



**LEADING AGE SERVICES**  
AUSTRALIA

*The voice of aged care*

# SINGLE AGED CARE QUALITY FRAMEWORK

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**Leading Age Services Australia**

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## Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing and supporting Providers of age services across residential care, home care and retirement living.

Our vision is to enable a high performing, respected, sustainable age services industry delivering affordable, accessible, quality care and services for older Australians.

We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

Thank you for the opportunity to comment on the *Draft Aged Care Quality Standards Consultation Paper 2017* and the *Options Paper for Assessing Performance against Aged Care Quality Standards 2017*.

Should you have any questions regarding this submission, please do not hesitate to contact Dr Brent Davis, General Manager – Policy and Advocacy, on 02-6230-1676.

## Background and Context

The Australian Government, through the Department of Health (DoH), has initiated a public consultation process to develop a Single Aged Care Quality Framework (SACQF). The SACQF will be a key part of the Australian Government's broader policy objective of achieving an aged care system underpinned by the principles of ageing in place, consumer directed care and market based competition.

The SACQF is intended to build on three pillars: a single set of aged care Standards operating across all aged care services; a streamlined approach to assessing Provider performance against the quality Standards; and improved information on quality to assist consumers to make choices regarding the care and the services they need.

### The Standards

At present, there are essentially four sets of quality standards in operation, applying variously to aged care operators who receive Australian Government funding, compliance with which depends on the types of aged care services they deliver.

These four Standards are: Accreditation Standards, which apply to residential care and short term restorative care delivered in residential settings; Home Care Standards, which apply to home care and short term restorative care delivered in a home setting, as well as care delivered under the auspices of the Commonwealth Home Support Programme (CHSP); the National Aboriginal and Torres Strait Islander Flexible Aged Care Quality Framework Standards (NATSIFACQFS) applying to care delivered under a similarly named program; and, the Transition Care Standards, for flexible care.

The challenges experienced by the existence of four different sets of Standards are self-evident: consumers can find it difficult to understand what they can expect to receive from Providers of aged care services; Providers can find it difficult and complex to comply with the relevant Standards; and, for all participants, the multitude of standards can impede competition, contestability and initiatives to improve service quality and outcomes. In short, the proposed SACQF is intended to move the regulatory regime for aged care services from one which focuses on Providers' processes to one based more on outcomes-based standards (whilst also reducing unnecessary regulatory burdens and interventions in the aged care market place).

The proposed SACQF is expected to contain an integrated set of eight Standards dealing with: consumer dignity, autonomy and choice (Standard 1); ongoing assessment and planning with consumers (Standard 2); delivering personal care and/or clinical care (Standard 3); delivering lifestyle services and supports (Standard 4); service environment (Standard 5); feedback and complaints (Standard 6); human resources (Standard 7); and, organisational governance (Standard 8). However, Providers will not be required to comply with each and every Standard; only those Standards relevant to the types of care and services they deliver. Having said that, the DoH has indicated it would expect all Providers, regardless of their stream of activity, to comply with Standards 1, 2, 6, 7 and 8).

The new Standards, when complete, will contain three key elements: a statement of outcome(s) for the consumer; a statement of expectations for the Provider; and, a statement of requirements for Providers to demonstrate how they have met the Standard.

Compliance with the Standards will be mandatory, and the Federal Government will have a reserve right to take enforcement action for non-compliance either through the aged care legislation or any funding agreement(s) with the organisation concerned. Having said that, the Standards are only intended to be minima, with Providers able to go above and beyond those core Standards, delivering higher quality care services and outcomes as part of their 'value-proposition' in the competitive marketplace.

### Assessment

The public consultation process also seeks industry views on three potential approaches for assessing the performance of Providers against the proposed Standards.

The three potential approaches (badged as Options in the consultation paper) are: assessing compliance based on the aged care setting, with different approaches for residential and for home community care (seen to be a modified form of the current model: Option 1); introducing a single risk based assessment model which is applicable to all aged care arrangements (Option 2); and, adopting a safety and quality declaration by Providers who are delivering low risk services to the broader population (for example, gardening services: Option 3).

Under Option 1, all organisations would be required to meet the new aged care Standards, with one quality assessment process for residential care (accreditation) and another for home/community care (quality reviews). Both residential and home/community care Providers would receive reports on the findings of assessments, with residential care Providers also being given a decision in relation to the accreditation of the service.

