CHAPTER 3

THE AGED CARE STANDARDS AND ACCREDITATION AGENCY

3.1 This chapter discusses the performance and effectiveness of the Aged Care Standards and Accreditation Agency (the Agency) in terms of:

- assessing and monitoring care, health and safety of residents in aged care facilities;
- identifying best practice and providing information, education and training to aged care facilities; and
- implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.

3.2 The Agency plays an important role in the regulation of the aged care industry. Evidence to the inquiry strongly emphasised that an effective regulatory regime is important to protect elderly people placed in aged care facilities – people who represent some of most vulnerable, frail, and dependent members of the community. The regulator also has an important role in ensuring accountability of the sector – a sector that receives very considerably public monies to provide aged care services.

Role of the Aged Care Standards and Accreditation Agency

3.3 The Agency is an independent company established by the Commonwealth Government under the *Aged Care Act 1997*, is limited by guarantee incorporated under the *Corporations Act 2001* and is subject to the *Commonwealth Authorities and Companies Act 1997*. The Agency was appointed as the 'accreditation body' for residential care services and the *Accreditation Grant Principles 1999*, made in accordance with the Aged Care Act, specify the functions of the accreditation body and the procedures it is to follow in carrying out those functions.

3.4 The core functions of the Agency include:

- managing the accreditation process using the Accreditation Standards;
- promoting high quality care, and assisting the industry to improve service quality, by identifying best practice and providing information, education, and training to industry;
- assessing and strategically managing services working towards accreditation; and
- liaising with the Department of Health and Ageing (DoHA) about services that do not comply with the Residential Care Standards or the Accreditation Standards.

3.5 Operationally these functions translate into activities that can be described as:

- assessing homes for compliance with the Accreditation Standards and determining the period of accreditation; and
- promoting high quality care and helping homes improve service quality by providing education and information.

3.6 The Agency works within the broader regulatory framework that governs the funding and provision of residential aged care. The framework includes the Aged Care Act, the various Aged Care Principles, the Complaints Resolution Scheme and State and local government legislation.[1]

Assessing and monitoring care, health and safety

3.7 The Agency assesses compliance of residential aged care services against the Accreditation Standards made under the *Quality of Care Principles 1997* that consist of four parts involving:

- management systems, staffing and organisational development – 9 expected outcomes;
- health and personal care – 17 expected outcomes;
- resident lifestyle – 10 expected outcomes; and
- physical environment and safe systems – 8 expected outcomes.

3.8 The Standards specify the outcomes that are to be achieved for residents but they do not prescribe how the home must achieve the outcome. This approach provides the opportunity for providers to tailor care and services in a way that best meets the residents' needs and expectations.

3.9 The accreditation process involves a team of at least two registered aged care quality assessors evaluating all aspects of a home's performance through an assessment of the accreditation application and a two to three day site audit. The site audit includes interviews with residents, their families, staff and management. The assessment team will examine relevant documentation, and observe the living environment and practices of the home. Information is gathered to analyse the home's performance against the 44 outcomes.

3.10 There were 2949 accredited homes as at 30 June 2004 – 2640 homes (or 90 per cent) were accredited for three years, 78 (3 per cent) for between two and three years, and 225 (8 per cent) for two years or less. Some 6 homes have accreditation for four years.[2]

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1 *Submissions* 105, pp.2-5 (ACSAA); 191, pp.27-30 (DoHA).

2 The Aged Care Standards and Accreditation Agency, *Annual Report 2003-04*, p.17.

3.11 The Agency also monitors the performance of all accredited homes to ensure quality care is provided to residents in accordance with the Accreditation Standards. Visits to homes to monitor their performance may be 'support contacts' or 'review audits'. The Agency also conducts some of its visits at short notice ('spot checks').

3.12 All accredited aged care homes are subject to a regular series of support contacts conducted by the Agency, the purpose of which is to monitor a home's ongoing compliance with the Accreditation Standards and the Aged Care Act. A support contact involves either a visit to the home or a telephone contact, conducted by quality assessors. A support contact (site) generally lasts from half to one-day and may involve an overview of the home's performance against all the Accreditation Standards, or may be focussed on certain aspects of care or services. A support contact (desk) is a one or two hour teleconference between a quality assessor and the management of the home. In 2003-04, 2904 support contacts were undertaken, of which 2815 were site visits and 89 were phone contacts.[3]

3.13 Review audits assess the quality of care provided by a home against the expected outcomes of the Accreditation Standards. Review audits may be conducted if the Agency has reason to believe a home is not complying with the Accreditation Standards; there has been a change to the home such as a change of ownership or key personnel; or the home has not complied with the arrangements made for support contacts. In 2003-04, 86 review audits were conducted, and 82 decisions were made following the review audits. Of these decisions, 44 were to vary the period of accreditation, 36 were to not vary accreditation and two were to revoke accreditation.[4]

3.14 The Agency also conducts random and targeted spot checks. They can either be support contacts or review audits. A spot check is a visit where homes are given less than 30 minutes notice. Approximately 15 per cent (553) of all Agency site visits in 2003-04 were conducted as spot checks.

3.15 Under the Deed of Funding with DoHA, which commenced in July 2004, the Agency is required to visit each home at least once a year and maintain an average visiting schedule of 1.25 visits per home per annum. These visits may either be a site support contact or review audit (and may also be conducted as spot checks). Additional visits are arranged where the Agency assesses that there is a need for more visits such as a reason for concern or serious risk has been identified.[5]

Views on quality of care

3.16 Evidence to the inquiry expressed a range of views on the impact of accreditation on the quality of care in aged care facilities. Aged care providers, in particular, suggested that since the introduction of accreditation the overall quality of

3 Annual Report, p.19.

4 Annual Report, p.20.

5 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

care standards has improved across the industry. The Australian Nursing Homes & Extended Care Association (ANHECA) noted that:

> ...the introduction of the accreditation system has had a profound effect upon residential aged care and has driven a significant improvement in the quality of services, but more particularly, led to the adoption within residential care services of the systemisation of quality improvement systems within organisations leading to services incorporating these systems within their day to day service delivery framework.[6]

3.17 Catholic Health Australia (CHA) also recognised a lift in overall quality of care standards across the industry as a whole, while the Review of Pricing Arrangements in Residential Aged Care (Hogan Review) noted that 'submissions and evidence presented at consultations indicate broad support for accreditation. There is general acknowledgment that standards of care and accommodation across the industry have been improved substantially by accreditation'.[7]

3.18 Other submissions have, however, raised concerns about the standards of care across the industry. The Health Services Union (HSU) noted argued that the Agency 'is failing in its duty to ensure that an adequate standard of care and safety is provided to elderly residents in aged care facilities'.[8] The Australian Nursing Federation (ANF) also noted that many of its members have raised issues about inadequate standards of care and inadequate staffing levels in aged care facilities.[9]

3.19 Seniors groups raised similar concerns. COTA National Seniors expressed concerns as to the extent to which accreditation has contributed to high quality care for residents and real options about lifestyle for residents.[10] The Combined Pensioners & Superannuants Association of NSW (CPSA) stated that the performance of the agency 'leaves much to be desired'. The Association argued that part of the problem is that the Agency is not set up to directly control aged care facilities. The accreditation system gives substantial power to proprietors – 'they are allowed considerable leeway in terms of how services are carried out'.[11] The Association argued that the Agency should be abolished and aged care brought under the direct control of DoHA.

3.20 Evidence indicates that there is little systematic data that demonstrates how accreditation has impacted on quality of care. One submission noted that the Agency has 'not produced any material which would provide the sector or the community with

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6 *Submission* 74, p.8 (ANHECA).

7 *Submission* 166, p.6 (CHA); Hogan WP, *Review of Pricing Arrangements in Residential Aged Care, Final Report*, Canberra, 2004, p.239.

8 *Submission* 122, p.18 (HSU).

9 *Submission* 201, p.10 (ANF). See also *Committee Hansard* 27.4.05, pp.47-50 (ANF).

10 *Submission* 174, p.8 (COTA National Seniors).

11 *Submission* 79, p.5 (CPSA).

any level of assurance that the overall intention of accreditation in improving service quality has been achieved'.[12]

3.21 The Audit Office also raised this as an issue in a recent audit report. It recommended that the Agency and DoHA plan an evaluation of the impact of accreditation on the quality of care in the residential care industry.[13] This recommendation was accepted by both the Agency and the Department and the project is expected to be completed in 2006.

3.22 While anecdotally it appears that quality of care has improved in aged care facilities since the introduction of accreditation, a number of concerns were raised in evidence and these are discussed below.

Ensuring adequate standards of care

Improved accreditation processes

3.23 Evidence indicates that there is a need for improvements in accreditation processes.

3.24 A number of criticisms of the Agency by providers and their peak bodies were raised especially relating to the first round of accreditation. The criticisms centered on inconsistencies between assessors' approaches, problems with duplication in the Accreditation Kit, inaccurate comments appearing in final reports, lack of process to correct mistakes and inconsistency where some decisions were overturned and other seemingly similar decisions were not.[14]

3.25 Comments from providers during the inquiry generally indicated that many of these problems were addressed in the second round of accreditation. CHA noted that due to the more rigorous requirement in round two for assessors to have evidence of non-compliance, member services found that the process was fairer and more balanced.[15] Aged and Community Services (ACS) SA & NT also reported that while their members were initially critical of the Agency and its processes a more recent survey of members indicated 'overwhelming support for the agency and the accreditation process'.[16]

3.26 A number of current issues of concern were, however, raised during the inquiry and these are discussed below.

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12 *Submission* 74, p.8 (ANHECA).

13 ANAO, *Managing Residential Aged Care Accreditation*, Audit Report No. 42, 2002-2003, pp.19,82.

14 *Submission* 170, p.9 (ACS of NSW & ACT).

15 *Submission* 166, p.6 (CHA).

16 *Committee Hansard* 22.2.05, p.3 (ACS SA & NT).

Lack of consistency in assessments

3.27 Aged care providers, provider peak bodies and others complained of the lack of consistency in the assessments made by different assessors. Blue Care noted that:

> ...[there are] inconsistencies in the understanding and knowledge of different auditors when applying the standards to an aged care facility. It is important that there is a consistent approach to assessing and monitoring the health and safety among auditors.[17]

3.28 The HSU stated that 'even the most casual analysis of the publicly available reports produced by the agency shows huge inconsistencies in the level of scrutiny applied by agency inspectors and in the reports they produce'. The HSU reported that many of its members expressed concerns regarding the way accreditation visits are carried out and the level of scrutiny applied by inspectors.[18]

3.29 Submissions noted that a facility may achieve 44 satisfactory outcomes during accreditation and be accredited for 3 years. Within months a support visit may find that the facility is non-compliant with one or more outcomes. A finding of this nature can be difficult to explain and demonstrates an unacceptable level of subjectivity in the process.[19]

3.30 CHA noted that the main reason for the lack of consistency is the Agency's approach focuses primarily on examining the systems and processes that facilities have in place to demonstrate that they meet each of the expected outcomes – 'as these outcomes are expressed in generalised terms, assessment of compliance must, as a requisite, involve subjective elements of judgement'.[20] The HSU commented that the vague nature of the Accreditation Standards and the lack of guidelines contributes to the problem as is the use of less qualified contract staff by the Agency at times of peak demand.[21]

3.31 Submissions also argued that training of assessors needs to be improved. The CPSA argued that the training courses for assessors are inadequate – 'QSA's training courses for aged care assessors run for 5 days and appear to have no pre-requisites apart from a willingness to learn. The courses are presumably of a high standard but 5 days does seem too short to guarantee assessors will be trained to make appropriate assessments of added care facilities' standards'.[22]

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17 *Submission* 116, p.3 (Blue Care). See also *Submission* 162, p.3 (Baptistcare).

18 *Submission* 122, pp.19-20 (HSU).

19 *Submissions* 170, p.9 (ACS of NSW & ACT); 166, p.6 (CHA). See also *Committee Hansard* 22.2.05, p.3 (ACS SA & NT).

20 *Submission* 166, p.6 (CHA).

21 *Submission* 122, p.19 (HSU).

