



LASA
LEADING AGE SERVICES
AUSTRALIA
The voice of aged care

RESPONSE TO THE REVIEW OF THE NATIONAL AGED CARE QUALITY REGULATORY PROCESSES

The LASA Carnell Paterson Report Response

The voice of aged care
www.lasa.asn.au

Leading Age Services Australia

P: 02 6230 1676 | **F:** 02 6230 7085 | **E:** info@lasa.asn.au

First Floor, Andrew Arcade, 42 Giles Street, Kingston ACT 2604

PO Box 4774, Kingston ACT 2604

ABN: 7115 6349 594

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 purpose is to enable a high performing, respected and 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.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 10% of our Members are government providers, 57% are not-for-profit and 33% are for-profit providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

Thank you for the opportunity to comment on the Carnell Paterson Report. Should you have any questions regarding this submission, please don't hesitate to contact Ms Kate Lawrence-Haynes (General Manager – Policy & Advocacy) on (02) 6230 1676 or katel@lasa.asn.au.

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The context for the response

Given that the Commonwealth Government has said that the Carnell Paterson recommendations will be considered alongside other reform proposals (e.g. the Tune Report), this LASA submission should be read in conjunction with LASA submissions on:

- The Tune Report – December 2017
- The Pre-Budget Submission – December 2017

In addition, workforce reform directions are an essential part of the quality assurance picture and LASA has been closely involved with the work of the new Aged Care Workforce Strategy Taskforce. LASA will be making submissions on options for workforce reform in 2018 and these directions should be part of the overall quality agenda for the Government. So far, our Members have identified these issues as important for workforce reform, and hence quality outcomes:

- Improvements to workforce training: work with the training sector from VET through to universities to lift standards. Refocus the taught nursing model from clinical to 'ageing well'.
- Improving the image of the aged care sector: a possible marketing campaign, with further support for essential positive cultural features - focusing on meaningful work in aged care, highlighting relationship-based models of care, scope of roles and opportunities available.
- Improved funding to reward workforce skills: avenues for generating additional revenue need to be developed as a priority, including revised consumer contributions, and increasing government funding through a variety of levers.
- Flexible Industrial Relations Instruments: key to delivering Consumer Directed Care.
- Improvements to IT literacy skills: a skills acquisition issue.

High level observations

The Report on the Review of the National Aged Care Quality Regulatory Processes (the Carnell Paterson Report) was finalised in October 2017. LASA takes the opportunity to provide feedback on this Report, noting that the Commonwealth Government is currently examining its recommendations.

LASA notes that the Report states that *“Community expectations lie at the heart of our Review. We were asked to examine whether the community can justifiably have such assurance on the basis of current Commonwealth quality regulatory processes. A similar question is asked by England’s regulator of residential aged care, the Care and Quality Commission (CQC). Does care meet the ‘Mum Test’— is it good enough for my Mum or any other member of my family?”*

Despite reforms to improve the quality of residential aged care, our Review has identified that current regulatory mechanisms do not consistently provide the assurance that the community expects. Oakden Older Persons Mental Health Service (Oakden) had significant failures of care, and the Commonwealth’s regulatory framework failed to detect them. Many aged care residents, including some of the most vulnerable and unwell in the aged care system, received poor-quality care and suffered as a consequence. While the situation at Oakden is not typical, the circumstances that led to it are certainly not unique. Oakden is a sentinel case and highlights areas for improvement in the regulatory system”.

While LASA understands this context for the review, our Members have some high-level observations that further illuminate the context for review.

Providers of age services work diligently to care for and support older Australians and their families, during what can be very difficult times in their lives. This is done with the compassion and professionalism that you would expect in a world class, age services system.

Notwithstanding this, no system is perfect and there are times when things do not go as planned. There are occasions where the care and support provided has fallen short of expectations. However, the number of these instances are isolated. For example, the Aged Care Complaints Commissioner recently reported that of the 1.3 million older Australians who received aged care services last year, there were a total of 4,700 complaints. That is less than half of one percent. And of the 4,700 complaints received – around 3,500 related to residential aged care. This represents less than 2% of the older Australians in residential aged care.

Older Australians and their families need to feel assured they are receiving quality care and services that meet stringent national standards of quality and safety. Despite the relatively low numbers of complaints it is important to acknowledge issues when they arise, and it is equally important to recognise that adverse incidents are unfortunate and unacceptable. Our Members acknowledge the significant trauma that residents and their families felt and continue to feel because of the failures at Oakden. However, the Oakden situation is not indicative of our industry overall.

There is a shared interest across older Australians and their families, age services providers, and government policy makers and regulators, in ensuring Australia’s age services system is safe, fair and sustainable. This provides a platform for the collaboration that will be needed to translate findings and recommendations into appropriate actions and outcomes that will address any identified shortcomings and contribute to continuous improvement and community confidence.

LASA asks that the Government considers the following perspectives in responding to the Report as a whole:

- The Oakden older persons mental health facility is a purpose-built, mental health facility for older people experiencing significant mental health issues. It is not a residential aged care facility. As such, residential aged care accreditation for this facility would appear to be inappropriate.
- The Government has faced poor performance from its own regulatory bodies who all had ability to deal with the issues found at Oakden. LASA is concerned that the Carnell Paterson Report recommendations do not fully reflect that a key problem for the Oakden facility was not with the Accreditation Principles or processes, but rather that the Australian Aged Care Quality Agency (AACQA) failed to apply them properly. The AACQA should be held accountable for its performance as part of the Government's response to the Report.
- Similarly, the South Australian Government should also be held accountable for the Oakden issues as the operator of the facility in the same way other operators would be held accountable for such issues.
- The Carnell Paterson Report very much tars the whole residential age care industry with the Oakden brush, despite the incidents being at a State-run mental health facility – which is now closed.
- While the merits and issues of unannounced visits are discussed in the section on recommendation 8, LASA wants it recognised, in line with above, that the AACQA has always had the option of conducting an unannounced visit if they have a concern about a facility.

In framing a way forward, LASA proposes that any changes should be:

- carefully designed, taking into account the detailed issues noted for each recommendation in the following sections, noting that none of the recommendations are at an implementation-ready stage
- considered in the context of the ongoing reform agenda
- consistent with the underpinning principles of the reform agenda and acknowledging both the Aged Care Sector Committee's 'roadmap' and the NACA 'blueprint'
- considered alongside work currently underway with regards to the Single Quality Framework, quality indicators, and consumer reporting initiatives
- rigorously assessed with regards to intent, cost, logistics and regulatory impact for providers/consumers/governments.

Executive Summary - the Recommendations

Detailed considerations for each recommendation, as well as specific Member feedback, is contained in the sections following this table.