Under Option 2, all organisations would also be required to meet the new aged care Standards, as well as being subject to regular assessments to enable the Provider to show performance against the Standards and, where they did not meet the Standards, ongoing monitoring by the Australian Aged Care Quality Agency (AACQA). Performance against the Standards, and any monitoring which may be necessary, will be proportionate to the health, safety and wellbeing of the consumer.

Under Option 3, organisations providing low-risk (for example, gardening) services would be required to make a declaration they are compliant with basic safety and quality requirements, rather than meeting the aged care Standards or engage in a quality assessment process.

The three Options proposed in the consultation paper reflect several considerations. These include: the need to improve the consistency and the coherence of the approach to quality assessment across the aged care sector; existing assessment arrangements do not reflect the risk to consumers of the increasingly complex nature of care being provided in home settings; Providers delivering services under multiple programs bear unnecessary costs of complying with different quality assessment processes; and, the current approach delivers little information which can be used by consumers (actual or potential) to compare quality of services offered by different Providers.

External quality assessment, when done efficiently, objectively and transparently, can be an asset to the recipient organisation, where it usefully identifies areas for improvement and/or drives continuous improvement in the quality of care and services delivered to consumers.

### Other Steps

LASA notes the current public consultation process on the content of the SACQF – both the single national Standards, and the single national assessment model – are just a staging post, not the end-point, in the development of the Framework. We also note:

- detailed guidance material will be produced to assist Providers, and others, to understand and comply with the new system. This material will provide information to inform market participants (consumers, Providers and regulators) about how the Standards will be measured and, for consumers, what they should expect from the new arrangements;
- there will be a piloting of the new Standards during the second half of 2017 (presumably, to pre-test them in a controlled experimental manner before they are rolled out for wider application);
- the relevant aged care legislation will need to be amended to reflect the revised Standards;
- the Charters of Care Recipients Rights and Responsibilities will also be reviewed and revised to form a single national charter across all aged care; and,
- education and guidance material will be developed to support the introduction and the implementation of the new Standards.

The new Standards and assessment, subject to the legislative et al, processes would take effect from 1 July 2018.

## Recommendations

- LASA supports the introduction of an SACQF;
- Whatever assessment option is chosen, it should apply to all aged care organisations funded by the Australian Government;
- LASA supports Assessment Option Two, in combination with Option Three for relevant Providers; and,
- A common Glossary of key concepts and terms be included in both documents.

## Key Points

- LASA supports the development of these draft Standards to enable the consumer to be placed at the centre of their care, with greater choice and flexibility;
- LASA supports the premise whereby standards can promote consumer confidence in a safe system that is of consistent quality;
- The format of the Standards - that is, a statement of the outcome for the consumer, a statement of expectation for the organisation and organisational requirements to demonstrate the Standard has been met - are clearly articulated, easy to read and understand;
- The SACQF supports the consumer as the driver for quality improvement and provides an essential framework for Providers to ensure quality care and services are delivered;
- LASA suggests the Standards, by themselves, will not drive quality improvement or innovation, however, the framework articulated in the draft Standards is a good place to start to build on the system we current enjoy, place the consumer at the centre of care and service delivery, and support Providers to continuously review and improve;
- LASA supports the development process underway and offers any assistance required to support the revision to, and piloting of, the proposed new Standards;
- LASA support the complementary work of the assessment process to the development of the new Standards;
- 'Choice' needs to be in the context of what is reasonable in a capped funding environment; and,
- LASA recognises the Options Paper does not include the development of opportunities for accreditation services to be provided by private organisations. However, this 2015-16 Budget announcement cannot be forgotten or put aside.

## New Single Quality Standards System

LASA supports the introduction of an SACQF.

In response to the Consultation Paper, LASA does not intend to 'wordsmith' per se. This work will obviously occur post the consultation phase and LASA is very willing to work with the DoH in this activity.

LASA, through its Position Statement 9, *Provision of Quality Care and Services<sup>i</sup>*, has called on Government to promote the provision of quality care and services across the spectrum of age services and advocated for the development of an industry-wide set of Standards.

We therefore support the development of these draft Standards to enable the consumer to be placed at the centre of their care, with greater choice and flexibility. We also support the premise whereby standards can promote consumer confidence in a safe system, that is of consistent quality. The aim of a single set of standards reducing unnecessary regulatory burden must be at the forefront of how assessments against the Standards are undertaken.

LASA supports the diagrammatic view of how the Standards interrelate. From an overarching view, the draft Standards include the most important aspects of care and service delivery, no matter what setting or delivery service type.

