Catholic Health Australia (CHA) submits that the current process by which services are accredited to provide care for older Australians can be easily improved by moving to a system of continuous accreditation based on rolling audit activity.

The current system for many has also become unnecessarily adversarial in the way that the combined interactions of the Aged Care Standards and Accreditation Agency, the Department, and Government contribute to create an environment in which accreditation is becoming punitive. An enhanced process would instead be incentive driven to create service cultures aimed at improvement of care.

The current system is also heavily reliant on a review of documentation, whereas an enhanced process would place more emphasis on residents’ care experiences.

A. Essential attributes of an accreditation system in aged care

In seeking to enhance the process of accrediting services to provide quality care for older Australians, CHA proposes five attributes that are considered essential for an effective accreditation system in residential aged care. These attributes were used to guide the formulation of our views on options to improve current accreditation processes.

a) Person centred

Because of the vulnerable nature of the client group and the long term nature of the relationship between the carer and the care recipient, it is essential that the accreditation process focuses on and tests the experience of the care recipient and their family, including consideration of the ‘resident journey’ from entry to departure.

In assessing quality of life and wellbeing, satisfaction levels will be a matter of opinion, judgement and geography, not just statistics.

b) Consistent and fair

The validity and credibility of an accreditation system in aged care, especially when future funding is directly linked to successful accreditation outcomes and services relate to the long term care of a very vulnerable section of the community, relies heavily on community confidence that assessment is fair, consistent and evidence based and that accreditation decisions are sustainable.

The provision of comprehensive and appropriate training of assessors is crucial to achieving this objective, including provision for refresher training to reflect continuous improvement and informed by regular ‘inter-assessor’ performance assessment.
c) Cost effective

An accreditation process should be cost effective and avoid duplication of effort which dilutes ‘front line’ services. In this regard, assessment should be based on documentation required for the effective operation of a service and not require the production of documentation exclusively for the purpose of accreditation auditing.

d) Collaborative

The accreditation process should be collaborative and supportive, and not punitive. This extends to matters such as embracing language which is empowering rather than regulatory in flavour, avoidance of any ‘presumption of guilt’ on the part of assessors, greater use of rewards for good accreditation outcomes and more judicious use of unannounced visits.

e) Incentive to improve

The accreditation process should act to recognise quality care, and offer incentives for improvement. The current process is feared by many staff and services. There are opportunities for the accreditation system to highlight best practice across the aged care sector, and to create local area forums in which services meet under the coordination of the agency to receive and exchange information on trends and improvements in quality care.

B. Review questions for consideration

1. Self assessment

a) 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?

Comment

Providers should not have to reapply for accreditation. Accreditation should be the same as Certification, in other words, once accredited always accredited until it is revoked.

Instead of the current three-yearly audits, and reflecting the growing understanding and maturity of accreditation in the sector, auditing should be on a rolling basis whereby homes are assessed, say, annually, employing modules which audit a cross section of the standards/outcomes on each visit. The current Support Contacts (renamed and reconfigured) could become the basis for the rolling audits.

If significant non-compliance is identified, Review Audit processes would be commenced with a view to determining suitability for ongoing accreditation.

A rolling program of audits would relieve homes of the significant investment in staff and, in some cases, consultant time needed to complete the re-accreditation application self assessment process. It would also remove the three yearly peak in audit activity and enable
the Agency to employ dedicated staff for continuous audit activity, minimise its reliance on contract assessors and to have an annual accreditation fee arrangement.

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

Comment

No. It would be more cost effective if the assessment team were to review each home’s quality care documentation and regular internal self assessment process and outcomes during audit visits.

c) **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?**

Comment

No, but assessors and providers would need to adopt a collaborative approach and assessors would need to provide clear evidence to substantiate any non compliance. Providers would also need to complete documentation and self-assessment diligently.

Assessors would also need to recognise the need for some flexibility concerning requirements in relation to smaller services which cannot be expected to have the same systems as larger providers.

2. **Use of electronic information**

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

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

Comment

Some providers report assessors are often not prepared to accept electronic records and require hard copy.

There is a need for assessors to be trained to use electronic records and not insist on print outs of documents. This training would be more effective if it were delivered by the software developer/owner, and should include refresher training as part of professional development, as new software and new versions are released.

It should be clear that the provider will control assessor access to its electronic systems.

Some providers report that they have had to outlay money on a computer terminal solely for assessors. Assessors often have very onerous expectations of services.
3. Nomination of a member of the assessment team

   a) 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?

   b) If yes:
      • Why? How does this improve the assessment process?
      • How can issues of perceived conflict of interest be managed?

Comment

The advantage of the current provision for a provider to nominate a quality assessor is that it reduces the time needed to orientate the assessors to the characteristics of the home, including its layout, management arrangements and systems.

Under the regime envisaged above where accreditation would involve a more collaborative model based on a rolling program of audits, the objective of greater familiarity with the home could be achieved by having a group of assessors dedicated for each region.

In the absence of the revised arrangements suggested above, it would be desirable to continue to allow the provider to nominate a quality assessor in order to facilitate the audit process in the home.

