficulty in meeting the demand for transport.

Results from the Surveys and the SARs both indicate that the number of complaints made about the day respite service is low. According to SAR data there were *less than 3 complaints per 100 carers/care recipients* who used the DDR services, suggesting that the program is operating without any major problems.

Findings about Effectiveness

Effectiveness concerns the extent to which the program's objectives are being achieved, or are expected to be achieved, and the benefits for its participants.

The DDR services have received very positive ratings from all four stakeholder groups surveyed regarding their effectiveness and their impact. A range of benefits arising from the program have been identified for carers and the person in their care – indicating that DDR services are being designed and provided with the caring relationship taken into account. Three types of benefits were identified – those relating to the respite provision itself (eg provision of a break for carers, provision of a range of opportunities for care recipients), those relating to carer health and wellbeing (including reduced stress, time to address their own health issues) and those relating to service access and usage (including making carers more confident about using residential respite and increasing carer awareness about available services). However, carers were less likely to see the DDR services as linking them to other services.

Extensive literature reviews have found no reliable experimental evidence that respite care provides significant short or long term benefits to care recipients (Arksey *et al*, 2004) or that it adversely affects them (Mason *et al*, 2007), regardless of respite care model – see **Accompanying Report 1**. Nevertheless, Carers, Care Workers and Care Coordinators surveyed for the evaluation have identified benefits relating to the DDR services' social impact on care recipients, but less so in relation to improving physical or cognitive functioning.

Less expected have been benefits identified for RACF residents through sharing in DDR services, for RACF staff through exposure to a wider range of clients and services than normal, and for participating RACF organisations in terms of synergies achieved in resource usage and cross-fertilisation across programs. This has been particularly evident when a suite of services and programs can be drawn from, including the DDR service.

Combining Site Data information with that received from our surveys with carers, care workers, care coordinators and service directors and our case studies with selected sites, it would appear that the day respite services are likely to have delayed entry into residential care while facilitating that transition when it was needed. However, this finding should be treated with some caution as it is based on the perceptions of key stakeholders and not on measured, assessment based change (such as an ACAT assessment provided on entry to the DDR service and upon exit from the service). While these perceptions have been triangulated and show agreement across key stakeholder group, without the recognised national measure offered by an ACAT, this cannot be treated as a definitive finding.

A key mechanism for the transition from community to residential care has been the residential and overnight respite services offered to day respite clients, which carers and care workers report as having demystified residential care. This, combined with the sharing of some services between day respite and residential clients, can be seen as likely to have reduced the fear of entering residential care for many carers and care recipients. Furthermore, Site Data and SAR analysis shows that when DDR care recipients have entered full time residential care, three quarters have been admitted to *high level* care, which provides a further indicator of their degree of need and by implication, the reduction of demand placed on carers. As discussed, analysis of Site Data and SAR data shows that approximately one third of the care recipients who exited DDR services in 2009/10 entered a *high care* residential service, whereas less than 15% exited to enter a *low care* residential service.

FINDINGS ABOUT EFFICIENCY

Efficiency is concerned with how economically resources have been utilised, and how inputs (funds, expertise, time, etc.) are converted to results or outputs. The evaluation has collected information about staffing levels and usage (both DDR funded and unfunded) and staff : client ratios, as key *input* factors and taken as *results* quantifiable information about hours and days of respite delivered, management of demand levels, carer satisfaction with outcomes and whether or not projects are in deficit or surplus. In addition, evidence of economies of scale and value-adding have been identified as an indicator of effective and efficient use of resources.

However, it should also be noted that is difficult to determine precisely the cost effectiveness of the DDR Initiative as a whole as there are a range of variables to take into account. Relevant variables include location (the more remote the higher many costs will be and the greater will be the difficulty of achieving economies of scale), the level of care provided, the needs of care recipients (for example, those with dementia will require significantly more support), facility size and the capacity to achieve synergies in resource usage. Furthermore, as new initiatives there will be start up costs for DDR services that will reduce over time.

INPUTS

The DDR services have been able to achieve economies of scale by sharing staff-related and service provision-related resources. In addition, the RACFs have benefitted from the infrastructure provided through the DDR Initiative, with service users also gaining from the enhanced service provision made possible by day respite focused building design and renovation. Sharing of staff across programs is also exposing staff to wider learning opportunities, and residents as well as care recipients can be expected to benefit from this. In addition, DDR clients are likely to benefit from the value-add of access to services available in the RACF. The two most commonly cited services were nursing services and referral to other RACF health and support services (27 sites), followed by use of residential respite (26 sites), RACF allied health services (24 sites), health monitoring (22 sites) and hygiene services (21 sites) – refer to *Accompanying Report 7*.

According to Site Data submitted for July-December 2009, for every FTE day respite staff member (regardless of role) there were on average 7.7 day respite places used per week. In terms of staff providing direct care to care recipients, there was on average one direct care staff member per 12 places. However, within this range there was substantial variation between projects, perhaps reflecting operational characteristics such as the specialist focus of each service (for example, dementia-specific) and the implications of that focus on staff : care recipient ratios.

In addition, most of the sites indicated that operating their DDR service involved the use of additional unfunded staffing from the RACF. Most commonly, this involved *Managers, Nursing staff*, particularly RNs, and *Domestic staff*. While this has entailed a small amount of time per week per site, when considered across the DDR program as a whole it represented the equivalent of over 30 full time staff per week (30.5 FTE) in total, an average of 1.1 full time staff members per project (based on detailed data provided in the first Site Data Collection). This is not necessarily an efficiency indicator for individual projects, but from a program perspective is a further value-add for overall respite resource provision.

OUTPUTS

Based on information gathered in the first Site Data Collection regarding the number of day respite places offered by each site in July-December 2009 (refer to *Accompanying Report 7*), it was estimated that more than 1,400 day respite places were being *offered* per week under the DDR scheme. Therefore, if each carer were to receive one occasion of respite each week (i.e. the average indicated by the detailed Site Data collected on individual care recipients), more than 1,400 carers could use the service each year.

This is consistent with information from the Service Activity Reports (SARs) regarding the *number of carers actually receiving a service* – 1,262 in 2008/09 and 1,427 in 2009/10, an increase of 13.1% (refer to **Accompanying Report 9**)[3]. If each of these carers used the service once per week (as is the average indicated by data from the first Site Data Collection), this would mean that the original Budget estimate for the DDR Initiative quoted by the Department, which estimated that the measure would help carers of frail older people at a rate of 1,200 per week, had been met.

Based on the sites' operating days and hours as at December 2009, the DDR Pilot *offered* over 73,000 days of respite per annum and over 700,000 hours of respite per annum. Operating days and hours remained unchanged at most of the sites in 2010 (final Site Data Collection round – refer to **Accompanying Report 8).** While the number of days offered exceeds the original target set for the DDR Initiative (62,400 days of respite for carers of frail older people), according to the Service Activity Reports (SARs) few sites had actually reached full capacity by the end of 2009/10. The total number of hours of respite *actually delivered* per annum had increased by 33.8% from 252,788 hours in 2008/09 to 338,302 hours in 2009/10. However, this still only represented around half of the total capacity of the program in terms of the *funded hours* reported in the SARs and the *operating hours* reported in the Site Data Collection.

According to the SARs the *number of respite hours delivered per annum per carer* (i.e. the total number of hours delivered divided by total number of carers) **increased** from 200 hours in 2008/09 to 237 hours in 2009/10, an increase of **18.5%.** This equates to an average of 3.9 hours per carer per week in 2008/09 and **4.6 hours per carer per week** in 2009/10. However, it should be noted that there can be a very broad range of service use patterns, with some carers using the day respite service only occasionally, others using it weekly, and others using it up to 7 days per week. Some sites limit the amount of respite offered to individual carers, whereas other sites offer almost unlimited use. Therefore a slightly different picture of the average number of hours delivered per carer will be generated when using data based on *individual care recipients*, as was collected for the period July-December 2009 (see **Accompanying Report 7**). Statistics calculated using these data showed that the average (mean) number of hours that each care recipient attended day respite during that period was just over 6 hours per week, higher than the figure based on SARs data, due to the very high usage of care recipients at some services (e.g. 7 days per week).

COST OF DDR SERVICES

The *cost (expenditure) per hour of respite funded,* the *cost per hour of respite actually delivered* and the *cost per carer* was calculated for the Demonstration Day Respite program as a whole and for individual projects, by combining data from Service Activity Reports (SARs) with expenditure data from the Financial Accountability Reports (FARs). A summary of that information is presented below – refer to **Accompanying Report 10** for further details.

[3] Note that activity data for 2007/08 was deemed too unreliable to be included in final reporting.

The *cost per hour of respite delivered* for the program as a whole appears to have **decreased** over the last two financial years, from $35.75 in 2008/09 to **$30.37** in 2009/10. In comparison, the cost per hour delivered across 138 NRCP Day Care projects in 2008/9 (provided by the Department for comparison purposes) was $17.28. There is potential for DDR service delivery costs to decrease to this level over time as the program moves further towards service capacity and thereby towards equivalence with the cost of DDR hours *funded* ($16.92 in 2009/10, based on additional data extracted from hardcopy SAR forms for the purpose of the evaluation). The annual *cost of respite delivered per carer* had remained steady at around $7,000 ($7,161 in 2008/09 and $6,940 in 2009/10) – refer to **Accompanying Report 10** for details).

The FAR data showed that the DDR program as a whole was operating with a modest surplus. More than half of the individual projects reported a surplus rather than a deficit in both 2008/09 and 2009/10, and most of the projects which had reported a surplus for 2008/09 also reported a surplus for 2009/10. The average surplus/deficit reported by individual projects had reduced from just under $25,000 in 2008/09 to just over $14,000 in 2009/10.

This can be seen as an indicator of efficient use of resources. Apart from avoiding a deficit situation, a modest surplus as opposed to a significant surplus, indicates a maximising of available resources to meet consumer need.

DEMAND AND UNMET NEED

In reviewing demand levels, the evaluators extracted additional data from hardcopy SAR forms pertaining to the number of hours of respite funded (rather than hours actually delivered) and the reasons given by projects for any difference between the hours funded and hours actually delivered. Those data items are not normally entered into the Department's spreadsheets.

Each project receives an agreed amount of funding each financial year to cover the delivery of a certain number of respite hours. The difference between the number of *funded respite hours* and the *number of respite hours actually delivered* can be seen as a measure of unused (or over-used) capacity in a service. An indicator of unused/overused capacity was defined as the proportion of funded respite hours that were actually delivered, i.e. calculated as *hours delivered as a proportion of hours funded*.

For the program as a whole, the proportion of funded hours that were actually delivered rose from 38% in 2008/09 to 51% in 2009/10. **This suggests that while the number of respite hours delivered increased by about a third between 2008/09 and 2009/10, it appears that around *49%* of the stated capacity is still unused and therefore there is scope for substantial growth in the program** (see *Section 3.3* of **Accompanying Report 9**).

It is also important to note that almost all of the individual projects, including two of the projects identified as showing the greatest underuse, did demonstrate growth between 2008/09 and 2009/10 in terms of the proportion of funded hours that they actually delivered. While many projects clearly faced unexpected challenges in establishing and running their service, it appears that over time these issues are being addressed.

These findings are further explained by information from the Site Data Collections which indicated that in an attempt to better meet *actual demand*, more than half of the projects had changed their operating days/hours from those originally proposed, and that these variations had mostly continued through 2010.

Reasons given indicated that demand levels had not been accurately forecast prior to opening the service. This issue was also acknowledged by many sites when giving reasons in their SARs for significant variations between their funded respite hours and the actual respite hours delivered.

Demand is also reflected in *vacancy rates* (ie the average number of vacant places per week as a percentage of the average number of places offered per week, as collected in the first Site Data Collection), and *waiting lists* (collected by the SARs). These showed that –

- The *vacancy rate* varied greatly across projects – ranging from a high of 67.0% to zero vacancies (i.e. operating at capacity). The overall vacancy rate during the period July-December 2009 was 32%, representing over 400 vacant places per week in total. Furthermore, 81% of these vacancies were mainly due to lack of demand. This information raises concerns about methods used to determine demand levels.
- At 30 June 2009 there were only 28 carers on *waiting lists* for the program as a whole. By 30 June 2010 this had more than doubled to 67 carers – an increase of 139.3%. Only six projects reported a waiting list at 30 June 2009, however, at 30 June 2010 ten projects had a waiting list. As the DDR services become more established it can be expected that waiting lists will increase and these rates need to be plotted over time.

It was not possible to benchmark these rates against other NRCP funded day respite services due to a lack of available comparable data.

In order to accurately assess which services had the greatest *unmet need*, the SAR data on waiting lists was combined with the SAR data on service capacity (see **Accompanying Report 9**). In 2009/10 six projects were delivering 100% or more of the respite hours for which they had been funded, *and* had a waiting list, indicating clear unmet need for those services. Other projects with a waiting list in 2009/10 had delivered less than 70% of their funded respite hours, which reflected situations where the particular days or times requested by carers were unavailable rather than overall lack of capacity.

For those projects where unmet need is clearly evident, should ongoing funding be sought, it would be important to identify other day respite services in or near the same location as part of the process of determining the most efficient way to meet demand.

FUTURE FUNDING MODEL

Should the DDR services be continued as an ongoing component of the aged care respite service system, it is highly unlikely from the evaluation findings that they will be able to rely on a user pays model (if they are to be equitable and accessible). This means that funding will need to be recurrent, but based on meeting a set of required deliverables that reflect the purpose of the program and its service model.

The grants based funding provided for the DDR pilots has been effective not only in meeting service costs but for a number of other reasons –

- ⇒ Its four year timeframe, as opposed to a one year timeframe, has enabled issues associated with service establishment to be addressed and lessons learned from the path-finding nature of these pilots to be identified and absorbed.
- ⇒ The long timeframe has also supported services to be *innovative* and *flexible*, which would have been far less likely if funding had been provided on an annual basis.

⇒ It is very important for carers and care recipients to have a guarantee of service continuation.

At the same time, the provision of a service for four years will have raised expectations among service users of the continuation of DDR services and if the Program is not continued or absorbed into the NRCP, the negative impact on them will be significant (based on the positive feedback that the evaluation has identified).

There is inconclusive evidence about whether the amount of funding provided has inhibited or enhanced the services provided. However, it is more likely that the guarantee of four years of funding support has been deemed by providers to be worth investing RACF time and resources in developing DDR services.

EXECUTIVE SUMMARY

(This Executive Summary is designed to be a stand-alone document, hence it has more detail than would normally be provided in this part of the report.)

INTRODUCTION

The *Demonstration Sites for Day Respite in Residential Aged Care Facilities* (DDR) Initiative was announced as part of the 2007/2008 Federal Budget with $41.2 million provided over four years by the National Respite for Carers Program (NRCP) to establish demonstration sites for day respite care in aged care facilities. Thirty providers from metropolitan and rural and remote areas across Australia were offered funding. (One of these providers operates its services over two sites, and asked the evaluators to treat the sites separately, so for the purpose of the evaluation, there have been 31 sites, representing 30 projects.)

EVALUATION REQUIREMENTS

The evaluation of the *Demonstration Sites for Day Respite in Residential Aged Care Facilities* Initiative is to investigate and report on the following 9 factors:

1) The **efficiency, effectiveness and appropriateness** of funding DDR services in residential aged care facilities.
2) The **benefits** to the carer and care recipient of accessing DDR services, including the extent to which this model of respite care supports home-based care, the caring relationship and the well-being of the carer and the care recipient.
3) Any **unintended effects** of the Initiative, including adverse consequences for the carer or care recipient.
4) The **impact** of accessing DDR services on the care recipient's entry to permanent residential care, including the extent to which the receipt of day respite delays or else facilitates entry into full-time residential care.
5) The effects of providing DDR services on the **operations** of residential aged care facilities in providing care to full time residents.
6) The **demand** for DDR services in residential aged care facilities.
7) The **costs** of delivering DDR services, taking into account relevant variables including: locality, level of care provided, needs of care recipients, facility size etc.
8) Appropriate levels of **user fees** for DDR services.
9) Appropriate **options for future funding** of this type of respite, such as a day respite subsidy and/or grant funding.

EVALUATION METHODOLOGY

A methodology involving both quantitative and qualitative approaches was designed, involving –

⇒ A *review of Australian and international research* relating to day respite (*A* Discussion Paper presenting its findings is available in **Accompanying Report 1.**)

⇒ A *Monitoring and Evaluation Framework* was developed to guide the evaluation (A copy of the Framework is presented in **Accompanying Report 2**).

⇒ From June to October 2009, the evaluators visited 13 of the sites in order to undertake in depth qualitative analysis which was reported in the form of individual *Case Studies*, brought together in a single report that also identified trends and differences across the sites studied. Case Study sites were selected to yield rich qualitative information and provided a range of locations (metropolitan, regional and rural), auspice types, States and Territory, size (small, medium, large) and a culturally-specific or Indigenous-specific focus. (A copy of the Case Study report can be found in **Accompanying Report 3**).

⇒ In late 2009, the evaluators distributed *four surveys* – one for CEOs and Service Directors, one for Care Coordinators/Managers, one for Day Respite Care Workers, and one for Carers – to collect information on the experiences and opinions of those stakeholders regarding the appropriateness, effectiveness and impact of the DDR service. (A copy of the Survey Report can be found in **Accompanying Report 4**).

⇒ Based on initial interviews with DDR Site Managers and a survey of existing project data collection, a *Site Data Collection* tool was developed to extend and complement data provided by sites through the *Financial Accountability Report* (FAR) and *Service Activity Report* (SAR) processes. The *Site Data Collection* was undertaken twice. The first round related to the period 1/7/09 to 31/12/09 and collected detailed information on operations, service delivery and staffing. The second round, in late 2010, identified any changes that had occurred since 2009, so that an up to date picture could be obtained. (The first Site Data report can be found in **Accompanying Report 7** and the final Site Data report in **Accompanying Report 8**).

⇒ In 2010, analysis was undertaken of available *Financial Accountability Reports* (FARs) for the financial years 2008/09 and 2009/10 and *Service Activity Reports* (SARs) for 2007/08, 2008/09 and 2009/10. A preliminary analysis (**Accompanying Reports 5 and 6**) was superseded by a final analysis of 2008/09 and 2009/10 data (**Accompanying Reports 9 and 10**) using cleaned and updated datasets.

⇒ The evaluators facilitated a *Workshop* in Melbourne in May 2009, with multiple representatives from all sites and from the Department. The Workshop presented the draft *Monitoring and Evaluation Framework* and the *Site Data Collection* tool, and provided an early opportunity for the evaluators to meet all site representatives, and for those representatives to meet each other.

⇒ **Synthesis and analysis of findings** from these different evaluation activities has been designed to enable triangulation of results.

⇒ **Reporting** has been continuous, with individual reports for each major evaluation activity being provided, together with four Progress Reports.

FINDINGS ABOUT THE MODEL OF SERVICE

The provision of DDR services usually occurs in a community rather than a residential care setting, and this is the distinguishing feature of the DDR model – its location. From this base several other differentiating features are evident –

➢ Co-location of day respite in a RACF brings together residential and community care staff, offering scope for the development of enhanced knowledge and skills on the part of both groups of staff, and can provide the day respite service with access to staff they may not normally be expected to work with (eg Lifestyle Coordinators). It can also mean that activities are designed with the support of specialist RACF staff not always available in day respite programs – for example, a dedicated

Activities Officer or Recreation Coordinator. However, if the transition of the implementation of the day respite service is not managed effectively, with RACF staff being consulted, informed and so on, there can be resentment on the part of residential staff which takes months to overcome.

- Co-location also offers the opportunity for residential and DDR service recipients to share in activities, broadening the range otherwise possible. In smaller communities (eg rural or culturally specific) many of the residents are known to day respite users and given the opportunity to re-connect. However, the sharing of activities and facilities requires sensitive management. It is important that residents do not feel 'overtaken' and it is important that individual user needs are taken into account when bringing both groups together.

- Co-location brings the risk that the stigma associated with a residential care setting will deter carers and care recipients from accessing the DDR service. Fortunately, the DDR Initiative has offered funding for infrastructure that enables RACFs to provide a separate day respite centre or renovations designed to support flexible service provision and to create a homelike setting. A critical factor in the application of the model is sensitive infrastructure design. It has also been evident from the evaluation that stigmatisation has generally been an initial rather than an ongoing issue as familiarisation with the RACF and the day respite service increases over time.

- Co-location and the familiarisation involved also means that many carers and care recipients can more easily access residential respite, and that if the care recipients' needs change and they require long term residential care, this is less threatening. The evaluation has not found that the service model encourages premature entry to residential care, but rather, that it delays admission and eases the transition when it does occur.

- For all of the above reasons, the DDR model can be seen as building a bridge between community and residential care, providing an important component of the care continuum and easing the carer and care recipient journey in the process.

What did carers seek from the DDR service?

Based on survey findings, the main reasons given by carers for using DDR services reflected a duality of need, with the two most commonly cited reasons being to provide the care recipient with an *opportunity to socialise* (77.4%) and *giving the carer a break* (68.4%). In addition, information provided by carers about their health showed that–

- nearly one third of carers (32.0%) reported that they had no disabilities and no chronic health conditions;
- 39.0% reported one or two disabilities and/or chronic health conditions; and
- 16.5% reported three or more disabilities/conditions. Refer to Accompanying Report 4.

This information points to the important role played by day respite services providing a **specialist focus on carer health and wellbeing**, as occurs with the *Healthy Ageing Centre* at Rooty Hill (one of the sites case-studied for the evaluation – details in **Accompanying Report 3**).

Did the DDR service provide what carers were seeking?

It is of paramount importance that any new respite care service actually provides what carers want and need. Consumers usually make a clear choice between care in the community and care in a residential facility, but the DDR model blurs this distinction and carries the risk that people seeking a service that is essentially at the community end of the care spectrum will find the residential location to be a deterrent. The stigma associated with residential services has been significant for some, but certainly not the majority.

It is evident from the literature review (Accompanying Report 1) undertaken for the evaluation that it is not the model *per se* of respite care but how it is delivered that affects carer and care recipient preferences (Mason *et al*, 2007: 3). In particular, the **flexibility** and **responsiveness** to individual need emerge as the most consistent themes in the preferences of carers identified by researchers, as well as the provision of **quality** services that enable the carer to entrust the person in their care to those services (Pollock *et al*: 2007). The survey feedback provided by carers for this evaluation has reinforced the accuracy of these findings, and the DDR model has been rated by them as achieving the key requirements of flexibility and quality care and support.

The survey of carers sought a rating from '1'(most negative) to '5' (most positive) about a number of features of the DDR service. The 297 carers in the sample indicated that the service was meeting their needs, however, their ratings – while high – were slightly lower than those of Care Workers and Coordinators/Managers on most dimensions. The table below summarises what carers were seeking from the DDR service, and how well it was rated by them in achieving these goals.

Carers' reasons for using the DDR service against average ratings applied by carers

Reason	DDR capacity to meet this need (Average rating)
To provide the care recipient with an opportunity to socialise more*	4.5
To give the carer 'time out' / a break*	4.4
To give the carer time for their other responsibilities	
To provide the care recipient with an opportunity to participate in activities that help with their condition*	4.3
To delay the need to place the care recipient in full time care*	4.1
The carer's own health issues – positive impact of service on carer health and well-being*	3.9
Positive impact of service on carer mental health/stress management*	4.3

**Carers' ratings on these dimensions were significantly lower (p<.05) than those applied by care workers and care coordinators, indicating that staff and managers hold a more positive view of the DDR Pilot that needs to be 'reality checked' against carer perceptions.*

Against these very positive findings, there are a relatively small number of service provision features that were rated significantly less positively by carers. These relate to the DDR service's capacity to –

- Improve their own health and well being (3.9)
- Improve the physical functioning (3.8) and cognitive functioning (3.7) of care recipients
- Reduce carer anxiety about the care recipient needing to enter full time residential care (3.8)
- Link carers to services that they would not otherwise have known about (3.7).

Diversity and specialisation in applying the DDR model

There is significant diversity across the sites in the application of the model, indicating that a range of carer needs is being met, and that the model has the capacity to be applied to a range of settings and diverse needs. The evaluation has identified diversity in relation to:

⇒ The *level of integration with the residential care service*, ranging from full integration to quite distinct services which do not 'cross over' with the residential service, and from complete physical separation to complete integration.

⇒ The *range of services offered* – including the balance of on- and off-site activities, and the way in which transport is provided (which is highly flexible being adapted to local conditions and user needs).

⇒ *Service intensity*, including operating hours and the number of carers assisted. Also, the number of days of service available to individuals ranges from occasionally to fortnightly, weekly or daily, and sometimes includes weekend provision.

⇒ *Focus of the service* – for example, some sites offer a traditional 'drop off' respite program, while others have adopted more innovative approaches including on-site carer programs some of which involve the care recipient simultaneously, carer health and well being programs and a one stop shop providing seamless linkage to a range of services, including primary health care. Some provide culturally specific and holistic services tailored to local need (particularly evident in Indigenous specific services located in remote areas, the *So Wai* service for Chinese people and the St*epping Out* service for Jewish people). Refer to **Accompanying Report 3** (Case Studies) and **Accompanying Reports 7 and 8** (Site Data Analysis).

Innovation in the DDR model

Evaluation feedback from the surveys and case studies indicates that the DDR model is supporting innovation in day respite provision. In part this stems from co-location with residential care services which is requiring both day respite and residential care staff to think and operate outside of their usual paradigms. In addition, the Pilot has encouraged services to trial different approaches to providing day respite and approaches that place the carer and care recipient at the centre of service delivery.

Across all projects, site data analysis identified that approximately **30%** of total activity hours per week were shared with residential care recipients. All projects gave day respite clients access to some type of additional service provided by the RACF and these represent value-add services that would not normally be accessible in community-delivered day respite care.

Sharing of resources between the RACF's other programs and the day respite services was also evident in relation to staffing. Site Data show that many DDR staff members were also employed part time by other areas of their organisation. Almost half **(49%)** of all DDR staff also worked in their RACF's *Residential care* service but this practice varied greatly across project sites. This means that DDR and RACF staff are being exposed to a wider than normal range of work experience, which can be seen as beneficial for them and therefore, for their clients. (This was also the view of staff surveyed by the evaluators in our surveys of care workers, care coordinators and service directors.)

Impact on use of residential respite services

Guiding Evaluation Question

*What has been the **impact** of accessing DDR services on the care recipient's use of residential respite, including the extent to which the receipt of day respite either discourages or facilitates use of residential respite?*

The DDR model is seen as enabling carers' access to overnight or residential respite and providing a seamless link between day and residential respite services. Site Data Analysis identified a total of **1,004 nights of residential respite** used by carers during July to December 2009 (the six month period studied in detail as part of the first Site Data Collection), at an **average of 2.0 nights per care recipient.** Case study findings indicated a trend for access to residential respite to be enhanced.

Impact on entry to residential care

Guiding Evaluation Question

*What has been the **impact** of accessing DDR services on the care recipient's entry to permanent residential care, including the extent to which the receipt of day respite either delays or facilitates appropriate entry into full-time residential care?*

A concern that has been expressed by some is that locating day respite services in a RACF could work against the objective of keeping care recipients in the community for as long as possible. Apart from the fact that this overlooks the gate-keeping role played by Aged Care Assessment Teams, the evaluation evidence does not support this concern.

In their comprehensive review of the literature, Mason *et al* (2007) found no widespread reliable evidence that respite (regardless of setting) can delay entry to residential care. This is due largely to the difficulty of separating the impact of other factors (DoHA: 2002), including the care recipient's own need for care, the carer's capacity to manage, and the confounding effect of the existence of other services being provided at the same time as respite, making it difficult to isolate the specific effect of respite care on delayed entry to residential aged care (Keefe & Manning, 2005: 10).

However, more recent pathway analysis by the Australian Institute of Health and Welfare (2006: 1, 12) has found that the use of community care services by residential care clients appears to delay entry into permanent residential care. Their study found that although a 'substantial proportion' of people using residential respite care enter permanent residential care, the use of the residential respite was not a 'necessary precursor' into permanent residential care.

Combining Site Data and SARs data with perceptions of stakeholders from surveys of carers, care workers, care coordinators and service directors and our case studies with selected sites, it would appear that the use of day respite services can delay entry into full time residential care and can facilitate that transition when it is needed. The stakeholders clearly indicated that the DDR service enabled carers to continue in their caring role, allowing the care recipient to remain in the community and thereby delaying entry to residential care. The Site Data demonstrated the significant levels of need of care recipients, and therefore the need for significant levels of support and assistance to carers to enable them to continue to provide care at home. According to the both the Site Data and the SARs, around half of the care recipients leaving the DDR service entered some form of full time residential care, with three quarters of

those entering *high level* care. It therefore seems reasonable to conclude that DDR services may have assisted in delaying entry to full time residential care until care recipient needs become quite high.

However, without data on the pathways of carers who did *not* use the DDR service, and without formal assessments of individual change over time (such as an ACAT assessment provided on entry to the DDR service and upon exit from the service), it is difficult to draw direct causal links regarding the effect of the DDR service on entry to permanent residential care.

The evaluators will be conducting a separate client pathway analysis as a supplement to this evaluation, and it is expected that this will provide additional information about the carer and care recipient journey and the role played by day respite services.

A key mechanism for the transition from community to residential care has been the residential and overnight respite services offered to day respite clients, which carers and care workers report as having demystified residential care. This, combined with the sharing of some services between day respite and residential clients, can be seen as likely to have reduced the fear of entering residential care for many carers and care recipients. Survey findings (see **Accompanying Report 4**) confirm this finding.

> *'Carers and care recipients become more receptive to nursing home care. The day respite centre is co-located with the nursing home. Carers visit the nursing home frequently and understand the nursing care services much better, thus removing the stigma and concern related to the service.' (care coordinator)*

Challenges associated with implementing the DDR model

The two most commonly identified challenges related to countering stigmatisation associated with residential care provision and ensuring that this did not deter potential consumers, and managing the (initially) negative reactions by some RACF staff to the day respite service.

Apart from the combined positive impact of time, increasing knowledge and understanding of the day respite service and its associated model and seeing the benefits that can arise from co-location, it is clear that the management of the DDR service's implementation and integration into RACF programs is crucial. Preparing staff and developing specific processes for communication and coordination of staff have emerged from interviews and open-ended feedback as important strategies for smoothing the integration process.

Stigma

Feedback from carers surveyed for the evaluation shows that some were initially deterred and that some of these continued to be uncomfortable with the setting for the day respite service. However, most could see advantages associated with the co-location, including the provision of a wider range of activities for care recipients, familiarisation and therefore greater access to residential respite services, and reduced anxiety about the person in their care entering long term residential services should this be needed. Refer to **Accompanying Report 4** which details these survey findings.

It was common for DDR staff at the sites case-studied to report that the stigma held by many service users about residential aged care, while initially acting as a deterrent for some to access the day respite service, was reduced through familiarisation when using the day respite service. This was seen by some as making residential care a choice when once it would not have been considered.

It was also evident that the issue of stigmatisation was less apparent when the service was culturally-specific or Indigenous-specific, and regarded by the target community as a trusted and culturally-relevant form of support – regardless of co-location in a RACF. Further information can be obtained in **Accompanying Report 3** which provides case study detail.

Synergies generated by the DDR model

DDR providers reported significant economies of scale due to sharing and consolidating resources with their auspicing RACF. These can be seen as beneficial for both residents and day respite users, and as bringing benefits to the RACF that range from the tangible (sharing of staff resources, staff training, equipment, purchasing of goods and stores, meals preparation, laundry services, transport services) to the intangible (raised profile in the local community, increased staff experience across programs).

At the same time, RACFs were found to be providing an unfunded contribution in terms of staff time (FTE) that equated to an average of 1.1 full time staff members per project (see the first **Site Data Report, Accompanying Report 7.**) In terms of time, most of this contribution came from *Care/support workers*, *Domestic staff* and *Managers*. The final Site Data Analysis for the year 2010 found that unfunded contributions had continued to be a feature of the service model – see **Accompanying Report 8.**

Findings relating to the Appropriateness of the DDR model

Guiding Evaluation Question

*To what extent has the **model** of respite care supported home-based care, the caring relationship and the well-being of the carer and the care recipient?*

Appropriateness relates to a program's suitability in terms of achieving its desired effect and being used by its intended participants.

Administrative and Program Guidelines for the National Respite for Carers Program (2004) identify a number of target groups of which the following are relevant to the DDR initiative –

- people with dementia;
- people with dementia and challenging behaviour;
- frail older Australians (65 years or over, or 50 and over if Indigenous).

Consistent with the original intention of the day respite program, according to the SARs almost all of the care recipients attending the program over the past two years were aged over 65 (or over 50 if from an Aboriginal or Torres Strait Islander background). In terms of health and functioning, over half of all care recipients had dementia, around a quarter had dementia with challenging behaviours, and around a quarter had a disability. The characteristics of the carers and care recipients attending the program in 2008/09 and 2009/10 are summarised in Tables 14 and 16 of *SAR* Report **Accompanying Report 9.** The results show that –

- The proportion of care recipients from *Aboriginal and/or Torres Strait Islander* backgrounds had remained constant at around 3 to 4% of all carers and care recipients.

- Approximately one in five care recipients were from **culturally and linguistically diverse** (CALD) backgrounds.
- Those with **dementia** represented around 57% of all care recipients, while those with **dementia and challenging behaviour** represented around 23% of all care recipients.
- The proportion of care recipients with a **disability** had increased slightly from 23.2% in 2008/09 to27.7% in 2009/10.
- The proportion of carers using the service who were living in **rural locations** appeared to increase slightly from 15.1% in 2008/09 to 21.6% in 2009/10, due to the increased service delivery of some of the rural-based DDR projects. However the number of carers living in **remote locations** dropped slightly from 5.5% in 2008/09 to 3.0% in 2009/10.
- The proportion of carers from **financially or socially disadvantaged backgrounds** remained steady at 24.5%.
- **Employed** carer numbers reduced slightly from 1 in 3 carers (33.3%) in 2008/09 to 27.5% of carers in 2009/10.

More detailed information on the health and functioning of care recipients was collected in the first round of our Site Data Collection (refer to *Accompanying Report 7*). That report illustrates that, at assessment –

- the *General health status* of nearly half (48.2%) of all care recipients was *Fair*,
- the *Level of care required* was assessed as *High* for 45.1% of care recipients,
- the *Priority level for entry* to the day respite service was assessed as *High* for nearly half (49.0%) of the care recipients, and
- *Special care needs* were reported for 67.6% of the 896 care recipients, of which the most common special care need was *Dementia* (27.2% of all care recipients).

The Final Site Data Collection identified a change in the profile of carers and recipients by 12 of the 31 sites (38.7%) that included a trend in 2010 towards increasing high care needs and clients from diverse cultural and linguistic backgrounds. Some sites also noted an increase in the number of carers presenting with stress or health issues – see **Accompanying Report 8.**

The evaluators note that almost half of all projects reported *High-level care needs* (i.e. requiring two staff) as a reason for ineligibility or exclusion of applicants. The second most frequently cited reason for ineligibility or exclusion, reported by more than a third of projects, was *high-level challenging behaviours,* that is, abusive, intrusive or inappropriate behaviours – see the Site Data Reports. **This is a concern as this is one of the NRCP's key target groups and the burden for their carers is significant**.

According to the both the Site Data and the SARs, around half of the care recipients leaving the DDR service entered some form of full time residential care, with three quarters of those entering *high level* care. It therefore seems reasonable to conclude that DDR services may have assisted in delaying entry to full time residential care until care recipient needs become quite high.

However, despite the number of people excluded because of their level or complexity of need, Site Data and SAR data regarding the destination of those exiting the DDR service indicate that over 60% of DDR care recipients had significant levels of need, with exit occurring due to acceptance into *full-time residential care* or due to death. Level of need is further reflected in the proportion who were admitted to *high level residential care* – three quarters of all clients entering full time residential care.

It is important to note that assessment practices and care recipient characteristics may vary greatly between DDR projects as there is an absence of uniform, nationally consistent assessment (such as would be provided by an ACAT) informing the overall client profile. **The evaluators believe that a nationally consistent and recognised assessment process, as is provided by ACAT services, should be required to achieve entry to DDR services. Standardised assessment would allow more reliable quantification of the characteristics of carers, and promote a better understanding the impact of DDR services on entry to permanent residential care**.