The format of the Standards - that is, a statement of the outcome for the consumer, a statement of expectation for the organisation and organisational requirements to demonstrate the Standard has been met - are clearly articulated, easy to read and understand. The SACQF supports the consumer as the driver for quality improvement and provides an essential framework for a Provider to ensure quality care and services are delivered.

Generally, there are no substantive matters missing from the draft Standards, however some of the rationale and evidence material might benefit from review. LASA has made specific comment below where this is the case.

LASA suggests an important aspect to consider in the development of Standards is what role they play in the system, and how they might promote safety, quality and innovation. The aged care system and industry in Australia is world renowned, where quality care and services are an expectation of the community. Providers are consistently looking for innovative ways to deliver care and services.

For decades, it has been understood the obligation to the consumer never ceases and great gains can be made through a continuous process of improvement, where a status quo will not do. It is hoped these draft Standards take the industry above the status quo and set new (but achievable) expectations.

However, the Standards, by themselves, will not impact quality improvement or drive innovation, though, the framework articulated in the draft Standards is a sound place to start to build on the system we current enjoy; place the consumer at the centre of care and service delivery; and support Providers to continuously review and improve.



Many Providers across the aged care industry will have no challenge or particular difficulty in implementing the Standards, and in fact, given the aim is to reduce duplication and support a 'lighter touch' where applicable, many Providers will welcome the draft Standards and an opportunity to consider different options for assessing against the Standards. However, this will not be applicable for all. Some organisations may find it difficult to change a mindset of demonstrating processes, without identifying results, to an outcome focus that reflects the consumers' needs, goals and preferences.

For those organisations who have not undergone an accreditation process this will be a completely new concept, and will require systems and processes to be developed to support an outcome focussed approach to care and service delivery. In an industry undergoing constant change, and will continue to do so over the next five to ten years, this could be a major hurdle to success.

Having said that, for many services, including those providing the Commonwealth Home Support Programme (CHSP) and Home Care Packages, the move from Quality Reporting to an accreditation system may not be difficult given the Quality Reporting process encourages community aged care Providers to review, refine and continuously improve the quality of their service delivery.

Assuming the Standards will be written in legislation, LASA is concerned where, as a standalone piece of legislation, the Standards may be interpreted in different ways. To alleviate the risk of this occurring, LASA supports the rationale and evidence developed to support and better explain the intent of the Standards. How this support information is used will need thorough consideration, to not detract from innovation and individuality on how Providers might demonstrate compliance.

In developing this submission, LASA convened several Member forums to obtain first-hand Member feedback on the issues raised in the proposed Standards. One comment received from a LASA Member was the draft Standards are too residential focussed, while other views show a broader understanding and see how the Standards can be applicable across the industry given a risk based, proportionality framework is used as part of the assessment process. One way the different perceptions might be addressed is better explanation in the rationale and evidence and examples provided for various settings.

It must be remembered, only the Standards will appear in legislation (not the rationale and evidence) and when non-compliance is found it is to the words within legislation. Therefore, the Standards must be able to standalone as much as possible, with subjectivity removed.

Another broader comment from LASA Members is their concern for residential services, a form of Consumer Directed Care (CDC) will be introduced through the Standards without appropriate industry consultation. Some Members even described the draft Standards as 'CDC in residential care by stealth'.

## Consultation Paper

### Draft Standards

#### Standard 1 Consumer dignity, autonomy and choice

LASA Members have observed the proposed Standards apply to current clients/residents who have already made a major decision about the care and services they need. That is, they have entered into an agreement with a Provider, generally via a written / signed agreement that outlines what care and services will be provided. There appears to be no reference to agreements in the draft Standards, nor whether such agreements would be used to confirm the care and service being delivered is what has been agreed to. However, it is recognised, agreements could be part of the assessment process under this Standard One or Standard Eight.

The rationale and evidence section to this Standard could be the place to introduce agreements as an example of choice.

The tenet of consumer dignity, autonomy, and choice are core to quality of life. Standard One promotes the understanding of the consumer, and knowing what they want to support them in living the life they choose.

LASA's focus has always been to help older Australians to live well; this Standard enables Providers to continue to improve their service delivery.

Given there is a responsibility at Standard Eight for information management, Standard One may duplicate what is required to meet Standard Eight. However, this Standard highlights the information required to make an informed choice.