Any perceived conflict of interest would continue to be managed by the Agency as at present.

There should also be a formal capacity for the provider to appeal an Agency appointed assessor on the grounds of perceived conflict of interest, with an assessor’s failure to disclose a conflict being a relevant consideration in any performance assessment.

4. Skills of quality assessors

   a) 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?

Comment

This question may be more relevant once the accreditation standards are reviewed.

As the current role of assessors is to assess how approved providers demonstrate that their approved services comply with the Outcome Standards, having specific clinical qualifications is not essential. However, there may be an advantage in providing assessors and the Agency access to expert advice where the audit involves services specialising in certain special needs groups.

b) 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?

c) 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?
Any provisions should relate to access to expert advice as needed, not the inclusion of ‘experts’ on assessment teams.

It is not the role of the assessors to be making judgements on clinical care as this is the responsibility of the relevant clinicians. If a team was to include an ‘expert member’ who is not a registered aged care quality assessor, this would lead to clinical judgements and assessors exceeding their assessing responsibilities.

The inclusion of a registered nurse quality assessor is desirable where homes have significant numbers of high care residents. However making it a legislative requirement may compromise the Agency’s audit program given the overall shortage of registered nurses.

5. Announced site audits

a) Should accreditation site audits be unannounced?

Audit visits, whether as part of a rolling program as we propose, or as currently undertaken, should be announced. This should include provision to agree a date which does not conflict with other planned activities at the home eg an open day or planning day or some other major special event.

b) If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a home’s general performance be addressed?

Announced visits are also essential as a means of ensuring that the appropriate management and expert staff are available to facilitate the audit process. This is especially relevant for multi site providers who have expert staff essential to the audit located off site in a corporate office. Moreover, there is no evidence that announced visits lead to incorrect decisions, nor to an undermining of public confidence in the accreditation system. This would be even more the case with a regime of more regular rolling audits.

Unannounced visits should be only on a risk assessed basis eg where there is a history of significant non compliance or serious and immediate risk to residents.
c) If yes, what strategies need to be put in place to minimise disruption to staff and residents?

Comment

A home should be able to nominate ‘black-out’ days as is the case now.

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

Comment

Greater emphasis needs to be placed on meeting with residents and their representatives as a significant part of the assessment process. It currently tends to play a secondary role to the process of examining a service’s documented policies, procedures, processes, meeting minutes, reports and trend analyses.

Assessors need to spend more time being a part of the service rather than being in an office separated from the day to day life of the facility. A focus on a resident’s ‘life journey’ from entry to departure should be included as a component of the audit assessment.

e) 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?

Comment

Yes.

6. Consumer focus

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

Comment

The Agency should use a number of techniques to encourage greater levels of consumer input.

The Agency could provide to each approved service a consumer engagement letter, on Agency letter head, to be sent to each resident/relative ahead of the site audit inviting consumer participation. The letter could invite the consumer to contact the service to arrange to meet with the assessors. The letter could also include Agency prepared material explaining accreditation and its processes. Feedback cards could be left at the facility for residents and relatives following a visit.

As canvassed in the Discussion Paper, extending the period for consumer comment direct to the Agency for a period after the assessment visit would be useful, providing the person commenting was not anonymous and had a connection with the home.
The Agency’s website section for Residents and Relatives could also include a feedback comment link.

b) **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?**

Comment

The current minimum target of 10% is an appropriate minimum. Under international auditing standards 10% is an accepted minimum. In practice the Agency exceeds the 10% minimum where the numbers of residents warrants it.

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

Comment

Attending out of normal business hours would require a different type of visit. It would not be possible to examine relevant documents nor engage with staff in any meaningful way as the focus of the available staff should be exclusively on the care of the residents.

Given the current way residential aged care is funded, reduced staffing levels are on duty after hours and the assessors would be merely observers of the after-hours life of facilities. The staff on duty would find these visits an imposition as they would compromise their ability to attend fully to the care needs of the residents. If this led to staff being disinclined to want to work after hours, resident care would suffer.

Visits outside business hours would continue to be appropriate in cases where immediate and serious risk to residents has been identified.

7. **Communication with residents about serious non-compliance**

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

   Comment

   Providers should not be required to convene residents’ meetings to discuss all incidences of non compliance. Many instances of non-compliance are easily and quickly corrected and would not pose serious risk.

   A requirement to arrange residents’ meetings for all instances of non compliance would add to costs, take resources away from care delivery and achieve very little of substance.

   The current requirement to convene a meeting following the application of sanctions in response to serious and immediate risk is all that is required.

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

Comment

There is a concern that the lack of confidentiality for staff may act as a barrier to them providing information to the Agency in certain circumstances.

b) **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?**

Comment

Staff should be able to provide information to assessors on a confidential basis.

However, as is currently the case for staff providing information confidentially under the Complaints Investigation Scheme, there need to be arrangements to identify and deal with vexatious behaviour.

Accordingly, assessors need to be sensitive to and trained in the appropriate approach to assessing confidential comments to ensure that they are tested (triangulated), including with facility managers, and can be substantiated with a body of evidence. There is the potential for comments to be subjective assertions and from persons with their own agendas. There would be a real risk of a denial of natural justice if assessors accepted unsubstantiated confidential comments at face value.