22 *Submission* 79, p.7 (CPSA).

3.32 Regarding the qualification of assessors, the Agency conceded that there is no formal qualification requirements prior to selection however, they stated that only persons who are registered aged care assessors are permitted to conduct assessments. There are 362 registered aged care quality assessors registered by the Quality Society of Australasia. Some 65 of those assessors are currently permanent employees of the Agency. Over half of them are registered nurses (RNs) and about 80 per cent have post-secondary qualifications other than registered aged care assessor qualifications. Additional contractors are used to supplement the permanent assessors, especially during peak times. Assessors are required to successfully complete a training course on aged care quality assessment and complete an orientation program.[23]

3.33 ANHECA submitted that the Agency also needs to provide more data analysing the effectiveness of assessors in their auditing role. The Association noted that the Agency needs to 'apply resources to the development of a substantially improved data mining and reporting capacity, which would have the capacity to report on assessors and audit outcomes at an individual, regional, state and national level'.[24] UnitingCare Australia suggested that more consistency may require the use of benchmarking or external auditors.[25]

3.34 The Agency noted that it is reviewing and further developing its quality assurance measures, including:

- reviewing arrangements for the registration of quality assessors including improved competency specifications, and revised training and assessment program;
- introduction of internal and independent reviews of samples of accreditation decisions and audit reports to evaluate their conformity with Agency standards; and
- organisational restructuring including the creation of Principal Assessor and Assessment Manager positions in each State office.[26]

Conclusion

3.35 The Committee believes that the Agency should ensure that there is a consistent approach by assessors at all times in conducting assessments. The Committee notes that the Agency is reviewing and further developing its quality assurance measures and believes that these initiatives should continue.

3.36 The Committee also considers that the Agency should establish benchmarks against which assessors' decisions can be evaluated and that this information should

23 *Submission* 105, p.8 (ACSAA); *Committee Hansard* 19.8.04, pp.83,96-97 (ACSAA).

24 *Submission* 74, p.8 (ANHECA).

25 *Submission* 57, p.7 (UnitingCare Australia).

26 Annual Report, pp.20-21.

be published annually. The Committee also believes that a significant reason for the lack of consistency relates to interpretation of the Accreditation Standards which are expressed in very generalised terms and therefore open to markedly different interpretations. The Committee has made recommendations later in this chapter addressing this issue.

Recommendation 8

3.37 That the Agency ensure that the training of quality assessors delivers consistency in Agency assessments of aged care facilities.

Recommendation 9

3.38 That the Agency publish data on the accuracy of assessors' decisions in conducting assessments against Agency benchmarks and that this data be provided in the Agency's annual report and on its website.

'Enhancement' of facilities prior to accreditation visits

3.39 Some submissions argued that accreditation processes encouraged some homes to employ additional staff and generally 'tidy up' the facility prior to the arrival of assessors which created a false impression of the true nature of the facility and the services provided.

3.40 The HSU noted that:

> Scheduled accreditation gives management the opportunity to roster extra staff on, adjust menus and activities, and generally have everything looking ship shape for the accreditors. However, members argue that the standards shown off at accreditation are rarely maintained outside of accreditation periods.[27]

3.41 The NSW Nurses' Association also noted that members routinely reported that 'the accreditation process is a farce as everything is set up for the day and then disappears'.[28] The Nurses Board of WA similarly commented that:

> Arriving as anyone would arrive to an institution, you do get a feel of what normally happens. With the provision of notice, there is opportunity for preparation that may not normally be done.[29]

3.42 The Agency countered these claims stating that it receives information from time to time about homes attempting to mislead assessors about their compliance with the Standards by increasing staff and doing other things before a visit – 'however in

27 *Submission* 59, p.12 (HSU - NSW Branch).

28 *Submission* 179, p.6 (NSWNA).

29 *Committee Hansard* 23.2.05, p.17 (Nurses Board of WA).

these few cases, our follow up has failed to find evidence that supports the claims made to us'.[30]

3.43 The Agency advised that:

> Accreditation is not a one-off event…Assessors triangulate evidence of homes meeting the expected outcomes by interviewing residents and staff, reviewing the systems, policy and processes documentation and other records such as care plans, staff rosters and menus etc.[31]

3.44 The Committee is concerned, however, that the evidence received suggests that some homes may engage in the practices described above. It notes that complaints of this nature come from staff 'on the ground' and therefore people in a position to know the day-to-day management practices of homes. The Committee believes that the Agency should continue to review the nature and extent of these practices including carefully targeted spot checks.

Improved consumer focus

3.45 Evidence indicated the need for the Agency to involve residents and their families to a greater extent than currently occurs in the accreditation process and also in promoting informed consumer choice.

3.46 Prior to an accreditation visit, providers must inform residents and relatives when the visit will occur, and that residents and relatives will have an opportunity to speak with assessors in confidence. The Agency stated that assessors are required to meet with a minimum of 10 percent of residents or their representatives as part of the accreditation process. When assessors speak to residents they are required to do so in a way that does not identify residents and does not cause residents to be identified, although the Agency conceded that 'that does not mean that an approved provider of care might not be aware that certain residents had spoken to assessors'.[32] The Agency asks providers to ensure that there is a private room or space available to interview residents who wish to speak to assessors. Residents are often interviewed in the privacy of their own rooms.[33]

30 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

31 *Submission* 105, Supplementary Information, 27.5.05, (ACSAA). See also *Committee Hansard* 19.8.04, p.95 (ACSAA).

32 *Committee Hansard* 19.8.04, p.96 (ACSAA).

33 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

3.47 Advocacy Tasmania stated that:

> Residents are often not aware of their rights to contribute to the process of accreditation or understand the level of care required to be provided by the facilities to meet each standard.[34]

3.48 The advocacy group noted that residents are often not aware that meeting many of the 44 outcomes requires a facility to demonstrate a process of consultation with residents and family members.[35]

3.49 The Aged Care Lobby Group argued that the proportion of residents and their families required to be interviewed by assessors should be increased.[36] Advocacy Tasmania also agued that the Agency should conduct a mid-cycle survey of all residents to assist in monitoring standards of care between accreditation rounds.[37] COTA National Seniors considered that:

> Residents and their families must understand the accreditation process and be directly involved in the process not just as complainants or informants but assessing the quality of care particularly in relation to Standard 3: Resident Lifestyle.[38]

3.50 COTA suggested that even the term 'accreditation' is a difficult concept for consumers to understand:

> …it is a real challenge to get the information out to the consumer. It does get out in some way, but, from the feedback we get from people who are going through the process of looking for a place in an aged care facility, just the word 'accreditation' is wrong. How does the normal consumer know what the terms 'certification' and 'accreditation' mean? As a consumer organisation…we provide information, but still people are at a loss when it comes to knowing about accreditation.[39]

3.51 Submissions argued that the Agency needs to improve its information strategies to residents and families from culturally and linguistically diverse (CALD) backgrounds. The NSW Aged Care Alliance noted that accreditation reports do not provide adequate information either about care strategies or outcomes for consumers

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34 *Submission* 158, p.1 (Advocacy Tasmania). See also *Submission* 198, p.2 (Aged Care Lobby Group).

35 *Submission* 158, p.2 (Advocacy Tasmania).

36 *Committee Hansard* 22.2.05, p.28 (Aged Care Lobby Group).

37 *Submission* 158, p.3 (Advocacy Tasmania).

38 *Submission* 174, p.9 (COTA National Seniors).

39 *Committee Hansard* 27.4.05, p.31 (COTA National Seniors).

from CALD backgrounds.[40] Submissions also noted that the Agency's use of interpreting services during accreditation visits is limited.[41]

3.52 The Hogan Review suggested that the Agency needs to significantly improve its focus on supporting informed consumer choice and consumer input to monitoring standards by improving direct communication with consumers, including those with special needs. The review argued that the Agency's website should be improved to make it more 'user friendly' for older people and their families. The review also suggested that the Agency explore, with consumers and the industry, a star rating system to assist consumers to more readily compare services and to provide incentives for providers to become more competitive in providing quality services.[42] The HSU strongly supported the introduction of a star rating system to improve informed consumer choice.[43]

3.53 The Department advised that improvements to the Agency's website are being developed and that a prototype version has been developed. The Commonwealth has provided $2.1 million for the development of this website and the establishment of a rating system for aged care facilities. A working group is currently undertaking further development work on this prototype. The improved website is expected to be operational in early 2006. The website aims to provide older Australians, their families and carers, with a user friendly and comprehensive online guide to aged care services and choices. The site will include features that will enable consumers to search for standard information about all aged care homes in Australia, such as location, business address, contact details, type of care provided, number of residents and current accreditation status.

3.54 Initial work has been completed on the star rating system and this is being developed in conjunction with the new website to enable consumers to search for relevant information on aged care facilities. DoHA stated that decisions have yet to be made on the form that a star rating system could take but work being undertaken on the development of the website is providing useful information about what consumers are seeking to assist them in making informed choices about meeting their, or their families', aged care needs. Research to date indicates that consumers require a system that will allow them to find and match aged care homes against their own personal criteria. Relevant factors include issues such as location of homes within a reasonable distance to family/friends; whether there are vacancies; costs involved; services offered and individualised activities provided; staff skills at homes; information on the 'environment' of the home such as type of room, shared or private bathrooms, security,

40 *Submission* 203, p.6 (NSW Aged Care Alliance).

41 *Submissions* 82, p.2 (ECCV); 178, pp.12-14 (ECC of NSW).

42 Hogan Review, pp.244-45.

43 *Submission* 122, p.22 (HSU).

access to gardens etc; safety and privacy policies and practices; languages spoken; and information related to complaints and complaints feedback.[44]

Recommendation 10

3.55 That the Agency further develop and improve information provided to residents and their families about the accreditation process, including those from CALD backgrounds and Indigenous people, and more actively involve residents and their families in the accreditation process.

Recommendation 11

3.56 That the Agency develop a rating system that allows residents and their families to make informed comparisons between different aged care facilities. The Committee notes that work is being done on a web-based prototype; however it considers that the rating system should not be limited to a 'star rating' but should include easily understood descriptions of a range of attributes, such as type and range of services provided; physical features of homes; staffing arrangements; costs of care; and current accreditation status.

JAS-ANZ and the accreditation process

3.57 Many aged care providers and peak bodies representing the industry argued that accreditation services would be better provided by enabling providers to select from a range of agencies as is common in other industries, rather than through a government monopoly of these services in the form of the Aged Care Standards and Accreditation Agency, as is currently the case.

3.58 Groups such as ANHECA and ACSA argued that it would be more appropriate to bring residential care accreditation services within the Joint Accreditation Service-Australia and New Zealand (JAS-ANZ) framework.[45] JAS-ANZ would be responsible for accrediting a number of quality improvement organisations to undertake accreditation in the residential care sector. An open contestable quality improvement environment would also provide a further benefit to the residential care sector. Many providers of residential care are also providers of other services to older people, including community aged care packages, Home and Community Care programs, retirement villages and other community based and residential programs for the elderly and others. Under current arrangements they are required to participate in multiple accreditation systems to cover the whole scope of their activities. This problem would be addressed if a market in the provision of

44 DoHA, personal communication, 6.6.05; Supplementary Information, 20.6.05 (DoHA).

45 JAS-ANZ was established by formal agreement between the Governments of Australia and New Zealand. Its main activity is the assessment and accreditation of certification bodies.

accreditation services were allowed to be developed to respond to the industry's wider accreditation needs.[46]

3.59 Other providers, including CHA, did not favour this approach. CHA argued that providers would be dealing with another party in the accreditation/compliance processes with possibly greater intrusion and disruption to staff time. In addition, there could be an increase in costs when two agencies have responsibility for two separate accrediting/compliance monitoring tasks.[47] CHA added that:

> Allowing a number of accredited certifying organisations to compete to provide accreditation of an approved service and have responsibility to the Government for compliance would result in even less consistency of assessments and decisions. CHA considers that neither consumers nor the community would accept this approach.[48]

3.60 The Committee does not support the suggestion proposed by several providers of allowing a range of agencies to provide accreditation services. It believes that such an approach has the potential to lead to greater inconsistency in assessment outcomes by involving a greater number of organisations in providing accreditation services. The Committee also considers that it may encourage providers to 'shop around' for a 'soft' auditor and is not convinced that the JAS-ANZ arrangements would militate against this potential outcome.