LASA has heard concerns on access to services (especially for those who may be vulnerable or marginalised) is an area not addressed in the Standards. LASA agrees 'access' is a core domain of quality<sup>ii</sup>, however LASA contends the Standards are not the place to address this issue. Some feedback also raised concerns over the processes of My Aged Care. Again, Standards are not the place to address this issue (as important as it may be).

Although consumers may be willing to take risks, *duty of care* is consistently raised by care staff. It would be of value if this concept can be further explained.

Choice needs to be in the context of what is reasonable in a capped funding environment; this could be further explained in the rationale and evidence.

Concerns over choice and adjacent legislation have been raised. The perennial example of the Food Authority legislation in relation to soft boiled eggs remains relevant. Providers are concerned existing legislation has not caught up with current (let alone innovative) practices and the possibility of legislation outside the *Aged Care Act 1997* will stifle innovation and more importantly consumer choice.

Without wanting to 'wordsmith' the proposed Standards, Providers are concerned with the word "each", in this Standard. What if during assessment visits, the AACQA finds a single person who felt they were not treated with dignity and respect? Would this mean the service would be found noncompliant? How will the AACQA assess this Standard? This same argument is promoted in Standard Seven and will be highlighted further in this submission.

LASA Members feel the words “*where appropriate*” need to be included in relation to ‘choice’.

Providers are also concerned with Clause 1.5 where “*effectively communicated*” could be interpreted as requiring formal interpreters and written material in all languages. The intent of this provision could be better explained in the rationale and evidence.

### Standard 2 Ongoing assessment and planning with consumers

LASA supports the consumer being at the centre of ongoing assessment and planning, and recognises there are a range of tools and mechanisms to support good assessment and planning processes.

Some LASA Members are concerned ongoing assessment is not particularly relevant in the CHSP, and the role of Aged Care Assessment Teams (ACAT) and Regional Assessment Services (RAS) need to be considered in this Standard.

Without expecting all such tools to be listed in the rationale and evidence section, one set of guidelines supporting a holistic approach to care are the *National Guidelines for Spiritual Care in Aged Care*<sup>iii</sup>. These Guidelines might also be used to support compliance to Standard Four.

LASA Member feedback identified the possibility of needing to discuss assessment and planning with guardians (formally) or advocates where the person has no family or friends. Involving these parties might be difficult where *ongoing* assessment and planning is required.

This Standard needs clarity that planning and assessment must be considered in the confines of levels of care and service the person is funded for. This is especially pertinent in CHSP and Home Care Packages.

A level of risk management must be considered when assessing to this Standard and where prioritising consumer choice is required.

Some LASA members have suggested amending Clause 2.3 to remove “*continuously monitored*”, replacing it with “*regularly monitored*”.

### Standard 3 Delivering personal care and/or clinical care

LASA endorses the separation of personal / clinical care, and lifestyle services and supports. This will be particularly important for Providers who deliver care and services according the Schedules 1 and 3 of the *Quality of Care Principles 2014*<sup>iv</sup>.

There are several requirements identified in this Standard which need further clarification:

Clause 3.2: despite the description of best practice being outlined in the rationale and evidence, this is a subjective area that needs to be more clearly defined. The issue is how will this Standard be assessed? Who will make the decision as to what is “*best practice*”, and whether such clinical care is delivered?

Clause 3.3: referring to the Australian Commission of Safety and Quality in Health Care (NSQHS) *National consensus statement: essential elements for safe and high-quality end-of-life care*, (in the rationale and evidence) may be very confusing to Providers, especially when the Consensus Statement sets out suggested practice for the provision of end-of-life care in settings where *acute care* is provided. The Consensus Statement states it:

*“is generally targeted at acute health services, including intensive care and the emergency department. It applies in all types of public and private acute hospitals, from large tertiary hospitals to small district and community hospitals”<sup>v</sup>.*

It is also more confusing for residential service Providers, where the requirements to claim for subsidy under the Aged Care Funding Instrument (ACFI), ‘end of life’ is defined in the Palliative Approach Toolkit for Residential Aged Care Facilities March 2016, Fact Sheet 10<sup>vi</sup> as:

*“An end of life (terminal) care pathway (or plan) is a document that guides the steps needed to provide high quality care to the resident in the last week or days of their life. A resident will be started on a pathway when there are signs or they show symptoms or physical changes suggesting that they may be dying. The final decision to commence a resident on a pathway is made by the doctor and care team after talking with the resident, their family and/or substitute decision maker”.*

To have one definition for Standards and another for funding may cause significant variation in what this Standard is expecting as an outcome.

