CATHOLIC HEALTH
Australia

Submission to the House of Representatives Standing Committee on Health, Aged Care and Sport's Inquiry into the Quality of Care in Residential Aged Care Facilities

Introduction

Catholic Health Australia (CHA) represents the largest owner grouping of health and aged care services in Australia. The Catholic sector embraces 66 hospitals, eight dedicated hospices with palliative care services and over 550 aged care services. CHA's aged care services comprise 22,500 residential aged care beds and 11,900 home care packages for older people with higher care needs, and provide basic home support services to some 23,500 older people annually. CHA members also operate around 6,000 retirement and independent living units for seniors and low-income residents.

Australia's aged care system is recognised as being one of the best in the world. Within a federated governance system, aged care operates under national legislation and regulations designed to produce national consistency in quality and service delivery, and is funded to be affordable for all Australians needing aged care.

In 2016-17, 239,379 people received permanent residential aged care within 2,672 aged care homes operated by 902 approved providers, and 59,228 people received short-term respite care in aged care homes. The 200,689 operational residential aged care places with an average occupancy rate of 91.8 per cent delivered 67.2 million days of care.[1]

2. The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers

CHA is not aware of the existence of any specific measure of the incidence of all mistreatment of residents in aged care homes. The primary proxy measure used to gauge the extent of mistreatment is the level and nature of complaints received under the Aged Care Complaints Scheme.

In 2016-17, the Aged Care Complaints Commissioner received 3,656 complaints relating to residential care. The most common complaints were about medication administration and management (559), falls prevention and post fall management (382), and personal and oral hygiene (365). Ninety-two percent of complaints were resolved within 30 days.[2]

When measured against the 67.2 million days of care, the incidence is low, but not low enough. The target for any quality compliance system should be zero.

Reportable assaults is another indicator of mistreatment of residents.

Aged Care providers are required to report suspicions or allegations of assaults to the police and to the Australian Government Department of Health within 24 hours of becoming aware of suspecting a reportable assault. Providers are also required to put in place care arrangements within 24 hours to manage the suspected or alleged behaviour. In 2016-17, the Department of Health received 2,853 notifications of reportable assaults, compared with 239,379 residents cared for in aged care homes

[1] Report *on the Operation of the Aged Care Act 1997 2016-17,* Australian Government Department of Health.
[2] *Resolve, Protect, Improve: Aged Care Complaints Commissioner Annual Report 2016-17*, Australian Government.

in 2016-17. Care is required in interpreting reportable assaults data, as there is no data available that indicates what proportion of the suspected assaults are substantiated.

Another indicator of mistreatment is research published by the Victorian Institute of Forensic Science at Monash University in 2016. An examination of coroners' files by the Institute reveals that at least 28 residents in aged care homes between 2000 and 2013 died following incidents of 'resident aggression', typically involving residents with dementia.

In response to risks posed by residents with challenging behaviours to other residents, staff and themselves, the Australian Government has established Severe Behaviour Response Teams to support providers with the management of residents with challenging behaviours. The Government has also committed to establish a regional network of specialist severe behaviour dementia units.

Treatment of whistleblowers

One of the strengths of Australia's aged care system is the independent and free Aged Care Complaints Scheme funded by the Australian Government.

The Aged Care Complaints Scheme supplements complaints systems operated by individual services. The Scheme supports residents, their families and friends, staff and members of the public who might otherwise be reluctant to raise concerns directly with the service provider. Importantly, the Scheme offers people wishing to raise concerns to do so in a way that preserves confidentiality and anonymity in order to guard against the risk of retribution.

CHA is not aware of evidence of adverse consequences for whistleblowers, including staff of aged care homes. The capacity to inform the Scheme of instances of mistreatment and inadequate care confidentially or anonymously probably partly accounts for this.

A major motivation behind aged care staff choosing to raise issues confidentially or anonymously is a concern about how they might be treated both emotionally and psychologically by colleagues and management of the service, or that they might suffer financially. This is particularly a concern when the dominant culture in an organisation is not to respect or value the consumer.

A case in point was the culture that prevailed at the Oakden Older Person's Mental Health Service where "the dominant culture makes it very difficult for those who want good things to flourish. Instead, they become more frustrated, eventually needing to either leave, because they cannot conform to the dominant culture, or because they can no longer protest and not be heard, or leave. For many, they leave rather than become "acculturated", for others who may have no other options, they slowly become part of the system."[3]

It is instructive that, despite many years of inadequate care at the Oakden Older Persons Health Service, complaints about the quality of care at that service were not received by the Aged Care Complaints Scheme. What this demonstrates is that care quality regulation cannot rely on complaints schemes and whistleblowers alone. This is acknowledged under the current arrangements by virtue of the existence of an overall quality framework of which the Scheme is one component.