Recommendation	LASA response	Key Issues for attention
<p>1. <i>Independent Aged Care Quality and Safety Commission</i></p>	<p>Further investigation is required</p>	<p>While this may have merit in terms of a ‘one stop regulatory shop’, the overall consideration is the extensive regulatory framework that currently exists and the fact that Oakden was basically an isolated systemic problem in a State-run mental health facility. It was in no way typical of residential care generally. Clear augmentation of current systems to rectify any gaps and optimise the regulatory approach to ensure quality should be the focus, drawing on a good understanding of what currently exists, including sanctions. As such, reform of the relationships and working arrangements between the Department, Aged Care Quality Agency and Complaints Commissioner should be considered. Notwithstanding this, LASA expects that should a new Commission be established, then there will be an understanding that bureaucracy and ‘red tape’ will be minimised, with outcomes improved.</p>
<p>2. <i>A centralised database for real-time information sharing.</i></p>	<p>Further investigation is required</p>	<p>LASA notes that, in-principle, the real time sharing of data could mean that responses to incidents and responses to systematic issues can be more evidence based, rapid and effective. This might save three different groups AACQA, ACCC and DoH looking at the issue in different ways.</p> <p>Key to effectiveness will be system design and adequate resourcing. All the issues with My Aged Care and the implementation of Increasing Choice in Home Care are testament to how difficult system changes can be. Much of the impact will depend on the specific Government response to this recommendation and how it approaches implementation. It also links to recommendation 8 and risk based auditing.</p> <p>Consideration must also be given to a cost/benefit analysis to determine the value and effectiveness of this recommendation.</p> <p>Obtaining views from 20% of clients or their families is unlikely to be realistic with unannounced re-accreditation visits.</p> <p>Any efforts on better information need to have a clear link to helping to build industry capability. Benchmarking is already heavily in use in the industry – encouraging this, using systems that make sense to providers, is supported.</p>

Recommendation	LASA response	Key Issues for attention
3. <i>Mandatory participation in the National Quality Indicators Program</i>	Supported in principle with reservations	Mandatory participation in the National Quality Indicators Program appears to be a sound approach as long as the overall program is effective, and efficient, with minimised compliance costs and 'red tape'. Any mandatory participation would need to recognise the resources required, with Government support for this. It should be noted that Members have reservations about the National Quality Indicators themselves
4. <i>A star rating system</i>	Not supported	<p>This risks consumers being swayed by ratings that may not really reflect what they value, and which may be tainted by gaming or inaccurate data.</p> <p>More needs to be done to understand what consumers value and how they can get accurate information to help them make decisions. LASA notes that AACQA has commissioned COTA to look at consumer experience quality indicators but this may not be enough to develop an optimised solution. It may be that clinical and consumer experience indicators need to be looked at separately with operators and the AACQA having the technical expertise to deliver on clinical indicators. Consumers may place higher value on factors such as location and services when making their initial choice of provider, and after that, on factors such as management being responsive to complaints and residents being treated with dignity.</p> <p>LASA Members also note that there are a number of existing, and emerging rating systems that provide consumer perspectives on service quality and consumer experience. The question is raised as to whether these mechanisms already provide a system to assist consumers. Equally, there are also significant lessons to be learnt from the UK experience that need to be better understood prior to any commitment to embark on a star-rating model.</p>

Recommendation	LASA response	Key Issues for attention
<p>5. <i>Consumers and their representatives to exercise their rights</i></p>	<p>Support in principle but further refinements are required</p>	<p>The main question in this context is what is really needed above what we have now?</p> <p>This recommendation might be better framed as part of cultural change towards more consumer driven care. And it may also be a matter of looking at both rights and responsibilities including for the families of residents.</p> <p>Mandating training via the Older Person’s Advocacy Network is too prescriptive as there are other options.</p> <p>Providers need to be adequately resourced to undertake support for consumer rights.</p>
<p>6. <i>A serious incident response scheme (SIRS) for aged care</i></p>	<p>Not supported</p>	<p>LASA believes that this approach could be going too far by placing new and extended reporting responsibilities on providers. LASA is concerned that these responsibilities are proposed without empirical evidence as to their necessity or effectiveness in terms of better safety for people in aged care.</p> <p>The focus should be on looking at what improvements to current systems are required and ensuring a streamlined approach that works with the systems that providers currently use to manage their operations. As one alternative, LASA considers that improvements in training, culture and the existing reporting mechanisms may contribute to meaningful improvements.</p> <p>There may be a need to look at specific issues such as what is needed to ensure effective management of difficult behaviours with the increasing numbers of people with dementia in residential aged care. This is linked in part to the adequacy of the Aged Care Funding Instrument (ACFI).</p>

Recommendation	LASA response	Key Issues for attention
<p>7. <i>Standards will limit the use of restrictive practices</i></p>	<p>Further investigation is required.</p>	<p>It would be impractical to introduce an additional level of approvals via the Commission, when compared to the approvals currently being sought for restraint (GP, family and facility manager). It also needs to be noted that consent is required and consent may go against all medical or advisor recommendations.</p> <p>It is important to recognise that there is already much regulation in this area. An alternative could be the development of best practice guidelines for the management of challenging behaviours in the context of restriction as a measure of last resort. Given existing guidance, these may be about a national and streamlined approach and they may only need to focus on extreme challenging behaviours. Developing the guidelines could occur under the advice of an expert reference group and would replace the role of the Commissioner.</p>

8. *A focus on unannounced visits*

Not supported but further investigation is warranted including on a move to risk based visits

Given unannounced visits are already in place, a move to replace reaccreditation with unannounced visits may be counter-productive. The current process for reaccreditation enables a communication strategy to help residents and families be engaged. Consumer readiness for engagement, especially for families, is not aligned with “surprise visits”.

The broad logistics of moving to only unannounced visits needs to be considered with more detail in the section on this recommendation. Current practices for announced visits provide for an efficient process that ensures key staff are available, documentation is collated and provided in appropriate formats, residents and families are invited to participate, etc. For unannounced visits, this will not be the case.

The cost of any move to a focus on unannounced visits will need to be determined and negotiated with industry to work through who pays and how much. Similarly, any cost impost associated with unannounced visits will need to be measured against the added benefits to quality and confidence.

But an important element of this recommendation is the risk-based process to determine the frequency and rigour of visits. The AACQA states that it already applies a risk based approach to its accreditation activities. Further investigation as to the current risk based approach is needed.

Notwithstanding this, whether visits are announced or unannounced, risk based approaches make sense, as long as risk is fairly and properly identified. LASA notes that the Nous Group has done work on this topic for the AACQA. If a risk - based approach is to be implemented, any proposed approach should be tested with the sector and refined as needed with consideration of the psychology of compliance and performance, as well as the Single Aged Care Quality Framework.

Recommendation	LASA response	Key Issues for attention
<p>9. <i>Assessment against Standards to be consistent, objective and reflective of current expectations of care</i></p>	<p>Supported with caveats</p>	<p>This is an important recommendation and goes to heart of the issues with the Oakden facility. If the AACQA had applied objective and consistent review of this facility, then the issues may have been identified properly. The AACQA should be held accountable for its failings and it should be explicit that best practice regulatory oversight practices are central to effective regulation.</p> <p>The forthcoming Single Aged Care Quality Framework will also be central to this – standards that apply irrespective of setting should contribute to more efficient and transparent oversight.</p> <p>There are practical and funding issues with the proposed changes to medication reviews – see detailed section on this recommendation.</p>
<p>10. <i>Enhance complaints handling</i></p>	<p>Further investigation is required</p>	<p>A key issue with this recommendation is the costs/ benefits analysis for this approach. At a recent forum between provider peaks and consumer representatives it was concluded that more could be done to resolve complaints at the facility level. For instance, improved capabilities, systems and processes to identify and resolve complaints.</p> <p>Other models such as that used by the Victorian Health Complaints Commission could be investigated. In this case, the provider’s response goes to the complainant and as a result, the response is fashioned in a much more consumer-focussed way.</p> <p>Any system must also have fair approaches to deal with unreasonable and vexatious complaints.</p>

DETAILED ANALYSIS

Recommendation 1

Establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling.

