



## **REVIEW OF THE ACCREDITATION PROCESS FOR RESIDENTIAL AGED CARE HOMES.**

**Aged and Community Services Australia Inc is the national peak body in Australia representing over 1,100 church and charitable and community based organisations providing accommodation and care services to over 700,000 older people, people with a disability and their carers.**

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## Introduction

The aged care industry supports a robust accreditation system for residential aged care which concentrates on continuous quality improvement. Quality improvement has a focus on finding the underlying causes of errors or system failures so that their future incidence can be reduced which is the basis of the best international accreditation systems. Aged care needs an accreditation system that takes this approach and is transparent, consistent and independent.

Taking this approach means that residential care accreditation must define and measure what is important to the older people who live in residential care. Quality indicators to measure this should be based on:

- the client population, including many people with dementia or receiving palliative care; and
- the lack of an individual's choice in entering residential care, and associated family guilt, which impacts on how people view the care they receive.

This marks a significant shift from the current system which is process based and largely ignores quality of life or service outcomes.

A major issue with the current system is the confusion of roles that is built into the operation of the system. The role of the Aged Care Standards and Accreditation Agency (the Agency) has been progressively blurred with complaints and compliance monitoring requirements rather than on accreditation and quality improvement. These roles are currently unbalanced with the focus of the current system far more heavily weighted towards compliance.

This is reflected in the changing nature of the visits and the relationship between the Agency and the aged care industry in general. Aged care staff routinely report to industry peak bodies that accreditation visits are stressful and take a "policing" approach to quality. They do not report this in feedback to the Agency for fear of reprisal. Similarly providers report a feeling that best practice events should be attended for the same reason.

This may in part be the result of the Agency being established (in 1997) and operated as a government owned company. The Agency operates as a monopoly with all residential care providers having to be accredited by it.

There are other services and structures which can provide quality management and quality improvement services in a competitive marketplace. Using the structure established under the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) would deliver high quality accreditation services to the industry.<sup>1</sup> The JAS-ANZ framework is already used for other Australian Government programs, such as disability employment services and would provide high quality accreditation to the aged care industry at a lower cost to both the Australian Government and the industry.

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<sup>1</sup> Aged Care Standards and Accreditation Agency Ltd Annual report 2007/2008: Part Eight: Financial Statements [http://www.accreditation.org.au/site/uploads/2007\\_2008\\_AgedCare\\_AR.pdf](http://www.accreditation.org.au/site/uploads/2007_2008_AgedCare_AR.pdf)

## **ACSA Submission**

ACSA is heartened that this review is occurring but it must result in real change to the current system for accreditation to be meaningful for consumers, industry and Government.

It is suggested that a review of the standards themselves, including the development of quality of life indicators, would have been sensible prior to reviewing the accreditation system. ACSA urges that the review of the standards proceed as soon as possible and that its results are combined with the findings of this review and are used to design an effective and meaningful quality improvement accreditation system.

This submission responds to the Departmental discussion paper as well as raising a range of other issues that must be addressed.

## **Responses to the Areas/Questions Posed by the Discussion Paper**

### **Self-Assessment**

*Should approved providers have to apply for re-accreditation or should the accreditation body conduct a rolling program of accreditation audits, which ensures that each home is reassessed prior to their current period of accreditation running out (without the need for the approved provider to put in an application)? What are the advantages/disadvantages of the two approaches?*

*Should the provision of detailed self-assessment data continue to be a requirement of any application process? If so, why?*

*Would the removal of the requirement to provide self-assessment data on application create a more stressful accreditation site audit? If so, how might this be avoided?*

The Self-assessment process is a time consuming exercise that adds minimal, if any, value to the overall accreditation system. The majority of providers have their own mechanisms of self-assessment against the aged care standards. This makes the self-assessment a superfluous and duplicative exercise particularly given industry feedback that it is only rarely referred to by auditors during site visits and audit reports. Other specific issues raised by industry with the self-assessment process include:

- Information contained in the self-assessment is dated (having been completed 6 months prior to accreditation occurring) and may well have been superseded by the time of the site visit;
- Agency staff have a large amount of information available at their disposal from previous audits (new services are obviously an exception); and
- Its current format is repetitive, as many of the outcomes overlap.