[3] Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report*. Adelaide, South Australia: SA Health, Department for Health and Ageing.

3. The effectiveness of the Australian Aged Care Quality Agency

The Australian Aged Care Quality Agency is an independent statutory agency responsible for reviewing and monitoring the performance of aged care providers against legislated quality of care standards, and for determining whether services should be accredited to receive care subsidies paid by the Australian Government on behalf of eligible consumers.

The Quality Agency and the Aged Care Complaints Scheme, supplemented by a number of reporting requirements placed on providers, are the key elements of Australia's quality regulatory framework for residential aged care.

The Quality Agency's 2016-17 Annual Report records that the Agency made 3,964 visits to aged care homes in 2016-17, including site audits, review audits and assessment contacts. Of these, 2,688 were unannounced visits and 472 were site audits where a service was assessed against the care standards as either a new service or one that is undergoing re-accreditation. The current practice is that every aged care home will receive at least one unannounced contact visit each year.

The Agency also conducted 33 review audits of aged care homes where it had concerns that care standards were not being met, and 73 aged care homes were placed on a timetable for improvement after not meeting one or more expected outcomes of the standards. During 2016-17, 79 aged care homes recorded a 'Not Met' expected outcome.

More than 47,000 residents and their representatives were interviewed as part of the Agency's assessment of services against the care standards. Since 30 June 2017, the Agency has also been publishing the new Consumer Experience Reports alongside the site audit reports. These reports provide information to assist in assessing performance against the care standards and in helping consumers and their families choose a residential aged care service.[4]

Even taking into account where 2016-17 falls in the mandated three-year accreditation cycle, the above indicates that the Agency has significant contact with and exposure to aged care homes. In the case of the Oakden Older Persons Mental Health Service, the Agency's contact with the service was extensive and virtually ongoing, yet poor standards of care apparently persisted over much of that time. This suggests a need for strengthening the capacity and competence of Agency assessors in reviewing services with particularly challenging resident profiles.

Scope to improve the effectiveness of the accreditation arrangements

A widely held view in the sector is that the introduction of accreditation effective for all approved services from 1 January 2001 has contributed to an improvement in the overall quality of residential aged care. This was the finding of an evaluation of accreditation (the Campbell Report, 2007) commissioned by the Department of Health and Ageing, which concluded that accreditation, together with the regulatory framework in which it operates, has achieved an overall improvement in residents' quality of care and quality of life[5].

The recent Carnell/Paterson Review of national aged care quality regulatory processes concluded that overall, the limited available data suggests that residential aged care is, in general, of a high standard.

[4] Annual Report 2016-17, Australian Aged Care Quality Agency, Australian Government.
[5] *Evaluation of the Impact of Accreditation on the Delivery of Quality of Care and Quality of Life of Residents in Australian Government Subsidised Residential Aged Care Services*. October 2007, Department of Health and Ageing.

The percentage of residential aged care services that complied with all 44 expected outcomes under the care standards at the last accreditation site audit was 95.3 percent. There has been an increase on the proportion of aged care homes meeting all 44 expected outcomes since accreditation was introduced. This is often cited as another indicator that accreditation is contributing to improve standards.

Nevertheless, the Carnell/Paterson Review identified a number of changes that would improve the effectiveness of the accreditation arrangements. The changes are based on the principle that the Quality Agency's review and monitoring activities should be more focussed on providers where there is evidence of poor performance and/or providers who have a higher risk resident profile. The complementary changes recommended by the Carnell/Paterson Review involve the following:

- Combining all quality regulatory functions under a single independent Commission in order to create a combined database for real time sharing of information to inform evidence-based risk rating of aged care providers, and to promote better coordinated and timelier interventions.

- Giving greater attention in assessing performance against the standards to care as delivered, as well as assessing governance and care system policies and procedures.

- Replacing the three-year mandatory accreditation cycle with ongoing accreditation and replacing re-accreditation visits with unannounced visits to assess performance against all standards, but using a risk-based process to determine the frequency and rigour of visits.

- Strengthening the capability and competence of assessment teams, especially with regard to assessing services with higher risk resident profiles (such as Oakden).

Adopting a more evidenced risk-based approach has the advantage of enabling limited resources to be applied more effectively, and allows greater use of 'responsive regulation' to, in the words of the Carnell/Paterson Review, "nudge providers to go beyond compliance" and to acknowledge and reward them for doing so.

CHA supports these changes.

The intention to phase in revised quality of care standards that have a greater focus on assessing the consumer experience from 1 July 2018 should also improve the effectiveness of the accreditation system and the quality of information available for consumers.

By supporting a greater focus on the consumer experience when reviewing performance, CHA is not proposing less attention to governance aspects.