9. **Monitoring failures**

a) **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?**

Comment

There is scope to improve the current monitoring system to make it more effective and efficient.

The current process is not cost effective as it is highly random, unnecessarily disruptive for staff and residents and fosters an adversarial approach which is not conducive to collaborative approaches and continuous improvement.

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

Comment

Under our proposal for rolling audits, the monitoring regime would be risk assessed, targeting those homes considered to be at risk of significant non compliance.
Such risk assessments would rely on information obtained as part of the rolling audits and investigations under the Complaints Investigation Scheme.

In principle, such risk assessments could also be informed by the periodic provision by providers of a minimum data set to the Agency, on the basis that the data set comprises data which the home would be expected to collect routinely to support its own quality assurance arrangements (see further comments below).

Review audits would only be undertaken when there is evidence of potential serious and immediate risk to residents.

There is also a case for reducing the current 44 Expected Outcomes in order to simplify the monitoring process. CHA does not recommend abandoning the intent of the 44 Outcomes, but rather proposes a less duplicated process of reporting against the intent of the existing 44 Outcomes, many of which are repetitive.

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

Comment

We support in principle the development of a set of aged care quality indicators, drawing on data that a home would normally collect as part of its quality assurance arrangements.

The selection of indicators will require careful consideration in order to minimise the potential for misinterpretation. Those that could be seen as superficially appropriate may need too many caveats on the data with respect to specific resident acuity, co-morbidities and drug regimes in order to avoid incorrect interpretations of conclusions about the substandard of care. We are mindful that the indicators will effectively become public information and subject to superficial and misleading interpretation.

10. Reconsideration, review rights and offences

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

b) Should the accreditation body be able to undertake ‘own motion’ reconsideration of decisions in certain circumstances?

Comment

Based on our earlier comment that accreditation should be permanent until revoked, the decisions that should be appealable to the AAT following reconsideration by the Agency would be:

• Revocation of accreditation;

• Finding of serious risk.
The Agency should have the power to reconsider decisions it has made, but there should be a requirement that the circumstances leading to the ‘own motion’ review are fully disclosed in the resulting report.

11. Reporting of accreditation decisions

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

Comment

The current practice of publishing both the audit report of the assessment team and the Agency’s decision is confusing and unhelpful for people seeking a clear, simple and readily accessible statement of accreditation outcomes, rather than ‘work in progress’. The current arrangements are especially confusing when the Agency’s decision differs from that of the assessment team’s recommendations.

Under the current three-year audit arrangements, the only document that should be published in the Agency’s decision, which is based of information contained in the assessors reports, as well as other sources, and includes information provided by the approved provider.

Under our proposal for rolling audits, the Agency’s reports following each audit should be published, along with the provider’s comments.

Providers should receive the assessors Site Audit Report if it differs from the Statement of Major Findings.

b) *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?*

Comment

Any publishable reports should only be published once the Agency reconsideration processes have been completed. To allow publication beforehand could lead to inaccurate damaging reports being published. It is not appropriate for a home’s reputation or financial viability to be put at risk through publication before a review process is complete.

Appeals to the AAT would still be outside this restriction, as would reports dealing with serious and immediate risk to residents.

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

Comment

Providers should be required to alert residents and their representatives of the existence of publishable reports, but should only be required to provide a copy if
requested. This approach would achieve both information disclosure objectives and administrative efficiency.

12. **Distinction between various types of visits**

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

   **Comment**

   Based on our earlier comment that accreditation should be permanent, there needs to be only two types of visits; Review Audits and reconfigured Support Contacts as part of a rolling audit process. See earlier comments under ‘Assessment’.

   The Review Audit would examine all Standards Outcomes in the case of potential serious non-compliance. The reconfigured Support Contacts would examine a cross section of standards /outcomes, but could be extended to all Expected Outcomes (a Review Audit) if the extent of non-compliance warranted a Review Audit.

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

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

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

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

   d) *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?*

   **Comment**

   It is appropriate for the Agency to provide education to the industry. The education programs run by the Agency are of a high standard and have been very well accepted by the majority of providers and the care staff working in them.

   We note that fees apply for Agency training programs. This places an onus on the Agency to provide value for money. The generic peak bodies and their state associations, who are accredited training bodies, also conduct education sessions for their members on a range of topics including quality monitoring and accreditation. They are an accepted source of advice on matters to do with accreditation and improving performance.

   Concern has been expressed by some providers that some assessors value attendance at Agency-conducted education sessions over other training and that this may count against them in audit processes. The Agency needs to ensure that such attitudes do not influence audit assessments.
14. Period of accreditation

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

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

c) Are there other means of rewarding good performance?

Comment

The maximum period specified in the legislation should be until revoked or circumscribed as a result of a Review Audit. The latter may include re-accreditation for a period until the Agency is satisfied that ongoing accreditation can be sustained.

Loss of approved provider status would also automatically result in loss of accreditation.

Catholic Health Australia

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