The self-assessment process should cease, or at least be made optional; enabling providers to prepare for accreditation in a way that best allows them to provide a quality service. This should in no way make the site audit more onerous as auditors must assess each outcome regardless. ACSA suggests that if necessary a reduced range of data could be provided to auditors prior to a site visit giving an orientation to the service being accredited.

Applying for accreditation should be a simple process. Once accredited services would remain so, subject to satisfactory performance by the provider, until such time as the standards were no longer being met, and then accreditation could be revoked. Annual monitoring of performance would occur. Providers would pay a smaller annual accreditation fee in place of the application fee.

#### **Use of electronic information**

*What problems, if any, have approved providers /services experienced in respect of accreditation audits and electronic records?*

*What are the current barriers to assessment teams utilizing electronic records and how might these be overcome?*

An over riding concern in allowing access to personal information must be the ethics, and privacy requirements, of provision to any external organisation such as the Agency. This discussion paper does not address this issue at all but it must be considered as part of this review.

Aged care providers have reported barriers for assessment teams in utilising electronic records. Such barriers largely relate to the auditors skill in using such systems. ACSA contends that it is the responsibility of the Agency to ensure its staff, either employed or contracted, has the skills and knowledge necessary to use the most common computer programs/records systems being used by aged care providers. Currently aged care staff are required to assist auditors who do not have these skills taking valuable time away from direct care of residents.

#### **Nomination of a member of the assessment team**

*Should approved providers continue to be able to nominate a quality assessor as a member of the assessment team that will be conducting the site audit on their aged care home?*

*If yes:*

- *Why? How does this improve the assessment process?*
- *How can issues of perceived conflict of interest be managed?*

The system currently enables providers to nominate someone they do want involved in their audit but there is no guarantee that they will then get that person. There is little benefit in providers nominating quality assessors for the site audit, as in many cases, the auditors are unknown to the provider and there are no details available about the knowledge and skill levels of the auditors.

ACSA recommends that this process be turned around to enable providers to object to auditors where there is a conflict of interest (e.g. previous professional conduct, protection of organisational intellectual property where a contracted auditor may benefit in other roles). This change can be made easily with the Agency advising providers of the composition of audit teams prior to visits and allowing objections based on broad conflict of interest categories (as described above) or on other legitimate grounds. Providers would be able to have 1 assessor removed from the team on this basis.

#### **Skills of Quality Assessors**

*Should the accreditation body have the flexibility to contract 'expert members', who are not quality assessors, to participate on an assessment team? If not, why not?*

*If yes, what sort of 'expert members' might be used and what safeguards, if any, would need to be put in place to maintain the integrity of the assessment process?*

*Should it be a legislative requirement for assessment teams conducting visits to high care facilities, or to low care facilities with a significant number of high care residents, to include a quality assessor who is a registered nurse?*

The Agency checks that providers' staff has the right skills mix and qualifications to deliver quality aged care services. It is an Agency responsibility to ensure the same of its audit teams.

It must be stressed that all Assessors must be trained and aware of their responsibility to take an overview and system-based assessment approach rather than being prescriptive about how things are to be done based on their own practice or previous experience. This is not currently the case with auditors often bringing individual preferences to bear during the accreditation process. This creates inconsistencies in accreditation outcomes for providers which should not be the case in a robust accreditation system.

As many of the expected outcomes are clinically orientated it is important to ensure that auditors have the necessary skill to assess clinical systems and processes. In many instances this will require that at least one quality assessor at a site audit is a Registered Nurse (RN) with experience in aged care and knowledge of best practice. This should be a requirement whether the home being accredited is low or high care. If an RN with aged care experience is not available, the assessor team should have phone access to a suitable RN for clarification when needed. ACSA acknowledges that there is significant movement afoot in nursing scope of practice and accreditation needs to be able to move with such changes. For example, in the future an Enrolled Nurse may be appropriately qualified to fulfill the assessment role that now effectively requires an RN.