Actions

Establish an Aged Care Commissioner who chairs umbrella regulatory body, overseen by an Aged Care Commission Board, with:

- (i) Care Quality Commissioner
- (ii) Complaints Commissioner
- (iii) Consumer Commissioner
- (iv) Chief Clinical Advisor

Further investigation is required

A clear agenda in this is to separate policy from the regulatory side of aged care. And this may create a “one-stop regulatory shop”. This is often a sound public policy approach but there can be costs and inefficiencies in large new government agencies. One of the main questions is to what extent a new agency will be an effective and efficient response to any current system shortcomings.

Organisational cultures are difficult to change and are rarely achieved through compliance drivers. However, reforms intended to overhaul the design and operations of the existing accreditation and complaints functions could provide greater efficiency than in the existing Australian Aged Care Quality Agency (AACQA) and the Aged Care Complaints Commission (ACCC).

A continued focus on developing a collaborative, person-centred complaints resolution processes underpinned by continuous improvement, like that adopted by the Disability Services Commissioner and Victorian Health Complaints Commission, might deliver better outcomes for consumers.

The Aged Care and Safety Commission may have been designed to mirror the Australian Commission on Safety and Quality in Health Care (ACSQHC).

A Member observed that:

“Whilst implementation of the standards for health care services was time consuming and costly for hospitals and health services, the process for accreditation and certification of these services is now more streamlined. There is also a much greater degree of understanding across the system of what “good” looks like and what an underperforming health service looks like”.

But Members also observed:

“We operate in each Australian state and recently identified over 100 legislative instruments with which we must comply across our business streams. While the move to coordinate the regulating bodies under one umbrella may be an ideal move, it may potentially add more red tape processes in an already highly regulated industry”.

“Some of the positive changes seen in the Aged Care Complaints (ACCC) Commissioner since 2016 could be eroded. Since 2016 we have experienced a significant improvement in the ACCC. However, we have also seen more effective models such as that used by the Victorian Health Complaints Commission. In this case the provider’s response goes to the complainant and as a result the response is fashioned in a much more consumer focussed way”.

“Any comprehensive system will be accompanied by multiples of new systems and forms”.

“While we strongly support the continued development of streamlined, efficient and co-ordinated quality and safety monitoring systems, we remain concerned about the independence of the various government departments in this sense. We also be concerned if this recommendation was implemented within existing budget. Any change would need to be resourced properly”.

Members also asked:

“Why was the first step not to adjust the Australian Aged Care Quality Agency and the Aged Care Complaints Commission?”

“How will this sit with a move to more consumer centred care? There needs to be less risk aversion, otherwise that type of care simply cannot be delivered”.

Integrating the functions until now held by Department of Health (DoH), the Australian Aged Care Quality Agency (AACQA) and the Aged Care Complaints Commissioner (ACCC) into one regulatory body may assist coordination. If the body moves out of the bureaucracy, there may be greater scope for it to take a fresh approach. An approach focussed on continuous improvement and promoting good practice.

A focus on continuous improvement will assist in identifying/supporting any poor performers. This, coupled with risk based monitoring (see recommendation 8), will contribute to better early identification of issues and resolution limiting the need for sanctions.

An overall consideration is the extensive regulatory framework that currently exists and the fact that Oakden was basically an isolated incident in a State-run mental health system. It was in no way typical of residential aged care generally. Clear augmentation of current systems to rectify any gaps and optimise the regulatory approach should be the focus, drawing on a good understanding of what exists, including sanctions¹.

Comments under other recommendations relate to how the Commissioner functions could work in practice and significant care and careful design is required with this. For example, one question is: Would the role of Chief Clinical Advisor undermine the doctor’s role and the facility’s intimate knowledge of the resident? Geriatricians and many allied health professionals are also involved in the treatment of residents. Having a clinical decision maker who is not a part of the clinical care / specialist team may create further confusion for the clinical team, resident and family representatives, especially in situations where one or all are not in agreement.

¹ <https://agedcare.health.gov.au/ensuring-quality/residential-aged-care-sanctions/aged-care-sanctions-and-notice-of-non-compliance>

Members said:

“Concern is held with the introduction of the Chief Clinical Advisor that this will result in the completion of many more forms such as for a medication review and for the use of medication”.

“A preferred model would be the establishment of expert advisory committees tasked with producing practice standards for use in the industry (see the website for the ACSQHC for examples)”.

Recommendation 2

The Aged Care Commission will develop and manage a centralised database for real-time information sharing.

Actions

- (i) The Australian Health Ministers’ Advisory Council (AHMAC) consider options to improve sharing patient / resident information between state operated acute and mental health services and the Commission
- (ii) The Commission will develop options to capture the views of residents, families and staff all year round
- (iii) Assessment contact visits must seek the view of 20 per cent of consumers and their representatives
- (iv) The Commission will contemporise risk indicators
- (v) Residential aged care facilities must report risk indicators to the Commission when they occur
- (vi) The Commission will build an expanded risk-profiling tool that incorporates additional intelligence to better support risk management
- (vii) The Commission will develop a robust process to review provider risk profiling and publish outcomes
- (viii) The Commission will share information with residential aged care facilities about common areas of non-compliance and complaints

Further investigation is required

LASA Members have reservations about the costs and the need for effective cooperation with State governments on this. If this involves a significant ramp-up in mandatory reporting for the sector, then the costs and benefits of this need to be looked at more closely.

LASA notes that in-principle, the real time sharing of data could mean that responses to incidents and responses to systematic issues can be more evidence based, rapid and effective. This might save three different groups (the Australian Aged Care Quality Agency (AACQA), Aged Care Complaints Commission (ACCC) and the Department of Health (DoH)) looking at the one issue from different perspectives.

Key to effectiveness will be system design and adequate resourcing. All the issues with My Aged Care and the implementation of Increasing Choice in Home Care is testament to how difficult system changes can be. For this recommendation, much of the impact will depend on the specific Government response to this recommendation and how it approaches implementation.

Systems compatibility is also critical. This would involve significant cooperation between multiple parties and is potentially a significant challenge. Issues around privacy and commercial in confidence data would need to be considered. Data security could also be a problem with multiple 'owners' of information

Members observed:

"Given that the federal government has invested significantly in the development of the My Health Record why wouldn't an interface with this system be investigated and implemented?"

"From this provider's perspective, the Commonwealth has been notorious for not placing useful data on aged care in the public domain. Much of what it does release is general or only available at State level.

An integrated data management system incorporating information across the four offices of the Aged Care Quality and Safety Commission could provide a more comprehensive picture of conditions in aged care homes but input from external bodies, especially State governments may be problematic. For example, retrieval of data on hospital admissions of residents from aged care facilities will be an additional administrative function which will incur staff costs and software expenses if the hospitals' IT systems are incompatible with the Commonwealth's.

Likewise, the exchange of data between the members of the Commission will rely on their systems being compatible. If they are not, the costs to remedy this situation will be significant. Aged care providers experienced this impost when Consumer Directed Care and the My Aged Care website were introduced".

"Our view is that collecting and publishing 'quality data' of every poor health outcome is ridiculous. Every circumstance of every individual is different and only people with complex needs are admitted into our facilities. The current quality indicators would have been relevant 30 years ago but not today".