Improved compliance monitoring

3.61 The need for the Agency to improve compliance monitoring of aged care facilities between accreditation periods was raised in evidence. As noted above, aged care facilities are subject to a regular series of support contacts to monitor their ongoing compliance with the Accreditation Standards.

Support visits

3.62 Some providers criticised the way in which support visits are conducted by the Agency arguing that they are intimidating experiences and did not provide the 'support' expected – in fact some argued that the term 'support visit' was a misnomer. CHA noted that many of its members' experience of support visits 'had not been positive' reporting that 'there was a general view that support visits have not provided any 'support' and in fact hindered processes'.[49] ACS SA & NT commented that some members feel intimidated by support visits 'believing that if they do not comply, or object to the timing of the visit there will be retribution against them by the Agency'.[50]

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46 *Submissions* 74, pp.8-10 (ANHECA); 173, pp.3-4 (ACSA). See also *Submissions* 150, pp.10-12 (VAHEC); 170, pp.11-12 (ACS of NSW & ACT).

47 *Submission* 166, p.7 (CHA).

48 *Submission* 166, p.7 (CHA).

49 *Submission* 166, p.8 (CHA).

50 *Submission* 125, p.7 (ACS SA & NT).

The organisation noted, however, that members report more positive experiences of more recent support visits.[51]

3.63 The Agency's post-support visit questionnaires, however, indicate a high level of support with the role of the Agency during these visits – with a 2004 questionnaire indicating that 96 per cent of homes reported that is was 'a satisfying and useful experience' overall.[52]

3.64 The Committee notes that some concerns have been expressed by providers in regard to the efficacy of support visits. The Committee believes that the Agency should ensure that these visits, while monitoring compliance, also assist in providing positive feedback to homes.

Spot checks

3.65 As referred to previously, the Agency is required to visit each home at least once a year and maintain an average visiting schedule of 1.25 visits per home per annum. These visits may either be site support contacts or review audits – and they may be conducted as spot checks. Additional visits are arranged where the Agency assesses that there is a need for more visits such as a reason for concern or serious risk has been identified.[53]

3.66 Approximately 15 per cent (553) of all Agency visits in 2003-04 were conducted as spot checks. Of the 'repeat' spot checks in 2003-04, thirty-eight homes had 2 spot checks; eight had 3 spot checks; four had 4 spot checks; and six had 5 or more spot checks.

3.67 Spot checks may be targeted or random. Targeted spot checks are conducted where the Agency has reasonable grounds to believe there may be non-compliance, whereas random spot checks are conducted where there is no indication of risk or non-compliance. The Agency does not keep separate statistics on random and targeted spot checks. On average approximately 10 per cent of homes per annum will have an unannounced spot check.[54] Table 3.1 provides the number of spot checks undertaken by the Agency since 1999-2000.

51 *Committee Hansard* 22.2.05 p.3 (ACS SA & NT).

52 *Submission* 105, Attachment B (ACSAA).

53 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

54 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA); Annual Report, p.22.

Table 3.1: Number of spot checks undertaken by the Accreditation Agency

Year	Number of spot checks
1999 – 2000	107
2000 – 2001	360
2001 – 2002	449
2002 – 2003	242
2003 – 2004	553

Source: Aged Care Standards and Accreditation Agency, *Annual Reports*, (various years).

3.68 A number of groups argued that the Agency should undertake more spot checks. The HSU argued that:

> ...members consistently argue that spot checks or checks without notice would be more effective than the current scheduled visits. Members tell us that often management select the staff who are to speak with the accreditors when they come. Members advise that additional staff are rostered on and that much effort in the weeks leading up to accreditation goes on making sure that paperwork and documentation are up to date.[55]

3.69 Aged care provider peak bodies acknowledged the value of spot checks in ensuring compliance with the Standards, with Aged Care Qld proposing a more comprehensive system of spot checks instead of organised visits.

> We have talked to the accreditation agency and we have talked to many of our people, and we think that perhaps this whole system needs to be looked at. Perhaps we need to do away with having organised visits and instead have spot checks. The accreditation agency would drop in at any particular time and take the home as it is, not superprepared for the event.[56]

3.70 Aged and Community Services Australia (ACSA), while noting that spot checks are a valuable form of accountability, argued that the Agency needs to improve the way in which it conducts its spot checks:

> We certainly have talked to them [the Agency] about developing more refined approaches to spot checking, to targeting, to being clear about which visits are about providing support and training and which are in response to urgent issues that really cannot wait…Follow-up visits are a feature of all forms of accreditation. Certainly our advocacy of a more

55 *Committee Hansard* 19.8.04, p.65 (HSU). See also *Submission* 122, p.22; *Committee Hansard* 26.4.05, p.46 (HSU).

56 *Committee Hansard* 18.3.05, p.14 (Aged Care Qld).

> universal system of applying accreditation would not be at the expense of follow-up visits of all sorts of classes.[57]

3.71 Aged Care Qld argued that a system of spot checks could potentially ameliorate the heavy demands of paperwork imposed on homes under the current accreditation system.[58] Evidence also indicated that more spot checks would identify possible problems in homes, such as poor medication management, much earlier than occurs at present.[59]

Conclusion

3.72 The Committee believes that spot checks play an important role in ensuring compliance with the Accreditation Standards. It is vital that residents and their families, and the public generally, are confident that the standards of care assessed when homes are accredited are maintained at all times until the next accreditation round.

3.73 The Committee believes that the current system of spot checks is inadequate and needs to be considerably strengthened to ensure that all homes receive at least one spot check for each year that they are accredited. The Committee considers the fact that only one in 10 homes on average receive a spot check per year is grossly inadequate.

Recommendation 12

3.74 That the Agency ensure that all facilities be subject to a minimum of one annual random or targeted spot check and at least one site visit with notification over its accredited period.

Improving quality of care

3.75 The need to improve specific aspects of care in aged care facilities was highlighted during the inquiry.

3.76 As noted earlier, a core Agency function is the accreditation of aged care facilities against the Accreditation Standards. The Quality of Care Principles state that:

> The Accreditation Standards are intended to provide a structured approach to the management of quality and represent clear statements of performance. They do not provide an instrument or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suits the characteristics of each individual residential care facility and the

57 *Committee Hansard* 26.4.05, p.7 (ACSA).

58 *Committee Hansard* 18.3.05, pp.17-18 (Aged Care Qld).

59 *Committee Hansard* 22.2.05, p.32 (Aged Care Lobby Group).

> needs of residents. It is not expected that all residential care facilities should respond to a standard in the same way.[60]

3.77 It was claimed in evidence that the Standards are too imprecise and far too generalised to effectively measure care outcomes. The HSU stated that the Accreditation Standards 'need to be rewritten so that they are measurable and enforceable'.[61] The Aged Care Lobby Group also noted that while the Accreditation Standards assess standards of care to some extent – 'it needs some refinement. It is too subjective. It relies on what is written by the provider and statements by relatives and residents.[62]

3.78 A study by Professor Gray also noted that:

> To the extent that the Agency does not assess actual care delivered, but infers it from the information provided by residents, staff, families and relevant documentation, its capacity to provide objective information around care outcomes is limited.[63]

Issues related to the quality of care in a range of specific areas are discussed below.

Staffing levels and skills mix

3.79 Submissions pointed to inadequate staffing levels and poor skills mix in aged care facilities as compromising the quality of care available to residents. The Accreditation Standards do not prescribe minimum staffing levels in aged care facilities. The Accreditation Standards only require that there be 'appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards' (Standard 1.6) and that residents receive 'appropriate clinical care' (Standard 2.4) and that residents' 'specialised nursing care needs are identified and met by appropriately qualified nursing staff' (Standard 2.5).

3.80 The ANF noted that staffing levels and the skills mix of staff impact directly on the workloads of nurses and ultimately on the quality of health outcomes for residents. The ANF expressed concern that there are increasingly fewer registered nurses (RNs) and enrolled nurses (ENs) in aged care facilities and some high care residents in low care facilities have very limited or no access to a health care professionals such as RNs. The ANF also expressed concern at the practice of replacing RNs and ENs with unlicensed carers in order to provide a 'cheaper' alternative workforce where the work requires the skills and knowledge of either a RN or an EN.[64]

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60 Quality of Care Principles, section 18.9.

61 *Submission* 122, p.22 (HSU).

62 *Committee Hansard* 22.2.05, p.29 (Aged Care Lobby Group).

63 Gray L, *Two Year Review of Aged Care Reforms*, DoHA, 2001, p.91.

64 *Submission* 201, pp.16-18 (ANF). See also *Submission* 122, p.18 (HSU).

3.81 Submissions by unions with members working in the aged care sector pointed to evidence from their members and union surveys that show that nurses and other health care workers do not believe that they are able to spend enough time with residents to deliver the care that residents require; aged care workers regularly work unpaid overtime to complete tasks; and the excessive paperwork required places increasing demands on staff and draws them away from their primary caring role.[65] A recent survey of over 6000 care staff by the National Institute of Labour Studies confirmed these observations. The study found that:

- only 13 percent of nurses and 18 per cent of staff overall believed that they had enough time to properly care for residents;
- forty per cent of nurses and 25 per cent of allied health workers spend less than one third of their time providing direct care;
- almost half of all personal carers spend less than two-thirds of their time on direct care; and
- the major complaints of staff were that they did not have enough time to spend with residents and the facility where they worked did not employ sufficient staff.[66]

3.82 The HSU argued that international research establishes a clear link between staffing levels and quality of care.[67] A major report to the US Congress on the appropriateness of establishing minimum staffing ratios in nursing homes in the United States concluded that strong evidence supports the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems. However, above identified nurse staffing thresholds increased staffing did not result in improved quality. Depending on the nursing home population, these thresholds range between 2.4-2.8, 1.15-1.30, and 0.55-0.75 hours/resident day for nurse aides, licensed staff (RNs and LPNs combined) and RNs, respectively. Although no significant quality improvements were observed for staffing levels above these thresholds, quality was improved with incremental increases in staffing up to and including these thresholds.[68]

3.83 Some submissions, however, did not support the introduction of minimum staffing levels arguing that appropriate care depends on a range of variables that change frequently. The Nurses Board of WA stated that:

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65 *Submissions* 122, pp.2-10 (HSU); 179, pp.6-7 (NSW Nurses' Association); 59, pp.7-11 (HSU - NSW Branch).

66 Richardson S & Martin B, *The Care of Older Australians*, National Institute of Labour Studies, 2004, pp.32-34.

67 *Submission* 122, p.3 (HSU). See also *Submission* 66, p.2 (ANF- Vic Branch).

68 US Department of Health & Human Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, December 2001, pp.1.19-1.20. LPNs refer to Licensed Practical Nurses.

> The Board gets many requests by employers to come down and make a statement about minimum numbers. However, the Board is very much of the view that it is the appropriate skill mix in the context of where the care is being delivered that determines what you require at any given time. That is not helpful to employers and it is not helpful to the staff on the floor. But the context in which aged care is delivered is varied and it depends on a whole range of variables.[69]

3.84 Many submissions argued that a benchmark of care linked to minimum staffing levels should be established. The ANF argued that a benchmark of care which links resident outcomes, staffing levels and skills mix to funding should be developed for inclusion in regulatory instruments. The ANF further argued that guidelines should be developed providing for minimum staffing levels and skills mix in aged care settings and that there be a clear requirement for 24 hour RN cover for all high care residents in aged care facilities.[70]

3.85 The National Aged Care Alliance also called for the establishment of benchmarks for staffing levels and skills mix, which meet duty of care requirements; achieve optimal health and quality of life outcomes for residents; and provide flexibility at the local level to be able to respond in a timely manner to changes in the care needs or the way in which care is delivered.[71]

3.86 The Liquor Hospitality and Miscellaneous Union (LHMU) also argued for a national benchmark of care. This would encompass all aspects of care, including establishing minimum staffing levels and skills mix in delivering care. The benchmark of care, which would be fully costed, could be used as the tool to determine the funding that the government provided for care.[72]

3.87 The HSU also argued for the introduction of minimum staffing levels that should only be introduced after a process of industry consultation that involved providers, staff and residents – 'they would not be a one size fits all but a regulated minimum number determined by resident needs and acuity' involving a mix of nurses and personal care assistants in caring for residents.[73] The HSU added that:

> Those minimum staffing levels need to be flexible so that they can be adjusted for the particular care plans and circumstances of each facility. But underlying that there has to be a stage when government says: 'One person looking after 73 residents at night when 43 of them are high care is not something that as taxpayers we are going to fund'.[74]

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69 *Committee Hansard* 23.2.05, p.18 (Nurses Board of WA).