The discussion paper suggests that the Agency should be given flexibility to contract "expert members". As the accreditation process is based on assessing systems and processes it is unclear what other form of "expert" would be required and ACSA does not support the need for this to occur.

However, if such an 'expert' is to be utilised the Agency must be able to clearly explain:

- why it is deemed necessary;
- the qualifications of the expert; and
- the boundaries or limits to the role of the expert in the process.

Conflict of interest and privacy safeguards would need to be developed to govern the 'expert' role and to ensure the integrity of the assessment process. The 'expert member' would need to have a thorough understanding of the 'intent' of the outcome(s) they are assessing and/or have undertaken training relevant to being a quality assessor. Any cost associated with engaging an expert should be borne by the Agency and not passed on to the provider.

#### **Announced site audits**

*Should accreditation site audits be unannounced?*

*If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a homes general performance be addressed?*

*If yes, what strategies need to be put in place to minimise disruption to staff and residents?*

*What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?*

*Should a home be able to nominate some 'black-out' days, during which the accreditation body will try to avoid scheduling a site audit? If not, why not?*

The debate about announced and unannounced visits is premised on a view that providers need to be "caught out" to boost community confidence. It assumes that providers are hiding things at other times, including during announced visits, and reinforces the compliance role the Agency plays at the expense of quality improvement.

The view expressed by some commentators is that the current program of announced accreditation site audits merely looks at a snapshot point in time when the home will be doing its very best and putting its best foot forward. ACSA contends that this is a misconception.

The discussion paper refers to claims that providers roster extra staff, change menus and activities etc to assist with accreditation, implying that before and after accreditation the service runs differently. It should be noted that rostering extra staff is necessary and appropriate to ensure continuing quality care for residents and appropriate support for auditors during site visits. Such claims about provider behaviour should not be repeated without evidence. The accreditation system, and any review of its operations, should be based on evidence rather than allegation and perception.

Accreditation site audits should **not** be unannounced. We should never lose sight of the fact that the aged care facility is the resident's home and this needs to be recognised and respected within the accreditation process.

Announced site visits give residents, their families and representatives an opportunity to plan for meetings with the audit team. If accreditation site audits were all unannounced it would potentially reduce interaction between residents, families and auditors. (The current system allows for 10% of relatives and residents to be interviewed).

Experienced and trained auditors should be able to gauge continuous improvement and sustainable processes regardless of whether they are undertaking an announced or unannounced audit.

If unannounced visits are to continue the current provision for at least 1 annual unannounced support visit is sufficient to assist the public's perception that the auditors are gaining a picture of the homes general performance. It is suggested, however, that other mechanisms for developing community confidence, that add value to the system overall, should be explored and implemented.

Such mechanisms should aim to assist in the community understanding the difference between a one off 'occasion' of error (e.g. a resident receiving the wrong meal at one meal time) and a process/system error (where there is not a system in place to ensure that each resident receives the right meal) and how such errors are identified and addressed. Unannounced audits might detect an 'occasion' of error but this is not the primary concern of accreditation. Occasions of error should not be viewed as 'non compliance' which sometimes happens now.

Accreditation site audits are time intensive and require multiple people in various positions across the organisation to be available to explain procedures, audits and outcomes. Adequate notice is necessary to ensure that the right people are available to be interviewed by the auditors. For this reason organisations should be able to negotiate a mutually agreeable time for site audits. Such a demonstration of understanding on the demands facing aged care services would serve to improve the relationship between industry and the Agency.