Also, the Consensus Statement suggests<sup>vii</sup>:

*“some actions within the Consensus Statement are currently aspirational”* and:

*“the process of dying is not always straightforward, and it is likely that aspects of care will need to be revisited as a patient’s condition changes. For example, the patient’s preferred place of care, and their psychosocial, cultural and spiritual care needs may change over time, and must therefore be repeatedly assessed.*

- *when a patient is likely to die in the medium term (i.e. within the next 12 months), but episodes of acute clinical deterioration or exacerbation of the underlying illness may be reversible*
- *when a patient is likely to die in the short term (i.e. within days to weeks, or during the current admission) and any clinical deterioration is likely to be irreversible”.*

The variation of times to death (Consensus Statement compared to the ACFI) and what care expectations should be, will only lead to further confusion.

Cause 3.4: this item may be difficult in the community sector given some visits can be weeks apart. This needs to be clarified for the CHSP and Home Care settings.

Clause 3.5: the first version of the NSQHS *Draft National Safety and Quality Health Services Standards* was developed primarily for use in the *acute sector*, and resources have also been developed to interpret and implement the Standards in other sectors. Version 2 also has an *acute focus*.

LASA has consistently advocated residential services (let alone any other aged care program such as CHSP and the Home Care Package Program) are not acute care settings and to refer Providers to statements developed by the NSQHS can cause confusion and misinterpretation, and may cause unnecessary objection to the draft Standard when in fact the essence of the Standard is reasonable.

The spirit of Clause 3.5 is sound. However, a Provider does not always have the capacity to make or facilitate referrals. For example, a person may have a skin condition whereby a referral to a dermatologist would be a reasonable action and conform to 'best practice'. The Provider can suggest to the General Practitioner (GP) a referral is required. However, if the GP does not agree to write a referral the Provider has no avenue to override it.

In residential care, for more serious issues, a transfer to hospital may be the only way to address the scenario above. This is not only against the tenet of 'best practice' it may also go against the wishes of the person receiving care. Risk aversion behaviour may surface if Clause 3.5 is read literally.

Providers of community care may have even less capacity than Providers of residential care to ensure appropriate referrals are made. How will Clause 3.5 be assessed to demonstrate a Provider is compliant to the Standard?

Clause 3.6: the term "*critical*" in "*critical information*" needs further explanation.

Clause 3.7: LASA understands the literature has identified incidents as being of high-impact or high-prevalence risks associated with the care of each consumer. However, having a list may give the impression only those incidences listed need to be monitored to meet this Standard or it could be taken more literally. LASA has reservations about 'lists' per se, given they can change over time, as exemplified in the current Accreditation Standards.

Clause 3.7 could be modified to the following:

*"Identification and management of risks, especially noting those of high impact and or high prevalence risks associated with the care of each consumer."*

Any list can then be inserted into the rationale and evidence section which will be far more easily amended than what will be included in legislation.

Clause 3.8: antimicrobial stewardship is a relatively new concept to aged care and some Providers (especially those offering CHSP and Home Care Packages) have little to no power to influence the use of antimicrobial stewardship.

The definition provided in the rationale and evidence for this draft Standard describes what antimicrobial stewardship is, but given the structure/s aged care Providers work under, their role in supporting antimicrobial stewardship may be very limited.

Extensive examples of how this concept can be operationalised to ensure compliance to the Standard must be provided, otherwise subjectivity and confusion about the role of antimicrobial stewardship in age services and the responsibilities of Providers to apply antimicrobial stewardship will only be exacerbated.

To provide a clearer understanding of the Standard, LASA Members have suggested the distinction of personal care and clinical care be made. LASA notes the rationale and evidence does provide this distinction by offering examples, however LASA Members are seeking broader clarification.

Other feedback has highlight the need for this Standard to be linked to a clinical governance framework in Standards Seven and Eight (which would mean a broadening of those two Standards).

Some LASA Members also feel the word “safe” is too subjective and suggest the consumer outcome should be “*that care is right for me*”.

While the concepts in this Standard are generally supported. However, there appears to be too much subjectivity and the draft Standard may need further review. Has this Standard taken into consideration the work currently being developed by the AACQA in the development of the questions they will be asking consumers during an assessment process?

This Standard must make it clear personal care and/or clinical care are limited by the level of funding provided and must be delivered in the context of the Specified Care and Services Schedules in the *Quality of Care Principles 2016*.