The surveys of Carers, Care Workers and Coordinators/Managers contained common questions about the features of the day respite service model and its appropriateness. Specifically, they were asked to rate their day respite service on these eight key features –

- its *flexibility* in adapting to their needs, and to the needs of care recipients,
- the *appropriateness* of the service for the needs of carers and care recipients,
- the *quality of the care* and support provided to carers and care recipients,
- the provision of a *safe* environment for care recipients,
- the degree to which *sufficient staff* were being employed.

Comparative analysis showed that there were strong levels of agreement (expressed in average ratings of 4.4 to 4.7, where the lowest possible rating was 1 and the highest possible rating was 5) that all but one of these features was being achieved. The only exception to this trend related to the lowest rating given by all three groups regarding the *appropriateness of care worker to service user ratios*. **Given the survey has identified from staff that individualised care, rated as a key success factor for day respite, is dependent on an appropriate care worker to care recipient ratio this can be interpreted as an area of concern.**

Carers surveyed have provided positive ratings of the quality of day respite services they received. However, their ratings while high (average 4.6) were slightly **lower** than those of care workers and care coordinators (average 4.7) in assessing the quality of care provided to care recipients. They were significantly less positive ($p<.05$) in rating the *quality of support offered to carers* (4.4 as opposed to 4.6). **This then is an area in which DDR services can seek improvement.**

Managing cultural diversity

Although carers surveyed gave very positive ratings (average 4.6) about their DDR service's ability to meet their language and cultural needs, day respite staff in culturally generic DDR services were much less positive in rating their services' capacity to provide culturally appropriate services for Indigenous and for CALD background people, and for providing sufficient training and development opportunities to care workers. *These findings suggest areas for potential improvement by services not offering a program with a specific cultural focus.* The evaluators understand the pressures faced by day respite services in stretching finite resources, but note that investment in cross cultural awareness raising and the management of cultural diversity (for those services that are not culturally-specific) brings expertise that has generic relevance in service delivery - for example, an enhanced capacity to individualise care according to specific need.

Referrals

Of the 308 new referrals received by day respite projects during the period July-December 2009, only 23 (7.5%) did not meet the eligibility criteria for the project to which they applied – indicating that the projects had been promoted effectively and referral sources had been informed accurately. The final Site Data Collection in 2010 found that targeted promotion by DDR sites was thought to have led to increased awareness among local health care providers and increased word-of-mouth based information about the DDR services in the local community.

Almost half of all projects reported being unable to offer respite involving care recipients with *high-level care needs* (i.e. requiring two staff), and more than a third of projects were unable to offer respite for care recipients with *high-level challenging behaviours,* that is, abusive, intrusive or inappropriate behaviours – see the Site Data Reports. **Given the impact of these behaviours on carers, and their intensified need for respite and support, it is of concern that so many DDR projects are excluding people with such complex needs.** Reasons given for the inability to accommodate such clients included – insufficient staff resources (i.e. unable to provide the one-on-one support required), lack of staff with skills to manage challenging behaviours, and inappropriate physical infrastructure such as the lack of a secure facility.

All projects cited *community programs or services* as a source of referrals, indicating that this is probably the primary referral source for the day respite program as a whole. Most projects also received referrals from *health professionals* other than GPs and *self-referrals* from Carers. Hospitals were the fourth most common source of referrals, followed by an aged care facility and GPs. Interestingly, Commonwealth Carer Respite and Carelink Centres were identified by relatively few sites, despite playing a key role in linking carers to respite and other support services. This may be due to residential care staff being unaware of these services (which would be more familiar to those in the community aged care sector), or the Carer Respite and Carelink Centres not being aware of the DDR services, or both. A reconciliation was undertaken with the Commonwealth Respite and Carelink Centres database and this showed that 11 of the DDR projects were not recorded on the service directory data base.[4]

Assessments, Care Plans and Reviews

Analysis of detailed Site Data for the period July-December 2009 (see **Accompanying Report 7**) showed that the median time between referral and the completion of the assessment process was 7.0 days, with 15.2% of care recipients assessed on the same day that they were referred. Changes to assessment processes had occurred during 2010 at less a third of the sites, and these changes had mostly involved undertaking a more detailed assessment of the care recipient in relation to their health and medical status, behavioural profile, social needs and activity preferences. Some sites reported making changes that involved an increased focus on the needs of the carer, for example, their goals for respite and providing additional information about available services and resources at the time of assessment - refer to **Accompanying Report 8** for further details**.**

According to the Site Data for July-December 2009, a *Care Plan* had been prepared for 92% of clients. Of those who did *not* appear to have a care plan, the majority had only recently been referred to the service and had not yet received any respite. However, around 3% of care recipients spread across seven projects appeared to be without a care plan despite having received at least one day respite service.

[4] The evaluators are very appreciative of the assistance provided by Ms Kerry Fischbein, Assistant Director, Carer Programs, Community Programs and Carer Branch, Department of Health and Ageing.

Three quarters (74.5%) of care recipients had their first care plan prepared on or before the date of their *first service,* whereas one quarter had begun attending the service *before a care plan had been prepared*. The latter may in fact be an effective approach in cases where observation of the care recipient in the day respite context would assist in the development of their care plan, assuming that any risk factors had already been identified during the initial assessment process.

Around two thirds of care recipients with care plans had had those care plans *reviewed* at some time during their involvement with the day respite service. It appears that reviewing care plans every 3 months or so is a common practice, with 89% of care plans being reviewed within three months of the client's most recent service.

Final Site Data Analysis identified changes to care planning processes at around half of the sites, mainly involving a broadening of the scope of Care Plans to provide a more comprehensive view of both carer and care recipient goals and needs – see **Accompanying Report 8.**

Staffing

According to Site Data submitted regarding the staffing of the DDR services, the total FTE for most projects was split across many individual staff members which indicates that the majority of day respite staff were not employed full-time. Total FTE at each site ranged from 1.2 FTE at *Stepping Out* to 11.4 FTE at *Garden City* – with these two extremes corresponding to their operating hours.

Across all projects, for every FTE day respite staff member (regardless of role) there were on average 7.7 day respite places used per week. In terms of staff providing direct care to care recipients, there was on average **one direct care staff member per 12 places**.

However, within this range there was substantial variation in the ratio of FTE staff to the number of respite places used per week, perhaps reflecting operational characteristics such as the specialist focus of each service. For example, a service such as *Garden City,* which specialises in frail elderly care recipients with dementia, operated with only 3.7 care recipient places per direct care staff member, whereas a service specialising in younger clients such as *Bethavon* was able to operate with 23.3 care recipient places per staff member.

Sharing of staff

Sharing of resources between the RACF's other programs and the day respite services was evident in relation to staffing. Site Data show that many day respite staff members were also employed part time by other areas of their organisation. Almost half **(49%)** of all day respite staff also worked in their RACF's *Residential care* service.

This means that staff are being exposed to a wider than normal range of work experience, which can be seen as beneficial for them and therefore, for their clients. (This was also the view of staff surveyed by the evaluators in our surveys of carers, care workers, care coordinators and service directors.)

This practice varied greatly between project sites, from services where all day respite staff worked also in residential care through to projects where none of the day respite staff worked in residential care.

Days and Hours of operation

Across the sites significant diversity was evident in operating days and hours (as reported in the first Site Data Collection, with respect to the end of 2009), from smaller services with few operating days and relatively short operating hours such as *Stepping Out* in Melbourne (open for 8 hours per day on two weekdays only), through to large services such as *Garden City* in Brisbane which operates 7 days per week for 13 hours per day. Twelve projects reported that they were operating on exactly the same days/hours of which they were funded, whereas the actual operating hours of the other projects varied from their funded operating hours in a number of different ways, indicating that demand levels had not been accurately forecast.

DDR services were being provided on weekends[5] –

- On both weekend days at 7 sites
- On one weekend day at 10 sites
- Not at all at 12 sites.

The final Site Data Collection showed that the majority of sites (74.2%) had not changed their operating days or hours during 2010, and of those who did report change, all but one had increased their hours or days in response to changing client needs.

Although carers have been very positive in their ratings of DDR services, where unmet need was expressed through open-ended feedback, the most commonly cited area of unmet need related to accessibility outside of normal working hours. While the evaluators realise that service providers face challenges in providing these hours if demand is not sufficient to achieve viability, the impact on those carers needing this support is substantial.

Activities provided

DDR services are offering the range of activities to be expected in a day respite program (e.g. arts and crafts, games, music, physical activities), with some going beyond this to offer significantly different activities.

The initial Site Data analysis showed that over three quarters of the time spent in day respite across all projects involved some kind of activity, with the three activities involving the most time being games, exercise/physical activity and arts and crafts. Not surprisingly, the *proportion* of time spent engaged in organised activities varied greatly across projects, depending on specialist focus. The service model has the capacity to provide a wider range of activities for care recipients relative to most day respite services and is beneficial for RACF residents because of their ability to participate in day respite activities.

The final Site Data Collection found that 71% of sites reported changes in 2010 to the types of activities offered to care recipients, with many identifying a *broadening of activities.* Some sites had also focused on developing activity menus that were more appropriate for particular groups of clients while others had designed activities to increase care recipients' engagement with the local community.

[5] Two sites did not provide this information.

Additional services

Survey feedback from carers and care providers indicates that more activities than would otherwise be available in a day respite service are being provided, drawing on the programs and resources of the RACF, and the specialist focus of some DDR sites (eg healthy ageing). Site Data analysis shows that all projects gave day respite clients access to some type of additional service provided by the RACF. These involved –

- nursing services and referral to other RACF health and support services (93.1% of sites)
- use of residential respite (89.7% of sites)
- allied health services (82.8% of sites)
- health monitoring (75.9% of sites)
- hygiene services (72.4% of sites)
- medical services (51.7% of sites).

These represent value-add services that would not normally be accessible in community-delivered day respite care.

In 2010 thirteen of the 31 sites reported changing the *range of services* offered. Changes focused on *carers* included an increase in carer education and referral services, a streamlining of respite booking systems, the introduction of overnight respite and the provision of personal care services. New services for *care recipients* offered by some sites included occupational therapy, art therapy and music therapy.

Transport

The research literature is clear in finding that transport plays a key role in making day respite services accessible. For some carers, the time required to transport the person in their care to and from day respite may add to their burden and provide a disincentive to participate. Findings from the evaluation surveys and case studies reinforce the predominant literature view, confirming that transport is a critical success factor for the DDR service model.

According to the most recent Site Data Collection (2010), only three projects do not currently offer any type of transport to their care recipients. It was evident from the different approaches to transport that services are tailoring their transport to user need, and to local conditions.

Transport costs tended to be subsidised by the day respite service to minimise any financial burden on clients. Site Data collected for the period July-December 2009 showed that almost half of all projects which offered transport reported that this was *free* for all clients, while two projects sought donations for transport and the remainder charged a set fee. Fees charged for both-way transport ranged from $2 to $8, with the **average fee being $4.77**. Fees for one-way transport ranged from $2 to $5, with an average fee of $2.80.

It was evident from the Surveys and the Site Data Collections (see **Accompanying Reports 4, 7 and 8**) that services are tailoring their transport provision to user need, and to local conditions. Transport costs tended to be subsidised by the day respite service to minimise any financial burden on clients, however some sites have experienced difficulty in meeting the demand for transport.

Final Site Data Analysis found that during 2010, a third of sites reported a change in their transport service that in most cases involved additional servicing in response to increased demand. Sites also indicated that meeting transport demand is an ongoing challenge. Only two sites reported a change in

transport fees during 2010, while all other sites that charged a fee had kept these fees at the same level – see **Accompanying Report 8.**

Accessibility of DDR services

Findings from the analysis of site data and SAR reports, and from surveys with carers, care workers, care coordinators and service managers, indicate that DDR services are paying attention to accessibility issues on a number of issues.

- Services are financially accessible, with user financial means being taken into account and a low level of fee being charged for day respite services, including for transport.
- The provision of transport by almost all services has been a critical success factor in enabling carers to support the person in their care participating in DDR services. The means-tested cost of transport services reinforces their accessibility.
- Location has also been addressed with the higher than normal representation in inner regional, remote and very remote areas. The barriers faced by carers living in such locations will have been reduced or removed by this strategic placement of DDR services.
- The outcomes from the perspective of cultural accessibility are mixed. A number of services are either Indigenous-specific or culture-specific, and for these communities, DDR services are extremely accessible. However, survey feedback indicates that for culturally generic services, staff training and experience in working inclusively with people from Indigenous backgrounds, or from culturally and linguistically diverse (CALD) backgrounds, will need further development.
- Accessibility for carers of people with dementia appears to have been addressed by the many DDR services identifying this as a specific focus, and by some specialising in these services. However, the existence of challenging behaviours has been identified as a reason for exclusion and from this perspective, DDR services can be considered to be largely inaccessible.
- Employed carers are a special need group and few DDR services offer specialist services for them. A major need will be hours of operation that support carers' employment. Hours of opening varied significantly across projects so it is difficult to draw a conclusion about their accessibility on this dimension. However, a relatively small proportion of carers are dissatisfied with DDR services' hours of opening.
- The RACF location of DDR services can be a barrier for some carers and care recipients. However, in most cases this has acted as an initial deterrent only, and in reducing fears about residential care, has provided a bridge that smooths entry to permanent care if and when this becomes necessary.
- Finally, DDR services should link carers to a range of other services, and this appears to be an area requiring further investment, including linkage to Commonwealth Carer Resource Centres and Carelink. Without this linkage, DDR carers may be missing access to a range of community based respite services and support. However, the final Site Data Analysis findings showed that during 2010 some sites had actively fostered greater linkage with these Centres – see **Accompanying Report 8.**

Complaints about DDR services

All Care Coordinators and Service Directors who responded to our survey indicated that there was a formal complaints mechanism in place for their DDR service, as would be expected and the majority of RACFs indicated that no formal complaints had been made to date.

Thirteen carers (4.4% of those surveyed) reported that they had felt the need to make a complaint about their DDR service, only four of whom stated that the process for making a complaint was made clear to them. These carers came from eleven different sites, and related to –

- Reduced resourcing as the program has increased its numbers
- Resourcing that restricts services, particularly, transport and the range of activities available
- Failure to maintain continuity of care workers
- Billing processes
- Failure to provide after hours' access
- Poor quality of care.

These findings are consistent with those arising from the analysis of SAR data. The evaluators analysed four items from the complaints section of the SAR which are not normally entered into the Department's spreadsheet, extracting information from the paper forms for 2008/09 and 2009/10. This showed that:

- In *2008/09* there were **42** complaints recorded, 28 (66.7%) of which related to systemic issues. Of these, 16 (57.1%) were resolved.
- In *2009/10* there were **41** complaints recorded, 19 (46.3%) of which related to systemic issues (a reduction from the previous 12 months). Of these, 10 (52.6%) were resolved.
- Overall, in terms of the number of carers and care recipients involved with the program, the number of complaints is quite low – equivalent to **less than 3 complaints per 100 carers/care recipients** who used DDR services.

The complaints most commonly reported by the projects involved:

- Transport issues;
- Lack of availability of weekend or overnight respite, or limited availability of respite for care recipients with high care needs;
- Meals;
- Facilities (e.g. parking, toilet facilities, telephone system, entrance); and
- Fees.

The information provided by the projects indicated that almost all of the complaints made regarding transport, meals, facilities and fees had been resolved, commonly through changing the underlying procedures, processes, equipment or physical environs involved. The area where it was most difficult for the projects to effect change involved requests for respite at particular times of the day or week, and for particular types of care recipient such as those with high care needs. However a number of projects did respond to those requests by changing their hours of operation and/or staffing.

Findings relating to the Effectiveness of the DDR model

Guiding Evaluation Question

*What have been the **benefits** to carer and care recipients accessing DDR services?*

Effectiveness concerns the extent to which the program's objectives are being achieved, or are expected to be achieved, and the benefits for its participants.

Respite-related benefits and outcomes

Carers have provided very high survey ratings (out of a maximum 5 points) for the following benefits of DDR services –

⇒ Provision of a break or 'time out' (average rating 4.4)
⇒ Provision of time for carers to fulfil other responsibilities (4.4)
⇒ Provision of increased socialisation opportunities for care recipients (4.5)
⇒ Provision of opportunities for care recipients to participate in activities helpful to their condition (4.5)
⇒ Delaying of the need to place the care recipient in full time care (4.1).

And to a lesser extent -
⇒ Provision of more time for carers to work (3.8).

Open-ended feedback from carers further supports these ratings.

> *'Without the help I received, I wouldn't have been able to carry on.'*

> *'It is something that is needed for carers as you know that they are safe and in good hands and you get a chance to do a lot of things that take a fair bit of time.'*

Health and wellbeing related benefits and outcomes

The survey profile of DDR carer health and wellbeing highlights the importance of day respite services being able to deliver health-related benefits for carers. From the carer perspective, their participation in the program has -

➢ reduced their stress (4.3)
➢ reduced worrying about care recipient (4.3)
➢ had a positive impact on their mental health (4.3)
➢ provided more time to address own health issues (4.1)

And to a lesser extent -
➢ improved their health and wellbeing (3.9).

Survey feedback from care workers and care coordinators supports these findings. Care workers and care coordinators also rate highly the program's –

➢ provision of effective ongoing support to carers (4.5 and 4.6 respectively).

> *'It has reduced the stress I was feeling immensely and given me a greatly needed break. I can relax knowing Mum is in good care and having a good time. (carer)*

Service access and usage benefits and outcomes

A potential benefit of the DDR service model lies in the capacity to make carers more aware of, and more linked to other services that can support them, or the person in their care. Carers were less positive than the two groups of service provider stakeholders in rating the program on its service access and usage related benefits. However, their survey ratings confirm the DDR services' provision of these benefits -

- Made carers more aware and informed about residential aged care (4.1)
- Made carers more aware of other services for them or for care recipients (4.1)
- Made carers more confident about using respite in a residential setting (4.2)
- Made it easier for carers to access other services for them or for care recipients (4.0)

And to a lesser extent –

- Linked carers to other services for them or for care recipients (3.7).

As linkage to other services is a key requirement of NRCP funding, this is an area requiring attention. In particular, a close collaboration between DDR services and the network of regional Commonwealth Carer Respite Centres is required. This will link carers to emergency or unplanned short-term respite access, ensuring their access to a range of respite services to meet changing or diverse needs.

Care workers and coordinators also identify the benefit of –

- making it easier for carers to access respite services offered elsewhere (4.3).

Benefits and outcomes for care recipients

Extensive literature reviews have found no reliable experimental evidence that respite care provides significant short or long term benefits to care recipients (Arksey *et al*, 2004) or that it adversely affects them (Mason *et al*, 2007), regardless of respite care model – see **Accompanying Report 1** for further details. Nevertheless, Carers, Care Workers and Care Coordinators surveyed for the evaluation have identified benefits relating to the DDR services' social impact on care recipients, but less so in relation to improving physical or cognitive functioning.

Carers have given very positive ratings to the achievement of –

- The opportunity for increased socialisation (average rating 4.5)
- The opportunity to participate in activities (4.3)
- Improved social functioning of care recipients (4.1)
- Delaying the need for care recipients to enter full time residential care (4.1).

> *'Activities have been so beneficial. Within a couple of weeks of attending my mum is a lot happier, eating properly and giving her something to talk about. Been Brilliant.'*

Benefits and outcomes for RACF residents

Benefits have been identified for RACF residents, which is a less expected finding. *Unintended* positive effects of the program identified by care workers, care coordinators and service directors cited benefits for residents that include –

- A wider range of activities to access and
- Increased socialisation opportunities through their interaction with DDR care recipients.

The positive impact of new infrastructure and related resources will also be benefitting residents in some facilities, and less directly, residents can be expected to benefit from the increased learning and training opportunities available to staff.

Unintended positive outcomes

Guiding Evaluation Question

*What have been the **unintended effects** of the Initiative, including any adverse consequences for carer/recipient?*

Across all four stakeholder groups surveyed there was a pronounced trend to identify significantly more positive than negative unexpected outcomes. These involve six types of benefit –

- **Improvements in the care recipient's condition** (identified by all four stakeholder groups)
- **Improvements for carers** - more informed about aged care services, making new friends, becoming less socially isolated, less stressed, having more time, able to be in paid work, improved confidence to use respite services (identified by all four stakeholder groups)
- **Facilitation of the transition from community care to residential care** when this is needed, in part due to **demystifying** the residential care environment (identified by all four stakeholder groups)
- **Benefits for the RACF** – improved service networking and profile with other services, enhanced public image through reduced stigmatization of residential provision, cross-fertilisation of resources; enhanced physical infrastructure, staff have wider range of training etc (all three service provider groups)
- **Benefits for residents** – wider range of activities to access, wider socialisation opportunities through interaction with DDR service (all three service provider groups)
- **Flexibility** and **quality** of services provided; receiving services not expected eg health monitoring (identified by carers only).

Unintended negative outcomes

The following unexpected negative effects were identified by one stakeholder group each – either carers, or care workers.

- **Dissatisfaction with fees** charged or inefficient billing processes (carers only)
- **Dissatisfaction with the standard of care** provided (carers only)
- **Anxiety about relinquishing care** during the respite period (carers only)
- **Initially negative behavior by RACF community care staff** due to lack of understanding of DDR service and its relationship to RACF community services (care workers only)
- **Difficulties arising from co-location with a RACF**, in particular, possible cross-infection risks (care workers only)
- Challenges associated with **providing individualised and quality care for consumers with high or complex need** (care workers only).

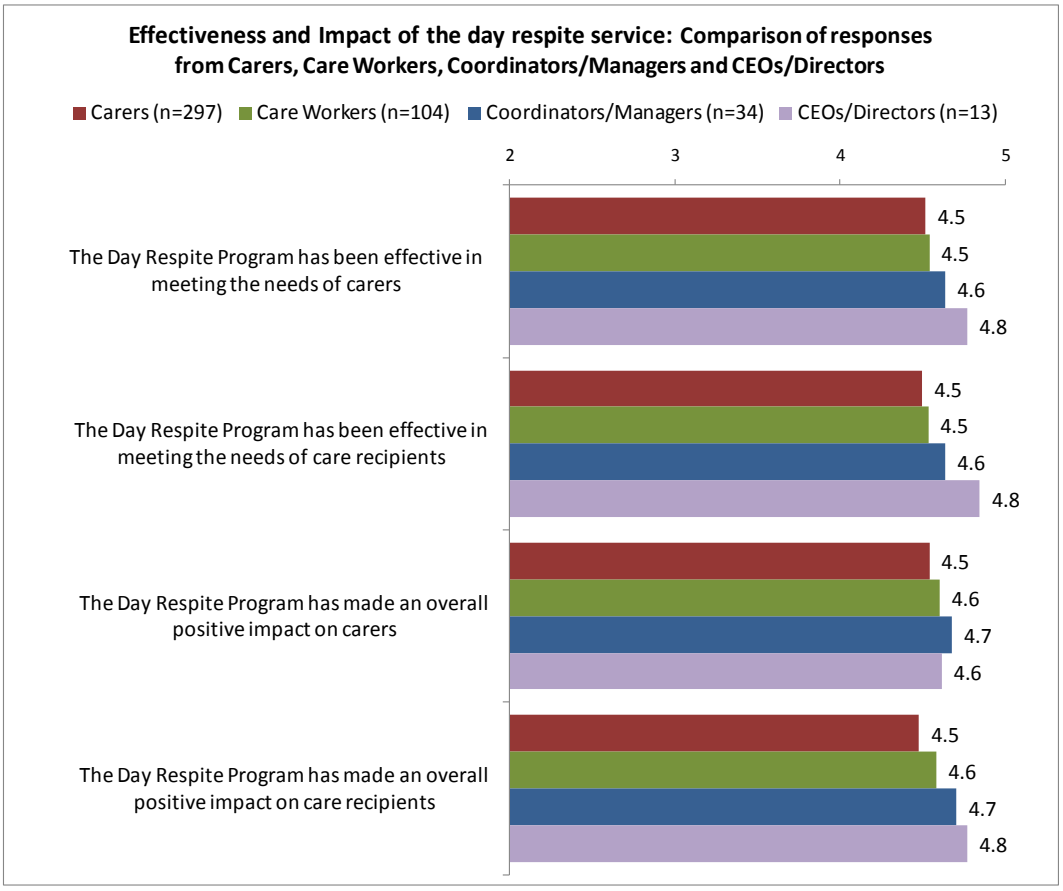
It can be seen that carers' unexpected negative effects of the DDR service were quite different from those of care providing staff and managers, with the exception of concerns about resourcing.

Rating the overall effectiveness and impact of DDR services

All four stakeholder groups surveyed were asked to provide overall ratings for the (a) effectiveness and (b) impact of the program and these were remarkably consistent across all four groups surveyed indicating strong and positively directed agreement about the Program outcomes for both carers and care recipients.

However, Carers have been consistently less positive in comparison to staff and managers, in line with the findings of other comparative analyses undertaken for the evaluation. They have provided average ratings of **4.5** for both the effectiveness and impact of DDR services. While these are very positive, those of Care Workers are slightly higher (4.5 and 4.6), those of Care Coordinators are higher again (4.6 and 4.7) and those of Service Directors are the highest (4.6 and 4.8). Carers' ratings of the effectiveness and impact of DDR services also varied significantly across sites – as the Figure below demonstrates.

Comparative ratings of effectiveness and impact of DDR services on carers and care recipients



Impact of providing DDR services on participating RACFs

Guiding Evaluation Question

*What have been the effects of providing DDR services on the **operations** of residential aged care facilities in providing care to full time residents?*

The provision of DDR funded day respite services has had a number of impacts on participating RACFs, and in large part, these have been positive in nature. The four key impacts identified concern -

i. **Physical infrastructure** - improvements to the physical infrastructure funded by the day respite service, either in developing new buildings or renovating existing buildings, have been of benefit to the organisation as a whole. These offer new opportunities for service delivery while being critical to the effectiveness of the DDR service.
ii. **Staffing** - the impact of the DDR Initiative on the staff of participating RACFs has been mixed but in the longer term brings benefits for most (depending on how effectively the integration of the day respite service is managed and staff are supported in this process). The sharing of staff between the respite and residential services was often reported as leading to healthy cross-fertilisation and exchange of ideas across program areas. It also means that staff are being exposed to a wider than normal range of work experience and service users and able to benefit from broader learning opportunities (for example, through shared training programs). This can be seen as beneficial for them and therefore, for their clients.
iii. **Resource usage** – it was common for day respite service providers to report significant economies of scale due to sharing and consolidating resources with their auspicing RACF. Such vertical integration is described as bringing financial benefits from resource sharing, and service delivery benefits arising from shared staffing, rostering and training arrangements and the development of common social and recreational programs. This was usually regarded as **adding value** – for both the RACF and the day respite service and clients of both programs.
iv. **Service networks** – as discussed, the impact on RACF service networks was variable, and would have been influenced by pre-existing service provision range and therefore, networks with other providers. Impact appears to have varied according to the work role of staff and managers.

In addition, DDR services have been found to bring benefits for RACF residents through increased socialisation and access to a wider range of activities – as discussed earlier.

Some case study sites, and some of those surveyed, reported initial resistance by RACF staff to the presence of the day respite service, particularly when co-location and sharing of resources was involved. However, over time, and as communication and other processes were streamlined, there was also a trend for increasing acceptance. Many sites reported a smooth transition from implementation of the day respite service to ongoing collaboration between RACF and respite staff.

Findings relating to the Efficiency of the DDR model

Efficiency is concerned with how economically resources have been utilised, and how inputs (funds, expertise, time, etc.) are converted to results or outputs. The evaluation has collected information about staffing levels and usage (both DDR funded and unfunded) and staff : client ratios, as key *input* factors and taken as *results* quantifiable information about hours and days of respite received, management of demand levels, carer satisfaction with outcomes and whether or not projects are in deficit or surplus. In addition, evidence of economies of scale and value-adding have been identified as an indicator of effective and efficient use of resources.

However, it should also be noted that is difficult to determine precisely the cost effectiveness of the DDR Initiative as a whole as there are a range of variables to take into account. Relevant variables include location (the more remote the higher many costs will be and the greater will be the difficulty of achieving economies of scale), the level of care provided, the needs of care recipients (for example, those with

dementia will require significantly more support), facility size and the capacity to achieve synergies in resource usage. Furthermore, with new initiatives there will be start up costs that will reduce over time.

Inputs

The DDR services have been able to achieve economies of scale by sharing staff-related and service provision-related resources. In addition, the RACFs have benefitted from the infrastructure provided through the DDR Initiative, with service users also gaining from the enhanced service provision made possible by building design and renovation. During 2010, 42% of sites reported that they were continuing to receive additional infrastructure support to better meet the needs of high care recipients (refer to Final Site Data Analysis in **Accompanying Report 8**).

Sharing of staff across programs is also exposing staff to wider learning opportunities, and residents as well as care recipients can be expected to benefit from this. In addition, DDR clients are likely to benefit from the value-add of access to services available in the RACF. The two most commonly cited services were nursing services and referral to other RACF health and support services (27 sites), followed by use of residential respite (26 sites), RACF allied health services (24 sites), health monitoring (22 sites) and hygiene services (21 sites).

Across all projects, for every FTE day respite staff member (regardless of role) there were on average 7.7 day respite places used per week. In terms of staff providing direct care to care recipients, there was on average one direct care staff member per 12 places. However, within this range there was substantial variation perhaps reflecting operational characteristics such as the specialist focus of each service and the implications of that focus on staff : care recipient ratios.

In addition, 23 projects indicated that operating their DDR service involved the use of additional unfunded staffing from the RACF. Most commonly, this involved *Managers, Nursing staff*, particularly RNs, and *Domestic staff*. In terms of *time*, the greatest unfunded contributions came from *Care/Support Workers*, *Domestic staff* and *Managers*. While this has entailed a small amount of time per week per site, when considered across the DDR program as a whole it represented the equivalent of over **30** full time staff per week (30.5 FTE) in total, an average of **1.1 full time staff member per project.** This is not necessarily an efficiency indicator for individual projects, but from a program perspective is a further value-add for overall respite resource provision. The trend to receive unfunded support in the form of input from RACF staff was found to have continued during 2010, based on reporting for the final Site Data Analysis (**Accompanying Report 8**.)

Outputs

According to SAR data, the *number of care recipients assisted by DDR services* increased **14.6%** from 1,246 in 2008/09 to 1,428 in 2009/10, and the *number of carers using the DDR service* had increased by **13.1%** from 1,262 in 2008/09 to 1,427 in 2009/10 (refer to **Accompanying Report 9**)[6]. If each of those carers used the service once per week (as is the average indicated by data from the first Site Data Collection), this would mean that the original Budget estimate for the DDR Initiative quoted by the Department, which estimated that the measure would help carers of frail older people at a rate of 1,200 per week, had been met.

[6] Note that activity data for 2007/08 was deemed too unreliable to be included in final reporting.

The *total number of hours of respite delivered per annum* had increased **33.8%** from 252,788 hours in 2008/09 to 338,302 hours in 2009/10, partly due to ongoing growth in service delivery and partly due to delays in commencement of the service at some sites.

The *number of respite hours delivered per annum per carer* (i.e. the total number of hours delivered divided by total number of carers) increased from 200 hours in 2008/09 to 237 hours in 2009/10, an increase of **18.5%.** This equates to an average of 3.9 hours per carer per week in 2008/09 and 4.6 hours per carer per week in 2009/10. However it should be noted that there can be a very broad range of service use patterns, with some carers using the day respite service only occasionally, others using it weekly, and others using it up to 7 days per week. Therefore a slightly different picture of the average number of hours delivered per carer will be generated when using data based on *individual care recipients*, as was collected for the period July-December 2009 (see *Accompanying Report 7*). Statistics calculated using this data showed that the average (mean) number of hours that each care recipient attended day respite during that period was just over 6 hours per week, higher than the figure based on SARs data, due to the very high usage of care recipients at some services (e.g. 7 days per week).

DEMAND AND UNMET NEED

Demand for DDR services in RACFs

Guiding Evaluation Question

*What have been the levels of **demand** for DDR services?*

In reviewing demand levels, the evaluators extracted additional data from hardcopy SAR forms pertaining to the number of hours of respite funded (rather than hours actually delivered) and the reasons given by projects for any difference between the hours funded and hours actually delivered. Those data items are not normally entered into the Department's spreadsheets. The difference between the number of *funded respite hours* and the *number of respite hours actually delivered* can be seen as a measure of unused (or over-used) capacity in a service. An indicator of unused/overused capacity was defined as the proportion of funded respite hours that were actually delivered, i.e. calculated as *hours delivered as a proportion of hours funded*.

For the program as a whole, the proportion of funded hours that were actually delivered rose from 38% in 2008/09 to 51% in 2009/10. **This suggests that while the number of respite hours delivered increased by about a third between 2008/09 and 2009/10, it appears that around *49%* of the stated capacity is still unused and therefore there is scope for substantial growth in the program** (see *Section 3.3* of **Accompanying Report 9**).

These findings are further explained by information from the Site Data Collections which indicated that in an attempt to better meet *actual demand*, more than half of the projects had changed their operating days/hours from those originally proposed, and that these variations had mostly continued through 2010. Reasons given indicated that demand levels had not been accurately forecast prior to opening the service. This issue was also acknowledged by many sites when giving reasons in their SARs for significant variations between their funded respite hours and the actual respite hours delivered.

It is also important to note that almost all of the individual projects, including two of the projects identified as showing the greatest underuse, did demonstrate growth between 2008/09 and 2009/10 in terms of the proportion of funded hours that they actually delivered. While many projects clearly faced

unexpected challenges in establishing and running their service, it appears that over time these issues are being addressed.

Demand is also reflected in *vacancy rates* (ie the average number of vacant places per week as a percentage of the average number of places offered per week, as collected in the first Site Data Collection), and *waiting lists* (collected by the SARs). These showed that –

- The *vacancy rate* varied greatly across projects – ranging from a high of 67.0% to zero vacancies (i.e. operating at capacity). The overall vacancy rate during the period July-December 2009 was 32%, representing over 400 vacant places per week in total. Furthermore, 81% of these vacancies were mainly due to lack of demand. This information raises concerns about methods used to determine demand levels.
- At 30 June 2009 there were only 28 carers on *waiting lists* for the program as a whole. By 30 June 2010 this had more than doubled to 67 carers – an increase of 139.3%. Only six projects reported a waiting list at 30 June 2009, however at 30 June 2010 ten projects had a waiting list. As the DDR services become more established it can be expected that waiting lists will increase and these rates need to be plotted over time.

It was not possible to benchmark these rates against other NRCP funded day respite services due to a lack of available comparable data.

In order to accurately assess which services had the greatest *unmet need*, the SAR data on waiting lists was combined with the SAR data on service capacity (see Accompanying Report 9). In 2009/10 six projects were delivering 100% or more of the respite hours for which they had been funded, *and* had a waiting list, indicating clear unmet need for those services. Other projects with a waiting list in 2009/10 had delivered less than 70% of their funded respite hours, which reflected situations where the particular days or times requested by carers were unavailable rather than overall lack of capacity.

For those projects where unmet need is clearly evident, should ongoing funding be sought, it would be important to identify other day respite services in or near the same location as part of the process of determining the most efficient way to meet demand.

Costs of delivering DDR services in RACFs

Guiding Evaluation Question

*What have been the **costs** of delivering DDR services?*

As the literature review indicated (see **Accompanying Report 1**), there is little consensus among researchers about the variables required to measure the cost-effectiveness of respite care services (Carers Australia, 2007: 20). Determining the range of variables that can be taken into account when determining the costs of respite is an inexact science, and setting the boundaries for inclusion and exclusion is difficult. Should it, for example, include the costs to government of medical care for carer stress or ill health arising from their caregiving role? Should it include the taxes lost when carers must leave the paid workforce in order to provide care? (Keefe & Manning, 2005: 8).

It is difficult to determine the cost effectiveness of the DDR Initiative as a whole, as there are a range of variables to take into account. Relevant variables include location (the more remote the higher many costs will be and the greater will be the difficulty of achieving economies of scale), the level of care

provided, the needs of care recipients (for example, those with dementia will require significantly more support), facility size and the capacity to achieve synergies in resource usage.