#### **Consumer Focus**

*Does the current accreditation process allow for appropriate levels of consumer input? If not, why not? How might this be improved?*

*Should there be a minimum target set for consultations with residents and/or their representatives during visits to a home by the accreditation body? If so, what would be an appropriate number or percentage?*

*Should assessment teams seek to attend homes out of normal business hours? Would this increase opportunities for consultation with relatives/representatives?*

*Are there other strategies that may increase engagement with residents and/or their representatives?*

It is important and appropriate that the residents and their families/representatives are able to contribute to the accreditation process. Residents and their representatives are actively engaged under the current system.

The current target sample size of 10% is reasonable regardless of the size of the facility. It is important to remember that the Agency can already increase the sample size if it has particular areas of concern and that if there is a question of non-compliance it is able to visit the facility after hours and at weekends.

In addition to the direct interviews the Agency is able to use other information/strategies to increase engagement with residents and representatives including having access to customer survey results and resident meeting minutes. The Agency should ensure it is effectively using all of the tools at its disposal before any changes to the current arrangements for engaging residents and their representatives are made. The impact of the current approach and the demand it places on services, in terms of quality service continuity and Agency support, has already been discussed in this submission and ACSA suggests that attending out of normal business hours will just increase these demands for an unclear return.

If changes are to be made in the engagement of residents and their representatives there must be a standardised and consistent approach so that all parties - residents, families, the care provider and the Agency - are clear about the process and objectives. Any developments along this line should be done in consultation with consumer and industry peak bodies.

#### **Consumer advice about serious Non-compliance**

*Should approved providers be required to organise a meeting with residents and their representatives to discuss incidences of non-compliance?*

*If so, should this be a general requirement for any non-compliance, or should it only apply where there is major non-compliance, for example, non-compliance with four or more expected outcomes, or non-compliance against specified outcomes?*

Most providers already communicate (via newsletters, emails and other mediums) with their residents and representatives on results of Agency visits. The judgement of whether to organise a meeting with residents and representatives to discuss incidences of non-compliance, taking into account the seriousness of the findings, should lie with the aged care provider. Details of relatively minor infringements can only unnecessarily erode resident confidence.

The use of the term “non-compliance” and “major non-compliance” (which is now used but has no legislative basis) needs to be considered and clarified by this Review. There is currently considerable variance as to the application of, and the penalties applied, for non-compliance which should not occur in a robust accreditation system.

The standards are linked and an issue with one will cascade and show up as a number of non-compliances stemming from one system problem which may not relate to actual harm.

ACSA suggests that a more sophisticated assessment of compliance, based on risk including perceived system risk and risk that causes actual harm, is required. Time to remove the risk (24-48 hrs) should be provided before any non-compliance is issued.

Government introduced greater access to accreditation information for consumers on the 1<sup>st</sup> July 2009. Unfortunately the information provided is relatively meaningless and does nothing to assist consumers or accurately represent an aged care provider's services.

The accreditation system needs to be meaningful, consistent and transparent which it currently is not. The more sophisticated approach recommended above would improve the transparency and consistency of the system. It would also provide clearer and more accurate information about aged care homes to consumers.

### **Confidentiality**

*Does the lack of confidentiality for staff act as a barrier to them providing frank information to the accreditation body?*

*Should the confidentiality protections provided in the Aged Care Principles for residents or their representatives be extended to all persons who provide information to the accreditation body?*

ACSA contends that the current confidentiality provisions are satisfactory. It is already common practice for Auditors not to reveal the identity of people (residents/representatives or staff) they have interviewed and the majority of staff state that they are happy to answer the questions of auditors candidly and without fear of reprisal. The Investigation Principles 2007 gives protection to any informant who desires to keep their identity confidential when making a complaint.

It is the Agency's responsibility to ensure that its auditors have the skills to manage confidential information. This should include the ability to corroborate and verify facts raised by any confidential individual claim.

The Agency is able to act on confidential information it receives from the Complaints Investigation Scheme (CIS). Such information must give evidence of a systemic problem, not just an individual complaint being investigated by the CIS, before the Agency is required to take any action.