70 *Submission* 201, p.2 (ANF).

71 National Aged Care Alliance, Additional Information, 20.4.05.

72 *Submission* 124, p.18 (LHMU).

73 *Submission* 122, p.14 (HSU)

74 *Committee Hansard* 26.4.05, p.49 (HSU).

3.88 The HSU argued that the regulatory requirements for staffing, stripped away by the current government, need to be re-introduced and significantly extended – 'minimum staffing levels covering all care and ancillary staff are the only way to provide a basic guarantee of care and safety for residents and their families'.[75]

3.89 CHA also proposed a quality of care compact based on an agreed level of care which commits government, providers and staff to achieve specific care results for the frail and sick. A key component would be the establishment of an aged care benefit schedule to modernise government care subsidies and to deliver appropriate support to the frail elderly. CHA stated that:

> …a compact would include a commitment to introducing a benchmark of care which is fully funded by government and provides clearly defined levels of service. It is linked to the benchmark. There needs to be a commitment of funding to ensure appropriate staffing levels are in place for facilities, depending on their size, and the resident profile. The benchmark of care needs to take into account all aspects of a person's needs: physical, emotional, social and spiritual.[76]

3.90 CHA further explained how the benchmark of care would operate.

> Under the benchmark of care approach, what we would be saying is that there are certain dependency levels and clinical groupings of care need for residents. When you have a group of residents that are in a similar care cohort or casemix, then you really need a mix of staff to meet that care need for that particular casemix of residents.[77]

Conclusion

3.91 Evidence to the inquiry indicated that quality of care for residents in aged care facilities could be improved by the introduction of greater regulation in relation to staffing levels and skills mix in aged care facilities. Many submissions argued for the introduction of a benchmark of care or a quality of care compact that links resident outcomes, staffing levels and skills mix.

3.92 Evidence indicates that the introduction of such a system would ensure that realistic staffing levels are in place in aged care facilities. The Committee believes, however, that such a system would need to be sufficiently flexible to take into account the changing needs of residents.

Recommendation 13

3.93 That the Agency, in consultation with the aged care sector and consumers, develop a benchmark of care which ensures that the level and skills mix of staffing at each residential aged care facility is sufficient to deliver the

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75 *Submission* 122, p.14 (HSU).

76 *Committee Hansard* 11.2.05, pp.4-5 (CHA).

77 *Committee Hansard* 11.2.05, pp.11-12 (CHA).

care required considering the needs of the residents. The benchmark of care that is developed needs to be flexible so as to accommodate the changing needs of residents.

Access to medical and allied health workers

3.94 Submissions referred to the difficulty in attracting doctors and other health professionals to attend to the medical needs of residents in aged care facilities. The Australian Society for Geriatric Medicine (ASGM) noted 'older people in residential care facilities are significantly disadvantaged and have poor access to both basic medical care and specialist medical care'.[78] The Australian Medical Association (AMA) noted that only 16 per cent of GPs are visiting nursing homes on more than 50 occasions a year – that is once a week.[79]

3.95 The AMA noted that disincentives for health professionals in providing care in nursing homes included lack of remuneration, a deficient rebate structure for doctors, the absence of appropriate MBS items for geriatricians, the large amount of paperwork required by aged care facilities and the absence in many facilities of consultation rooms with adequate treatment facilities and computer facilities to facilitate access to patient records.[80] Witnesses commented that the Aged Care GP Panels Initiative announced in November 2003, which aims to improve access to primary medical care for residents of aged care homes, has only been successful in some areas in attracting GPs to aged care facilities either because of the shortage of GPs in general and a reluctance by some GPs to provide services in nursing homes.[81]

3.96 The ASGM noted that few geriatricians or other specialists are prepared to work in aged care facilities and pointed to the fact that a GP assessment in a facility is now remunerated at a higher level than a complex, comprehensive specialist geriatric assessment. In addition, there are few geriatricians who consider residential care their area of particular interest in geriatric practice. The ASGM noted that 'the best models of care focus on a multidisciplinary approach to care, with allied health, nursing and medical practitioners working together. That does not happen in this country in residential care'.[82]

3.97 Residents in aged care facilities are required to have access to a range of specialist care including speech therapy, podiatry, occupational care and physiotherapy. The Accreditation Standards state that residents be referred 'to appropriate health specialists in accordance with the resident's needs and preferences'

78 *Committee Hansard* 19.8.04, p.35 (ASGM).

79 *Committee Hansard* 11.2.05, pp.21,28 (AMA).

80 *Committee Hansard* 11.2.05, pp.21-21 (AMA); *Submission* 129, p.5 (AMA).

81 *Committee Hansard* 11.2.05, pp.13-14 (UnitingCare Australia); 22.2.05, pp.54-55 (Regional Medication Advisory Committee).

82 *Committee Hansard* 19.8.04, p.35 (ASGM).

(Standard 2.6), although evidence indicated that there are huge variations in the quality and provision of these services. The Australian Physiotherapy Association (APA) expressed concerns that the Agency places insufficient emphasis on ensuring the presence of preventive programs and that therapy is properly provided in facilities. The APA noted that some aged care facilities that advertise a comprehensive physiotherapy service do not employ sufficient physiotherapists to provide this service.[83] The Australian Psychological Society called for the increased use of psychologists in aged care facilities especially in the areas of mood and anxiety problems and physical disorders. The Society argued that psychologists have little current role in aged care despite the effectiveness of psychological interventions in these situations.[84]

3.98 The provision of adequate dental care was also cited as a problem in aged care facilities. The Accreditation Standards require that residents' 'oral and dental health is maintained' (Standard 2.15). The Aged Care Lobby Group noted that 'oral care is often lacking and as a follow-on…there are dental problems' for residents in homes.[85] The CPSA also noted that studies have reported poor dental care in nursing homes and commented that this situation was 'not exactly a glowing testimony to the way accreditation is carried out'.[86]

Medication management

3.99 A number of issues in relation to medication management were raised in evidence including significant problems regarding medication use in aged care facilities. These include selection of management options, prescribing decisions, administration and use of pharmaceuticals and the lack of ongoing review and follow-up of residents.[87] The Accreditation Standards provide that residents' medication 'is managed safely and correctly' (Standard 2.7). The Australian Pharmaceutical Advisory Council's *Guidelines for Medication Management in Residential Aged Care Facilities* (2002) provide guidelines about improving the quality use of medicines in aged care facilities. It was suggested that, while the facilities pick up on those guidelines as part of the accreditation process, 'there are very major gaps…between what is recommended in guidelines and what actually happens in practice'.[88]

3.100 There was evidence to suggest that medication is used in some aged care facilities to deal with a range of behavioural and other problems that could best be

83 *Submission* 72, pp.3-4 (APA).

84 *Submission* 207, pp.1-3 (Australian Psychological Society).

85 *Committee Hansard* 22.2.05, p.32 (Aged Care Lobby Group). See also 19.8.04, p.41 (ASGM).

86 *Submission* 79, p.6 (CPSA).

87 *Submission* 120, Supplementary Information, 22.2.05 (Adelaide NE Division of General Practice).

88 *Committee Hansard* 22.2.05, p.52 (Adelaide NE Division of General Practice Regional MAC).

dealt with by other approaches. The Australian Society for Geriatric Medicine noted that:

> The problem of polypharmacy and drug use is a very serious and significant one in residential care facilities, and in part it comes from the ignorance and skill mix of those who provide care. The answer to behavioural problems in patients with dementia, for example, is not to give them antipsychotic medications but to put in pace appropriate behavioural and environmental strategies.[89]

3.101 One submission also pointed to studies that show CALD residents with dementia in generic aged care facilities are often over medicated with sedatives, although this is a less serious problem for CALD residents in ethno-specific facilities.[90]

3.102 The ASGM suggested that medication use in aged care facilities could be improved if a multidisciplinary approach was adopted involving doctors, nursing staff, geriatricians, with pharmacy input 'in order to help work out what is the best evidence in terms of treatment approaches…we have really fallen short of having a proper multidisciplinary approach to medication management'.[91]

3.103 The issue of the relative effectiveness of different medication systems was raised in evidence, especially possible means of streamlining the process. The Centre for Research into Aged Care Services conducted a study into a comparison of two types of medication administration systems, particularly in terms of the time and resources involved in the two systems. One was the traditional dosette box and the other was the computerised sachet. The study found that with the computerised delivery system 'there were fewer errors, there was more confidence with the people dispensing the medications and they were able to move away from the big trolley and all that stuff that takes up time'.[92]

Nutrition

3.104 Advocacy groups and others commented on the poor standard of food in some aged care facilities, although these groups could not provide substantive evidence of the extent of the problem throughout the industry.[93] The Dietitians Association of Australia stated that the Agency in recent years has given increasing attention to

89 *Committee Hansard* 19.4.04, p.41 (ASGM).

90 *Submission* 224, p.6 (Fronditha Care); *Committee Hansard* 27.4.05, p.44 (Fronditha Care).

91 *Committee Hansard* 19.8.04, p.41 (ASGM).

92 *Committee Hansard* 23.3.05, pp.10-11 (Centre for Research into Aged Care Services).

93 *Committee Hansard* 28.4.05, pp.2-15 (Advocacy Tasmania); 22.2.05, pp.28-32 (Aged Care Lobby Group).

nutrition standards in aged care facilities and more dieticians are now employed directly by facilities than in the past.[94]

3.105 Complaints to the inquiry included poor quality of the food, lack of variety, and lack of fresh food in some facilities. Poor nutrition can lead to a range of health problems. The Accreditation Standards merely require that residents receive 'adequate nourishment and hydration' (Standard 2.10).

3.106 The importance of good quality food for residents was emphasised by the Aged Care Lobby Group:

> Most people never see fresh fruit in a nursing home unless it is brought by relatives. For elderly people, and for us all, food is a celebration and we hang our day on what we are going to have…That is one of the real pleasures that most aged care facilities do not provide.[95]

3.107 Groups argued that that Standards in relation to food and nutritional care need to be further defined or enhanced.[96] The Aged Care Lobby Group suggested that a committee should be established to assess the nutritional needs and types of food that should be available in homes.[97] The Dieticians Association also argued that the Agency should consult with the profession on continuous improvement in assessment and review processes of the Standards.[98]

Transport needs

3.108 Submissions noted the lack of accessible and affordable transport options available to people in residential aged care.

3.109 NCOSS, in a report on the transport needs of people in aged care facilities in NSW, found that:

- most residents relied on family and friends as their primary source of transport support;
- a third of residents reported having no significant access to family and friends and thus great difficulty in accessing transport support;
- many residents would prefer to use transport services more often to travel to appointments and outings;

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94 *Submission* 184, p.3 (Dietitians Association).

95 *Committee Hansard* 22.2.05, pp.29-30 (Aged Care Lobby Group).

96 *Committee Hansard* 22.2.05, p.32 (Aged Care Lobby Group); *Submission* 184, p.4 (Dietitians Association).

97 *Committee Hansard* 22.2.05, p.29 (Aged Care Lobby Group).

98 *Submission* 184, p.4 (Dietitians Association). See also *Committee Hansard* 22.2.05, p.42 (Healthy Ageing Project).

