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3 August 2017

Senator Rachel Siewert
Chair
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600
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Dear Senator Siewert

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

The Aged Care Guild ('the Guild') welcomes this opportunity to contribute to the Senate Community Affairs References Committee Inquiry ('the Inquiry') and comment on the assessment and accreditation framework and regulatory activities applying to the residential aged care sector.[1]

Aged Care Guild

The Guild is an association of nine of the largest private residential aged care providers in the sector, including three publicly listed companies*:

- Allity Aged Care
- Arcare Aged Care
- BlueCross Community and Residential Services
- Bupa Aged Care
- Estia Health*
- Japara Healthcare*
- McKenzie Aged Care Group
- Opal Aged Care
- Regis Healthcare*.

The Guild works collaboratively with government and other stakeholders to communicate the concerns and requirements of the sector, to ensure that it operates effectively, grows sustainably, and best caters for and meets the needs of Australia's ageing population.

Together, our members provide care for around 37,000 residents (circa. 20% of the sector) and employ over 48,000 staff across 418 facilities Australia wide. With a further 27 facilities currently under construction, and 18 refurbishments/extensions in progress, our members are ideally positioned, and actively seeking to drive, the sectors required expansion. Into the future, Guild providers will provide care for an increasing number and proportion of Australians in residential aged care; an undertaking and responsibility that is underpinned by a commitment to continuous improvements in quality and care standards.

Examination of failings in residential care

The Guild fully appreciates that publicly reported care failings at Oakden have affected perceptions of Commonwealth oversight and the quality of care provided by the sector. At the outset, it should be acknowledged that the Oakden Older Persons Mental Health Service was established as a specialist mental health facility and so is not reflective of the care provided by the wider sector. The residents, staffing,

[1] Parliament of Australia, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised*, <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality>, accessed 17 July 2017.

relationship with the South Australian government and specific care provided are fundamentally different to the wider sector.

However, a critique of the effectiveness of regulatory activities is very much warranted and, if aspects of the system are considered inadequate, evidence-based adjustments should be made in the interests of residents and consumers. The Guild considers it important that clear failings (of regulatory oversight and within facilities) are acknowledged, better understood, and responded to appropriately, through this Inquiry and the concurrent Independent Review ('the Review').[2] However, it is also important that resident and consumer confidence, and public perceptions of the sector, are not informed by rare instances of quality failure alone. Failings reported at Oakden, in the media, and those that will be detailed and submitted to this Inquiry should not define the sector as a whole.

In addition to the regulatory framework, Guild members have their own internal standards and quality assurance processes to ensure the delivery of high quality care. The Guild is concerned that without an objective review and consideration, a misinformed perception of the sector will perpetuate, which is not in the interest of residents, consumers or the sector. For these reasons the Guild welcomes this Inquiry and looks forward to contributing in any way required.

a. *The effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised* [3]

Broadly, the Guild considers the individual regulatory activities and processes of government agencies to be robust and meet their intended purpose. The Guild believes that the regulatory framework, when applied appropriately, provides a very comprehensive protection and assurance that residents in aged care facilities are receiving a high level of care. In providing a publicly funded care service, it is important that providers demonstrate that they are delivering high quality care, that residents and consumers can have confidence in. The Guild considers that the likelihood of consumers receiving high quality care is increased because of regulatory activities, which provide a high level of protection and surety to residents and consumers.

Accreditation is about providing a reliable view of quality in the context of the accreditation standards; it is the fit for purpose nature of the Standards and quality of the auditing that provides the view.[4] Regulatory oversight is designed to ensure that providers are best prepared to deliver quality care and identifying instances where risks may be present. Accreditation and regulatory oversight is designed to protect residents and consumers, but cannot be expected to be effective 100% of the time. No amount of regulation will be able to address and prevent errors that occur in a human services environment.

The Guild is of the view that critical incidences, when they do occur, are by no means reflective of the quality of care delivered by the broader aged care sector or of a regulatory system that is fundamentally insufficient. Critical incidents are deeply regrettable and warrant increased scrutiny by government agencies However, our experience is that critical incidents are largely isolated and reflective of poor leadership and oversight of staff adherence to care standards and existing practices and procedures.

Even so, there are several areas for improvement that Guild members have observed and suggest warrants further attention and investigation. These have been brought to the attention of the Review as well and are detailed at Attachment 1.[5]

Of these, the Guild is particularly concerned about the application of a coordinated approach by the Department of Health ('the Department'), the Australian Aged Care Quality Agency ('the Quality Agency'), and the Aged Care Complaints Commissioner ('the Commissioner') to regulatory activities and processes. Our members have observed that inconsistencies in approach and a lack of coordination sees these

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[2] Department of Health, *Review of Aged Care Quality Regulatory Processes*, <https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes>, accessed 14 July 2017.
[3] The Guild will additionally comment on broader regulatory activities in this section.
[4] Australian Aged Care Quality Agency, *Accreditation standards*, <https://www.aacqa.gov.au/providers/accreditation-standards>, accessed 1 August 2017.
[5] Aged Care Guild, *Aspects of aged care regulatory oversight requiring attention*, 24 July 2017.

regulatory agencies consider facilities and single issues with only a limited insight and perspective, resulting in jurisdictional conflicts. The Guild asks that the Inquiry too consider how these agencies might address the inconsistencies in application and coordination between regulatory agencies, and/or the utility of an Australian Aged Care Commission, as recommended by the Productivity Commission, as a means to introduce a single culture, agreed approach and more efficient outcomes.

A good regulatory framework should not only well be understood by providers but also users of the system, with clear delineations between who is responsible for policy, who is responsible for regulation and who is responsible for complaints. It is also important that a mechanism for appeals of regulatory decisions is in place. The Guild is not of the view that this exists at this time. Consideration of these aspects would increase the efficiency and effectiveness of regulatory activities and the protections and assurance provided to residents and consumers.

b. The adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms

Consumer comments and complaints are important feedback, which providers utilise to continually improve their business and the experiences of residents. Providers have very structured methods and frameworks through which they manage and monitor comments and complaints – see Enclosure 1 and Enclosure 2.[6]

Complaints should be taken seriously and used to drive improvement. Providers remain proactive in seeking out insights from residents and their families, including via formal and informal complaints, and feeding this into their systems and processes. Often, complaints arise due to ineffective communication between providers and residents, or their families, and concerns can be effectively resolved through mediation. The real issue is the extent to which they are responded to in an open, transparent and timely matter.

Complaints in and of themselves are a good thing to the extent that an issue has been identified and can be dealt with. Whilst it is not ideal that residents and their families feel the need to have complaints dealt with by an external party, the Guild acknowledges and accepts the need for an independent advisor to manage complaints that are unable to be resolved through internal processes, or where residents or their families might feel more comfortable raising these externally.

