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Audit Report No. 42, 2002–03

Managing Residential Aged Care Accreditation

Introduction

Background

2.1 The aim of the Commonwealth's aged care program is to provide "support for healthy ageing for older Australians and quality and cost-effective care for frail older people and support for their carers"[1]. The principal methods of delivering aged care are community care and residential care.

2.2 The *Aged Care Act 1997* (AC Act) provides the framework for Commonwealth aged care funding and the administration of Commonwealth-funded aged care, and for the obligations of approved providers of aged care services.

2.3 Residential aged care homes are operated by the not-for-profit and private sectors, and by local and state governments. A new accreditation-based

1 Department of Health and Ageing (Health), *Portfolio Budget Statements 2002–03, Health and Ageing Portfolio, Budget Paper No. 1.11*, p. 99.

quality assurance system for residential aged care homes was proposed in the 1996–97 Budget. The Aged Care Standards and Accreditation Agency Ltd (the Agency) is the independent, wholly owned Commonwealth company that manages the accreditation process.

2.4 The Agency works with the Department of Health and Ageing (Health) to promote quality residential aged care. Health is responsible for ensuring homes meet their other obligations under the AC Act and for taking compliance action such as sanctions.

The Audit

2.5 The Australian National Audit Office (ANAO) audit was conducted during July to September 2002. The objective was to determine whether the Agency's management of the residential aged care accreditation process was efficient and effective. It did not examine issues concerning the quality of care in residential aged care homes. However, it did examine whether the Agency was able to fulfil its statutory responsibilities.

2.6 Two rounds of accreditation had occurred since commencement of the accreditation process, pursuant to provisions of the AC Act, allowing the Agency scope to review a sample of its decisions. The audit focused on management of the accreditation process, by examining the Agency procedures that lead to accreditation decisions. The audit also included aspects of Health's role in the accreditation process.

Audit Findings

2.7 While operating under challenging circumstances, the Agency had successfully assessed all residential aged care homes by 1 January 2001, as required by the AC Act, and had implemented a process to accredit and support services.

2.8 ANAO concluded that the Agency had adequately identified its legislative responsibilities for accreditation and had implemented an adequate process to meet them. In general, its management of its people and the workflow facilitated the accreditation process.

2.9 ANAO also concluded, however, that there were some weaknesses in the Agency's management systems which impact adversely on its implementation of the accreditation process. These included shortcomings in the Agency's costing systems, information management, and quality assurance mechanisms.

2.10 ANAO made six recommendations, all of which were agreed to by the Agency. In summary, the Agency should have a robust function for determining and allocating the costs of its functions; review its accreditation management information system; implement an analysis of the accreditation system; introduce performance indicators; plan an evaluation of the accreditation system on the quality of aged care; and review its quality mechanisms.

2.11 ANAO endorsed the Agency's positive responses to the audit and noted that the Agency was putting in place systems to correct the weaknesses raised during the ANAO audit.[2]

The Committee's Review

2.12 On 18 August 2003 the Committee held a public hearing to review the progress made against ANAO's recommendations.

2.13 The public hearing was attended by the following organisations:

- Australian National Audit Office;
- Department of Health and Ageing;
- Aged Care Standards and Accreditation Agency Ltd;
- Australian Nursing Homes and Extended Care Association;
- Aged and Community Services Australia; and
- Catholic Health Australia.

2.14 The Committee took substantive evidence on the following issues:

- Difficulties completing the accreditation process;
- Assessor inconsistencies;
- Measuring the effectiveness of accreditation and quality of aged care;
- Costing methodology;
- Training of nurses; and
- Facility ownership.

2 Australian National Audit Office (ANAO), *Transcript, 18 August 2003*, p. 13.

Difficulties completing the accreditation process

2.15 The Committee noted the highly variable nature and intensity of the accreditation workload, essentially deriving from the three-year accreditation cycle. As all first round accreditations took place concurrently, reaccreditations similarly took place concurrently, but three years later. This tight cyclical pattern placed pressure on Aged Care Standards and Accreditation Agency Ltd (the Agency) to complete the bulk of its accreditation tasks, for each round, in a very short space of time. It coped by augmenting its team of full-time assessors by hiring contract assessors. Aged and Community Services Australia (ACSA), however, opined that this uneven workload was not an ideal arrangement in terms of ensuring consistency.[3]

2.16 Several witnesses including Catholic Health Australia (CHA), and Health concurred with, and elaborated on, this view.

2.17 ACSA observed that the uneven workload experienced by the Agency meant that the Agency had to take on extra staff to cope during the peak periods, making overall accreditation consistency a challenge. ACSA said that it favoured a broader accreditation arrangement whereby the Agency could be responsible for accrediting other aspects of clients' facilities in addition to aged care. In this way, ACSA reasoned, the Agency could spread its workload to ensure a more regular workflow and avoid a peak in one year and then a trough for the next two years, a situation which occurred when it only had to contend with aged care accrediting.[4]

2.18 CHA commented on the evolution of the accreditation system since its formation in October 1997. It noted that only after gazettal of the principles in September 1999 could the Agency commence audits. This imposed a time pressure situation, "not of its own making"[5], on the Agency, particularly in terms of the first round of accreditation.

2.19 Health noted, however, that accreditation audits are just one part of the Agency's work cycle.

> …continuous improvement models… is a job of work the Agency is doing continually.[6]

3 Aged and Community Services Australia (ACSA), *Transcript, 18 August 2003,* p. 2.

4 ACSA, *Transcript, 18 August 2003,* p. 2.

5 Catholic Health Australia (CHA), *Transcript, 18 August 2003,* pp. 2-3.

6 Health, *Transcript, 18 August, 2003,* p. 3.

2.20 The Agency commented on the uneven work cycle deriving from the maximum period of grant of accreditation being three years, but it believed the matter to be more of a logistical issue than anything else. "To try to smooth it out artificially would be to destroy the integrity of the whole process, I suspect".[7]

2.21 Clearly there is an uneven cycle to the actual accreditation work because almost all homes qualify concurrently for the maximum period of three years. A commencing service is entitled to a one year accreditation period only, but because of the comparatively small number involved, there is little scope for significant accreditation workload smoothing over time.

> …the accreditation visit is just one part of the whole cycle of monitoring of homes. In the other years the agency… has a very big job to do outside the accreditation visits. I think it is an issue about workload. While the income might be slightly [peaky] the workload is pretty well distributed, albeit with a necessary decision-making load in one year—but I think the workload for visits is high across the whole time.[8]

2.22 The Agency pointed out there were benefits arising from the cyclical nature of the accreditation assessments activity including that some assessors with aged care experience were added to the assessment teams and in so doing, teams achieved an efficient mix of skills.[9]

2.23 The Agency advised the Committee that the task of training assessors was well advanced.

Committee comment

2.24 The Committee notes that there is a peaking of the accreditation work load clearly due to the three-year cycle. However it feels that, on balance, any staggering of the accreditation process would not reduce the peaking significantly in early years. Artificial staggering would probably pose problems of its own (such as, how to choose the aged care homes that would be placed on a shorter term of accreditation, initially). Further, any natural smoothing by new entrants to the business would be insignificant given the very small number of new entrants as opposed to the thousands of existing homes.

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7 Aged Care Standards and Accreditation Agency Ltd (the Agency), *Transcript, 18 August 2003*, p. 3.

8 Health, *Transcript, 18 August 2003*, p. 11.

9 The Agency, *Transcript, 18 August 2003*, p. 3.

2.25 In the Committee's view, the Agency is coping with its uneven workload as well as could be expected, aided by scheduling its ongoing work in off-peak periods.

Assessor inconsistencies

2.26 The Committee expressed concern that significant variations in compliance ratings recorded by assessors on a state-by-state basis as reported by ANAO[10], may have resulted from different regulatory regimes set by different states, or involved varying judgements by different assessors, or indeed, variable performances by individual homes. Lack of consistency in accreditation standards clearly could result in, at best misleading, or at worst unjust accreditation outcome ratings.

2.27 ACSA opined that there was variability between assessors - different judgements by different people - during the first round but that that variability had been ironed out by the second round. The view put forward by the witness was that there was no robust mechanism, during the first round of accreditations, for establishing rating reliability between different teams.

> …in the first round of accreditation the consistency of assessments was a major issue for the industry. We all had access to the statistics, and peers talking to peers could not believe there was a real difference in the quality of services of this order of magnitude, so we think it did come down to variability between individual assessors;…different judgments being applied by different people, and in that round of accreditation… there was no robust mechanism for establishing inter-rater reliability between the different teams…in place at the first round.[11]

2.28 CHA described how it has observed a "sea change" in the way the Agency performed its assessments, after the media reports of the kerosene bath affair in 2000 in the Riverside Nursing Home in Melbourne, leading the witness to question the fairness of assessments prior to the affair, compared to those undertaken after its exposure. CHA said that there appeared to be a significant point of change between the way facilities visited pre February 2000 and facilities visited post February 2000 were

10 ANAO, Audit Report No. 42, 2002-2003, *Managing Residential Aged Care Accreditation*, p. 74.

11 ACSA, *Transcript, 18 August 2003,* pp. 3-4.

assessed, particularly in Victoria; there was an issue of lack of consistency.[12]

2.29 The administration and management of medication was put forward as a typical example of where variation could be expected, resulting in possible inconsistencies in accreditation. Different management styles could be expected from different nurses trained in different schools expressing differences in their professional judgments as to what is an adequate level of medication documentation.

> They may have been trained differently. One or both of them has the power to write the report, but they could quite easily make a different judgment about what is a safe practice regarding medication.[13]

2.30 The Agency advised that the ratings categories had been simplified for the second round of accreditations to two categories - compliant and non-compliant.[14] As well much had been done to improve the skills of assessors including upgrading the level of training of the assessors, and introducing an assessor handbook and a results and processes handbook.

2.31 The Agency further advised that audit methodology training, involving a standardised assessment of all quality assessors doing round two assessments, was now compulsory for all assessors. Data are collected to determine the extent of any variations between assessors, in the ways they carry out audits. Further, efforts are being put in to determine the need for, and the development of, further training for assessors.[15]

2.32 Based on anecdotal feedback, the Agency advised that clients' opinions regarding its services had been favourable, and the Agency was complimented on the professionalism of its assessors, which "in this round has far exceeded the first round".[16]

Committee comment

2.33 The Committee recognises that there is significant potential for inconsistencies in accreditation. It concludes that the problems noted

12 CHA, *Transcript, 18 August 2003*, p. 4; The Agency, 2000, *Riverside Nursing Home Review Audit Reports*, 16 and 17 February, 25 pp; 29 February and 1 March 2000, 23 pp; Minister for Aged Care, 2000, *Delegates decision on elderly residents of Riverside Nursing Home*, Media Release 6 March 2000. Following the two review audits which rated the nursing home a "serious risk" against several criteria, the home was closed.

13 ACSA, *Transcript, 18 August 2003*, p. 4.

14 The Agency, *Transcript, 18 August 2003*, p. 5.

15 The Agency, *Transcript, 18 August 2003*, p. 10.

16 CHA, *Transcript, 18 August 2003*, p. 13.

during the first round have diminished in subsequent rounds in magnitude and importance, following the adoption by the Agency of a simplified ratings system. This system has reduced the likelihood of arbitrary assessor inconsistencies. As well, the Committee is satisfied that the Agency has improved the training of assessors and has upgraded the written guidelines for assessment.

2.34 The Committee also encourages the expansion of the practice of voluntary benchmarking by the industry, as a means of adding rigour to the accreditation process.

Measuring the effectiveness of accreditation and quality of aged care

2.35 Witnesses were asked if data were available that could be analysed for incidence of quality failures in the services that aged care homes provided. The Committee was told that, generally, time series data are not routinely collected for that purpose. Notwithstanding, the Committee heard that these data could be used to determine if the services being provided were improving or getting worse but would need to be collected on a resident mix adjusted basis as well as a case mix adjusted basis.[17]

2.36 According to Health there had been a change from using an input model (which measured services provided) to the adoption of an output model (which measured achievements). Health said that this approach had been undertaken to improve the consistency of the assessments of the many aspects of the aged care industry. Adoption of the output model also ensured that a single system applied right across the whole industry. Nevertheless there was still a need for balance between subjectivity and objectivity.[18]

2.37 *Clinical quality* measures of resident care, such as number of falls, restraint and infection controls, should be augmented by social engagement measures such as residents talking to people and engaging with staff.[19] A bland statistical approach (such as numbers of events and whether medicine arrives on time) tended to obscure the fact that there were distinct sub-groups in high care populations. Further, such an approach tended not to record *quality-of-life* issues.

17 The Agency, *Transcript, 18 August 2003*, p. 5.

18 Health, *Transcript, 18 August 2003*, p. 8.

19 Health, ACSA, *Transcript, 18 August 2003*, pp. 8-9.

2.38 The Committee raised as an important issue, whether the quality of aged care had improved as a result of the accreditation process which has now proceeded beyond the second round. It noted that accreditation had gone well but queried whether there were any measures indicating that the residents' *quality-of-life* had improved.

2.39 ACSA responded that there were processes that could amount to proper benchmarking between countries, and over time. However, data of the nature required were not currently readily available at present.[20]

2.40 Since the introduction of accreditation, every home receiving Commonwealth funds had been seen by the Agency and measured against a set of outcomes.[21] Certification and accreditation had meant that a culture of continuous improvement had been imbued in the industry, according to the Australian Nursing Homes and Extended Care Association (ANHECA). Indeed some homes had left the industry at the commencement of accreditation and those that remain were committed to improving services. The accreditation process was more robust and independent and the focus was now on quality systems.[22]

2.41 ACSA suggested that there were strong reasons for "a more open approach [towards the process of accreditation] because the majority of our members do more than one thing".[23] A less rigid approach would open up the opportunity to employ benchmarking practices used in other community care industries. ACSA believed there should be a number of accreditation service providers operating under the Joint Accreditation System of Australia & New Zealand (JAS-ANZ) framework. Further, the aged care facility operators may also have as many as a dozen other types of services or streams that require accreditation. These may include a more comprehensive range of services to older people, as well as perhaps disability services, in total requiring around six different accreditations. Hence, it was argued, it was possible for one accrediting team to do all a particular company's accreditations in one campaign.[24]

2.42 An estimated 600 of the 3000 aged care facilities facing accreditation undertook voluntary benchmarking for their clinical services. This assisted the efficiency of the accreditation process because,

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20 ACSA, *Transcript, 18 August 2003,* p. 5.

21 Health, *Transcript, 18 August 2003,* p. 13.

22 Australian Nursing Homes and Extended Care Association (ANHECA), *Transcript, 18 August 2003*, p. 15.

23 ACSA, *Transcript, 18 August 2003,* p. 6.

24 ACSA, *Transcript, 18 August 2003,* p. 6; ACSA, *Submission No. 1,* pp. 2-4.

> …when assessors visit facilities which have those sorts of systems in place, they use them extensively to demonstrate the quality improvement framework.
>
> As people see that it assists their accreditation process quite specifically and demonstrably, that assistance and take-up rate will grow.[25]

2.43 The Committee was advised by ACSA that the JAS-ANZ[26] (the body that sanctions accreditation agencies) had developed a set of criteria for accreditation,[27] and hence a mechanism for accrediting the accreditors was in place. ACSA contended that,

> …placing accreditation for aged care services under an open accountability framework such as JAS-ANZ would be the best way of ensuring that the concerns and issues identified by ANAO are addressed for now and into the future.[28]

Committee comment

2.44 Notwithstanding the evidence presented to it, the Committee feels that there is scope for variations to exist in assessments without invalidating the assessments themselves. The Committee believes also that reasonable progress is being made on quality and reliability of accreditation services provided by the Agency.

2.45 The Committee finds compelling ACSA's argument that over-arching JAS-ANZ certification of the Agency as an accreditation body ensures that the Agency's systems remain robust. The possibility of collateral benefits to the broader community care sector warrant review by Health.

2.46 The Committee notes that the areas where improvements can be made to the *clinical quality* of aged care have been adequately identified. However, the Committee recognises that the *quality-of-life* experienced by the residents of aged care homes is more difficult to characterise and measure objectively, and hence this aspect appears not to have been factored into the overall accreditation process in a meaningful way.

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25 ANHECA, *Transcript, 18 August 2003*, p. 7; ANHECA, *Submission No. 2*, p. 30.

26 JAS-ANZ Committee was established in 1991 by a formal agreement between the Governments of Australia and New Zealand. It has the legal status of an International Organisation. It assesses and accredits personnel, systems and products. The principal advantage of using a JAS-ANZ accredited certification body is that it has demonstrated it uses competent and impartial personnel in all stages of its auditing and certification process. ANHECA, *Submission No. 2*, pp. 31-6.

27 ACSA, *Transcript, 18 August 2003*, p. 17.

28 ACSA, *Submission No. 1*, p. 4.

2.47 The Committee finds that, despite all the effort and cost to date in implementing accreditation, the Agency's current system of accreditation tells little about whether the quality-of-life of people in aged care facilities *has actually improved*. The Committee concludes therefore that a better mechanism for assessing quality-of-life for residents in aged care facilities needs to be developed, without imposing additional costs on the aged care facilities or further complicating the accreditation process. Clinical quality data need to be complemented by quality-of-life data possibly including impressions gained during interviews by accreditors with residents, their families and visitors. The Committee recommends accordingly.

Recommendation 1

2.48 **The Aged Care Standards and Accreditation Agency Limited broaden the focus of the quality assessment data currently used for accreditation purposes, to include quality-of-life information experienced industry-wide by residents of aged care homes. Overall, the resultant data collection mechanism must not impose additional costs on the aged care facilities nor further complicate the accreditation system.**

Costing methodology

2.49 ANAO found that the Agency employed a "suspect system" to cost its services – its costing methodology did not embrace time sheet usage, and the Agency was still in the process of establishing a system to monitor budget variances.

2.50 the Agency explained that its costing model involved three stages, the first two of which were in place:

- Budget estimates;
- Expensing according to function; and
- Budget validation.

2.51 The volatility of the financial results reported by the Agency, whereby significant losses were made in the years between the accreditation peaks, was of concern to the Committee. The Agency explained that generally it operated at a loss for two years and then in the third year, recorded an operating profit. Negotiating "certainty of funding" from Health, rather

than a particular appropriation would allow the Agency to achieve long term solvency.[29]

Committee comment

2.52 The Committee is concerned that the Agency's revenue flow is highly volatile. It concludes, however, that considering the cyclical nature of the workload, and with the accreditation process having only just completed its second round, it is not realistically possible, at this stage, to achieve a uniform revenue flow. Nevertheless the Committee is encouraged that processes are being put in place by the Agency to ensure rigorous cost supervision.

Training of nurses

2.53 The Committee investigated whether there was sufficient emphasis on aged care skills training in the academic courses that nurses were required to undertake to gain their nursing accreditation,

2.54 ACSA advised the Committee that there were significant variations in the content of nursing training across Australia, in terms of time and content on aged care and indeed, on processes such as accreditation. On this basis there was a need to base training on quality of service rather than strictly aged care. Pressures on maintaining quality of aged care were exacerbated by a shortage of nurses. Therefore, any steps aimed at improving the quality of care needed to take into account the resources actually available, not some desired but ultimately unrealistic resourcing level.[30]

Committee comment

2.55 The Committee accepts that resourcing constraints exist, particularly with respect to overall nurse numbers, but it considers that academic institutions providing nursing training need to include in their curricula adequate levels of training specifically relating to aged care.

29 The Agency, *Transcript, 18 August 2003*, p. 11.

30 ACSA, *Transcript, 18 August 2003,* p. 15.

Facility ownership

2.56 The Committee questioned whether ownership of aged care facilities – not-for-profit, private, state, or municipal – had any impact on quality of care.

2.57 The Committee was advised that data that could be used to determine whether quality of aged care varied according to the nature of facility ownership, were not available. The Committee suggests that some research by Health is warranted, to determine if the nature of facility ownership affects quality of aged care.