The *cost (expenditure) per hour of respite funded,* the *cost per hour of respite actually delivered* and the *cost per carer* was calculated for the Demonstration Day Respite program as a whole and for individual projects, by combining data from Service Activity Reports (SARs) with expenditure data from the Financial Accountability Reports (FARs). A summary of that information is presented below – refer to *Section 5.4* of this report, and **Accompanying Report 10**, for further details.

The *cost per hour of respite delivered* for the program as a whole appears to have decreased over the last two financial years, from $35.75 in 2008/09 to $30.37 in 2009/10. There is significant potential for DDR service delivery costs to decrease over time to towards equivalence with the cost of DDR hours *funded* ($16.92 in 2009/10).

The annual *cost of respite delivered per carer* had remained steady at around $7,000 – $7,161 in 2008/09 and $6,940 in 2009/10.

Revenue, expenditure and surplus

According to FAR data for the year **2008/09** for the 30 DDR Pilot projects the *total revenue (income)* was $9.79m and the *total expenditure* was $9.04m, leaving a *surplus* of $0.75m. Based on the 27 projects for which 2009/10 data was available, it appears that the total revenue and total expenditure will be slightly higher in 2009/10 compared with 2008/09, however, the surplus is likely to be of similar magnitude. The surplus for 2008/09 was modest, representing 7.7% of total revenue that year. This can be seen as an indicator of efficient use of resources. Apart from avoiding a deficit situation, a modest surplus as opposed to a significant surplus, indicates a maximising of available resources to meet consumer need.

In 2008/09 eighteen of the 30 DDR projects reported a surplus and the remaining twelve reported a deficit. Averaged over all 30 projects, the average surplus/deficit was **$24,964.** In 2009/10, 16 of the 27 DDR projects which supplied FAR data reported a surplus, one project reported an even balance ($0) and 10 reported a deficit. The average surplus/deficit for these 27 projects was **$14,021**.

The total revenue reported for the program in each financial year mainly comprised operational revenue – 84% of total revenue. The remainder included the surplus retained from the previous financial year (12% of total revenue in 2008/09 and 10% of total revenue in 2009/10), fees collected from users of the service (3% in 2008/09 and 5% in 2009/10), and other revenue including small amounts of interest received on government funds (less than 1% of total revenue).

The total expenditure reported for the program in each financial year mainly comprised direct costs – 75% of total expenditure in 2008/09 and 71% of total expenditure in 2009/10 – the remainder being indirect costs.

Appropriate levels of user fees for DDR services

Guiding Evaluation Question

*What have been the levels of **user fees** for DDR services and how efficiently and appropriately have these been applied?*

The DDR sites are clearly taking into account financial need in the fees or donations being charged, and in some cases, waiving these altogether. The first Site Data Collection revealed that the majority **(89.7%)** of DDR clients were charged a small *fee*, with the average set fee for a day respite attendance being **$12.60.** Some paid *donations in lieu of fees* (5.2%), and n*o fee* was charged for **5.1%** of all clients, spread across 16 projects. Sites are also heavily subsidising the costs of transport (see *Section 3.8.3*).

A *care package* was specified as the source of the fees/donations for 12.3% of care recipients indicating that these individuals were already part of the aged care service system, for which an assessment of ability to pay fees would have also been made.

It is therefore unlikely that fees paid by users will cover the costs of delivering DDR services – funding provided to sites as pilot projects will have been critical to meeting those costs. Any contribution to service delivery costs by fees will have been minimal rather than significant, as demonstrated by the proportion of total revenue accounted for by fees collected from users of the service (3% of total revenue in 2008/09 and 5% of total revenue in 2009/10) – see Section 5.4.2.

Our feedback from interviews and surveys with care coordinators and service directors indicates that consultation has occurred between sites and carers, and that fees being charged are likely to be appropriate and reflect capacity to pay. This means that appropriate means testing has taken place, and this applies to both service fees as well as transport fees (see Section 3.8.3). Survey feedback from carers indicates that they are satisfied with current fee rates (see Section 4.3) and open ended feedback from them provided only a few instances of specific dissatisfaction with fees.

Future funding options

Guiding Evaluation Question

*What are the appropriate **options for future funding** of this type of respite?*

Case study findings reported most of the 13 sites studied to be financially viable due to the grant-based nature of funding, but unable to survive on user pays funding. FAR and SAR data analysis confirm that services are operating with a modest surplus, as discussed.

The grants based funding provided for the DDR pilots has been effective not only in meeting service costs but for a number of other reasons –

- ⇒ Its four year timeframe, as opposed to a one year timeframe, has enabled issues associated with service establishment to be addressed and lessons learned from the path-finding nature of these pilots to be identified and absorbed.
- ⇒ The long timeframe has also supported services to be *innovative* and *flexible*, which would have been far less likely if funding had been provided on an annual basis.
- ⇒ It is very important for carers and care recipients to have a guarantee of service continuation.

  At the same time, the provision of a service for four years will have raised expectations among service users of the continuation of DDR services and if the Program is not continued or absorbed into the NRCP, the negative impact on them will be significant (based on the positive feedback that the evaluation has identified).

There is inconclusive evidence about whether the amount of funding provided has inhibited or enhanced the services provided. However, it is more likely that the guarantee of four years of funding support has been deemed by providers to be worth investing RACF time and resources in developing DDR services.

Should the DDR pilot be continued as an ongoing component of the aged care respite service system, it is highly unlikely from the evaluation findings that it will be able to rely on a user pays model (if it is to be an equitable and accessible program). This means that funding will need to be recurrent, but based on meeting a set of required deliverables. These could be derived from the findings of this evaluation.

1 EVALUATION REQUIREMENTS AND METHODOLOGY

The *Demonstration Sites for Day Respite in Residential Aged Care Facilities* (DDR) Initiative is funded by the National Respite for Carers Program (NRCP) and was announced as part of the 2007/2008 Federal Budget. The NRCP aims to contribute to the support and maintenance of caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances, and those of the people for whom they care.

The objectives of the Initiative are to:

- ⇨ Provide new day respite options for carers of frail aged people;
- ⇨ Showcase innovative models of respite; and
- ⇨ Provide an opportunity to conduct research into the provision of day respite services in residential aged care facilities.

Under the Initiative $41.2 million has been provided over four years to establish demonstration sites for day respite care in aged care facilities. Applications for funding to establish and operate a demonstration day respite service were sought from approved providers of residential aged care. Thirty providers from metropolitan and rural and remote areas across Australia were offered funding. One of these providers operates its services over two sites, and asked the evaluators to treat the sites separately, so for the purpose of the evaluation, there have been 31 sites.

1.1 EVALUATION REQUIREMENTS

The evaluation of the *Demonstration Sites for Day Respite in Residential Aged Care Facilities* Initiative investigated and reported on the following 9 factors:

1. The **efficiency, effectiveness and appropriateness** of funding DDRservices in residential aged care facilities.
2. The **benefits** to the carer and care recipient of accessing DDR services in residential aged care facilities, including the extent to which this model of respite care supports home-based care, the caring relationship and the well-being of the carer and the care recipient.
3. Any **unintended effects** of the Initiative, including adverse consequences for the carer or care recipient.
4. The **impact** of accessing DDR services on the care recipient's entry to permanent residential care, including the extent to which the receipt of day respite delays or else facilitates entry into full-time residential care.
5. The effects of providing DDR services on the **operations** of residential aged care facilities in providing care to full time residents.
6. The **demand** for DDR services in residential aged care facilities.
7. The **costs** of delivering DDR services, taking into account relevant variables including: locality, level of care provided, needs of care recipients, facility size etc.
8. Appropriate levels of **user fees** for DDR services.
9. Appropriate **options for future funding** of this type of respite, such as a day respite subsidy and/or grant funding.

The DDR Initiative has had a timeframe of approximately two and a half years (mid 2008 to late 2010) to undertake the following main requirements:

- Develop and implement a national Evaluation Framework for the Initiative (including developing data collection tools and methodologies) and use this framework as the basis for the evaluation for the life of the project.

- Design and deliver a Workshop in 2008 with DDR providers and the Department to:
  - ⇒ Present the Evaluation Framework to providers and to ensure their understanding of it, modifying the Framework where necessary as a result of workshop feedback.
  - ⇒ Support providers to use the evaluation data collection tools
  - ⇒ Establish a working relationship with DDR providers to support the evaluation process.

- Report on activities of the DDR services in 2008, 2009 and 2010, drawing on Service Activity Reports (SAR) and Financial Accountability Reports (FAR). The evaluators have added to this requirement the design, collection and analysis of a Site Data Collection instrument which provides more detailed information about service activities than is available through the SAR and FAR reports.

- Provide a report to the Department which presents findings in relation to each of the evaluation objectives:
  - i. The appropriateness, effectiveness and efficiency of funding DDR services; and
  - ii. Appropriate options for future funding of this type of respite. The options should identify appropriate levels of government funding and appropriate fee structures. The options should cover the possibility of a subsidy payments scheme that aligns with the current residential aged care subsidy structure.

1.2 EVALUATION METHOD

A methodology involving both quantitative and qualitative approaches was designed.

1 A *review of Australian and international research* relating to day respite was undertaken, and was designed to elucidate the lessons learned from this knowledge base. The ten lessons that emerged from the review have been taken into account in our implementation of the evaluation methodology. *A Discussion Paper presenting these findings was delivered in April 2009 and updated in July 2010.* A copy is presented in **Accompanying Report 1.**

2 An *Ethics* proposal was presented to The University of Adelaide Human Research Ethics Committee early in 2009 and approval was received. This has ensured that feedback sought from carers has adhered to acceptable ethical standards.

3 *Initial interviews* were undertaken during March and part of April 2009 with all DDR Site Managers to obtain early information about their programs and to pilot a *Site Data Collection* tool. This yielded initial profile information about –

- the sites and services provided in them;
- clients, care recipients and services provided; and
- the format of their data collections (electronic/paper based) and data storage methods.

Data were received from all sites. Feedback from this process enabled the AISR to design a monitoring *Site Data Collection* that met the needs of different service sites.

4 A *Monitoring and Evaluation Framework* was drafted and presented to the Department for feedback, and then to representatives at all sites in Workshop 1. A copy of the Framework is presented in **Accompanying Report 2**.

5 The evaluators facilitated a national *Workshop* in Melbourne in May 2009, with multiple representatives from all sites and from the Department. The Workshop presented the draft *Monitoring and Evaluation Framework* and the *Site Data Collection* tool, and provided an early opportunity for the evaluators to meet all site representatives, and for those representatives to meet each other. It was well attended with 55 representatives from the 31 DDR services, 8 representatives from the Department of Health and Ageing - central and State/Territory officers - and 1 peak body representative participating.

6 From June to October 2009, the evaluators visited 13 of the sites in order to undertake in depth analysis which was reported in the form of individual *Case Studies*, brought together in a single report that also identified trends and differences across the sites studied. Case Study sites were selected to yield rich qualitative information and provided a range of locations (metropolitan, regional and rural), auspice types, States and Territory, size (small, medium, large) and a culturally-specific or Indigenous-specific focus.

CHART 1 below maps the case study sites chosen against these characteristics.

A template was designed to support consistency in case study information collection. A copy of the individual Case Studies and the Overview Case Study Report can be found in **Accompanying Report 3.**

CHART 1: Case Study sample characteristics

State,Territory / No of sites	Organisation	CALD/ Indigenous	Size	Metro	Regional	Auspice
Victoria 3	Jewish Care Victoria, *Stepping Out* program	Jewish	Small - 12 carers	Inner city Melbourne		Aged & community care provider
	Inner East Community Health Service, Richmond *The Caring Café*	Greek and Vietnamese	Large- 30 carers	Inner city Melbourne		Community Health Service
	Lyndoch, *Homestead Day Stay Respite*		Large- 30 carers		Warrnambool Vic	Aged care provider
NT 1	Uniting Church *Rocky Ridge*	Indigenous (98%)	Med – 22 carers		Katherine, NT	Church organisation
Qld 2	Alzheimer's Brisbane, *Garden City Respite Centre*		Large- 40 carers	Inner city Brisbane		Peak body
	Churches of Christ, *Bribie Island Retirement Village*		Large- 40 carers		Bribie Island, Qld	Church organisation
Tas 1	Glenview Homes, *Bisdee House*		Large stand alone facility	Metropolitan Hobart		Aged care provider
SA 2	Ross Robertson Memorial Care, *Club Ross Robbie*		Med 20 p/week		Victor Harbor, SA	Aged care provider
	Southern Cross Care & Alzheimer's Aust SA, *Myrtle Cottage*		Med 20 per week	Metropolitan Adelaide		Aged care provider and peak body
WA 1	City of Swan Aged Persons Trust *Morrison Lodge*		Small – 10-12 carers/day	Metropolitan Perth		Local government
NSW 3	Catholic Care, *Cooinda Hostel Day Respite*		Small low care facility (5/day)		Singleton, NSW	Church organisation
	Our Lady of Consolation, *Centre for Healthy Ageing*		Large (up to 70/week or 15/day)	Outer metropolitan Sydney		Church organisation
	Australian Nursing Home Foundation, *So Wai*	South East Asian	Med 15/day 4 days/wk	Metropolitan Sydney		Aged care provider
TOTAL **13 sites**	**13 organisations**	**3 x CALD** **1 x Indigenous**	**6 large** **4 medium** **3 small**	**8 metro**	**5 rural, regional, remote**	

7 In late 2009, the evaluators distributed *four surveys* – one for CEOs and Service Directors, one for Care Coordinators/Managers, one for Day Respite Care Workers, and one for Carers – to collect

information on the experiences and opinions of those stakeholders regarding the appropriateness, effectiveness and impact of the DDR service. A copy of the Survey Report can be found in **Accompanying Report 4.**

8 Based on initial interviews with DDR Site Managers and a survey of existing project data collection, a *Site Data Collection* tool was developed to extend and complement data provided by sites through the *Financial Accountability Report* (FAR) and *Service Activity Report* (SAR) processes. The *Site Data Collection* was undertaken twice. The first Site Data round collected very detailed information from services regarding their general operations, service delivery and staffing during the period 1/7/09 to 31/12/09. The final round, conducted in late 2010, identified any changes that had occurred since 2009 so that an up to date picture could be obtained. A copy of the two Site Data reports can be found in **Accompanying Reports 7 and 8.**

9 In early 2010, analysis was undertaken of available *Financial Accountability Reports* (FARs) for the financial years 2008/09 and 2009/10 and *Service Activity Reports* (SARs) for 2007/08, 2008/09 and 2009/10. Copies of those preliminary reports can be found in **Accompanying Reports 5 and 6** respectively. When data for the 2009/10 financial year became available in November 2010, the 2008/09 data was cleaned and reanalysed and presented along with the 2009/10 data in **Accompanying Reports 9 and 10.** Note that these reports *supercede* Reports 5 and 6.

10 **Synthesis and analysis of findings** from these different evaluation activities has been designed to enable triangulation of results.

11 **Reporting** has been continuous, with individual reports for each major evaluation activity being provided, together with four Progress Reports.

CHART 2 summarises the key evaluation requirements against the different components of the methodology and how these have been applied to each requirement.

CHART 2: Key evaluation requirements against methodology

Required Information	Method				
	Surveys	Interviews & Case Studies	Site Data Analysis	FAR/SAR Analysis	Literature Review
Efficiency, effectiveness and appropriateness of funding DDR services in RACFs	■	■	■	■	■
Benefits to carer and care recipient of accessing DDR services	■	■			■
Impact of DDR services on care recipient's entry to permanent residential aged care	■	■	■		
Any unintended consequences of the Initiative	■	■			
The effects of providing DDR services on the operations of residential aged care facilities	■	■	■		
Report on financial and service activities of the day respite services in 2008, 2009 and 2010			■	■	
The demand for DDR services in residential aged care facilities	■		■	■	
Costs of delivering DDR services in residential aged care facilities			■	■	
Appropriate levels of user fees for DDR services in residential aged care facilities	■	■			
Appropriate options for future funding of this type of respite, eg a day respite subsidy, grant funding		■			■

2 APPLICATION OF THE SERVICE MODEL

Findings are presented to reflect the Evaluation Framework which in turn responds to the evaluation terms of reference and has structured the evaluation methodology. The Framework provided a number of guiding Evaluation Questions and accompanying Performance Indicators. These are presented at the beginning of each sub-section of the Findings component of this final report.

The evaluation has focused on providing information about the **Appropriateness, Effectiveness** and **Efficiency** of the *Day Respite Services in Residential Aged Care Facilities (DDR) Initiative*. Consequently, our reporting reflects this focus, with *Section 3* bringing together information relating to the Appropriateness of the Initiative, *Section 4* providing findings related to its Effectiveness, and *Section 5* presenting findings related to its Efficiency.

However, as the DDR service model represents a new addition to the overall aged care system in Australia, information directly relevant to exploring the appropriateness, effectiveness and efficiency of *the model* is grouped together in *Section 2.*

In each of the sections which follow, findings from the different components of the methodology have been synthesised and triangulated.

2.1 GUIDING OBJECTIVES AND EVALUATION QUESTIONS

The guiding objectives of the DDR Initiative suggest the following Evaluation Questions –

- ***To what extent is the Initiative providing new day respite options for carers of frail older people?***
- ***How well does the Initiative meet the needs of carers of frail older people?***
- ***To what extent is the Initiative supporting innovative models of respite?***
- ***What are the implications of locating day respite services in residential aged care facilities?***
- ***Should this model be continued and integrated into the broader aged care system?***

Service commencement was staged across the country for a number of reasons, and construction of purpose built facilities or renovation to existing infrastructure delayed many sites in implementing their DDR service. It was clear to the evaluators, especially in the first year of this review, that sites were at different stages of development largely for this reason. It was also evident that most sites had been on a learning curve in applying a new model and integrating the DDR service into the operations of the residential aged care facility (RACF). Some had projected demand accurately while others had not, some had experienced relatively smooth implementation while some had struggled. This is not surprising given the lack of benchmarks for the DDR model, with good practice lessons evolving over time, and participating sites being the pathfinders in this process. The evaluation has been designed to document those lessons. As one Care Coordinator observed –

> *'Observation and feedback from carers and care recipients indicate a very positive impact has been made by this model of respite. Care recipients are particularly benefitting from the opportunities for: social interactions and formation of friendships; increased confidence to try new activities; participation in regular gentle exercise and an understanding of their relevance to activities of daily life; and development of a more positive view of residential care options. Carers are particularly benefitting from: time to engage in individual pursuits such as work, hobbies or getting to town to shop or pay bills; relief of stress by knowing their relative is enjoying themselves in safe environment with quality care; ability to learn about other care options including community and residential care and ease of transition when residential respite or permanent care is required.' (Care Coordinator)*

2.2 THE PROVISION OF NEW DAY RESPITE OPTIONS

The provision of day respite services usually occurs in a community rather than a residential care setting, and this is the distinguishing feature of the DDR model – its location. From this base several other differentiating features are evident –

- Co-location of day respite in a RACF brings together residential and community care staff, offering scope for the development of enhanced knowledge and skills on the part of both groups of staff, and can provide the day respite service with access to staff they may not normally be expected to work with (eg Lifestyle Coordinators). It can also mean that activities are designed with the support of specialist RACF staff not always available in day respite programs – for example, a dedicated Activities Officer or Recreation Coordinator. However, if the transition of the implementation of the day respite service is not managed effectively, with RACF staff being consulted, informed and so on, there can be resentment on the part of residential staff which takes months to overcome.

- Co-location also offers the opportunity for residential and DDR service recipients to share in activities, broadening the range otherwise possible. In smaller communities (eg rural or culturally specific) many of the residents are known to day respite users and given the opportunity to re-connect. However, the sharing of activities and facilities requires sensitive management. It is important that residents do not feel 'overtaken' and it is important that individual user needs are taken into account when bringing both groups together.

- Co-location brings the risk that the stigma associated with a residential care setting will deter carers and care recipients from accessing the DDR service. Fortunately, the DDR Initiative has offered funding for infrastructure that enables RACFs to provide a separate day respite centre or renovations designed to support flexible service provision and to create a homelike setting. A critical factor in the application of the model is sensitive infrastructure design that provides a specific identity for the DDR service and supports flexible service provision. It has also been evident from the evaluation that stigmatisation has generally been an initial rather than an ongoing issue as familiarisation with the RACF and the day respite service increases over time.

- Co-location and the familiarisation involved also means that many carers and care recipients can more easily access residential respite, and that if the care recipients' needs change and they require long term residential care, this is less threatening. The evaluation has not found that the service model encourages premature entry to residential care, but rather, that it delays this and eases the transition when it does occur.

- For all of the above reasons, the DDR model can be seen as building a bridge between community and residential care, providing an important linking component of the care continuum and easing the carer and care recipient journey in the process.

These features mean that the DDR model is providing new day respite options for carers.

2.3 MEETING THE NEEDS OF CARERS

It is of paramount importance that any new respite care service actually provides what carers want and need.

It is evident from the literature review undertaken for the evaluation that it is not the model per se of respite care but how it is delivered that affects carer and care recipient preferences (Mason *et al*, 2007: 3). In particular, the **flexibility** and **responsiveness** to individual need emerge as the most consistent themes in the preferences of carers identified by researchers, as well as the provision of **quality** services that enable the carer to entrust the person in their care to those services (Pollock *et al*: 2007).

The feedback provided by carers for this evaluation has reinforced the accuracy of these findings, and the DDR model has been rated by them as achieving the key requirements of flexibility and quality care and support - as the following sections illustrate.

An overview of research undertaken in the UK (Arksey *et al*: 2004) identified a range of indicators, both quantitative and qualitative, against which the effectiveness of respite services should be measured – see **Accompanying Report 1.** It was concluded that the key measure should be the outcome (s) sought by the

carer, not the functions carried out by the respite service. Outcomes need to encompass health and social benefits and broader quality of life. The following specific qualitative measures were proposed:

- *The appropriateness, timeliness and availability* of the service to the identified need (s).
- The *degree of readiness* with which care recipients and carers accepted the service.
- The *degree of enjoyment and stimulation* the care recipients gained from the service.
- The *degree of confidence* felt by carers about the service.
- The *outcomes achieved for carers* – including, reduction of 'burden of care', increased feeling of being supported.
- The *outcomes achieved for the care recipients* – including, attention to safety needs, having a positive experience, support for quality of life (Arksey *et al*, 2004: 93-94).

2.3.1 WHAT DID CARERS SEEK FROM THE DDR SERVICE?

The main reasons given by carers for using the Day Respite Program reflected a duality of need, with the two most commonly cited reasons being to provide the care recipient with an *opportunity to socialise* (77.4% of the survey sample) and *giving the carer a break* (68.4% of the survey sample) – see *Table 1*.

Table 1: Carers' reasons for using the DDR service – listed in descending order of frequency

Reason	No. of responses	% of respondents*
To provide the care recipient with an opportunity to socialise more	230	77.4%
To give the carer 'time out' / a break	203	68.4%
To provide the care recipient with an opportunity to participate in activities that help with their condition	181	60.9%
To delay the need to place the care recipient in full time care	148	49.8%
To give the carer time for their other responsibilities	134	45.1%
The carer's own health issues	86	29.0%
To give the carer time to work	54	18.2%

** Respondents could specify more than one main reason, therefore the total does not add to 100%.*

2.3.2 DID THE DDR SERVICE PROVIDE WHAT CARERS WERE SEEKING?

The survey of carers sought a rating from '1'(most negative) to '5' (most positive) about a number of features of the DDR service. The 297 carers providing feedback provided ratings indicated that the service was meeting their needs, however, their ratings – while high – were slightly lower than those of Care Workers and Coordinators/Managers on most dimensions.

Table 2: Carers' reasons for using the DDR service against average ratings applied by carers

Reason	DDR capacity to meet this need (Average rating)
To provide the care recipient with an opportunity to socialise more*	4.5
To give the carer 'time out' / a break*	4.4
To give the carer time for their other responsibilities	
To provide the care recipient with an opportunity to participate in activities that help with their condition*	4.3
To delay the need to place the care recipient in full time care*	4.1
The carer's own health issues – positive impact of service on carer health and well-being*	3.9
Positive impact of service on carer mental health/stress management*	4.3

**Carers' ratings on these dimensions were significantly lower (p<.05) than those applied by care workers and care coordinators, indicating that staff and managers hold a more positive view of the DDR Pilot that needs to be 'reality checked' against carer perceptions.*

Against these very positive findings, there are a relatively small number of service provision features that were rated significantly **less positively** by carers. These relate to the DDR service's capacity to –

- Improve their own health and well being (3.9)
- Improve the physical functioning (3.8) and cognitive functioning (3.7) of care recipients
- Reduce carer anxiety about the care recipient needing to enter full time residential care (3.8)
- Link carers to services that they would not otherwise have known about (3.7).

Again, care workers and care coordinators applied more positive ratings to the DDR service's ability to achieve the above outcomes. Further information about carers' responses to the services provided can be found in *Section 3.*

2.3.3 DIVERSITY AND SPECIALISATION IN APPLYING THE DDR MODEL

There is significant diversity across the sites in the application of the model, indicating that a range of carer needs is being met, and that the model has the capacity to be applied to a range of settings and diverse needs. The evaluation has identified diversity in relation to:

⇒ The *level of integration with the residential care service*, ranging from full integration to quite distinct services which do not 'cross over' with the residential service, and from complete physical separation to complete integration.

⇒ The *range of services offered* – including the balance of on- and off-site activities, and the way in which transport is provided (which is highly flexible being adapted to local conditions and user needs).

⇒ *Service intensity*, including operating hours and the number of carers assisted. Also, the number of days of service available to individuals ranges from occasionally to fortnightly, weekly or daily, and sometimes includes weekend provision.

⇒ *Focus of the service* – for example, some sites offer a traditional 'drop off' respite program, while others have adopted more innovative approaches including on-site carer programs some of which involve the care recipient simultaneously, carer health and well being programs and a one stop shop providing seamless linkage to a range of services, including primary health care. Some provide culturally specific and holistic services tailored to local need (particularly evident in Indigenous specific services located in remote areas, the *So Wai* service for Chinese people and the Ste*pping Out* service for Jewish people).

According to Site Data provided with respect to July-December 2009, only two sites indicated that they do not provide any specialist focus while another four cited 'frail aged' as their specialisation which should be their target group and therefore does not represent a specialisation. As Table 3 indicates, the most common specialisation offered is for care recipients with **dementia** (86.2% of sites), followed by the provision of **emergency respite** (69% of sites). In addition –

o 17 sites (59%) report that they offer a specific focus on **cultural and linguistic diversity** (CALD) background, and some of these provide exclusively for particular communities. Further analysis indicated that the proportion of carers and care recipients born outside of Australia is consistent with 2006 Census (ABS) birthplace data on the wider Australian population. Similarly, the proportion of carers and care recipients who *spoke a language other than English at home* was 18.9% and 17.0% respectively, which is close to the 2006 Census figure of 21.5% of the Australian population as a whole. Therefore, there will be a need for services to manage cultural diversity – as discussed in *Section 3.3.*

o Five sites (17.2%) offer a focus on **Indigenous** people, and Site Data analysis reports some 4% of care recipients and carers as being Indigenous which is higher than the 2006 Census proportion of approximately 0.6% of Australians aged over 65 and around 2.4% of the population as a whole.

Table 3: Main project specialty focus areas, listed by frequency

Specialist Focus	No. of projects citing this focus	% of all Projects
Dementia	25	86.2%
Emergency respite	20	69.0%
Other cultural/language background	17	58.6%
Other clinical needs	14	48.3%
Younger (aged <65 years)	8	27.6%
Indigenous	5	17.2%
'Other' focus		
Working carers	2	6.9%
Working care recipients	1	3.4%
Challenging behaviours	2	6.9%
Financially disadvantaged	1	3.4%
High care needs	1	3.4%
Mental illness or intellectual disability	1	3.4%
'Frail aged'	4	13.8%

(Source: Table 2, Site Data Analysis Report, Accompanying Report 7; note that only 29 of the 30 projects provided data)

In addition, the DDR Initiative is reaching Australians in **inner regional, remote and very remote** locations at slightly higher representation levels than in the general population (based on the remoteness profile for Australians aged 65+ in the 2006 Census). This is a function of the location of the sites chosen to participate in the DDR Initiative.

Most of the 13 sites case-studied reported that activities were also designed to reflect **gender-based** preferences and so offered specific activities for men (eg Men's Shed which was consistently popular) and for women (eg arts and crafts).

Table 14, SAR Report (**Accompanying Report 9**) compares carer profiles in 2008/09 and 2009/10[7]. This showed that –

- The proportion of carers from **Aboriginal and/or Torres Strait Islander** backgrounds had remained constant at 3.3%.
- Approximately one in five care recipients were from **culturally and linguistically diverse** (CALD) backgrounds.
- The proportion of carers using the service who were living in a **rural location** appeared to increase slightly from 15.1% in 2008/09 to 21.6% in 2009/10, due to the increased service delivery of some of the rural-based DDR projects. However the number of carers living in a **remote location** had dropped slightly from 5.5% to 3.0% of all carers.
- The proportion of carers from **financially or socially disadvantaged backgrounds** remained steady at 24.5%.
- **Employed** carer numbers reduced slightly from 1 in 3 carers (33.3%) in 2008/09 to 27.5% of carers in 2009/10.

[7] Note that SAR data from 2007/08 was too unreliable to be included in these comparisons.

Consistent with the original intention of the day respite program, according to the SARs, almost all of the care recipients attending the program over the past two years were aged over 65 (or over 50 if from an Aboriginal or Torres Strait Islander background). In terms of health and functioning, over half of all care recipients had dementia, around a quarter had dementia with challenging behaviours, and around a quarter had a disability. More detailed information on the health and functioning of care recipients was collected in the first round of our Site Data Collection (refer to **Accompanying Report 7**). That report illustrates that, at assessment –

- the *General health status* of nearly half (48.2%) of all care recipients was *Fair*,
- the *Level of care required* was assessed as *High* for 45.1% of care recipients,
- the *Priority level for entry* to the day respite service was assessed as *High* for nearly half (49.0%) of the care recipients, and
- *Special care needs* were reported for 67.6% of the 896 care recipients, of which the most common special care need was *Dementia* (27.2% of all care recipients).

The Final Site Data Collection identified a change in the profile of carers and recipients by 12 of the 31 sites (38.7%) that included a trend in 2010 towards increasing high care needs and clients from diverse cultural and linguistic backgrounds. Some sites also noted an increase in the number of carers presenting with stress or health issues. These trends are in line with DDR pilot goals.

2.4 ACCESSIBILITY OF DDR SERVICES

Findings from the analysis of site data and SAR reports, and from surveys with carers, care workers, care coordinators and service managers, indicate that DDR services are paying attention to accessibility issues on a number of issues.

- Services are financially accessible, with user financial means being taken into account and a low level of fee being charged for day respite services, including for transport.
- The provision of transport by almost all services has been a critical success factor in enabling carers to support the person in their care participating in DDR services. The means-tested cost of transport services reinforces their accessibility.
- Location has also been addressed with the higher than normal representation in inner regional, remote and very remote areas. The barriers faced by carers living in such locations will have been reduced or removed by this strategic placement of DDR services – over 20% of carers using the DDR service live in a rural or remote area.
- The outcomes from the perspective of cultural accessibility are mixed. A number of services are either Indigenous-specific or culture-specific, and for these communities, DDR services are extremely accessible. However, survey feedback indicates that for culturally generic services, staff training and experience in working inclusively with people from Indigenous backgrounds, or from culturally and linguistically diverse (CALD) backgrounds, will need further development.
- Accessibility for carers of people with dementia appears to have been addressed by the many DDR services identifying this as a specific focus, and by some specializing in these services. However, the existence of challenging behaviours has been identified as a reason for exclusion and from this perspective, DDR services can be considered to be largely inaccessible.
- Employed carers are a special needs group and few DDR services offer specialist services for them and the most recent SAR data indicate that the proportion has reduced from 33.3% to

27.5% in the past 12 months. A major need will be hours of operation that support carers' employment. Hours of opening varied significantly across projects so it is difficult to draw a conclusion about their accessibility on this dimension. However, a relatively small proportion of carers are dissatisfied with DDR services' hours of opening.

- The RACF location of DDR services can be a barrier for some carers and care recipients. However, in most cases this has acted as an initial deterrent only, and in reducing fears about residential care, has provided a bridge that smooths entry to permanent care if and when this becomes necessary.
- Finally, DDR services should link carers to a range of other services, and this appears to be an area requiring further investment, including linkage to Commonwealth Carer Resource Centres and Carelink. Without this linkage, DDR carers may be missing access to a range of community based respite services and support.

2.5 SUPPORTING INNOVATION

Evaluation feedback from the surveys and case studies indicates that the DDR model is supporting innovation in day respite provision. In part this stems from the co-location with residential care services which is requiring both day respite and residential care staff to think and operate outside of their usual paradigms. In addition, the Pilot has encouraged services to trial different approaches to providing day respite and approaches that place the carer and care recipient at the centre of service delivery.

> *'This program is the jewel in the crown. It is innovative and constantly changing and as the manager I must congratulate the staff who are involved. It has brought home to me that you need "special" staff, and these are difficult to find. These programs are an opportunity for aged care workers to be able to work across residential and community care. By doing this we would increase our number of staff, encourage diversity and cross fertilisation of skills and ideas. It would also assist in the retention of staff - residential care is often heavy and many workers leave because of this. If they can work across both sectors then their employment opportunities are increased.' (Care Coordinator)*

The Case Study examples of DDR services (below) exemplify this innovation.

CASE STUDY 1: *ROCKY RIDGE* INDIGENOUS-SPECIFIC SERVICE, KATHERINE

The Indigenous-specific program at *Rocky Ridge* has been designed in collaboration with carers and care recipients, who are reported as being confident about expressing their preferences. The site itself was described as being very appealing to Indigenous users, with its large physical space including the large verandah area which is enjoyed as a place of meeting and talking. However, off-site outings are also offered, and unlike most/all other services studied, the bus transport service was reported as being an integral part of activities because it involves driving through the town and to roadside locations where people known to the participants can be seen.

Many of the activities are oriented to Indigenous community interests, for example, fishing, storytelling, music therapy, campfires and traditional painting. Cooking activities are popular and the service includes meals, washing of clothes and personal care – with staff reporting that care recipients are more amenable to receiving these services at *Rocky Ridge* than in their own homes. Co-location with the Transitional Care Unit as well as the RACF has also meant that activities can be planned with the input of a range of staff, and not only those from respite care.

CASE STUDY 2: *MYRTLE COTTAGE,* ADELAIDE, MONTESSORI DEMENTIA-SPECIFIC

The *Myrtle Cottage* Respite House is a collaboration between Southern Cross Care (SA) Inc – a major not for profit provider of aged care services - and Alzheimer's Australia South Australia (AASA) to trial an innovative model of respite provision for carers of people with dementia. The service is offered in a day respite setting on the campus of a Southern Cross Care residential facility site in metropolitan Adelaide.

Myrtle Cottage has one of the most diverse activity programs of the 13 sites studied. Day respite services are based on the *Montessori Dementia* model which is an innovative method of working with older adults with cognitive and/or physical impairments developed from the method and philosophy of educator, Maria Montessori. Montessori activities, in the context of activities programming, enable people with dementia to function at a higher level of competence because these activities access 'spared ability' while providing ways to circumvent memory deficits.

RACF staff are being trained in the Montessori method and are finding that it is very relevant to the delivery of care in a residential setting.

Myrtle Cottage is able to offer a highly responsive and accessible service. The program is able to take bookings on the same day as respite is required when a vacancy exists. Transport is available with an hour's notice and under individualised arrangements.

CASE STUDY 3: *SO WAI* CHINESE AND DEMENTIA SPECIFIC SERVICE, SYDNEY

The Australian Nursing Home Foundation (ANHF) was established in 1980 as Australia's first Chinese-specific aged care provider. ANHF offers a range of aged care services and respite services to older people from Chinese and South East Asian countries as well as a range of resources and carer education services to the Chinese community. The *So Wai* Day Respite program is in inner western metropolitan Sydney, and the local area surrounding the program has a high number of ageing people from a Chinese background, many of whom have dementia. Consequently the program also has a dementia-specific focus.

The *So-Wai* program provides activities that differ significantly from those at other DDR sites. These include provision of Chinese newspapers and television, horticultural therapy, exercise and physical activity, sensory exploration including Chinese artefacts, bubble column, water features, aromatherapy and a culturally inspired, professionally designed sensory garden, as well as craft activities that incorporate Chinese art and calligraphy. *So Wai* also has access to a large range of information and carer education products that have been translated into Chinese languages.