### **Monitoring failures**

*Is the current accreditation and monitoring regime for residential aged care homes effective in identifying deficiencies in care, safety and quality? If not, why not?*

*If the accreditation and monitoring regime was to be enhanced, what approaches should be adopted?*

*Should homes be required to collect and report against a minimum data set?*

It should be stated at the outset that the effectiveness of the current monitoring regime in identifying deficiencies depends on the quality of the auditor rather than on the frequency of visits by the Agency. Auditors should be able to determine if a quality process is mature, robust and effective at any of the various visits undertaken. Increasing the frequency of site or random visits would do nothing to improve the effectiveness of the current monitoring regime. In fact, the current accreditation statistics do not warrant an increase in the number of audits implying instead that quite the opposite should be the case.

Auditors must be able to show systemic deficiencies in care, safety and quality. If auditors have concerns about systemic problems in relation to the quality process or compliance, then this information should be used in developing a provider's risk profile for a targeted approach for more frequent visits by the Agency. Alternatively, providers who have robust and effective quality processes should be rewarded within their risk profile by reducing the number of visits required.

The current approach enables individual auditors to take different approaches resulting in inconsistencies. This needs to be addressed.

The discussion paper proposes the development of a minimum data set (MDS). There is some attraction to the creation of an MDS but it would need to be developed in close consultation with the industry and focus on resident lifestyle as well as clinical facts. Collection and interpretation of data needs to be consistent with clear guidelines to ensure accuracy and avoid misrepresentation of the facts.

Any requirement for a minimum data set should not be an additional requirement of the outcomes, but rather should replace existing data requirements.

#### **Review rights**

*Should decisions only be appealable to the Administrative Appeals Tribunal if they have already been subject to reconsideration by the accreditation body?*

*Should the accreditation body be able to undertake 'own motion' reconsideration of decisions in certain circumstances?*

All appeals and reconsiderations should apply natural justice principles and be subject to a clear and independent review process.

The Agency should be able to reconsider decisions with a review of independence. ACSA suggests the introduction of Review Panels convened for certain types of appeals. Panels could comprise an Agency decision maker from the state where the service appealing is located, another one from interstate and an advisor for the Department of Health & Ageing's approved list of nursing and administrative advisors. This approach provides a level of independence by removing the appeal from the same body which made the original decision. The panel should be convened at the Agency's expense.

The appeal process to the AAT is an expensive and time consuming option, so should be the last resort for providers rather than being used concurrently as is the procedure now.

### **Reporting of decisions**

*Is the current way in which audit reports and decisions are published adequate? If not, why not?*

*Should audit reports and decisions of the accreditation body that are subject to reconsideration or review be made publicly available prior to the finalisation of the review process? If not, why not?*

*Should approved providers be required to provide residents and carers with access to reports and decisions of the accreditation body?*

The current way in which audit reports and decisions are published does not meet the needs of the general public or the approved provider. Currently, the reports are open to misinterpretation by the general public who do not have the knowledge to understand and interpret the report.

The Government's decision to publish non-compliance information on its website from 1 July 2009 will lead to increased disputation and litigation in aged care. Providers may well fight harder than they do now to protect their reputations against criticism from the Agency or the Department which they consider to be incorrect. In our experience providers do not always agree with the reasons stated for non-compliance but take the approach of working with the Agency and Department to achieve a finding of compliance. Adopting a practice that allows the publication of non-compliance history and the reasons makes it more likely that approved providers will challenge the decisions.

For reports to be meaningful for all parties they must be:

- timely, current and include unannounced and announced reports; and
- written in plain English with a summary explaining each standard and the home's performance in a short, succinct manner.

If a report is subject to reconsideration of appeal it should only be made publicly available after all the review processes have been exhausted.

This review should seriously consider all of the reports provided and ensure they are relevant and meet the needs of all parties.