The aged care human services sector combines ongoing delivery of complex clinical and personal care by care staff required to make judgements and decisions within their scope of practice to frail aged residents with chronic health conditions and deteriorating functional and cognitive capacities. As in the acute hospital sector, people providing care on occasion make mistakes, have lapses in judgement, or fail to follow policies, practices and procedures.

What is important is that the organisations delivering the care have the governance systems in place to quickly identify incidents and failures, undertake root cause analysis and implement corrective actions. The Quality Agency's audits indicate a high level of compliance on the part of providers in having robust governance systems in place.

A role for greater consumer choice and control

A key feature of Australia's aged care system is that, unlike most other service industries, it is almost exclusively reliant on regulations to ensure the delivery of quality services and to protect consumers. The contribution that competition in service provision and greater consumer choice and control can make to supporting higher quality services that are more responsive to consumer needs and preferences is diluted in the aged care sector by the rationing of services and the regulated balance of supply of home care and residential care services.

Recent reform is moving aged care towards increasing consumer choice and control by, for example, allowing home care package holders to direct their government subsidy to their preferred provider. Quality in aged care services would be enhanced by moving the aged care system further towards a consumer-driven market-based system. Reforms in this direction would supplement quality regulations, not substitute for them. Achieving quality care should not depend on regulation alone.

It is also the case that the quality of care that can be delivered is, in part, dependent on the availability of resources. In other service industries, a natural balance is achieved between price and quality through the operation of the market, albeit in most cases within regulated minimum standards, such as safety standards. This mechanism is largely absent from aged care where the level of funding for care services and daily living expenses for aged care residents is determined by regulation. The quality of care is therefore in part determined by regulated funding levels.

The current level of care funding to providers under the Aged Care Funding Instrument (ACFI) determines the resourcing available to provide staffing levels for the varying levels of dependency. The current average ACFI payment of $173 per resident per day limits the providers' capacity to deliver the staffing levels and skills mix often expected by relatives.

4. The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

Aside from the existing Aged Care Complaints Scheme, older people and residents have access to the Older Persons Advocacy Network (OPAN). OPAN supports older people at all points of their aged care journey through a network of nine organisations across Australia, by providing independent advocacy, information and education focussed on the rights of older Australians in need of care.

In 2016-17, the organisations that comprise the OPAN network handled over 5,500 advocacy cases, 3,300 general inquiries and delivered over 1,700 face-to-face education sessions.[6]

There may be a case for requiring OPAN's independent advocacy to be targeted more towards older people who do not have family, friends or other representatives to help them exercise choice and with their rights in aged care.

The Community Visitors Scheme funded by the Australian Government is also available to provide social support for residents of aged care homes (as well as home care package holders). Older homeless persons are assisted to access aged care services through the Assistance with Care and Housing program (ACHA), a sub-program of the Commonwealth Home Support Program.

[6] *Report on the Operation of the Aged Care Act 1997 2016-17,* Australian Government Department of Health.

However, there is a case for strengthening protection and support arrangements for older people who do not have family, friends or other dependents to help them exercise choice and with their rights in care. This is particularly the case as aged care moves further towards a consumer-driven market-based aged care service industry, but also because of the increased demand for aged care services as Australia's population profile ages.

The need for strengthened supports in this area is recognised in the *Aged Care Roadmap* prepared by the Minister for Ageing's Aged Care Sector Committee and in the National Aged Care Alliance's *Blueprint for Aged Care Reform*. This need was most recently recognised by the *Legislated Review of Aged Care 2017,* which recommended that the government introduce aged care system navigators and outreach services to assist older people who have difficulty accessing and engaging with the aged care system through existing channels such as MyAgedCare.

In order to strengthen current consumer protection arrangements, CHA also sees merit in each aged care home being funded to provide pastoral care and support. Specialist pastoral care staff can provide consumer assistance and advocacy independently from day-to-day personal and clinical care.

5. Conclusion

CHA considers that care quality in the current aged care system is relatively well regulated by international standards, but needs to embrace continuous improvement by introducing measures that increase consumer choice and control and competition in the provision of services.

This includes extending 'funding following the consumer' to residential care (currently confined to home care packages), increasing the availability of subsidised services - eventually removing service rationing and the regulated balance of care ratios which constrain choice - and further strengthening the quality and availability of information to better enable consumers to make service choices.

There is also scope to improve the effectiveness of quality regulation by placing responsibility for all aspects of quality regulations under a single body and introducing ongoing accreditation and replacing re-accreditation visits with unannounced visits using a risk-based approach to determine the frequency and rigour of visits. These changes would involve giving greater attention to poor performing services and/or services with higher risk resident profiles, and modifying the review process to give greater attention to assessing the daily experiences of residents.

In order to strengthen current consumer protection arrangements, CHA also sees merit in funding being provided to each aged care home to provide pastoral care and support.

Catholic Health Australia
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