- a major barrier to travel for many older residents was the lack of an accompanying escort;
- people from CALD backgrounds were unlikely to use transport services other than family;
- there were significant inequities in access and eligibility to subsidised taxi transport; and
- many facilities had great difficulty in providing available, affordable and accompanied transport services for residents.

3.110 The NCOSS study recommended that more information needs to be provided to residents on their rights in relation to transport and the options available upon entry to nursing homes and that this information be provided on an regular ongoing basis; that additional funding be available for the taxi subsidy scheme and that the eligibility criteria for the scheme be expanded; and that a more coordinated approach be adopted for the effective use of existing transport resources.[99]

3.111 The NSW Aged Care Alliance noted that, while aged care providers carry some responsibility for providing transport services to residents, current funding levels do not adequately cover the costs of providing residents with appropriate transport options.[100] NCOSS proposed the introduction of a residential aged care transport supplement. This supplement to be funded by the Commonwealth – and be similar to other supplements under the Aged Care Act – would provide a dedicated funding allocation towards transport support for people living in aged care facilities.[101]

Needs of people from culturally and linguistically diverse backgrounds

3.112 Submissions and other evidence from groups representing people from culturally and linguistically diverse (CALD) backgrounds argued that the Accreditation Standards do not adequately address the needs of residents from these backgrounds. Fronditha Care noted that:

> The current regulatory framework…is deafening in its silence on the importance of language and cultural identity, to service delivery and the experience of CALD elders.[102]

3.113 The projected demographic profile of Australia's CALD population indicate significant increases in demand for aged and community services over the next 20 years. Currently the number of elderly from CALD backgrounds is 20 per cent of

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99 *Submission* 204, Appendix 1 (NCOSS).

100 *Submission* 203, pp.17-18 (NSW Aged Care Alliance).

101 *Submission* 204, Appendix 1 (NCOSS).

102 *Submission* 224, p.4 (Fronditha Care & DutchCare). See also *Committee Hansard* 27.4.05, pp.38-42 (ECC of Victoria/Fronditha Care).

the population aged 65 years and over. This is projected to increase to 23 percent, or almost a quarter of the aged population 65 years and over, by 2016.[103]

3.114 Submissions noted that only one of the 44 expected outcomes makes reference to cultural identity (Resident Lifestyle Standard 3.8) and there is no mention at all in relation to language and the importance of communication in the residents' own language. One witness cited the example of elderly Greek-speaking women in their mid-80s who speak very little English:

> They are in a mainstream nursing home for 24 hours a day, 365 days of the year…how does this elderly person connect with their carers and with the social system that forms that nursing home or hostel? If you do not have the language and if you do not share a common sense of history, values, music or food…then it is an extraordinarily isolating experience.[104]

3.115 Submissions also noted that often the Agency assessors do not utilise interpreting services during their assessment visits to facilitate effective communication with residents who do not speak English and therefore argued that they would be unable to obtain adequate feedback from residents as to whether their needs are being met.[105]

3.116 The Agency stated that when visiting services that cater for specific, or large numbers of CALD residents, 'it may be appropriate' to engage the services of a translator to assist assessors to communicate effectively with residents. The decision to engage a translator rests with the local State manager and will be based on information collected regarding the dominant cultures and languages used in the service. It may also be appropriate to discuss the need for a translator with the provider at the service. The Agency noted that 'it is not practical' for it to provide a translator for every cultural group or language group in a particular service.[106]

3.117 Submissions and other evidence argued that the Accreditation Standards need to address the needs of CALD residents in the following areas:

- Cultural diversity needs to be effectively addressed across all the Standards, as all are relevant in meeting the full range of individual care and health needs of CALD residents.
- Specific expected outcomes need to be introduced relating to the language and communication needs of CALD residents.
- Agency auditors should be trained in cultural competency in aged care service provision. 'Cultural competence' refers to the ability of an individual to function effectively in cross-cultural situations taking into account the culture,

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103 *Submission* 178, p.4 (ECC of NSW).

104 *Committee Hansard* 27.4.05, p.38 (Fronditha Care).

105 *Submissions* 82, p.2 (ECCV); 224, p.4 (Fronditha Care).

106 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

lifestyles and experiences of the particular individuals with whom they are interacting.

- The Agency should develop and utilise standard cultural competence assessment tools.
- A designated position to represent CALD residents should be created on the Board of the Agency.[107]

3.118 Regarding the qualifications of assessors, the Agency stated that some registered assessors do have specific knowledge or language skills for certain CALD groups – 'whenever possible these assessors should be used as part of a team'. Cultural factors, language and ethnicity is included in the attributes identified for quality assessor registers. The Agency also maintains its own list of staff who speak a language other than English.[108]

Needs of Indigenous aged people

3.119 Evidence indicates that the needs of aged Indigenous Australians are currently not being met in many aged care facilities. Some witnesses called for the construction of more Indigenous-specific aged care facilities in areas of large Aboriginal populations or the construction of specific wings in local nursing homes in other areas. There are only two Indigenous-specific residential care facilities in NSW.

3.120 Evidence pointed to the need for culturally appropriate residential aged care that is conveniently located. One witness noted that:

> We have a lot of people out west [of NSW] who want – who need – to go into residential care and just cannot access to it, because it means leaving their homes, their regions and their families. Aboriginal communities and Aboriginal people do not particularly want residential care anyway, but when we get to the point where we need it, we would like to be able to have something that is culturally appropriate, that is close by and that has Aboriginal workers providing that care.[109]

3.121 Evidence also emphasised the importance of Indigenous staffing of aged care facilities:

> Aboriginal staff actually address a lot more issues than just carrying out their required duties – it entails the emotional care of our elders, which no non-Aboriginal person with any amount of cultural awareness can address. There are also our historical conversations, if you like – some of our elders

107 *Submissions* 178, pp.12-14 (ECC of NSW); 82 p.2 (ECCV); 224, p.4 (Fronditha Care); 203, p.6 (NSW Aged Care Alliance); *Committee Hansard* 11.3.05, pp.1, 4-5 (ECC of NSW).

108 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

109 *Committee Hansard* 11.3.05, p.49 (NSW Aboriginal Community Care Gathering).

> with dementia go back to things that happened in the past. Aboriginal people are much more empathetic…and we deal with it much better.[110]

3.122 Witnesses also commented that where non-Aboriginal staff are employed they should be trained in cultural competency and be aware of cultural issues relevant to Indigenous aged people.

Conclusion – how effective are the Accreditation Standards?

3.123 Evidence indicates that in a range of areas from medication management to access to medical services there are significant problems in the provision of services to residents in aged care facilities.

3.124 It was suggested in evidence that the Accreditation Standards are failing to measure areas where care is clearly deficient. The Committee believes that the Accreditation Standards are too generalised to effectively measure care outcomes. The wording of the Standards necessarily lead to varying levels of service being provided in homes because the Standards are open to widely different interpretations by proprietors and assessors. The Committee believes that the Accreditation Standards need to be defined more precisely so that standards of care in aged facilities can be delivered – and measured – in a consistent manner across all aged care facilities.

Recommendation 14

3.125 That the Commonwealth, in consultation with industry stakeholders and consumers, review the Accreditation Standards to define in more precise terms each of the Expected Outcomes and that this review:

- **address the health and personal care needs of residents, especially nutrition and oral and dental care; and**
- **include specific consideration of the cultural aspects of care provision, including the specific needs of CALD and Indigenous residents.**

Recommendation 15

3.126 That the Agency make greater use of interpreters during accreditation visits to aged care facilities, especially those facilities that cater for specific or predominant numbers of CALD or Indigenous residents; and that assessors be trained in cultural competency as part of their formal training courses.

Complaints mechanisms

3.127 A number of complaints mechanisms operate for people concerned about possible breaches of a provider's responsibilities under the Aged Care Act. All aged care services are required to establish an internal complaints system. The Aged Care Complaints Resolution Scheme (CRS) also operates to enable people to formally raise

110 *Committee Hansard* 11.3.05, pp.49-50 (NSW Aboriginal Community Care Gathering).

concerns about aged care services. DoHA also funds aged care advocacy services in each State. These services provide independent advocacy and information to residents of aged care services and family members.

Complaints Resolution Scheme

3.128 The Complaints Resolution Scheme enables people to raise concerns about aged care services funded by the Commonwealth Government, including Community Aged Care Packages (CACPs), residential care and flexible services. The Scheme is based on alternative dispute resolution principles and provides an opportunity to both parties to address a grievance in a way that enhances or rebuilds the relationship between the provider, the care recipient and their family. The Scheme, which is free, offers a means of making a complaint, independent from a residential facility. Complaints can be made verbally or in writing and can be dealt with in an open, confidential or anonymous basis. A national toll free number is available to ensure people have access to the scheme.

3.129 Resolution processes under the Scheme include preliminary assessment which is handled by complaints resolution officers prior to the acceptance or non-acceptance of a complaint; negotiation is managed by complaints resolution officers; mediation is conducted by qualified, external officers; determination of complaints is conducted by committees, which are constituted of independent members with skills in aged care and complaints resolution, where complaints cannot be resolved through negotiation or mediation; and determination review and oversight of the Scheme is conducted by the Commissioner for Complaints.

3.130 The Scheme is administered by DoHA. The Commissioner for Complaints has a statutory requirement to oversight the effectiveness of the Scheme. The Commissioner also deals with complaints about the operation of the Scheme; manages the determination process; and promotes an understanding of the Scheme.

3.131 As noted above, all aged care services are required to establish an internal complaints system and advise care recipients of any other mechanisms available to address complaints as well as providing such assistance as the care recipient requires to use those mechanisms.[111]

3.132 Some evidence suggested that the internal complaints system is less than satisfactory while other evidence suggested it operates effectively. The Aged Care Lobby Group noted that 'some homes have very good internal complaints mechanisms which make it unnecessary to go to the complaints resolution unit'.[112] The Group

111 Commissioner for Complaints, *Annual Report 2003-04*, pp.8-13; *Submission* 191, pp.14-15 (DoHA).

112 *Committee Hansard* 22.2.05, p.33 (Aged Care Lobby Group).

noted, however, that in some instances family members have found the internal complaints system 'unsatisfactory'.[113]

3.133 In 2003-04, the CRS received 967 complaints. This represents a 21 per cent reduction in the number of complaints over 2002-03. The Commissioner for Complaints argued that the principal reasons for the decline were the increased use of internal complaint mechanisms and ongoing refinement in the practices adopted by the Scheme.[114] The Committee notes, however, that statistics are not kept on the number of internal complaints.

3.134 The majority of complaints (97 per cent) related to residential aged care services and 3 per cent related to CACPs. Relatives lodged the majority of complaints (67 per cent). Nine per cent of complaints were lodged by staff, while care recipients lodged eight per cent of complaints. Some 126 complaints (13 percent) of all complaints were not accepted by the Scheme. A complaint may be refused if it is frivolous or vexatious; the matter is subject to legal proceedings; or there is an alternative way of dealing with the subject matter of the complaint and the complainant agrees to have the matter dealt with in that way. The majority of complaints are resolved by negotiation and/or referral, 2 per cent through mediation by an independent mediator, and 3 per cent are finalised by a determination by a committee.

3.135 The nature of complaints are becoming more complex and multifaceted. Complaints have changed from concerns about single issues such as laundry, cleaning and catering to more intricate issues such as security of tenure, clinical care, medication, resident safety and communication and management. The main complaint issues raised in 2003-04 were health and personal care (300 complaints), consultation and communication (240), physical environment (180), choice and dignity (170), personnel (150) and medication management (100).[115]

Concerns with the Complaints Resolution Scheme

3.136 A number of concerns were raised in relation to the operation of the Scheme. Submissions argued that the complaints mechanisms often do not work in the interests of consumers, and the mechanisms are unclear, unnecessarily complex and in some cases complaints are actively discouraged.[116]

3.137 Evidence indicates that the CRS needs to become more accessible and responsive to consumers.

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113 *Submission* 198, p.2 (Aged Care Lobby Group).

114 Commissioner for Complaints, *Annual Report*, p.23.

115 Commissioner for Complaints, *Annual Report*, pp.23-30.

116 *Submissions* 204, p.5 (NCOSS); 203, pp.6-7 (NSW Aged Care Alliance).