### **Distinction between types of visits**

*Are the current distinctions between different types of visits conducted by the accreditation body appropriate? If so, why? If not, why not?*

One of the key issues between the types of visits relates to the linkages of the accreditation system with compliance monitoring. In fact if the Agency's only concern was accreditation and quality improvement, and there was no role in compliance, much of the current confusion and need for distinguishing between the types of visits would be removed. All visits would in fact relate to accreditation and quality improvement. This would be simpler and more transparent for all concerned.

However, if the Government persists in mixing these roles then distinguishing between visits is extremely important. Most importantly the Agency should not be able to move between the different types of visits within the one contact as this is a confusing and non-transparent process and approach.

The terminology "support contacts" is a misnomer, when they are in fact compliance monitoring visits, and should be replaced.

**Provision of industry education by the accreditation body**

*Is it problematic for the accreditation body to provide education to industry?*

*If not, why not? What are the benefits of the current approach?*

*If yes, what are some alternate models for providing education to industry?*

*Does there need to be another source of advice for industry, besides the accreditation body, about issues in respect of accreditation and improving performance? If so, what would be an appropriate source for such advice?*

ACSA reiterates that the main role for the Agency is accreditation. There is a real conflict of interest in the body providing education given the way the Agency effectively undertakes compliance monitoring for Government.

Aged care providers report feeling compelled to attend Agency events to avoid having a "black mark" recorded against them. The auditors promote Agency events, and other available education, whenever they are on site which is clearly in the Agency's own interest. Some facilities report having been contacted by the Agency to see why they haven't registered to attend events. This is unacceptable.

There is no shortage of alternative education providers including Registered Training Organisations and industry peak bodies.

The newsletter published by the Agency is the most appropriate vehicle to inform the industry of best practice and to give examples of innovative approaches to care.

## **Period of Accreditation**

*Should there be a maximum period of accreditation specified in the legislation?*

*Should homes that have sustained compliance with the Accreditation Standards over a number of years be rewarded with a longer period of accreditation?*

*Are there other means of rewarding good performance?*

Positive reinforcement of continuous quality improvement is a better option than negative, punitive approaches to compliance.

This submission has already recommended that accreditation should be ongoing until such time as a service has its status revoked. ACSA has also recommended a more sophisticated approach, based on a risk management approach, which would reward good performance. These recommendations should be considered by the review in determining the period of accreditation.

## **OTHER ISSUES FOR REVIEW.**

### ***Accreditation Timelines***

The Agency has its own time frames to address non-compliance issues which bear no relevance to the type of non-compliance identified. Time frames to address non-compliance need to be realistic and be based on the specific detail of what has to be addressed. It is important for the focus to be on effectively addressing the issue, rather than a politically driven exercise.

Time frames for applications for reconsiderations and/or appeals need to be reviewed to be workable with consideration given to expanding them to working days instead of days at the very least.

### ***Non compliance and the accreditation period***

There should be a “line drawn in the sand” when past non-compliances no longer impact on the accreditation period granted. The link between past non-compliance and the accreditation period is not transparent and it should be.

### ***Internal Agency processes***

Internal Agency processes need to be tightened. It is not uncommon for providers to receive an unannounced visit close to the time of their scheduled accreditation site visit. Other providers, with facilities of less than 30 residents, will have 3 auditors on site for 3 days – and they are all auditing the facility (no observers). This does not seem to be an effective use of available resources.

### ***The cost of accreditation***

Residential care accreditation is expensive when compared with other similar accreditation systems. In addition, fees are indexed annually using the CPI while aged care providers are indexed by COPO which is often less than CPI.

Aged care providers have no choice but to be accredited by the Agency so the cost and indexation anomaly need to be addressed as a matter of fairness.

## **IN CONCLUSION**

This is an important review. The findings of this review should be combined with a review of the standards and be used to develop a robust accreditation scheme which is independent, transparent and provides consistent results. The basis of the new system must be on quality improvement on the things that matter most to the older people who live in residential care.

Consultation with the industry and consumer peak bodies on the findings and any proposed changes is imperative to establish a partnership between stakeholders to deliver quality care for older Australians.