#### Standard 4 Delivery lifestyle services and supports

The only aspect not covered materially in this Standard is the right of the person not to want to participate in receiving lifestyle services and supports. Clause 4.2 could be expanded with a new sub-clause d. to the effect “*not participate in the community should they desire.*”

LASA Members have also raised concerns for faith-based services who may not be able to provide certain activities due to their beliefs. How will this be considered when this Standard is assessed?

Particularly pertinent for CHSP and Home Care Package providers, but also relevant in residential settings, this Standard must make it clear lifestyle services and supports are limited by the level of funding provided and delivered in the context of the Specified Care and Services Schedules in the *Quality of Care Principles 2016*.

#### Standard 5 Service environment

Under the Requirements of Standard Five there is reference particularly at Clause 5.1.b. to “*comfortable internal temperatures*”. This may be interpreted that all services are required to have air-conditioning. This needs to be clarified in the rationale and evidence section.

There is concern with “*secure*” in Clause 5.1. a. as to the strict meaning of “*secure*” and how it relates to ‘restrictive practices’.

At Clause 5.3, there is reference that consumers can move freely within the service environment, including both indoor and outdoor areas. This needs to be clarified for those services where a secure dementia specific area is located within the service. How will this Standard relate in such circumstances?

This Standard must also make it clear the service environment is limited by the level of capital and operational funding provided.

Clause 5.1. b. touches upon a number of issues: should these requirements be separated? A “*welcoming*” environment is open to various, subjective interpretations; this requires further clarification.

### Standard 6 Feedback and complaints

LASA supports Standard Six, and suggests in the rationale and evidence a reference to advocacy groups could be included. However, some LASA Members have proposed this Standard would be better placed in Standard Eight.

The Consumer Outcome section may be better worded if the provision read: *“When I give feedback or make complaints, this is acknowledged and I see action taken. I feel comfortable making complaints”*.

Also at Clause 6.4 the word *“appropriately”* could be deleted.

### Standard 7 Human resources

LASA supports Standard Seven as it aligns with the LASA, Position Statement 16 Workforce<sup>viii</sup>.

However, as identified in Standard One the use of *“each”* member of the workforce will make assessment difficult. The same question applies elsewhere: what if the AACQA finds a single member of the workforce who does not interact with consumers in a way that is culturally appropriate, respectful and considerate, or does not have skills capability etc.? Would this mean the service would be found non-compliant? How will the AACQA assess this Standard?

LASA agrees requirements for the qualifications of nursing and care personnel must be adhered to, however there are many other professional groups that could also be included in the rationale and evidence. For example, those professions requiring registration with the Australian Health Practitioner Regulation Agency (AHPRA). Singling out nurses as distinct from other professionals is not necessarily helpful. Therefore, should AHPRA also be referred to along with the National Regulation and Accreditation Scheme (NRSA)?

LASA aims for:

- sufficient people and resources be available to meet industry demand via a workforce that is available, inspired, skilled and valued;
- an age services industry workforce equipped to meet the changing needs of all older Australians regardless of their circumstance or background; and,
- an age services industry funded and structured to perform highly in the areas of worker skills, health, safety and positive work life balance via consistent and appropriate education and training delivery ensuring worker capability.

When assessing to this Standard, it needs to be recognised the workforce is more than the numbers that can be counted from those people ‘on the floor’. This is especially so for community care services where all staff, not just those visiting a person’s home, need to be recognised.

Within the entire Standard, and particularly at Clause 7.2.b., the skills, capabilities, qualification etc. need to be considered as to whether they meet the requirements of the consumer. The argument being, people might have such qualifications and qualities and still may not meet the needs of the consumer. How will this be measured?

In Home Care, and particularly in the CHSP, consumers have the right to make a choice about who delivers their care and services. What if the consumer chooses a non-qualified Provider, and how might this impact the Provider who receives the subsidy (and therefore responsible to the Standards)?

As mentioned above in relation to Standard Three, some LASA Members support the inclusion of clinical governance within this Standard.

### Standard 8 Organisational governance

LASA supports the approach this Standard takes and the recognition of 'no one size fits all'. Given this Standard will be applicable to all Providers, it recognises the broad range of structures that define the aged care industry.

Identifying corporate governance and clinical governance separately is a positive move to ensure, where clinical care and services are delivered, clinical governance is required to not only meet the Standard but to support 'best practice' and quality outcomes for the consumer.