The Guild is of the view that the complaints handling processes overseen and applied by the Commissioner are very thorough and provide an effective mechanism for residents, their families and consumers, that is increasingly well utilised. The Commissioner's staff are thorough and the escalation process and use of people with clinical expertise mean that a high level of detail is ascertained and addressed. Guild providers work positively with the Commissioner when required in order to seek speedy and appropriate resolutions, however do identify some inconsistencies and issues within the Commissioner's processes and resolution times, for instance:

- Complaints that are closed off and then are reopened as complainants put forward their concern again, sometime after their initial complaint has been investigated and closed. This is an ineffective use of the Commissioner's and providers' time and should be rectified.
- Timeframes for the Commissioner's management of complaints can be extremely lengthy and communicating outcomes and advice back to providers is inconsistent.
- Guild providers have observed an increasingly combative approach with some complaints. For instance, one Guild provider has observed a tendency to issue Notices of Intention to Issue Directions as an early tool in investigations.
- It is sometimes unclear to providers what is sought as a satisfactory outcome, which contributes to some complaints being resolved with a conflicting outcome/perspective.

[6] Aged Care Guild, *Case study, Internal quality assurance at BlueCross Community and Residential Services*, 14 July 2017; Aged Care Guild, *Case study, Incident response and monitoring at Regis Healthcare*, 20 July 2017.

The Inquiry should not view rising or significant numbers of complaints as indicative of dissatisfaction with the sector. Rather, statistics will likely show increased activity by the Commissioner, which is to be expected as awareness of her role and functions becomes more widely known. Guild providers are of the view that external complaints mechanisms available to residents, their families and consumers are well known and utilised.

On the whole, the Guild considers internal and external complaints handling processes to be effective. However, there remains an unclear distinction between the areas of responsibility overseen by the Quality Agency and the Commissioner, whereby the complaints that are being taken on for investigation, and subsequent advice, suggest competing mandates with the role and function of the Quality Agency, and/or the Department. The Guild is very supportive of the role and function of the Commissioner but feels that this delineation should be made clearer.

c. Concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements

The Guild recognises that this Inquiry will receive submissions that detail concerning instances of failures by providers and unmet expectations by residents and families. The Guild reiterates that critical incidences, when they do occur, are by no means reflective of the quality of care delivered by the broader aged care sector or of a regulatory system that is fundamentally insufficient. Our members' experience is that such instances are largely isolated and reflective of poor leadership and oversight of staff adherence to care standards and existing practices and procedures. They are exceptional events and infrequent, noting that over 192,000 Australians are in receipt of residential aged care at any one time.[7]

The Guild does not see an answer to these issues through the introduction of additional or unnecessary red tape, which would divert staff attention towards further administrative work, away from the delivery of care and services to residents. The Guild feels that the regulatory and compliance framework is sufficiently rigorous and involved as is, though improvements should be considered, regarding how regulatory activities and oversight are coordinated and informed at a macro level.

The Guild acknowledges that concerns and complaints can also be reflective of the transparency of sector, and unmet or unclear expectations from residents and their families. There is merit in having providers work alongside consumers to develop a system that identifies consumer expectations, which are proactively monitored, with performance against expectation. Additionally, Enclosure 2 provides details of a typical providers' communication with families.[8] The Guild asks that the Inquiry consider the following measures to address consumer expectations around responses and feedback from providers:

- Peak provider bodies meet with key consumers to understand expectations.
- Providers invest more effort in upfront expectation agreements (e.g. advanced care directives).
- Providers conduct customer satisfaction surveys that they can act upon.
- Providers implement transparent customer feedback escalation process.
- Provider peaks set an expectation for providers to meet and a zero tolerance for poor behaviour.

Guild members deeply regret the failures of care that are being reported in the media and will be submitted to the Inquiry. Accreditation and regulatory oversight is designed to protect residents and consumers, and though it cannot be expected to be effective 100% of the time, it would be misleading to consider critical incidents as reflective of the quality of care provided by the broader aged care sector or of a regulatory

[7] Aged Care Financing Authority, *Fourth report on the funding and financing of the Aged Care Sector*, <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2016/acfa_annual_report_on_funding_and_financing_of_the_aged_care_industry_2016.pdf>, accessed 25 July 2017, p12.
[8] Aged Care Guild, *Case Study, Incident Response and Monitoring at Regis Healthcare*, 21 July 2017.

system that is fundamentally insufficient. The Guild acknowledges that there is scope for more open communication with residents and their families and looks forward to constructive opportunities to do so.

d. *The adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden*

It would not be appropriate for the Guild to comment on specific medication handling practices and drug administration methods pertaining to Oakden.

e. *The adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents*

The Guild considers that the processes and practices in place to monitor and report on adverse incidents (both internally – typically employed by providers and as assessed by the Quality Agency – and externally, delivered to regulatory bodies) to be suitable, along with the existing arrangements for mandatory reporting. The Guild notes that increased transparency and information would provide an additional and important assurance to consumers, if presented in an appropriate format.

Enclosure 1 provides an example of the internal quality assurance (including the collection and evaluation of clinical data) practiced by residential aged care providers.[9] This is representative of the proactive approach that residential aged care providers apply as a fundamental component of day-to-day business and of the systems and processes that providers are expected to have in place. Enclosure 2 expands on this, detailing how providers typically monitor, respond to and report on adverse incidents.[10]

The collection of data on a range of incidents contributes to internal quality assurance and improvements to practices (including injury prevention), as detailed in the two case studies. Many of these incidents are reportable to regulatory agencies as well, which is again audited by the Quality Agency. It is important to note that while this specific information is collected and utilised internally, and reported to regulatory agencies, it will be of little utility when considered in isolation by consumers or other stakeholders.

However, the Guild recognises that there is a lack of transparency and information available to consumers about quality in aged care, which was noted and reported on to the Review.[11] This Inquiry too might consider how information about quality assurance might be introduced to provide an increased understanding and transparency concerning the delivery of high quality care. This would need to be meaningful and account for the inherent difficulties of considering clinical indictors in isolation and without contextual information. The information available via the Care Quality Commission (United Kingdom) is an example of what could be presented in this regard.[12]

The Guild considers that the monitoring and reporting mechanisms, supply of mandatory reporting data to regulatory bodies and other internal processes and practices to be suitable, contribute to good governance and clinical oversight within facilities and to regulatory agencies' oversight of providers. Any extension to these arrangements would need to be evidence-based and demonstrate a direct application to improving care standards and regulatory oversight.

The Inquiry will likely consider the Australian Law Reform Commission (ALRC) Report *Elder Abuse – A National Legal Response*, which considers Commonwealth laws and legal frameworks and how they might better protect older persons from misuse or abuse, and safeguard their autonomy.[13] The Report makes 43 recommendations for law reform, addressing the legal aspects of elder abuse. Some of these recommendations address monitoring and reporting of adverse incidents:

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[9] Aged Care Guild, *Case Study, Internal Quality Assurance at BlueCross Community and Residential Services*, 14 July 2017.
[10] Aged Care Guild, *Case Study, Incident Response and Monitoring at Regis Healthcare*, 21 July 2017.
[11] Aged Care Guild, *Review of Aged Care Quality Regulatory Processes*, 24 July 2017, p6.
[12] Care Quality Commission, <http://www.cqc.org.uk/>, accessed 13 July 2017.
[13] Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, <https://www.alrc.gov.au/publications/elder-abuse-report>, accessed 26 July 2017.