3.138 The Committee received an example of a concerned citizen who tried to make a complaint about an incident at a nursing home and found the whole process extremely harrowing.

> …[I] wrote to the Department of Health and Ageing. I got a standard reply, saying, 'Please go to the Aged Care Complaint Resolutions Scheme'. The standard letter – everything was standard. I rang the number. It was one of those 'you want this, buzz number 1 or 2', and I thought, 'If I were an NESB person I would probably not have a clue how to do that.' I finally got onto that, and again they were saying, 'You have to get onto the mediation action.' I said: 'No, I am not a relative of the nursing home resident or anything. I am just a concerned member of the public.[117]

3.139 NCOSS noted that instances such as the above are not uncommon:

> The very strong message that NCOSS gets from the Aged Care Alliance consumer groups is that the complaints mechanism is not accessible to people and not responsive. There are some disjoints between making a complaint, how that goes through the scheme, whether or not it gets to the agency…and then how that is enacted.[118]

3.140 The Aged Care Lobby Group argued that family members have given up complaining to the CRS because the overall impression is that 'their complaints are trivialised or are made by an over-fussy, neurotic or guilt-ridden family member'. The Group also complained that anonymous complaints are not treated as seriously as other complaints.[119] DoHA conceded that due to the nature of these complaints there can be no ongoing two-way communication with the complainant to provide feedback about their complaint, although they may be used to illustrate in a general sense particular problems.[120]

3.141 Evidence suggests that complainants have difficulty getting complaints accepted by the CRS. Submissions noted that complaints made to the CRS have not been accepted because documentation and staff reports have not been available to substantiate a breach of standards.[121] The CRS can accept complaints about any aspect of aged care which may be a breach of an approved providers responsibilities under the Aged Care Act. The Commissioner of Complaints noted that a preliminary assessment of a complaint is made to determine whether or not the complaint is to be accepted. This assessment is made on the information available and a complaint is accepted only if 'sufficient information' is provided in relation to the complaint.

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117 *Committee Hansard* 11.3.05, p.59 (Mrs J Ma).

118 *Committee Hansard* 11.3.05, p.60 (NCOSS).

119 *Submission* 198, p.2 (Aged Care Lobby Group). See also *Committee Hansard* 22.2.05, p.31 (Aged Care Lobby Group).

120 *Submission* 191, Supplementary Information, 26.5.05 (DoHA).

121 *Submission* 158, p.2 (Advocacy Tasmania).

Moreover, the CRS must be satisfied that accepting the issue as a formal complaint is the best way to handle the problem.[122]

3.142 Advocacy Tasmania explained this process and the frustration that it causes complainants:

> The process is that they will then take the complaint to the home and there will be an investigation. Because there is an allegation, there is not automatically a complaint in a technical sense. That whole thing does not make any sense to consumers – if you have a complaint, it is a complaint – and it is very difficult to explain that technicality to people. So they go along and investigate what has been said. Of course they go to the home and ask about the incident and they look in the documentation….It boils down to one person's word against another, and because nothing in the documentation seems to suggest that this [incident] happened then there is no complaint. The complainer is told, 'Sorry, your complaint is not accepted'.[123]

3.143 Evidence suggests that the number of complaints would be considerably higher if the CRS did not use such strict criteria for accepting complaints – in effect the CRS 'culls' the number of potential complaints. This also has the effect of discouraging many potential complainants from making complaints.

3.144 As noted above, some 13 per cent of all complaints lodged in 2003-04 were not accepted by the Scheme. The rate of non-acceptance of complaints was 33 per cent in the Northern Territory, 31 per cent in Tasmania, 26 per cent in Victoria, 8.5 per cent in Western Australia, 5.2 per cent in the ACT, 3 per cent in NSW and 1.9 per cent in South Australia. In Queensland all complaints lodged were accepted.[124]

3.145 Witnesses also expressed dissatisfaction with the mediation process arguing that in many instances it is difficult to mediate, especially when serious incidents are involved, and often complainants are not given sufficient support.

> …you cannot mediate about some things. It depends on the actual incident that has happened…Mediation is fine if there has been some behaviour – [for example] someone being nasty. Ideally it should be recognised that that did happen and there should be some acknowledgment of the fact that it happened…mediation is not always satisfactory, and unless people are supported it can be extremely intimidating.[125]

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122 Commissioner for Complaints, *Annual Report*, p.30.

123 *Committee Hansard* 28.4.05, pp.4-5 (Advocacy Tasmania).

124 Commissioner for Complaints, *Annual Report*, p.31.

125 *Committee Hansard* 28.4.05, p.5 (Advocacy Tasmania).

> It is rather difficult to mediate with your jailors. If the climate in a particular home is more concerned with matters other than the care of the elderly then it is very hard to bring about change.[126]

3.146 Submissions also argued that complaints about care are not necessarily passed on to the Agency by the Scheme unless they are serious or relate to a facility about which persistent complaints have been received.[127] DoHA noted, however, that all complaints are passed on to the Agency some individually, in the case of serious complaints, and others collectively in the sense that they may indicate broader trends or problems within facilities.

3.147 Submissions pointed to the need for whistleblower protection so that staff can report inadequate standards of care without rear of reprisal.[128] The ACT Disability, Aged & Carer Advocacy Service (ADACAS) noted that many complaints schemes and similar bodies charged with the investigation of community concerns include protection for people who reveal information which identifies deficiencies in systems, or alleged criminal activity by individuals.[129]

3.148 Concern was also expressed about the apparent overlap of complaints schemes and the feeling that complainants are 'shunted' from one agency to another. As one witness noted:

> In our case we have exercised all available complaints processes at state and Commonwealth levels about the serious situation of poor care and abuse. Two years after the completion of those processes our situation is actually worse than when we began. So we think our case is valuable in the sense that we are a rare test case of just how well the current system works.[130]

Independent complaints agency

3.149 A number of submissions argued that due to the inadequacies of the CRS an independent complaints agency should be established. NCOSS argued that such an agency should:

- provide an accessible avenue for complaints and identify sector trends;
- report publicly and use transparent and independent processes;
- respond to the specific needs of people from culturally and linguistically diverse backgrounds and Indigenous Australians;

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126 *Committee Hansard* 22.2.05, p.33 (Aged Care Lobby Group).

127 *Submission* 198, p.2 (Aged Care Lobby Group).

128 *Submission* 198, pp.2-3 (Aged Care Lobby Group).

129 *Submission* 167, Supplementary Information, 7.2.05 (ADACAS).

130 *Committee Hansard* 11.3.05, p.73 (Mr C Way). See also *Submissions* 211, p.3 (Dr N Duncan); 237 (Mr E Saul).

- involve independent advocacy at individual and systemic levels; and
- establish a transparent relationship with the Agency.[131]

3.150 The LHMU argued that an aged care ombudsman should be established to provide transparency and accountability in the management of complaints. The ombudsman would also have a role in educating residents, families and the broader community about the rights of older Australians receiving aged care services.[132]

Conclusion

3.151 Evidence to the inquiry suggests that there are deficiencies with the operation of the Complaints Resolution Scheme. Concerns were expressed that the Scheme is not accessible nor sufficiently responsive to the needs of consumers, and the complaints mechanisms are unclear, unnecessarily complex and in some cases complaints are actively discouraged. The relatively high non-acceptance of complaints by the Scheme would indicate that there are grounds for concern.

3.152 While some evidence argued that an independent complaints agency should be established to improve the transparency and accountability of the complaints mechanism the Committee is not convinced that such an agency would necessarily address the concerns raised during the inquiry. The Committee therefore favours a reform of the current arrangements.

3.153 The Committee also considers that whistleblower legislation is required for those people wishing to disclose inadequate standards of care in aged care facilities.

Recommendation 16

3.154 That the Commonwealth review the operations of the Aged Care Complaints Resolution Scheme to ensure that the Scheme:

- **is accessible and responsive to complainants;**
- **provides for a relaxation of the strict eligibility criteria for accepting complaints;**
- **registers all complaints as a complaint, with the complaints being categorised by their degree of severity, such as moderate level of complaint, complaints where mediation is required or where more significant levels of intervention are required; and**
- **provides that the mediation process is responsive and open and that sufficient support for complainants is provided in this process.**

131 *Submission* 204, p.5 (NCOSS). See also *Submission* 203, pp.6-7 (NSW Aged Care Alliance).

132 *Submission* 124, p.20 (LHMU).

Recommendation 17

3.155 That the Commonwealth examine the feasibility of introducing whistleblower legislation to provide protection for people, especially staff of aged care facilities, disclosing allegations of inadequate standards of care or other deficiencies in aged care facilities.

Retribution

3.156 Evidence was presented during the inquiry detailing the fear of, or instances of, actual retribution and intimidation of residents and/or their families if residents or their families complained about conditions in homes or the quality of care. One submission noted that 'the scope of the issue is difficult to determine. Its very existence means people are afraid to report it, disclosing it only when they feel safe to do so. They may remain silent, even though significant efforts are made…to inform people of their right to complain'.[133] Information indicated that retribution or threats could occur in a number of situations, for example, staff against residents, management against residents or management against staff.

3.157 The types of retribution of residents are varied and include:

- being embarrassed or humiliated in front of other people;
- being forced to conform to routines;
- being called a 'dobber' if they complain;
- not encouraged to participate in activities;
- not being allowed to sit with friends at the lunch table;
- having personal items removed from their rooms;
- staff becoming less friendly, more formal with the resident;
- being shouted at and abused by staff; and
- any form of bullying or harassment.[134]

3.158 Some indication of the extent of retribution was provided during the inquiry. In the ACT, the Disability, Aged & Carer Advocacy Service (ADACAS) reported 55 instances of actual retribution in aged care facilities from 2001-2004. Of the 23 homes in the ACT retribution was reported in 13 homes – almost half of all homes in the ACT. In nine homes the retribution reportedly came from management; in six it came from staff and in two it came from both management and staff. In five homes the number of reported cases of actual retribution was high, ranging from four to 10 cases. In the other nine homes, the number of cases ranged from one to three instances.[135] In

133 *Submission* 167, Supplementary Information, 7.2.05 (ADACAS).

134 See, for example, *Submission* 167, Supplementary Information, 7.2.05 (ADACAS).

135 *Submission* 167, Supplementary Information, 1.4.05 (ADACAS). See also *Committee Hansard* 11.2.05, pp.62-68 (ADACAS).

relation to the ACT, in 2003-04, the CRS dealt with four cases which raised the issue of real or potential retribution. All four of these complaints have been finalised.[136]

3.159 The Committee questioned the Service as to whether retribution was part of an entrenched management culture in the aged care industry. The Service stated that this was not the case adding that where management is involved in cases of retribution – 'I would see that as a systemic issue within those particular homes. The others may be isolated'.[137]

3.160 The Committee pursued this issue during the hearings in other States. In South Australia, the Aged Rights Advocacy Service stated that it provides advocacy services to an average of 800 people per year through its residential care program with another 300 people seeking information about their rights as consumers. Retribution or fear of retribution is raised in approximately 15-20 percent of these contacts.[138] The Aged Care Lobby Group in South Australia also noted that 'fear of reprisal and victimisation is a very real fear in nursing homes, particularly in smaller ones owned by some of the private providers'.[139]

3.161 Advocacy Tasmania noted that it only receives 'a handful of actual instances of retribution' a year, but added that this 'is not the same as the number of people who fear retribution'.[140] The group also noted that residents and family members often fear retribution if they speak to assessors with concerns during accreditation visits.[141]

3.162 ADACAS stated that all State and Territory advocacy groups have reported to the Service instances of actual retribution in their respective jurisdictions.[142]

3.163 The CPSA stated that the low proportion of complaints to the CRS by residents compared with relatives 'does indicate that intimidation could be a factor' – 'nursing home residents have to put up with any possible retribution. Relatives do not'.[143]

3.164 The issue of retribution in aged care facilities was highlighted by the Commissioner for Complaints in a recent annual report.

> Many discussions with relatives and friends of care recipients reveal an obvious and pervasive attitude – one where there is an expressed anxiety

136 *Submission* 191, Supplementary Information, 26.5.05 (DoHA).

137 *Committee Hansard* 11.2.05, p.64 (ADACAS).

138 Cited in *Submission* 167, Supplementary Information, 1.4.05 (ADACAS).

139 *Committee Hansard* 2.2.05, p.29 (Aged Care Lobby Group).

140 *Committee Hansard* 28.4.05, p.15 (Advocacy Tasmania).

141 *Submission* 158, p.2 (Advocacy Tasmania).

142 *Submission* 167, Supplementary Information, 1.4.05 (ADACAS).

143 *Submission* 79, p.8 (CPSA).

> not to make a fuss, not to complain, not to inquire too often and not to be noticed for fear that it would reflect badly on their relative and lead to some kind of retribution.[144]

3.165 While advocacy and other groups argued that retribution is a problem in nursing homes, providers and unions representing workers in the aged care sector suggested that it is not a significant issue, although the fear of retribution may be an issue.

3.166 The ANF stated that the issue 'is not something that we would ever condone at all and it has come up from time to time. Sometimes it is more a fear than something that actually happens' but the union stated that it was not a significant problem in aged care facilities.[145] The ANF submitted that it was not raised in recent phone-in surveys in relation to issues in aged care nor in surveys conducted in the union's journal. The AMA also indicated that it was not aware of any reports of intimidation of residents or their families made to its members.[146]

3.167 Providers indicated that they were not aware of retribution being a significant problem in homes. A representative of ACSA noted:

> …I have heard no instance of bullying or intimidation by providers of residents or their families…I meet quite regularly with the residents' rights association. We sit on the same committees and so on. No-one has raised that issue with me.[147]

3.168 One provider noted that residents 'may have a fear of retribution and it would never be actualised, but the fear is enough if you are on your own and do not have a choice. The biggest challenge is really creating an environment for people to feel safe to raise the point'.[148] Another provider noted that 'we would love to think that we could eliminate that perceived fear. Certainly, I am not aware that anybody would actively pursue that sort of retribution. We are very aware, and want to act immediately, if there is any suggestion that any of our staff may be acting inappropriately in how they care for and respond to the care needs of a resident'.[149]

3.169 Advocacy groups stated, nevertheless, that there needs to be an investigation to identify the actual level of retribution in aged care homes. The groups also proposed that a national strategy for the elimination of retribution, and fear of retribution in aged care facilities, should be implemented involving all stakeholders. ADACAS noted that a national strategy should identify and trial ways of eliminating

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144 Commissioner for Complaints, *Annual Report 2002-03*, p.29.

145 *Committee Hansard* 11.2.05, p.46 (ANF).

146 *Committee Hansard* 11.2.05, p.26 (AMA).

147 *Committee Hansard* 26.4.05, p.19 (ACSA).

148 *Committee Hansard* 23, 2.05, p.32 (Silver Chain).

149 *Committee Hansard* 23.2.05, p.32 (Baptistcare).

the fear of retribution and identify and implement ways to eliminate actual retribution.[150]

3.170 DoHA advised the Committee that the Department and the Commissioner for Complaints have met with ADACAS to seek their views on options for addressing the issues of actual and perceived fear of retribution. Since then the Department has sought and received feedback from ACT-based homes. The Commissioner for Complaints has also undertaken a project to review available literature and evidence and identify strategies that could be considered; and in May 2005 the Aged Care Advisory Committee, the major forum for consultation with the aged care sector, considered these issues – industry groups have agreed to consider specific initiatives to address both any incidence and perceptions around this issue in aged care homes.[151]

Conclusion

3.171 Evidence to the Committee pointed to instances of retribution and intimidation of residents in aged care facilities and their families across many States. The Committee found this evidence particularly disturbing and reprehensible as these practices prey on particularly vulnerable people and cause obvious concern to the families of residents some of whom may themselves be victims of intimidation.

3.172 The Committee was unable to form a view as to the possible extent of the problem. The Committee believes, however, that there needs to be a comprehensive investigation of this issue to determine how widespread it is and the extent to which it represents an entrenched culture in aged care facilities or sectors of the industry. The Committee believes that the review should also examine the feasibility of introducing a national plan of action to address this issue should the problem be found to be extensive across the industry.

Recommendation 18

3.173 That the Commissioner for Complaints conduct an investigation into the nature and extent of retribution and intimidation of residents in aged care facilities and their families, including the need for a national strategy to address this issue.

Promoting education and training

3.174 One of the functions of the Agency is to promote high quality care, and assist the industry to improve service quality, by identifying best practice and providing information, education and training to the industry. The Agency's underlying philosophy for education is that high quality care will be promoted through a

150 *Submission* 167, Supplementary Information, 7.2.05 (ADACAS).

151 *Submission* 191, Supplementary Information, 26.5.05 (DoHA).

combination of education and accreditation activities – 'neither strategy alone will bring about sustained improvement in the sector'.[152]

Promoting best practice

3.175 The Agency seeks to promote best practice through a number of means, including:

- internal identification of best practice – Agency assessors report examples of better practice and where the Agency considers the practice warrants wider distribution, the provider is contacted.
- articles in the Agency's quarterly newsletter, *The Standard*, on better practice – the Agency's publication regularly showcases facilities willing to share their better practice systems and processes.
- Better Practice events – programs on better practice have been held in several capital cities and other centres.
- Better Practice compendium – the compendium showcases some of the homes that achieve an Agency higher award.
- Higher awards – homes achieving a higher award are showcased on the Agency website.[153]

3.176 The Agency's efforts to promote best practice have been generally viewed favourably. One witness commented that the Better Practice events have been seen 'in a very positive light' by participants.[154] One industry peak body noted, however, that the seminars did not involve formal consultation with the industry, but relied on the practices demonstrated by those facilities which had been awarded meritorious or commendable ratings by the Agency.[155]

3.177 Some areas for improvement were, however, suggested. CHA argued that the Agency should develop a standard evidence-based approach to defining what is actually 'best practice' in aged care.[156] Blue Care argued that the showcasing of best practice initiatives should be an ongoing process rather than at the end of an extensive round of accreditation.[157] UnitingCare Australia argued that the Agency should provide aggregated information about the best approaches to improving the quality of service provision in facilities. While facilities seek to continuously improve standards, improved access to annual comparative information on successful ways of operating

152 *Submission* 105, p.11 (ACSAA).

153 *Submission* 105, p.11 (ACSAA).

154 *Committee Hansard* 26.4.05, p.22 (VAHEC). See also *Submission* 166, p.8 (CHA).

155 *Submission* 170, p.11 (ACS of NSW & ACT).

156 *Submission* 166, p.9 (CHA).

157 *Submission* 116, p.4 (Blue Care).

would be helpful.[158] Benetas noted that the identification of best practice by the Agency remains 'elusive' but inroads are being made through evidence based practice and other key initiatives.[159]

Education and training

3.178 The Agency provides a number of education and training initiatives. These include:

- Seminar series – the Agency conducted a seminar series for the industry *Turning Data into Action* in 2003. Some 68 seminars were conducted in capital cities and rural and regional areas, with 1507 participants attending.
- Self-directed learning packages – these packages, on the Agency web-site, cover self assessment, continuous improvement and data and measurement issues.
- Assessor and provider resource material – the *Audit Handbook for Quality Assessors* and *Results and processes in relation to the expected outcomes of the Accreditation Standard* handbook are available on the Agency web-site. These provide information about the Accreditation Standards and how the assessments are undertaken.
- Agency newsletter – the Agency's newsletter, *The Standard*, is distributed nationally to industry and other stakeholders.
- Education during support visits – education sessions are available – delivered by trained Agency staff – as part of support contact arrangements.
- Satellite television – the Agency is conducting a pilot to evaluate the use of satellite television as a medium for delivering training particularly to remote sites.
- Consumer education – the Agency conducted 40 information sessions directed at residents and relatives across Australia in 2004. Some 1169 people attended these sessions.
- Presentations at industry conferences.[160]

3.179 The Committee received a variety of views on the appropriateness of the Agency's education and training role. Some provider peak bodies noted that there was a potential conflict of interest in the Agency's dual roles of monitoring compliance in addition to promoting quality improvement.

158 *Submission* 57, p.7 (UnitingCare Australia).

159 *Submission* 73, p.2 (Benetas).

160 *Submission* 105, pp.12-13 (ACSAA).

3.180 ANHECA noted that:

> …[we] see no difficulty with an agency that purely has quality improvement as its objective, undertaking this role. However, an organisation that also has a large compliance role is not able to effectively do this as the industry will not seek advice and support from an organisation, that the next day can be 'inspecting' its services and ensuring compliance.[161]

3.181 ACS of NSW & ACT also noted that education is not the Agency's core business and there are other better qualified organisations which could fulfil this role for the industry.[162]

3.182 The Hogan Review also argued that the role of the Agency should be directed primarily to accreditation services and the dissemination of accreditation results. The review questioned the expansion of the Agency's education role to compete in areas of staff training where there are other competent providers. The review also questioned the appropriateness of an agency tasked with evaluating performance also being a major source of training relating to performance.[163]

3.183 Other provider peak bodies, however, supported the Agency's education role. CHA argued that if the Agency took on a purely 'policeman' role it would create a 'them and us' situation between the Agency which would be counter-productive. CHA added that:

> The Agency gains a significant amount of information from the auditing and compliance processes. Sharing this information is a valuable way for the industry to learn about 'best practice' in quality management and to gain from their peers.[164]

3.184 CHA in a survey of its members found that they rated the education and training role of the Agency as generally favourable. Some respondents, however, expressed the view that that the Agency needs to be more proactive with an education process that reflects industry issues. They felt that education and training is irregular and not readily accessible. Others considered that the education packages produced by the Agency are comprehensive but an ongoing program of training in their use would be beneficial. While the packages are available on the website, not everyone has access to the internet and in some cases facilities were unaware of the packages' existence.[165]

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161 *Submission* 74, p.10 (ANHECA). See also *Submission* 196, p.5 (Aged Care Qld).

162 *Submission* 170, pp.10-11 (ACS of NSW & ACT).

163 Hogan Review, p.243.

164 *Submission* 166, p.7 (CHA).

165 *Submission* 166, pp.7-8 (CHA).

3.185 While ACSA in its submission to the inquiry noted that, while the Agency operates as a monopoly, it would be better to confine its education and training role to ensuring that the industry is fully informed about the accreditation system, in oral evidence the organisation indicated that it was not opposed to the Agency providing training courses.[166] ACSA stated that:

> …[we] have got no objection to it being a participant in that marketplace for the provision of quality training but I think it needs to be careful not to overuse its strong position in that regard…They are a legitimate player but by no means the only one.[167]

Conclusion

3.186 The Committee believes that the Agency has a legitimate role in promoting 'best practice' throughout the industry. The Committee considers that the Agency's involvement in these activities can assist in the promotion of high quality care in aged care facilities. The Committee believes, however, that the Agency should not have a direct role in staff training due to the potential conflict of interest that that involves.

Recommendation 19

3.187 That the Agency's role in promoting 'best practice' continue and that it:

- **develop a standard evidence-based approach to defining 'best practice' in aged care; and**
- **provide regular aggregated information to the industry on methods for achieving 'best practice' in the provision of aged care services.**

The Committee further recommends that the Agency consider ceasing its direct role in providing direct staff training given the potential conflict of interest that this entails.

Reducing excessive documentation

3.188 Evidence to the inquiry, especially from providers and unions with staff employed in the aged care sector, complained of the excessive administrative and paperwork demands placed on staff as a result of accreditation and the requirements of the RCS.

3.189 ANHECA noted that:

> …the current accreditation system does [not] in any way assist the sector to reduce administrative and paperwork demands on staff, in fact, the reverse. Because the Agency is so focused on the minutia of day to day activities and not on systems improvement, it is forcing residential aged care

166 *Submission* 173, p.4 (ACSA).

167 *Committee Hansard* 26.4.05, p.2 (ACSA).

> providers to focus on forms and ticking of boxes, rather than ensuring that the quality systems work effectively for overall service improvement.[168]

3.190 The Royal College of Nursing, Australia (RCNA) noted that its members:

> …have expressed their frustration at the huge amount of documentation required by the accreditation process and the increasing amount of time they have to spend on paperwork to meet accreditation requirements instead of providing hands-on nursing care.[169]

3.191 The HSU noted that members consistently express concern about the amount of documentation required of them.[170] The LHMU also noted that 'paperwork is one of the largest barriers to the direct delivery of care. It is also one of the largest frustrations of those that work in aged care'.[171] The Nurses Board of WA noted that the administrative and paperwork demands 'have a real cost in dollar terms and a cost on the emotional and morale demands on staff'.[172]

3.192 The Agency, responding to these concerns, stated that that it does not expect homes to create paperwork or documentation other than the accreditation application. For most homes this requirement falls only once every three years. The Agency stated that the application form has recently been simplified following consultation with the industry.

> The assessment process seeks evidence of compliance with the Accreditation Standards. Agency assessors have no expectation to see any more documentation than that which would exist within a quality management framework.[173]

3.193 The documentation required for accreditation, *Application for Accreditation,* consists of a 49 page document. The main part of the document consists of a 'self-assessment' section which consists of blank pages where the provider is required to provide information that demonstrates that the provider has achieved the Expected Outcomes of the various Accreditation Standards.[174]

3.194 The Agency noted that the accreditation application information and forms are available on-line on its website. The Agency encourages all homes to apply for their accreditation on-line. A version is also available on CD. A printed version is also available for those unable to access a computer or have difficulty down-loading a

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168 *Submission* 74, p.10 (ANHECA).

169 *Submission* 71, p.4 (RCNA). See also *Submission* 201, p.22 (ANF).

170 *Submission* 59, p.11 (HSU - NSW Branch).

171 *Submission* 124, p.18 (LHMU).

172 *Submission* 89, p.3 (Nurses Board of WA).

173 *Submission* 105, p.14 (ACSAA).

174 The *Application for Accreditation* may be accessed at www.accreditation.aust.com

printed version, or who would prefer to fill in a printed application rather than on-line.[175]

3.195 Some groups were of the view that the documentation requirements are not excessive. Geriaction noted that aged care services with well established quality management systems 'do not find the administrative requirements of the three year accreditation application onerous'. Geriaction noted, however, that there may be opportunities for refining processes related to the accreditation of newly established or restructured services to minimise paperwork demands on staff.[176] The Victorian Branch of the ANF also commented that the accreditation paperwork was not 'overly burdensome compared to other such systems'.[177]

3.196 Throughout its hearings the Committee pressed groups concerned about excessive documentation to be specific as to what documentation they considered was not required. Some suggestions to reduce the amount of paperwork required were made during the inquiry. Some witnesses suggested the interRAI (Resident Assessment Instrument) as a useful model. The interRAI series of assessment protocols consist of a series of data items that constitute a clinical assessment. One witness stated that the Instrument:

> …will effectively reduce paperwork….Currently, in order to substantiate our funding, we are required to generate very text-driven documentation…what is being proposed…it is almost like a tick system, I guess. It is a very prescriptive set of assessment documents.[178]

3.197 The Australian Society for Geriatric Medicine suggested that systems such as the internationally benchmarked interRAI Instrument 'may appear complex when first examined, but in the long run are the most efficient since they achieve the desired outcomes'.[179]

3.198 CHA noted that some of its members argued that provision of an annual summary of activities to the Agency would reduce the three year 'panic' when the audit time comes around again.[180] The RCNA suggested that the Agency should further refine the Accreditation Kit to reduce unnecessary repetition between visits; and not require already accredited facilities to complete the full version of the Kit – this should only be required of new services or those requiring improvements. The College also suggested that the dual system of accreditation should be abandoned for

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175 *Submission* 105, Supplementary Information, 27.5.05 (ACSAA).

176 *Submission* 88, p.2 (Geriaction).

177 *Submission* 66, p.2 (ANF - Vic Branch).

178 *Committee Hansard* 28.4.05, p.39 (Mary Ogilvy Homes Society). See also *Committee Hansard* 27.4.05, pp.9,11-12 (Melbourne Citymission).

179 *Submission* 80, p.1 (ASGM).

180 *Submission* 166, p.8 (CHA).

facilities that are part of a larger organisation and undergo Australian Council on Healthcare Standards accreditation.[181]

3.199 The Committee examined the issues of reporting by exception and the increased use of IT as possible means of reducing the burden of excessive paperwork arising out of the accreditation process.

Reporting by exception

3.200 Reporting by exception was supported by a number of organisations. Aged Care Qld noted that:

> We would certainly say that it would be helpful if more of the reporting could be done on an exception basis rather than having to tick the box every time you did something or write a comment every time, with every detail needing to be recorded.[182]

3.201 The Nurses Board of WA also indicated its support noting that 'most documentation across all areas of health is by exception. Clearly if you have the care planning processes in place and the understanding of what is normal then exception reporting is by far the better approach'.[183]

3.202 Witnesses noted, however, that the requirements of the accreditation process are a barrier to its introduction. Bennetas stated that it would take substantive change to the accreditation process for the system to be introduced.

> At the moment we have a system where, if you cannot prove that you have provided care to a resident…you would not actually pass accreditation because you have no evidence to back up what you have done.[184]

3.203 Another problem identified was that with a the high turnover of staff in many aged care facilities, especially agency staff or staff that work on a temporary or casual basis, there would need to be an effective system in place that records what tasks have and have not been performed. The Victorian Association of Health & Extended Care (VAHEC) noted that while reporting by exception could be introduced in a facility with regular staff – 'certainly staff turnover and the skills set of staff would be very important' in moving to this system.[185]

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181 *Submission* 71, p.5 (RCNA).

182 *Committee Hansard* 18.3.05, p.18 (Aged Care Qld). See also *Committee Hansard* 26.4.05, p.10 (ACSA).

183 *Committee Hansard* 23.2.05, p.18 (Nurses Board of WA). See also *Committee Hansard* 23.2.05, p.6 (Centre for Research into Aged Care Services).

184 *Committee Hansard* 27.4.05, p.4 (Benetas).

185 *Committee Hansard* 26.4.05, p.10 (VAHEC).

IT systems

3.204 The increased use of IT, including palm pilots and other systems, to reduce paperwork was also raised in evidence. Witnesses commented that such systems have the potential to free-up staff to devote more time to patient care.

> If the format of the software was very much a click-and-flick type process…it would free up time for someone to be able to provide care to residents instead of sitting down with paper based systems and writing out in longhand what they had done that day.[186]

3.205 Witnesses noted, however, that the underlying reporting systems would need to be compatible with any new IT system.

> …even if you have a system that is electronic rather than paper based, unless the systems underlining that are streamlined it is not going to make it any easier...So, while there may be some gains…there has to be some underlying work to the reporting systems.[187]

3.206 Aged Care Qld noted that there has been some resistance to utilising IT systems in the aged care sector – 'there is a fear that you might end up with a standard care plan produced by the system, not personalised enough for the person. So the system is producing a standard rather than the staff directing specific things for each resident'.[188]

3.207 Witnesses argued that the level of investment in IT would need to be substantial. ACSA noted that there has not been any explicit investment in IT by 'any of the funding levels of government', in contrast with the acute health sector where there has been substantial government investment in such systems.[189] One provider submitted that at present the return on investment in IT 'would not be there in either efficiency or productivity, so we are reliant on a document system'.[190]

3.208 DoHA is currently working with the aged care sector to develop an information management and communications technology framework that will support a planned and coordinated approach to the use of IT in the sector. The framework will incorporate outcomes from the Clinical IT in Aged Care project. This project is investigating how clinical IT applications or tools can support and improve care standards for residents in aged care homes. A series of projects are being funded to trial clinical IT tools or applications that are not currently in use in the sector to evaluate their ability to assist in the delivery of care for residents. The tools focus on point of care assistance and the increasing interrelationship between aged care and the

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186 *Committee Hansard* 27.4.05, p.4 (Benetas).

187 *Committee Hansard* 26.4.05, p.11 (Victorian Healthcare Association).

188 *Committee Hansard* 18.3.05, p.18 (Aged Care Qld).

189 *Committee Hansard* 26.4.05, p.11 (ACSA).

190 *Committee Hansard* 27.4.05, p.4 (Benetas).

broader health sector, such as GPs and pharmacists. The projects include the use of computerised medication management in aged care facilities and electronic prescribing between homes and local GP practices.

3.209 The Department is also sponsoring a series of seminars around Australia to assist providers to better understand how IT and electronic commerce, if implemented appropriately, can improve the efficiency of aged care services. DoHA is also working on a project to develop electronic channels for submission of various aged care forms from facilities to the Department. [191]

Resident Classification Scale

3.210 The second area of concern relating to excessive documentation was with the paperwork required by the Resident Classification Scale (RCS).[192] The RCS is a validation system which monitors and determines the care level classification – and thus the funding level – of residents in aged care facilities. Some submissions suggested that the documentation required of the RCS imposes greater paperwork demands on staff than accreditation paperwork requirements.[193]

3.211 The RCS is to be replaced in 2006 with a new funding Instrument – the Aged Care Funding Instrument (ACFI). DoHA stated that the new funding assessment tool will improve the funding system so services will spend less time on paperwork and more time in providing care. The Department acknowledged that:

> The existing RCS framework has become an administrative concern for aged care providers. RCS ratings that were originally intended to be drawn from existing care documentation developed by aged care homes to provide care for each resident have increasingly become a driver of care documentation rather than being a by-product of it.[194]

3.212 DoHA stated that in contrast to the RCS, the ACFI:

- focuses on those areas of care that are the best predictors of differences in the relative cost of care, so it has fewer care domains than the RCS.
- is designed to measure the need for care, *not* the care provided (as supported by documentation) when determining funding.
- supports a different model of accountability for funding. The focus of the ACFI will be on the resident and on assessments of care need required by the ACFI rather than being based on the care plan and the on-going record of care delivery.[195]

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191 *Submission* 191, Supplementary Information, 20.6.05 (DoHA).

192 *Submissions* 201, p.22 (ANF); 179, p.6 (NSWNA).

193 *Submission* 66, p.2 (ANF - Vic Branch).

194 *Submission* 191, Supplementary Information, 20.5.05 (DoHA).

195 *Submission* 191, Supplementary Information, 29.5.05 (DoHA).

3.213 The ACFI will be tested in a national trial during 2005. The data collection of the national trial will be conducted during July and October 2005, followed by an assessment of the results. Data collected during the trial will allow a detailed analysis of the documentation burden of ACFI on assessors and aged care home staff.

3.214 The Committee welcomes the development of the ACFI, especially in its aim to reduce the paperwork burden on staff in aged care facilities, and looks forward to a successful outcome of the trial into the Instrument.

Conclusion

3.215 The Committee received evidence indicating that the administrative and paperwork demands in connection with accreditation and the RCS pose a considerable burden on providers and staff. Time spent complying with excessive paperwork was significantly affecting the time spent by staff in providing care. The Committee believes that the Agency should review its documentation requirements in relation to accreditation with a view to streamlining the paperwork requirements where possible without compromising the accountability requirements of providers. The Committee notes that the RCS is to be replaced in 2006 with a new funding Instrument with one of the aims of the new system being a reduction in paperwork for aged care services. The Committee supports this initiative.

3.216 The Committee also considers that the Agency should examine other possible options of reducing paperwork including reporting by exception. The Committee notes the current initiatives that the Department is undertaking in relation to the promotion of IT in the aged care sector and believes that such initiatives should be implemented as a matter of priority as another means of streamlining operations and reducing the paperwork burden on services and staff.

Recommendation 20

3.217 That the Agency, in consultation with industry stakeholders and consumers, review the information required to be provided in the document *Application for Accreditation* and consider the feasibility of other options such as reporting by exception, with a view to reducing superfluous and time consuming reporting.

Recommendation 21

3.218 The Committee welcomes the Commonwealth's initiatives in promoting IT in the aged care sector and recommends that the implementation of these initiatives, as well as increasing the take-up rate, should be a matter of priority.