However, as mentioned above in Standard Three, some LASA Members support the suggestion to include clinical governance within this Standard.

At one of the forums run by the DoH, feedback included financial transparency as part of the responsibility for financial governance, with suggestions this should be a prerequisite to Standard Eight. Other feedback noted there is sufficient requirement under legislation which protects consumers in relation to the transparency, for example, in agreements and the treatment of Refundable Accommodation Deposits.

LASA suggests Standard Eight is sufficient in its expectations and does not need to duplicate other consumer protections. There remains the expectation that what an agreement states will be delivered, is in fact delivered.



## Options Paper

### Assessing Performance against Aged Care Quality Standards

As stated earlier, LASA supports the introduction of a SACQF.

LASA supports the complementary work of planning a customised assessment process with the development of new Standards as part of the SACQF, and agrees whatever option is chosen, it should apply to all aged care organisations funded by the Australian Government.

LASA recognises the Options Paper does not include the development of opportunities for accreditation services to be provided by private organisations. However, the relevant 2015-16 Budget announcement cannot be forgotten or put aside. The industry, along with the DoH and Government need to proceed with this work in a timely manner. This work should follow the principle of a competitive, market based system where consumers drive quality and where red tape is reduced for organisations.

The existing assessments are different for the community and the residential settings. However, processes within the various settings are similar. This increases the complexity for Providers to necessarily draw from the same information and yet articulate it in different ways for each assessment process.

For example, governance information should be transferable between settings for Providers that service community and residential care. Scalability needs to be investigated, as to how best it can work across the various systems.

The Aged Care Roadmap<sup>ix</sup> goal for how quality will be achieved is:

*“greater consumer choice drives quality and innovation, responsive Providers and increased competition, supported by an agile and proportionate regulatory framework”.*

Any assessment process must have the consumer at the centre and ensure Providers can demonstrate quality improvement and innovation.

The current system certainly involves the consumer in residential services, but not so in the community. Avenues for consumer feedback during an assessment process need to be investigated.

Any new assessment process should be based on proportionality and risk, and provide sufficient information to assist Providers to continuously improve service delivery. As LASA indicated earlier in this paper, we support the development of the draft Standards to enable the consumer to be placed at the centre of their care, with greater choice and flexibility and we support the premise whereby Standards can promote consumer confidence in a safe system, that is of consistent quality.

Therefore, an assessment process which defines whether a Provider is or is not compliant to a set of Standards must be based on best evidence. Articulating non-compliance to the Provider as early as possible in the assessment process is vital, and should provide an opportunity to the Provider to rectify problems where possible, before the assessment process is complete.

Features of the existing assessment and monitoring process that should be retained include: education for the consumer and Provider; the use of the Aged Care Complaints Commissioner where required; self-assessment processes; the identification of concerns during the assessment process (thus providing an opportunity to the Provider to rectify problems where possible, before the assessment process is complete); and, the 'exit interview'.

Features of the existing assessment and monitoring process that need to be changed include: broadening the way consumers are involved in the community setting; transparency in the way risk assessment of a Provider is undertaken; and,

The Options identified in the paper have both positive and negative components. LASA supports Option Two in combination with Option Three. The reasons for this position are outlined below.

### Option 1

*An assessment process based on aged care setting with different approaches used for residential settings and home/community settings (based on the status quo with improvements).*

This option does not enable the industry to move to the SACQF approach being proposed by the Government. It disjoints the service trajectory for consumers, giving rise to different expectations of the industry as a whole, and could cause confusion for the consumer as they move between care and service delivery types.

From a Provider perspective, one of the intents of the SACQF is to simplify regulation and reduce effort for Providers by minimising duplication between the Standards, other Provider responsibilities and legislation.

Adopting Option One will not enable this to occur. As stated in the Options Paper, this will continue to drive Accreditation for one part of the industry and Quality Reporting for another, using the same Standards. This will only confuse and confound Providers and consumers alike.

As mentioned earlier in this paper, 'a status quo will not do' and this Option promotes existing arrangements.

### Option 2

*Introducing a single risk based assessment process that is applicable to all aged care settings.*

LASA supports Option Two in combination with Option Three for relevant Providers. This will enable Providers to implement one set of Standards and undergo similar /same assessment processes across their services. This should reduce red tape and be more active in streamlining assessment processes.

Services will be recognised as 'accredited' rather than distinguished between achieving accreditation for residential services and achieving an outcome through Quality Review.