Existing approaches to provider risk profiling are reasonably sound but need to be considered in the context of an ever changing, fast paced service environment. Lower risk providers can become high risk due to sudden changes in management and key personnel. In addition, residents care needs can escalate and change quickly creating increased risk.

LASA is not sure of the detail and to what extent it would be linked to any public reporting and any ratings for facilities. The sector would need to be consulted on any proposals to make any of this data public. And there may be practical issues with having the data truly 'real time'.

Another consideration is linking real time data to the systems and data that operators already use to monitor their businesses. There is a risk of complex and duplicative reporting with this recommendation.

The Government needs to look at the costs and benefits of a number of options in this context

The section on Recommendation 8 should also be noted as it refers to the 20% of consumers being interviewed, as well as a risk based approach to visits. It should be noted that the AACQA already uses a risk profile that includes change in key personnel and change in approved provider. Risk factors that might be considered include the number of unexpected deaths or serious illnesses.

A Member notes that:

“In Queensland we have already seen assessment contacts seeking the views of 20% of consumers and their representatives. However, what we have experienced through the new survey being applied by the AACQA at reaccreditation surveys is that all consumers are potentially being interviewed with no consideration of the cognitive capacity to understand the questions being asked”.

Recommendation 3

All residential aged care services in receipt of Commonwealth funding must participate in the National Quality Indicators Program.

Actions

- (i) The Commission will develop and pilot an algorithm to support performance benchmarking
- (ii) The Commission will provide residential aged care facilities with a ‘performance card’ comparing them to services with similar profiles
- (iii) The Commission will pilot and validate additional clinical and consumer experience quality indicators

Supported in principle with reservations

Mandatory participation in the National Quality Indicators Program appear to be a sound approach as long as the overall program is sound, effective, and efficient with minimised compliance costs and ‘red tape’.

While participation of all providers makes sense in principle, this would need to recognise the resources required at the provider level to participate and a commitment from Government for support of implementation. Further, some Members have reservations about the National Quality Indicators themselves.

Members observed:

“It would be worth the Government exploring the reasons for non-participation in the National Quality Indicators Program - from my own team I know the biggest issue is contention over the measures themselves and their lack of connectedness to a risk based approach- The Carnell report just assumes that the measures are best practice and best fit”.

“Whilst this is voluntary now I believe this indicates it will become compulsory. There is likely to be resource constraints for small providers, in particular, to complete relevant data. Depending on the accuracy of the data obtained, it may not be possible to compare facilities with a ‘performance card’ approach”.

“We currently collect a range of quality indicator data internally for our residential and home care services. We have been doing so for a number of years. The challenge with the National Quality Indicators Program across both residential and home care services is finding common ground in terms of definitions that are acceptable across the industry. This was not achieved during the piloting stage and many organisations have subsequently opted out of the Program”.

“There may be some benefit in this recommendation, however, the current National Quality Indicators are time consuming and need review. Without a change in the way providers are expected to collect data for the national quality indicators program, there will be significant costs to providers”.

“The Quality Indicators concentrate on clinical matters to the exclusion of psycho-social matters. Whilst clinical errors can be fatal, social isolation and boredom pose real risks to resident well-being too. Given the significant proportion of people from a non-English speaking background who are now entering residential aged care facilities, this aspect of care needs serious attention”.

“The mandatory collection and publication of data about health/clinical outcomes is predicated on organisations potentially publicly owning poor results and the commercial reality of doing this. This was seen in the provider feedback throughout the trial of the National Quality Indicators and is one of the reasons that many providers are not currently participating in the (currently voluntary) program”.

Benchmarking can play a useful role as long as the indicators are sound and fair, and the data is accurate, with gaming minimised. Consideration must be given to ensuring that duplication of data collection is minimised. And it should be noted that the industry is already benchmarked through external and internal review processes e.g. currently via AACQA. The Government needs to be clear about what this recommendation is adding to the system and what is the value and outcome of that. It would be difficult for organisations, especially smaller ones, to absorb additional processes and costs

Care should be taken with additional clinical indicators to make sure that they are relevant, outcome focussed and meaningful. Increasingly, frail and complex consumers are coming into residential aged care later in life which means that the clinical indicators of yesterday are not the ones likely to drive a culture of quality. In addition, clinical indicators need to have a good mix of lead and lag indicators to assure a robust and effective quality system. The system should also not be over-crowded with too many indicators and new indicators may mean that some existing ones should be retired. Any work in this area needs to be linked into the forthcoming Single Aged Care Quality Framework.

The Quality Indicator program should also have a mechanism in it to recognise different types of facilities and the 'rights of residents to take risks', i.e. falls can be a natural part of a person's ageing process including where they are encouraged to maintain independence and/or exercise which may increase the risk of falls.

LASA notes that the AACQA has commissioned the Council on the Ageing (COTA) to look at consumer experience quality indicators. Care needs to be taken in establishing any consumer experience quality indicators and it may not be appropriate for these to cover clinical care given the expertise required to understand such indicators and target outcomes e.g. the point about falls above.

In rating the consumer experience, there needs to be an appreciation of the fact that many judgements will be made by family members who may not rate the experience in the same way as the resident does. What really matters to residents and their families will be somewhat subjective and care is needed to identify the various contributors to the consumer experience, with recognition of subjectivity.

In terms of the consumer experience, one consideration may be the United Kingdom ‘Mum test’ mentioned in the introduction - *A similar question is asked by England’s regulator of residential aged care, the Care and Quality Commission (CQC). Does care meet the ‘Mum Test’— is it good enough for my Mum or any other member of my family?*

Recommendation 3 (iii) may have some linkages to the next recommendation on star ratings and again, this needs to be considered carefully.

Overall action in response to this recommendation should be targeted at continuous improvement and the sector reaching agreed standards over sensible timeframes and with adequate sector resourcing.

Recommendation 4

The Aged Care Commission will implement a star-rated system for public reporting of provider performance.

Actions

- (i) Residential aged care services rated against key domains
- (ii) Adopt mandatory reporting of provider performance against quality indicators
- (iii) Publish accessible, plain English residential service performance reports on the My Aged Care website (in one place)
- (iv) Develop tools to enable consumers to compare the performance of residential services in an area

Not supported

LASA assumes that the number of stars a home receives might be based on its averaged performance across the Quality Indicators. But with such as system consumers might be swayed by 4 or 5 stars instead of focusing on non-Indicator factors which are most important to them such as location, the provision of first languages or a high-quality recreation program during weekends.

The market benefits and works best when consumers are informed and empowered to make good choices. LASA supports the ability of consumers to make informed comparisons between residential care homes but there can risks, gaming and over-simplification with star rating systems. Trip Advisor rating being one example.

A variety of rating systems are already being used by consumers and providers and are likely to continue to evolve as consumers become more aware of the different information sources.

The question of ‘who’ rates needs to be considered and taken into account in the design of any rating system. Many of our Members have noted that consumers and their families/carers can have very different expectations and experiences and rate service quality differently.

Members observed:

“The current system provides full transparency with reporting against 44 expected outcomes. They are readily available to consumers and they now have the new consumer experience reporting also. We need to challenge assumption about what a star rating would add. The industry now has a plethora of ratings tools and yet evidence is that consumers are not using them. We need to minimise blaming facility management and focus on regulatory bodies doing their job properly”.

“This would have to be carefully managed and thought through before proceeding with any type of ratings system. It definitely could not work if the consumers were given access (like Trip Advisor) as this is not just rating services like a hotel - there are so many other factors – family friction, expectations etc. If the system followed an approach that allowed someone independent to make the determination based on meeting standards, complaint level etc. it may work. However, allowing consumers to make comments on websites and rating providers themselves is asking for trouble”.

“There is a risk that if an unfavourable star rating is applied, the provider may be unable to fairly defend itself”.

“Having had experience with job services providers in the past, a star rating system can mean facilities become ‘all about the star rating’ to the detriment of service provision. Job service providers were known to manipulate data. And the resource issues in collecting and reporting data, particularly for small providers must be recognised”.

A key consideration is also the value of responsiveness and engagement with customer feedback by service providers. This element seems to be missing from this approach. Ratings and stars do not give the customer the confidence that anything is done about their rating, nor does it give a provider a sense of what is wrong that they need to fix. If a consumer is not satisfied with an element of the care or services received then the consumer will want to know that their provider will be responsive to their concerns.

As a first step, we need to draw on the forthcoming Single Aged Care Quality Framework and other evidence as to what drives quality of care from clinical and consumer perspectives. Then decide upon the best indicators. Any system should also have strong design input from provider and consumer representatives and these parties should be part of any rating system. It may be that any ratings need to be derived from mixed data: consumers/relatives, staff and care standards and management and prudential (industry).

The factors driving quality can be complex. A number of providers have observed, for instance, that the quality of the manager of the facility is essential to its quality and culture. Across a single provider, quality can vary greatly between different sites due to this factor.

At a recent aged care provider and consumer representatives forum there was significant discussion on this recommendation. There were many questions around how performance would be measured and the scope for more pro-active roles for consumers and providers in this. A question was posed as to the extent to which such a system would be useful given location and availability of a place can be key factors in choosing a provider. But there was also discussion around this and other possible drivers for a cultural shift to more consumer-centred residential aged care.

It may be, as mentioned above, a simpler system is required that might draw on the concept of the United Kingdom's 'Mum test'. The United Kingdom uses a simplified inspection framework against five key criteria i.e. Safety, Leadership, Effectiveness, Responsiveness and Care.

One Member reports that the factors that often matter most for residents and their relatives include:

- Management is responsive to complaints
- Communication is open and effective
- Residents are treated with dignity
- Residents are encouraged to be independent

Other factors that may be relevant to facilitate initial consumer choice include facility location, choice of activities and the quality of 'hotel services' etc. Therefore, any approach may need to be more of an industry and consumer driven approach.

Similarly, it should be noted that there are a growing number of independent rating tools and systems available and emerging that give voice to consumers' experiences and providers responses.

Separately to the consumer focus, it may be that, as is the case now, the Government regulatory system should focus on the quality of clinical care given the professional expertise required to judge this. It is reasonable that we should expect a system where all residents, regardless of their health literacy, can have confidence in the clinical quality of care, including the systems to identify and respond to any problems.

Overall, more work needs to be done on different options before adopting a Government-run star-rating system.

Recommendation 5

The Aged Care Commission will support consumers and their representatives to exercise their rights.

Actions

- (i) The Consumer Commissioner, in partnership with the Complaints Commissioner, will promote and protect consumer rights
- (ii) All approved providers must inform and educate consumers and their representatives about consumer rights
- (iii) All approved providers must ensure all staff undertake regular Older Persons Advocacy Network education on consumer rights

Support in principle but further refinements are required

A key question is what is really needed above what we have now? Further, the proposed actions are very much focussed on promoting and protecting consumer rights. The distinction between consumer rights, legal rights and human rights could be clearer.

Aged care policy and practices are placing more responsibility on the consumer to assume control of their care. In this it is assumed that the consumer or his/her representative speaks English competently, is health literate, computer literate and can manage money. This will not always be the case and the Government and consumer advocates have a role to help ensure consumer literacy.

But, in supporting consumers and their representatives to exercise their rights, the Commission will need to address any unrealistic expectations, and what is possible given privacy and confidentiality legislation.

This recommendation might be better framed as part of cultural change towards more consumer driven care. And it may also be a matter of looking at both rights and responsibilities including for the families of residents.

Members noted that:

“The Commission might also focus on consumer responsibilities. In a communal care setting, these become more critical because of the behavioural challenges that may emerge”.

“There needs to be a greater balance on the rights and responsibilities that are outlined in the Charter of Resident Rights. If the emphasis is only placed on rights, there could be an expectation that there are no responsibilities”.

“There are systems in place protecting consumers and their rights. They are educated and informed and these rights are also a part of their contract / agreement. I do not believe any stone has been left unturned in this space”.

“There are already significant requirements on providers in respect of publishing resident rights and responsibilities including handbooks, policies and public area promotional material. We don't really see the necessity for anything further”.

“Staff currently undertake training on consumer rights but not necessarily from OPAN. This is mainly because the resources of this service are stretched very thin and they are frequently not available. We suggest training on consumer rights, while it should be mandatory, could be provided by any number of providers, especially in rural areas”.

“We do not use OPAN for training. As an organisation we ensure that our staff understand consumer rights through our in-house ‘essentials’ program. This includes mandatory completion of Elder Abuse and Notifiable Incidents training. We would see this recommendation as too prescriptive”.

“Providers should be financially supported if their role is to include consumer education and mandatory third-party staff education. However, what other industries are required to also educate their consumers about their consumer rights? The role of a business is not to be in breach of a consumer's rights”.

LASA notes that the surveys the Commission will conduct in respect of residential aged care consumers and their representatives should help to direct its efforts.

In his recent Report on the Aged Care Legislated Review, David Tune supported further work being undertaken on the outreach and system navigation roles. In line with this, the focus may be on consumer education about the aged care sector generally, not just consumer rights.

It is also important not to duplicate current activity, for instance, staff currently complete mandatory elder abuse/compulsory reporting education.

But one Member observed that:

“Our only funding instrument is being cut to the bone and there is little left for education and training”.

Recommendation 6

Enact a serious incident response scheme (SIRS) for aged care.

Actions

- (i) The SIRS will require approved providers to inform the Aged Care Commission of:
 - (a) an allegation or a suspicion on reasonable grounds of a serious incident; and
 - (b) the outcome of an investigation into a serious incident, including findings and action taken.
- (ii) The Aged Care Commission will monitor and oversee the approved provider’s investigation of, and response to, serious incidents and will be empowered to conduct investigations of such incidents.

Not supported

LASA notes that this recommendation reflects recommendations (including 4–1, and 4-2) in the Australian Law Reform Commission (ALRC) Report regarding a new serious incident response scheme for aged care, where approved providers would have to notify to an independent oversight body of such incidents. LASA believes that this approach could be going too far by placing new and extended reporting responsibilities on providers.

Providers are already required to have systems and processes in place to manage and report serious incidents as defined by the Aged Care Act (Compulsory Reporting Guidelines). The Department of Health provides extensive guidance on reporting including a guide on compulsory reporting and a guide on reportable assaults². There appears to be no evidence that having a mandatory SIR process in place reduces the risk of elder abuse occurring or improves the quality of care or outcomes for consumers. Members note that evidence for this is a lack of follow up by the Department in relation to reported serious incidents.

Although this sort of system applies in hospitals, this is a more acute care setting and it is not clear that there is direct translation to the aged care setting.

The focus should be on strengthening and streamlining existing systems and processes for managing serious incidents and supporting providers to ‘raise the bar’ in terms of risk management and incident management. Approaches need to work with the systems that providers currently use to manage their operations.

As one alternative, LASA considers that improvements in training, culture and the existing reporting mechanisms may contribute to improvements but with less ‘red-tape’. There may be a need to look at specific issues such as what is needed to ensure effective management of difficult behaviours with the increasing numbers of people with dementia in residential aged care. This is linked in part to the adequacy of the Aged Care Funding Instrument (ACFI) which requires review.

² <https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/compulsory-reporting-for-approved-providers/guide-for-aged-care-staff-compulsory-reporting>
<https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportable-assaults>

Members said:

“There are systems already in place for the reporting of serious incidents and also legislation which can affect a person who does not report. The complaints systems and quality processes clearly display serious incidents and what was done about it. There is also a multiple of other legislative requirements in this area. Enough is enough”.

“Most facilities already take risk seriously and take action to remove or reduce risk related to serious incidents. This is via mandatory reporting legislation and also via our own internal systems to ensure resident safety”.

And in any approach, Members said:

“It is important that system design includes a sound definition of ‘serious’ so that providers are not tied up in red tape describing and acting on trivial or accidental incidents”.

“The big issues with a SIRS is definition of critical incident. For instance, I fully disclosed a matter to both the Agency and DoH at the time of notification because of the criminal nature of the issue. The issues is ‘what is a critical incident that would warrant open disclosure?’”

Another observation is that:

“The issues of malpractice cover and insurance also needs to be covered in a disclosure framework. Providers are obligated to their insurer for policy coverage and some of these issues could pose coverage risks that need to be understood”.

Given this, the focus should be on working with and improving the existing system, rather than establishing an additional SIRS system.

Recommendation 7

Aged care standards will limit the use of restrictive practices in residential aged care.

Actions

- (i) Any restrictive practice should be the least restrictive and used only:
 - (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
 - (b) to the extent necessary and proportionate to the risk of harm;
 - (c) with the approval of a person authorised by statute to make this decision;
 - (d) as prescribed by a person's behaviour support plan; and
 - (e) when subject to regular review.
- (ii) Approved providers must record and report the use of restrictive practices in residential aged care to the Aged Care Commission
- (iii) Accreditation assessments will review the use of psychotropic agents
- (iv) Chief Clinical Advisor must approve the use of antipsychotic medications for aged care residents

Further investigation is required

Much has been written on restrictive practices in the Carnell Paterson Report. This is a complex area made more difficult by the factors listed on pages 120 and 121 of the Report, some of which include funding, time constraints and pressure from family members.

Further controls on restrictive practices were examined by the ALRC and have influenced this recommendation. LASA notes that while having suitable standards is sensible, aged care restrictive practices have been legislated since 2012 stipulating the approval and recording of restraints. The issue is what improvements are required?

As noted in the first Member comment below, it would be impractical to introduce an additional level of approvals via the Commission, when compared to the approvals currently being sought for restraint (GP, family and facility manager). The proposal would slow the responsiveness of GPs and other health professionals which could have a significant impact on a person's quality of life.

Residents and their representatives also need counselling on the contemporary management of challenging behaviours in a communal setting where such behaviours impact the wider community in the home, not just the individual.

Key Member observations are:

"The suggestion that the proposed Chief Clinical Advisor approve the use of all psychotropic drugs does not appear to be practical. What are the other options? At what point is his or her approval sought? Before the drugs are administered, or on review after a few days? This needs to be clarified because in the case of a resident's violence towards himself or others, what are providers expected to do if time delays are involved in gaining approval?"

“The regulatory bodies already have a plethora of best practice guidelines re restraints (physical and chemical). If there is a gap in the guidelines, then we should close that gap before we start tying the system up with central approvals. The support contacts and accreditation reviews would check against those guidelines”.

“This recommendation is very reflective of, and highly reactive to, the Oakden context and not the aged care sector in general. We would want to see more evidence from across the aged care sector to support such an onerous recommendation”.

“Every individual is different and responds to all sorts of medication differently. Why does the Government need to be regulating what should occur between doctor and patient?”

“There are existing regulations surrounding restraint; physical and chemical including guidelines produced by the Department. It's hard to think of another realm of care which has been subject to more scrutiny. In addition, GPs and specialists play an independent role in determining appropriate medication and there are independent reviews by pharmacists. Before the sector accepts additional regulation, it needs to push the Commonwealth to disclose whether the Oakden incidents represent a failure of practice or a failure of oversight”.

“An alternative could be the development of best practice guidelines for the management of challenging behaviours in the context of least restriction on the client in managing this behaviour. Developing the guideline could occur under the advice of an expert reference group and would replace the role of the Commissioner”.

Most facilities have clear guidelines in place re restraint/restrictive practices, perhaps more streamlining of guidance on a national level is required.

The use of best practice guidance is a sensible way forward and is supported by a number of Members, with good industry application of other standards. One Member also noted that these guidelines might focus on situations where there are extreme challenging behaviours.

The government cut funding for behaviour support when they implemented the behaviour supplement scheme. This has proven to be ineffective. More funding is required for providers to deliver better support.

As part of this, it is also important that families are educated on this issue and understand that risks to other residents and staff have to be managed.

Recommendation 8

Ongoing accreditation, with unannounced visits, to assure safety and quality of residential aged care.

Actions

- (i) The initial accreditation visit will be announced.
- (ii) Eliminate re-accreditation visits and replace with unannounced visits:
 - (a) conducted over at least two days;
 - (b) assess residential service performance against all standards;
 - (c) risk-based process used to determine frequency and rigour of visits.

Not supported but further investigation is warranted including on a move to risk based visits

Minister Wyatt has indicated that the Government will introduce unannounced audit visits as soon as possible and LASA understands that more details will be forthcoming. However, the timeframe for this change is not clear and this approach poses a number of issues.

While the changes to Accreditation principles and processes for compliance and monitoring are recommended to support aged care providers to maintain minimum standards of care and service, they cannot be relied upon to identify or manage systemic failings in organisational leadership and governance. This is the domain of good corporate and clinical governance. Strong, well informed and educated Boards (of Management), leadership and staff will create a culture of quality rather than compliance.

If this recommendation is implemented in isolation, providers will be operating in an environment marked by the current outcome standards, an unreformed (but tweaked) AACQA, and an absence of readily accessible expert advice and training on the handling of challenging behaviours. In addition, the Single Aged Care Quality Framework is not due to be finalised until mid-2018 and it is unclear as to the timeframe for implementation of this.

An important element of this recommendation is the risk-based process to determine the frequency and rigour of visits. Whether visits are announced or unannounced, risk based approaches make sense as long as risk is fairly and properly identified. This would reflect concepts of 'earned autonomy' employed in other contexts. Ideally, operators assessed as providing a "quality service" should face less frequent and onerous reviews. LASA notes that the Nous Group has done work on this topic for the AACQA - *a key diagram from this report is shown at the end of this section*. If a risk -based approach was to be implemented, any proposed approach should be tested with the sector and refined as needed before implementation. In other earned autonomy models³, there is often careful consideration of the drivers of risk, compliance and performance linked to psychological factors and use of behavioural economics. This aspect may need to be looked at further.

³ [https://pure.york.ac.uk/portal/en/publications/aligning-incentives-and-motivations-in-health-care-the-case-of-earned-autonomy\(6617b7d9-b6df-483d-a3f5-ca10ff150b62\).html](https://pure.york.ac.uk/portal/en/publications/aligning-incentives-and-motivations-in-health-care-the-case-of-earned-autonomy(6617b7d9-b6df-483d-a3f5-ca10ff150b62).html)
<http://www.epa.vic.gov.au/business-and-industry/guidelines/licensing-and-works-approvals/earned-autonomy-pilot>

Member concerns with the recommendation generally, include:

“All this proposal does is further complicate the process for providers. Those organisations that always do the right thing will be penalised for the behaviours of the few that consistently lodge information late”.

“Un-announced accreditation visits are a retrograde step, a major knee jerk reaction and not founded on evidence. Unannounced accreditation visits will not solve the Oakden scenario. The report shows that both the Agency and DoH were both active in this matter. Remember the legislation already provides for Review Audits and they don't have to be announced. In a risk based scenario this is what should have happened for Oakden with non-compliance dealt with strongly”.

Further Member input was:

“The Carnell Paterson Report has also recommended the development of more informed risk indicators which will help target homes for unannounced visits. It lists more vulnerable residents who, in themselves, will single out homes for special attention. Its list does not include people from a non-English background - consumers with poor English skills can lead to poor clinical and social outcomes because of their inability to communicate. This in itself can lead to medication errors, poor assessment of pain, injury, incidents or behaviour, and involuntary isolation”.

“Currently, we can expect unannounced visits at any time. Will the costs of accreditation reduce? But 2-3 year periodic accreditation could be very costly”.

LASA notes that the Minister's intention is to ensure quality of care 365 days per year and to mitigate risks that announced visits may mask some underlying quality issues. LASA observes that the AACQA has always had the option of conducting an unannounced visit if they had a concern about a facility. In 2016-17 AACQA conducted 2,688 unannounced visits⁴ monitoring performance as part of the Australian Government's requirement that every aged care service receives at least one unannounced visit per year.

As covered in the section on recommendation 9, the quality of the process of assessment of a facility against standards is critical. The Government should consider whether any aspects of its approach creates risks of sub-standard care not being identified. It is possible that unannounced visits are intended to identify what is really happening on a day to day basis, rather than looking at whether paperwork is up to date, for instance. But in designing the accreditation visits it must be explicit that consistent and evidence-based identification of issues is central to the visits, with strong links to sound rectification. Achieving this may not be as simple as moving to only unannounced visits.

Regardless of the approach to visits, plans, aligned with a risk based approach, are needed for early identification and rectification of issues to minimise the chance of any closures which disrupt residents.

⁴ <https://www.aacqa.gov.au/about-us/annual-reports/AACQAAnnualReport2017PRINTED.pdf>

The broad logistics of moving to unannounced visits would also require the Quality Agency's methodology for conducting accreditation visits to be revised. Current practices for announced visits provide for an efficient process that ensures key staff are available, documentation is collated and provided in appropriate formats, residents and families are invited to participate, etc. For unannounced visits, this will not be the case.

Unannounced visiting assumes that teams will be accessible, yet managers may be on leave or away for conferences or meetings – you need the manager to help the assessor understand the provider's plan for compliance with the evidence checked against that and linked to the consumer experience. A focus on unannounced visits will create uncertainty that may deter people from joining the industry. It is also something that would be difficult for homes in regional areas which may have more limited support systems.

Carnell and Paterson also propose obtaining 20% of consumer feedback during audit visits. While this may help to provide a more complete picture of the service, this may be impractical for unannounced visits where family members may not be available to give feedback. It could also make these visits very time consuming. One option might be to obtain telephone input.

If visits take more time this will increase the cost of visits. With significant cuts to ACFI impacting providers, we well as other cost pressures, provider sustainability is compromised⁵. Modelling commissioned by LASA shows a significant revenue gap emerging for residential aged care providers. Imposts from the costs of unannounced visits are unreasonable. Already, LASA has campaigned extensively against previously announced charging for unannounced visits. Other questions might be posed such as would relatives choose to pay for an extra visit to allay or vindicate their concerns about a home?

More generally, the cost of any move to a focus on unannounced visits will need to be determined and negotiated with industry to work through who pays and how much. Similarly, any cost impost associated with unannounced visits will need to be measured against the added benefits to quality and confidence.

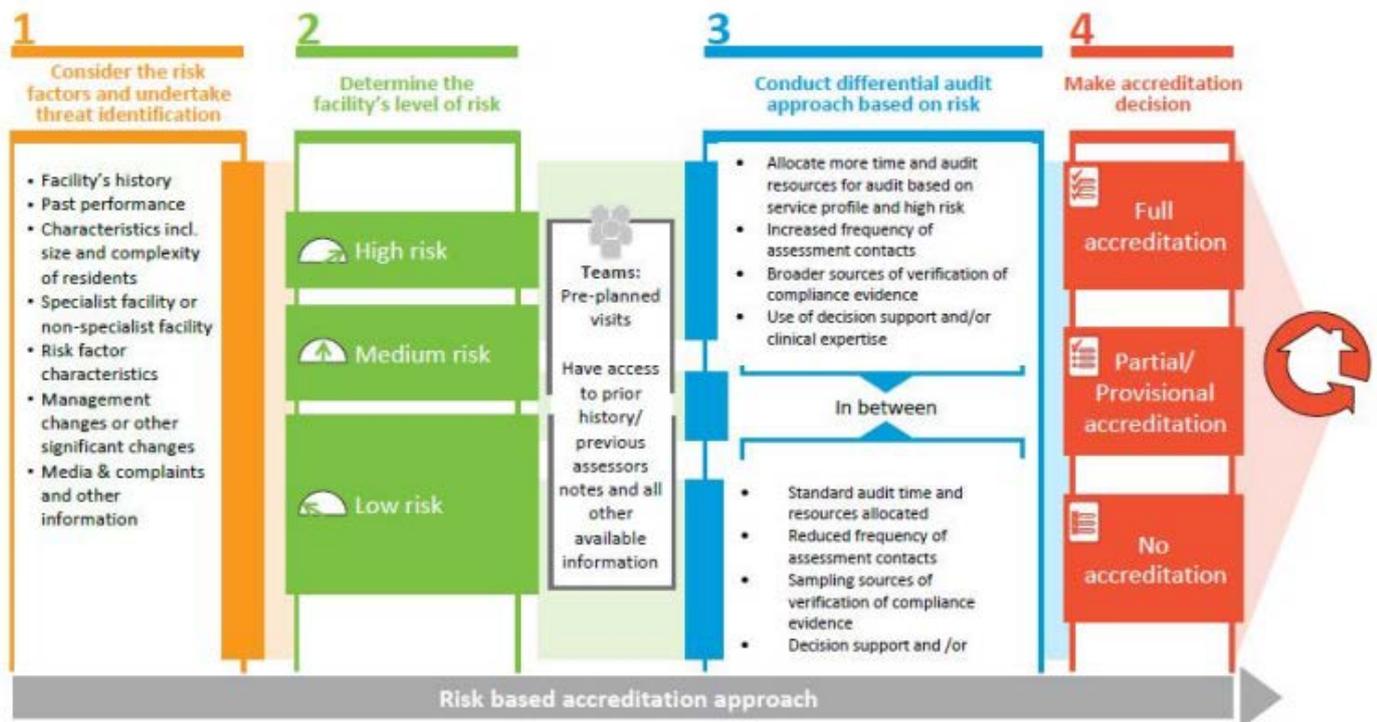
A Member noted:

“We believe that ongoing accreditation with unannounced visits may be costly to providers as they will have to invest in larger risk management teams to ensure that all visits will be successful, and the right documentation and analysis is available to prove that all risk is prioritized and controlled”.

⁵ Detailed information on the financial viability of residential aged care, based on modelling done for LASA, is available in LASA's December 2017 Pre-Budget Submission to the Commonwealth Government.

Appendix A Risk-based audit model

Figure 2: A strengthened risk-based audit model for the Quality Agency



Recommendation 9

Ensure that assessment against Standards is consistent, objective and reflective of current expectations of care.

Actions:

- (i) Strengthen capability of assessment teams
- (ii) Clearly define outcome measures in standards guidance material, with reference to best practice resources for clinical measures (i.e. clinical care and clinical governance)
- (iii) Work with the Australian Commission on Safety and Quality in Health Care to develop a clinical governance framework and clearer guidance on assessment of clinical care measures to ensure they are fit for purpose for residential
- (iv) Review Aged Care Standards every five years to ensure that they are fit for purpose
- (v) A Residential Medication Management Review (RMMR) must be conducted on admission for residents to an aged care service, after any hospitalisation, upon deterioration of behaviour or any change in medication regime

Supported with caveats

This is an important recommendation and goes to the heart of the issues with the Oakden facility. If the AACQA had applied objective and consistent review of this facility, then the issues may have been identified in a timely manner. The AACQA should be held accountable for its failings and it should be explicit that best practice regulatory oversight practices are central to effective regulation.

With changes in this area though, there should be a focus on consumer directed outcomes – not predetermined outcomes. The service provider should be measured against whether they have delivered on what's important to the individual care recipient. This can look vastly different from an outcome in the Standards.

Members observed:

“For this recommendation to be met, the Quality Agency needs to be up to date with contemporary auditing practice. It also needs to have staff who are appropriately trained to assess the standards of the day”.

“Our experience is that the AACQA has surveyors who may have an 'audit' background but lack any experience in the health sector to be able to identify clinical concerns. This is of significance given that 50% of the expected outcomes are in Standard 2. The new single quality framework has an increased focus on clinical outcomes and there is a significant concern that if the AACQA does not move to change its recruitment strategy, this will result in matters of clinical care not being identified by the AACQA surveyors”.

“The government should allow alternative accreditation providers that are able to respond to requests for a visit but who also work to develop a collegiate and supportive relationship with the staff working in the facilities”.

On the subject of training, much has been said in the Carnell/Paterson Report of the mental health status of the residents of Oakden. Based on current trends, an increasing proportion of residents in residential aged care facilities have dementia of some kind. This may be accompanied by other mental health issues such as depression and anxiety. The increase in the number of residents with other complex needs such as people who have experienced significant trauma also needs to be considered.

The complexity of the needs of residents requires very specialised training in how to care for and accommodate these people in a communal setting and manage the impact of their behaviours.

This is also a message for researchers and the training authorities of the nursing and medical professions to acknowledge this cohort and introduce relevant treatment programs.

Little is known of the quality assurance practices of the Quality Agency. In fact, who audits the auditors? Although Team Leaders may sometimes accompany Agency teams during their accreditation visits, what measures are taken to ensure their audits meet best practice in this area?

How often are Quality Agency’s handbook and guidelines reviewed for currency and relevance? Logic suggests that if the standards are a work in progress, the same principle should apply to the Agency’s auditing practices and indicators. Assessors need to possess the skills to assess the issue within the context in which they are operating. More consideration should be given to the health needs of the residents and the background of assessors and clinical measurement.

While supportive of this recommendation, LASA notes there is further work required e.g. it needs to be linked to the development of risk based oversight (refer to the prior section).

The forthcoming Single Aged Care Quality Framework will also be central to this – standards that apply irrespective of setting should contribute to more efficient and transparent oversight.

Regarding recommendation 9 (v), it should be noted that the Residential Medication Management Review is currently funded under Medicare and eligibility is generally every two years (unless under special requirements). Funding may be an issue with this recommendation. This level of Medication Management Reviews may require more funding for GP or other professional assessments. Under some circumstances a resident may have all four circumstances mentioned in the recommendation occur in a short period (e.g. one month). The recommended approach may also potentially undermine the role of GPs, specialists and hospitals. Again, the costs and benefits of such a change should be assessed.

Recommendation 10

Enhance complaints handling.

Actions:

- (i) Increase the powers of the Complaints Commissioner
- (ii) The Complaints Commissioner will modify the Australian Open Disclosure Framework for residential aged care
- (iii) Residential services will adopt the modified open disclosure framework
- (iv) Complaints Commissioner will develop an online register of all complaints received and their handling
- (v) The Complaints Commissioner will track and publish outcomes of complaints referred to other bodies
- (vi) Clarify processes for reporting concerns raised by visitors participating in the Community Visitors Scheme

Further investigation is required

The Commonwealth has only accepted complaints which fall within the ambit of the Aged Care Act 1997. Others, such as personnel or professional conduct issues, are referred to appropriate bodies, where they exist. As the Carnell Paterson report suggests, feedback from this is inconsistent and patchy.

The suggestion that all complaints received by the Complaints Commissioner are referred to the Quality Agency may be helpful because the range of complaints will certainly paint a fuller picture of what may be happening in a home.

However, a key issue with this recommendation is the costs/benefits analysis for this approach. At a recent forum between provider peak bodies and consumer representatives it was concluded that more could be done to resolve complaints at the facility level, including improved capability, competency, systems and processes to identify and resolve complaints. Support for consumers, their families and advocates, as well as age services providers and their staff were also identified as requiring further attention. Comments under the section on recommendation 1 should also be noted.

There could be merit in expanding the function of the Aged Care Complaints Commissioner to include an education/sector enhancement role around improved complaints management, front line complaints handling training and information that forms part of a broader quality culture that sees complaints as an opportunity for service improvement. The Complaints Commissioner may also provide a more valuable service to the provider, if it contributed recommendations on how to resolve issues.

Members observed:

“Hasn’t the complaints system just changed around 12 months ago? And are these recommendations assistive in resolving complaints? I do not think so”.

“This is overkill. More needs to be done at facility level to manage complaints – some staff and senior managers do not know how to manage complaints appropriately. With support this could be managed much more effectively. How about an independent objective support person (from the community not government) to come in the first instance to mediate?”

“Timeliness of responses and consultation regarding the outcome of complaints does need to be improved”.

Any system must also have fair approaches to deal with unreasonable and vexatious complaints. For instance, State Ombudsmen and Health Care Complaints Commissions are well aware of this factor and have guidance and processes to address this.

One Member observed:

“To address vexatious complaints perhaps it’s time that anonymous complaints should not be dealt with - the complainant and specific incident should be divulged and in an appropriate time frame”.

There is also a question as to how complaints, whether they are validated, and the nature of the resolution might affect any ‘star-rating’ for an operator. There are risks of gaming and unfair outcomes depending on who makes the complaints and to what purpose.