CASE STUDY 4: *CENTRE FOR HEALTHY AGEING*, ROOTY HILL, NSW, HEALTH AND WELL BEING FOCUS

The model underpinning the *Centre for Healthy Ageing* was developed in consultation with carers, and this identified that a need to develop a respite service to focus on the needs of carers, rather than a 'drop and run' service where care recipients are 'looked after' while the carer has time out from their caring role. The Centre provides services for both carers and care recipients that promote healthy ageing and wellness and this focus distinguishes it from most other DDR services and day respite services generally.

The service is based in a renovated building within the grounds of Our Lady of Consolation (OLOC) aged care services, which occupy a very large site in Rooty Hill, on the western fringe of Sydney. Some of the services/activities are designed for carers only. For example, carer-only outings, counselling, pamper sessions and 1:1 personal fitness programs. Those undertaking structured exercise programs with the Exercise Physiologist have a range of data collected in order to monitor their progress. This assists in the design of programs that increase functional ability, reduce pain, attain weight loss or other identified goals. OLOC residents visit the Centre for Healthy Ageing from time to time (eg to use gym equipment, participate in special events/activities).

An independent evaluation of the Centre (Elton Associates, November 2009) identified a number of positive impacts for carers accessing the Centre, and included measurement of carer well being using the Personal Wellbeing Index (PWI), which provides an overall score out of 100, with the normal range being between 70 and 80. Carers accessing the Centre had an average PWI of 76.4, which is much higher than that of carers nationally (58.5), and this score increased with length of time using the Centre's services.

2.6 ASSESSING THE DDR SERVICE MODEL

Day respite has traditionally been located in a community setting and an important part of the evaluation has been to determine consumer and service provider views about the impact of this location on access, on appropriateness and effectiveness of service provision, and on efficiency in resource usage.

There are relatively few studies in the research literature that are focused on day respite provision in residential aged care facilities – no doubt because this is not a common model. Earlier studies, when day care was first provided in residential aged care settings, found this care to be of poor quality in most instances, with participants having no structured program of activities and simply joining others in the recreation room (Twigg: 1992; Pickard: 2004). Clearly the DDR Initiative has seen a significant move forward in the application of this approach, with the day respite service being clearly distinguishable from residential services, often with their own physical infrastructure and their own staffing. Furthermore, the evaluation has also identified opportunities for cross-fertilisation between the two groups of services – as is discussed in *Section 2.8*.

Surveys of Carers, Care Workers, Care Coordinators/Managers and Service Directors/CEO identified that these four groups of stakeholders were generally consistent in their views regarding the provision of day

respite services in residential facilities. *Figure 1* shows the average ratings applied by each group against a series of statements pertaining to the DDR model. It can be seen that –

- Carers have given their lowest rating (2.5) to assessing the model as suffering from negative perceptions associated with residential aged care, and DDR staff and managers have given their second lowest rating (2.8) to this.

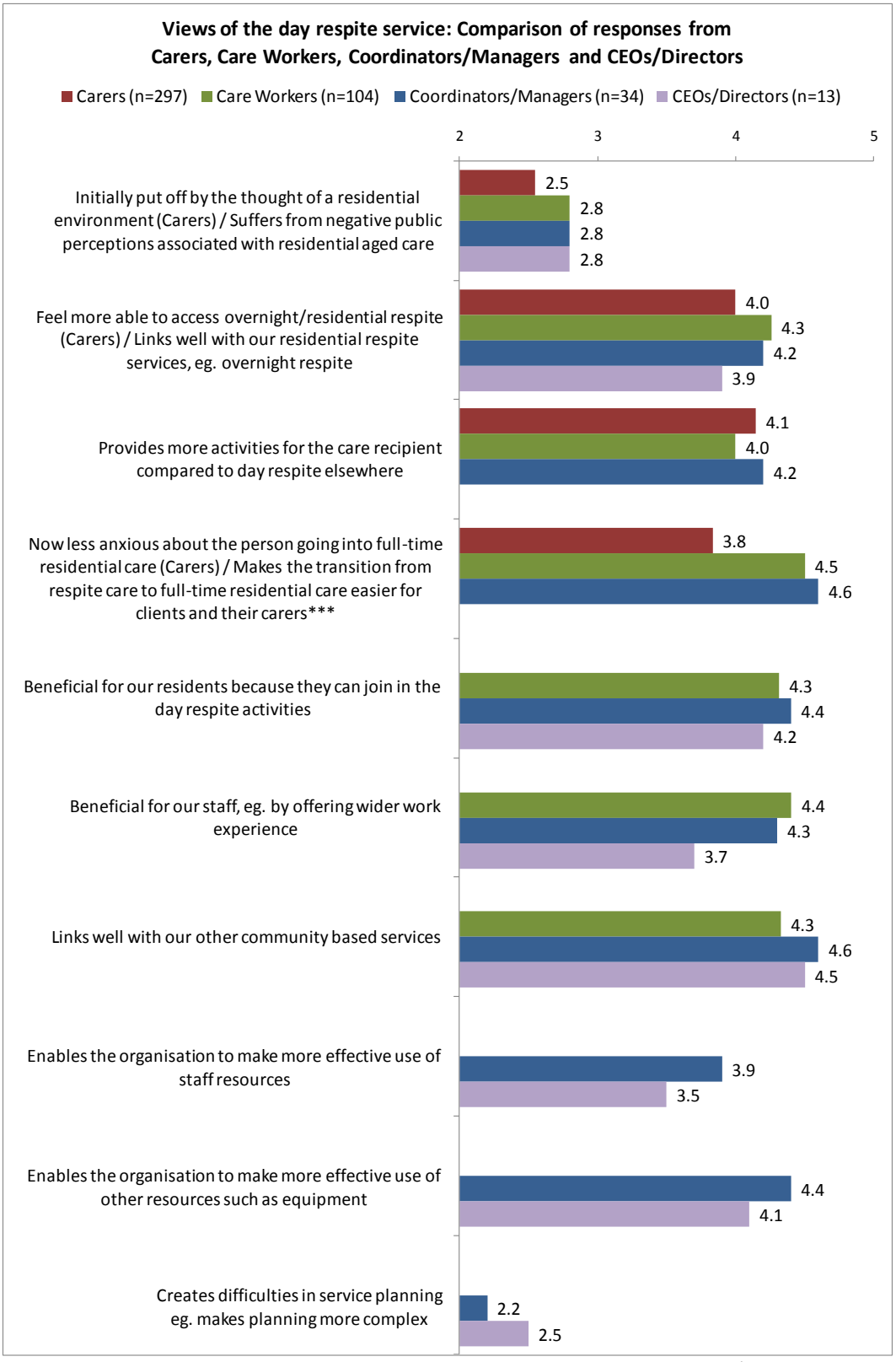
- The model is also seen as enabling carers' access to overnight or residential respite and providing a seamless link between day and residential respite services.

- The transition into full time residential care is seen as being eased for carers and care recipients by DDR staff but the statistically significant difference between their ratings and those of carers on this issue suggests that there may be a tendency for Care Workers and Coordinators/Managers to overestimate the positive impact of the day respite service on the psychological challenges faced by Carers when placing their loved one into full time residential care.

- Carers, Care Workers and Coordinators have expressed a reasonable degree of agreement regarding the service model's capacity to provide a wider range of activities for care recipients relative to most day respite services. Care Workers and Coordinators are in agreement that the model is beneficial for residents because of their ability to participate in day respite activities, and staff and managers regard the DDR service as linking well to other RACF community services.

- The two groups with service management responsibilities appeared to be slightly more likely to see the model as enabling more effective use of equipment and similar resources than they were to see it making more effective use of staff resources, and while CEOs/Service Directors appeared to be less likely to rate the model as offering wider work experience for staff than were Care Workers and Coordinators, this was not statistically significant.

Figure 1: Comparative views of the DDR service



*** Carers had a significantly less positive view than both Care Workers and Coordinators/Managers (p<.05).

The majority of open-ended comments from Care Workers about the model were positive and pointed to the benefits arising from its bridging of residential and community aged care.

> *'A good in between service from home care and residential respite.'*
>
> *'I feel the Day Respite experience helps break down negative perceptions of residential care.'*
>
> *'Initial 'fear' of coming into a nursing home environment. Once in they can see that it's not as bad as initially thought.'*

Carers have made similar observations.

> *'We have used the residential facility for a two-night stay on a couple of occasions when I needed to go away for a few days. It is a very good service. My mother is content there.'*
>
> *'Great for socialising and awareness that a nursing home isn't to be feared. Even though ... [name of service] is totally separate, stand-alone building, the group go for walks around the gardens and other areas of the site.'*
>
> *'The day care program has become a 'half-way house' for my husband and when he eventually has to go into 'care' full time he will settle in much more easily. It has also enabled him to remain at home much longer.'*

2.7 CHALLENGES IN IMPLEMENTING THE MODEL

Open-ended survey feedback identified seven key challenges associated with implementation of the DDR services. As CHART 3 indicates, across the three groups of care providers and managers, the two most commonly identified related to countering stigmatisation associated with residential care provision and ensuring that this did not deter potential consumers, and managing the initially negative reactions by some RACF staff to the day respite service.

CHART 3: Challenges associated with implementing the DDR model of service

Challenge identified	Care Workers	Care Coordinators	Service Directors
Countering negative perceptions and stigmatisation regarding residential care provision			
Managing initially negative reactions by RACF staff, managing lack of understanding of community care services, educating staff			
The need to develop processes for communicating and coordinating different groups of staff in the organisation			
Training and developing day respite staff with appropriate skills and values to implement the model			
Industrial issues associated with the existence of different awards for staff			
Maintaining a flexible service that meets carer and care recipient needs, including in transport provision			
Establishing the DDR service – recruiting staff, building client base, establishing data collection system			

> *'The stigma of RACFs and Day Respite being linked has some doctors and local community members believe that the facility where day respite is run is full of bugs, viruses and infections.' (Care Coordinator)*

'Organisational issues - 2 sets of awards has not assisted with more effective use of staffing resources. A 'community' care worker needs to be registered with the Regional Care Worker Team and a separate agreement needs to be drawn up as there are different rates of pay.' (Care Coordinator)

'It takes time to build up communication among staff of the aged care facility and respite day care centre in service planning and sharing of resources.' (Care Coordinator)

'Issues we have faced: not enough space, lack of communication between RACF and Respite service, RACF and Respite staff not understanding each other's roles, the residents' families are complaining that they pay a huge amount of money to send their loved in to the RACF whereas Respite clients only pay a small fee to be looked after their during the day.' (Care Coordinator)

'… we need a "special' type of care worker who is confident and savvy enough to understand how the program works, encourage independence in the guests, does not work to a menu or timetable and basically can "think on their feet".' (Care Coordinator)

Apart from the combined positive impact of time, increasing knowledge and understanding of the day respite service and its associated model and seeing the benefits that can arise from co-location, it is clear that the **management** of the DDR service's implementation and integration into RACF programs is crucial. Preparing staff and developing specific processes for communication and coordination of staff have emerged from interviews and open-ended feedback as important strategies for smoothing the integration process. See *Section 4.4.4* for further discussion of the impact of the DDR Initiative on participating RACFs.

2.8 SYNERGIES OFFERED BY THE MODEL

The evaluation surveys, analysis of Site Data and the Case Study field work have all identified several areas of synergy in resource usage between the RACF and day respite service. These can be seen as beneficial for both residents and day respite users, and as bringing benefits to the RACF that range from the tangible (sharing of staff resources, pooling of resources to purchasing consumables etc) to the intangible (raised profile in the local community, increased staff experience across programs).

A review of available research (Zarit: 2001) identified that the effectiveness of respite is highest when it is provided in association with other community support programs. In other words, respite cannot be considered to be a stand-alone service and has a more positive impact if other supports and services are being provided. Other researchers have also identified that respite services should not be evaluated in isolation from the rest of the service system, and from other supports provided (Arksey *et al*: 2004). Across all projects, approximately **30%** of total activity hours per week were shared with residential care recipients. All projects gave day respite clients access to some type of additional service provided by the RACF and these represent value-add services that would not normally be accessible in community-delivered day respite care - see *Section 3.7.1.*

Improvements to the physical infrastructure funded by the day respite service were also seen as benefitting the organisation as a whole.

'1. Enables use of existing infrastructure, services and skills of nursing home. 2. Enhancements: new user-friendly kitchenette and bathroom, easier access to courtyard, small sensory garden. 3. Enabled the purchase of new equipment and furniture.' (Care Coordinator)

'The day centre has its own equipment etc. Day centre clients mainly join in activities with facility residents. Occasionally facility residents join with day centre clients and are always welcomed.' (Care Coordinator)

Sharing of resources between the RACF's other programs and the day respite services was evident in relation to staffing. Site Data show that many day respite staff members were also employed part time by other areas of their organisation. Almost half **(49%)** of all day respite staff also worked in their RACF's *Residential care* service but this practice varied greatly between project sites – see *Section 5.1.4*.

This means that staff are being exposed to a wider than normal range of work experience, which can be seen as beneficial for them and therefore, for their clients. (This was also the view of staff surveyed by the evaluators in our surveys of carers, care workers, care coordinators and service directors.)

At the same time, RACFs were found to be providing an unfunded contribution in terms of staff (FTE) time that equated to **an average of 1.1 full time staff members per project per week** which is a value-add for the DDR program as a whole. (See *Tables 9 and 10* of the Site Data Report – **Accompanying Report 7.)** In terms of total time, most of this contribution came from *Care Workers*, *Domestic staff* and *Managers*. Final Site Data analysis shows that this trend has persisted during 2010 (refer to *Section 3.7.2* for further details and **Accompanying Report 8**).

2.8.1 IMPACT ON THE ORGANISATION THROUGH ECONOMIES OF SCALE

It was common for day respite service providers to report significant economies of scale due to sharing and consolidating resources with their auspicing RACF. These usually related to sharing staff, staff training, equipment, purchasing of goods and stores, meals preparation, laundry services, transport services - and application of policies and practices, such as, medication management.

Such vertical integration is described as bringing financial benefits from resource sharing, and service delivery benefits arising from shared staffing, rostering and training arrangements and the development of common social and recreational programs. This was usually regarded as **adding value** – for both the RACF and the day respite service and clients of both programs.

In many of the Case Study sites, the DDR funding had enabled organisations to increase care staff and specialist staff (eg Lifestyle Coordinators) levels from part time to full time, or to employ specialist staff for the benefit of both the day respite and RACF services.

The Caring Café day care recipients and carers benefit from its auspicing organisation's links not only to an RACF, but to a range of primary and allied health services, while those at the *Homestead Day Stay Respite* benefit from being able to access a suite of respite services. Co-location of different services not only benefits service users but enables staff to experience different types of care provision and achieves economies of scale in their training and deployment.

The *Rocky Ridge* service achieves significant synergy from its co-location with the RACF and Transitional Care Unit (TCU). Apart from economies of scale achieved from sharing resources, the collaboration between staff of the different programs, including in planning activities, has meant a broader range of expertise which brings benefits for service users. Both residents and day care participants are described as benefitting from the interchange and access to each other's services.

Day respite service staff report that RACF residents benefit from the more stimulating environment of the day respite service, which is described as having a 'different atmosphere' that is attributed to the higher level of independence of day respite participants. Co-location of the day respite service, Transitional Care Unit and RACF also means that a greater number of friends and families visit, while the TCU and RACF enable the provision of longer hours of care for those day respite users who need this.

Service Directors commented on the positive impact of the DDR service on their organisation's resources through a *sharing resources* and making *effective use of resources* by coordination and planning – or through the *addition of valuable resources* such as, new buildings, which could be shared.

> *'1. Resources are being shared which is a financial benefit to both parties. 2. Provides diversity for staff.' (service director)*

> *'It has added additional resources to a small rural aged care facility and expanded the type of skills employed (e.g. OT).' (service director)*

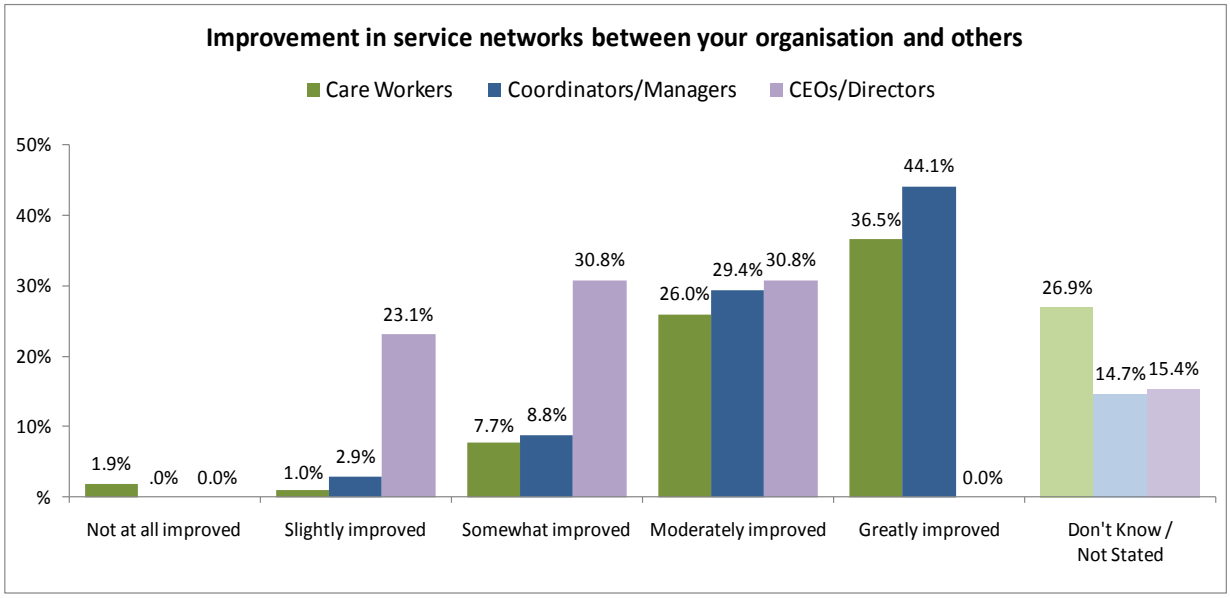
> *'Positive impact on financial, personnel and resources as the program is fully integrated into residential care and not operated separately.' (service director)*

2.8.2 IMPACT ON RACF SERVICE NETWORKS

Depending on the range of community care services offered by RACFs, it can be expected that their service networks could be expanded as a result of providing a day respite service. Surveys with participating providers were designed to explore this issue.

Service Directors had a much more conservative view about the day respite program's impact on service networks compared with the views of both Care Workers and Care Coordinators (see *Figure 2*) and this difference was statistically significant ($p<.05$). 62.5% of Care Workers and 73.5% of Care Coordinators rated the DDR's impact as having *moderately or greatly improved* service networks compared with 30.8% of Service Directors, 53.9% of whom rated the improvement as *slight to somewhat* better.

Figure 2: Improvement in service networks



The evaluators have concluded from these findings that the DDR service has brought different degrees of service network enhancement, varying in direct proportion with levels of staff and management. Care Coordinators appear to have experienced the greatest impact of the groups surveyed, and Service Directors the least impact.

2.9 ENTRY TO RESIDENTIAL CARE

A concern that has been expressed by some is that locating day respite services in a RACF could work against the objective of keeping care recipients in the community for as long as possible. Apart from the fact that this overlooks the gate-keeping role played by Aged Care Assessment Teams, the evaluation evidence does not support this concern.

Providers regard the service as delaying entry into residential care for many participants by improving or at least maintaining their functional abilities and by enhancing the carer's capacity to continue in their role. Both the case studies and survey findings report that DDR services have increased users' familiarity with the RACF and in the process made for a smoother and less stressful transition to residential aged care - if and when this was needed.

> *'We have had many clients and carers comment on how Day Respite is a good stepping stone before accessing permanent care. It allows them to 'dip their toes in the water' and assists them to explore different aged care options.' (Care Coordinator)*

This familiarisation has arisen from –

- the shared location,
- the participation by residents and day respite recipients in some shared activities, and
- the linking of carers to residential respite care, often as an extension of day respite with overnight stay achieved when a respite bed was available and needed - 89.7% of projects offer overnight and residential respite options (*see Section 3.7.1* and *Section 5.2.5*).

These findings are confirmed by a small number of studies that have found provision of respite in a residential facility (in the form of overnight or extended residential respite) may encourage entry to residential aged care because of familiarisation with the setting or because carers were seeking this form of care and using the respite as a stop-gap (Keefe & Manning: 2005; Pickard: 2004). In such cases, respite was found to enable a planned rather than crisis admission to residential aged care, acting as a bridge.

Linking administrative data for the residential aged care and CACP programs, and HACC minimum data set information, more recent pathway analysis by the Australian Institute of Health and Welfare (2006: 1, 12) has found although 40% of people who completed a period of respite care in one quarter were admitted to permanent residential care by the end of the following quarter, use of the residential respite was not a 'necessary precursor' to entry into permanent residential care (AIHW, 2006: 12).

The AIHW research found that the use of community care services by residential care clients appears to delay entry into permanent residential care. Some 46% of people who used residential respite without also using HACC or CACP services in one quarter were admitted to permanent residential care by the end of the next quarter, compared with 35% of those who also access these community care services (2006: 4).

> *Among users of residential respite care, use of community care services appears to delay entry into permanent residential aged care: around 46% of people who use residential respite but neither HACC nor CACP services in one quarter are admitted to permanent RAC by the end of the next quarter, compared with 35% of those who also access these community care services* (AIHW, 2006: 1).

Some sites (for example, *The Caring Café* and *Stepping Out*) identified the DDR funded day respite service as also reducing entry into hospital care because of the support provided to care recipients. However, without linked data it is not possible for the evaluators to quantify this observation.

Further analysis regarding the potential effect of day respite in delaying entry to permanent residential care can be found in *Section 4.4* of this report.

2.9.1.1 IMPACT OF RACF LOCATION ON CARER ACCESS TO THE DAY RESPITE SERVICE

Consumers usually make a clear choice between care in the community and care in a residential facility, but the DDR model blurs this distinction and carries the risk that people seeking a service that is essentially at the community end of the care spectrum will find the residential location to be a deterrent. The stigma associated with residential services has been significant for some, but certainly not the majority.

Feedback from carers surveyed for the evaluation shows that 29.0% were initially deterred and that 13.0% continued to be uncomfortable with the setting for the DDR service. While this can be due to individual preference, it is likely to be somewhat dependent on how the day respite environment has been designed.

> *'… my husband will not willingly go. While the facilities are excellent they are still obviously part of an institution and do not provide the homelike atmosphere best suited to Dementia sufferers. The other Day Respite that I use is in a more homelike facility and is now my husband's second home.' (Carer)*

However, most could see advantages to the co-location, including the provision of a wider range of activities for care recipients, familiarisation with and greater access to residential respite services, and reduced anxiety about the person in their care entering long term residential services should their needs change.

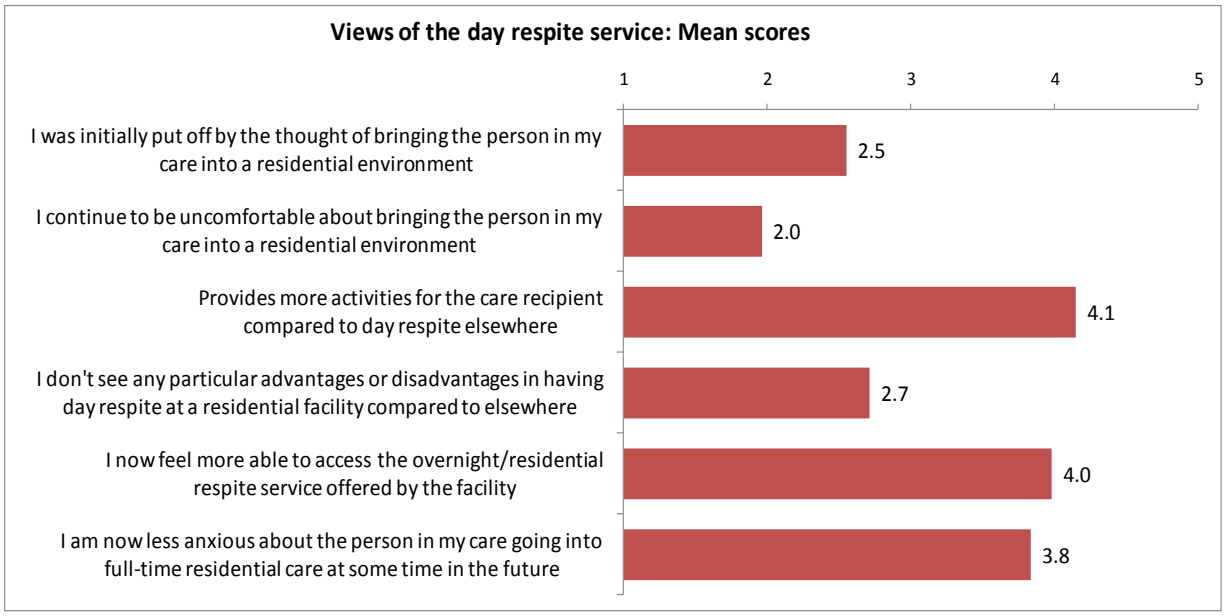
> *'Think having Day Care attached to residential care good. It gives client a chance to get used to environment and friends used to the idea of where client will be.' (Carer)*

> *'Having day respite in this facility provides a great way to introduce the person to the facility and make them and myself more comfortable.' (Carer)*

> *'Carers and care recipients become more receptive to nursing home care. The day respite centre is co-located with the nursing home. Carers visit the nursing home frequently and understand the nursing care services much better, thus removing the stigma and concern related to the service.' (Care Coordinator)*

Figure 3 illustrates these findings, which have been reinforced by survey findings from care workers, care coordinators and service directors (see **Accompanying Report 4**).

Figure 3: Carers' views on the DDR service – Mean scores



Reinforcing the carer perspective, it was common for DDR staff at the sites case-studied to report that the stigma held by many service users about residential aged care, while initially acting as a deterrent for some to access the day respite service, was reduced through familiarisation when using the day respite service. This was seen by some as making residential care a choice when once it would not have been considered. Carers were described by some providers as being better prepared for any transition to residential care by the person in their care.

> *'This thought of being put off about residential environment never crossed my mind, the facility brings much needed warmth and understanding in the care of others.'*

It was also evident that the issue of stigmatisation was less apparent when the service was culturally-specific or Indigenous-specific, and regarded as a trusted and culturally-relevant form of support –

regardless of co-location in a RACF. This was evident in relation to the Jewish *Stepping Out* service, the *So-Wai* service and the Indigenous *Rocky Ridge* service – all of which are auspiced by organisations that have designed their programs to meet the needs of their communities and have earned trust in the process. A similar trend was apparent in services located in smaller rural communities.

> *'Having a Chinese language centre is so fortunate. My wife certainly would not be able to participate in a program that was not Chinese specific. We feel very lucky that So Wai exists.'*

> *'Having such a wonderful program that is culture and language appropriate has provided my wife with so much happiness. She was feeling very isolated and increasingly depressed prior to this. All the staff at … [name of service] are so caring and kind. It has been such a great thing for our whole family ….'*

3 THE APPROPRIATENESS OF DAY RESPITE SERVICES IN RACFS

Appropriateness relates to a program's suitability in terms of achieving its desired effect and being used by its intended participants.

Guiding Evaluation Question

*To what extent has the **model** of respite care supported home-based care, the caring relationship and the well-being of the carer and the care recipient?*

Performance Indicators

- ✓ Maintenance of home based care arrangements where appropriate
- ✓ High level of access to day respite
- ✓ Timeliness from referral to acceptance on program
- ✓ High level of support provided
- ✓ Diverse range of care recipients and carers serviced
- ✓ Needs of care recipients met
- ✓ Needs of carer met
- ✓ Carer satisfaction
- ✓ Numbers of complaints

3.1 RATING THE APPROPRIATENESS OF DDR SERVICES

The surveys of Carers, Care Workers and Coordinators/Managers contained common questions about the features of the day respite service model and its appropriateness. Specifically, they were asked to rate their day respite service on these key features –

- its *flexibility* in adapting to their needs, and to the needs of care recipients,
- the *appropriateness* of the service for the needs of carers and care recipients,
- the *quality of the care* and support provided to carers and care recipients,
- the provision of a *safe* environment for care recipients,
- the degree to which *sufficient staff* were being employed.

Comparative analysis showed that there were strong levels of agreement (expressed in ratings of 4.4 to 4.7) that all but one of these features is being achieved. The only exception to this trend related to the lowest rating given by all three groups regarding the *appropriateness of care worker to service user ratios*. **Given the survey has identified from staff that individualised care, rated as a key success factor for day respite, is dependent on an appropriate care worker to care recipient ratio this can be interpreted as an area of concern.**

Carers had a significantly less positive view of the statement "*Offers good quality support for carers*" than did Care Workers and Coordinators/Managers ($p<.05$) **which would also indicate an area for potential improvement in service delivery.**

The importance of providing *transport* as part of the DDR service has been evident in carers' positive feedback about this, and the burden placed on them when transport is not provided, or in a way that is considered appropriate by them.

Carers surveyed have provided average ratings of 4.2 or better in relation to a number of dimensions of DDR services that provide an indication of their appropriateness. These concern service flexibility, accessibility, sufficiency. The fourth dimension – linkage to other services that carers would otherwise not have known about received the lowest rating of 3.7. Table 4 summarises these findings.

Table 4: Carers' assessment of service flexibility, accessibility, sufficiency and linkage

Dimension	Average rating
Flexibility	
Usually flexible in adapting to care recipient needs	4.4
Usually flexible in adapting to care recipient needs	4.4
Accessibility	
Provides transport	4.2
Does not present language barriers	4.6
Does not present cultural barriers	4.6
Opening hours suit my needs	4.3
Fees are affordable	4.4
Fees are fair	4.4
Sufficiency	
Provides enough hours/days of respite	4.2
Linkage	
Links carers to other services would not have known about	3.7

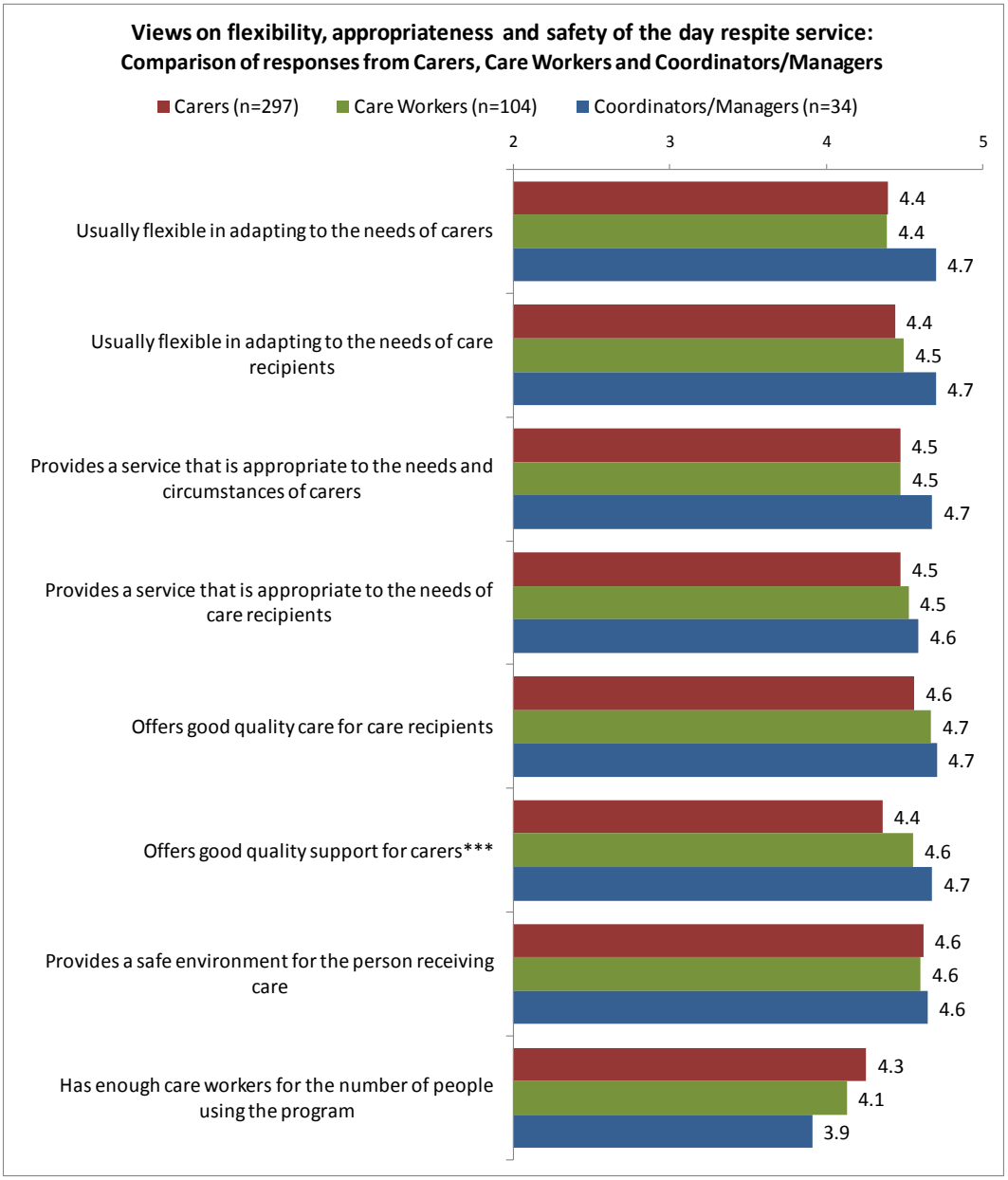
As Figure 4 indicates, carers' ratings – while positive - are also lower than those of DDR staff and managers in relation to the following service dimensions –

- flexibility in relation to meeting carer needs
- flexibility in relation to meeting care recipient needs
- providing a service that is appropriate to carer needs
- providing a service that is appropriate to care recipient needs

Agreement was evident in ratings about DDR services' provision of a safe environment for care recipients.

By contrast, carers were more likely than staff and managers to perceive staff to care recipient ratios as being sufficient, whereas care workers and especially care coordinators gave these their lowest ratings.

Figure 4: Comparing views on flexibility, appropriateness and quality of the DDR service



*** Carers had a significantly less positive view than Care Workers and Coordinators/Managers (p<.05).

3.2 RATING THE QUALITY OF DDR SERVICES

Carers surveyed have provided positive ratings of the quality of day respite services they received, as Table 5 indicates. However, their ratings while high (average 4.6) were slightly **lower** than those of care workers and care coordinators (average 4.7) in assessing the *quality of care provided to care recipients*.

They were significantly less positive (p<.05) in rating the *quality of support offered to carers* (4.4 as opposed to 4.6). **This then is an area in which DDR services can seek improvement.**

Table 5: Carers' assessment of DDR service quality

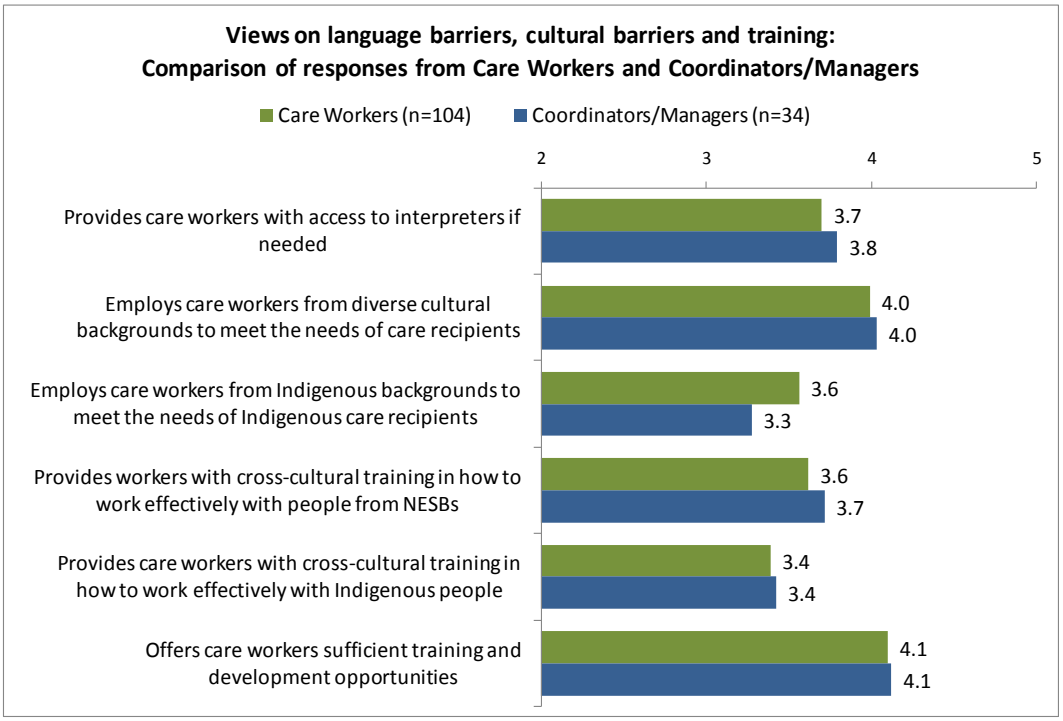
Carers' ratings of service quality	Average rating
Staffed by caring and kind workers	4.7
Staffed by competent workers	4.6
Provides safe environment for care recipients	4.6
Provides good quality support for carers	4.4
Provides good quality care for care recipients	4.4
Has a sufficient ratio of care workers to care recipients	4.3

3.3 MANAGING CULTURAL DIVERSITY

Although carers surveyed gave very positive ratings (average 4.6) about their DDR service's ability to meet their language and cultural needs, day respite staff were much less positive – *see* Figure 5. Relatively low ratings by both Care Workers and Coordinators were applied to service features relating to capacity to provide culturally appropriate services for Indigenous and for CALD background people, and for providing sufficient training and development opportunities to care workers. There was a reasonable level of agreement between the two sets of stakeholders on these issues. *These findings suggest areas for potential improvement by services not offering a program with a specific cultural focus.*

It is important to place these findings in context. Some of the DDR services are designed for specific cultural groups – some are Indigenous-focused, some are targeting particular linguistic and cultural groups, for example, South East Asian people. Those services need to be excluded from the lower ratings applied by staff to their service's cultural capacity, and reflect the challenges faced by culturally generic services. These relate to the need for resources for staff cross cultural training and awareness raising, and for access to accredited interpreters, as well as to the need for recruiting staff with specific language and cultural skills which reflect local need. The evaluators understand the pressures faced by DDR services in stretching finite resources, but note that investment in cross cultural awareness raising and the management of cultural diversity brings expertise that has generic relevance in service delivery - for example, an enhanced capacity to individualise care according to specific need.

Figure 5: Comparing views on language barriers, cultural barriers and training



3.4 ACCESSIBILITY - DAYS AND HOURS OF OPERATION

The accessibility of DDR services is based on a number of factors, including affordability (see *Section 5.6* which shows that fees and transport costs are heavily subsidised by sites), the provision of transport services (which almost all services are providing – see *Section 3.8*), addressing cultural and linguistic barriers (occurring in those sites offering specific services for CALD and Indigenous consumers – see *Section 3.3*) and offering services at times that meet the needs of carers.

Across the sites significant diversity was evident in operating days and hours, from smaller services with few operating days and relatively short operating hours such as *Stepping Out* in Melbourne (open for 8 hours per day on two weekdays only), through to large services such as *Garden City* in Brisbane which operates 7 days per week for 13 hours per day.

Twelve projects reported that they were operating on exactly the same days/hours for which they were funded. The *actual* operating hours of the other projects varied from their *funded* hours in a number of different ways, indicating that demand levels had not been accurately forecast. (Refer to Table 3, and Figure 1, Site Data Analysis Report – **Accompanying Report 7**, for actual operating days and hours per week, by Project.) The final Site Data Collected revealed that the majority of sites (74.2%) had not changed their operating days or hours during 2010, and of those who did report change, all but one had increased their hours or days in response to changing client needs – see **Accompanying Report 8**.

Across sites there is substantial variation in DDR services' provision of weekend respite care[8] –

- 7 sites provide respite on both weekend days at (24.1%)

[8] Note that two sites did not provide information on opening hours.

- 10 sites provide respite on one weekend day (34.5%)
- 12 sites do not provide any weekend services (41.4%).

Although carers have been very positive in their ratings of DDR services, where unmet need was expressed through open-ended feedback, the most commonly cited area of unmet need related to accessibility outside of normal working hours. While the evaluators realise that service providers face challenges in providing these hours if demand is not sufficient to achieve viability, the impact on those carers needing this support is substantial, as the comments below illustrate.

> *'I would like respite to be available at the weekend. Having no family it is tiring caring for a hyperactive 90 year old on my own.'(carer)*
>
> *'Hours - it is never open on public holidays, which is problematic for me.' (carer)*
>
> *'The program is only available for three of the seven days of the week.' (carer)*
>
> *'Service only provides Monday, Wednesday. Friday, Saturday. Still a big problem.' (carer)*
>
> *'Sometimes I go out on the weekend. I can't do this as often as I would like. I cannot find respite for weekend for one day.' (carer)*
>
> *'Hours not long enough and has to attend two residential high-care centres. (Working carer of high-care recipient)*

3.5 REFERRAL PATTERNS

3.5.1 REFERRAL SOURCES

As shown in *Table 6* (from the first Site Data Collection), all projects cited *community programs or services* as a source of referrals, indicating that this is probably the primary referral source for the day respite program as a whole. Most projects also received referrals from *health professionals* other than GPs and *self-referrals* from Carers. Hospitals were the fourth most common source of referrals, followed by an aged care facility and GPs. The final Site Data Collection (2010) found that targeted promotion by DDR sites had led to increased awareness among local health care providers and increased word-of-mouth based information about the DDR services in the local community - **Accompanying Report 8.**

Interestingly, Commonwealth Carer Respite and Carelink Centres were identified by relatively few sites, despite playing a key role in linking carers to respite and other support services**.** This may be due to residential care staff being unaware of these services (which would be more familiar to those in the community aged care sector), or the Carer Respite and Carelink Centres not being aware of the DDR services, or both. A reconciliation was undertaken with the Commonwealth Respite and Carelink Centres database and this showed that only 11 of the DDR projects were not recorded on the service directory data base.[9] However, the final Site Data findings showed that some sites had actively fostered greater linkage with these Centres – see **Accompanying Report 8.**

As linkage to other services is a key requirement of NRCP funding, this is an area requiring attention. In particular, a close collaboration between DDR services and the network of regional Commonwealth Carer

[9] The evaluators are very appreciative of the assistance provided by Ms Kerry Fischbein, Assistant Director, Carer Programs, Community Programs and Carer Branch, Department of Health and Ageing.

Respite Centres is required. This will link carers to emergency or unplanned short-term respite access, ensuring their access to a range of respite services to meet changing or diverse needs.

Table 6: Referral sources, listed by frequency

Referral Source	No. of projects	% of all Projects[1]
Community program or service	29	100.0%
Self (carer)	23	79.3%
Other health professional (i.e. not GP)	21	72.4%
Hospital	18	62.1%
Aged Care Facility	12	41.4%
GP	11	37.9%
Other eg C'wealth Carer Respite & Carelink Centres, word of mouth, local government	*13*	*45.0%*

1 Note that only 29 of the 30 projects provided data.

3.5.2 ACCURACY OF NEW REFERRALS

Of the 308 new referrals received by DDR services during the period July-December 2009, only 23 (7.5%) did not meet the eligibility criteria for the project to which they applied – indicating that the pilot projects had been promoted effectively and referral sources had been informed accurately. These 23 ineligible referrals were spread across six projects.

3.5.2.1 EXCLUSION OF SOME APPLICANTS

In 2009 the most common reasons cited for *ineligibility or exclusion of applicants* to the DDR service were *High-level care needs* (i.e. requiring two staff), cited by almost half of all projects, and *High-level challenging behaviours* (i.e. abusive, intrusive or inappropriate behaviours), cited by more than a third of projects – see **Accompanying Report 7.**

The final Site Data Collection showed that little had changed in 2010 – the most commonly cited reason for rejecting applicants was an inability to accommodate care recipients with complex and high level care needs, particularly arising from behavioural issues, mobility issues and other health issues requiring one-on-one support see **Accompanying Report 8**. Furthermore, most sites reported that they were rejecting around the same proportion of applicants as they had in the previous 12 months. A small number of sites (6 sites, 77.4%) reported a decrease in the percentage of applicants rejected, which they mostly attributed to a reduction in inappropriate referrals.

The evaluators note the exclusions based on high level challenging behaviours with concern but are unable to determine from the information obtained whether this is due solely to insufficient staff numbers or whether it is also due to limitations in the skills or training of staff. However, this group is a key NRCP target and represents significant respite need for their carers.

3.6 TIMELINESS OF DDR SERVICE PROVISION

3.6.1 ASSESSMENTS

Analysis of detailed Site Data for the period July-December 2009 (see **Accompanying Report 7**) showed that the **median**[10] time between referral and the completion of the assessment process was **7.0 days**, with 15.2% of care recipients assessed on the same day that they were referred ().

Changes to assessment processes had occurred during 2010 at less a third of the sites, and these changes had mostly involved undertaking a more detailed assessment of the care recipient in relation to their health and medical status, behavioural profile, social needs and activity preferences. Some sites reported making changes that involved an increased focus on the needs of the carer, for example, their goals for respite and providing additional information about available services and resources at the time of assessment - refer to **Accompanying Report 8** for further details**.**

3.6.2 CARE PLANS AND REVIEWS

According to the Site Data for July-December 2009, a *Care Plan* had been prepared for **92%** of clients. Of those who did *not* appear to have a care plan, the majority had only recently been referred to the service and had not yet received any respite. However, around 3% of care recipients spread across seven projects appeared to be without a care plan despite having received at least one day respite service.

Three quarters (74.5%) of care recipients had their first care plan prepared on or before the date of their *first service,* whereas one quarter had begun attending the service *before a care plan had been prepared*. The latter may in fact be an effective approach in cases where observation of the care recipient in the day respite context would assist in the development of their care plan, assuming that any risk factors had already been identified during the initial assessment process.

Around two thirds of care recipients with care plans had their care plans *reviewed* at some time during their involvement with the day respite service. It appears that reviewing care plans every 3 months or so is a common practice, with 89% of care plans being reviewed within three months of the client's most recent service.

Final Site Data Analysis identified changes to care planning processes at around half of the sites, mainly involving a broadening of the scope of Care Plans to provide a more comprehensive view of both carer and care recipient goals and needs – see **Accompanying Report 8.**

3.7 APPROPRIATENESS OF ACTIVITIES PROVIDED

DDR services are offering the range of activities to be expected in a day respite program (eg arts and crafts, games and physical exercise), with some going beyond this to offer significantly different and innovative activities – *see Case Studies 1 to 4, Section 2.5*. Survey feedback from carers and care providers

[10] Mean (average) time was unreliable due to highly skewed data.

also indicates that more activities than would otherwise be available in a day respite service are being provided, drawing on the programs and resources of the RACF – as discussed in *Section 2.2*.

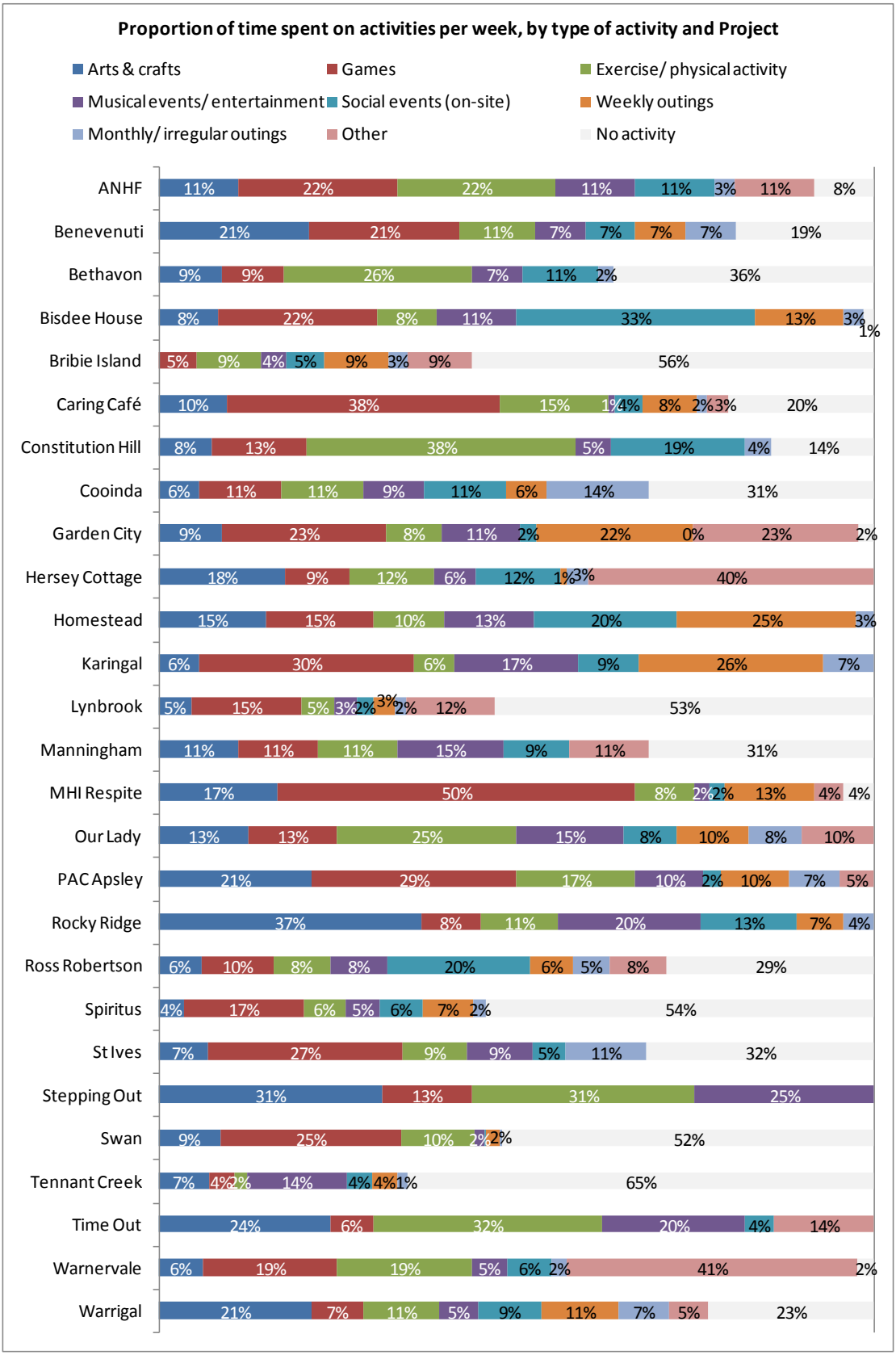
The first Site Data Collection revealed that over three quarters of the time spent in day respite across all projects involved some kind of activity, with the three activities involving the most time being games, exercise/physical activity and arts and crafts. Not surprisingly, the *proportion* of time spent engaged in organised activities varied greatly across projects, depending on specialist focus. The service model has the capacity to provide a wider range of activities for care recipients relative to most day respite services and is beneficial for RACF residents because of their ability to participate in day respite activities.

To enable valid comparisons between projects regarding time spent on activities, the number of hours spent on each type of activity per week at each site, as reported for the period July-December 2009 (first Site Data Collection), was converted to a proportion of that project's weekly operating hours. **This showed that over three quarters (77%) of the time spent in day respite across all projects involved some kind of activity.** The three activities involving the most time overall were **Games** (comprising 17% of total day respite time), **Exercise/physical activity** (13% of time) and **Arts and crafts** (12% of time).

Not surprisingly, the proportion of time spent engaged in these activities varied greatly across projects. Some projects had a particular focus on *exercise and physical activities,* namely Bethavon, Constitution Hill, The Centre for Healthy Ageing, Stepping Out and Time Out. Other projects had a greater focus on *games* (Caring Café, MHI Respite, PAC Apsley, St Ives, City of Swan), or on *social events* or *outings* (Bisdee House, Garden City, Homestead, Karingal). This diversity is illustrated in Figure 6 below.

The final Site Data Collection found that 71% of sites reported changes in 2010 to the types of activities they offered to care recipients, with many identifying a *broadening of activities.* Some sites had also focused on developing activity menus that were more appropriate for particular groups of clients while others had designed activities to increase care recipients' engagement with the local community.

Figure 6: Proportion of time spent on activities per week, by type of activity and Project[1]



1 Information not provided by Ave Maria and Perry Park.

3.7.1 ADDITIONAL SERVICES PROVIDED BY THE RACF TO DAY RESPITE CLIENTS

Apart from providing a range of appropriate activities for day respite clients, DDR services broaden this range by linking users to services provided through other programs of the organisation. Site Data analysis shows that all projects gave DDR clients access to some type of additional service provided by the RACF. As shown in *Table 7* these involved nursing services, referral to other RACF health and support services, use of residential respite, allied health services, health monitoring, hygiene services and medical services.

Table 7: Type of additional service offered to DDR service clients, listed by frequency

Type of RACF Service Offered	No. offering access to this service	% of all Projects[1]
Access to nursing services	27	93.1%
Referral to other health & support services	27	93.1%
Use of residential respite	26	89.7%
Access to allied health services	24	82.8%
Health monitoring	22	75.9%
Hygiene services	21	72.4%
Access to medical services	15	51.7%
Other eg Carer Support Group	*9*	*31.0%*

1 Note that only 29 of the 30 projects provided data.

These represent value-add services that would not normally be accessible in community-delivered day respite care.

In 2010 (final Site Data Collection) nearly 42% of sites reported changing the *range of services* offered. Changes focused on *carers* included an increase in carer education and referral services, a streamlining of respite booking systems, the introduction of overnight respite and the provision of personal care services. New services for *care recipients* offered by some sites included occupational therapy, art therapy and music therapy – see **Accompanying Report 8.**

3.7.2 ADDITIONAL UNFUNDED SUPPORT PROVIDED BY THE RACF TO THE DAY RESPITE SERVICE

Operating a Day Respite service within a RACF often requires the involvement of staff who are *not* specifically funded by the DDR service. For example, senior managers, nurse educators, administrative staff, domestic staff, quality assurance staff and financial officers may all contribute to the operation of the day respite service as part of their job without being specifically funded for doing so.

Twenty three of the 29 projects (nearly 80%) who reported data to the first Site Data Collection indicated that operating their DDR service involved the use of additional unfunded staffing from the RACF - most commonly, from managers, nursing staff and domestic staff. This involved **an average of 8 staff members per project.**

The greatest unfunded contributions in terms of time (FTE) came from *Care/Support Workers*, *Domestic staff* and *Managers*. While most of the additional unfunded staff individually spent only a small amount of time per week assisting the DDR service, when considered in its entirety this represented a significant unfunded contribution that equated to **over 30 full time staff per week (30.5 FTE) in total, an average of 1.1 full time staff members per project.** (See Tables 9 and 10 of the Site Data Report, Accompanying Report 7.)

The trend to receive unfunded support in the form of input from RACF staff was found to have continued during 2010, based on reporting for the final Site Data Analysis (**Accompanying Report 8**.) In addition, 42% of sites reporting receiving additional infrastructure to better meet the needs of high care recipients (refer to **Accompanying Report 8**).

The cross-fertilisation of resources between the RACF and DDR service can be seen as beneficial for both residents and day respite users, and as bringing benefits to the RACF that range from the tangible (sharing of staff resources, pooling of resources to purchase consumables etc) to the intangible (raised profile in the local community, increased staff experience across programs). This is also discussed in *Section 2.8 and Section 5.1.4.*

3.8 TRANSPORT SERVICES PROVIDED

According to the two Site Data Collections, most projects provide transport both to and from the DDR service for care recipients, and only three projects do not currently offer any type of transport to their care recipients. Buses, vans and cars owned by the RACF were the most commonly offered types of transport – see *Table 8*. If taxis were used, it was common for a protocol to have been developed with a taxi company to ensure that clients' needs were able to be met.

Final Site Data Analysis found that during 2010, a third of sites reported a change in their transport service that in most cases involved additional servicing in response to increased demand. Sites also indicated that meeting transport demand is an ongoing challenge – see **Accompanying Report 8.**

Table 8: Types of transport offered to DDR service users

Type of transport offered	No. of projects	% of all Projects[1]
Bus or van	20	69.0%
Car(s) owned by RACF	19	65.5%
Taxi	14	48.3%
Private limousine service	2	6.9%
Other	*12*	*41.4%*

1 Note that only 29 of the 30 projects provided data (first Site Data Collection).

3.8.1 THE IMPORTANCE OF TRANSPORT BEING PART OF THE SERVICE MODEL

The research literature is clear in finding that transport plays a key role in making day respite services accessible (refer to **Accompanying Report 1**). For some carers, the time required to transport the person in their care to and from day respite may add to their burden and provide a disincentive to participate (Baumgarten *et al*, 2002: 255; Urbis, 2008: 131).

Findings from the evaluation surveys and case studies reinforce the predominant literature view, confirming that transport is a critical success factor for the DDR service model.

3.8.2 CARER SATISFACTION WITH TRANSPORT SERVICES

80.4% of those who need to use the DDR transport services reported that they were **Very Satisfied**. Only **5.4%** of carers surveyed were **dissatisfied** with transport arrangements and these commented on the unsuitability of taxis for some care recipients, or a lack of flexibility in the transport service provided, or the additional burden placed on them by transport not being provided. Their comments illustrate the importance of providing transport as part of the day respite service, and of tailoring this to the needs of carers.

> *'He used to travel by the bus from Respite and now it's all Maxi Cabs and you don't get the same contact with the ones looking after him. In summer Mum gets up 5am - 6 am. I now take her to respite arriving at opening time - 8am. It is a long wait for the bus to arrive at about 9.30am. During the wait she convinces herself the bus isn't coming and can become quite agitated.' (carer)*

> *'Centre started transport then changed the route which stops 10 minutes from our home. We live in a transport deprived area and have to use community transport 2 times per week which does not pick up til 9.45am and return by 3pm which gives my husband only 4 hours per Day Respite.' (carer)*

> *'To have transport with understanding drivers for the first few visits was a great help. I believe this was discontinued owing to funding restraints. I am able to drive but find it very demanding on my time ….' (carer)*

3.8.3 COST OF TRANSPORT FOR CLIENTS

Transport costs tended to be subsidised by the day respite service to minimise any financial burden on clients. Site Data collected for the period July-December 2009 showed that almost half of all projects which offered transport reported that this was *free* for all clients, while two projects sought donations for transport and the remainder charged a set fee. Fees charged for both-way transport ranged from $2 to $8, with the **average fee being $4.77**. Fees for one-way transport ranged from $2 to $5, with an average fee of $2.80.

Final Site Data Analysis found that only two sites reported a change in transport fees during 2010, while other charging fees had kept these fees at the same level – see **Accompanying Report 8.**

3.8.4 FLEXIBILITY IN TRANSPORT PROVISION

Carers place a high value on service flexibility, and this extends to transport provisions. DDR services have demonstrated flexibility in tailoring transport to carer and locality needs. The different approaches to transport, illustrated below, illustrate how case-studied services are tailoring their transport to user need, and to local conditions. Further information is provided in Accompanying Report 3.

⇒ *The Caring Café* faced the challenge of using taxis for short distances in a congested inner city location in Melbourne and addressed this issue by providing direct transport using their own staff, especially for care recipients with high level need, and developing a protocol with a taxi service.

⇒ *Bribie Island* uses a mini bus that collects and delivers care recipients at fixed times. The bus trip takes one hour each way and care recipients were reported by staff as enjoying the trip, which contrasts with many other services who reported that lengthy bus trips were tiring and not enjoyable, leading them to offer taxis as an alternative.

⇒ In direct contrast, the *Rocky Ridge* bus service for day respite participants was reported to be an enjoyable experience, with care recipients relishing the opportunity to see people they knew as the bus includes on its route both homes and sites where people are likely to be found. In this sense, it is proactive in seeking out care recipients, including in the 'long grass' by road sides. A highly flexible service, it is a central part of all activities offered, and integral to the day respite service's success.

⇒ *Stepping Out* was initially funded to purchase a mini bus but care recipients expressed a wish for flexibility in the times they would be transported to and from their homes, and were not willing to sit in the bus while others were being transported. To address the need for a more tailored transport service, *Stepping Out* has used taxis, including maxi taxis for those with restricted mobility. A protocol was developed with one taxi company and drivers were given additional training in working with older and disabled people, and were police checked. Working carers who transport care recipients on their way to work are able to bring the person in their care dressed in their pyjamas to reduce the amount of time involved for them.

⇒ *Hamersely House* - Morrison Lodge provides individual pick up and drop home service using cars driven by qualified aged care staff. On occasion, the pickup service may result in some home help/personal care activities (e.g. to assist with dressing) to help the care recipient prepare to attend the service. This usually happens where the primary carer has left for work prior to the pickup. Two staff members have designated pickup and drop off routes. The transportation of care recipients to and from *Hamersley House* requires approximately five hours per day per staff member, making it a significant investment for the service.

3.9 PROFILE OF CARERS AND CARE RECIPIENTS

Site Data analysis across the 29 projects which submitted data for the **July-December 2009 period** yielded this profile information –

- *Females* were over represented in the carer group (74.5%) compared to the care recipient group (56.4%), as would be expected.

- The *age profile* of carers was clearly younger than that of care recipients, as anticipated, with 53.3% of carers aged under 65 versus 7.1% of care recipients aged under 65.

- Very few carers had been *Widowed* (3.1%) compared to care recipients (40.0%), reflecting the younger age profile of carers. Correspondingly, just over half (52.5%) of care recipients were in a *Married/Defacto* relationship, compared with 83.9% of carers.

- As discussed in *Section 2.3.3*, care recipients' cultural profile was consistent with that of the wider Australian population, while Indigenous service users were represented at higher proportions than occurs in the population as a whole, as were those living in regional, remote and very remote locations.

Additional profile information from the 2009/10 SARs (**Accompanying Report 9**) indicated that around a quarter of carers using the service that year were from *financially or socially disadvantaged backgrounds,* and more than a quarter of carers were *employed***.**

As Figure 12 in the Site Data Analysis report (**Accompanying Report 7**) illustrates, at assessment the needs of care recipients were relatively high with –

- the *General health status* of nearly half (48.2%) being assessed as *Fair*,
- the *Level of care required* being assessed as *High* for 45.1% of care recipients, and
- the *Priority level for entry* to the day respite service assessed as *High* for nearly half (49.0%) of the care recipients.

Special care needs were reported for two thirds of the care recipients. By far the most common special care need cited was *Dementia* – refer to **Accompanying Report 7**. A range of *Mobility/ADL needs* were reported, as well as other *Physical disabilities or needs*. *Behavioural* issues (aggression, challenging behaviour or other behavioural issues) were reported for a small number of care recipients. Additional profile information from the 2009/10 SARs (**Accompanying Report 9**) quantified the special needs as of care recipients as follows –

- Over half of all care recipients had **dementia**,
- Around a quarter of care recipients had **dementia with challenging behaviours**,
- Around a quarter of care recipients had a **disability**, and
- Around 1% of care recipients were **receiving palliative care**.

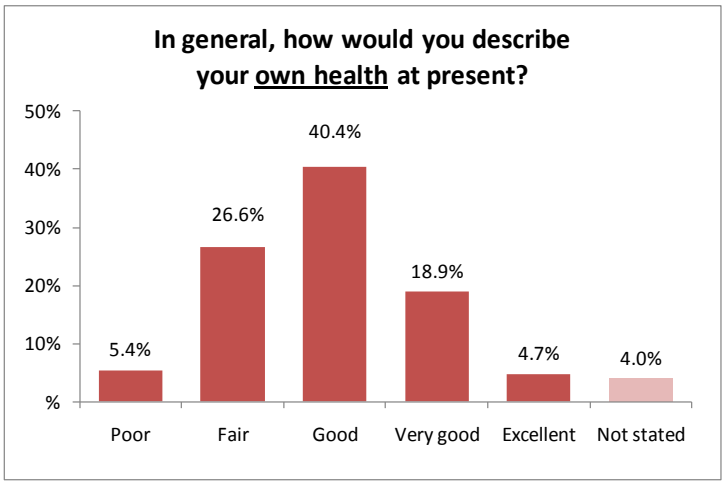
As *Section 4.3* discusses, three quarters of all care recipients exiting the DDR service to enter full time care were admitted to *high level residential care*, further indicating the level of their care needs.

Final Site Data Analysis identified a change in the profile of carers and recipients by 12 sites (38.7%) that included a trend towards increasing high care needs and clients from diverse cultural and linguistic backgrounds. Some sites also noted an increase in the number of carers presenting with stress or health issues – see **Accompanying Report 8.**

3.9.1 CARER HEALTH AND DISABILITY PROFILE

Over 60% of Carers surveyed in 2009 described their current health as *Good, Very Good or Excellent*, while 32% rated their health as Fair or Poor – see *Figure 7*.

Figure 7: Carers' description of their present health

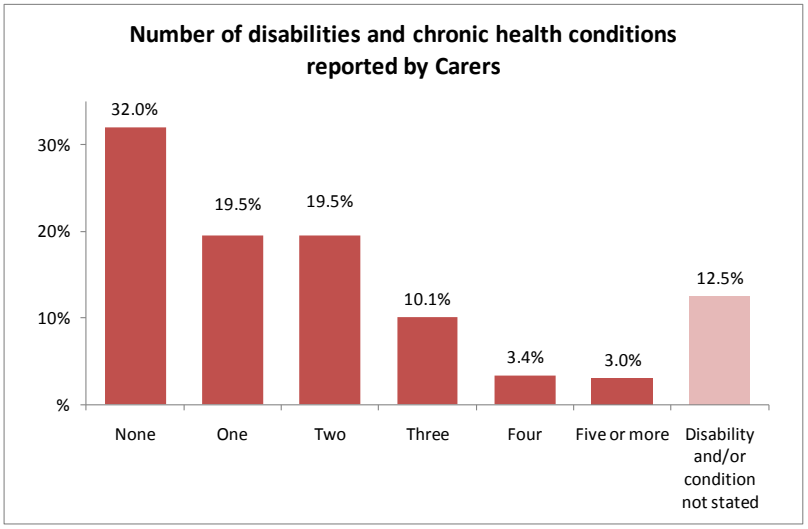


Approximately one third (34%) of Carers reported at least one disability, and 4.4% reported more than one disability. The most commonly reported types of disability was *Physical disability* (21.2% of Carers) followed by *Hearing problems* (11.4%) and *Sight problems (not corrected by spectacles or contact lenses)* (5.4%).

More than half (56.5%) of the Carers reported at least one chronic health condition, and nearly a quarter (23.2%) indicated that they had more than one chronic health condition. The most frequently identified condition (37.0%) was *Bone, Muscle or Joint problems*, followed by *Heart condition* (10.1%) and *Diabetes* (88%). Taking information on disabilities and chronic health conditions together –

- Less than one third of Carers (32.0%) reported that they had *no* disabilities or no chronic health conditions;
- 39.0% reported one or two disabilities and/or chronic health conditions; and
- 16.5% reported three or more disabilities/conditions – see *Figure 8*.

Figure 8: Number of disabilities and chronic health conditions reported by Carers



This information points to the important role played by day respite services providing a specialist focus on carer health and wellbeing, as occurs, for example, with the *Healthy Ageing Centre* at Rooty Hill.

3.10 COMPLAINTS

All Care Coordinators and Service Directors who responded to the 2009 survey indicated that there was a formal complaints mechanism in place for their DDR service, as would be expected. While respondents at the majority of RACFs indicated that no formal complaints had been made to date, respondents at four RACFs reported that one complaint had been made about their DDR service, one RACF reported that two formal complaints had been made, and one RACF reported that five complaints had been made.

Thirteen carers (4.4% of those surveyed) reported that they had felt the need to make a complaint about their DDR service, only four of whom stated that the process for making a complaint was made clear to them. These carers came from eleven different sites, and related to –

- Reduced resourcing as the program has increased its numbers
- Resourcing that restricts services, particularly, transport and the range of activities available
- Failure to maintain continuity of care workers
- Billing processes
- Failure to provide after hours' access
- Poor quality of care.

In addition, the evaluators analysed four items from the complaints section of the SAR which are not normally entered into the Department's spreadsheet, extracting information from the paper forms for 2008/09 and 2009/10. This provided a further source of data about the number and types of complaints made by day respite clients.

In *2008/09* there were **42** complaints recorded, 28 (66.7%) of which related to systemic issues. Of these, 16 (57.1%) were resolved.

In *2009/10* there were **41** complaints recorded, 19 (46.3%) of which related to systemic issues (a reduction from the previous 12 months). Of these, 10 (52.6%) were resolved.

Overall, in terms of the number of carers and care recipients involved with the program, the number of complaints is quite low – equivalent to **less than 3 complaints per 100 carers/care recipients** who used DDR services.

The complaints most commonly reported by the projects involved:

- Transport issues;
- Lack of availability of weekend or overnight respite, or limited availability of respite for care recipients with high care needs;
- Meals;
- Facilities (e.g. parking, toilet facilities, telephone system, entrance); and
- Fees.

The information provided by the projects indicated that almost all of the complaints made regarding transport, meals, facilities and fees had been resolved, commonly through changing the underlying procedures, processes, equipment or physical environs involved.

The area where it was most difficult for the projects to effect change involved requests for respite at particular times of the day or week, and for particular types of care recipient such as those with high care needs. However a number of projects did respond to those requests by changing their hours of operation and/or staffing.

4 THE EFFECTIVENESS AND IMPACT OF DDR SERVICES

4.1 BENEFITS TO THE CARER AND CARE RECIPIENT OF ACCESSING DDR SERVICES

Effectiveness concerns the extent to which the program's objectives are being achieved, or are expected to be achieved, and the benefits for its participants.

Guiding Evaluation Question

*What have been the **benefits** to carer and care recipients accessing DDR services?*

Performance Indicators

- ✓ High level of access to day respite
- ✓ Responsiveness from referral to acceptance on program
- ✓ High level of support provided
- ✓ Carer satisfaction
- ✓ Positive benefits for carer and care recipient health and well being
- ✓ Use of community supports and resources
- ✓ Maintenance of home based care arrangements where appropriate
- ✓ Needs of care recipients met
- ✓ Needs of carer met

4.1.1 BENEFITS AND OUTCOMES FOR THE CARER

The research literature (**Accompanying Report 1**) yields little reliable evidence demonstrating any significant impact of respite services on carer wellbeing, with at best only modest benefits identified (Mason *et al*: 2007; Keefe & Manning: 2005; Arksey *et al*: 2004; McNally, Ben-Schlomo & Newman: 1999). However, there is a reasonable amount of evidence that identifies a reduction in 'carer burden' (Zank & Schacke: 2002; Mason *et al*: 2007).

Given the responsibility of caring for a frail older person or a person with dementia usually involves increasing levels of care, it is not surprising that the impact on carer health and well being is not large. It is perhaps unreasonable to expect that respite care could achieve such an outcome, as it is designed to provide a break from caregiving, not to change the underlying causes of carer stress or responsibility.

There is, however, a strong trend in the literature for studies to report **high levels of carer satisfaction** (Mason *et al*: 2007; Irigoyen *et al*, 2002; Zank: 2000; Pickard: 2004) with respite care services. However, different assessment tools have been employed across the different studies making comparability and

the identification of clear trends extremely difficult. There is also a clear relationship between carer and care recipient satisfaction with respite services, illustrating the importance of the caring relationship in defining the impact of services on either party (Van Exel *et al*: 2006). This finding was evident in the feedback provided by carers for this evaluation about what they sought from the DDR service (see *Section 2.3.1).*

4.1.1.1 DDR RESPITE-RELATED BENEFITS AND OUTCOMES

As Table 2 in *Section 2.3.2* documented, according to our survey findings carers have provided very high ratings for the following benefits of DDR services –

- ⇒ Provision of a break or 'time out' (average rating 4.4)
- ⇒ Provision of time for carers to fulfil other responsibilities (4.4)
- ⇒ Provision of increased socialisation opportunities for care recipients (4.5)
- ⇒ Provision of opportunities for care recipients to participate in activities helpful to their condition (4.5)
- ⇒ Delayed the need to place the care recipient in full time care (4.1).