Option Two would allow a proportionate risk based assessment process to be undertaken across service types. Where Option Three is included, for some services a safety and quality declaration would enable the consumer to have more confidence in the service and know the service Provider remains accountable for certain activities (such as gardening and community transport).

It is anticipated those organisations who have a strong performance record and history of compliance should have a 'lighter touch' obligation than others.

Option Two should enable recognition of other relevant schemes, resulting in a more streamlined approach to assessment and reduce duplication.

LASA supports reducing the need for the AACQA to replicate assessment at each site where an organisation has demonstrated effective organisational governance. LASA would also support the idea of sampling of individual services within an organisation rather than assessment of each individual site.

LASA agrees with the Options Paper that implementing Option Two would provide consistent expectations of quality across the sector, consumers with an assurance of a level of quality across the system, and organisational efficiencies can be realised.

LASA recognises the possibility of an increased load on those Providers who only deliver community care, however believes this may be offset by the advantages for all Providers if streamlining the process is achieved.

Consumers want to ensure appropriate safeguards are in place to uphold safe, quality services being delivered. This option will not diminish legislative responsibilities of Providers, rather it will streamline processes to achieve positive outcomes. With any accreditation system, there will always be inherent legislative responsibilities. How these are met may be easier to manage under this option compared to the current system.

### Option 3

*Use of a safety and quality declaration by organisations providing low risk services readily available to the broader population. (If supported this option can be combined with Option 1 or Option 2).*

As discussed above, LASA supports Option Three being included with Option Two. This will enable a more streamlined approach, with less 'red tape' for low risk services.

LASA supports the accountabilities outlined in the Options Paper at page 25 for those Providers who may be "verified" rather than "accredited", as this provides certainty and confidence for the consumer and an appropriate level of accountability for the Provider.

LASA suggests the treatment of 'verified' Providers compared to those undertaking accreditation needs to be clearly identified on the My Aged Care website so consumers can distinguish which process Providers have undertaken.

The advantages for relevant Providers is a more streamlined approach to assessment of service delivery, a regulatory alignment to what is already available to the broader community and consumer protections.

LASA understands the concern among Providers that new entrants to the industry might require more extensive review (based on risk and proportionality) than those currently in the system. However, that should not exclude the consideration of Option Three for those Providers who are of low risk.

There appears to be concern some Providers may take advantage of consumers when only a declaration is required to be 'verified'. There is no evidence to suggest this is the case, and all Providers would still need to undergo the rigors of applying for Approved Provider status.

Increase in cost has also been identified as a potential outcome under this option. LASA considered this in the context of a consumer driven, market based system and remains supportive of Option Three for relevant service Providers.

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- <sup>i</sup> Leading Age Services Australia, Position Statement 9 *Provision of Quality Care and Services* <http://www.lasa.asn.au/wp-content/uploads/2017/03/LASA-2016-policies-and-position-statements-final.pdf>
- <sup>ii</sup> National Health Performance Framework <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550571>
- <sup>iii</sup> *National Guidelines for Spiritual Care in Aged Care* [http://meaningfulageing.org.au/downloads/ms\\_7526.pdf](http://meaningfulageing.org.au/downloads/ms_7526.pdf)
- <sup>iv</sup> Quality of Care Principles 2014 <https://www.legislation.gov.au/Details/F2016C00451>
- <sup>v</sup> Australian Commission of Safety and Quality in Health Care, National consensus statement: essential elements for safe and high-quality end-of-life care, Sydney, 2015.
- <sup>vi</sup> Palliative Approach Toolkit for Residential Aged Care Facilities March 2016, Fact Sheet 10 [https://www.caresearch.com.au/caresearch/Portals/0/PAToolkit/Resources\\_2016\\_Update/Fact\\_Sheet\\_10\\_End\\_of\\_Life\\_Terminal\\_Care\\_Pathways.pdf](https://www.caresearch.com.au/caresearch/Portals/0/PAToolkit/Resources_2016_Update/Fact_Sheet_10_End_of_Life_Terminal_Care_Pathways.pdf)
- <sup>vii</sup> *ibid*
- <sup>viii</sup> Leading Age Services Australia, Position Statement 16 *Workforce* <http://www.lasa.asn.au/wp-content/uploads/2017/03/LASA-2016-policies-and-position-statements-final.pdf>
- <sup>ix</sup> Aged Care Roadmap <https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap>