Evaluation of the Aged Care Quality Standards

Evaluation Report

January 2022

Acknowledgements

KPMG acknowledges the Aboriginal people of the many traditional lands and language groups of Australia.

We acknowledge the wisdom of Aboriginal Elders both past and present and pay our respects to Aboriginal communities of today.

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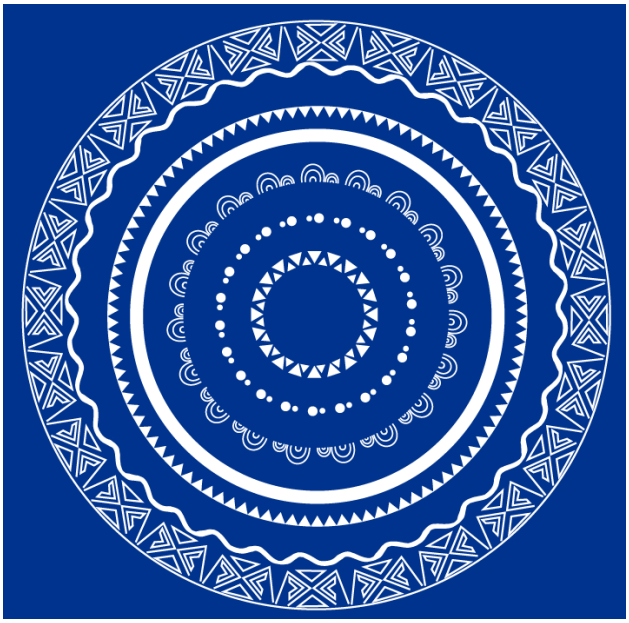
KPMG would like to sincerely thank all stakeholders for making themselves available throughout the evaluation, and for supplying their data, documentation, and insights to support this Evaluation.



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The findings in this document have been formed on the above basis.

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Contents

Glossary

Term	Definitions
AACQA	Australian Aged Care Quality Agency
Accredited Service	A service which has been approved by the Commission to provide care and services to aged care consumers
ACFA	Aged Care Financing Authority
ACSQHC	Australian Commission on Safety and Quality in Health Care
Approved Provider	A provider or service approved by the Commission to deliver residential care, home care package or flexible care program care and services
AN-ACC	Australian National Aged Care Classification
CALD	culturally and linguistically diverse
CHSP	Commonwealth Home Support Programme
Commission	Australian Aged Care Quality and Safety Commission (ACQSC in referencing)
Consumer	A care recipient, or a person who is a recipient of a Commonwealth-funded aged care service
CER	Consumer Experience Reports
Department	The Commonwealth Department of Health
Flexible Care	Various flexible and short-term care programs, including multi-purpose services, innovative care, transition care and short-term restorative care
Guidance	Guidance and Resources for Providers to support the Aged Care Quality Standards
HCP	Home Care Packages
Home Care	Home Care refers to the two main care programs in Australia provided in a home or community setting, including HCP and CHSP programs. It can also refer to other flexible care programs provided in a community (non-residential) setting
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NSQHS	National Safety and Quality Health Service Standards
NDIS	National Disability Insurance Scheme, may also refer to the NDIS Commission or Standards
Peak representative	Representative from a number of aged care consumer and provider representative peak bodies and organisations
QI Program	National Aged Care Mandatory Quality Indicator Program
Royal Commission	Royal Commission into the Quality and Safety of Aged Care
Service Provider	Provider of CHSP or NATSIFACP, not required to be an approved provider
SIRS	Serious Incidence Report Scheme
Stakeholder	KPMG consulted a range of stakeholders as part of this evaluation, including aged care service providers, consumers, carers or family members of a consumer, health professionals, consumer peak bodies and provider peak bodies.
STRC	Short-term Restorative Care Programme
Standards or Quality Standards	Aged Care Quality Standards

Executive summary

Executive Summary

Project context

The Aged Care Quality Standards (the Standards) were introduced on 1 July 2019. The Standards are the first single set of standards to apply across all Commonwealth subsidised aged care service types in Australia.

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) made a number of findings and recommendations in relation to the effectiveness and monitoring of the Standards. There was support for the 'consumer' focus of the Standards, but experts were critical of their lack of detail and lack of objective measurements and identified specific gaps in the Standards. The Royal Commission recommended that an urgent review of the Quality Standards be undertaken, and that the review should be repeated on a periodic basis (Recommendation 20).

KPMG was commissioned by the Commonwealth Department of Health (the Department) in May 2021 to undertake an evaluation of the Aged Care Quality Standards (the Standards). The Evaluation included examination of:

- The clarity of the wording and intent of the Standards
- The relevance of the Standards to each aged care service program
- Whether the Standards are achievable and measurable
- The impact of the Standards on consumers, providers and other key stakeholders including on the regulator's assessment, monitoring, compliance and complaints activities
- Contextual factors that have impacted the implementation of the Standards.

Evaluation Findings

A summary of findings against each Key Evaluation Question for the Evaluation is presented below.

Summary of findings	
 **Key Evaluation Question 1:** **How have broader contextual factors impacted on the implementation of the Standards?**	• The Commission and Department undertook a range of activities to support the implementation of the Standards with the sector. • A number of providers reported that implementation activities had supported their organisation to implement the Standards. However, concerns were raised surrounding the timeframes for implementation of the Standards, the level of detail provided in guidance material, the mode of delivery and audience for certain activities, and provider perceptions on their readiness to implement the Standards were mixed. • A number of themes emerged as enablers and barriers to implementing the Standards, including workforce and governance, implementation support from other sector stakeholders, resourcing and associated costs and reform and change fatigue. A majority of survey respondents from providers indicated that they experienced challenges with implementing the Standards. The most common reported barriers experienced by providers in implementing the Standards were related to workforce, including staff availability, capacity and skills and cost of compliance. • Specific recommendations were made by stakeholders to improve the implementation of the Standards, including increased learning opportunities and guidance, increased implementation time and support, consistent and transparent information about how the Commission assesses provider

Summary of findings	
	performance against the Standards and increased consultation and promotion of the Standards to consumers. • Changes to the Standards will need to be considered and aligned to a range of future reform initiatives identified by the Royal Commission and some existing aged care programs.
 **Key Evaluation Question 2:** **What improvements could be made to refine the Standards' clarity, validity, applicability, and reliability?**	• The majority of stakeholders agreed that the wording of the Standards is clear and that they understand the intent of the Standards. However, some providers raised challenges in putting certain more complex themes of the Standards into practice such as cultural safety and cultural diversity, dignity of risk, best practice and governance. A large proportion of providers consulted also highlighted challenges in understanding the expectations of the Commission and how they assess performance against the Standards. • There was a high level of agreement that the Standards represent stakeholder expectations of quality aged care, however 'gap areas' were identified. New issues or requirements were identified under each Standard and stakeholders articulated the need for the Standards to address specific themes articulated in the Royal Commission. • Overall providers perceived that they can consistently assess their own performance against Standards. However, there was a view by providers that there is a level of inconsistency in the Commission's assessment of provider performance. The assessment methodology used by the Commission was out of scope for this Evaluation. KPMG did not evaluate the effectiveness of the assessment process as part of the evaluation and any references made to the assessment process relate specifically to stakeholder views. The Commission continuously refines and improves its assessment methodology and there are certain design aspects of the assessment methodology that may have influenced these views. The Evaluation found that the Standards are sufficiently flexible across all service types and settings, however some home care providers expressed a view that the Standards were more targeted at residential aged care. The majority of stakeholder also supported further harmonisation of the Standards. • There are improvements that could be made to individual standards, including removal of perceived repetition within the Standards and reducing instances where there are multiple concepts contained within a requirement. There is also opportunity to introduce more prescriptive or detailed requirements within the Standards to address the issue of measurability identified by the Royal Commission and meet provider requests for clarity on the expectations of the Commission.
 **Key Evaluation Question 3:** **What impact has the Standards had on consumers, providers and other key stakeholders? To what extent are the intended outcomes being achieved?**	• There is evidence of providers making changes to meet the new Standards. The most common activities undertaken were revisions to policies and procedures, workforce development and training, consultation with consumers, their families and carers, and revisions to governance arrangements. • There is evidence that providers have an increased focus on quality for consumers in some segments of the sector. A majority of stakeholder groups surveyed reported the Standards have improved quality outcomes for consumers, and some data indicates potential improvements of consumer outcomes. • There are differences in impact based on service types, consumer diversity and location. Ongoing impact for providers included some identified improvements in work practices in some segments. Providers raised significant concerns of the increased regulatory burden and impact on the workforce. The impact on the Commission was significant, particularly to

Summary of findings	
	support ongoing education activities for the sector and increased regulatory activity. • Some examples of unintended consequences were raised by some stakeholder groups, including in relation to the use of restrictive practices by providers. • Overall, stakeholders confirmed it was too early in the implementation phase and there are limits in the available data to determine the extent of the impact of the Standards.

Conclusions

The implementation of any new set of standards is intentional and transformational for a sector or industry and was a significant change for the aged care sector. The Standards introduced new themes and requirements centred on consumer outcomes. The framing of the new Standards introduced more complex dimensions to meeting specific requirements which were less binary in nature. As such, a high proportion of providers experienced challenges with implementing the Standards and some providers continue to experience challenges with implementing more complex domains within the Standards and understanding the expectations of the Commission and how they assess performance against the Standards.

The Royal Commission highlighted a range of improvement areas for the Standards which were consistent with stakeholder perspectives provided during this Evaluation. Despite having these concerns, the Royal Commission noted that 'the current Aged Care Quality Standards have only relatively recently come into effect and were the result of an extensive process of consultation', and as such did not recommend introducing a new set of Standards at this time.

There is opportunity to enhance the current set of Standards in the short to medium term, as part of the process for reviewing of the Standards, to address concerns raised during the Royal Commission and this Evaluation. This is likely to require more focused attention and refinements to the requirements statements within the Standards, including:

- **Addressing gaps** identified by the Royal Commission and supported by stakeholders as part of this Evaluation.
- **Removing perceived repetition within specific Standards** through the inclusion of more detailed requirements under existing Standards to distinguish between requirements under different Standards where there are common elements or perceived repetition.
- **Expanding requirements statements with multiple concepts** into separate requirements statements.
- **Improving measurability of the Standards** through amendments to existing requirements or the introduction of new, more detailed requirement statements.

In the longer term there is opportunity to pursue greater alignment of standards between sectors. Any changes to the Standards need to be considered and designed within the context of broader changes occurring within the aged care sector including those that directly relate to the Standards and with consideration of the significant investment to implement. This includes relevant reform commitments by the Australian Government such as:

- Quality Indicators Program and introduction of further indicators should be aligned with/or inform measuring performance against the Standards
- Review and amendments to the Clinical Standard by ACQSHC
- Introduction of new measures to monitoring the quality and safety of aged care, including a new star ratings system.

1. Introduction and context

Introduction and Context

This section presents the project context and the purpose, scope and methodology employed to conduct this Evaluation.

1.1 Project context

The Aged Care Quality Standards (the Standards) were introduced on 1 July 2019. The Standards are the first single set of standards to apply across all Commonwealth subsidised aged care service types in Australia. The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services.

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established on 8 October 2018. A number of findings and recommendations were made in relation to the effectiveness and monitoring of the Standards. The Royal Commission highlighted a number of urgent priority areas covering clinical and infection control outcomes, nutritional needs including preferences and religious and cultural considerations, dementia care, palliative care and provider governance (Recommendations 19 and 90). Additional areas for review included matters relating to workforce training and deployment, advance care plans, the Aged Care Diversity Framework and a focus on quality of life (Recommendation 21). The Royal Commission recommended that an urgent review of the Quality Standards be undertaken, and that the review should be repeated on a periodic basis (Recommendation 20).

On 1 March 2021, the Australian Government announced its intention to undertake an urgent review of the Standards. The final report for the review is due to Government in December 2022. In addition to addressing Recommendation 19, the review will consider and include findings in relation to Recommendations 20 and 21. It was separately announced that the review of clinical care standards for aged care would be the responsibility of the Australian Commission on Safety and Quality in Health Care (ACSQHC) from 1 July 2021. The Government also committed to reviewing four key priority areas: diversity, dementia, food and nutrition and governance. Further information on the Royal Commission findings and recommendations is presented at Section 3 of this report.

1.2 Purpose and scope of this project

To inform the Australian Government's review of the Standards, KPMG was engaged by the Department of Health (the Department) to undertake an evaluation of the Standards (the Evaluation). The Evaluation included examination of:

- The clarity of the wording and intent of the Standards
- The relevance of the Standards to each aged care service program
- Whether the Standards are achievable and measurable
- The impact of the Standards on consumers, providers and other key stakeholders including on the regulator's assessment, monitoring, compliance and complaints activities
- Contextual factors that have impacted the implementation of the Standards.

The questions and sub-questions presented in Table 1 guided the conduct of the Evaluation. The evaluation questions were developed through a co-design approach with the Department and the Aged Care Quality and Safety Commission (the Commission).

Table 1: Evaluation questions and sub-questions

	Question	Sub-Questions	
 **Key Evaluation Question 1**	**How have broader contextual factors impacted the implementation of the Standards?**	(a)	What were the key barriers and enablers to the implementation of the Standards?
		(b)	What other external factors have impacted the implementation of the Standards?
		(c)	What implementation activities were conducted for providers and other stakeholders to support the implementation of the Standards (e.g., guidance materials, tools, resources)?
		(d)	How effectively have guidance materials, tools, resources and activities supported the implementation of the Standards by providers?
		(e)	What can be learnt from the implementation of the Standards to inform future review and changes to the Standards?
		(f)	What changes are required to align the Standards with future reform in the aged care sector?
 **Key Evaluation Question 2**	**What improvements could be made to refine the Standards' clarity, validity, applicability and reliability?**	(a)	Are the Standards clear and easy to understand?
		(b)	Are the Standards valid and reliable? Do they represent stakeholders' expectations of quality aged care? Do they support consistent assessment of performance?
		(c)	Are the Standards sufficiently flexible for application across all service types and settings?
		(d)	Are there any gaps?
		(e)	Are there aspects of the Standards that could be harmonised? What benefit would this provide?
		(f)	Are there suggestions for improving individual Standards?
 **Key Evaluation Question 3**	**What impact has the Standards had on consumers, providers and other key stakeholders? To what extent are the intended outcomes being achieved?**	(a)	To what extent are the intended outcomes being achieved (short-term outcomes)? Is there evidence of providers making changes to meet the new Standards? Do service providers have an increased focus on quality outcomes for consumers? I.e. are service providers achieving the consumer outcomes (defined under each Standard)?
		(b)	Is there a difference in impacts based on service types, consumer diversity, location of service provider or diversity of service provider, and regulator?
		(c)	What other factors may have contributed to or hindered the achievement of the outcomes?

Source: KPMG.

Out of scope

The following domains were out of scope for this evaluation:

- Evaluation of the development of the Standards[1]
- Evaluation of the regulation of performance against the Standards.

1.3 Limitations

The following limitations should be considered when reviewing and interpreting the findings presented in this report:

- **Timeframe explored for this Evaluation:** The Standards have only been in place for two years. As such, this evaluation did not focus on the medium- and longer-term impacts associated with the Standards.

[1] A separate evaluation of the development of the Standards was completed in 2020 for the Department by Australian Healthcare Associates.

- **Availability of quantitative data to support the evaluation and to complete a pre-post study:** A pre-post study was not able to be completed. Given the differences between the sets of standards in place prior to and post 1 July 2019, it was not appropriate to compare levels of compliance against the different sets of standards. Performance data is also not yet available for every provider in the sector as the Accreditation and Quality Review Cycles (timeframes up to three years) have not been completed for all providers. As such, this evaluation has drawn on stakeholder perspectives shared through the survey and consultations, the lightning review and findings from the Royal Commission.
- **Representativeness of participants in stakeholder consultations:** A range of stakeholders were identified to participate in interviews. In some cases, these stakeholders represented a sample of a broader group. These samples had the potential of being biased and indicative, rather than definitive. Wherever possible, stakeholders from an organisation or group were representative of an organisation or held an official role and were asked to provide information to support their views when that information was not already being collected from other sources.
- **Attribution:** In the absence of data to support a pre-post study, it is difficult to attribute the changes observed solely as a result of the Standards. A range of additional contextual factors were raised by stakeholders which impacted the implementation of the Standards and the experience of providers in transitioning to the Standards which are documented in this report. The aged care sector has been significantly affected by these and other contextual factors during the period of implementation of the Standards. It is envisaged that these contextual factors impact findings of this evaluation more significantly than would otherwise be the case, or may be the case during future evaluations of the Standards.
- **Availability and accuracy of data:** There are limitations on the availability and reliability of data sources to understand impact and quality of the aged care sector as well as other relevant data points. Where there are limits on available and reliable data to support conclusive evidence of findings of the evaluation questions, these are highlighted throughout the report.
- **Alignment of evaluation questions:** The evaluation required analysis against each evaluation question as agreed with the Department. However, some evaluation questions related to more than one given evaluation domain, which meant that some findings were discussed across several domains where necessary.

1.4 Structure of the report

This report is structured in the following sections:

- **Section 1:** Provides the project context and the purpose, scope and methodology employed to conduct this Evaluation
- **Section 2:** Provides important contextual information about the Standards
- **Section 3:** Presents the findings and recommendations from the Royal Commission in relation to the Standards.
- **Section 4:** Provides the methodology used to conduct this Evaluation.
- **Section 5:** Presents findings from the Evaluation related to Key Evaluation Question 1: How have broader contextual factors impacted on the implementation of the Standards?
- **Section 6:** Presents findings from the Evaluation related to Key Evaluation Question 2: What improvements could be made to refine the standards' clarity, validity, applicability and reliability?
- **Section 7:** Presents findings from the Evaluation related to Key Evaluation Question 3: What impact has the Standards had on consumers, providers and other key stakeholders? To what extent are the intended outcomes being achieved?
- **Section 8:** Provides areas for the Department to consider for the review of the Standards and future amendments to the Standards.
- **Appendices:**
  - Appendix A: Program logic
  - Appendix B: Stakeholder participation

- Appendix C: Consumer Outcome Statements of the Standards
- Appendix D: Additional information on the Commission's assessment methodology.

2. The Aged Care Quality Standards and Royal Commission findings

The Aged Care Quality Standards and Royal Commission findings

This section provides important contextual information about the Standards.

2.1 About the Aged Care Quality Standards

The Standards apply to all approved aged care providers, and providers who deliver Commonwealth Home Support Programme (CHSP) and National Aboriginal and Torres Strait Islander Program Flexible Aged Care Programme (NATSIFACP).[2] The eight Standards are outlined in Figure 1. Depending on the scope of services provided, some aged care services are not required to meet all requirements under the Standards. For example, Standard 5 'Organisation's service environment' applies to the physical service environment that the organisation provides for residential care, respite care and day therapy centres but does not apply to home care services where the environment is the consumer's home.

Figure 1: The Aged Care Quality Standards

Standard 1:
Consumer dignity and choice

Standard 2:
Ongoing assessment and planning with consumers

Standard 3:
Personal care and clinical care

Standard 4:
Service and supports for daily living

Standard 5:
Organisation's service environment

Standard 6:
Feedback and complaints

Standard 7:
Human resources

Standard 8:
Organisational governance

[2] The providers of CHSP and NATDIFACP are not required to be approved providers but must still adhere to the Standards under the *Aged Care Quality and Safety Commission Act 2018*, (Cth) s. 8.3.

Source: Aged Care Quality and Safety Commission[3].

Each Standard includes a statement of outcome for the consumer, a statement of expectations for the organisation and the organisational requirements to demonstrate that the Standard has been met. The Standards were introduced on 1 July 2019.

Regulatory context

Aged care service providers' performance is assessed against the Standards, however the assessment requirements are different for each aged care program. Residential aged care services must be accredited. The accreditation and re-accreditation process for residential aged care services includes performance assessment against the Standards, with the Commission determining the accreditation period for services. The accreditation period for commencing services is normally one year, and the accreditation period following re-accreditation site audits differs based on various matters, including the providers compliance with Standards. Residential services receive at least an annual assessment contact which assesses performance against a part of the Standards.

For home services (home care, STRC provided in a home care setting and CHSP), the Commission conducts quality reviews against the Standards at least once every three years. The Commission may conduct further assessment and monitoring activities of residential or home care service in accordance with service risk profiling at all other times.

The Commission has powers to respond to non-compliance against the Standards through its regulatory and compliance functions, including variance to the frequency of monitoring activities, imposing sanctions, revocation or variation of accreditation and issuing notices. The Commission seeks both to determine whether services have failed to meet their aged care obligations and takes a risk based and proportionate approach in determining how to address non-compliance.

Public reporting or information

The outcome of a provider's assessment against the Standards is publicly reported. The My Aged Care website (managed by the Department) enables a user to search for any approved provider and view their performance against each Standard and their Service Compliance Rating. Provider assessments are also published on the Commission's website.

The My Aged Care website also has a "non-compliance checker" where a user can search a provider's name and view any non-compliance notices issued to the provider. The Commission's website also provides access to historical audit reports for each approved provider and publishes a non-compliance register detailing providers who have been found to be non-compliant with their responsibilities under the *Aged Care Act 1997*. The annual reports on the operation of the *Aged Care Act 1997* also details providers' issued notices of sanctions, as well as the number of providers issued notices to agree and notices of non-compliance.

The Commission publishes performance information about individual aged care services including performance reports in relation to performance assessment activities undertaken, decisions relating to accreditation of residential services and other historical performance information.

The Commission also publishes sector performance data each quarter, which includes information about providers' compliance with the Standards.

Guidance material

The Commission has published a range of guidance material and resources to support providers, consumers and other sector stakeholders to understand the Standards. Further detail on the guidance material and resources available is provided in Section 5.

[3] Aged Care Quality and Safety Commission, Quality Standards, www.agedcarequality.gov.au/providers/standards

Previous Standards

The Standards were established to harmonise and lift quality and compliance of all aged care service programs under a Single Quality Framework. By moving towards a Single Quality Framework, the Australian Government sought to develop an end-to-end, market-based aged care system, supported by a single set of Standards, streamlining of performance assessment, and increased informed decision-making by consumers.[4] The harmonisation undertaken to implement the Standards impacted different programs due to comparative differences in requirements under previous standards.

The former Accreditation Standards[5]

Approved providers of residential aged care were previously assessed against the Accreditation Standards. The former Accreditation Standards were enacted with the introduction of the *Aged Care Act in 1997*. By 2016, almost 98% of all providers of residential aged care met all 44 outcomes of the Accreditation Standards, further determining need for a review of the Standards.

The introduction of the new Standards presented new challenges for existing providers due to established implementation of the former Accreditation Standards. The level of prescription of the old and new sets of standards was similar, however overall scope had broadened. Neither provide specific detail on how providers can meet the standards. However, the framing of the new Standards introduced more complex dimensions to meeting specific requirements which are less binary in nature, including delivering care that is 'best practice' while delivering care in a way that 'meets consumers' preferences' and supporting consumers to take risks. As a result, providers now need to demonstrate multiple competencies across what providers may perceive as conflicting domains. Some of these dimensions require a greater level of judgement by the regulator and providers to determine if the requirement is being met.

The former Home Care Common Standards[6]

Service providers of Home Care Package (HCP) and CHSP programs (collectively home care) were previously required to comply with Home Care Common Standards. The shift to the new Standards significantly lifted the requirements for home care services, although not all services are currently required to comply with all requirements under the new Standards.

The former NATSIFACP Quality Standards[7]

The NATSIFACP program provides mixed aged care services to meet the needs of Aboriginal and Torres Strait Islander peoples, to allow them to remain close to home and community. Most services are in rural and remote locations.

The previous NATSIFACP Quality Standards were smaller in scope and requirement and involved a low regulatory burden overall to support services. NATSIFACP services have come under the Standards which significantly increases requirements placed on the services.

The former Flexible Care Standards for short-term restorative care[8]

Flexible Care Standards were previously set out under the *Quality of Care Principles 2014* and aligned requirements based on whether flexible care services were provided in a residential aged care or home care setting.

[4] Australian Department of Health (2017), Single Aged Care Quality Framework Consultation Paper, www.agedcare.royalcommission.gov.au/system/files/2020-06/RCD.9999.0018.0001.pdf
[5] Aged Care Quality and Safety Commission, Accreditation Standards Fact Sheet, www.agedcarequality.gov.au/sites/default/files/media/accreditation_standards_fact_sheet_updated.pdf
[6] Aged Care Quality and Safety Commission, Home Care Common Standards Fact Sheet, www.agedcarequality.gov.au/sites/default/files/media/home%20care%20common%20standards%20v1.1.pdf
[7] Aged Care Quality and Safety Commission, National Aboriginal and Torres Strait Flexible Aged Care Program (NATSIFACP) Quality Standards Fact Sheet, www.agedcarequality.gov.au/sites/default/files/media/flexible_aged_care_program_standards_updated.pdf
[8] Aged Care Quality and Safety Commission, Old Standards, www.agedcarequality.gov.au/providers/standards/old-standards

Table 2: Snapshot comparison of former standards for residential and home care programs with new Quality Standards

Pre 2019 Standards: Accreditation Standards	**Pre 2019 Standards: Home Care Common Standards**
• Less detail (for example Accreditation Standards contained four standards, 44 expected outcomes) • Process and systems outcomes-defined • Themes of clinical and personal care, consumer well-being and systems for a safe environment. Governance was described as management systems • Continuous improvement outcomes under each of four standards • Regulatory compliance outcome under each of four standards • Sub-themes such as palliative care defined • Phrased in a binary way	• Less detail and smaller scope (for example Common Standards contained three Standards, 18 expected outcomes) • Standards covered are Effective Management, Appropriate Access and Service Delivery, Service User Rights and Responsibilities • Highlights additional 'responsibility' of the 'service user' • No addressing of clinical care, home or service environment and other outcomes captured under new Standards • Overall lower regulatory burden • Phrased in a binary way

New Standards (1 July 2019)
• More detail (eight standards, 42 requirements with additional sub-requirements) • Consumer and care principal outcomes ('requirements') defined. A shift away from process- and system-based to outcome-based standards • Includes a specific consumer outcome statement for each standard • Additional scope themes of consumer dignity and choice, organisational governance, human resourcing, feedback and complaints and other sub-themes. Broadening of previous themes, for instance, instead of palliative care, clinical and personal care, end of life care and planning has multiple relevant requirements to palliative care • Phrased with more complex dimensions to meeting requirements, including sub-requirements

Source: KPMG.

3. Royal Commission findings and recommendations

Royal Commission findings and recommendations

This section presents the findings and recommendations from the Royal Commission in relation to the Standards.

3.1 Royal Commission findings

A range of findings were made in relation to the Standards by the Royal Commission. The evidence received by the Royal Commission about the Standards was mixed. There was support for the 'consumer' focus of the Standards, but experts were critical of their lack of detail and lack of objective measurements. Specific issues raised by the Royal Commission are presented in Table 3.

Table 3: Royal Commission findings related to the Standards

Issue	Royal Commission findings
Gaps within the Standards	It was noted that the Standards lack detail or contain gaps in particular areas. For example, the Royal Commission noted that the Standards fail to outline high-quality dementia care and palliative care. The Final Report noted that these types of care require immediate improvement to become core business of aged care services and should be considered more closely in an urgent review of the Standards. Gaps within the Standards are presented at a high level in the recommendations below and further explored in Section 6 of this report.
Measurability of the Standards	The Royal Commission was critical of the measurability of the Standards. It described that any standards 'must clearly communicate what providers must do to deliver high quality aged care' and provided an example of how the requirements under Standard 7 could be strengthened to include a requirement that 'food service staff are specifically trained in food provision in residential aged care'. In this way the Royal Commission's articulation of measurability talked to the level of prescription and detail of requirements contained in a Standard and their ability to present a clear view to consumers, providers and the regulator what providers must do to demonstrate that they are meeting the outcome of the Standard. The Royal Commission also explored the inclusion of requirements within the Standards that can support additional measurement and benchmarking of performance. For example, it noted a requirement could be included 'that menu details include quantities of serves of each of the food groups, so the adequacy of the menu can be benchmarked against Australian standards'.
Ability to use performance assessment data to differentiate performance of providers to support consumer decision making	The Royal Commission highlighted that while the Aged Care Quality Standards rating and Service Compliance Ratings are published for all residential aged care services, 'they do not differentiate between services that barely meet those minimum standards and those that have achieved excellence'. This issue has a direct relationship with the assessment framework for the Standards. The current assessment framework rates performance against the Standards in a binary way, as either met or not met, as distinct from assessment approaches in some other sectors or jurisdictions which offer a graded assessment of performance with more than two assessment levels to support greater differentiation of performance of different providers. The Royal Commission specifically commented that 'the regulator should adopt a more rigorous, graded assessment of service performance against the Aged Care Quality Standards'.

Issue	Royal Commission findings
Transparency of information currently collected in the aged care system at a provider level to support consumer decision making	The Royal Commission noted that 'useful and relevant information on aged care services is difficult to come by'. In particular it articulated that information currently collected through the aged care system is not accessible at either a provider or a service level to support consumer decision making, for example information about the nature, number and disposition of complaints and the number of reportable assaults.
Availability of broader data sets to understand the quality and safety of aged care	Standards are one lever to measure the quality and safety of care in a system. There are a range of other levers available to measure the quality and safety of aged care, including that offer transparency of 'outcomes' achieved within a system. Certain levers already exist within the current aged care system, including National Aged Care Mandatory Quality Indicator Program (QI Program) and the Serious Incident Response Scheme. The Royal Commission specifically highlighted that there is a lack of 'quality data about older people and their experiences of aged care' and staffing levels. The Australian Government's response to the Royal Commission accepted Recommendation 23 to incorporate greater use of quality indicators for continuous improvement through the expansion and development of the QI Program. Recommendation 24 was also accepted, outlining that star ratings will be published on My Aged Care by the end of 2022, providing performance information for people seeking residential aged care. Star ratings will include information on quality indicators, consumer experience reporting, staffing levels and service compliance ratings.
Alignment of the Standards with broader changes within the aged care sector	The Royal Commission also raised concerns related to the alignment of the Standards with broader reform and changes that had occurred within the sector. It noted that 'changes to the Standards had sometimes been developed in isolation from other changes to the broader system, in response to a particular issue of public concern, and therefore lack any strategic context'.

Source: Analysis of findings from the Royal Commission Final Report series[9]

These issues are explored in the findings sections of this report where there is alignment to the scope of this Evaluation.

[9] Royal Commission into Aged Care Quality and Safety (2021), Final Report, www.agedcare.royalcommission.gov.au/publications/final-report

3.2 Royal Commission recommendations

The recommendations of the Royal Commission included four specific recommendations for the Standards.

Recommendation 18:

Aged care standard-setting by the renamed Australian Commission on Safety and Quality in Health and Aged Care

1. Section 9 of the *National Health Reform Act 2011* (Cth) should be amended to:
    a. rename the Australian Commission on Safety and Quality in Health Care as the 'Australian Commission on Safety and Quality in Health and Aged Care', and
    b. confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality.
2. Amendments to section 10 of the *National Health Reform Act* 2011 (Cth) should also be made to provide for a consultation process for the Commission's aged care functions.

Figure 2: Summary of relevant recommendations, Royal Commission Final Report

Recommendation 18:

Aged care standard-setting by the renamed Australian Commission on Safety and Quality in Health and Aged Care

1. Section 9 of the *National Health Reform Act 2011 (Cth)* should be amended to:
    a. rename the Australian Commission on Safety and Quality in Health Care as the 'Australian Commission on Safety and Quality in Health and Aged Care', and
    b. confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality.
2. Amendments to section 10 of the *National Health Reform Act 2011 (Cth)* should also be made to provide for a consultation process for the Commission's aged care functions.

Recommendation 19:

Urgent review of the Aged Care Quality Standards

1. By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care the following matters for urgent review and, if the Commission considers appropriate, amendment of the Aged Care Quality Standards:
    a. requiring best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, and infection control, and providing sufficient detail on what these requirements involve and how they are to be achieved
    b. imposing appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard to a person's preferences and religious and cultural considerations
    c. sufficiently reflecting the needs of people living with dementia and providing high quality dementia care
    d. provider governance, and
    e. high quality palliative care in residential aged care, including staff capacity (number, skill and type), processes and clinical governance, for recognising deterioration and dying

Recommendation 19:

Urgent review of the Aged Care Quality Standards

2. The Australian Commission on Safety and Quality in Health and Aged Care should complete its review by 31 December 2022.

Recommendation 20:

Periodic review of the Aged Care Quality Standards

The renamed Australian Commission on Safety and Quality in Health and Aged Care should complete a comprehensive review of the Aged Care Quality Standards within three years of taking on the standard-setting function and every five years after that. It should also be empowered to undertake ad hoc reviews and make corresponding amendments either of its own motion or where issues are referred to it for consideration by the System Governor, the Inspector-General of Aged Care or the responsible Minister.

Recommendation 21:

Priority issues for periodic review of the Aged Care Quality Standards

1. By 1 July 2022, the responsible Minister should refer the following matters for the Australian Commission on Safety and Quality in Health and Aged Care to consider as part of its first comprehensive review of the Aged Care Quality Standards:
   a. imposing appropriate requirements relating to the professional development and training for staff
   b. including sufficient reference to and delineation between staff practice roles and responsibilities
   c. requiring providers to assist people receiving care to make and update advance care plans if they wish to, and ensuring that those plans are followed
   d. reflecting the Aged Care Diversity Framework and underlying Action Plans, including considering making them mandatory

Source: Royal Commission Final Report[10].

3.3 Australian Government response to the Final Report

The Australian Government gave a comprehensive response to the Final Report of the Royal Commission.[11]

Recommendation 18 was accepted-in-principle by the Australian Government. The Australian Government stated that the formulation of the clinical care standards for aged care will be transferred to the ACSQHC from July 2021, with the intention of the ACSQHC being able to leverage its established clinical and standards

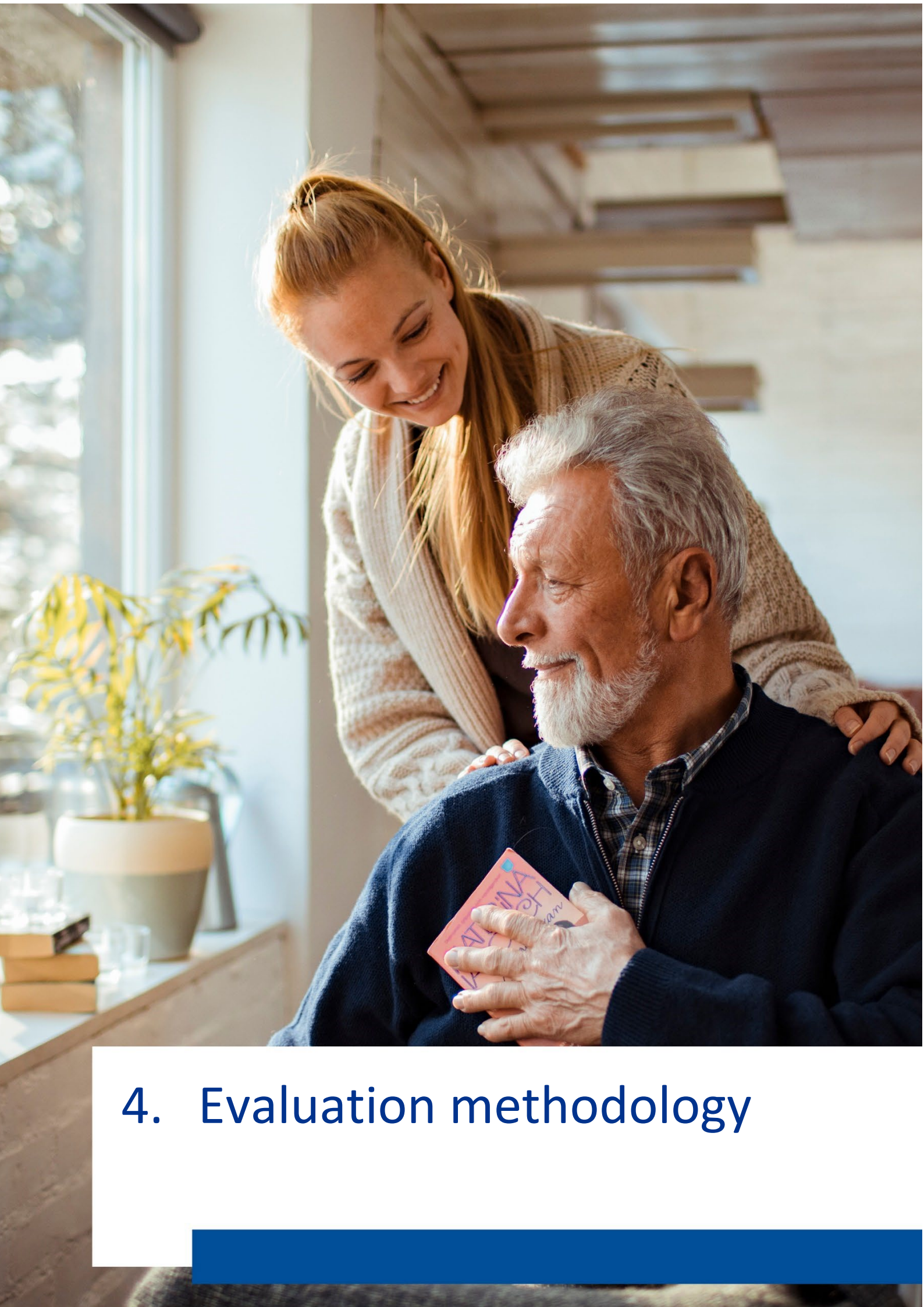
[10] Royal Commission into Aged Care Quality and Safety (2021), Final Report, www.agedcare.royalcommission.gov.au/publications/final-report

[11] Department of Health (2021), Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

expertise. Therefore, the Department will retain its responsibility for all non-clinical standards and the development of the consolidated set of standards under the Act.

The Australian Government accepted Recommendations 19 – 21 and announced a review of the Aged Care Quality Standards on 1 March 2021. The Government responded through the measure: Residential Aged Care Quality and Safety – Aged Care Immediate Priorities – Strengthening Provider Quality.[12] The review will be completed by December 2022 and will inform the subsequent implementation of strengthened Standards. The review will consider all matters raised by the Royal Commission in Recommendation 19, and will inform the scheduling, scope and frequency of periodic reviews, outlined in Recommendation 20. Periodic reviews were also noted to include consideration of whether the Standards are effectively meeting the needs of individuals with diverse characteristics and life experiences, people living with dementia, and the priority issues identified in Recommendation 21. A review of the clinical care Standards will be the responsibility of the ACSQHC from 1 July 2021.

[12] Department of Health (2021), Residential aged care quality and safety (Pillar 3 of the Royal Commission response) – Strengthening provider quality Budget Announcement Fact Sheet 2021-2022 www.health.gov.au/sites/default/files/documents/2021/05/residential-aged-care-quality-and-safety-pillar-3-of-the-royal-commission-response-strengthening-provider-quality.pdf



4. Evaluation methodology

Evaluation methodology

Several different data sources were drawn on to answer the evaluation questions. Data from different sources was triangulated where possible to enable a balanced analysis of information and response to each evaluation question.

4.1 Desktop review

The desktop review focused on the analysis of documents provided by the Department and the Commission related to the implementation of the Standards and review of other sector reports and evaluations, including the Royal Commission Final Report.

KPMG also received written submissions from a small sample of stakeholders to support the Evaluation. These submissions were reviewed as part of the desktop review.

4.2 Lightning review

KPMG conducted a lighting review to understand best and emerging practice of quality standards used in aged care and other related sectors locally and internationally. This included identifying how other quality standards are structured and how they operate in practice. The following materials were reviewed for the quality standards in scope:

- The text of the quality standards
- Provider and consumer guidance material and resources relating to the quality standards
- Material relating to inspection / assessment / reporting and enforcement
- Where available, independent evaluations relating to the quality standards.

Stakeholder consultation

Stakeholders were consulted from August to September 2021 to ascertain their views on each of the evaluation questions. Stakeholder consultations were conducted in a semi-structured way and through virtual focus groups. A total of 323 stakeholders from various stakeholder groups (as shown in Table 4) participated in 35 focus groups conducted during this period.

Table 4: Focus group participants

Stakeholder group	Number of focus group participants
Consumers, family members, carers or representatives of a consumer	37
Consumer peaks	12
Aged care providers	113
Provider peaks	18
Department of Social Services, Department of Veterans' Affairs and the NDIS	8
Special interest groups	62
Aged Care Quality and Safety Commission	11
Department of Health	34
Australian Commission on Safety and Quality in Health Care	3
Other stakeholders	25
Total	323

Source: KPMG.

Stakeholders were invited to participate in the stakeholder consultations and online survey (described below) via the Aged Care Sector Newsletter. The KPMG project team also sought consumer participants through direct engagement with consumer peak bodies.

Stakeholder survey

To allow a greater number of consumers and people working in or adjacent to the sector to participate in the evaluation, a stakeholder survey was developed. The online survey was developed in collaboration with the Department and the Commission. The survey was published on the Department's Consultation Hub and available to anyone working or consuming services in the aged care sector, as well as any stakeholder with an interest in this area.

The survey was qualitative in nature, asking a range of single and multi-response, Likert scale, and free-text questions. A total of 1,377 stakeholders participated in the survey; these respondents reflected a range of stakeholder groups as highlighted in Figure 3. 29% of respondents were aged care service provider representatives, 24% were consumers, carers or family members of a consumer, 22% were aged care workers (including volunteers), 14% were health professionals, 2% were consumer peak representatives, 2% were provider peak representatives and 7%identified themselves as 'other' stakeholders. Respondents could select more than one stakeholder group that applied to them.

Figure 3: Overview of stakeholder participation in the Evaluation [13]

Source: KPMG.

4.3 Program Logic

A program logic was developed as part of an evaluation framework to support the evaluation of the Standards. The program logic was subsequently revised for this evaluation and is shown in Appendix A. This Evaluation explored the short-term outcomes of the Standards presented in the program logic.

[13] The figure highlights the overall participation level in the evaluation. The total figure of 1,700 is approximate. Some stakeholders may have participated in both the focus group sessions and the online survey.

5. Findings: Key evaluation question 1

Findings: Key Evaluation Question 1

This section presents findings related to Key Evaluation Question 1: How have broader contextual factors impacted on the implementation of the Standards?

This question sought to understand the effectiveness of implementation activities that were conducted by the Commission and the Department to implement the Standards and what barriers and enablers impacted the implementation of the Standards. The following areas were key domains when exploring this question:

- What implementation activities were conducted for providers and other stakeholders to support the implementation of the Standards (e.g. guidance materials, tools, resources)?
- How effectively have guidance materials, tools, resources and activities supported the implementation of the Standards by providers?
- What were the key barriers and enablers to the implementation of the Quality Standards? What other external factors have impacted the implementation of the Quality Standards?
- What can be learnt from the implementation of the Quality Standards to inform future review and changes to the Quality Standards?
- What changes are required to align the Quality Standards with future reform in the aged care sector?

The table below presents a summary of findings against this evaluation question.

Table 5: Summary of findings for Key Evaluation Question 1

	Key Evaluation Question 1 **How have broader contextual factors impacted on the implementation of the Standards?**
Summary of findings	
The Commission and Department undertook a range of activities to support the implementation of the Standards with the sector. A number of providers reported that implementation activities had supported their organisation to implement the Standards. However, concerns were raised surrounding the timeframes for implementation of the Standards, the level of detail provided in guidance material, the mode of delivery and audience for certain activities, and provider perceptions on their readiness to implement the Standards were mixed. A number of themes emerged as enablers and barriers to implementing the Standards, including workforce and governance, implementation support from other sector stakeholders, resourcing and associated costs and reform and change fatigue. A majority of survey respondents from providers indicated that they experienced challenges with implementing the Standards. The most common reported barriers experienced by providers in implementing the Standards were related to workforce, including staff availability, capacity and skills and cost of compliance. Specific recommendations were made by consumers, providers, peaks, care experts and other stakeholders to improve the implementation of the Standards, including increased learning opportunities and guidance, increased implementation time and support, consistent and transparent information about how the Commission assesses provider performance against the Standards and increased consultation and promotion of the Standards to consumers.	

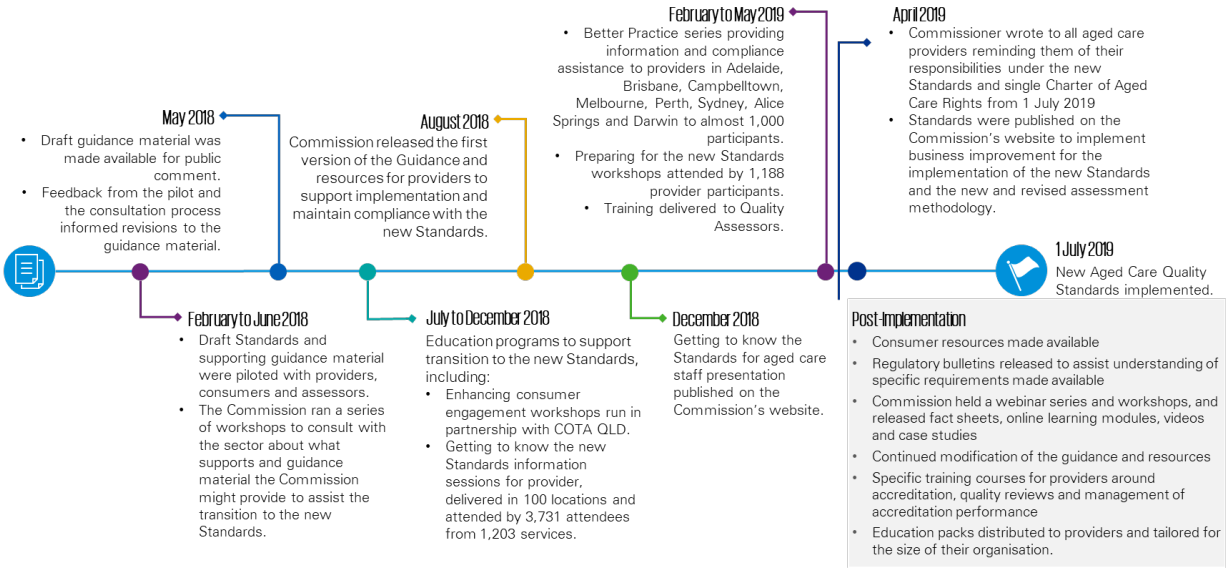
Changes to the Standards will need to be considered and aligned to a range of future reform initiatives identified by the Royal Commission and committed to by Government and some existing aged care programs.

5.1 What implementation activities were conducted for providers and other stakeholders to support the implementation of the Quality Standards?

The process to implement the Standards began in 2018 and occurred concurrently to the development of the Standards. The Department was responsible for the development of the Standards, while the Commission played a primary role in supporting implementation within the sector including the development of guidance material to support sector understanding of the Standards.[14]

An overview of implementation activities conducted leading up to and post 1 July 2019 is presented in Figure 4 and is detailed further below.

Figure 4: Timeline of activities undertaken by the Department and Commission to support implementation of the Aged Care Quality Standards



Implementation activities by the Commission

The Commission undertook a range of activities to support the implementation of the Standards. This included:

- **Development of guidance material:** The primary guidance document for the Standards is the *Guidance and resources for providers to support the Aged Care Quality Standards*. This document is intended to assist aged care services to implement and maintain compliance with the Quality Standards. It includes detail for each Standard regarding their purpose and scope, relevant legislation, resources and references. The document also includes detail regarding the intent of each requirement, as well as reflective questions and examples of actions and evidence of compliance for each requirement. It also provides an indication of

[14] The process to develop the Standards was out of scope for this Evaluation as a separate evaluation was completed for this domain in 2020.

matters that quality assessors consider in assessing compliance.[15] The Commission consulted with aged care providers, consumers and their representatives, peak bodies and subject matter experts to develop this document. Following the consultation process, the draft guidance material was made available for consultation from 3 – 31 May 2018 and feedback was incorporated into an updated version of the guidance material.

- **Workshops:** The Commission conducted a series of workshops targeted at supporting providers to transition the Standards. Between July and December 2018, the Commission conducted 'Getting to know the New Standards' information sessions and the Commission partnered with COTA Queensland to deliver 'Enhancing consumer engagement workshops'. In the lead up to the go-live date, the Commission delivered two series of workshops: 'Better Practice' and 'Preparing for the new Standards'.
- **Webinars:** Webinars were delivered to provide updates on implementation of the Standards.
- **Regulatory bulletins:** Regulatory bulletins, include 'Aged Care Quality Standards performance assessment methodology', were used to communicate progress of implementation and to assist services to understand how requirements and processes fit within the broader aged care regulatory framework. The Commission's Regulatory Strategy is also available on the Commission's website to support understanding of the Commission's approach to regulation including the assessment methodology.
- **Online materials:** A range of resources and materials were published on the Commission's website, including training videos to support providers to prepare for the Standards and how each of the Standards apply to different service types and settings.
- **Consumer resources:** A range of resources were designed for consumers to understand the Standards including a consumer outcomes poster (available in 25 languages other than English), a short video entitled 'What the new Aged Care Quality Standards mean for you' (available in 25 languages other than English) and an Aged Care Quality Standards chatterbox.[16]

Post the implementation of the Standards, the Commission continued to release additional resources for the sector. Providers have access to fact sheets, webinars, educational videos, team activities, self-assessment tools, staff learning modules and storyboards.[17] The Commission has published a 'Guide to Assessment of Commonwealth Home Support Programme (CHSP) Services' which details the Standards that apply to certain CHSP service types.[18]

[15] Aged Care Quality and Safety Commission (2021), Guidance and resources for providers to support the Aged Care Quality Standards, www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V14.pdf
[16] Aged Care Quality and Safety Commission, Resource Library, www.agedcarequality.gov.au/resource-library?resources%5B0%5D=topics%3A211
[17] Ibid.
[18] Aged Care Quality and Safety Commission (2019), Guide to Assessment of Commonwealth Home Support Programme (CHSP) Services, www.agedcarequality.gov.au/sites/default/files/media/guide_to_assessment_of_chsp_services.pdf

Use of implementation activities

Participation in Commission implementation activities was high. Over 5,000 representatives from aged care providers participated in Commission workshops held prior to 1 July 2019. An audit of the guidance material and resources conducted by the Commission also demonstrates high uptake of resources made available by the Commission to support the Standards. For example, the *Guidance and resources for providers to support the Aged Care Quality Standards* has been accessed close to half a million times between 1 January 2019 – 3 February 2021.

Table 6: Top 10 most accessed resources related to the Standards on the Commission's website

Resource	Download Result
Guidance and Resources on the Aged Care Quality Standards for Providers	490,136
COVID-19 (coronavirus) information	100,913
Aged Care Quality Standards (video)	88,070
Make a complaint	56,186
Self-Assessment	45,862
Clinical governance in aged care	37,944
Continuous improvement	35,125
Minimising the use of restraints	21,012
Case Studies (all)	19,428
Clinical governance in aged care (residential-focused resources library)	15,481

Source: ACQSC Audit of Resources, 2021 [19]

Implementation activities delivered by the Department

In addition to leading the development of the Standards, the Department provided additional support to the sector to implement the Standards. This included:

- **Additional funding for residential aged care providers:** The Australian Government provided $50 million to residential aged care providers to assist them to implement aged care quality reform measures, including the new Standards.
- **Resources for spiritual elements of the Standards:** Meaningful Ageing Australia was funded to develop materials for consumers and providers on the spiritual elements of the Standards. This work included the production of a range of materials including short films, posters and postcards. Meaningful Ageing Australia has promoted these materials, including at conferences and seniors expos. The campaign posters and postcards have been translated, including into Italian, Greek and Mandarin, and distributed to communities in association with the Federation of Ethnic Communities' Councils of Australia.
- **Funding for NATSIFACP providers:** The Australian Government funded the delivery of targeted training and assistance to support NATSIFACP service providers to understand requirements under the Standards.
- Additional sector support included informational webinars conducted by the Department, website updates, electronic newsletters and emails to peak organisations.

[19] Assessment Data Page hits and resource download figures are included for activity within the period 1 January 2019 to 3 February 2021.

5.2 How effectively have guidance materials, tools, resources, and activities supported the implementation of the Standards by providers?

A number of providers, peak representatives and other stakeholders reported that the implementation activities conducted by the Commission and the Department had supported their implementation of the Standards. For example, providers commented that the guidance document had supported their organisation to understand what was required and undertake a detailed comparison of their current systems, policies, and processes against the new requirements. Other providers reported using posters published by the Commission as a tool within their service to educate staff and support consumers and their families to understand the Standards and how the organisation is making changes to adopt them.

KPMG's lightning review of quality standards in Australia and internationally also found that the guidance material and resources provided for the Standards are comparable to those found in other jurisdictions. Most regulators publish detailed guidance for providers on meeting the relevant standards such as the *Guidance and resources for providers to support the Aged Care Quality Standards.* Many jurisdictions also make available evidence guides, self-assessment tools and resources for consumers, similar to that provided by the Commission to support interpretation of the Standards.

While the Commission has published resources outlining the assessment methodology used by quality assessors when undertaking performance assessments under the Standards, some jurisdictions also provide more detailed guidance on the specific evidence points [20]. For example, some regulators in other jurisdictions or sectors publish the forms, accreditation guides and/or training modules used by quality assessors to undertake assessments. This provides visibility on the evidence points used to assess performance against their respective set of standards.

However, concerns were raised during consultations surrounding the timeframes for implementation of the Standards, the level of detail provided in guidance material, and the mode of delivery and audience for certain activities. Provider perceptions on their readiness to implement the Standards during consultations were also mixed. Reasons for this were often across several themes, first as a reflection on the timing of commencement of transition activities and then the perceptions on the scale of change that was required to meet the new Standards. In addition, while there was a high level of understanding of the intent of the Standards, most providers highlighted challenges in understanding the expectations of the Commission against the Standards, particularly when assessing performance. Feedback from providers suggested uncertainty and expressed a gap between understanding how they were to implement requirements against the understood intent. Providers demonstrated some understanding that the Standards were written with flexibility to adapt to service needs and that they were responsible to implement, however they perceived that gap to also be between unclear expectation and alignment of assessment teams concerning flexible implementation, leaving them exposed to non-compliance and uncertainty of performance overall. Peaks and other representatives confirmed there were challenges for providers in understanding how to apply and monitor requirements effectively and in line with expectations when assessed. This is explored further in Section 6 of this report.

Specific concerns related to the implementation activities that arose during consultations are presented below.

Timeline for implementation of the Standards

While the implementation of the Standards occurred over an 18-month period, some stakeholders reported that the timeframes for implementation of the Standards were too short for the level of change that was required within the sector.

[20] Evidence points may include systems, processes, practices and consumer feedback received during assessments.

The development of the Standards and supporting guidance material was an iterative process, and some providers perceived that the timing for finalisation of the Standards and guidance material occurred too close to the go-live date and did not provide adequate time for providers to adapt their systems, policies, and processes to the finalised wording by 1 July 2019. These findings are consistent with an evaluation of the development of the Standards that was conducted by the Department in 2020, which noted that stakeholders perceived that the 'timeframes for development of implementation resources were too compressed and left providers inadequately prepared when the new Standards were introduced'.[21]

Other providers consulted as part of the Evaluation reported that they were comfortable with the timeframes for the implementation of the Standards and had begun activities to transition to the Standards at their organisation prior to the guidance material and wording of the Standards being finalised.

Guidance material

Provider perceptions on the *Guidance and resources for providers to support the Aged Care Quality Standards* were mixed. Some providers commented that the guidance document had supported their organisation to understand what was required and to undertake a detailed comparison of their current systems, policies, and processes against the new requirements. Some providers reported that the guidance document was too long. Others reported that there was a need for more prescriptive guidance to understand the Commission's expectations of performance against each Standard. For example, case studies to support understanding of how to implement more complex themes that are new in the Standards such as dignity of risk. These findings are consistent with an evaluation conducted by the Commission in 2020 related to the implementation of the Standards.[22]

Mode of delivery and audience of activities

Providers who participated in consultations and the survey provided observations on both the mode of delivery and audience for certain activities. Positive reports were made on implementation activities that involved two-way dialogue between the Commission and providers such as workshops conducted by the Commission. Positive experiences were specifically identified by providers on the Commission workshops which involved working through practical scenarios and case studies. There was also preference for face-to-face workshops, to provide an opportunity for interaction and discussion. In comparison, activities that were focused on one-way communications from either the Department or the Commission and did not facilitate interaction between stakeholders, such as webinars, were not viewed to be as beneficial to understanding and implementing the Standards.

Some providers stated that the guidance material, resources and implementation activities were not always applicable to all providers, positions and levels of staff employed in aged care. Some providers observed that the content of the guidance material and implementation activities was often targeted at senior and middle management, and did not sufficiently allow for interpretation and understanding by other audiences such as clinicians, direct support staff and volunteers. For example, one provider commented:

> ***The resources for support staff are not in their language and do not reflect the diversity of the workforce, not only from a cultural perspective but also from a staff position level…so organisations need to put in work to add that context.***

[21] Australian Healthcare Associates (2020), 'Evaluation of the Aged Care Quality Standards Phase 1: Development of the Standards' for the Department of Health

[22] Social Research Centre (2020), 'Aged Care Quality Standards Implementation Evaluation – Interim Evaluation One: Preliminary Results Final Report' for the Aged Care Quality and Safety Commission

5.3 What were the key barriers and enablers to the implementation of the Standards? What other external factors have impacted the implementation of the Standards?

Providers consulted as part of this Evaluation and those that participated in the survey were asked about their experience in implementing the Standards. They were also asked to identify factors which either enabled or constrained their ability to implement the Standards. A number of themes emerged as enablers and barriers to implementing the Standards.

Overall, 66% of survey respondents (379 of a total of 570 aged care service providers and workers, including volunteers who completed the survey) reported that they had experienced challenges in implementing the Standards. The most common reported barriers experienced by providers in implementing the Standards were related to workforce, including staff availability, capacity and skills and cost of compliance (as presented in Table 7). Stakeholder views presented in Table 7 below may reflect their experience implementing the Standards prior to 1 July 2019 and ongoing challenges embedding the Standards within their organisations.

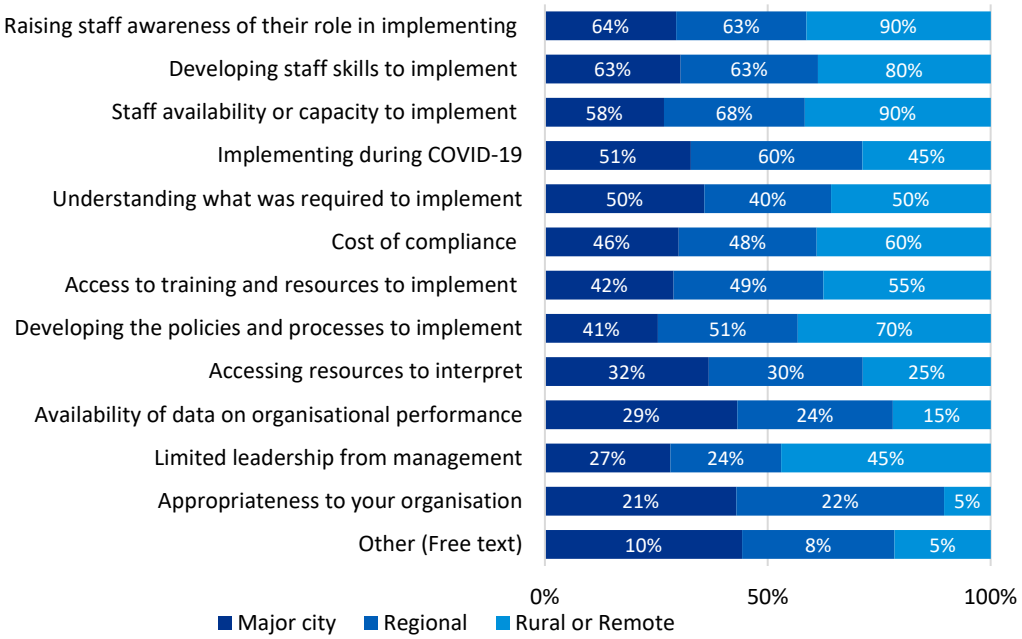
Table 7: 'What barriers existed in your organisation putting the Quality Standards into practice?', count and percentage

What barriers existed in your organisation putting the Quality Standards into practice?		
Response option	**Number of responses**	**% of total respondents**
Staff availability or capacity to implement the Quality Standards	240	63%
Raising staff awareness of their role in implementing the Quality Standards	238	63%
Developing staff skills to implement the Quality Standards	228	60%
Cost of compliance with the Quality Standards	207	55%
Implementing the Quality Standards during COVID-19	189	50%
Developing the policies and processes to implement the Quality Standards	186	49%
Understanding what was required to implement the Quality Standards	172	45%
Access to training and resources to implement the Quality Standards	167	44%
Accessing resources to interpret the Quality Standards	128	34%
Availability of data on your organisation's performance to prioritise areas for improvement or evaluate performance	102	27%
Appropriateness of the Quality Standards to your organisation	101	27%
Limited leadership from management to support implementation of the Quality Standards	81	21%
Other (Free text)	38	10%

Source: Analysis of Evaluation Survey, KPMG.

Of the barriers experienced by providers, there was a difference in the barriers observed by service delivery setting. Survey respondents from providers in rural and remote areas overall selected a slightly higher number of barriers in the survey (6.35) than those in regional areas (average of 5.51) and major cities (5.35). Workforce and cost of compliance acted as a more significant barrier to providers in rural and remote locations than to those in regional and major city areas (as presented in Figure 5).

Figure 5: 'What barriers existed in your organisation putting the Quality Standards into practice?', percentage



Source: KPMG.

Governance and workforce

Governance and workforce were raised as both enablers and barriers to the implementation of the Standards. Common themes raised as enablers were as follows:

- **Governance and leadership within an organisation:** The Royal Commission highlighted the role of leadership and governance in supporting high quality and safe care.[23] Feedback received from some providers related to workforce highlighted that the leadership and governance of their organisation had acted as an enabler to their organisation implementing the Standards. Examples were raised that the culture and leadership set by senior leaders and managers within their organisation meant there was a strong focus on implementing the Standards, including investing in staff training and implementation activities, which had enabled their organisation to implement the Standards:

> **Organisational governance, supportive leadership, adequate resources and time allowed to ensure we have the tools to document what we do and we record the evidence of it being done.**

- **Quality management roles:** Some organisations either employed or utilised existing Quality Management personnel to support implementation of the Standards. Such personnel were tasked by such organisations with championing the change within their service such as through delivering training and developing policies and practices to support the adoption of the Standards.

> **Another factor in implementing the quality standards is the employment of a competent and very skilled Quality Manager who drove all changes and updates required.**

- **Culture of the workforce:** A number of stakeholders from providers commented that despite other barriers faced by their organisation, there was a strong culture within the workforce and desire by staff to implement the Standards, which had ensured their organisation was able to adopt the Standards.

[23] Royal Commission into Aged Care Quality and Safety (2021), Final Report, www.agedcare.royalcommission.gov.au/publications/final-report

Genuine desire from individuals working in the sector to improve outcomes for older people.

A number of barriers were also highlighted related to workforce. The ability of providers to implement the Standards was impacted by recruitment and retention of the workforce, as well as high rates of attrition and staff turnover within the sector.[24] This issue has been exacerbated by broader workforce constraints from limited migration activity during COVID-19 and workforce constraints in other sectors. Some providers experienced challenges with upskilling new staff on the Standards or employing suitable staff to support implementation activities. Other providers reported that their ability to fill vacancies in direct care roles had meant there was limited capacity within their workforce to dedicate time to upskilling and training on the Standards outside of their direct care role.

Qualitative survey responses from segments of the aged care workforce highlight that broader organisational leadership and governance has played a role for some providers in the ability of the workforce to access training and implement the Standards. For example, one workforce member described that there had been limited communication from leadership and management in relation to the Standards and no protected time in their day to participate in training opportunities. It was also noted by some providers that there was a lack of willingness to change in some segments of the workforce, both at a leadership and a workforce level.

Implementation support from other sector stakeholders

A number of other organisations within the aged care sector, including aged care peak bodies and consumer representative organisations, published guidance material and resources and delivered training on the Standards. Providers reported that these activities had supported their organisation to understand how to prepare for the Standards and how to adapt their systems, policies and processes in preparation for 1 July 2019. Other sector support and development functions funded by the Department, such as the Sector Support and Development Program, also delivered support, which received positive feedback from providers.

Provider representatives also highlighted that their existing working relationships with other providers within the sector promoted information sharing in relation to the Standards. Stakeholders explained that they utilised tools other organisations had developed in response to the Standards, and that this relationship served as a quality check to their organisation's preparation for the Standards.

Resourcing and associated costs

Provider and peak representatives highlighted that there were a number of impacts related to resourcing and associated costs of implementing the Standards. Providers noted that there was a cost and time impact related to adapting their systems, policies, and procedures to the new requirements and educating their workforce on the Standards.

For example, some providers created new roles such as quality managers or hired consultants to assist with the implementation process at their organisation. There was a broader concern raised by some providers that there was a 'lack of recognition by Government on the cost to the sector from this rework'.

Reform and change fatigue

During implementation of the Quality Standards, a range of broader reforms were occurring in the sector, including Serious Incidence Report Scheme (SIRS), the QI Program and strengthened regulations related to restrictive practices (formerly referred to as restraints). Providers reported experiencing challenges with balancing implementation efforts between reform and the Standards. Some providers operating in adjacent sectors also reported that they experienced particular challenges with understanding how to align systems, policies and practices with requirements in other sectors.

[24] The recent Aged Care Workforce Census highlights the broader issues related to workforce attraction and retention within the sector. For example, residential aged care facilities reported a total of 9,404 vacancies in direct care roles. Home Care Package providers and CHSP providers reported similarly high vacancy numbers of 6,479 and 6,117 respectively at the time of the Census. Attrition was also high within the sector with residential aged care facilities reporting a rate of 29% on average, HCP providers reporting an average rate of 34% and CHSP providers reporting an average of 26% over the 12 months from November 2019 to November 2020.

5.4 What can be learnt from the implementation of the Standards to inform future review and changes to the Standards?

Stakeholders were asked to identify improvement and learning opportunities for any future reform or review of the Standards, including improvements to implementation. A number of recommendations were provided through both consultations and survey responses, including:

- Increased learning opportunities and guidance
- Increased implementation time and support
- Consistent and transparent assessment
- Increased consultation and promotion to consumers.

Increased learning opportunities and guidance

Providers and provider peak body representatives highlighted a need to improve ongoing learning opportunities to support best practice approaches and to support workforces with understanding of the requirements. The feedback on the learning opportunities and improvements is consistent with the barriers to implementation through workforce skills and investment, explored under Section 5.3 above. Stakeholders raised a range of options for improved support, including further guidance, case studies, definition of terms, audit tools and general support to improve understanding of requirements and implementation into the future.

A number of representatives from providers asked for the Standards to be 'simplified' and to increase clarity around terms and expectations. This feedback was in line with consultation feedback further explored under Section 6.1 of this report.

Additional guidance and support were requested in relation to implementation of the Standards in specific service settings, especially home care. Some providers also requested guidance that supports home care providers to understand relevance and application of requirements and to clarify scope of responsibilities that were identified for the service. Providers raised that the HCP program funding caused confusion for providers and consumers in connection with the Standards. For example, where the 'beginning and end' of provider responsibilities sat in relation to contracted services requested by consumers.

Providers, peaks, consultants and advocacy groups also called for increased tailored guidance and learning opportunities for services in rural and remote settings as well as smaller service settings. Examples raised included increased guidance under Standards 7 and 8 where services may face increased staff challenges, have a smaller governance structure or where services respond to complex Indigenous cultural challenges.

Both consumers and providers also raised that there were important opportunities to increase guidance in other languages to support segments of the workforce that had English as a second language.

Increased timeframe and support

Providers frequently suggested that options to explore increased time and funding to support implementation be explored in the future. Some providers raised that the implementation timeframe for Standards acted as a barrier to implementing the Standards and that future reform to the Standards needed a significantly longer period of time to implement. A smaller number of providers also raised the high cost of implementation to their service and proposed that the sector needed increased funding support to implement and meet the Standards.

Consistent and transparent assessment

Providers and peak representatives continued to raise that they wanted clarity and transparency around the assessment of the Standards and to have consistent understanding of the assessment methodology with the Commission in the future. Stakeholders described both transparency of the assessment methodology through guidance material and education at the point of assessment as future improvement opportunities. Providers sometimes expressed the view that assessment teams did not explain or educate sufficiently on the achievement of requirements at the time of the assessment and that this experience could be improved to support future adoption of the Standards. During assessment, assessment teams feedback observations and any key issues identified but do not confirm performance outcomes. Providers and peak representatives explained that along with limitations of clarity in the guidance there was a lost opportunity to better understand meeting of requirements at the point of assessment, for example, understanding monitoring and review expectations for requirements. This issue was linked to calls for audit tools and is also closely related to the level of detail and prescriptiveness of the Standards and guidance material which is discussed further in Section 6. Additional information provided by the Commission as part of this evaluation in relation to the assessment methodology is provided at Appendix D. The Commission also publishes information about the assessment methodology on the Commission's website[25].

Increased consultation and promotion to consumers

While the development of the Standards was out of scope for this Evaluation, a number of stakeholders including consumers, providers and peak representatives, expressed the view that the consultation process for the development of future changes to the Standards should be expanded to increase the involvement of consumers, providers and other stakeholders.

Stakeholders also recommended that the Standards could be further promoted to consumers and that there should also be an increased effort to promote the Standards to culturally and linguistically diverse consumers and communities.

Overall, stakeholders and particularly providers and peak representatives raised that the high impact of implementation to the sector needed to be recognised and further acknowledged through increased sector support into the future. The options for improvement were raised with a high degree of consistency and aligned to the identified challenges for implementation raised by stakeholders (presented in Section 5.3).

5.5 What changes are required to align the Standards with future reform in the aged care sector?

The Royal Commission recommendations and the Australian Government's response to the Royal Commission have laid a pathway of reform for the aged care sector. The Royal Commission also highlighted that reform has at times been fragmented and disjointed, and that it had resulted that:

> **Changes to the aged care Standards have sometimes been developed in isolation from other changes to the broader system, in response to a particular issue of public concern, and therefore lack any strategic context.[26]**

A number of the recommendations will intersect and need to be considered with future changes to the Standards. Stakeholders raised examples of both current policy and new requirements and regulations which will need to be aligned with future changes to the Standards. Specific areas highlighted during consultations are presented below.

[25] www.agedcarequality.gov.au/providers/assessment-processes
[26] P. 124, Royal Commission into the Quality and Safety of Aged Care (2021), Final Report Volume 3, www.agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-3a_0.pdf

Future Reform	Stakeholder responses
New Aged Care Act[27]	Any new amendments to the Standards should be aligned to all other obligations under the new Aged Care Act There is opportunity to clarify obligations outside of the Standards, such as the clarification and separation of provider level and site-specific (service level) governance obligations under Standard 8
Australian National Aged Care Classification (AN-ACC)[28]	Alignment to AN-ACC to improve clarity and linkage of staffing requirements and care assessment activities under Standards 2 and 7
Review of clinical Standard by ACQSHC[29]	Any future amendments the clinical Standard should be presented with consistency and alignment to other Standards
Single In-Home Care Program[30]	Improve clarity of expectations of requirements for home care providers as the new Single In-Home Care Program is designed and introduced
Workforce reforms[31]	Identify regulation and workforce screening requirements under Standard 7 Identify improved workforce training and qualification expectations under Standard 7[32] Introduction of further mandatory training requirements as well as staff ratios suggested under all future Standards
Dementia, diversity, food, nutrition and palliative care improvement reforms[33]	Dementia, palliative care, diversity, food and nutrition and palliative care among various announced priority improvements for the sector Reflect and align these reforms in Standards, guidance material in particular Standards 3, 4 and best practice guidance in these areas of care
Governance and prudential monitoring reforms[34]	Alignment of the Standards to all future prudential governance, sector governance and provider governance reforms Ensure reporting obligations and requirements (for example, Basic Daily Fee) are streamlined and linked under the Standards

In addition to future and speculated areas of reform, stakeholders also raised that there were alignment opportunities to existing aged care programs:

[27] Department of Health (2021), Governance (Pillar 5 of the Royal Commission Response) – a new Aged Care Act, Budget Announcement Fact Sheet 2021-2022, www.health.gov.au/sites/default/files/documents/2021/05/governance-pillar-5-of-the-royal-commission-response-a-new-aged-care-act.pdf

[28] Department of Health (2021), Residential aged care services and sustainability (Pillar 2 of the Royal Commission response) – Reforming residential care funding to drive better care and a viable system, Budget Announcement Fact Sheet 2021-2022, www.health.gov.au/sites/default/files/documents/2021/05/residential-aged-care-services-and-sustainability-pillar-2-of-the-royal-commission-response-reforming-residential-care-funding-to-drive-better-care-and-a-viable-system_0.pdf

[29] P. 18, Department of Health (2021), www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

[30] Department of Health (2021), Home Care (Pillar 1 of the Royal Commission Response) – Future design and funding, Budget Announcement Fact Sheet 2021-2022, www.health.gov.au/sites/default/files/documents/2021/05/home-care-pillar-1-of-the-royal-commission-response-support-for-informal-carers.pdf

[31] Department of Health (2021), Five pillars to support aged care reform: Workforce, www.health.gov.au/initiatives-and-programs/aged-care-reforms/five-pillars-to-support-aged-care-reform#workforce

[32] Department of Health (2021), Workforce (Pillar 4 of the Royal Commission response) – Growing a skilled and high quality workforce to care for senior Australians, Budget Announcement Fact Sheet 2021-2022 www.health.gov.au/sites/default/files/documents/2021/05/workforce-pillar-4-of-the-royal-commission-response-growing-a-skilled-and-high-quality-workforce-to-care-for-senior-australians.pdf

[33] Department of Health (2021), Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

[34] P. 58, 87, Department of Health (2021), Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

Current Program	Stakeholder responses
Alignment to other reporting and indicators	Ensure reporting obligations and requirements for the QI Program and SIRS are sign posted within the Standards
Schedule of specified care and services for residential aged care	Ensure obligations under the Schedule of specified care and services for residential aged care are reviewed for consistent alignment to the requirements of the Standards.

Overall, stakeholders expressed strongly that there was a need to review and align the Standards against all other reforms since the sector was undertaking significant transformation through a parallel reform agenda.

6. Findings: Key evaluation question 2

Findings: Key Evaluation Question 2

This section explores findings related to Key Evaluation Question 2: What improvements could be made to refine the Standards' clarity, validity, applicability, and reliability?

This question sought to understand the characteristics of the Standards and potential areas for refinement. The following areas were key domains when exploring this question:

- Are the Standards clear and easy to understand?
- Are the Standards valid and reliable:
  - Do they represent stakeholders' expectations of quality aged care?
  - Do they support consistent assessment of performance?
- Are the Standards sufficiently flexible for application across all service types and settings?
- Are there aspects of the Standards that could be harmonised? What benefit would this provide?
- Are there any gaps?
- Are there suggestions for improving individual Standards?

The table below presents a summary of findings against this evaluation question.

Table 8: Summary of findings for Key Evaluation Question 2

Key Evaluation Question 2 What improvements could be made to refine the Standards' clarity, validity, applicability, and reliability?
Summary of findings
• The majority of stakeholders agreed that the wording of the Standards is clear and that they understand the intent of the Standards. However, some providers raised challenges in putting certain more complex themes of the Standards into practice such as cultural safety and cultural diversity, dignity of risk, best practice and governance. A large proportion of providers consulted also highlighted challenges in understanding the expectations of the Commission. • There was a high level of agreement that the Standards represent stakeholder expectations of quality aged care, however 'gap areas' were identified. New issues or requirements were identified under each Standard and stakeholders articulated the need for the Standards to address specific themes articulated in the Royal Commission report, including nutrition, diversity, palliative care, dementia, clinical and infection control outcomes and provider governance. • Overall providers perceived that they can consistently assess their own performance against Standards. However, there was a view by providers that there is a level of inconsistency in the Commission's assessment of provider performance. The assessment methodology used by the Commission was out of scope for this Evaluation. KPMG did not evaluate the effectiveness of the assessment process as part of the evaluation and any references made to the assessment process relate specifically to stakeholder views. The Commission continuously refines and improves its assessment methodology and there are certain design aspects of the assessment methodology that may have influenced these views. • The Evaluation found that the Standards are sufficiently flexible across all service types and settings, however some home care providers expressed a view that the Standards were more targeted at residential aged care. The majority of stakeholder also supported further harmonisation of the Standards. • There are improvements that could be made to individual standards, including removal of perceived repetition within the Standards and reducing instances where there are multiple concepts contained

within a requirement. There is also opportunity to introduce more prescriptive or detailed requirements within the Standards to address the issue of measurability identified by the Royal Commission and meet provider requests for clarity on the expectations of the Commission. However, this issue is likely to be a choice between additional detail or prescription within the Standards themselves and including further detail in guidance material.

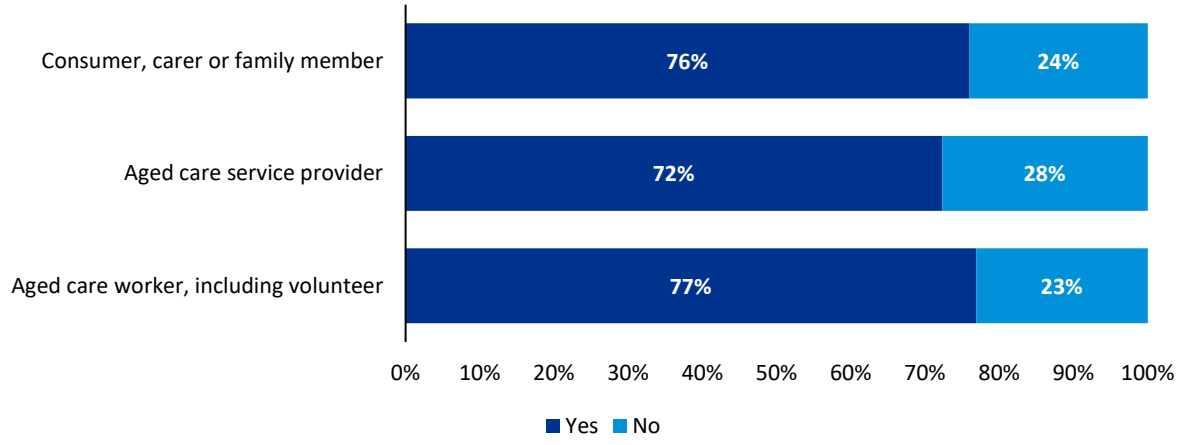
6.1 Are the Standards clear and easy to understand?

The majority of stakeholders agreed that the wording of the Standards is clear and that they understand the intent of the Standards. However, some providers raised challenges in putting certain more complex themes of the Standards into practice. A large proportion of providers consulted also highlighted challenges in understanding the expectations of the Commission against the Standards. The introduction of multiple dimensions of each Standard and the approach to assessing performance appear to influence this perception as described further below.

Clarity of wording and intent of the Standards

The majority of stakeholders during consultations and 75% of all survey respondents agreed that the wording and intent of the Standards are clear (a breakdown by stakeholder type presented in Figure 6 below shows limited variation between the stakeholder groups).

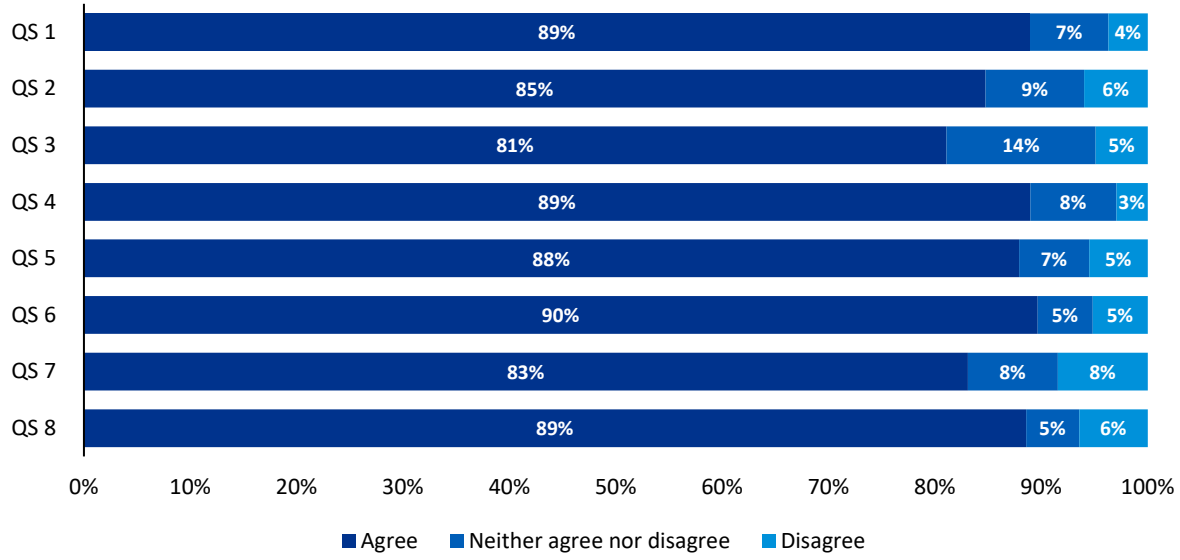
Figure 6: Characteristics of the Quality Standards by stakeholder group - Are the Standards clear? percentage



Source: KPMG.

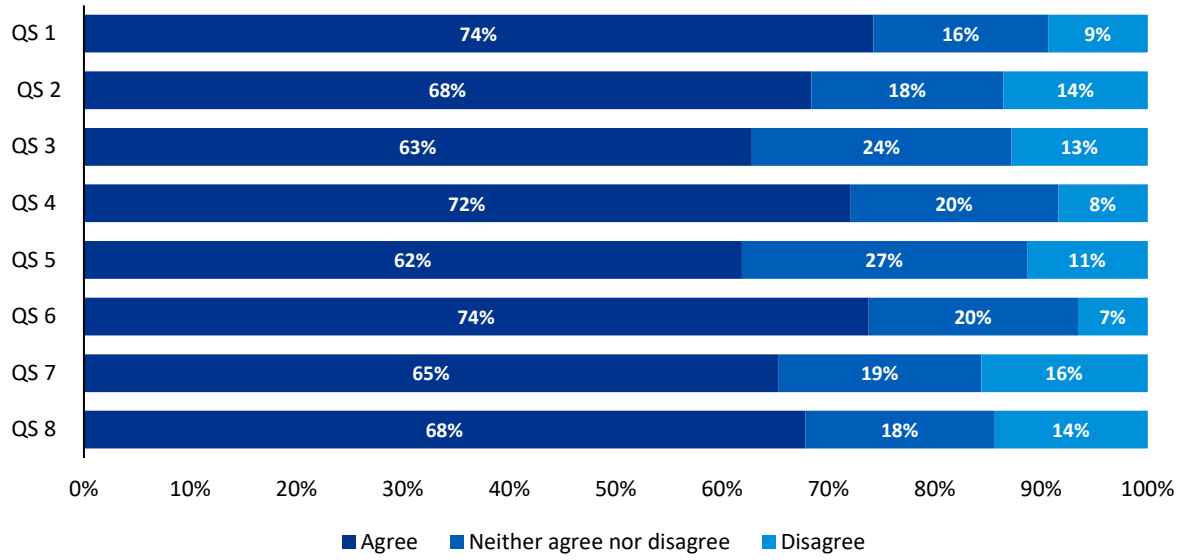
Similarly, the majority of providers reported that they understand how to implement each Standard as presented in Figure 7 below). However, the level of understanding of how to implement the Standards by aged care workers and volunteers is slightly lower to that of leaders and senior managers of providers (as depicted in Figure 8) which may be explained by staff having less responsibility to direct how the Standards are implemented.

Figure 7: 'I know what I need to do to implement the QS', by provider, percentage



Source: KPMG.

Figure 8: 'I know what I need to do to implement the QS' by providers and aged care workers, percentage



Source: KPMG.

The consumer outcome section was viewed positively by all stakeholders. This was consistent with findings from the Royal Commission. For example, family members of consumers reported that the consumer outcome section of the Standards had supported them to work in partnership with providers to discuss expectations of care and services as it describes the quality and safety of care they can expect from a provider. The Law Council of Australia had an alternative view, where they consider that the consumer statement is providing context which may limit a provider's understanding of exactly which part of the Standards must be complied with.[35]

Consumer participants in stakeholder consultations also specifically noted that they found the Standards to be clear. However, survey respondents had mixed views on the clarity of the Standards for consumers, with some concerns raised about the use of jargon and the understandability of the Standards for those from backgrounds other than English. There were suggestions by some stakeholders for a separate consumer version of the

[35] P.14 Law Council of Australia (2021), Submission to Review: Aged Care Quality Principles for Department of Health

Standards that is more comprehensible and user friendly. A similar point was made for the understanding of provider staff whose first language is not English. However, it should be noted that the Commission already publishes some resources to support the Standards for consumers and in languages other than English so perhaps more work could be undertaken to raise awareness of such resources.

New complex themes and/or dimensions to the Standards

While the majority of providers agreed that the wording of the Standards is clear and that they understand the intent of the Standards, providers expressed that certain themes and/or dimensions of the Standards were more challenging to understand and implement in practice.

Many of these themes or dimensions of the Standards are new to this set of Standards. Specific themes or dimensions raised included:

- **Cultural safety and cultural diversity:** Providers felt that these concepts were difficult to reflect in care planning and that the meaning of cultural safety can vary between communities and locations.
- **Dignity of risk:** While the introduction of "dignity of risk" under Standard 1 was viewed as a positive change for consumers, providers expressed that they can experience challenges with balancing this requirement with Standard 8 (including managing high-impact or high-prevalence risks associated with the care of consumers). One provider consultation group suggested that, on balance, requirements under Standard 8 created the impression that risk is a negative thing and should be avoided. It is important to note that Standard 8 includes a requirement in relation to 'supporting consumers to live the best life they can' and that this example may reflect challenges related to a provider's understanding of the Standards. For example, a provider explained that they had concluded they could not allow a resident to enjoy a runny egg, which was of the consumer's choosing, because it carried greater health risks.

  This theme is also raised by the Law Council of Australia in their submission to the evaluation[36], who suggested greater clarity could be offered to providers "in relation to obligations on an aged care provider to empower and support an aged care recipient to exercise choice on one hand, and to provide a safe environment on the other". Beyond this issue, the Law Council also point to an additional tension beyond the Standards, suggesting circumstances where the Standards requirements relating to the rights of consumers may also conflict with a provider's other legal obligations.
- **Best practice:** During stakeholder consultations, stakeholders expressed that there could be different interpretations of "best practice" in Standard 3. They felt this measure was subjective and shifting. Some providers suggested "evidence-based practice" could be a better term to use.
- **Governance:** While 89% of providers stated they personally understood how to implement Standard 8, only 39% of providers felt their organisation was able to understand and assess against Standard 8. Overall, stakeholders communicated that there is a lower level of understanding of good governance processes than the other factors described above. Providers say they understand the intent of the requirement but are less certain about how to demonstrate proficiency to support assessment against the standard. This is consistent with Royal Commission findings which highlighted that "deficiencies in the governance and leadership of some approved providers have resulted in shortfalls in the quality and safety of care".[37]

Understanding of expectations under the legislation

A large proportion of providers consulted highlighted challenges in understanding the expectations of the Commission against the Standards as set out under the Legislation. Providers and peaks raised that the experience of assessment and the accompanying guidance material did not consistently inform or clarify their understanding of the requirements of the Standards, as set out under the Legislation. Providers described how their confidence and understanding of the assessment was impacted by a limited understanding of the complex choices made by the Commission in relation to accreditation assessment, methodology and judgement. Whilst the assessment methodology was not in scope for this Evaluation, some providers perceive that the Commission's assessors have access to more detailed internal guidance about the Standards against

[36] P.16 Law Council of Australia (2021), Submission to Review: Aged Care Quality Principles for Department of Health
[37] P. 206, Royal Commission into Aged Care Quality and Safety (2021), Final Report Volume 2, www.agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-2_0.pdf

which they are assessed. The Lightning Review found other regulators avoid this risk by publishing their full assessment frameworks, so providers and assessors are working from the same documentation (as described in Section 5).

An additional perspective was offered by the Law Council of Australia who consider that "legislation should be the primary means to set out and clarify the parameters for future aged care governance and accountability requirements." [38] Such an approach would strengthen the role of legislation as the main reference point for providers. However, as discussed in the Lightning Review, this may come at the cost of provider understanding.

6.2 Are the Standards valid and reliable?

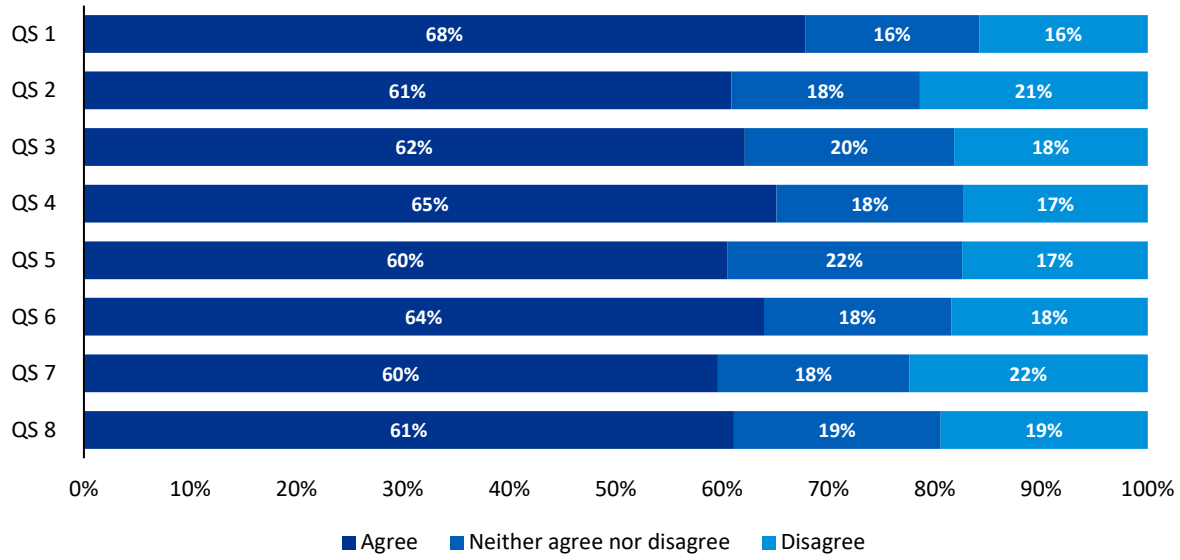
To answer this question the Evaluation asked two linked questions, "Do the Standards represent stakeholder's expectations of quality aged care?" and "Do they support consistent assessment of performance?". There was a high level of agreement from stakeholders that the Standards represent their expectations of quality aged care, however 'gap areas' were identified, which were often consistent with the Royal Commission findings (as presented in Section 3).

There are two parts to consistent assessment of performance: a providers' ability to consistently assess their own performance against the Standards, and the ability of the Commission to use the Standards to consistently assess provider performance. Overall, providers perceived that they can consistently assess their own performance against Standards. However, there was a view by providers that there is a level of inconsistency in the Commission's assessment of provider performance. These areas are discussed further below. Additional information provided by the Commission as part of this evaluation in relation to the assessment methodology is provided at Appendix D.

Expectations of quality aged care

There was a high level of agreement across stakeholder groups in consultations that the Standards represent stakeholders' expectations of quality aged care. Between 60% and 68% of the respondents to the survey also agreed that at least one of the Standards covered the areas they are most concerned about (as presented in Figure 9 below).

Figure 9: 'The QS cover the areas I am most concerned about', all stakeholders, percentage

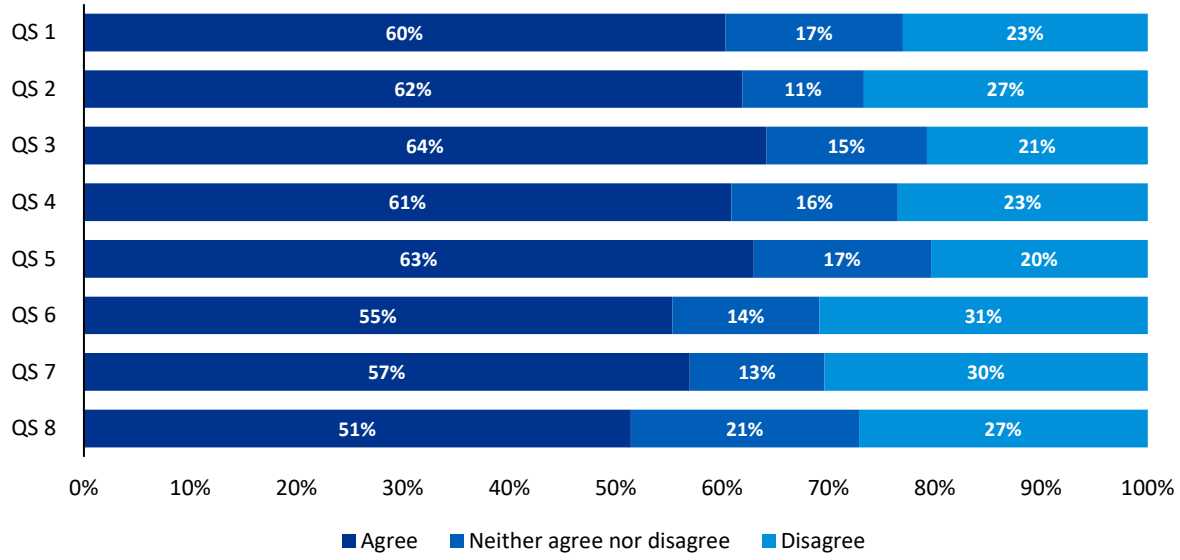


Source: KPMG.

[38] P.10 Law Council of Australia (2021), Submission to Review: Aged Care Quality Principles for Department of Health

However, there was higher level of agreement amongst providers compared to consumers, carers or family members of a consumer about whether the Standards cover the areas about which they are most concerned. There was also differentiation between stakeholder groups about which Standards covered the areas most of concern to them. Consumers and carers were most focused on Standards 1 – 5. The highest positive response for this group was for Standard 3, with 64% agreeing it covered the areas about which they were most concerned.

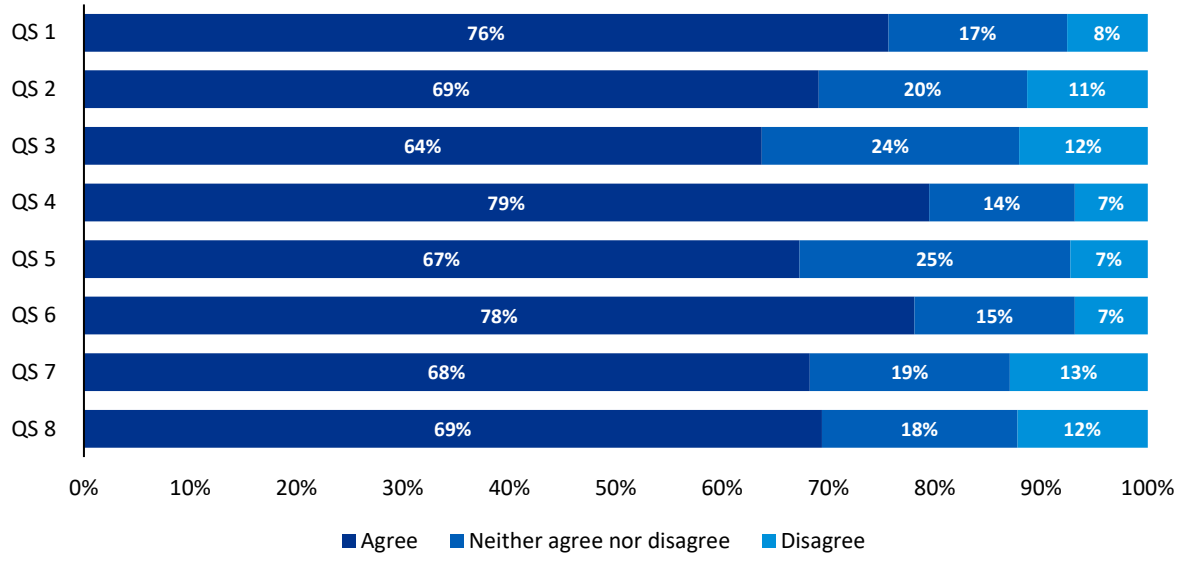
Figure 10: 'The QS cover the areas I am most concerned about' by consumers and carer, percentage



Source: KPMG.

Providers are more likely than consumers to agree one of the Standards covers the areas about which they are most concerned. For providers, Standard 3 recorded the lowest level of agreement at 64%. Standards 4, 6 and 1 solicited the most agreement in the provider cohort (79%, 78% and 76% respectively) as shown in Figure 11.

Figure 11: 'The QS cover the areas I am most concerned about' by aged care service provider and staff, percentage



Source: KPMG.

These differing responses were explained during the stakeholder consultations, which indicated that consumers, carers and family members perceive Standards 1 – 5 as the most relevant to how and where care is delivered and consequently the group is most concerned is done well. Providers' concerns (from the

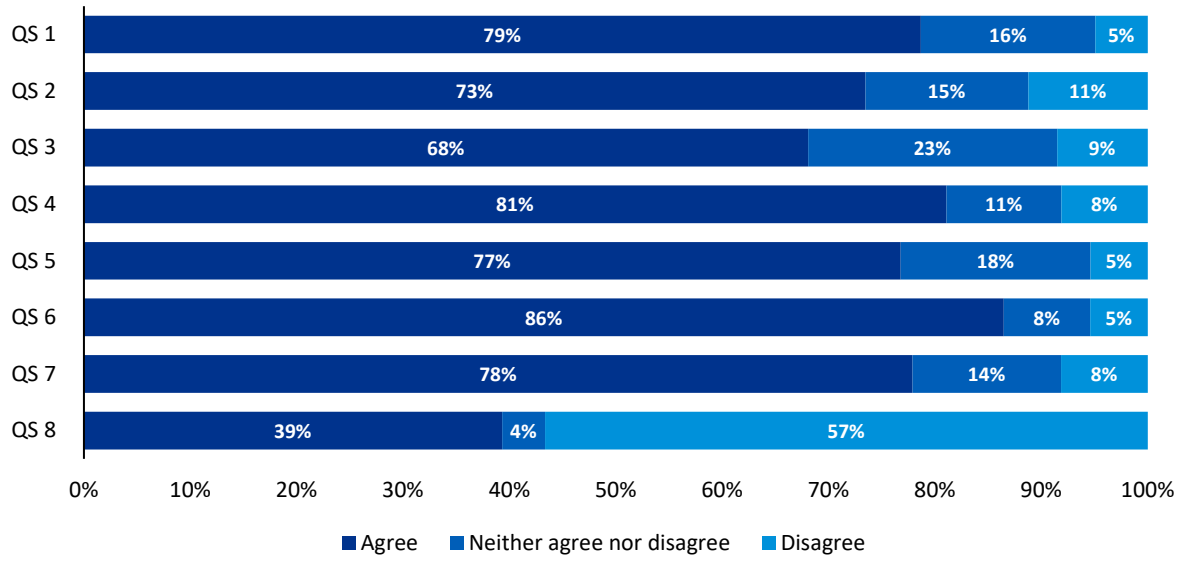
stakeholder consultations) focused on assessment and therefore their 'concern' maps to where they are most focused on achieving compliance. The fourth most in agreement was directed at Standard 8, which is an ongoing point of tension for providers in their understanding of requirement under this standard, as discussed above.

However, 'gap areas' were identified and were often consistent with the Royal Commission findings (as presented in 3). New issues or requirements were identified under each standard and stakeholders articulated the need for the Standards to address specific themes articulated in the Royal Commission report, including nutrition, diversity, palliative care, dementia, clinical and infection control outcomes and provider governance.

Provider assessment against the Standards

Overall, providers reported that at an organisation level, they are able to understand and assess their performance against the Standards, with the exception of Standard 8. Across all providers, the level of agreement with this statement was lower than that of the previous question (I know what I need to do to implement the standard) by between 5% and 14% for Standards 1-7 as shown in Figure 12 below.

Figure 12: 'My organisation is able to understand and assess against the QS', percentage



Source: KPMG.

Provider feedback received during consultations conveyed that the difference in the results of this question compared to whether an individual personally understood how to implement the Standards were related to differences in provider understanding of their own performance compared to the interpretation of by the Commission during assessment.

Providers expressed mixed views about their organisation's ability to understand and assess against the Standards. Their comments in stakeholder consultations reflect doubts about organisational capacity to deliver services in a way that meets the Standards. Specifically, standards 2, 3, and 6 see significant discrepancy between understanding and confidence in assessment, which may reflect provider awareness that their organisations have more to do in these areas. This finding/hypothesis is supported by the Commission's published sector performance data[39] which shows that the highest rates of non-compliance between 1 July 2019 – 31 March 2021 continue to include Standard 2(a), (c) and (e) and Standard 3(a)-(b).

Providers also noted that the idea of 'understanding' may be limited across organisations when collectively all staff may have a lower skill level or where English was not their first language.

Standard 8 (Governance) is a notably low outlier in Figure 12 above. The challenge faced by providers in understanding and assessing this Standard was also identified by the Royal Commission, which concluded

[39] Aged Care Quality and Safety Commission, Sector Performance Data, reports covering July 2019 – March 2021, www.agedcarequality.gov.au/sector-performance

"Deficiencies in the governance and leadership of some approved providers have resulted in shortfalls in the quality and safety of care." [40] The Commission's published performance data supports this finding as it shows Standard 8 (c), (d) and (e) are repeatedly included in highest non-compliance rates for the same period. [41]

Ability of the Commission to use the Standards to consistently assess provider performance

There was a view by providers that there is a level of inconsistency in the Commission's assessment of provider performance. These views were expressed by providers in relation to a number of the Key Evaluation Questions, including:

- How effective have guidance materials, tools resources and activities supported the implementation of the Standards by Providers?
- What can be learnt from the implementation of the Standards to inform future review and changes to the Standards?
- Are the Standards clear and easy to understand?
- Are the Standards valid and reliable? (sub) Do they support consistent assessment of performance?

The assessment methodology used by the Commission was out of scope for this Evaluation and any references made to the assessment process relate specifically to stakeholder views. The Commission continuously refines and improves its assessment methodology to more accurately assess performance, which may explain some of the concerns raised by providers as they become familiar with the new Standards and the Commission's regulatory approach. There are certain design aspects of the assessment methodology that may have also influenced these views. For example, in undertaking performance assessments against the Standards, the Commission may choose to focus on assessing performance against specific Standards during assessment contacts.

The level of consistency in rates of non-compliance across specific requirements (published on the Commission's published sector performance reports) may both reflect the ability of the Commission to consistently assess performance as well as key performance challenge areas of the sector. The repeated high rates of non-compliance of outcomes across Standards 2, 3, Standard 7(d) and Standard 8 (c)-(e) are also consistent with key gap areas identified by the Royal Commission. Additional information provided by the Commission as part of this evaluation in relation to the assessment methodology and how it supports consistent assessment of performance against the Standards is provided at Appendix D.

Providers views in relation to this area are set out in the table below.

Table 9: Collated feedback from providers regarding their challenges during the assessment process.

Evidence Management	
Who evidence is collected from	• Providers suggested that questions are asked of staff members who may not know the answers where the topics are beyond their area of responsibility. For example, a care worker's knowledge of the organisation's governance frameworks. They suggested that management-level staff may be able to produce the relevant evidence more quickly and completely. • Providers perceive that evidence collected from consumers is prioritised but is sometimes not tested or set in context. For example, suggesting consumer choices are not being reflected consistently when only one or two examples are provided and explained by other constraints, such as staff shortages on a single day. • It is of note however that providers do however have an opportunity to respond to evidence in the report before a performance report is prepared by a delegate of the Commissioner.

[40] P. 206, Royal Commission into Aged Care Quality and Safety (2021), Final Report Volume 2, www.agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-2_0.pdf
[41] Aged Care Quality and Safety Commission, Sector Performance Data, reports covering July 2019 – March 2021, www.agedcarequality.gov.au/sector-performance

How evidence is collected	• There is a perception that while two services might have similar systems, policies and practices, the assessment outcome differs due to assessment questions being different across the two services. Providers infer there was a variation in the assessment approach which caused the different outcome.
How evidence is evaluated	• Providers considered there were examples of contradictory evidence not being balanced appropriately, for example where feedback from consumers and systems and policies do not align. • Without an understanding of the assessment framework, some providers perceive that assessors' personal ideas or beliefs may frame their evaluations. • Providers expressed frustration that non-compliance with a requirement under one Standard can be used to support findings of non-compliance across other Standards. This was another reason that providers raised in stakeholder consultations for the view that the Standards can be repetitive. However, this may also relate to provider maturity for some providers. For example, it is conceivable that an ineffective approach to care planning will impact compliance with Standards 2, 3 and 8 if the root cause is based in other factors, for example workforce performance. • Providers feel there could be more acknowledgement that the provider has limited control over some matters that they are held accountable for, such as a GP's judgement about medication supporting negative findings regarding the provider's restraint or anti-microbial stewardship practices. • The Commission advised that the assessment method considers the totality of evidence. Where findings may be contradictory, further evidence is collected to form a sufficient view. The Commission also advised that since the Standards are designed around consumer outcomes with interconnection of requirements, evidence may be used as relevant across requirements but do not include the same capture of evidence overall.

Source: KPMG.

6.3 Are the Standards sufficiently flexible for application across all service types and settings?

The Evaluation found that the Standards are sufficiently flexible across all service types and settings. Home care providers reported a higher level of agreement that they understood the Standards than residential care providers. In stakeholder consultations, some providers suggested that there were elements of the Standards which are less relevant to home care. Rural and remote providers did not agree that the Standards should be tailored to their setting, but rather suggested the accreditation process should allow for their unique challenges, as described further below.

Application across service types

While there was high agreement amongst home care providers that they understand the Standards, a common theme raised by providers was a lack of certainty about the extent to which all Standards are relevant to all providers. Home care providers in particular felt that certain Standards were targeted at residential aged care rather than home care. For example, providers described themselves as less-clinically focused and less likely to complete a full assessment of needs and preferences especially for consumers of lower care needs, as this was considered potentially invasive.

Where providers perceived certain requirements were not applicable to their service, they presumed they were required to demonstrate compliance. Citing the example of infection control, some home care providers

did not interpret this in the limited way of creating a sterile field when changing a wound dressing but rather as creating an obligation on them to apply infection control processes throughout the consumer's home. In responding to the survey, other providers felt not enough emphasis was placed on the fact that, for home care, the service environment is the consumer's home. This different environment justified a different approach to the Standards.

The differing views between residential aged care providers and home care providers is discussed in more detail under the question of harmonisation.

Application across settings

In stakeholder consultations, providers in rural and remote areas considered they faced particular challenges around delivering services and therefore meeting requirements under the Standards, including managing the clinical aspects of risk, maintaining staffing levels and accessing allied health specialists. There was also a view that the meaning of Standards can vary with the environment. For example, what is culturally safe in a metropolitan area may be different to that experienced on country.

Overall, providers reported that the Standards were drafted appropriately in the context of rural and remote services but suggested that, rather than differentiation of the text of the Standards, the assessment process should consider these unique contextual challenges.

6.4 Are there aspects of the Standards that could be harmonised? What benefit would this provide?

There are aspects of the Standards that could be harmonised. The majority of stakeholders that responded to this question supported further harmonisation of the Standards. Such an approach would be consistent with Royal Commission recommendations and the direction of broader reform occurring in the sector. A small sample of home care providers observed that certain aspects of the Standards were targeted at residential aged care rather than home care and felt further harmonisation may not address this issue. Stakeholder perceptions on the issue of harmonisation and analysis on the relative benefits and approaches to harmonisation are presented below.

Stakeholder perceptions on harmonisation

Overall, stakeholders across government, provider and peak representative groups were positive about the harmonisation of the residential and home care standards that occurred to create the current Standards. As noted, a small segment of home care providers observed that certain aspects of the Standards were targeted at residential aged care rather than home care and felt the harmonisation of the current Standards could be reversed to address this issue.

Some providers suggested that further alignment with NDIS and human service standards was desirable, particularly by providers who work within other human service sectors. Providers and staff reported it was common to work where both the Standards and the NDIS standards, and that ensuring compliance with both increased the administrative burden, required additional training and was potentially confusing for staff. For example, one provider explained their service operated in a way that meant seven different standards or requirements applied to their service delivery. For these providers, they perceived that greater harmonisation would lower their regulatory and administrative burden, improve staff understanding and reduce the training needs of staff.

Opportunities for further harmonisation

The Royal Commission made specific recommendations to harmonise the Aged Care Quality Standards with the National Safety and Quality Health Service Standards (NSQHS). As part of the 2021-22 Budget, the Australian Government announced its intention to progress better regulatory alignment across the aged care, disability

and veterans' care sectors. The Australian Government stated that the formulation of the clinical care standards for aged care will be transferred to the ACSQHC from July 2021, with the intention of the ACSQHC being able to leverage its established clinical and standards expertise. Previous and future changes to other parts of the regulatory system have had a focus on harmonisation which would complement future harmonisation of the Standards, for example the alignment of restrictive practice definitions between the aged care sector and the recognition of NDIS worker screening clearances within the aged care sector.

The key advantage of harmonisation of requirements is that it reduces the compliance burden on providers who operate across multiple sub-sectors as they only need to be familiar with one regulatory approach across all their business areas. Harmonised standards can also support a seamless experience for clients moving across service types to understand quality requirements.

A disadvantage of harmonisation is reduced tailoring to each service type delivered within the aged care sector. For example, in the introduction to the New Zealand Standards which covers multiple sub-sectors, the authors note:

> **The broad diversity and uniqueness of the health and disability sector has necessitated the use of generic phases and terminology throughout the standard.**[42]

Harmonisation that is accompanied by less specificity and relevance for specific service types may also have a direct impact on provider understanding of the Standards and how to meet requirements underneath them.

The Lightning Review considered the themes, topics or issues that overlap between the Standards and various national and international quality standards. Of all the standards considered, the NDIS standards included themes most like the Standards, suggesting harmonisation of the two could be possible. However, there is a level of variation in standards across the human services sector as exemplified by the different human services standards in Queensland and Victoria. Therefore, it is unlikely that harmonisation of standards between the aged care and human service sectors is possible from a content perspective, in addition to the cross-government work which would be necessary for such alignment. However, there is scope for some improvement that may assist providers. For example, one provider suggested that aligning the definitions used between the Standards and the NDIS standards (described as a "shared dictionary") would lessen the confusion for staff working across both standards.

One route that may support providers' understanding of greater harmonisation is to use a structure which has modular components. All providers comply with a baseline set of standards, but additional modules can apply based on service type. The Lightning Review showed some standards like the NDIS and the New Zealand standards adopt a modular approach, which makes it clearer which requirements apply to which service types. Figure 13 shows how the New Zealand standards present this information to providers in their standards document using a table format called the criteria application framework.[43]

[42] Standards Review (2019 – 2021), Ministry of Health NZ, www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards/standards-review-2019-2021
[43] Ngā Paerewa Health and Disability Services Standard NZS 8134:2021, Ministry of Health NZ.

Figure 13: Extract from New Zealand Standards Criteria Application Framework Table

	Criterion	Aged residential care services	Assisted reproductive technology services	Home and community support services	Residential disability services	Residential mental health and addiction services	Public and private overnight hospital inpatient services	Birthing unit services
1.6 Effective communication occurs	1.6.1	✓	✓	✓	✓	✓	✓	✓
	1.6.2	✓	✓	✓	✓	✓	✓	✓
	1.6.3	✓	✓	✓	✓	✓	✓	✓
	1.6.4	✓	✓	✓	✓	✓	✓	✓
	1.6.5	✓	✓	✓	✓	✓	✓	✓
	1.6.6	✓	✓	✓	✓	✓	✓	✓
1.7 I am informed and able to make choices	1.7.1	✓	✓	✓	✓	✓	✓	✓
	1.7.2	✓	✓	✓	✓	✓	✓	✓
	1.7.3	✓	✓	✓	✓	✓	✓	✓
	1.7.4	✓	✓	✓	✓	✓	✓	✓
	1.7.5	✓	✓	✓	✓	✓	✓	✓
	1.7.6	✓	✓	✓	✓	✓	✓	✓
	1.7.7	✓	✓	✓	✓	✓	✓	N/A
	1.7.8	N/A	✓	N/A	N/A	N/A	✓	✓
	1.7.9	✓	✓	✓	✓	✓	✓	✓

Source: NZ Health and Disability Service Standards 2021.

Therefore, it may be possible to increase harmonisation in a way that does not lower provider understanding and that meets some providers' requests for greater harmonisation. However, delivering this effectively requires that there is adequate guidance within the Standards or in linked guidance material to assist providers' understanding and adoption of the Standards. It is possible the views expressed by a small number of home care providers indicate this is something which could be improved in the current Standards.

6.5 Are there gaps?

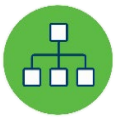
Stakeholders agreed the current Standards contain gaps. Forty-four percent of survey respondents agreed that there are gaps in the Standards. Gaps were usually presented as issues which could fall within a current Standard but could be addressed in more detail or the absence of a theme altogether.

New or more detailed requirements under existing Standards

The following table groups suggestions for new issues or requirements from stakeholders within the most suitable Standard.

Table 10: Collated feedback from stakeholders from surveys and focus group responses on their view of current gaps in the Standards

Standard		Stakeholder suggested additions
	**Standard 1:** Consumer dignity and choice	• Place greater emphasis on 'lifestyle', and on quality of life, both processes to support this to happen and measurable outcomes. • Recognise spiritual care and spiritual needs as part of consumer lifestyle. • Provide clearer instructions around how providers can support consumer's choices. • Increase the focus on supporting future consumers / consumers in the community from diverse backgrounds who aren't engaged or encouraged to engage with aged care services. • Clarify the balancing of choice, duty and risk. • Provide further guidance about how to support consumers with cognitive impairment exercise choice. • Include themes of reablement and mobility for consumers.
	**Standard 2:** Ongoing assessment and planning with consumers	• Recognise the capacity of consumer to make choices when they have dementia. • Provide more guidance for situations where family members appear to make unwise choices on behalf of consumers with cognitive impairment.
	**Standard 3:** Personal care and clinical care	• Provide specific references to elements of personal and clinical care such as; medication management, clinical governance, palliative care, dementia care, mental health, medication management, wounds, falls oral health and blood management. • Provide greater guidance about around the role of allied health professionals. • Further develop infection protection and control standards. • Recognise the impact of isolation and confusion of residents when hearing devices are not managed well. • Include references to Enduring Power of Attorney and guardianship decision making.
	**Standard 4:** Service and supports for daily living	• Provide greater guidance on when to use interpreters.
	**Standard 5:** Organisation's service environment	• Increase the emphasis on the service environment being an older person's home when it is home care delivery. • Increase the focus on workplace health and safety for aged care staff. • Include fire safety compliance requirements for providers.
	**Standard 6:** Feedback and complaints	• Include expectations on residents / consumers and their interactions with providers to address reports of verbal abuse, or unfounded threats of reporting the provider from consumers and consumer representatives.
	**Standard 7:** Human resources	• Clarify guidelines regarding the use of contractors. • Add a requirement for specified staffing levels and skills mix. • Include requirements of minimum qualifications for aged care workers and training requirements (especially in regard to dementia and palliative care, mobility and reablement training).

	**Standard 8:** Organisational governance	• Add new requirements to include consumers or consumer representatives in the governance bodies of organisations. • Add a reference to the Aged Care Clinical Governance Framework. • Include requirements relating to IT system security and protection of client data. • Only require that governance measures are assessed at a corporate provider level and not the home care level for home care providers.

Source: KPMG.

Additional or strengthened themes

The stakeholder consultations identified larger themes that stakeholders felt were currently not well addressed by the existing Standards. These themes overlapped with findings from the Royal Commission findings and are presented below.

Clinical and infection control outcomes

The Royal Commission recommended that the Standards should address best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, and infection control, and should provide sufficient detail on what these requirements involve and how they are to be achieved.[44]

Providers, care experts and other stakeholders also cited some of these areas as gaps as illustrated in Table 10 above, including oral care, medication management and measures to increase mobility. However, infection control and anti-microbial stewardship was an area where providers felt there was already repetition within the Standards.

Providers stressed the importance of recognising that for residential care, environments are intended to be long-term homes for consumers and should not feel overly clinical.

Dementia care

The Royal Commission found that care should sufficiently reflect the needs of people living with dementia and allow them to receive high quality dementia care.[45]

Stakeholders including consumers, providers, care experts and peak representatives agreed with this finding, explaining it is relevant to how care is delivered and the importance of dedicated staff training on these topics. Within the dedicated stakeholder consultation on dementia, stakeholders resisted the idea that this was an issue within one Standard. They argued good dementia care spanned all Standards, from facilitating a consumer with dementia's participation in exercising choice, involving them to the extent they are able in care planning through to adapting the service environment to be as dementia friendly as possible.

Palliative care

The Royal Commission stressed the importance of high-quality palliative care in residential aged care, including staff capacity (number, skill and type), process and clinical governance, for recognising deterioration and dying.[46]

The stakeholder group focused on palliative care agreed. They explained that consumers in aged care are in the later stages of their life and should be supported in their choices to experience a comfortable and dignified death. Stakeholders considered this was not well articulated within the current Standards. Providers in this consultation group discussed the challenges of accessing appropriate allied health support for palliative care, especially in rural and remote settings. This may be addressed by the Australian Government's acceptance of

[44] Royal Commission into Aged Care Quality and Safety (2021), Final Report, www.agedcare.royalcommission.gov.au/publications/final-report
[45] Royal Commission into Aged Care Quality and Safety (2021), Final Report, www.agedcare.royalcommission.gov.au/publications/final-report
[46] Ibid.

Recommendations 36-38 of the Royal Commission to increase the availability of allied health for residential and home care providers.

Providers also felt that the medication elements to support palliative care, and in particular supporting consumers to die in their homes, was a very high-risk activity from a provider perspective which leads to them approaching it in the 'risk management' lens of Standard 8 rather than the 'risk enabling' lens of Standard 1 which was discussed above.

Nutrition

The Royal Commission considered the Standards lacked appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard for a person's preferences and religious / cultural considerations.[47]

Stakeholders agreed that nutrition was a gap in the Standards, including details about hydration, dysphasia, diabetes and the dining environment. The stakeholder focused on group on food and nutrition felt consumers should be supported to prepare their own food even in residential care if they wish. They also stated the choice of menu available should reflect the cultural diversity and religious needs of consumers in residential care.

Diversity

Challenges in this area reflect both evolving expectations of how this issue may apply across the Standards by consumers, and providers seeking greater guidance on its direct implementation in Standard 1. Therefore, there are a number of ways of addressing this "gap" in terms of the Standards, linked guidance, or some other instrument such enhancing the existing Aged Care Diversity Framework.

The Royal Commission recommended that the review of the Standards should consider "reflecting the Aged Care Diversity Framework and underlying Action Plans, including considering making them mandatory".[48] The Diversity-focused stakeholder consultation group agreed. There was recognition that issues relating to diversity, equality and access are now expected to form a part of a person's care and would be appropriate to address potential barriers to access and reference to diversity action plans. One group considered Standard 1 could be split into new headings of diversity and respect.

However, themes relating diversity in Standard 1 were identified as a source of confusion for providers, especially the concept of cultural safety. The Commission's assessment of performance data supports this, noting for Standard 1(3)(b) "staff did not understand what cultural safety was, or how a consumer's background and preferences may be reflected in their preferences for delivery and receipt of care and services".

Therefore, providers may need additional support to ensure any changes can be better implemented on this topic.

Provider governance

Provider governance is already included in Standard 8. It is a theme where the Evaluation found providers experience difficulty in understanding and assessing their performance against this Standard. This is supported by the Commission's assessment of performance data which confirms that provider understanding in this area is still maturing.

The Royal Commission's concerns about governance extended beyond the Standards and included issues relating to the independence of provider boards, the skill mix of senior leaders within provider organisations, board members not sufficiently able to interrogate care quality data in a similar way to that taken to financial data from within their organisations. To address this, Recommendation 90 proposed to amend the governance Standard so that providers have governing bodies with an appropriate skill mix and implement a care governance committee and feedback mechanisms relating to quality and safety. The requirements for Standard

[47] Ibid.

[48] P. 224, Royal Commission into Aged Care Quality and Safety (2021), Final Report Volume 1, www,agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf

8 already contain elements of these behaviours. A small change to enhance the language in these areas could be considered.

A further challenge could be ensuring that additional proposed changes to provider governance in other legislation are aligned with the Standards and guidance so as to not further increase the broader provider obligations on this theme.

An area of analysis in the Lightning Review was how different sets of standards address these themes. The findings of this research are summarised in Table 11 below.

Table 11: Findings from Lightning Review on gap themes identified by the Evaluation.

Theme	Lightning Review Finding
Clinical and infection control outcomes	The Lightning Review found that, comparatively, the Standards lacked detail on infection control. The NSQHS Standards includes a section 'Preventing and Controlling Infections', the CQC Code of Practice on the Prevention and Control of Infections and Related Guidance is 97 pages and the New Zealand Standard relating to infection control contains 30 criteria. However, all of those examples apply to acute hospital settings, so it is appropriate that those standards are more detailed.
Dementia	The Lightning Review had little to contribute on this theme as only two of the international standards reviewed address this element of care and both of them are voluntary standards. The Canadian Qmentum Standards include dementia on an early screening list where partners should be identified to assist with early detection and the US Joint Commission's (CAMNCC) Standards contains an optional Memory Care Certification set of standards which refers to particular adaptations needed to the environment, staff training, the dining experience and recreational activities to best engage residents with dementia.
Palliative care	The Canadian Qmentum Standards make specific reference to palliative care at Standard 17: "The team provides comprehensive, interdisciplinary, and individualised palliative and end-of-life care using a whole-person approach" and this concludes a longer section which describes best practice for end of life care, including how and when to communicate with families. The CAMNCC Standards require "[the consumer's] conform and dignity receive priority during end-of-life care" (Standard PC.02.02.13).
Nutrition	The Lightning Review found the Standards were unusual in their omission of details about nutrition, with the NSQHS Standards, Care Quality Commission (CQC) Standards, New Zealand Standards and Ontario Regulations all containing more requirements about how nutritional needs should be met.
Diversity	The Lightning Review did not find many examples that contained more detail on diversity than the current Standards. Only the NSQHS Standards contain a fuller reference to diversity, with Action 1.15c requiring "The health service organisation… incorporate information on the diversity of its consumers and higher-risk groups into the planning and delivery of care". This goes slightly further than the Standards in its link to care planning.
Governance	The Lightning Review found governance was a very common theme in many of the standards considered. The NDIS Practice Standards include eight standards under the 'Provider Governance and Operational Management' section of the core module. These standards are considerably detailed with 38 specific quality indicators included under the following standards: governance and operational management, risk management, quality management, information management, feedback and complaints management, incident management, human resources management and continuity of supports. The NSQHS, New Zealand, CQC and US and Ontario Regulations all contain further details on governance.

Source: KPMG Lightning Review.

6.6 Are there suggestions for improving individual standards?

Overall, there are improvements that could be made to individual standards. The Royal Commission highlighted priority areas for improvement of the Standards, including the need to address gaps and improve the measurability of the Standards. Feedback on gaps was largely consistent across all stakeholder groups and was consistent with Royal Commission findings and could be addressed as part of the review of the Standards (as detailed above). Feedback received during consultations also highlighted the need to improve clarity of intent within the Standards through more prescriptive or detailed requirements, in line with the Royal Commission findings related to measurability. Some stakeholders from providers and specialist organisations also provided feedback on the level of repetition within the Standards and on certain Standards where there are multiple elements contained within a single requirement. These areas are explored below.

Repetition within existing standards

There was a minority of stakeholder responses to the survey (37%) who considered the Standards are repetitious. There was limited commentary provided surrounding repetition in the survey responses. Providers during consultations observed that elements of infection control and anti-microbial stewardship appear in Standards 3, 5 and 8. It should be noted that, in such cases, the articulation of these requirements has different nuances under different Standards and does not, therefore, constitute a repetition of the same requirements across multiple Standards. Broader concerns were raised that repetition across standards can mean one piece of evidence can be used to support a finding of non-compliance for multiple standards. This issue may be able to be addressed through the inclusion of more detailed requirements under existing Standards to distinguish between requirements under different Standards where there are common elements or perceived repetition (discussed in more detail below).

Multiple elements within one requirement

Some standards challenge provider understanding because they contain distinct but linked themes within a single requirement. This means there is more than one way for a provider to be found non-compliant with one element when other elements may be performed correctly. For example, Standard 1(3)(a) addresses both “dignity and respect” and “[valuing] culture and diversity”. These combinations may lessen provider confidence if, for example, they are confident they treat consumers with dignity and respect, but are less mature in their understanding of recognising cultural diversity, and can be found non-compliant with the full requirement as a result. This issue may be able to be addressed by expanding requirements statements with multiple elements into separate requirements statements.

Measurability and understanding of the Standards

As outlined in Section 3, the Royal Commission was critical of the measurability of the Standards. The Royal Commission’s commentary on the measurability of the Standards related to two key issues:

- the level of prescription and detail of requirements and their ability to present a clear view on what providers need to do to demonstrate that they are meeting the Standard
- inclusion of requirements within the Standards that can support additional measurement and benchmarking of performance.

Feedback from the Royal Commission was consistent with the views of a number providers, who requested more detail or prescriptiveness within the Standards, or enhanced guidance about compliance with the Standards to support understanding of the Standards and the expectations of the Commission.

For standards that are framed around outcomes, like the Standards, the requirements of a set of standards often define the systems, processes and practices a provider and a regulator would expect to see in order to know that the outcome has been achieved.

The Law Council of Australia considered this issue to relate to drafting clarity. Referring to Standard 7 as an example, they suggest the requirements are "impressionistic and somewhat circular". Whilst the Council's view is objective, it is possible that the sector understanding of providers and the Commission lessen those impressionistic elements to make them more measurable, but it does suggest that some sector knowledge is required to support correct interpretation. To resolve this, the Council suggest "it would be preferrable to set a verifiable action or task or output in relation to each of those things… on which to assess performance. [49]

In observing standards in other sectors locally and internationally through the Lightning Review, a number of sets of standards contain similar themes and concepts to the Standards and use a similar structure to present their standards. However, some sets of standards that are greater in length appear to provide more detail within the requirements section of the Standard that are either:

- **More prescriptive and include statements that describe how a provider should deliver care to meet the requirement.** For example, the Ontario Long-Term Care Homes Regulations (the Ontario Regulations) includes many prescriptive requirements such as "resident beds have a firm, comfortable mattress that is at least 10.6 centimetres thick" [50]. The consequences of this prescriptive approach for the Ontario Regulations are quality standards that are a significant length, with 335 requirements, and more limited flexibility offered to a provider to adapt their service delivery to the unique circumstances of the consumer, their organisation and the settings in which they deliver care.
- **More detailed and include statements that describe how a provider can demonstrate that they are delivering care in a way to meet the outcome of the Standard.** For example, an indicator for meeting the Provider Governance and Operational Management area of the NDIS Practice Standards is 'There is a documented system of delegated responsibility and authority to another suitable person in the absence of a usual position holder in place' [51]. More detailed requirements similar to these were proposed as examples for inclusion in a future set of Standards by the Royal Commission.

For example, when comparing the Standards with the NDIS Standards, the NDIS standards both contain requirements related to the privacy of a consumer. The Standards' requirement related to this domain is framed as an outcome statement and, as such, is similar to the outcome statement defined under the NDIS standards. However, the NDIS standards also provide more detail through use of indicators to support provider understanding on how they can demonstrate they have met the outcome statement (as presented in Figure 14 below). However, it is important to note that while these indicators form the basis for measuring achievement against the standards, not all indicators are enforceable, which allows for proportionate testing of an indicator, where relevant during an audit.

[49] [49] P.14 Law Council of Australia (2021), Submission to Review: Aged Care Quality Principles for Department of Health
[50] P. 1, Queen's Printer for Ontario (2011, December), A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10, www.health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf.
[51] NDIS Quality and Safeguards Commission (2020), 'NDIS Practice Standards and Quality Indicators, Version 3', www.ndiscommission.gov.au/sites/default/files/documents/2019-12/ndis-practice-standards-and-quality-indicators.pdf

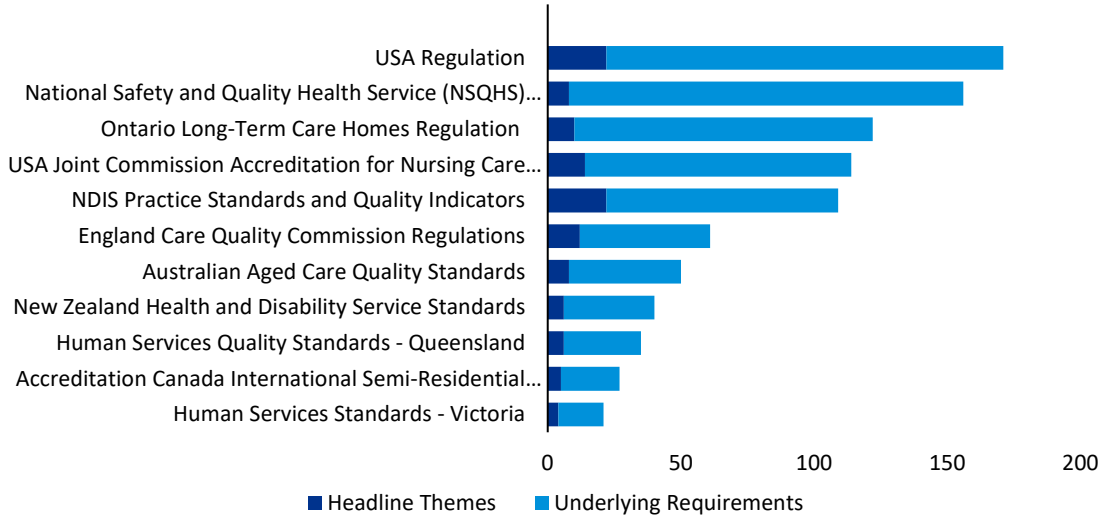
Figure 14: Comparison of privacy requirements under the Standards and the NDIS Practice Standards

Aged Care Quality Standards, Standard 1 [52]	NDIS Practice Standards, Core Module, Rights and Responsibilities – Privacy and Dignity [53]
Requirement: 1(3) (f) Each consumer's privacy is respected and personal information kept confidential.	**Outcome:** Each participant accesses supports that respect and protect their dignity and right to privacy. **Indicators:** • Consistent processes and practices are in place that respect and protect the personal privacy and dignity of each participant. • Each participant is advised of confidentiality policies using the language, mode of communication and terms that the participant is most likely to understand. • Each participant understands and agrees to what personal information will be collected and why, including recorded material in audio and/or visual format.

Source: Aged Care Quality Standards and NDIS Practice Standards.

When comparing the Standards to sets of standards in other jurisdictions locally and internationally explored as part of the Lightning Review, Figure 15 demonstrates that Standards sit in the middle in relation to the number of requirements that have been included.

Figure 15: Chart to show comparative level of detail of each standard considered in the Lightning Review. [54]



Source: KPMG analysis of quality standards in other sectors and jurisdictions.

Where requirements lack a level of detail or prescription, the role of defining an appropriate measure for determining that a provider is meeting the requirement and therefore has achieved the outcome falls to the regulator as part of its assessment framework. For Standards that are a less prescriptive or detailed in nature,

[52] Aged Care Quality and Safety Commission, Quality Standards, www.agedcarequality.gov.au/providers/standards
[53] NDIS Quality and Safeguards Commission (2020), 'NDIS Practice Standards and Quality Indicators, Version 3', www.ndiscommission.gov.au/sites/default/files/documents/2019-12/ndis-practice-standards-and-quality-indicators.pdf
[54] In this figure, headline theme refers to the major group heading in each standard, E.g., Human Resources in the Quality Standards. Underlying Requirements refer to the next relevant tier of requirements below that headline, so continuing the Human Resources requirement, the Quality Standards include five requirements from 7(3)(a) to 7(3)(e). Some sets of standards include two or three additional tiers of requirements beyond the tiers captured above, and so are even more detailed than the chart indicates. The ISO9001 Standard is not included in this figure as it is unique in only addressing quality management and comparatively includes highly detailed requirements for the issue.

regulators in other sectors often use guidance material or other supporting documents such as the publication of accreditation guidelines to support provider understanding of how to meet a Standard.

Therefore, introducing more detailed or prescriptive requirements could address the issues raised by the Royal Commission related to measurability and may meet provider demand for clarity of expectations of the Aged Care Quality and Safety Commission and the Law Council of Australia's concerns. However, the issue of measurability is also likely to be a choice between the level of prescriptiveness or detail included in each Standard when they are drafted compared to the guidance material and other resources that support the Standards. For example, greater visibility of the evidence points used by the Commission to assess performance against the Standards may be provided through guidance material in order to address demands for greater clarity regarding the expectations in relation to each standard.

Other levers that can support understanding of the quality and safety of care delivered within the aged care system

Standards are also one lever to measure the quality and safety of care in a system. The Royal Commission highlighted broader issues related to availability of data on the quality and safety of care. There are a range of other levers available to measure the quality and safety of aged care, including that offer transparency of 'outcomes' achieved within a system. Certain levers already exist within the current aged care system, including the QI Program and SIRS. The Australian Government has also made commitments to introduce new measures to improve measurement of the quality and safety of care delivered in the system. This includes incorporating greater use of quality indicators for continuous improvement through the expansion and development of the QI Program and publishing star ratings on My Aged Care by the end of 2022.

The Royal Commission also highlighted that while the Standards rating and Service Compliance Ratings are published for all residential aged care services, 'they do not differentiate between services that barely meet those minimum standards and those that have achieved excellence'. This issue has a direct relationship with the assessment framework for the Standards. The current assessment framework rates performance against the Standards in a binary way, as either met or not met. This is distinct from assessment approaches in some other sectors or jurisdictions which offer a graded assessment of performance with more than two assessment levels to support greater differentiation of performance of different providers. The Royal Commission specifically commented that 'the regulator should adopt a more rigorous, graded assessment of service performance against the Aged Care Quality Standards'. Such an approach may improve the ability of consumers, providers, the Commission and other key stakeholders to differentiate between the performance of different providers.

7. Findings: Key evaluation question 3

Findings: Key Evaluation Question 3

This section explores findings related to Key Evaluation Question 3: What impact has the Standards had on consumers, providers and other key stakeholders?

To what extent are the intended outcomes being achieved?

This question sought to understand the impact of the Standards overall and for different stakeholders, in particular the improvement of outcomes for care delivery for consumers. The following areas were key domains when exploring this question:

- To what extent are the intended outcomes being achieved? (Short-term outcomes)
  - Is there evidence of providers making changes to meet the new Standards?
  - Do service providers have an increased focus on quality outcomes for consumers? I.e. are service providers achieving the consumer outcomes (defined under each Standard)?
- Is there a difference in impacts based on service types, consumer diversity, location of service provider or diversity of service provider, and regulator?
- What other factors may have contributed to or hindered the achievement of the outcomes?

The table below presents a summary of findings against this evaluation question.

Table 12: Summary of findings for Key Evaluation Question 3

	**Key Evaluation Question 3** **What impact has the Standards had on consumers, providers and other key stakeholders? To what extent are the intended outcomes being achieved?**
Summary of findings	
• There is evidence of providers making changes to meet the new Standards. The most common activities undertaken were revisions to policies and procedures, workforce development and training, consultation with consumers, their families and carers, and revisions to governance arrangements. • There is evidence that providers have an increased focus on quality for consumers in some segments of the sector. A majority of stakeholder groups surveyed reported the Standards have improved quality outcomes for consumers, and some data indicates potential improvements of consumer outcomes. • There are differences in impact based on service types, consumer diversity and location. Ongoing impact for providers included some identified improvements in work practices in some segments. Providers raised significant concerns of the increased regulatory burden and impact on the workforce. The impact on the Commission was significant, particularly to support ongoing education activities for the sector and increased regulatory activity. • Some examples of unintended consequences were raised by some stakeholder groups, including in relation to the use of restrictive practices by providers. • Overall, stakeholders confirmed it was too early in the implementation phase and there are limits in the available data to determine the extent of the impact of the Standards.	

7.1 To what extent are the intended outcomes being achieved? (Short-term outcomes)

This question focused on understanding the extent to which the short-term outcomes defined under the Program Logic (at Appendix A) have been achieved. The short-term outcomes explored as part of this section are:

- Is there evidence of providers making changes to meet the new Standards?
- Do service providers have an increased focus on quality outcomes for consumers? I.e. are service providers achieving the consumer outcomes (defined under each standard)?

The findings against these questions are provided below.

Is there evidence of providers making changes to meet the new Standard?

Providers have made changes to meet the Standards. The majority of providers in consultations and survey responses (97%) indicated they undertook activities to implement the Standards. The most common activities undertaken were revisions to policies and procedures (58%), workforce development and training (54%), consultation with consumers, their families and carers (47%), and revisions to governance arrangements (38%). Further activities are shown in Table 13 below.

Table 13: What activities did your organisations undertake to implement the Quality Standards?'

Response option	Count of responses	% of total respondents
Revised policies and procedures	476	58%
Undertook workforce development and training	445	54%
Consulted with consumers, their carers and families	389	47%
Revised governance arrangements	314	38%
Accessed resources to support the workforce or consumers	305	37%
Invested in equipment and/or updating the service environment	208	25%
Redesigned services and or the care environment	207	25%
Established relationships with other providers to deliver care or services	175	21%
Increased staff allocations	146	18%
No activities have been undertaken	22	3%
Other (free text)	44	5%

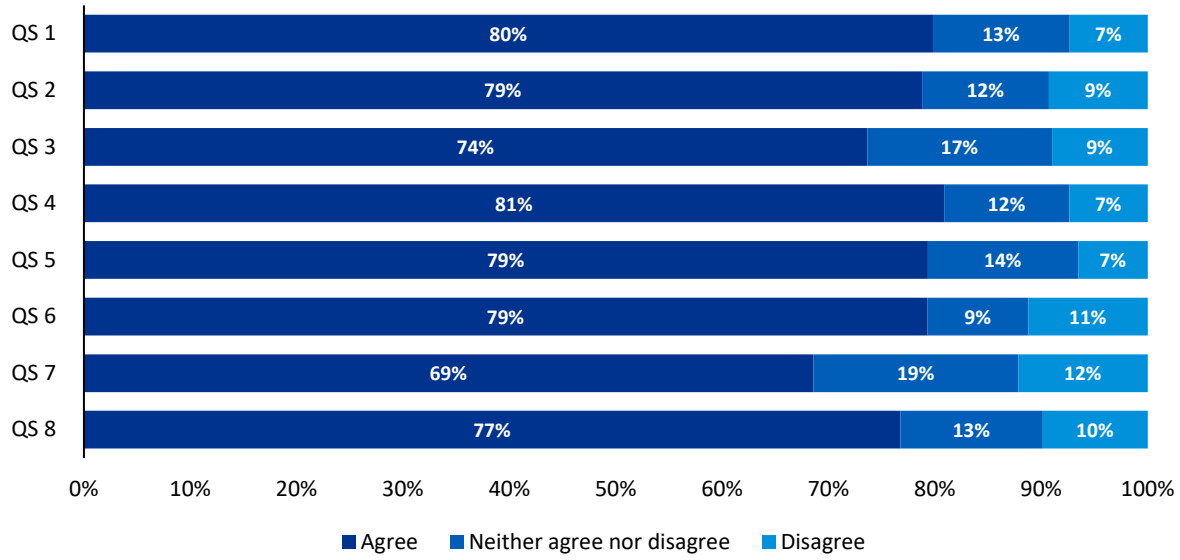
Source: KPMG.