Serious Incident Response Scheme[14]

The Guild is supportive of the intent of this recommendation, but notes that these practices are largely followed by providers as a matter of best practice, as per Enclosure 2.[15] However, there is no evidence that a new Scheme would improve safety or quality. Instead, it would likely create a significant administrative burden, thereby directing time and resources away from caregiving duties. Any amendments to existing arrangements should be evidence-based and not introduce more compliance with no clear evidence or affect.

The Guild is not of the view that the monitoring and reporting arrangements concerning serious incidents necessitate the Scheme suggested by the ALRC. The Guild also questions the efficacy of another level of senior bureaucracy when oversight is already provided by existing structures and would likely exacerbate concerns regarding a more coordinated approach by regulatory agencies.

Oversight of providers' investigations by the Aged Care Complaints Commissioner[16]

The Guild is strongly opposed to this recommendation, which would unnecessarily introduce another level of red tape. The Commissioner's role is to investigate and manage complaints, not provide regulatory oversight. This would likely introduce significantly more administrative work and detract clinical staff from caregiving duties. Providers should have appropriate systems in place to investigate adverse incidents, which is assessed by the Quality Agency. This recommendation would again contribute to an already unclear division of responsibility between the Commissioner and Quality Agency.

Regulation around restrictive practices[17]

The Guild supports this recommendation in principle but again questions the need for another level of senior bureaucracy when this can be supported by existing structures.

In summary, the Guild considers the existing arrangements to be effective. The ALRC report offers suggestions that might extend reporting and oversight of monitoring, which the Guild largely considers unnecessary for the reasons detailed above.

f. The division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents

The Guild considers that responsibility and accountability for reporting and acting on adverse incidents is well supported by the existing regulatory framework, noting earlier suggestions that a coordinated approach would improve this. Additionally, providers have internal structures in place, which are modelled on existing regulatory requirements and the expectations of the Department and Quality Agency.

Enclosure 2 provides an example of how providers (and staff) typically report, act on and monitor adverse incidents, detailing the division of responsibility and accountability between staff and aged care providers, whose quality assurance, comprehensive reporting and analysis, communication with families, and internal review processes complement external requirements.[18]

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[14] The ALRC proposes a new serious incident response scheme, to replace mandatory reporting. Under this, providers would undertake their own investigation into an alleged or suspected incident and notify a new independent oversight body of the allegation and the outcome of their investigation. The ALRC further proposes that the current timeframe for reporting alleged incidents be extended beyond the current 24 hours. Instead, providers would be required to notify the oversight body 'as soon as possible and no later than 30 days', in order to allow services to demonstrate a 'considered response to an allegation or suspicion of a serious incident.'

[15] Aged Care Guild, *Case Study, Incident Response and Monitoring at Regis Healthcare*, 21 July 2017.

[16] The ALRC proposes that the Commissioner monitor and oversee providers' investigations of, and responses to, serious incidents. The Commissioner would also be empowered to conduct investigations of such incidents, though 'its focus would be on overseeing providers' own responses to serious incidents, and building the capacity of providers in doing so.' The Commissioner could also publicly report on particular incidents or providers.

[17] The ALRC supports regulation around the use of restrictive practices in residential aged care facilities. This would be supported by a new independent 'senior practitioner' to provide 'expert leadership on and oversight of the use of restrictive practices' and for providers to record and report their use of restraints.

[18] Aged Care Guild, *Case Study, Incident Response and Monitoring at Regis Healthcare*, 21 July 2017.

As per above, the Guild does not consider the ALRC recommendations to improve on the processes currently in place or present any compelling evidence that the measures put forward would improve the quality of care delivered or oversight by regulatory agencies. Systems and processes that are employed by providers are rigorously assessed by the Quality Agency on a regular basis. Additional measures and oversight lends itself to the problems identified by the Guild, concerning unclear areas of responsibility and conflicting mandates.

The Guild is of the view that the division of responsibility and accountability for reporting and acting on adverse incidents is clear and is robustly applied by providers, as per the example in Enclosure 2.[19] The Guild is confident that, where a concern or incident is identified, staff and providers are aware of their responsibilities and accountability; the Quality Agency will critique systems and processes in place to facilitate this. The Guild also considers that the increasing awareness of consumers, and their interaction with the Commissioner, further hold providers to account. From a provider perspective, Guild members have rigorous processes in place to ensure incidents are reported and followed up on appropriately.

g. Any related matters

It is important to consider the funding pressures of the sector and how this impacts the capacity of the sector to attract and retain staff to deliver quality care to residents. A pattern of cuts and revisions to funding impacts the sectors capacity to attract the right staff and compete with the public and acute care sector:

- **2012 ACFI indexation freeze** (c.$120m across the sector in FY13).[20]
- **2013 loss of bond retentions from LLLB**.
- **2014 Budget removal of payroll tax supplement** (This measure impacts Guild members c.$103m p.a.).[21]
- **2015 MYEFO ACFI measures** ($472m over the forward estimates).
- **2016 Budget ACFI measures** ($1.2b over the forward estimates).
- **2017/18 Cost recovery by the Quality Agency** ($65.5m over 2018-2021).

The residential aged care sector is facing a very real workforce shortage, which will ultimately limit the sectors' ability to engage in compliance processes that take limited resources away from delivering care and improving quality of care. Funding and workforce challenges are important to acknowledge in this context.

The Guild submits that there is a pressing need to develop a sustainable aged care funding model. Without funding reforms, it is inevitable that the quality of aged care delivered in Australia will lessen over time, despite the effectiveness of the aged care accreditation, monitoring, review, investigation, complaints and compliance processes.

Workforce – staffing levels, Code of Conduct and screening[22]

The Guild considers the ALRC recommendation around staffing practices in residential aged care to be unnecessary and an unrepresentative perspective of staffing in residential aged care. There is no compelling evidence or literature to suggest any particular mix of clinical experience is better than another mix in residential aged care. The Guild completely disagrees with the notion of setting of 'benchmarks' or staffing ratios. As previously noted, critical incidents are nearly always due to poor leadership and oversight of staff adherence to care standards and existing practices and procedures, not a causal link to staffing levels.

[19] Ibid.
[20] Aged Care Financing Authority, Report on Funding and Financing the Aged Care Sector, July 2014.
[21] Independent Third Party Provider, *Aged Care Guild Data Collection, Analysis and Reporting*, as at June 2017.
[22] The ALRC noted that significant concerns had been raised around current staffing practices in residential care, recommending that the Department commission an independent evaluation of research on optimal staffing models and levels in aged care, which would be used as a benchmark to assess the adequacy of staffing in facilities. The ALRC supports unregistered personal aged care workers being subject to the planned National Code of Conduct for Health Care Workers and calls for a more extensive national employment screening process.

In 2011 the Productivity Commission outlined the inherent drawbacks and difficulties of mandated staffing ratios.[23] This recognised that aged care residents require access to tailored, person-centred, multidisciplinary services (including Allied health, social and cultural services) and other support. Aged care residents have different and varying needs. They live in a residential aged care environment, rather than staying for a defined period of time in hospital. It is therefore not appropriate to compare residential aged care with an acute care environment, where staffing ratios might be more appropriate. Residential aged care providers typically employ 'models of care' that are adaptive to the needs and requirements of individual residents and the evolving profile of a home to inform an appropriate and optimal staffing requirement for each home.

One example of this approach amongst the Guild members is Bupa's Model of Care; an innovative model that aims to promote better health outcomes for residents through access to medical services and choice in how and where they receive care. Person-centred care is delivered to Bupa residents through a multidisciplinary leadership team consisting of Registered Nurses (RNs) and the home's General Manager, who work together with a General Practitioner, the residents themselves and their relatives to manage their health and wellbeing. The Bupa model is designed to promote early intervention and treatment of conditions, and reduce unplanned transfers from aged care homes to the hospital.

The Guild considers that the requirement for providers to have appropriate staffing levels, and an adequate number of people with the right skills for the particular service in question, to be clear under the *Aged Care Act 1997*, assessed in line with best practice by the Quality Agency, and appropriately met through the application of tailored models of care, which would not be viable if mandated clinical staffing ratios were implemented.

Separately, the Guild acknowledges that attracting RNs to the sector is an ongoing concern. Many providers find it difficult to attract and retain RNs, particularly in rural and regional areas. It is important that all stakeholders hold discussions to agree on a way to fund the attraction of RNs, who can make good clinical decisions. The Guild also looks forward to participating in the development of a workforce strategy later this year.

The Guild supports the National Code of Conduct for Health Care Workers and agrees that a more extensive screening process would benefit the sector.

Conclusions

Thank you again for your time and consideration of the Guild's submission. Our members understand and appreciate the scrutiny that the sector is under and hope that this Inquiry shows that providers are very much engaged and proactive in their core business of delivering care. Our view is that the assessment and accreditation framework and regulatory activities applying to the residential aged care sector are largely robust and afford residents and consumers offer a high degree of protection and assurance. Despite the sectors best efforts, errors will still occur. We have made some suggestions concerning the efficacy of structures in place, which we feel would strengthen regulatory oversight further. The Guild hopes that recommendations made to government are appropriately evidence based and address core concerns.

In a more consumer-driven environment, the ultimate judges of quality are residents and consumers. Guild members, as multi-site operators, have their own internal standards, to ensure high quality care is delivered, and their reputation as care providers to safeguard, regardless of the regulatory framework. With modern social media channels, and the introduction of measures such as Consumer Experience Reports, transparency in the quality of care is becoming more assured.[24]

The Aged Care Guild would welcome the opportunity to appear before the Committee, or jointly with Aged & Community Services Australia (ACSA) and Leading Age Services Australia (LASA), at a future public hearing and respond to any further queries the Committee may have.

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[23] Productivity Commission, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, p206.
[24] Australian Aged Care Quality Agency, *Consumer Experience Reports*, <http://www.aacqa.gov.au/publications/consumer-experience-reports>, accessed 21 July 2017.

Please do not hesitate to contact me if I can provide any further clarification or to expand on the views Guild.

Kind regards

Cameron O'Reilly
Chief Executive Officer

Encl.
1. Aged Care Guild, *Case study, Internal quality assurance at BlueCross Community and Residential Services*, 14 July 2017.
2. Aged Care Guild, *Case study, Incident response and monitoring at Regis Healthcare*, 20 July 2017.

Att.
1. Aged Care Guild, *Aspects of aged care regulatory oversight requiring attention*, 24 July 2017.
2. Aged Care Guild, *Draft Aged Care Quality Standards*, 21 April 2017.
3. Aged Care Guild*, Options for assessing performance against Aged Care Quality Standards*, 21 April 2017.

ENCLOSURE 1

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14 July 2017

Case Study: Internal Quality Assurance at BlueCross Community and Residential Services

About the Case Study

This case study is intended to provide a short summary and example of the internal quality assurance (and collection and evaluation of clinical data) practiced by residential aged care providers. This is representative of the proactive approach that residential aged care providers apply as a fundamental component of day-to-day business and of the systems and processes that providers are expected to have in place. This case study highlights the monitoring and delivery of high quality clinical care provided by BlueCross Community and Residential Services ('BlueCross').

BlueCross Community and Residential Services

BlueCross is a large privately owned provider of residential and home care services in the Melbourne metropolitan area and its surrounds. BlueCross operates 23 residential aged care facilities (catering for permanent, dementia and respite care) and provides a range of home care services (domestic assistance, personal care, nursing services and case management). BlueCross is one of nine Aged Care Guild members.

Consolidated Register of Reportable Events

In accordance with legislative guidelines, and as best practice, BlueCross maintains an internal Consolidated Register of key/salient reportable events. Data from this is supplied to the relevant regulatory agencies and police (as a mandated requirement), whilst trends are analysed internally, as per detailed below.

1. **Elder abuse incidents – physical and sexual** These are generally aggressive incidents perpetrated by one resident towards another. While many of these are not mandated as reportable to the Department of Health ('the Department'), they are analysed to identify trends, provide an internal benchmark and contribute to internal targets and management of violence in the workplace.

2. **Missing resident incidents** These are reportable to the Department if Police are involved. However, BlueCross additionally report any such incident where a member of the general public is involved in either assisting in locating a missing resident, or assisting them to return to a residence.

3. **Cases referred to the Coroner** This data is collated analysed to develop and/or modify internal policies, practices and training.

4. **Significant falls** Any fall that results in a resident being admitted to hospital is reported and additionally logged in the Consolidated Register, to enable BlueCross to track where significant falls are occurring and consider organisational responses to these.

5. **Significant Medication Incidents** Medication errors are also reported and logged, as per above.

Other indicators

Additionally, the following indicators are also collected and reviewed:

1. **Skin tears** A mandatory incident report is completed for all skin tears, regardless of severity.

2. **Pressure injuries** A mandatory incident report is completed for all pressure injuries, regardless of severity. This is also added to the Consolidated Register, to identify trends at individual residences and develop organisational responses.

3. **Falls** A mandatory incident report is completed for all falls, regardless of severity, and is extended to include people 'rolling' out of bed or slipping to the floor from beds/chairs.

4. **Infections** A mandatory incident report is completed for all infections, including UTIs, chest infections, gastro, eye infections, wound infections etc.

5. **Medication incidents** A mandatory incident report is completed for a wide variety of medication incidents.

6. **Weights** All residents are weighed at a minimum monthly.

7. **Restraint** BlueCross does not specifically keep statistics on physical restraint, as they largely have a 'no restraint' policy and do not use restraint to physically control residents. When absolutely necessary, data on the rare application of restraint can be obtained through AutumnCare – BlueCross' Care Management System.

Monitoring and quality assurance

As part of BlueCross' Clinical Care Policy and practice, the above indicators, 1-6, are expected to be analysed monthly by the Clinical Care Coordinator at each residence. Coordinators determine trends by individual and/or residence and collectively determine what action needs to be taken.

The reporting of trends at each site is completed monthly at a Person Centred Care Meeting (where a large brains trust meets and discusses a broad range of individual complex care needs of specific residents sand the trends emerging from incident analysis) and at staff meetings to ensure the organisation is using data to drive improvement in care.

BlueCross Scorecard

BlueCross utilise a Scorecard, which combines many of the key quality indicators already collected, along with a number of new indicators, into one collated document. This enables the organisation to 'drill down' by individual residence, program, directorate or across the entire organisation, to monitor key data and develop remedial actions to address any results that fall outside expected parameters. The aim of the Scorecard is to raise awareness of the quality indicators and what they mean, raise expectations of quality outcomes (being a strong determinant of customer satisfaction, quality of care and organisational success), and to build capacity within individuals, teams and the wider organisation to implement strategies to address outlier results. This information is entirely transparent, with the results being visible to all BlueCross employees.

Comments, Concerns and Compliments

A BlueCross Quality and Risk Advisor is responsible for gathering data from an organisational wide Quality Register and provides senior management with quarterly updates on the number, severity and type of comments and concerns that have arisen across each residence, region and the organisation. BlueCross uses this information to inform management about collective issues that require an organisational response to address.

BlueCross also maintains a register for all complaints that are made directly to its corporate office or escalate to the Aged Care Complaints Commissioner ('the Complaints Commissioner'). This register is currently managed by the Executive General Manger – Operations. All complaints that escalate to the Complaints Commissioner are managed by this delegate. Evaluation of this data assists BlueCross in identifying trends or individual residences that appear over-represented in the area and implement strategies to address. More often than not, these complaints are due to communication.

Summary

BlueCross believes that a strong quality focus and framework provides the structure upon which quality of care can be assured. BlueCross has consistently invested in the ways through which quality is embedded in its activities, particularly in the area of Clinical Care. BlueCross' systems and processes are frequently commended by external Quality Surveyors. The strength of BlueCross' systems and the consistency with which they are applied has supported it to achieve an unblemished record for both re-accreditation and support contact visits.

ENCLOSURE 2

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21 July 2017

Case Study: Incident Response and Monitoring at Regis Healthcare

About the Case Study

This case study is intended to provide a short summary and example of how Regis Healthcare ('Regis') reports, acts on and monitors adverse incidents in residential aged care. This is with a view to inform the Committee about the division of responsibility and accountability between staff and aged care providers, whose quality assurance, detailed reporting and analysis, communication with families, and internal review processes complement external requirements.

Incident response and monitoring within Regis ensures accountability and contributes to a high quality of care and continual improvement of internal processes and procedures, which is further assessed and critiqued by the Australian Aged Care Quality Agency regularly.

Regis Healthcare

Regis is a publicly listed company and one of Australia's largest residential aged care providers. Regis operates 54 residential aged care facilities, offers a range of in-home care services and operates 7 retirement and independent living villages, which are co-located with its aged care facilities. Regis is one of nine Aged Care Guild members.

Incident Severity and Distribution Matrix

Regis employs a rigorous incident severity and distribution matrix (ISDM) that clearly articulates responsibility for the reporting of all incidents. Depending on the severity of an incident, the path of distribution requires certain key individuals to be advised. The higher the level of severity (1, 2, 3 and 4 – with 1 the highest) indicates the higher the risk, the potential for an adverse outcome, and the communication line that must be followed, including the business unit delegates that must be informed.

This ensures that there is a consistently well regulated approach to the reporting of adverse events, that the appropriate emergency response is activated and that information from an adverse event flows into incident databases that are tracked, analysed and trended, to initiate improvements or change business processes.

Classification of Incidents

All Level 1 and 2 incidents must be reported during the shift in which the incident occurred. Regis classifies these incidents as Level 1 (most severe) or Level 2 (severe).

Level 1 and 2 incidents

- Death from significant or life debilitating injury.
- Significant disruption that impacts on the delivery of care and services to residents.
- Deaths that meet the reporting requirements under the relevant state Coroners legislation.
- Infectious outbreaks (e.g. gastro/influenza etc.).
- Sexual or physical assault of a resident.
- Unexplained absence of a resident, with/or without police involvement.
- The death of one or more residents (as a result of any of the above).
- Other notifiable infections that are not an outbreak, e.g. shingles – as per State Health regulations.

Other incidents that are considered serious, and may or may not be reported to an external regulator (depending on the legislative requirements in each State), are:

Level 3 incidents

- Injury to a resident requiring hospitalisation/medical attention.
- Injury to a resident that involves equipment or consumables.

- S8 drug errors (NB there are different external reporting requirements in each State).
- Medications given to the wrong resident.
- Severe behaviour event impact on CR and staff safety.

The above incidents are considered Level 3 (serious) and are reportable during the shift in which they occurred (Monday to Friday) or before 10am on the next week day (if Saturday/Sunday). Other categories less severe are dealt with at site level and are not distributed outside the facility. They are, however, analysed and trended (see below).

Incident Response

Site Management has a responsibility to communicate to families and significant others and to advise of actions to be taken and preventative measures put in place. Within each facility, clinical and management teams are accountable to ensure that all incidents are reported and followed up appropriately. The site or business unit is instructed to report and therefore accountable for reporting. Confirmation of reporting is required and tracked via various data collection processes.

Specialist Teams within Regis, with portfolios of specific responsibility, are required to follow up on all Level 1 to Level 3 incidents, within 24 hours of becoming aware of the incident – a judgement concerning severity may indicate immediate follow up on receipt of advice of an incident. Specialist Teams (which include Clinical Support Specialists and Compliance Managers) are responsible for ensuring incident management processes are followed. These teams have remote visibility via an electronic care management system.

The **Compliance Unit** is responsible for ensuring all serious incidents are reported to the appropriate and relevant authority, as applicable.

Communicating to family

1. The following information is provided to family as soon as practicable: a) exactly what happened, b) when it happened, c) what may have precipitated the incident, d) what actions have been taken to remedy if appropriate, e). where is their loved one, f) offering counselling to family, and g) has their treating medical officer been informed.
2. Concerns regarding the care and services about adverse incidents are treated using the same internal complaints management system used for any concern or complaint. Regis believes that communication (open and transparent dialogue by the site teams) is key, as is demonstrating genuine empathy and understanding of the concerns they may have.
3. Being pragmatic also helps and communicating the legislative requirements that we have to comply with, which in some circumstances is enough to quell any negative perception the family may have.
4. Families are provided with information through various forums, meetings, newsletters, poster displays, via care consultation and via direct contact with management.

Reporting and Analysis

The reporting of incidents to regulatory authorities, when embedded in legislation to do so, is undertaken as a matter of course. Issues arise when. The Aged Care Complaints Commissioner may become involved when families become distressed regarding an incident or where communication has not been as rigorous as it could be, which can prolong the resolution of an issue of concern.

Families and or legal representatives of the resident must be notified immediately of any adverse incident that has occurred with their loved one. Delays in notifying these contacts is considered unacceptable therefore immediate contact and subsequent post incident follow up is required.

By comparison to the total number of incidents occurring in Regis facilities nationally the number of incidents (severe or very severe) complaints that have escalated to senior management (off site) or to the external regulators is negligible. This is because the reporting of adverse incidents is not only driven by legislation in most cases but is also driven by an internal policy that in most cases exceeds the requirements under the legislation.

Regis' Legal and Compliance Team meet on a regular basis to review adverse events and issues of concern. Regis utilises a data collection and analysis system for the trending and analysis of incidents both minor and adverse. These are trended locally, by state, nationally and recommendations or otherwise for improvement are communicated. Regis is in the process of setting up a 'Sentinel Committee', which will review adverse incidents involving residents only and provide strategies and learning to hopefully reduce the potential for adverse outcomes as a result of a similar significant event.

All staff in Regis are required to take responsibility and are accountable for reporting incidents, regardless of severity to their next in line manager. Managers are accountable for the escalation of incidents and ensure that appropriate actions are taken to mitigate or eliminate further risk. Ultimately, it is the responsibility of the senior management team and the executive to ensure that there are appropriate systems and processes in place for the management of adverse events.

Follow-up Actions/Investigations

Regis facilities are expected to function in an environment of Continuous Quality Improvement and demonstrate that all clinical indicators are trended analysed and inform CI. The specialist teams as previously referred to play very separate but important roles in the management and oversight of adverse events. Clinical governance and risk management are the key elements shared by both teams. Due to the compliance nature of Level 1 and 2 incidents, i.e. a requirement to not only meet Regis Policy and Process but also the applicable legislative obligations and timeframes, the Compliance Unit must be part of the decision making and reporting processes. All incidents must be followed up within 24hours depending, on the level of severity. Reporting to an external regulator is approved at a very senior level and authority can only be delegated by the CEO or the General Manger (Quality and Compliance).

Adverse incidents that do not result in death or catastrophic injury are followed up by Clinical Specialists to ensure that appropriate measures have been implemented and cares have been reviewed in line with change in needs.

The Compliance Unit follows up on incidents that in many cases involves notification to an external regulator. The Unit will assist with the investigation of the complaint/adverse event, review the resident's history, liaise with the regulator if improvement actions are required and provide information if and as required or requested.

Both teams are responsible for putting in place education and training programs for staff, conducted annually.

Summary

This is representative of a detailed and effective approach to reporting and acting on adverse incidents. Providers have a responsibility and accountability to residents, consumers and government to ensure that effective systems and processes are in place to report and act on adverse incidents when they occur.

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24 July 2017

Aspects of aged care regulatory oversight requiring attention

There are several areas for improvement that Guild members have observed and suggest warrants the attention of the Review and Inquiry, and would ultimately benefit residents and consumers, namely:

- Accreditation
- Single Aged Care Quality Framework
- Application of sanctions
- Assessor behaviours
- Unclear areas of responsibility
- Coordinated approach.

Accreditation
The Guild considers the processes and systems in place to accredit residential aged care facilities to be mostly effective.

Single Aged Care Quality Framework
The Guild submits that the assessment and accreditation framework would be strengthened further through implementation of the proposed Single Aged Care Quality Framework, with appropriate amendments made.[1] Guild submissions to this consultation are at Attachment 2 and Attachment 3.[2] The Guild endorses a risk-based approach to compliance activities in this regard and hopes that consultation on this work progresses as planned. The Review and Inquiry might consider whether the Standards contribute to protecting the health and well-being of residents and provide a reasonable view of quality in the home.

Application of sanctions
The Guild considers the use of sanctions as a penalty for extreme cases to be appropriate, if consistently and fairly applied, but notes the importance of a proportionate response by regulators.

Some Guild members have suggested that the Quality Agency might look to work more closely with providers, if requested, to improve processes and procedures, which would complement the application of sanctions – a more collaborative approach, instead of a response to a sanction. A focus on outcomes, and less on systems in place, would be appropriate in this sense. This would enable a facility to focus on implementing and sustaining relevant improvement actions to resolve an issue and would enable the Quality Agency to see first-hand how the situation had been rectified.

Assessor behaviours
The Guild considers the wide variation in approaches to, and application of, the Standards and how homes are assessed and monitored as evidence of an inconsistent approach and variation of the skills set and interpretation of the Standards. Despite the assurances of the Quality Agency, this is a common experience of Guild providers and facilities. Ultimately, this will see different approaches and interpretation of the Standards applied in different geographic regions.

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[1] Department of Health, *Single Aged Care Quality Framework – Draft Aged Care Quality Standards*, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft-standards/>, accessed 12 July 2017; Department of Health, *Single Aged Care Quality Framework – Options for assessing performance against aged care quality standards*, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-assessing-performance/>, accessed 21 July 2017.
[2] Aged Care Guild, *Draft Aged Care Quality Standards*, 21 April 2017; Aged Care Guild, *Options for assessing performance against Aged Care Quality Standards*, 21 April 2017.

Unclear areas of responsibility

Some Guild members have observed that there is an unclear distinction between the areas of responsibility overseen by the Quality Agency and the Complaints Commissioner whereby the complaints that are being taken on for investigation, and subsequent advice, suggest competing mandates with the role and function of the Quality Agency, and/or the Department. The Guild is very supportive of the role and function of the Complaints Commissioner but feels that this delineation should be made clearer.

Coordinated approach

Although the Guild considers existing assessment and accreditation activities to be effective at uncovering faults and possible risks in the delivery of care, our fundamental concern is that a more informed, coordinated and smart approach would strengthen these efforts. The efficacy of a coordinated approach to regulatory activities is questioned by the Guild and in our view lacking. Our members have observed that inconsistencies and a lack of coordination by the Department of Health, the Australian Aged Care Quality Agency, and the Aged Care Complaints Commissioner sees these regulatory agencies consider facilities and single issues with only a limited insight and perspective, resulting in conflicts of interest and jurisdiction.

It should be recognised that these regulatory agencies will approach issues with only a partial perspective and seek different outcomes from their engagement with a provider or facility. This concern was identified by the 2011 Productivity Commission Report *Caring for Older Australians*, which identified the following:

> ***New regulatory arrangements are needed***
>
> *Current problem*
>
> - *Governance arrangements in aged care do not clearly separate policy, regulation and appeals, which create inherent conflicts of interest within DoHA.*
> - *A number of regulatory functions are undertaken by multiple jurisdictions, agencies and departments. This duplication creates confusion for providers, adds to regulatory costs incurred by the industry and can compromise the quality of care.*
>
> *Proposed reform*
>
> - *Establish a new regulatory agency — the Australian Aged Care Commission — with statutory offices and Commissioners for Care Quality and for Complaints and Reviews.*
>
> *Main benefits of change*
>
> - *Removes potential conflicts of interests, ensures greater independence of regulatory roles and, thus, establishes a more effective regulatory governance structure.* [3]

Arguably, these concerns have not been addressed and still exist within the regulatory system. The Guild asks that the Inquiry consider how these agencies might address the inconsistencies in application and coordination between regulatory agencies, and/or the utility of an Australian Aged Care Commission, as articulated by the Productivity Commission, as a means to introduce a single culture approach and more efficient outcomes.

[3] Productivity Commission, Summary of Proposals, *Caring for Older Australians, Productivity Commission Inquiry Report*, <http://www.pc.gov.au/inquiries/completed/aged-care/report/aged-care-summary-proposals.pdf>, accessed 13 July 2017, p8.

ATTACHMENT 2

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21 April 2017

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Draft Aged Care Quality Standards

The Aged Care Guild ('the Guild') welcomes this opportunity to comment on the draft aged care quality standards. The Guild is broadly supportive of the development of a single set of aged care quality standards that can be applied across all care types and settings. However, the assessment of performance against the standard should be cognisant of the setting in which the service is delivered.

The other underlying concepts are that each standard must be able to demonstrate how it will contribute to the objective of the set of standards and be assessable. The purpose of having a set of standards is not clear from the consultation paper. Notwithstanding, the Guild has taken the approach that the standards exist to contribute to protecting the health, safety, wellbeing and rights of care recipients and to promote quality improvement.

A single set of standards will introduce efficiencies to the Australian Aged Care Quality Agency's ('the Quality Agency') accreditation and quality review activities. Providers will be better placed to utilise existing resources for the delivery of care and will benefit from a reduction in duplicated education and administration efforts. A single set of standards will also introduce increased scrutiny to the Home Care sub-sector, which is warranted, and support the changing nature and increasingly diversified offerings of providers. It is appropriate that shared assessment processes are applied to these standards as well.

The Guild is in agreement with the overall structure of the draft quality standards, but has identified areas where further clarification is required and amendments would be appropriate for a more effective design and smoother adoption. The Guild asks that the Department consider the following aspects when refining and introducing the single set of standards:

- Guidance material and/or specific evidence requirements will assist providers to understand and have confidence in the Quality Agency's intended assessment of the draft standards and the Guild welcomes the Quality Agency's intent to do so. It is difficult to consider how the draft standards will be assessed when considering them in isolation. Ultimately the Guild is supportive of the draft standards but has identified areas where assessment is likely to be open to some interpretation, certainly at this stage, without further clarification. The Guild suggests that in relation to residential care, the Results and Process Guide will require immediate update.

- The notion of 'reflect[ing] the future needs or ambitions of the consumer' is vague and needs to be explored and articulated further.

- A key theme throughout the draft standards is maximising choice and autonomy for care recipients. There needs to be further thought and clarity provided as to how this translates for the high percentage of care recipients who no longer have legal capacity or for those with representatives who have assumed the role of key decision-maker. There needs to be a recognition of the integrity and invariability of the dignity and right of every person to make choices and a clear mandate for providers to determine and support those choices wherever possible and in the best interests of the care recipient and those other residents in a home.

- The Department should consider that if the standards are overly prescriptive in terms of what is to be delivered, rather than a general statement which reflects the requirement for a process, structure or outcome, they may limit the innovative approaches and models of care that providers might otherwise

look to apply. It is important that consumers be afforded the opportunity to take risks. This submission highlights some areas where this risk is identified.

- This submission should be considered in tandem with Guild submission on a single risk-based approach to assessment.

1. *Consumer dignity, autonomy and choice*

Opportunity to take risks

- The Guild is supportive of the concept of 'dignity of risk' and comfortable supporting residents to make their own choices about care and services. Our members deal daily with people and have a duty of care for their health and wellbeing, so there must be standards to ensure their safety. The Department must find the balance between dignity of risk and duty of care. The Guild does understand that duty of care does not exist to create restrictions for people.

- The Guild queries how 'the nature of any risks to the consumer or others' will ultimately be interpreted and assessed. Some clarification or expansion on this point is necessary to fully understand and support the application of this standard. The Guild is also of the understanding that the definition of 'others', in this sense, extends to include the provider administering care.

- 'How risk can be managed to assist consumers to live in the way they choose' also warrants further explanation and advice on how this will be assessed. The standards need to not articulate a view that the provider has no duty of care to a resident and in all cases resident choice prevails. Similar to freedom of speech laws, freedom to choose has limits. It is important here to distinguish between the choices/autonomy of the care recipient and the choices of their representatives, particularly the day-to-day decisions that even the most vulnerable care recipient is able to express (such as when to wake, sleep, shower, how they would like to spend their time etc.).

2. *Ongoing assessment and planning with consumers*

Partnering with the consumer

- It is important to note that the term 'consumer' is used throughout the draft standards. Consideration should be given to residents vs. their representatives/those with or without power of attorney when considering privacy and decision making on behalf of residents. The definition of consumer might encompass any of these persons. This is particularly pertinent when considering a 'partnered' approach with residents that have dementia. How providers are to be measured against this standard is not yet clear.

- The Guild considers that adherence to this standard should be based on whether or not the provider can demonstrate to the Agency that the resident, and representative if appropriate, were engaged in the ongoing assessment and planning of that person's care and services. This duty was outlined in the Australian Human Rights Commission's Human Rights-Based Approach for Ageing and Health, which recommends assisted and supported decision-making rather than substitute decision-making.

> *In the situation where there is a cognitive impairment such as dementia, Article 12 of the Convention on the Rights of Persons with Disabilities emphasises that a person's decision-making capacity may not be taken away simply by reason of their disability. The Convention requires an approach that moves away from a paternalistic view of an older person with a disability, to an approach that centres on respecting the will and choices of a person and ensuring that they are supported in decision-making.* [Australian Human Rights Commission, *Respect and Choice: A human rights approach for ageing and health*, 2012, p17]

- The Guild notes the inclusion of '[focussing] on optimising health and wellbeing', which might be interpreted to infer a focus on rehabilitation and reablement. The Guild is supportive of this aim, though notes that alignment with the funding instrument – so as to incentivise such clinical outcomes – is necessary.

3. Delivering personal care and clinical care

- The Guild is of the view that aspects of this standard are overly prescriptive and will give effect to guiding clinical care, which is not appropriate. Aged care homes partner with their medical colleagues to deliver care. The standards should not dictate how they carry out their work. The standards should require particular processes to be in place but not articulate the detail of the process, e.g. it is acceptable for a standard to say that there must be a care planning process that reflects the needs, choices and expectations of the consumer, which is as far as it needs to go.

- '3.2 Clinical care is best practice…' The Guild agrees with this notion but queries how this will be assessed without further guidance or advice. This approach is not practically assessable as clinical best practice changes and evolves over time, and providers adapt and evolve to meet this. However, Quality Agency assessors should be aware of this and be able to identify best practice as it is applied. The Guild questions whether all assessors (or in fact all providers) will be able to apply a knowledge and understanding of best practice.

Falls
Choking

- The Guild is concerned how the opportunity to take risks sits with the assessment of these two aspects. Again, guidance material and better articulation in the standards would address how individual vs. organisational risk is expected to be reconciled and assessed.

Antimicrobial stewardship

- The Guild is concerned about the inclusion of this example in the draft standard. Antimicrobial stewardship is part of clinical care best practice. In addition to it being difficult to measure, 'stewardship' is an ambiguous term. The Guild is of the view that the prescription of antibiotics is the responsibility of general practitioners and other specialists. The example of antimicrobial stewardship does not fit well in the standards. More relevant measures are already covered in medication management (correct administration and completion of full course) and personal care/hygiene etc.

4. Delivering lifestyle services and supports

- The Guild is of the view that any assessment of this standard should be applied to what is required within specified care and standards only. As a broad principle, the Standards should not introduce concepts that do not appear in the primary legislation. The only regulatory activity over and above the minimum standards needs to be limited to a broad observation and reporting. Lifestyle services that are above and beyond what Government funds are not the subject of a 'decision' and are therefore beyond what Government is entitled to assess and evaluate.

5. Service environment

- The Guild is of the view that this standard is, in some areas, unnecessary and difficult to assess, whilst easy to observe. Consumers are often best placed to assess the physical environment for themselves.

- The Guild queries how older facilities will fare and the capacity of their broader organisations to bring them up to speed with accepted best practice and design.

6. Feedback and complaints

- The Guild queries how this standard is 'intended to be more comprehensive than existing requirements' without dictating how management of resident feedback should be sought and acted upon. The organisation 'Requirements' are comprehensive. It is essential that any further guidance is in the framework of that heading.

7. Human resources

The sufficiency of an organisation's workforce

- The Guild does not support the concept of assessing the sufficiency of its workforce. It is unclear what is meant by sufficiency. For instance, the current standards discuss the impact of staffing on residents

and is focussed more on the service that is delivered, not a judgement on appropriate staffing levels. The Guild suggests that 'sufficient' be changed to 'appropriate', which is more fitting. Hereby, providers can use their expertise to determine the number and workforce mix necessary to meet resident needs.

- The Guild considers that 7.2b should be deleted. Assessing 'attitude to effectively perform their role' is not possible without a comprehensive assessment of staff members.

8. Organisational governance

- This standard should be assessed in the context of the local environment. However, where governance is managed centrally, there will be opportunity to consider this standard once only for the group and thereby obviate the need to assess at each facility for those providers with multiple facilities.

The Guild suggests that the draft standards be assessed against the Guidelines and Principles for the Development of Health and Social Care Standards published by the International Society for Quality in Healthcare or the ISO requirements for conformance standards. This will provide some confidence in the robustness of the standards.

Thank you for your consideration of the Guild's comments on the draft aged care quality standards. Please do not hesitate to contact the Guild if we can provide any further advice or clarification.

Kind regards

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ATTACHMENT 3

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21 April 2017

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Options for Assessing Performance Against Aged Care Quality Standards

The Aged Care Guild ('the Guild') welcomes this opportunity to comment on proposed options for assessing performance against aged care quality standards. The Guild is broadly supportive of the development of a single set of aged care quality standards and so considers it important that the assessment process provides an accurate report of a home's performance against the standards.

The Guild is in favour of a single risk-based core assessment process that is applicable to all aged care settings (Option 2), with Option 3 applied to support and low risk services. The Guild's support for this approach is, however, contingent on improvements and a revised approach to assessment and monitoring, as detailed throughout this submission, which will focus on inputs to the design of its key features. The Guild did not consider Option 1 (which is essentially maintaining the status quo) to be a suitable option as, unlike Option 2, it would not accommodate future changes in service delivery.

This is an ideal juncture to revise the Australian Aged Care Quality Agency's ('the Quality Agency) approach to accreditation by defining a new risk-based approach, and how monitoring and assessment might be adapted to aid this. The Guild asks that the Department consider the following key features:

Risk profiling of providers
The Guild submits that aged care services should be profiled based on the existence of known risk creators and informed by shared organisational governance models and systems, so as to differentiate providers and inform the extent and nature of their interaction with the Quality Agency. Insomuch, the Guild suggests that risk-based assessments reference the broader organisation when profiling aged care services. The Quality Agency should consider the systems in place and performance across a wider organisation to identify inherent risks and to guide monitoring and assessment activities.

The standards include structure and process standards, that are led and managed by a wider organisation. These loosely fall into the category of governance standards. The Guild suggests that such standards be identified and, once assessed, are not reassessed at each site. For instance, the options paper lists the examples of 'sampling of individual services within an organisation' and 'reduced need to replicate assessments across services'.

Ongoing monitoring and regular assessments
The Guild believes that a triennial reaccreditation scheme and annual visits is flawed in that it promotes the notion of quality review as a once every three year event. While Guild members see quality and quality reviews as an on-going activity, experience for some reveals that intensive internal auditing in the lead up to accreditation can reveal problems. A preferable system would be to accredit the home initially and then under take monitoring through data and visits as required based on the data. There should also remain a component of unannounced visits.

The events and activities that create risk of non-compliance and quality failure are well documented. The other point to be made is that most non-compliance identified by accrediting bodies in health and aged care is not due to poor core systems but rather failure by staff to follow those systems.

Standardised approach and increased transparency
Some Guild members report that approaches to assessment and quality reviews can vary between Quality Agency assessors. The Guild acknowledges that these challenges have existed in accreditation in health and aged care for some time, however urges the Quality Agency to review the assessor training program and

internal quality assurance to minimise the opportunity for the adoption of a non-standard approach. The introduction of a standardised approach across all care services has it merits.

The Guild asks that information on trends and areas that providers should focus on, based on an analysis of current issues and identified risks, be made available. Increased transparency would see common risks communicated to providers and allow them to address areas of concern before they are identified as an issue.

Disclosing information

The current standards (indirectly) include requirements to conform or meet quality standards covered by other regulators. The Guild recommends that where a home can provide a current certificate from a competent authority, that the area covered by the certificate is not reassessed. Compliance with Food Safety Standards or other relevant compliance certificates/licences is an example.

Other considerations

The Guild asks that the Department consider the applicability of how the new single set of standards will be applied to recommencing services. The Guild is of the view that this is an opportunity to address certain instances where accreditation and/or oversight is currently unnecessary or poorly timed, chiefly accreditation for rebuild, where services are ongoing in tandem with a facilities expansion, and unannounced visits for very new facilities. Members have provided examples whereby accreditation has expired as an extension is made to an operational home, and Quality Agency staff have proceeded with an announced visit of a home with very few or no residents inside its first week of operation, respectively.

Arguably this is not required, timing should be reviewed and the deployment of resources better utilised. These visits seek to consider the suitability of the organisation/provider to deliver appropriate care and services to consumers, however delivers on an outcome that cannot be validated with little if any consumers to seek feedback from. The proposed standards continue to support the eliciting of feedback from consumers who do not exist yet. Neither the current or proposed standards cater for this occurrence.

The Department should be aware there are inherent costs that will be subsumed by providers in successfully shifting to this approach. For instance, the amalgamation of three quality management systems and training of staff. It is therefore important that any new approach to accreditation does not introduce additional costs or unnecessary red tape, which would divert resources away from delivering clinical care and be at odds with the approach that the Department is considering.

Finally, the Guild notes that the Quality Agency has undertaken to issue guidance in relation to how changes will be enacted and assessed. It will be beneficial for providers to continue to have access to the Assessors Handbook and Results and Processes Guide, as this is what the Agency has used as the driver for consistency in assessment and will likely provide more detail about exactly ‘how’ these new standards will be measured. This will be critical in enabling providers to review and update their existing quality systems.

Thank you for your consideration of the Guild’s comments on proposed options for assessing performance against aged care quality standards. Please do not hesitate to contact the Guild if we can provide any further advice or clarification.

Kind regards

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