  And to a lesser extent
- ⇒ Provision of more time for carers to work (3.8).

Open-ended feedback from carers further supports these ratings.

> *'Without the help I received, I wouldn't have been able to carry on.'*
>
> *'Having a day where I can plan ahead and do something for myself has made an invaluable difference to my life.'*
>
> *'It is something that is needed for carers as you know that they are safe and in good hands and you get a chance to do a lot of things that take a fair bit of time.'*
>
> *'I could not work without this program.'*
>
> *'I now am much more patient, as I get a little rest after the housework is done. When mum comes home, it's lovely to see her.'*
>
> *'The program enables me to keep my part time work, gives me a feeling of freedom for that day and security that I know Mum is being looked after.'*
>
> *'Program has allowed me the opportunity to meet with people in similar circumstances and compare notes - also to be able to attend to my own health issues.'*
>
> *'Certainly without respite I would not be caring for my mother. I rely on the program to tire her so she sleeps throughout the night.'*

4.1.1.2 HEALTH AND WELLBEING BENEFITS AND OUTCOMES

The profile of carer health and wellbeing identified in *Section 3.9.1* highlights the importance of DDR services being able to deliver health-related benefits for carers. Survey feedback has identified a number of positive outcomes for carer health being achieved by the DDR services. From the carer perspective, their participation in the program has -

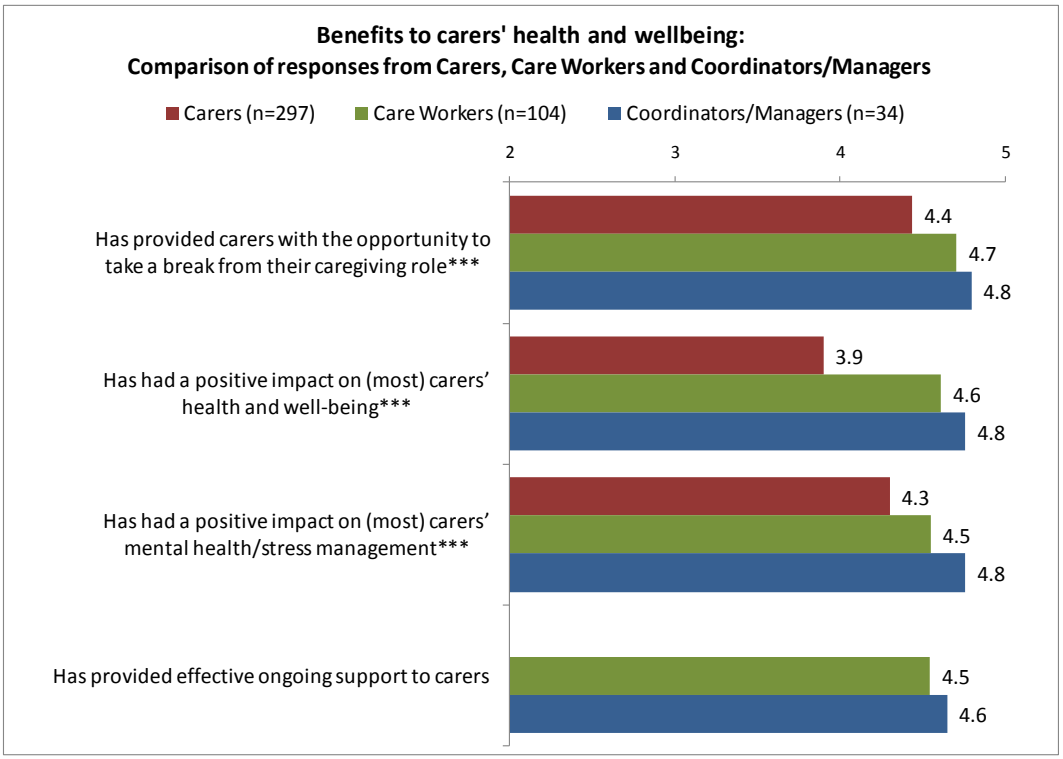
- ⇒ reduced their stress (4.3)
- ⇒ reduced worrying about care recipient (4.3)

⇒ positive impact on their mental health (4.3).
⇒ provided more time to address own health issues (4.1)
⇒ and to a lesser extent
⇒ improved their health and wellbeing (3.9) - see Figure 9.

Survey feedback from care workers and care coordinators supports these findings, with their average ratings also involving '4' or more, and being consistently higher than those of carers.

> *'It has reduced the stress I was feeling immensely and given me a greatly needed break. I can relax knowing Mum is in good care and having a good time. (carer)*

Figure 9: Comparative views on benefits to carers' health and wellbeing



*** Carers had a significantly less positive view than both Care Workers and Coordinators/Managers (p<.05).

4.1.1.3 SERVICE ACCESS AND USAGE BENEFITS AND OUTCOMES

A potential benefit of the service model lies in the capacity to make carers more aware of, and more linked to other services that can support them, or the person in their care. As *Figure 10* shows, carers were less positive than the two groups of service provider stakeholders in rating the DDR program on its service access and usage related benefits. However, their ratings confirm the DDR services' provision of these benefits -

⇒ Made carers more aware and informed about residential aged care (4.1)
⇒ Made carers more aware of other services for them or for care recipients (4.1)
⇒ Made carers more confident about using respite in a residential setting (4.2)
⇒ Made it easier for carers to access other services for them or for care recipients (4.0)

And to a lesser extent -

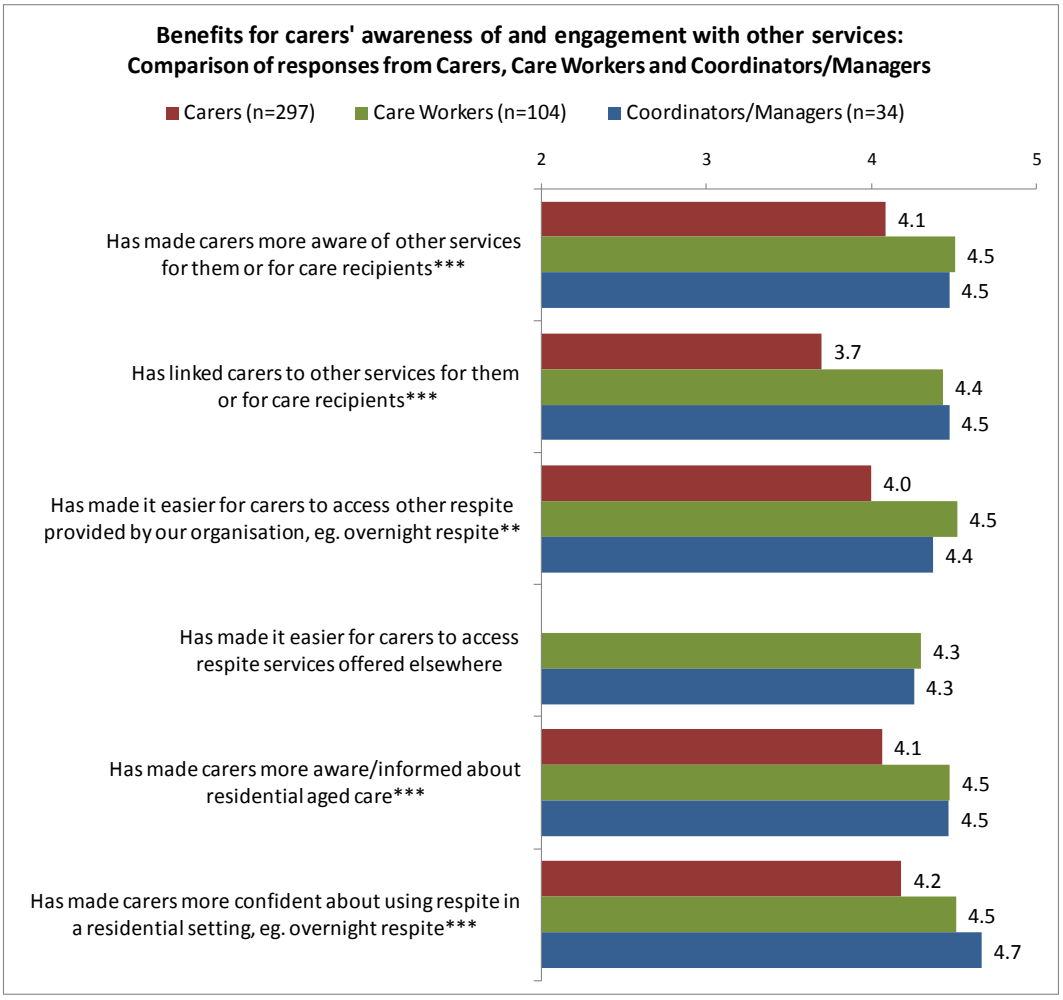
⇒ Linked carers to other services for them or for care recipients (3.7)

Care workers and coordinators also identify the benefit of –

⇒ making it easier for carers to access respite services offered elsewhere (4.3).

Again, survey feedback from care workers and care coordinators supports these findings, with their average ratings also involving '4' or more, and being consistently higher than those of carers.

Figure 10: Comparative views on benefits for carers' awareness of and engagement with other services



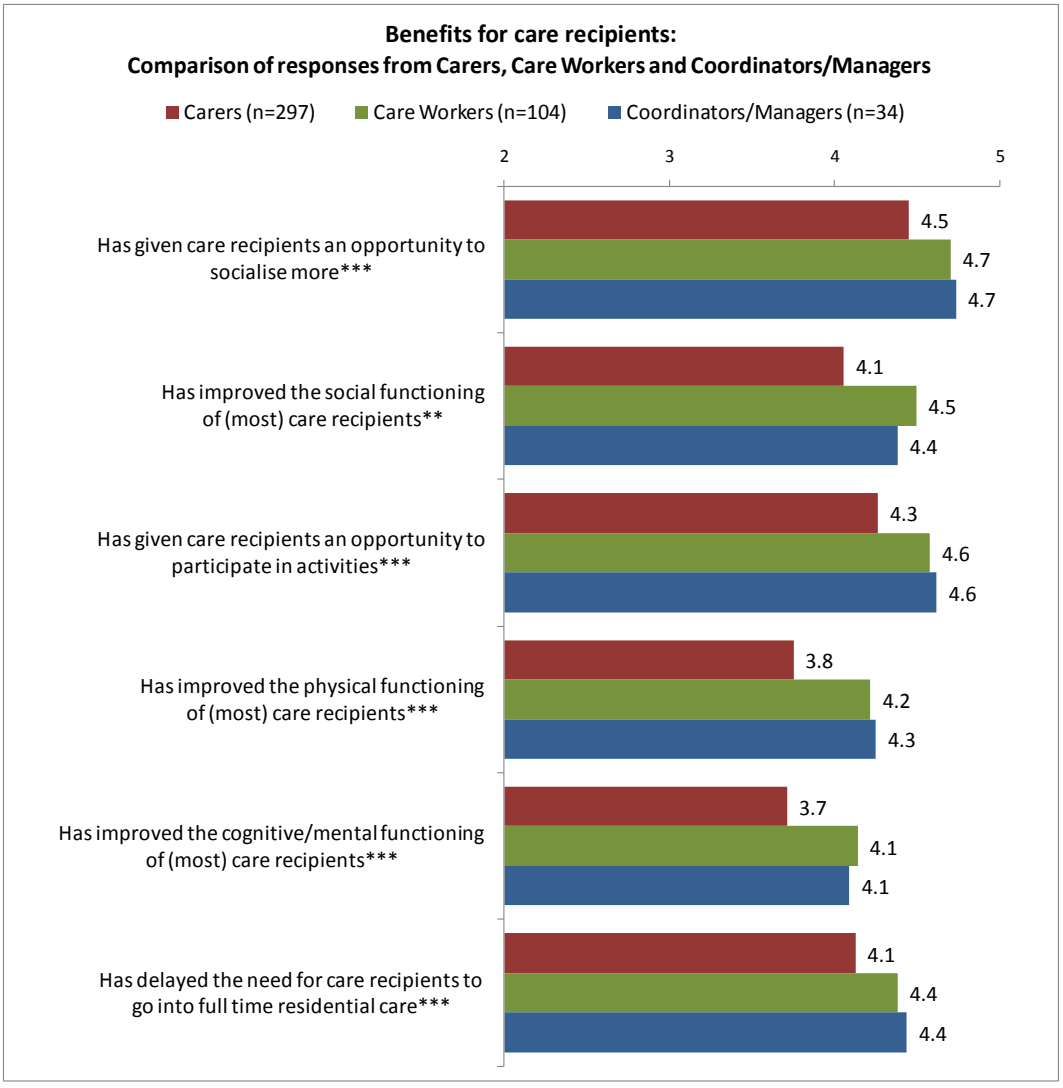
** Carers had a significantly less positive view than Care Workers (p<.05).
*** Carers had a significantly less positive view than both Care Workers and Coordinators/Managers (p<.05).

4.1.2 BENEFITS AND OUTCOMES FOR CARE RECIPIENTS

Extensive literature reviews (of research undertaken between 1985 and 2003) have found no reliable experimental evidence that respite care provides significant short or long term benefits to care recipients (Arksey *et al*, 2004: 9) or that it adversely affects them (Mason *et al*, 2007: 1), regardless of respite care model.

Nevertheless, Carers, Care Workers and Care Coordinators surveyed for the evaluation have identified benefits relating to the DDR services' social impact on care recipients, but less so in relation to improving physical or cognitive functioning – see *Figure 11*.

Figure 11: Comparative views on benefits for care recipients



** Carers had a significantly less positive view than Care Workers (p<.05).
*** Carers had a significantly less positive view than both Care Workers and Coordinators/Managers (p<.05).

It can be seen that Carers were significantly more conservative (p<.05) than staff in rating all six potential benefits for care recipients. However, they have given very positive ratings to the achievement of –

⇒ The opportunity for increased socialisation (average rating 4.5)
⇒ The opportunity to participate in activities (4.3)
⇒ Improved social functioning of care recipients (4.1)
⇒ Delaying the need for care recipients to enter full time residential care (4.1).

Open-ended feedback from carers reinforces their ratings of the program's benefits and effectiveness.

'Our teenage grandchildren have commented on their Pop's manner and actually now being able to have a conversation and joke with him - since attending Respite regularly it really gives him an input into their talks with him as recounts some of his experiences there.'

'Activities have been so beneficial. Within a couple of weeks of attending my mum is a lot happier, eating properly and giving her something to talk about. Been Brilliant.'

'Has allowed my husband to mix with people instead on sitting in a chair all day.'

'The transformation in the person I care for is phenomenal. The program has overcome social isolation, depression, stimulated activity and interest in others. Prevented the need to institutionalise my sister.'

'Absolutely a life saver for someone who was severely depressed and making no effort to socialise. Staff have been so supporting to us both.'

'My mum has really benefitted from attending the … [name of service]. She is happier, has a more positive outlook on life and is learning new things.'

'The person in my care is much happier with his days out and feel I will be able to care for him at home longer.'

Less positive has been their rating of the DDR services' impact on –

⇒ Improving care recipients' physical functioning (3.8)
⇒ Improving care recipients' cognitive functioning (3.7).

'Because of his condition it is difficult to judge benefits for the person in my care. For me it is a plus that he is happy to go and participate.'

'Person in care had Advanced Dementia, so no real improvement in condition. Eventually admitted in to high-care residential and has since passed away.'

(See also *Section 4.2.1* where unintended positive effects of the program identified by some carers include the improvement in care recipients' social functioning, and in some cases, mobility and ADL abilities.)

4.1.3 BENEFITS FOR RACF RESIDENTS

Benefits have been identified for carers, care recipients and for RACF residents, which is a less expected finding. Across all projects, approximately **30%** of total activity hours per week were shared with residential care recipients (reported in the first Site Data Collection), and balancing this has been DDR consumers' increased access to services intended for RACF residents.

Unintended positive effects of the program identified by care workers, care coordinators and service directors (see *Section 4.2.1*) cited benefits for residents that include –

⇒ A wider range of activities to access and
⇒ Increased socialisation opportunities through their interaction with DDR care recipients.

The positive impact of new infrastructure and related resources will also be benefitting residents in some facilities, and less directly, residents can be expected to benefit from the increased learning and training opportunities available to staff.

4.2 UNINTENDED EFFECTS OF THE INITIATIVE

Guiding Evaluation Question

*What have been the **unintended effects** of the Initiative, including any adverse consequences for carer/recipient?*

Performance Indicators

- ✓ Positive unintended effects identified
- ✓ Negative unintended consequences identified

The surveys with Care Workers, Care Coordinators and Care Managers identified a number of positive and negative unintended consequences of the DDR Pilot Initiative.

4.2.1 UNINTENDED POSITIVE EFFECTS

Survey feedback sought open-ended feedback about the unintended positive and negative effects of the DDR Initiative. Across all four stakeholder groups there was a pronounced trend to identify significantly more **positive** than negative unexpected outcomes. Details appear in CHART 4 and CHART 5. These involve six types of benefit –

- ⇒ **Improvements in the care recipient's condition** (identified by all four stakeholder groups)
- ⇒ **Improvements for carers** - more informed about aged care services, making new friends, becoming less socially isolated, less stressed, having more time, able to be in paid work, improved confidence to use respite services (identified by all four stakeholder groups)
- ⇒ **Facilitation of the transition from community care to residential care** when this is needed, in part due to **demystifying** the residential care environment (identified by all four stakeholder groups)
- ⇒ **Benefits for the RACF** – improved service networking and profile with other services, enhanced public image through reduced stigmatisation of residential provision, cross-fertilisation of resources; enhanced physical infrastructure, staff have wider range of training etc (all three service provider groups)
- ⇒ **Benefits for residents** – wider range of activities to access, wider socialisation opportunities through interaction with DDR service (all three service provider groups)
- ⇒ **Flexibility** and **quality** of services provided; receiving services not expected eg health monitoring (identified by carers only).

CHART 4 : Unintended positive effects of DDR services

Unintended positive effect	Stakeholder group identifying			
	Carer	CareWorker	Coordinator	Director
Improvements in care recipient's condition, enhanced mobility and ADL, social skills, increased friendships, enjoyment of the DDR program, access to range of services in a single setting and individualised care				
'I did not expect him to enjoy the centre as much as he does e.g. wakes early on the day to get ready, sometimes too early.' (carer) *'I am surprised Dad has been attending so happily and continues to want to attend. He was never very social, so this has been great.' (carer)* *'… cognitive skills improved which was a surprise. Yes, she wants to go each time, it changed her attitude ….' (carer)* *'Clients' improvements of mobility through exercises. Clients' ability to sing and dance and rediscover the music they loved. Rediscover their creativity. Improved eating habits through daily menus.' (care worker)* *'Yes I can honestly say that there has not been one client that has come through our door that has not had some improvement in their [sic] and in their family's quality of life. I didn't believe we would make 100% difference in some positive way but we have.' (care worker)* *'One of our guests knitted a pair of baby booties, without a pattern, who has not knitted for many years. Same guest is now writing again. No 2 guest now leaves house and never would previously, his wife says he looks forward to coming. He enjoys every moment here.' (care worker)* *'Have had clients who appeared to be withdrawn actually 'coming out of their shell' and participating in activities as well as interacting positively with other clients and residents.' ' (care worker)* *'Care recipients have become actively involved in decision making at the centre - contributing to activity plans that effect them. Designing gardens etc etc.' (care coordinator)* *'Care recipients can have all their services in one place, eg. physio, hairdressing, respite, stress management, podiatry and hydrotherapy.' (care coordinator)* *'Depth of relationships between clients and other clients and staff - when clients have gone to residential care they really miss the connection with the service. (care coordinator)*				
Eases the **transition from community care to residential care** when this is needed; demystifying of residential care environment				
'My mother will be willing to go into low care fulltime. She was negative towards it before Day Respite.' (carer) *'I've discovered that aged care is not nearly as fearful as I once thought. Nor do I have the stigma of 'shutting her away' bothering me anymore, thanks to the wonderful carers at … [name of service].' (carer)* *'The transition into full time residential care has been accepted much easier for both the client and carer.' (care worker)* *'Clients are able to access respite care at the facility and some clients have made the move to live in the facility. We are able to offer transitional [service] which helps to settle client into facility. If clients do have respite or full time care at facility they are welcome to visit and this has helped them a great deal.' (care worker)* *Offering a transition plan has helped in this area whereby clients continue for a designated time. … We have occasional drop in times for previous clients now in secure unit, they really look forward to these times and are so happy to see us.' (care coordinator)*				

Unintended positive effect	Stakeholder group identifying			
	Carer	CareWorker	Coordinator	Director
Improvements for carers - more informed about aged care services, making new friends, becoming less socially isolated, less stressed, having more time, able to be in paid work, improved confidence to use respite services				

'More information about services, facilities, problems and solutions, via facility staff and other carers/users. I can also socialise at the centre as I attend with my wife.' (carer)

'I have been able to mix with other carers at the centre - sharing thoughts and ideas, individual exercise classes and group Thai Chi and individual massage therapy and joining in general activities of the centre and learning new things' (carer)

'Stress levels are down. It's great to have time out for me the carer.' (carer)

'Having several hours free every Friday. I arranged with a friend to go walking. We walk for four or five hours in the beaches every week and my health has improved accordingly.' (carer)

'Carers - initially only accessing one event of respite are gaining the confidence to access more events of respite for themselves.' (care worker)

'Offers carers more changes/time to work and work stably.' (care worker)

'Carers start to use overnight respite, allowing themselves the opportunity to have a break from caring. Whereas before they would not have even thought about it. They do not feel as guilty about leaving their loved one.' (care coordinator)

'We have focused on carers, providing facilitated outings which have led to friendships between fellow carers. Carers have been provided with valuable information from the support group meetings.' (care coordinator)

'Independent surveys have indicated that the Personal Wellbeing Index on carers using the centre is significantly higher than the national average. The result is unexpected because the most frequent postcode reported lies in the first decile of disadvantage in both NSW and Australia.' (Service Director)

'The opportunity to offer education to carers and the broader community, eg. on falls prevention and reducing the risk of dementia, has opened up the relationship between the facility and the broader older community.' (Service Director)

Flexibility and **quality** of services provided; receiving **services not expected** eg health monitoring				

'The staff keep an eye on any health issues.' (carer)

'There are times when I have been late to pick up my husband and I rang in and he will still [be] cared for by the incoming staff.' (carer)

'When I unexpectedly went to hospital they were able to take him for the whole week, otherwise he would have had to go somewhere where he knew nobody.' (carer)

Unintended positive effect	Stakeholder group identifying			
	Carer	CareWorker	Coordinator	Director
Benefits for RACF – improved service networking and profile with other services, enhanced public image through reduced stigmatization of residential provision, cross-fertilisation of resources; enhanced physical infrastructure, staff have wider range of training etc				

'Carers involved in program give positive views and tell other people in community - this gives a lot of positive feedback about the high standard of care given by staff at our facility, to a wide selection of people.' (care worker)

'Networking between organisations, using services and facilitating has improved greatly. Able to utilise other services, venues, transport in isolated areas. Cost effective as not doubling up. Able to access skills, trained carers and able to share between services. Educational, able to share information and recourses.' (care worker)

'Expansion of the area including major building works to include more clients and give more space than was available before.' (care worker)

'We (staff) are all … [learning] Montessori Techniques. Residents loves these sessions and hover in close when Montessori material is uncovered.' (care worker)

'Residential staff realising that clients with high level needs can, with community supports, manage to have successful lives outside of a residential facility.' (care coordinator)

'Has provided residential staff with better understanding of community services and carer experiences - their relationships with residents' families are now very different.' (care coordinator)

'The staff and carers have provided us with greater insight into the conditions under which some carers are battling as they strive to keep their loved ones at home. '(Service Director)

'Wider profile amongst referral agencies.' (Service Director)

'We have learnt a lot about carer wellbeing, and it has helped us to understand our community better.' (Service Director)

'The employment of staff from a non residential care background has brought a more multi disciplinary perspective to the team.' (Service Director)

'The staff selected to work on the program have excelled in the provision of holistic client-centred care - I have been able to identify additional staff strengths and build upon these.' (Service Director)

Benefits for residents – wider range of activities to access, wider socialisation opportunities through interaction with DDR service				

'[residents] … are now being incorporated in pleasurable outings to Day Respite for 2 hour periods once a week (while usual clients are out on bus trips) ….' (care worker)

'Respite clients are happier and socialise well with residents.' (care worker)

'More activities/programs are now offered to residents of the nursing home.' (care coordinator)

'Several residential clients also attend and this has dramatically increased their quality of life.' (Service Director)

4.2.2 UNINTENDED NEGATIVE EFFECTS

Carers' unexpected negative effects of the DDR services were quite different from those of care providing staff and managers, with the exception of concerns about resourcing.

- ⇒ **Insufficient resourcing** provided for the DDR service, including transport, longer or out of hours provision; curtailing of activities that can be provided (carers, care workers and care coordinators)
- ⇒ **Initially negative behavior by RACF residential care staff** due to lack of understanding of the DDR service (care workers, care coordinators and service directors)
- ⇒ **Inadequate building design** that limits the effectiveness of DDR activities (care workers and care coordinators).

The following unexpected negative effects were identified by one stakeholder group each – either carers, or care workers.

- ⇒ **Dissatisfaction with fees** charged or inefficient billing processes (carers only)
- ⇒ **Dissatisfaction with the standard of care** provided (carers only)
- ⇒ **Anxiety about relinquishing care** during the respite period (carers only)
- ⇒ **Initially negative behavior by RACF community care staff** due to lack of understanding of DDR service and its relationship to RACF community services (care workers only)
- ⇒ **Difficulties arising from co-location with a RACF**, in particular, possible cross-infection risks (care workers only)
- ⇒ Challenges associated with **providing individualised and quality care for consumers with high or complex need** (care workers only).

Details follow in CHART 5.

CHART 5: Unintended negative effects of DDR services

Unintended negative effect	Stakeholder group identifying			
	Carer	CareWorker	Coordinator	Director
Dissatisfaction with the standard of care provided				
'When inappropriate behaviour by my husband appears to be endorsed rather than ignored. Probably due to the lack of training experience. ' (carer) *'Security of Dementia Patients unsupervised.' (carer)*				
Dissatisfaction with fees charged or inefficient billing processes				
'I did not appreciate a month fee taken out of my account without my knowledge, Unfortunately it was not explained to me.' (carer) *'Account problems, it has been ongoing - 1. Delays in billing 2. Incorrect billing days.' (carer)*				
Insufficient resourcing provided for the DDR service, including transport, longer or out of hours provision; curtailing of activities that can be provided				
'… the transport bus has no lift to access a wheelchair so I have to provide my own transport.' (carer) *'At times would like it to be longer or overnight.' (carer)* *'Limited funding e.g. retreats, bus trips, overnight stays.' (care worker)* *'Unable to meet the needs of carers if the recipients have high care needs. High care residential respite is very limited and carers are not able to access enough respite (day stay and overnight).' (care coordinator)*				
Initially **negative behavior by RACF residential care staff** due to lack of understanding of DDR service				
'Residential Staff - non co-operative to change of routine, including community guests … [in] residential activities.' (care worker) *'Facility staff have been negative and not supportive of the program. This is starting to change ….' (care worker)* *'Some negativity from residential staff in relation to community impact on the existing system/procedures etc.' (care worker)* *'Development of an "us and them" mentality on the part of some of the residential care workers/volunteers - we are intruding on their turf and residents.' (care coordinator)* *'The RACF staff can see the Respite clients as an extra work load for them. It has been hard managing with the amount of space we have in the RACF.' (care coordinator)* *'Residential staff are not keen to interlink (have a "them and us" mentality). Animosity shown to day respite staff by residential staff. Unprofessional interaction with care recipients from residential staff and volunteers.' (care coordinator)* *'There was some resentment from RACF staff especially in the first six months. When they looked in our activity room they often saw staff playing games with clients or talking with them over a cuppa and they thought they had it easy while they worked 'hard'.' (care coordinator)* *'A lack of respect for the value of community programs which has resulted in a segregation of day respite staff from residential staff.' (service director)* *'The pressure on the facility recreation space has meant there were some unexpected tensions between managers of different client groups at the same location re cleaning, room bookings, shared transport etc.' (service director)*				

Unintended negative effect	Stakeholder group identifying			
	Carer	CareWorker	Coordinator	Director
Anxiety about relinquishing care during the respite period				
'A little stressed about him not being in my care, to ensure he is okay.' (carer)				
Initially **negative behavior by RACF community care staff** due to lack of understanding of DDR service and its relationship to RACF community services				
'Initially there was some negativity from other community services about our new NRCP programs, however this has greatly improved and they now understand how the services complement each other.' (care worker)				
Inadequate building design that limits effectiveness of DDR activities				
'Facility is not lockable so 'wandering' Dementia clients are difficult to contain.' (care worker) *'Because we can't offer a completely secure environment (at the moment) it has created a feeling of insecurity in the community of our service. We have had feedback saying that potentially new clients won't use our service because of this.' (care worker)* *'No specific dedicated accommodation resulted in clients being cared for in several different areas of the facility (not in a group).' (care coordinator)*				
Difficulties arising from **co-location with a RACF**, in particular, possible cross-infection risks				
'Some … residents don't wish to engage with day residents as they see them as intruders.' (care worker) *'Only when hostel had influenza or gastro outbreak. Due to clients using Hostel entrance, day stay and weekend stay has to be cancelled. This has now been remedied by … having its own separate entrance allowing clients to totally by pass the hostel if necessary.' (care worker)*				
Challenges associated with providing **individualised and quality care for consumers with high or complex need**				
'Sometimes, one client can disrupt everyone with unacceptable behaviour. - Often, Dementia clients take 20 minutes to entice off or onto the bus. - Occasionally, the group has to be divided e.g. Staff member to 5 clients max. Then if one client occupies that staff member totally for a short time, the others are at risk if something else happens.' (care worker)				

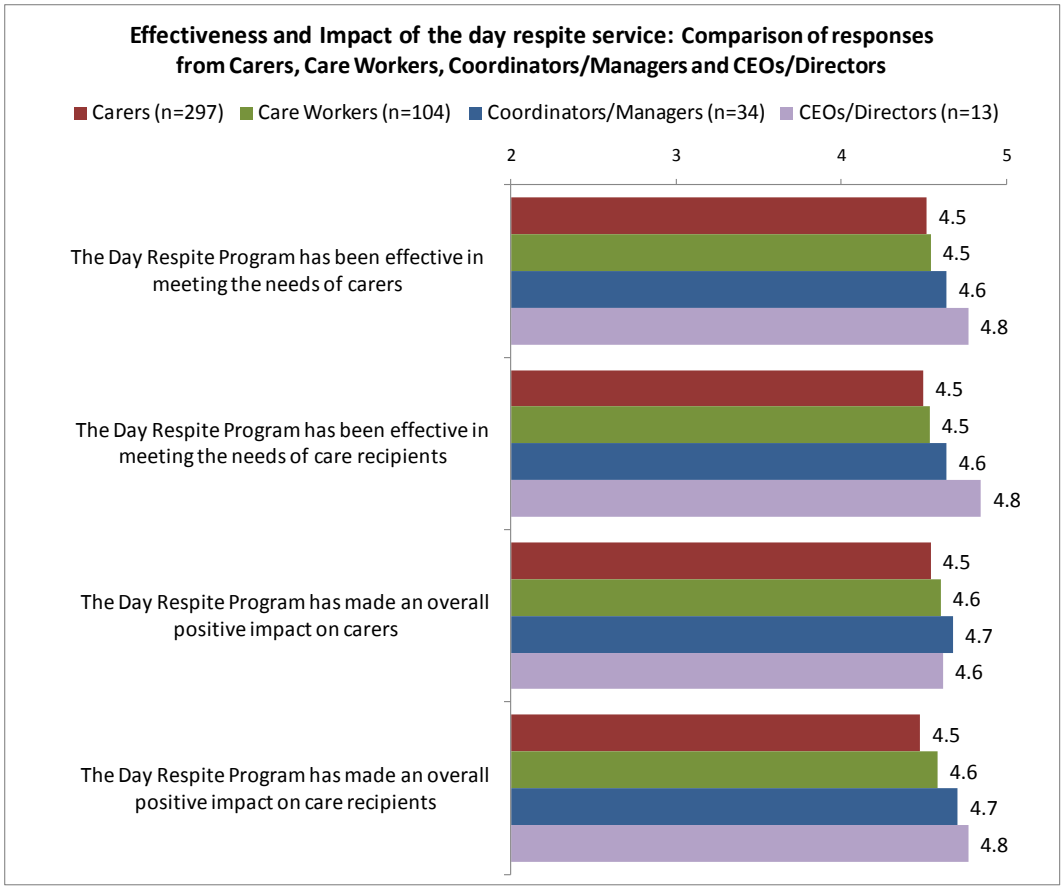
4.3 RATING THE OVERALL IMPACT AND EFFECTIVENESS OF DDR SERVICES

All four stakeholder groups surveyed were asked to provide overall ratings for the (a) effectiveness and (b) impact of the DDR program and these were remarkably consistent across all four groups surveyed (see *Figure 12*), indicating strong and positively directed agreement about outcomes for both carers and care recipients.

However, Carers have been consistently less positive in comparison to staff and managers, in line with the findings of other comparative analyses undertaken for the evaluation. They have provided average ratings of **4.5** for both the effectiveness and impact of DDR services. While these are very positive, those

of Care Workers are slightly higher (4.5 and 4.6), those of Care Coordinators are higher again (4.6 and 4.7) and those of Service Directors are the highest (4.6 and 4.8).

Figure 12: Comparative ratings of effectiveness and impact of the DDR service on carers and care recipients



4.3.1 CARER'S VIEWS OF EFFECTIVENESS AND IMPACT – DIFFERENCES BETWEEN SITES

Carers' ratings of the effectiveness and impact of DDR services varied significantly across sites – see *Figures 69, 70, 71 and 72* of the Survey Findings report – **Accompanying Report 4.**

The average ratings for the **effectiveness** statements were **greater than 4.0** (equivalent to the response category "Agree") for every site except one. The highest rating for effectiveness in meeting carer needs was 4.82 and for meeting care recipient needs was 4.80.

Average scores regarding overall positive **impact** on the carer and the care recipient were **greater than 4.0** at every site, with quite a number of sites scoring near the maximum possible score of **5.0** (equivalent to every respondent choosing the category "Strongly agree"). The highest mean rating for overall impact on carers was 4.80, scored by three sites. The lowest mean rating was 4.11. In relation to care recipients, the highest average rating was 4.89 while the lowest average rating was 4.08.

4.4 IMPACT OF ACCESSING DDR SERVICES ON THE CARE RECIPIENT'S ENTRY TO PERMANENT RESIDENTIAL CARE

Guiding Evaluation Question

*What has been the **impact** of accessing DDR services on the care recipient's entry to permanent residential care, including the extent to which the receipt of day respite either delays or facilitates appropriate entry into full-time residential care?*

Performance Indicators

- ✓ Rate of movement into full time residential care
- ✓ Carers report positive familiarisation with RACFs where this in an appropriate transition
- ✓ Carers hold positive views about reasons for entry into full time residential care

The setting in which respite care is provided can be a determining factor on impact and effectiveness, but the research holds contradictory findings on this issue – details appear in **Accompanying Report 1.**

In their comprehensive review of the literature, Mason *et al* (2007) found no widespread reliable evidence that respite (regardless of setting) can delay entry to residential care. This is due largely to the difficulty of separating the impact of other factors (DoHA: 2002), including the care recipient's own need for care, the carer's capacity to manage, and the confounding effect of the existence of other services being provided at the same time as respite, making it difficult to isolate the specific effect of respite care on delayed entry to residential aged care (Keefe & Manning, 2005: 10). At the same time, the presence of those other services has been found to affect the impact of respite in a positive way (Davies and Fernandez, 2000: 128-134).

A major study in the UK (Davies & Fernandez, 2000: 60-61) found that day respite had a positive effect on length of time in the community, although the size of the effect was shaped by **client characteristics** and the **amount of day care** received. Day care provided to people with cognitive impairment demonstrated a more pronounced impact on duration remaining in the community compared with other service users. The researchers calculated that one day a week of day care increased the time spent in the community by some 200 days, while two days a week increased this time to approximately 270 days (2000: 60, Figure 4.1).

Researchers from the Australian Institute of Health and Welfare examined the use of respite care in residential aged care facilities and the destinations of care recipients on completion of their respite stay. Analysing data on admissions and separations for low and high care facilities and on client characteristics for the period 1991 to 1995, they found that 57% of low care respite and 39% of high care respite residents returned to the community within twelve months, and that high care respite residents were more likely than those using low care respite to become permanent residents. The likelihood of permanent entry to residential care increased with age and was more likely for women than for men (Choi & Lui, 1998: 78).

The evaluators will be conducting a separate client pathway analysis as a supplement to this evaluation, and it is expected that this will provide quantifiable information about the carer and care recipient journey and the role played by day respite services.

4.4.1 EFFECT OF DDR SERVICES ON ENTRY INTO FULL TIME RESIDENTIAL CARE

Combining Site Data information with that received from our surveys with carers, care workers, care coordinators and service directors and our case studies with selected sites, it would appear that the DDR services are likely to have delayed entry into full time residential care while facilitating that transition when it was needed. Case study findings indicated a trend for entry into permanent residential care to be described as "more streamlined", "less stressful" and "more appropriate" due to involvement in the day respite service.

However, without data on the pathways of carers who did *not* use the DDR service, and without formal assessments of individual change over time (such as an ACAT assessment provided on entry to the DDR service and upon exit from the service), it is difficult to draw direct causal links regarding the effect of the DDR service on entry to permanent residential care.

The evaluators will be conducting a separate client pathway analysis as a supplement to this evaluation, and it is expected that this will provide additional information about the carer and care recipient journey and the role played by day respite services.

The evaluators believe that it is important for the Department to be able to quantify the impact of DDR services on entry into permanent residential care, and for this reason, believe that consideration should be given to requiring an ACAT assessment be established as a condition of entry to DDR services.

A key mechanism for the transition from community to residential care has been the residential and overnight respite services offered to day respite clients (see *Section 5.2.5*), which carers and care workers report as having demystified residential care. This, combined with the sharing of some services between day respite and residential clients, can be seen as likely to have reduced the fear of entering residential care for many carers and care recipients.

> *'Carers and care recipients become more receptive to nursing home care. The day respite centre is co-located with the nursing home. Carers visit the nursing home frequently and understand the nursing care services much better, thus removing the stigma and concern related to the service.' (care coordinator)*

The information obtained from stakeholder surveys, interviews and case studies finds a perception across different stakeholder groups of the DDR services' role in enabling carers to continue in their role and therefore, for the care recipient to remain in the community. As depicted in Figure 11, the program is clearly rated as having delayed entry to residential care, and the benefits for carers and care recipients documented in *Sections 4.1.1 and 4.1.2* also confirm the program's impact in extending the time spent by care recipients in the community.

Site Data Analysis reinforces these findings, showing the significant levels of need of day respite clients (and therefore, need for significant levels of support and assistance). When DDR care recipients have entered full time residential care, three quarters have been admitted to high level care, which provides a

further indicator of their degree of need and by implication, the reduction of demand placed on carers. Details follow in *Section 4.4.2.*

> *'The program has … prevented the need to institutionalise my sister.' (carer)*
>
> *'The facility my father attends is lovely. This weekly attendance has been a God send! Dad loves it and I get some much needed time away from caring. We could not have continued as we had prior to this Day Respite.' (carer)*

4.4.2 CARERS EXITING THE DDR SERVICE

Based on detailed Site Data collected for the period July-December 2009, on average care recipients spent **6.9 months** with the day respite service from their first attendance to their exit from the service.

The *overall exit rate* for the day respite program appears to have remained between 28% and 39% so far, with an exit rate of 27.9% calculated for the period July-December 2009 (first Site Data Collection), and exit rates of 37.3% and 38.9% reported for the full 2008/09 and 2009/10 financial years respectively (SARs).

Site Data and SARs data regarding the destination of those exiting the DDR service (see *Section 4.4.3*) indicates that over 60% of DDR care recipients had significant levels of need, with exit occurring due to acceptance into *full-time residential care* or due to death. Level of need is further reflected in the proportion who were admitted to *high level residential care* – three quarters of all clients entering full time residential care.

4.4.3 EXIT DESTINATION

The destination of care recipients leaving the program provides important information on the pathways that carers and care recipients take. Therefore, for the final analysis of SAR information, the AISR evaluators extracted data not normally entered into Departmental spreadsheets regarding exit destination from the paper forms for 2008/09 and 2009/10. This involved the following seven items –

- ⇒ Number admitted to full time residential High level care
- ⇒ Number admitted to full time residential Low level care
- ⇒ Number referred to another service provider
- ⇒ Number who moved from the area
- ⇒ Number deceased
- ⇒ Number exiting for other reasons
- ⇒ Other reasons given.

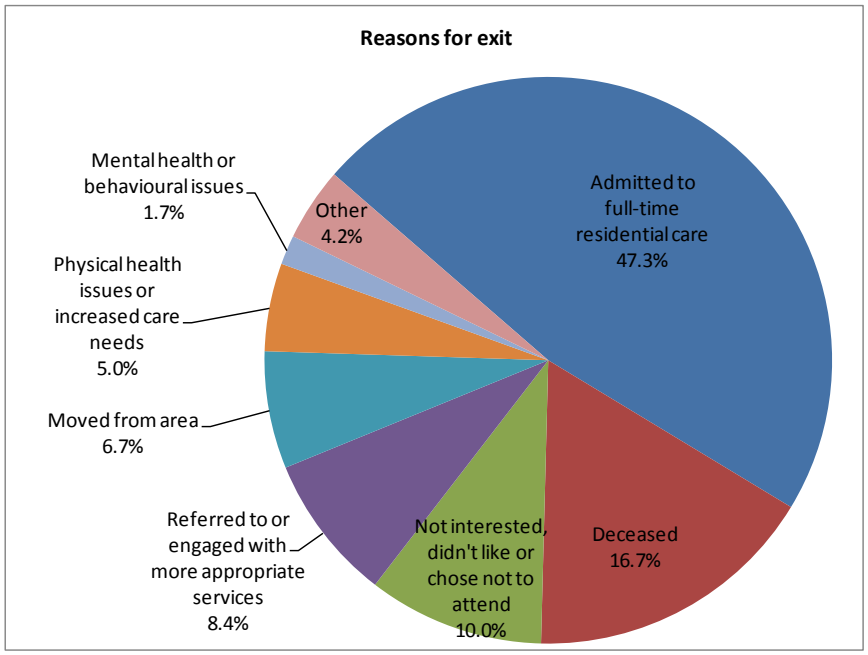
Overall, approximately one third **(33.7%)** of the care recipients who exited DDR services in 2009/10 entered a *high care residential service* (see Table 9 below). **This had increased from 27.4% in 2008/09.** Entry to *low care residential services* showed the opposite trend – **18.0%** of care recipients exited to enter a low care residential service in 2008/09, whereas only 13.9% did so in 2009/10. These trends may simply be a reflection of the relatively short length of time that the program has been operating, i.e. the ageing of the clients who were first engaged with the service. A stable level of exits to high care and low care residential services is likely to be reached as the DDR program matures and moves towards capacity.

Table 9: Summary of exit destinations of care recipients, as reported in SARs, 2008/09 and 2009/10

Exit destination	% of those who exited	
	2008/09	2009/10
Admitted to full time residential care – High Care	27.4%	33.7%
Admitted to full time residential care – Low Care	18.0%	13.9%
Referred to another service provider	11.5%	9.7%
Moved from area	4.2%	4.0%
Deceased	15.5%	15.9%
Other reasons for exit	23.4%	22.9%

The data collected via the first Site Data Collection and the SARs showed consistent results on exit destination, even though the Site Data Collection broadened this issue to seek details on *reasons* for exit. Both sources indicated that 16 to 17% of care recipients had exited the DDR service due to passing away, and that around half of care recipients entered some form of full time residential care upon their exit from the day respite service. More detailed analysis of the Site Data also showed that three quarters of those exiting to residential care had entered a *high level* residential service, consistent with results from the SARs. The broad results from the Site Data Collection are shown in Figure 13.

Figure 13: Reasons for exit from the DDR service



The "Other reasons for exit" reported by projects in the Site Data Collection mainly comprised the following:

⇒ Care recipients refusing to attend the service, preferring to stay home and/or to use other types of service such as local senior citizens clubs. Some felt 'not ready', some felt that the service did not meet their expectations or needs, and some were resistant to the service or to the residential care environment.

⇒ The deteriorating health, chronic ill-health, complex needs or behavioural problems of the care recipient.

⇒ The carer choosing other services that were more appropriate to their own needs.

⇒ A change in the carer's family situation, e.g. additional family members becoming available to assist the primary carer, or an improvement in the carer's health or circumstances.

⇒ Issues with transport.

The exit destination profile for each individual project will reflect factors such as the features of the day respite service offered, the target group of clients and the availability of other services in the area. The exit profile therefore varies substantially across projects – as illustrated in Table 21 of **Accompanying Report 9.**

It will be important to continue to track exit destination as the DDR program matures and moves towards capacity, in order to determine its true impact on entry to high level residential care**. Therefore we recommend that the Department begins to include the exit destination section of the SAR in the usual subset of items that are *entered electronically by the Department from the paper SAR forms.*** (That the Evaluators undertook to enter this data for 2008/09 and 2009/10 specifically to address this issue).

4.4.4 IMPACT OF PROVIDING DDR SERVICES ON THE OPERATIONS OF RESIDENTIAL AGED CARE FACILITIES

Guiding Evaluation Question

*What have been the effects of providing DDR services on the **operations** of residential aged care facilities in providing care to full time residents?*

Performance Indicators

- ✓ Staff shared between respite and residential care
- ✓ Efficiencies made in sharing of staffing and resources
- ✓ Benefits for residential staff
- ✓ Positive effects on full time residents of respite care program
- ✓ Positive impact of activities provided through respite care program for residents
- ✓ Vertical integration and internal referral

The provision of DDR services has had a number of impacts on participating RACFs, and in large part, these have been **positive** in nature. The four key impacts identified concern -

a) Physical infrastructure
b) Staffing
c) Resource usage
d) Service networks.

The first of these three have been the most far reaching in their impact.

e) In addition, DDR services have been found to bring benefits for RACF residents through increased socialisation and access to a wider range of activities – as discussed in *Section 4.1.3.*

4.4.5 PHYSICAL INFRASTRUCTURE IMPACT

Improvements to the physical infrastructure resulting from the DDR service –either in developing new buildings or renovating existing buildings, have been of benefit to the organisation as a whole. These offer new opportunities for service delivery while being critical to the effectiveness of the DDR service. Final Site Data Analysis indicates that this impact has continued during 2010 (**Accompanying Report 8**).

> *'The organisation invested significant capital resources in building the new centre, however this is a resource that can be used both by the respite program and the residents at other times. There has been greater use and shared costs of some resources such eg the bus. There is some strain on resources such as the kitchen which have required creative solutions.' (service director)*

4.4.6 STAFF-RELATED IMPACTS

The impact of the DDR Initiative on the staff of participating RACFs has been mixed but in the longer term brings benefits for most (depending on how effectively the integration of the DDR service is managed and staff are supported in this process). As discussed, some case study sites, and some of those surveyed, reported initial resistance by many RACF staff to the presence of the DDR service, particularly when co-location and sharing of resources was involved.

> *'Community care principles and knowledge, versus residential. Lack of understanding and interest.' (Service Director)*

> *'There are some difficulties between Residential Staff and Community Care staff who are employed to run Day Respite. I believe that the staff's belief in "ownership" is the biggest contributor. This is not an insurmountable problem and is being resolved.' (Care Coordinator)*

> *'Initially there was some negativity from other community services about our new NRCP programs, however this has greatly improved and they now understand how the services complement each other.' (Care Worker)*

> *'Staff at residential homes do not fully understand, they think it is easy driving around and picking clients up and bringing them back to the facility and if we only have one or two clients we are having an easy day and not doing any work. There needs to be more awareness and promoting of the program.' (Care Worker)*

> *'Staff within the residential facility have been largely unsupportive as they are already 'too busy' and 'don't need the bother of more clients coming in'. The program itself, the hours, and the transport are readily accepted but the 'turn off' comes when they realise the program is based in a room at … [the facility]. It takes much cajoling to break through that barrier and many times we have been unable to break through the barrier at all. The program encountered difficulties with clients with dementia in a shared area of the residential facility as there proved to be too much stimulus aggravating distressed behaviours.' (Service Director/CEO)*

However, over time, and as communication and other processes were streamlined, there was also a trend for increasing acceptance. Many sites reported a smooth transition from implementation of the DDR service to ongoing collaboration between RACF and respite staff.

Site Data show that many day respite staff members were also employed part time by other areas of their organisation. Almost half **(49%)** of all day respite staff also worked in their RACF's *Residential care* service but this practice varied greatly between project sites – see *Section 5.1.4*. This means that staff are being exposed to a wider than normal range of work experience and service users and able to benefit from broader learning opportunities (for example, through shared training programs). This can be seen as

beneficial for them and therefore, for their clients. (This was also the view of staff surveyed by the evaluators in our surveys of carers, care workers, care coordinators and service directors.)

The sharing of staff between the DDR and residential services was often reported as leading to healthy cross-fertilisation and exchange of ideas across program areas.

> *'1. The day respite program has helped us to develop new capabilities among staff. 2. The program motivated our Board to allocate funds to redevelop an existing building, so we now have an excellent facility.' (service director)*

The key challenges associated with implementing the DDR model of service identified by RACF staff and managers have mostly related to staff (see CHART 3). The most significant challenge identified was managing the initially negative reactions of some residential care staff and the need to educate them about community care services, and the DDR service in particular. Informing and reassuring staff about the relationship between the DDR service and existing RACF services (both community and residential care) has formed part of this challenge. Through trial and error, RACFs have needed to develop processes that support effective communication and coordination between different groups of staff in the organisation, and some have managed this better than others. Other staff-related challenges identified were –

- Recruiting staff during the establishment of the DDR service.
- Training and developing day respite staff to provide DDR services.
- Addressing industrial issues arising from the existence of different awards for staff.

4.4.7 RESOURCE USAGE IMPACT

It was common for DDR service providers to report significant economies of scale due to sharing and consolidating resources with their auspicing RACF. These usually related to sharing staff, staff training, equipment, purchasing of goods and stores, meals preparation, laundry services, transport services - and application of policies and practices, such as, medication management. In many of the Case Study sites, the DDR funding had enabled organisations to increase care staff and specialist staff (eg Lifestyle Coordinators) levels from part time to full time, or to employ specialist staff for the benefit of both the DDR and RACF services.

The cross-fertilisation of resources between the RACF and DDR service can be seen as having a positive impact on both residents and day respite users, and as bringing benefits to the RACF that range from the tangible (sharing of staff resources, pooling of resources to purchase consumables etc) to the intangible (raised profile in the local community, increased staff experience across programs).

At the same time, RACFs were found to be providing an unfunded contribution in terms of staff (FTE) time that equated to **an average of 1.1 full time staff members per project per week (**see Tables 9 and 10 of the Site Data Report – **Accompanying Report 7.)** Most of this contribution came from *Care Workers*, *Domestic staff* and *Managers*. As discussed previously, the trend to receive unfunded support in the form of input from RACF staff was found to have continued during 2010, based on reporting for the final Site Data Analysis (**Accompanying Report 8**.)

4.4.8 SERVICE NETWORKS IMPACT

The impact on RACF service networks was variable, and this would have been influenced by pre-existing service provision range and therefore, networks with other providers. Impact appears to have varied according to the work role of staff and managers. For example, CEOs and Service Directors could be expected to have wider ranging networks than Care Workers, and this appears to be reflected in our findings.

Service Directors had a much more conservative view about the DDR program's impact on service networks compared with the views of both Care Workers and Care Coordinators (see *Figure 2*) and this difference was statistically significant ($p<.05$). 62.5% of Care Workers and 73.5% of Care Coordinators rated the DDR's impact as having *moderately or greatly improved* service networks compared with 30.8% of Service Directors, 53.9% of whom rated the improvement as *slight to somewhat* better.

5 THE EFFICIENCY OF DAY RESPITE SERVICES IN RACFS

Efficiency concerns how economically resources have been utilised, and how inputs (funds, expertise, time, etc.) are converted to results or outputs.

The evaluation has collected information about staffing levels and usage (both DDR funded and unfunded) and staff : client ratios, as key *input* factors and taken as *outputs* quantifiable information about hours and days of respite received, management of demand levels, carer satisfaction with outcomes and whether or not projects are in deficit or surplus. In addition, evidence of economies of scale and value-adding has been identified as an indicator of effective and efficient use of resources.

However, it should also be noted that is difficult to determine precisely the cost effectiveness of the DDR Initiative as a whole as there are a range of variables to take into account. Relevant variables include location (the more remote the higher many costs will be and the greater will be the difficulty of achieving economies of scale), the level of care provided, the needs of care recipients (for example, those with dementia will require significantly more support), facility size and the capacity to achieve synergies in resource usage.

Inputs are reported in relation to staffing –

- ⇒ By total (FTE) numbers
- ⇒ By role
- ⇒ The relationship between total staffing and respite places used
- ⇒ Sharing of DDR and RACF staff.

Outputs are reported in relation to –

- ⇒ Carers and care recipients assisted by DDR services
- ⇒ Staffing and respite places used
- ⇒ Patterns of demand for DDR services
- ⇒ The costs of delivering DDR services
- ⇒ Efficiency-related benefits offered by locating day respite services in RACFs.

5.1 INPUT: STAFFING OF THE DDR SERVICES

5.1.1 TOTAL STAFFING (FTE) AND NUMBER OF INDIVIDUAL STAFF

The total FTE for most projects was split across many individual staff members and indicates that the majority of DDR staff were not employed full-time. Total FTEs at each site ranged from 1.2 FTE to 11.4 FTE– with these two extremes corresponding to their operating hours. (Refer to Figures 7 and 8 of the Site Data Analysis Report – **Accompanying Report 7**.)

However, within this range there was substantial variation in the ratio of FTE staff to hours of service provided.

5.1.2 STAFFING BY ROLE

As would be expected with this type of service, nearly 40% of total FTE across all projects comprised *Care/Support Workers*, and 17.4% of total FTE was allocated to *Diversional Therapists/Activity* staff.

In terms of coordinating and managing the service, nearly 14% of total FTE was allocated to *Service Coordinator/Liaison* staff, and 5.4% to other *Managers*. (Refer to Table 8 and Figure 6 of the Site Data Analysis Report - **Accompanying Report 7**.)

5.1.3 RELATIONSHIP BETWEEN TOTAL STAFFING (FTE) AND RESPITE PLACES USED

Total staffing (total FTE, regardless of role), and *Direct care staffing* (FTE for staff primarily involved in the direct care of clients) was examined against the number of day respite places actually used per week at each DDR service.

- **Across all projects, for every FTE DDR staff member (regardless of role) there were on average 7.7 day respite places**.
- In terms of staff providing direct care to care recipients, there was on average **one direct care staff member per 12 places**.

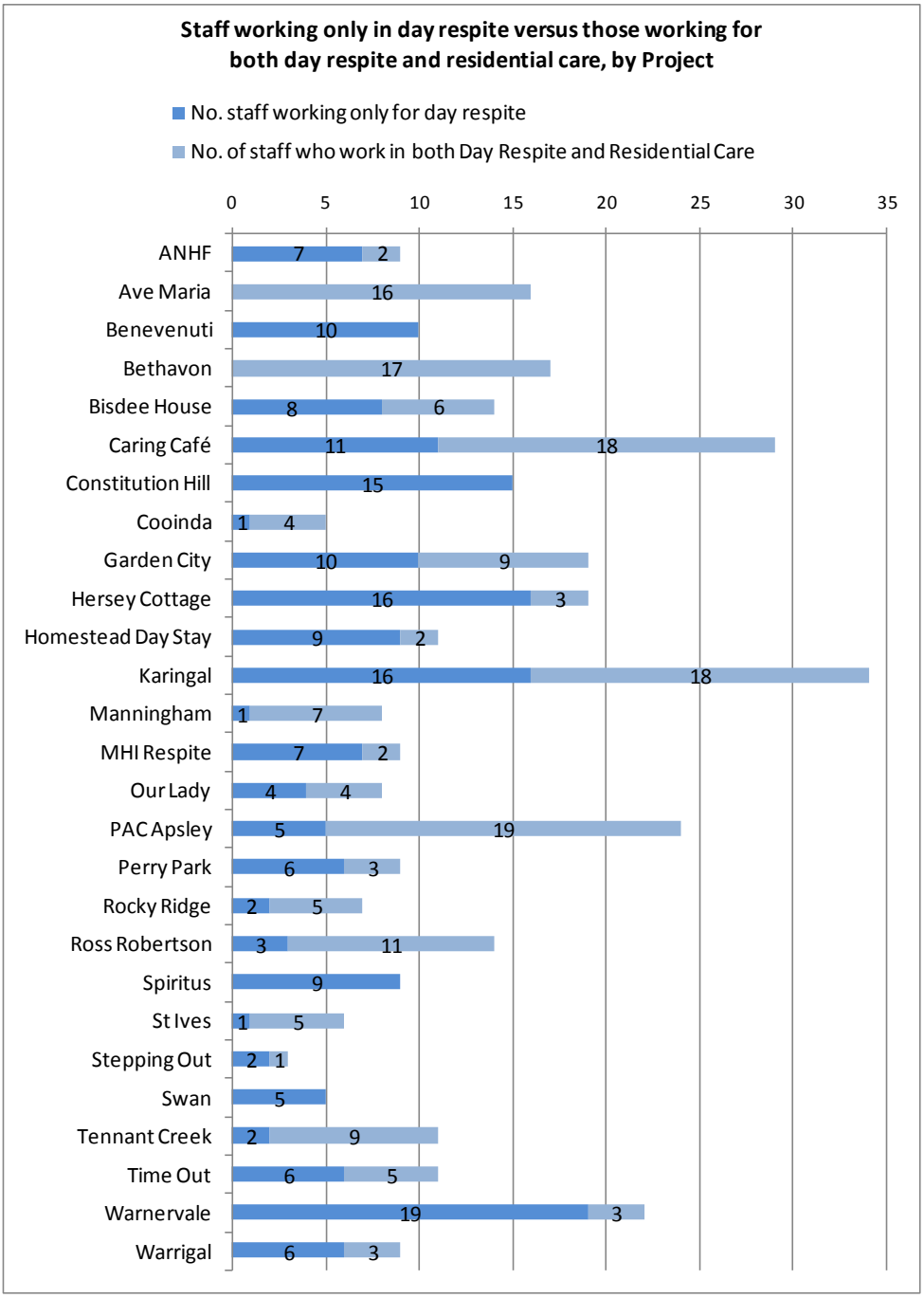
This ratio varied greatly across projects, perhaps reflecting operational characteristics such as the specialist focus of each service, and the implications of that focus on staff:care recipient ratios. For example, a service such as *Garden City,* which specialises in frail elderly care recipients with dementia, operated with only 3.7 care recipient places per direct care staff member, whereas a service specialising in younger clients such as Bethavon was able to operate with 23.3 care recipient places per staff member. (Refer to Figure 9 of the Site Data Analysis Report - **Accompanying Report 7**.)

5.1.4 SHARING OF DDR STAFF AND RACF STAFF

Sharing of resources between the RACF's other programs and the DDR services was also evident in relation to staffing. As discussed, Site Data show that many DDR staff members were also employed part time by other areas of their organisation. Almost half **(49%)** of all DDR staff also worked in their RACF's residential care service.

This practice varied greatly between project sites, from services where all day respite staff worked also in residential care (Ave Maria and Bethavon), through to projects where none of the DDR staff worked in residential care (Benevenuti, Constitution Hill, Spiritus, Swan). Figure 14 provides these details.

Figure 14: DDR staff who also worked in their RACF's residential care service, by Project[1]



1 Information not provided by Bribie Island and Lynbrook.

5.2 OUTPUT: RESPITE DELIVERED TO CLIENTS

5.2.1 CARERS AND CARE RECIPIENTS ASSISTED BY THE DDR INITIATIVE

According to the SARs (**Accompanying Report 9**), the total number of *primary carers* assisted by the Demonstration Day Respite program rose from 1,262 in 2008/09 to **1,427** in 2009/10, an increase of 13.1%.

Similarly, the total number of *care recipients* who attended a day respite service increased by 14.6% from 1,246 in 2008/09 to **1,428** in 2009/10.

5.2.2 RESPITE PLACES AND HOURS OFFERED VERSUS DELIVERED

Based on information gathered in the first Site Data Collection regarding the number of day respite places offered by each site in July-December 2009 (refer to **Accompanying Report 7**), it was estimated that more than 1,400 day respite places were being *offered* per week under the DDR scheme. Therefore, if each carer were to receive one occasion of respite each week (i.e. the average indicated by the detailed Site Data collected on individual care recipients), more than 1,400 carers could use the service each year.

This is consistent with information from the Service Activity Reports (SARs) regarding the *number of carers actually receiving a service* – 1,262 in 2008/09 and 1,427 in 2009/10, an increase of 13.1% (refer to **Accompanying Report 9**)[11]. If each of these carers used the service once per week (as is the average indicated by data from the first Site Data Collection), this would mean that the original Budget estimate for the DDR Initiative quoted by the Department, which estimated that the measure would help carers of frail older people at a rate of 1,200 per week, has been met.

Based on the sites' operating days and hours as at December 2009, the DDR Pilot *offered* over 73,000 days of respite per annum and over 700,000 hours of respite per annum. Operating days and hours remained unchanged at most of the sites in 2010 (final Site Data Collection round – refer to **Accompanying Report 8**). While the number of days offered exceeds the original target set for the DDR Initiative (62,400 days of respite for carers of frail older people), according to the Service Activity Reports (SARs) few sites had actually reached full capacity by the end of 2009/10, meaning that this target has not yet been met. As the sites continue to demonstrate growth in actual service delivery and therefore continue to move towards capacity, this target will be more than achievable. Funded capacity versus services actually delivered is discussed further in *Section 5.3.3*.

5.2.3 DAYS AND HOURS OF RESPITE PROVIDED WEEKLY AND ANNUALLY

Reflecting the increased client base (*Section 5.2.1*) and also the delay in establishment of some DDR projects, the *number of hours of respite delivered per annum* according to the SARs increased **33.8%** from 252,788 hours in 2008/09 to 338,302 hours in 2009/10. Twenty three of the 30 individual projects had shown growth in service delivery, and this appeared to reflect an increase in the number of respite hours delivered to *existing clients* rather than any significant increase in the number of carers using their service (refer Section 3.1.3 of **Accompanying Report 9**).Only four projects reported a decrease in respite hours delivered.

The *number of respite hours delivered per annum per carer* (i.e. the total number of hours delivered divided by total number of carers) increased from 200 hours in 2008/09 to **237 hours** in 2009/10, an increase of 18.5%. This equates to an average of 3.9 hours per carer per week in 2008/09 and 4.6 hours per carer per week in 2009/10. However it should be noted that there can be a very broad range of service use patterns, with some carers using the day respite service only occasionally, others using it weekly, and others using it up to 7 days per week. Some sites limit the amount of respite offered to individual carers, whereas other sites offer almost unlimited use. Therefore a slightly different picture of

[11] Note that activity data for 2007/08 was deemed too unreliable to be included in final reporting.

the average number of hours delivered per carer will be generated when using data based on *individual care recipients*, as was collected for the period July-December 2009 (see **Accompanying Report 7**). Statistics calculated using this data showed that the average (mean) number of hours that each care recipient attended day respite during that period was just over 6 hours per week, higher than the figure based on SARs data, due to the very high usage of care recipients at some services (e.g. 7 days per week).

5.2.4 REGULAR, IRREGULAR AND UNPLANNED RESPITE ATTENDANCES

Over the Site Data reporting period July to December 2009, the majority of day respite attendances (94.3%) were *Regular (scheduled) attendances*, 4.8% were *Irregular but planned attendances*, and 0.9% were *Emergency/unplanned attendances*.

The *average number of attendances per care recipient* over the 6-month reporting period was 24.1 attendances (22.7 Regular, 1.1 Irregular, and 0.2 Emergency/unplanned), which represents **around one attendance per week**. However this varied greatly across projects from around 3 times per week on average to less than once per fortnight on average.

5.2.5 THE USE OF RESIDENTIAL RESPITE CARE

Guiding Evaluation Question

*What has been the **impact** of accessing DDR services on the care recipient's use of residential respite, including the extent to which the receipt of day respite either discourages or facilitates use of residential respite?*

Performance Indicator

- ✓ Demand for residential respite

Site Data Analysis identified a total of **1,004 nights of residential respite** used by carers during the period studied (July to December 2009), at an **average of 2.0 nights per care recipient** over this six month period. Case study findings indicated a trend for access to residential respite to be enhanced.

> *'Having a Day Respite program in a residential care facility offers clients a chance to interact with residents and for their families to have access to residential respite and having confidence in the care that will be provided.' ' (Care Coordinator)*
>
> *'Carers start to use overnight respite, allowing themselves the opportunity to have a break from caring. Whereas before they would not have even thought about it. They do not feel as guilty about leaving their loved one.' (Care Coordinator)*
>
> *'Having a Day Respite program in a residential care facility offers clients a chance to interact with residents and for their families to have access to residential respite and having confidence in the care that will be provided.' ' (Care Coordinator)*

As discussed in *Section 2.9 and Section 4.4,* residential respite services have played a critical role in easing the transition process to full time residential care by demystifying the residential environment and associated stigma, while providing carers with a more coherent continuum of support services.

5.3 OUTPUT: PATTERNS OF DEMAND FOR DDR SERVICES

Guiding Evaluation Question

*What have been the levels of **demand** for DDR services in residential aged care facilities?*

Performance Indicators

- ✓ High percentage take up of places funded by care recipients
- ✓ Level of demand met
- ✓ No over-supply of places
- ✓ Waiting lists

In reviewing demand levels, the evaluators have documented the average number of respite places offered against the number actually used – see *Section 5.3.3* – and reported DDR managers' perceptions of actual against expected demand – see *Section 5.3.1*.

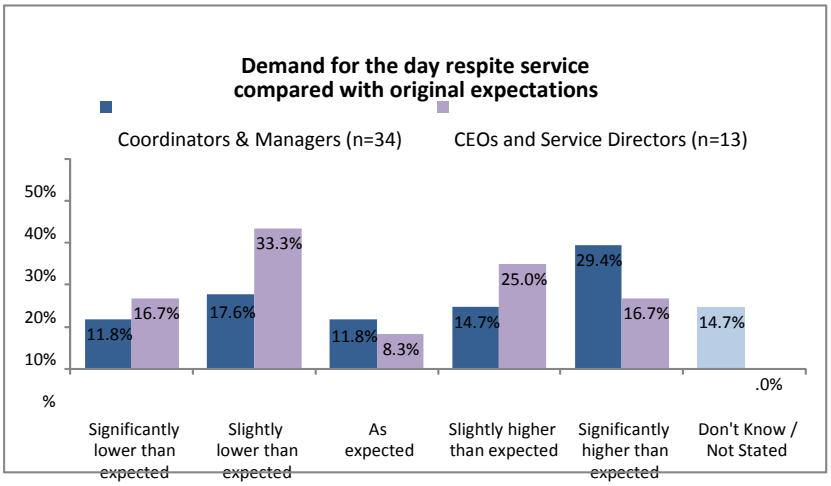
Demand is also reflected in vacancy rates (see *Section 5.3.2*) and waiting lists (see *Section 5.3.4*). It is not possible to benchmark these rates against other NRCP funded day respite services due to lack of comparability in data collection. However, the vacancy rate seems high in some projects, and the fact that few projects had a waiting list also suggests that supply may be exceeding demand for some sites. For those where this is evident, should ongoing funding be sought, it would be important to identify other day respite services in or near the same location.

5.3.1 ANTICIPATED AND REALISED DEMAND LEVELS

The two groups with management responsibilities were asked in the survey to rate the degree to which demand for the DDR service had or had not met original expectations, and the impact of the DDR service on demand for the organisation's residential care services.

CEOs and Service Directors were more likely than Care Coordinators to rate the demand for the DDR service as being *lower* than originally anticipated, with 50% taking this view compared with 29.4% of Care Coordinators – see Figure 15. By contrast, 44.1% of Care Coordinators rated the demand as being *higher* than expected.

Figure 15: Demand for the DDR service compared to original expectations

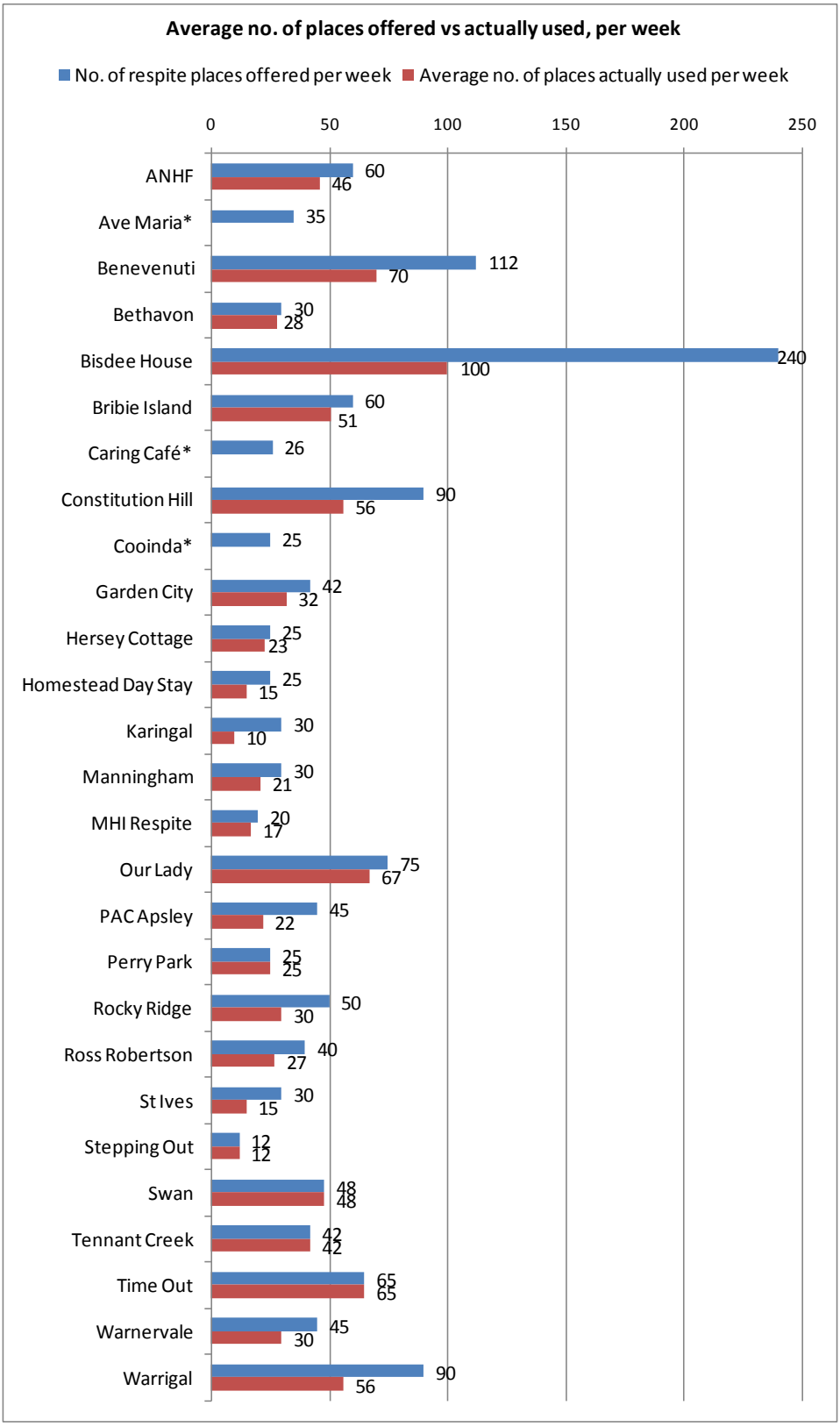


It is not known how the DDR sites predicted demand levels, but the Site Data Analysis indicated that at the end of December 2009 only 12 of the 29 projects **(41.4%)** which provided detailed data on operating days and hours were operating on exactly the same days/hours for which they were funded. This indicates difficulty in forecasting demand levels. However there is also evidence that sites were prepared to change their operating days or hours in response to client needs – the final Site Data Collection showed that around a quarter of the sites changed their operating hours during 2010 for that reason.

5.3.2 VACANT PLACES

The average number of day respite places offered by each project per week was plotted against the average number of places *actually used* per week, using data from the first Site Data Collection (July to December 2009). This showed that seven sites had precise or near to precise matches, a further seven had an unused gap of 15 places or more, on average, each week. One service stood out with a gap of 140 places and the second highest vacancy rate (discussed below). See Figure 16 for details.

Figure 16: Average number of places offered, versus places actually used, per week by Project[1]



1 Two projects, Lynbrook and Spiritus, did not provide reliable information on number of places offered.

* Information on vacancies was not available or was unreliable for these three projects (Ave Maria, Caring Café, Cooinda), therefore "places actually used" could not be derived for these.

The *vacancy rate* (ie the average number of vacant places per week as a percentage of the average number of places offered per week) varied greatly across projects. The highest vacancy rate was 67.0%. In contrast, five projects reported no vacancies (as illustrated in Figure 16) and another two projects reported a vacancy rate of less than 10%. Some services deliberately set aside a small number of places per day in case of requests for emergency respite.

The overall vacancy rate was **32%,** and represented a total of **over 400 vacant places per week** across those projects. (For details, refer to Figures 2 and 3, Site Data Analysis Report – **Accompanying Report 7**.) While 19% of these vacancies were due to cancellations, the remaining 81% of vacancies were mainly due to **lack of demand**. **This information raises concerns about methods used to determine demand levels during the planning phase of DDR services.**

There is evidence that vacancy rates are decreasing. The final Site Data Collection found that just over half of the sites (51.6%) reported that they had *fewer* vacancies at the end of 2010 compared with December 2009. This was due to increased demand levels. The 12 sites (38.7%) which reported no change in vacancies generally indicated that they had been, and continued to, operate at near capacity – see **Accompanying Report 8**.

Further analysis can be found in *Section 5.3.3* which explores unused service capacity by comparing funded hours with delivered hours.

5.3.3 UNUSED SERVICE CAPACITY: RESPITE HOURS FUNDED VERSUS DELIVERED

In reviewing unused service capacity, the evaluators extracted additional data from hardcopy SAR forms pertaining to the number of hours of respite funded (rather than hours actually delivered) and the reasons given by projects for any difference between the hours funded and hours actually delivered. Those data items are not normally entered into the Department's spreadsheets.

Each project receives an agreed amount of funding each financial year to cover the delivery of a certain number of respite hours. The difference between the number of *funded respite hours* and the *number of respite hours actually delivered* can be seen as a measure of unused (or over-used) capacity in a service. An indicator of unused/overused capacity was defined as the proportion of funded respite hours that were actually delivered, i.e. calculated as *hours delivered as a proportion of hours funded*.

For the program as a whole, the proportion of funded hours that were actually delivered rose from 38% in 2008/09 to 51% in 2009/10. **This suggests that while the number of respite hours delivered increased by about a third between 2008/09 and 2009/10, it appears that around *49%* of the stated capacity is still unused and therefore there is scope for substantial growth in the program** (see *Section 3.3* of **Accompanying Report 9**).

Common reasons cited by projects regarding discrepancies between hours funded and hours delivered were:

- a mismatch between their initial expectations of demand and the actual needs of eligible carers and care recipients in their community (either higher or lower demand) – e.g. the number of respite hours per day required by carers and/or appropriate for care recipients, and the level of demand for early morning, evening and weekend respite;

- high client turnover and frequent cancellations, e.g. due to the poor health of care recipients;
- high-need care recipients requiring one-on-one support, e.g. due to frailty, dementia and/or challenging behaviours; and
- carers accessing other forms of respite (e.g. overnight, residential).

It is clear that the profile of the care recipients attending each individual service can have a substantial impact on the number of respite hours that can be delivered by that project. For example, projects with a large proportion of "high need" care recipients (e.g. care recipients with dementia and challenging behaviours, or other significant health problems) will generally be unable to deliver as many respite hours in total as projects with a lower care recipient need profile, due to the greater level of staffing required to manage high need care recipients and the higher rate of cancellations and exits. Therefore **the profile of care recipients should be taken into account when assessing overall project performance.**

It is also important to note that almost all of the individual projects, including two of the projects identified as showing the greatest underuse, did demonstrate growth between 2008/09 and 2009/10 in terms of the proportion of funded hours that they actually delivered. **While many projects clearly faced unexpected challenges in establishing and running their service, it appears that over time these issues are being addressed.**

5.3.4 WAITING LISTS

According to SAR data, at 30 June 2009 there were only 28 carers on *waiting lists* for the program as a whole. By 30 June 2010 this had more than doubled to 67 carers – an increase of 139.3%. Only six projects reported a waiting list at 30 June 2009, however at 30 June 2010 ten projects had a waiting list.

Analysis from the first Site Data Collection showed that during the period July to December 2009 the maximum number of people on a project's waiting list in any given month was 12 people, and that the highest unmet demand was most likely to occur in the month of December.

The majority of sites (83.9%) reported in the final Site Collection that they had approximately the same number of people on their waiting list at the end of 2010 as they had for December 2009. Only 3 sites reported that they had a longer waiting list while 2 reported that their waiting list had decreased. This information is consistent with that provided in relation to changes in vacancies – refer to **Accompanying Report 8.**

As the DDR services become more established it can be expected that waiting lists will increase and these rates need to be plotted over time.

5.3.5 UNMET NEED

In order to accurately assess which services had the greatest *unmet need*, the SAR data on waiting lists was combined with the SAR data on service capacity (see **Accompanying Report 9**). Based on this information, it appears that the greatest level of unmet need in 2009/10 occurred at six projects (see Table 13, **Accompanying Report 9).** These six projects were delivering 100% or more of the respite hours for which they had been funded, *and* had a waiting list, indicating clear unmet need for those services.

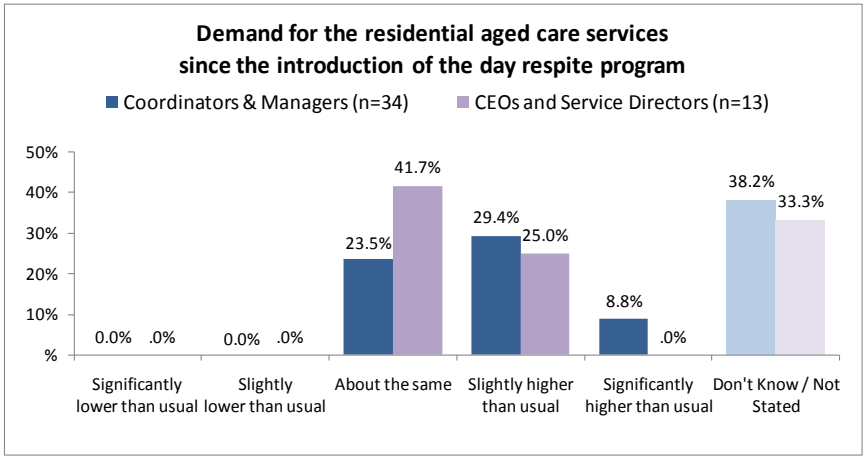
Other projects with a waiting list in 2009/10 had delivered less than 70% of their funded respite hours. According to other information that we collected as part of the Evaluation, we understand that for some projects waiting lists are mainly comprised of carers who require respite on a *particular day* or for *particular hours* during the most popular days/times offered by the project. This explains cases where significant unused capacity exists despite a waiting list.

For those projects where unmet need is clearly evident, should ongoing funding be sought, it would be important to identify other day respite services in or near the same location as part of the process of determining the most efficient way to meet demand.

5.3.6 IMPACT OF DDR SERVICES ON DEMAND FOR RESIDENTIAL CARE SERVICES

Over a third of Coordinators reported that the introduction of the DDR service had increased demand for the *residential* aged care service, but with most of these noting a *slight impact*. Service Directors saw the impact on demand levels for residential services as being *unchanged,* and were more likely to take this view than Coordinators –see Figure 17. However, these apparent differences between the two groups were not statistically significant.

Figure 17: Demand for *residential aged care services* since the introduction of the DDR service



This finding is consistent with other findings about the DDR service not encouraging unnecessary entry to residential care, but facilitating the transition process if this became necessary – see *Section 2.9.*

5.4 THE COSTS OF DELIVERING DDR SERVICES IN RESIDENTIAL AGED CARE FACILITIES

Guiding Evaluation Question

*What have been the **costs** of delivering DDR services in residential aged care facilities?*

Performance Indicators

- ✓ Costs per care recipient per hour, per day or per week
- ✓ Costs compared with other NRCP funded respite services

- ✓ Financial benefits are achieved from the integration with residential facility

5.4.1 COST EFFECTIVENESS AND COST CONSEQUENCES ANALYSIS

Cost-effectiveness has numerous definitions but essentially examines the balance between inputs and outputs (including outcomes) to determine if the intervention studied represents value for money. It also compares the intervention with others that can be implemented using the same resources (Keefe & Manning, 2005: 6). The difficulties of determining cost effectiveness are apparent in the existing literature (refer **Accompanying Report 1**).

There is little consensus among researchers about the variables required to measure the cost-effectiveness of respite care services (Carers Australia, 2007: 20). Determining the range of variables that can be taken into account when determining the costs of respite is an inexact science, and setting the boundaries for inclusion and exclusion is difficult. Should it, for example, include the costs to government of medical care for carer stress or ill health arising from their caregiving role? Should it include the taxes lost when carers must leave the paid workforce in order to provide care? (Keefe & Manning, 2005: 8).

Most of the available literature examines cost-effectiveness from the perspective of carers and care recipients, rather than from the perspective of service providers or funders (Arksey *et al,* 2004: 47). They are, therefore, actually 'cost-consequences'[12] rather than 'cost effectiveness' analyses.

The total cost of day respite care needs to take into account whether full time admission to residential care has been delayed and one extremely comprehensive study found no reliable evidence about the impact of respite on extending care recipients' capacity to remain in the community (and by implication for carers to be able to continue in their role). It found a lack of reliable evidence about the effectiveness of respite services but noted that does not necessarily mean that they are ineffective or without benefit (Arksey *et al*: 2004).

The cost of respite has been found to vary with the **type of respite**, the **provider** and the **needs of care recipients** – for example, older people with dementia require more input from staff and so costs associated with their respite care are higher than for other client groups (Mason *et al,* 2007: 4). In-home respite costs have been found to be considerably higher than those of community day care, and costs for out of hours provision, not surprisingly, to be higher than those for normal business hours (Mason *et al,* 2007: 4).

In determining the cost effectiveness of the DDR Initiative there are a range of variables to take into account that make it difficult to assess all sites as a single entity. Relevant variables include location (the more remote the higher many costs will be and the greater will be the difficulty of achieving economies of scale), the level of care provided, the needs of care recipients (for example, those with dementia will require significantly more support), and facility size and the capacity to achieve synergies in resource usage.

After a broad review of the available financial data collected via Financial Accountability Reports (FARs), the *cost (expenditure) per hour of respite funded,* the *cost per hour of respite actually delivered* and the *cost per carer* was calculated for the Demonstration Day Respite program as a whole and for individual

[12] *Cost-consequence* analysis combines information about costs and outcomes (including clinical) in the form of a balance sheet, and is particularly useful when evaluating human services programs

projects, by combining FAR data with data from Service Activity Reports (SARs).Additional data regarding *funded respite hours* was extracted from hardcopy SAR forms for the purpose of the analysis.

5.4.2 REVENUE, EXPENDITURE AND SURPLUS

According to FAR data for the year **2008/09** for the 30 DDR Pilot projects the *total revenue (income)* was $9.79m and the *total expenditure* was $9.04m, leaving a *surplus* of $0.75m. Based on the 27 projects for which 2009/10 data was available, it appears that the total revenue and total expenditure will be slightly higher in 2009/10 compared with 2008/09, however, the surplus is likely to be of similar magnitude. The surplus for 2008/09 was modest, representing 7.7% of total revenue that year. This can be seen as an indicator of efficient use of resources. Apart from avoiding a deficit situation, a modest surplus as opposed to a significant surplus, indicates a maximising of available resources to meet consumer need.

In 2008/09 eighteen of the 30 DDR projects reported a surplus and the remaining twelve reported a deficit. Averaged over all 30 projects, the average surplus/deficit was **$24,964.** In 2009/10, 16 of the 27 DDR projects which supplied FAR data reported a surplus, one project reported an even balance ($0) and 10 reported a deficit. The average surplus/deficit for these 27 projects was **$14,021**.

The total revenue reported for the program in each financial year mainly comprised operational revenue – 84% of total revenue. The remainder included the surplus retained from the previous financial year (12% of total revenue in 2008/09 and 10% of total revenue in 2009/10), fees collected from users of the service (3% in 2008/09 and 5% in 2009/10), and other revenue including small amounts of interest received on government funds (less than 1% of total revenue).

The total expenditure reported for the program in each financial year mainly comprised direct costs – 75% of total expenditure in 2008/09 and 71% of total expenditure in 2009/10 – the remainder being indirect costs.

5.4.3 COST PER HOUR OF RESPITE FUNDED AND DELIVERED

As Table 10 shows, the *cost per hour of respite delivered for the program as a whole* appears to have decreased from $35.75 in 2008/09 to $30.37 in 2009/10. Note however that the costs calculated for 2009/10 are based on data for only *27* of the 30 projects, therefore the apparent decrease between the years should be viewed with caution at this stage.

The *cost per hour of respite funded* has remained under $20 for the last two financial years. As the DDR program moves further towards service capacity, there is potential for the cost of hours *delivered* to move towards equivalence with the cost of hours *funded*.

Data on cost per carer and the number of respite hours delivered per carer have also been presented in Table 10 to assist interpretation. See *Section 5.4.4* for further information on those aspects of service delivery.

Table 10: Cost per hour and per carer for the program as a whole, 2008/9 and 2009/10

Year	Cost per hour FUNDED	Cost per hour DELIVERED	Cost per CARER	No. hours delivered per carer
2008/09	$13.54	$35.75	$7,161.31	200.3
2009/10[1]	$16.92	$30.37	$6,940.51	228.5

1 Based on data for 27 projects only, as FARs for three projects were not available at the time of analysis. When SAR data for all 30 projects is considered, the number of hours delivered per carer in 2009/10 is 237 hours.

5.4.4 COST OF RESPITE DELIVERED PER CARER

The annual *cost of respite delivered per carer* has remained steady at around $7,000 ($7,161 in 2008/09 and $6,940 in 2009/10). The most recent data (2009/10) showed that for most individual projects the cost per carer was in the range $5,000 to $10,000 per annum. Because this cost will tend to reflect the operational characteristics of each service, the prevalence of cancellations and exits from the DDR service, and the care needs of care recipients, it is important to take into account the number of respite hours delivered per carer (based on the SAR data) when viewing information regarding cost per carer – see Table 19 of **Accompanying Report 10.**

5.4.5 COMPARING DDR OUTPUTS AND COSTS WITH NRCP OUTPUTS AS A WHOLE

For comparison purposes, the Department provided the Evaluators with 2008/09 expenditure and service delivery data for 138 NRCP Day Care projects.

The cost of delivering the Demonstration Day Respite program in 2008/09 on a per hour and per carer basis was substantially higher than for the NRCP Day Care program in 2008/09 – see Table 11. However it is important to keep in mind that programs usually gain efficiencies over time. It is apparent from the cost of DDR hours *funded* ($16.92 in 2009/10, see Table 10) that as the DDR program moves further towards capacity there is potential for the service delivery cost to decrease to the level of the other NRCP Day Care programs (i.e. $17.28 per hour delivered in 2008/09). The year 2008/09 corresponded to the establishment phase for almost all of the Demonstration Day Respite (DDR) projects, and indeed some of those projects did not begin operating at all until part way through that financial year. More reliable comparisons between programs could potentially be made using data from a similar phase in the life of both programs, i.e. a certain period of time after establishment. Other factors which should also be kept in mind when examining apparent differences in program costs include the types of services offered and the characteristics of the carers and care recipients targeted by the program.

Table 11: Comparison of costs for the Demonstration Day Respite program and the NRCP Day Care program, 2008/9

Program	Cost per respite hour FUNDED	Cost per respite hour DELIVERED	Cost per carer	No. hours delivered per carer
Demonstration Day Respite program (30 projects)	$13.54	$35.75	$7,161.31	200.3
NRCP Day Care program (138 projects)	na	$17.28	$4,152.44	240.3

5.5 EFFICIENCY-RELATED BENEFITS OFFERED BY LOCATING DDR SERVICES IN RACFS

Analysis of site data has found that the DDR services have been able to achieve economies of scale by sharing staff-related and service provision-related resources. In addition, the RACFs have benefitted from the infrastructure provided through the DDR Initiative, with service users also gaining from the enhanced service provision made possible by building design and renovation. Sharing of staff across programs is also exposing staff to wider learning opportunities, and residents as well as care recipients can be expected to benefit from this. In addition, DDR clients are likely to benefit from the value-add of access to services available in the RACF. **However, it must be noted that these benefits depend on how effectively the integration of the DDR service has been managed by the RACF.**

Across all projects, approximately **30%** of total activity hours per week were shared with residential care recipients. All projects gave day respite clients access to some type of additional service provided by the RACF and these represent value-add services that would not normally be accessible in community-delivered day respite care (see *Sections 3.7.1* and *4.1.3*).

The synergies in resource usage between the RACF and day respite service can be seen as beneficial for both residents and day respite users, and as bringing benefits to the RACF that range from the tangible (sharing of staff resources, pooling of resources to purchasing consumables etc) to the intangible (raised profile in the local community, increased staff experience across programs).

Balanced against these benefits is the additional unfunded support being provided by 80 per cent of the RACFs to the DDR services – as discussed in *Section3.7.2*. This involved **an average of 1.1 FTE staff members per project and the equivalent of 30.5 FTE in total per week** across projects as a group. For each of these staff this involved a small amount of time by each per week, but taken together represents a significant contribution to the DDR Initiative as a whole. Final Site Data Analysis shows that this trend persisted during 2010.

In addition, as discussed in *Section 3.7.1*, most of the RACFs are providing DDR clients with access to additional services (particularly nursing) provided to residents that would not normally be available in a day respite program.

In exchange, RACF residents are able to benefit from the DDR services in a number of ways and the RACFs as organisations can benefit from a range of resource (both material and personnel-related) sharing opportunities.

While these benefits are not indicators of efficiency, from a program perspective they represent a value-add for overall respite resource provision.

5.6 APPROPRIATE LEVELS OF USER FEES FOR DDR SERVICES

Guiding Evaluation Question

*What have been the levels of **user fees** for DDR services and how efficiently and appropriately have these been applied?*

Performance Indicators

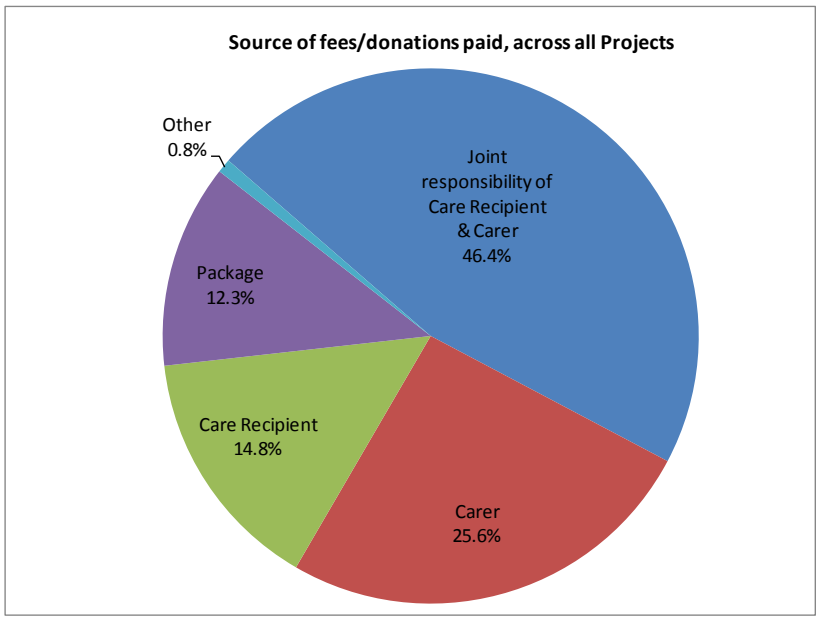
- ✓ Fee rates have contributed to costs of service delivery
- ✓ Carers satisfied with fee rates set
- ✓ Appropriate means testing processes in place for fees

The DDR sites are clearly taking into account financial need in the fees or donations being charged, and in some cases, waiving these altogether. This means that appropriate means testing has taken place, and this applies to both service fees as well as transport fees (see *Section 3.8.3*). Survey feedback from carers indicates that they are satisfied with current fee rates (see *Section 4.3*) and open ended feedback from them provided only a few instances of specific dissatisfaction with fees.

Site Data analysis for the period July to December 2009 showed that the majority **(89.7%)** of DDR clients were charged a small *fee*, with the average set fee for a day respite attendance being **$12.60.** Some paid *donations in lieu of fees* (5.2%), and n*o fee* was charged for **5.1%** of all clients, spread across 16 projects. Sites are also heavily subsidising the costs of transport (see *Section 3.8.3*). It is therefore unlikely that fees paid will have covered the costs of delivering DDR services, and that funding provided to sites as pilot projects will have been critical to meeting those costs. FAR analysis confirms that income from user fees currently represents only around 5% of total revenue for the program. Any contribution to service delivery costs by fees will have been minimal rather than significant. The trend for DDR sites to have only a small surplus (as discussed in *Section 5.4.2*) would seem to reinforce this assumption.

According to Site Data, the *care recipient and carer* shared the responsibility for paying the day respite fees/donations in nearly half (46.4%) of all cases – see *Figure 18*. In a further one quarter of cases (25.6%) the *carer* took sole responsibility for the fee/donation, however it was not possible to determine from these cases whether or not Carer Allowance was being used. For another 14.8% of cases, the *care recipient* paid the fee/donation, with a Commonwealth pension source being identified in some cases. A *care package* was specified as the source of the fees/donations for 12.3% of care recipients indicating that these individuals were already part of the aged care service system, for which an assessment of ability to pay fees would have also been made.

Figure 18: Source of fees/donations paid for DDR services



Our feedback from interviews and surveys with care coordinators and service directors indicates that consultation has occurred between sites and carers, and that fees being charged are likely to be appropriate and reflect capacity to pay.

5.7 APPROPRIATE OPTIONS FOR FUTURE FUNDING

Guiding Evaluation Question

*What are the appropriate **options for future funding** of this type of respite?*

Performance Indicators

- ✓ Funding options and possibilities identified
- ✓ Income and expenditure, current & projected identified

Case study findings reported most of the 13 sites studied to be financially viable due to the grant-based nature of funding, but unable to survive on user pays funding. FAR analysis confirms that income from user fees currently represents only around 5% of total revenue for the program.

The grants based funding provided for the DDR pilots has been effective not only in meeting service costs but for a number of other reasons –

- ⇒ Its four year timeframe, as opposed to a one year timeframe, has enabled issues associated with service establishment to be addressed and lessons learned from the pathfinding nature of these pilots to be identified and absorbed.
- ⇒ The long timeframe has also supported services to be *innovative* and *flexible*, which would have been far less likely if funding had been provided on an annual basis.
- ⇒ It is very important for carers and care recipients to have a guarantee of service continuation.

At the same time, the provision of a service for four years will have raised expectations among service users of the continuation of DDR services and if the Program is not continued or absorbed into the NRCP, the negative impact on them will be significant (based on the positive feedback that the evaluation has identified).

There is inconclusive evidence about whether the amount of funding provided has inhibited or enhanced the services provided. However, it is more likely that the guarantee of four years of funding support has been deemed by providers to be worth investing RACF time and resources in developing DDR services.

Should the DDR services be continued as an ongoing component of the aged care respite service system, it is highly unlikely from the evaluation findings that they will be able to rely on a user pays model (if they are to be equitable and accessible). This means that funding will need to be recurrent, but based on meeting a set of required deliverables that reflect the purpose of the program and its service model. These could be derived from the findings of this evaluation (for example, flexibility and choice for carers, providing an agreed number of respite places that reflect local demand, providing a range of activities – and other factors discussed in relation to Appropriateness and Effectiveness).

Finally, it is useful to determine funding for DDR services in terms of potential investment – specifically, in relation to delaying entry to permanent residential care and the savings associated with this. However, unless entry to the program is based on ACAT assessment, and the results of this integrated into SAR or similar reporting, it will not be possible to measure and monitor this outcome.

6 CONCLUSIONS

Drawing together the findings from the different data sources, a number of conclusions have been drawn.

1) The day respite in residential aged care facilities (DDR) model is meeting the needs of carers and care recipients. Critical to its success is flexibility of delivery and meeting carers' requirements for quality service provision to the person in their care. Services that address carer health and well-being are highly valued.

2) There is significant diversity across the sites in the application of the model, indicating that a range of carer needs is being met, and that the DDR model has the capacity to be applied to a range of settings and diverse needs.

3) Locating day respite services within a residential aged care facility offers significant scope for achieving effective resource usage, bringing benefits for carers, care recipients, residents, and staff – both day respite and residential. At the same time, DDR services benefit from the value-add arising from unfunded contributions by staff and managers.

4) Evaluation feedback from the surveys and case studies indicates that the DDR model is supporting innovation in day respite provision. In part this stems from the co-location with residential care services which is requiring both DDR and residential care staff to think and operate outside of their 'normal' paradigms. It also offers a wider range of activities than would normally occur in day respite programs. In addition, the Pilot has encouraged services to trial different approaches to providing day respite and approaches that place the carer and care recipient at the centre of service delivery.

5) The process of integrating a new day respite service into a RACF must be carefully managed with a view to minimising negative reaction by residential staff. This requires the development of information and, in some cases, education of residential care staff about the DDR service model and how it will be implemented in the RACF. It also requires designing communication and coordination processes that enable staff in different services within the RACF to work together effectively.

6) Regardless of whether the DDR service is physically separate from or integrated within the residential aged care facility, its design and infrastructure critically affects access to and participation in the service. Design is an important element in offering flexibility and choice of activities and in creating a homelike, user-friendly environment.

7) There can be stigma associated with a DDR service that is linked to a residential aged care facility, but much depends on the trust and credibility associated with the auspicing organisation. Stigma reduces as familiarity increases with the residential care facility and its services, but removing its influence on initial access is often a challenge.

8) The two most commonly identified implementation challenges for the DDR model relate to countering stigmatisation associated with residential care location and ensuring that this does not

deter potential consumers, and managing the (initially) negative reactions by some RACF staff to the day respite service.

9) Day respite staff have raised concerns about the capacity of DDR services not offering a specialist Indigenous or CALD focus to provide culturally appropriate services and to provide sufficient training and development opportunities to care workers to build this capacity. These findings suggest areas for potential improvement by those DDR services not offering a program with a specific cultural focus.

10) Referral patterns indicate that the DDR services have been promoted effectively and referral sources have been informed accurately. However demand levels appear not to have been accurately estimated for most projects.

11) Residential aged care residents and DDR service users can share activities and interact, but need to be gradually introduced to these, unless a pre-existing relationship exists – as occurs in small rural communities and culturally specific communities.

12) Transport is a critical success factor for DDR services but requires subsidisation for users and significant tailoring to meet the needs of service users and to reflect local conditions.

13) DDR service users' familiarity with the residential care setting supports a smoother transition to residential care if and when this is needed, and enhanced access to residential respite. The model has been found to enable carers' access to overnight or residential respite, providing a seamless link between day and residential respite services.

14) The DDR service model does not increase the likelihood of day respite users entering residential care. Instead it is more likely that it delays entry into residential care by improving care recipients' functional abilities and enabling carers to continue in their role. However, it would be necessary to quantify this and the evaluators believe that this would be most effectively achieved through requiring an ACAT assessment for entry to DDR services. This would ensure consistent and nationally recognized assessment of care recipient need that could be monitored over time. In addition, the ongoing monitoring of *exit destination* data through the implementation of compulsory data entry for those SAR items, would assist the Department in tracking changes in the rate of clients exiting to full time residential care.

15) The DDR model can be seen as building a bridge between community and residential care, providing an important component of the care continuum and easing the carer and care recipient journey in the process.

7 APPENDIX 1: EVALUATION METHODOLOGY

7.1.1 REVIEW OF THE LITERATURE

A review was undertaken of Australian and international research relating to day respite, and was designed to elucidate the lessons learned from this evidence base.

In researching the literature the following databases were interrogated – Google Scholar, Web of Science, Pub Med, and Science Direct. From the research identified through these sources we then 'snowballed' by exploring relevant references provided in that research. The review focused on studies with sound methodology, including several literature reviews that analysed both findings and the methods employed for individual studies.

The timeframe for the review is the past decade, with earlier studies included when they have been part of a comprehensive literature review undertaken by other researchers, or when the research has made a substantial contribution to the evidence base.

A Discussion Paper was prepared using the review findings, and this was structured to provide information about the following:

- The concept of respite care
- Models of respite care
- Barriers and facilitators to respite care
- The impact of respite care on carers, and factors that can affect that impact
- The impact of respite care on care recipients
- The impact of respite care on entry to full time residential care
- Cost effectiveness of respite care
- Good practice in respite care, including indicators of good practice
- A summary of the lessons arising from the research findings.

7.1.2 MONITORING AND EVALUATION FRAMEWORK

The Monitoring and Evaluation Framework is based on a Program Logic approach that focuses on a hierarchy of Inputs, Outputs, Outcomes and Impact.

7.1.3 CASE STUDIES

A total of 13 sites were case-studied, all of which were visited by the evaluators and information was collected through structured interviews and documentation review. A template was designed to support comparative analysis across sites and to ensure consistency in the information collected. Sites were selected to reflect diversity in service size, auspice type, location and service specialist focus.

7.1.4 FINANCIAL ACCOUNTABILITY REPORT (FAR) ANALYSIS

A Financial Accountability Report (FAR) is required to be completed by all NRCP funded respite services. The due date for submission is 30 September each year and it provides information relating to a standard financial year (1 July to 30 June). The Department provided spreadsheets to the evaluators containing the FAR data for 2008/09 and 2009/10.

Initial analysis of the 2008/09 FAR data was undertaken early in 2010, and then an *updated and extended analysis* using both the 2008/9 and 2009/10 data was undertaken in November 2010 (when the 2009/10 financial year's data became available). That analysis supercedes the previous analysis, with the Department's simplification of the FAR form for the 2009/10 financial year leading to more robust data for this final analysis. Note however that data for 2009/10 was not yet available for *three projects* at the time this analysis was undertaken.

The FAR datasets were linked with our SAR (Service Activity Report) datasets in order to extend the analysis.

The Department also provided a separate spreadsheet containing 2008/09 data on cost per carer and cost per hour for 138 NRCP Day Care projects in 2008/09. We used this data to perform comparisons with the Demonstration Day Respite program where appropriate.

7.1.5 SERVICE ACTIVITY REPORT (SAR) ANALYSIS

A Services Activities Report (SAR) is required to be completed by all NRCP funded respite services. Reports must be lodged twice per year – by 31 January for the 6 month reporting period 1 July to 31 December, by 31 July for the 12 month reporting period 1 July to 30 June.

A preliminary analysis was performed in early 2010 using SAR data for 2007/08 and 2008/09, at which time the data quality and the usefulness of the SAR as a data collection tool was also evaluated. Based on the extent of data quality issues found during the preliminary analysis, the evaluators subsequently sought hardcopy versions of the SARs and undertook a comprehensive quality control check of data for 2008/09 and 2009/10. Numerous data quality issues, which would have led to misleading results across important domains, were identified and corrected. Analysis of this revised SAR data was undertaken in late 2010.

The hardcopy SAR forms used in the data validation process were also used to extract additional quantitative and qualitative items of interest to the Evaluation – two items regarding *funding*, seven items regarding *exit destination*, and four items regarding *complaints*. These items are not entered electronically by the Department.

Relevant items from our revised SAR datasets were then linked to our FAR datasets in order to undertake additional analysis of costs.

7.1.6 SITE DATA ANALYSIS

Two Site Data Collection Tools was designed to collect information for the evaluation which was not available from any other source.

The first Site Data Collection Tool collected very detailed information using an Excel-based file specially designed for the purpose. Prior to implementing this tool a draft was distributed to sites for comment, with feedback being used to refine the tool and to compile an accompanying Guide for its use. Sites were then provided with this tool in July 2009 and were asked to submit data with respect to the period *1st July 2009 to 31st December 2009* inclusive. The tool covered three topics – *General Operations* (broad information about the service - 16 items); *Staffing* (the staff profile for the service, and the sharing of staff between the day respite program and the residential care facility - 2 tables); and *Service Delivery* (data on referrals, care recipients and carers and the services delivered to them during the period July-December 2009 - 45 items per care recipient).

For Round 1, all projects except *Coolibah Day Centre* (Mandurah Retirement Village, WA) submitted data. The two Spiritus sites submitted a combined report.

The second and final round of Site Data Collection focused on *changes* in the operations, staffing and service delivery of each project since December 2009. It was designed to enable the evaluators to construct an up to date picture of the operation of each site just prior to the end of the evaluation period, and to provide the sites with a final opportunity to supply information relevant to the evaluation. This was delivered as an online form comprising 25 simple questions, collecting both quantitative and qualitative information on changes.

7.1.7 SURVEYS

In late 2009, four groups of stakeholders involved in the DDR program – Carers, Care Workers, Coordinators/Managers and CEOs/Service Directors – were surveyed using a triangulated set of surveys designed specifically for the evaluation. The surveys were distributed either on paper, online, or both, with the assistance of the DDR sites. An extended collection period was used, along with several reminders, in order to collect as many responses as possible.

Very good representation was achieved across sites for the Carer and Care Workers surveys, with a total of **297** carers and **104** care workers across *28 of the 31 sites* participating in the survey. Participation by management level staff was somewhat lower, with **34** Coordinators/Managers from 19 sites and **13** CEOs/Directors from 10 sites participating in the surveys.

Response rates for carers varied greatly across sites, ranging from 20.0% to 72.2%. However, the overall response rate was **44.3%,** which is a very good result for surveys with time-poor and often stressed clients, and is testament to the distribution efforts of the site coordinators. The overall response rate for care workers was **60%.** The survey of Coordinators and Managers achieved a *site response rate* (the number of sites at which at least one Coordinator/Manager responded) of **61.3%.** At least one CEO/Service Director survey was completed at **10** of the 31 Demonstration sites, which equates to a *site response rate* of **32.3%.** Some may have completed surveys for Coordinators/Managers if their role included these functions.

The four surveys had a number of key questions in common, allowing triangulation of the perspectives from each group. These related to:

- Effectiveness and impact of the service - including key success factors shaping effectiveness and impact
- Appropriateness, flexibility and quality of the service provided
- Language barriers, cultural barriers and training
- The service model - perceived benefits of the service for carers and care recipients
- The service model - impact of location in a residential facility
- Impact of the day respite service on demand for residential care
- Effect of the day respite service on service networks.

7.1.8 REPORTING

Reporting has been ongoing throughout the evaluation, with a total of **18** reports provided.

1) Review of the Literature Report (April 2009)
2) Evaluation Framework (May 2009)
3) Progress Report 1 (May 2009)
4) Progress Report 2 (July 2009)
5) Workshop Report (August 2009)
6) Service Activity Report analysis, Report 1 (August 2009)
7) Case Study Report (November 2009)
8) Progress Report 3 (November 2009)
9) Service Activity Report analysis, Report 2 (March 2010)
10) Financial Accountability Report analysis, Report 1 (March 2010)
11) Site Data Analysis Report (round 1) (July 2010)
12) Progress Report 4 (July 2010)
13) Report of Survey Findings (August 2010) plus a Summary of Survey Findings report prepared for distribution to DDR sites
14) A Draft Report (October 2010)
15) Final Service Activity Report analysis, (December 2010).
16) Final Site Data Report (December 2010)
17) Final Financial Accountability Report analysis (December 2010)
18) A Final Report (December 2010).

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