Most providers who completed the survey (69 – 81% for each Standard) indicated that their organisation had implemented each Standard. The smaller number of providers who responded they have not implemented the Standards show the transition to the new Standards is still in progress for some providers, as shown in Figure 16 below.

In addition to the activities listed above, in consultations providers described that they had developed self-assessment tools, undertaken gap analysis exercises, advertised the new Standards around services, engaged external organisations to assist with implementation and connected with other aged care services to share information.

Overall a majority of providers and workers confirmed that their organisation had implemented each Standard:

Figure 16: 'My organisation has implemented the QS', percentage

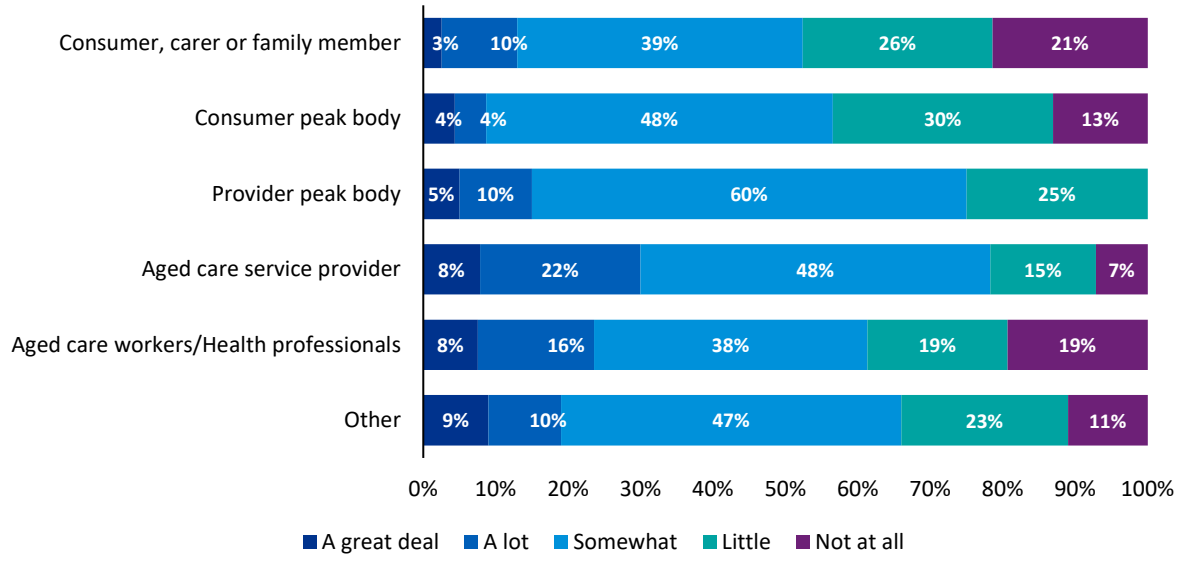


Source: KPMG

Standard 7 (Human resources) shows the lowest level of reported implementation. Stakeholders in consultations explained this was due to the broad workforce challenges, discussed further in Section 5.2.

The majority of respondents to the survey agreed the Standards had improved work practices in aged care services. Aged care providers agreed most strongly that there had been 'a great deal' or 'a lot' of improvement (30%) compared to other cohorts, whereas 21% of consumers and carers perceived no improvement. The full results are presented in Figure 17 below.

Figure 17: 'Have the Quality Standards improved work practices in aged care services?', percentage



Source: KPMG

Work practices would be most directly observed by providers, their peak bodies and aged care workers, whose responses are more positive. The lower agreement from consumers carer or family members (who may be less able to assess working practices) may show that these improvements do not consistently translate into a better consumer experience.

Improved record-keeping, consumer involvement and staff training were examples of the types of positive improvements the Standards had delivered. Providers stressed the importance of effective management in driving such improvements. Some respondents considered there had been a negative impact on work practices, suggesting the increased requirements of assessment and documentation had limited direct time with consumers, especially by registered staff.

Do service providers have an increased focus on quality outcomes for consumers? I.e. are service providers achieving the consumer outcomes (defined under each standard)?

As the Standards have only been in place for a short period of time, it is too early to make a conclusive statement as to whether service providers are achieving consumer outcomes (as defined under each Standard, see Appendix C), or increased quality of outcomes for consumers more broadly. This was consistently raised by various stakeholders during consultations. While there are higher rates of non-compliance under the new Standards, it is expected that this is a result of the overall higher-lifted expectation of quality care and services and does not necessarily represent a decline in outcomes for consumers.

There are a range of data points collected by the Department and the Commission in the aged care system that can provide a view on the quality and safety of aged care, noting the Royal Commission identified issues related to the measurability of the Standards and general data collection on quality and safety of care in the aged care system. Available data includes performance assessment data against the Standards, QI Program data, CER and SIRS data.

QI Program data demonstrates improvements of consumer outcomes in residential aged care. The most recent quarter report from April – June 2021[55] demonstrates a downward trend in reported unplanned weight loss, restrictive practice use and pressure injuries compared with the January – April 2021 quarter.[56]

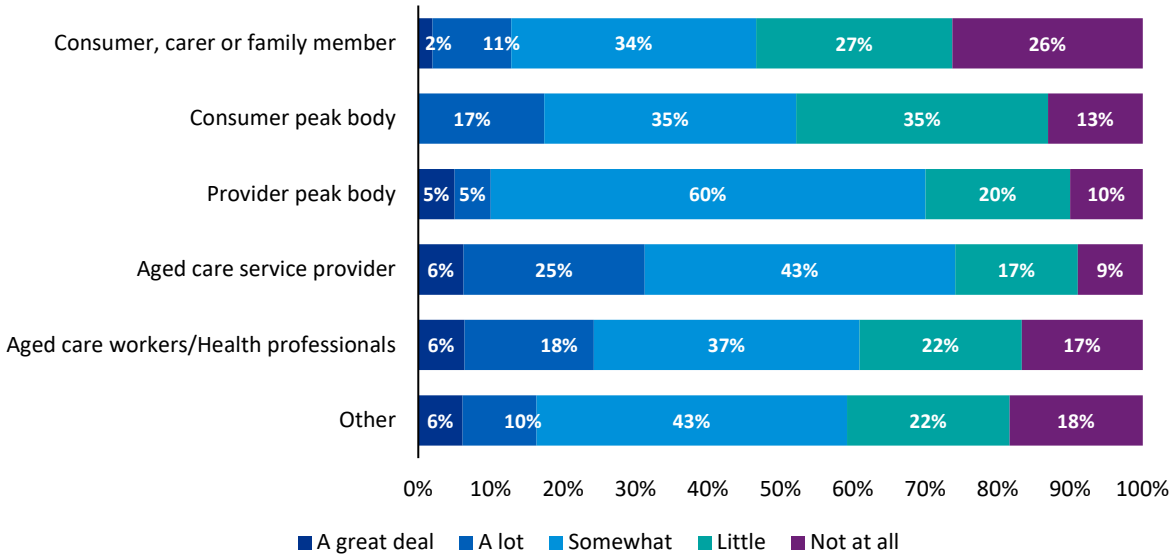
The Commission's published sector performance data[57] demonstrates some variability across the highest reported non-compliance notices of requirements), however there are limitations on the data to determine improvement trends for the period of time since implementation of the Standards. Similarly, the sector implemented Serious Incidence Reports on 1 April 2021, and early reporting[58] identifies the initial rates of varied reported incidences; however, the implementation timeframe does not enable ongoing trends for consumer outcomes to be identified at this time.

CER, capturing the experience of aged care consumers, has been gathered in residential aged care between 2017 – Dec 2019. A comparison of 2017-2018[59] with 2018- 2019[60] data demonstrates that consumers were slightly more likely to report in the following year that: staff followed up when they raised things (0.64%), were more likely to explain things (0.84%) and that they liked the food (1.12%), however they were less likely to report they had someone to speak to when they were sad or down (2.2%).[61] While the reported CER results end at the point in time of commencement of the new Standards, it is possible that these results are affected by the implementation period undertaken prior to the 1 July 2019 commencement period of the Standards. Since CER data is not available for the 2019-2020 year onward it cannot be determined whether the results relate to the new Standards or other reforms from this time, however these provide insight that results for consumers may be adjusting over a similar period.

[55] AIHW Gen Data (2021), Residential Aged Care Quality Indicators – April to June 2021, www.gen-agedcaredata.gov.au//Topics/Quality-in-aged-care/Residential-Aged-Care-Quality-Indicators-April-to-June
[56] A comparison of the reported results include a decline of intentional physical restraint (23,597 cases down from 24,476), unplanned weight loss of 3 or more kilograms (14,429 cases down from 14,985) and pressure injuries (11,554 cases down from 11,874).
[57] Aged Care Quality and Safety Commission, Sector Performance Data, reports covering July 2019 – March 2021, www.agedcarequality.gov.au/sector-performance
[58] Aged Care Quality and Safety Commission, SIRS reports, www.agedcarequality.gov.au/sirs/reports
[59] Aged Care Quality and Safety Commission, Consumer Experience Report Trends 2017-2018, www.agedcarequality.gov.au/sites/default/files/media/AACQAConsumerExperienceReportTrends.pdf
[60] Aged Care Quality and Safety Commission, Consumer Experience Reports 2018-2019, www.agedcarequality.gov.au/sites/default/files/media/Consumer%20Experience%20Report%202018-2019.pdf
[61] These results compare a combined response percentage of consumer responses, 'some of the time' or 'always'. For further analysis of Consumer Experience Reports, including limitations of the data, see AIHW Gen Data, Consumer experience of residential aged care 2017-2019, www.aihw.gov.au/reports/aged-care/consumers-experience-of-residential-aged-care/contents/table-of-contents

The majority of stakeholders surveyed reported the Standards have improved quality outcomes for consumers (74-91%). A minority of consumers, carers or family members disagreed, with 26% reporting no improvement as shown in Figure 18 below. Consumer peak bodies reported less disagreement (13%).

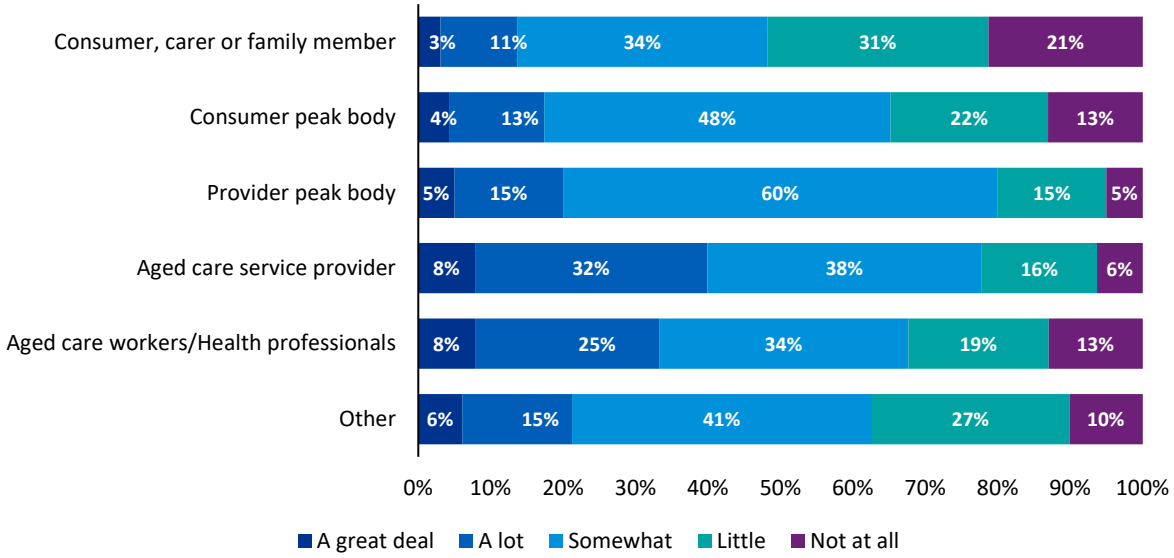
Figure 18: 'Have the Quality Standards improved quality outcomes for consumers?', percentage



Source: KPMG

Evaluation stakeholders reported that consumer involvement in care had improved. Of all stakeholder groups surveyed, 79- 95% agreed that consumer involvement had improved to some degree. Similar to the question above, consumers, carers or family members were likely to say there was no improvement (26% indicated there was no improvement at all), but again consumer peak bodies were more positive, with only 10% reporting no improvement. More results are presented in Figure 19 below.

Figure 19: 'Have the Quality Standards led to changes that support consumers being involved in their care and services?', percentage



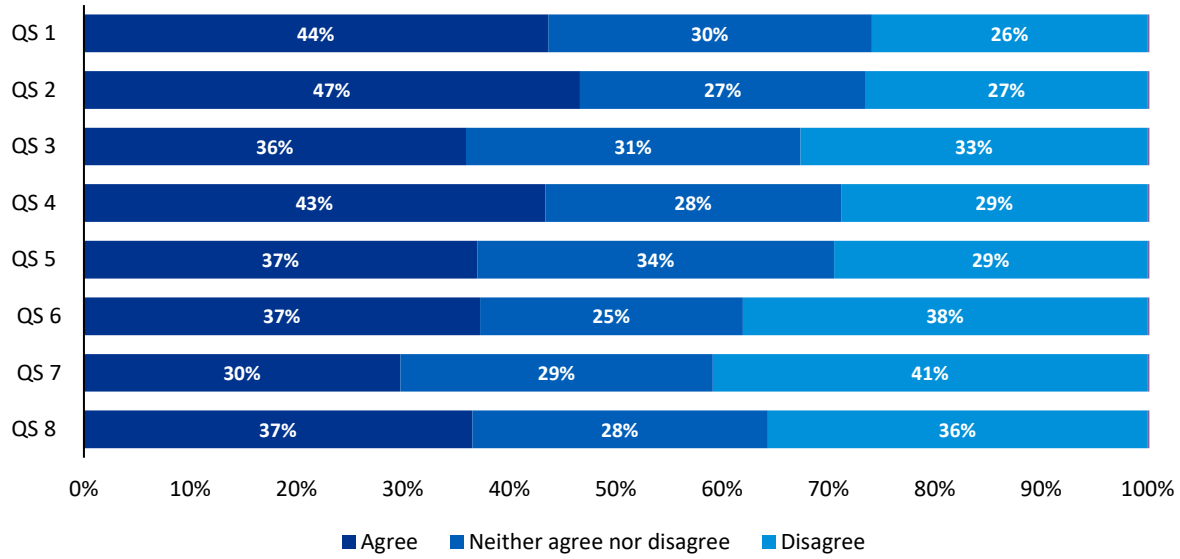
Source: KPMG.

Consumers seem to perceive less improvement than other stakeholders in their responses to the two questions above. However, consumer peak bodies are more positive. This finding suggests that the individual consumers

surveyed may be experiencing more limited improvement on a one-on-one basis, but the broad oversight of the consumer (and provider) peak bodies recognises the improvements the Standards are delivering.

Fewer than half of survey respondents agreed that each Standard had led to its intended outcome (i.e. 44% of respondents agreed that Standard 1 has led to consumers being treated with dignity and respect). The responses for all Standards are presented in Figure 20. Stakeholders perceived that Standard 7 was the least likely to lead to its desired outcome. This is supported by many consultation responses highlighting workforce challenges.

Figure 20: The Standard has led to… [example: consumers being more likely to be treated with dignity and respect], (all stakeholder respondents)



Source: KPMG.

These findings combine all stakeholder responses. Therefore, noting the lower level of consumer agreement with the two questions above, it follows that the average of the combined response is lower. It may also reflect the views expressed in consultations that providers can find it challenging to quantify specific consumer impacts as they adapt their service delivery.

The reasons that stakeholders gave for their disagreement related to gaps they perceived in the Standards which are discussed above.

Examples of improvements in care delivery

Consumers and their representatives, providers, peaks and other stakeholders also provided many examples of how the Standards had improved care delivery in consultations and survey responses. These examples are grouped by Standard and presented in Table 14 below.

Table 14: Stakeholder examples of improvements in care delivery against each Standard

Standard		Improvements noted by stakeholders
	**Standard 1:** Consumer dignity and choice	• Greater involvement of consumers and their families and representatives in the delivery of care and in engaging with providers on their needs and preferences. • Improved interactions between workforce and consumers, for example staff increasingly using consumer names and communicating with consumers more often. • Consumer and their family members feel more empowered to engage in conversations with a provider on the quality and safety of care delivered by an organisation.

		• Increased understanding and support provided to consumers to make choices, including decisions that increase their exposure to risk.
	**Standard 2:** Ongoing assessment and planning with consumers	• More holistic approaches to delivery of care and services are being conducted. • Overall improvements in the assessment of care needs and preferences for consumers. • Greater involvement of consumers in the care planning process and improved documentation of practices for recording consumer preferences and needs.
	**Standard 3:** Personal care and clinical care	• Greater engagement of consumers by the workforce in the delivery of care and services, including asking permission to complete certain care tasks.
	**Standard 4:** Service and supports for daily living	• Limited examples of improvements were provided by stakeholders for this Standard.
	**Standard 5:** Organisation's service environment	• Improvements to the home environment of residential aged care services to be more 'home-like' • Adoption of architectural styles into service designs that are reflective of consumer's needs and preferences.
	**Standard 6:** Feedback and complaints	• Increased emphasis on using 'feedback' rather than complaints to drive improvement in care delivery. • Observed cultural shifts within some providers towards a 'consumer first' approach.
	**Standard 7:** Human resources	• More training and development opportunities for the workforce. • Organisations are more likely to engage staff on quality expectations and how to deliver quality care.
	**Standard 8:** Organisational governance	• Open disclosure requirements have driven improvements in the transparency, accountability and communication between providers and consumers. • Enhanced systems to deliver safer and quality care, including governance arrangements.

Source: KPMG.

Unintended Consequences

During consultations, examples of unintended consequences were raised by some stakeholder groups. Aged care providers and palliative care specialists raised the concern that the perceived regulatory burden and scrutiny of restrictive practices obligations had caused providers to limit access to appropriate use of both palliative care and pain relief medications, as well as psychotropic medications, where they were perceived as restrictive practices. An example was provided of a consumer who entered into aged care with previous mental health management plans including ongoing prescription that became unavailable or limited once perceived as restrictive or behaviour-altering by the service provider. A further example of interpreted restrictive practice is where a consumer representative expressed that their family member wished to have a raised bed rail to offer support to move in and out of bed but had not been able to use this as a perceived restriction by the provider. These examples may be considered more reflective of providers' understanding of restrictive practices and may reflect a need for further guidance to support application of requirements under the Standards and the *Quality of Care Principles 2014*.

7.2 Is there a difference in impacts based on service types, consumer diversity, location of service provider or diversity of service provider, and regulator?

In addition to the outcomes described above, stakeholders provided observations on how the Standards had impacted consumers, providers and other key stakeholders in the sector, including the Commission. The Evaluation found that there has been evidence of improvements to care delivery in some segments of the sector which has led to positive outcomes for consumers (as described in the previous section). However, evidence of a difference in impact by consumer diversity was not observed during this Evaluation.

The impact on providers was varied and there was also some evidence of a difference in impact by provider type and service delivery setting. The impact on the Commission was significant, particularly to support ongoing education activities for the sector and increased regulatory activity. These areas of impact by stakeholder group are described below.

Impact on consumers

The Evaluation found that there has been evidence of improvements to care delivery in some segments of the sector which has led to positive outcomes for consumers (as described in the previous section). The most common raised impact was that consumers and representatives were increasingly involved in care and decision-making since implementation of the Standards.

However, evidence of a difference in impact by consumer diversity was not observed during this Evaluation. Instead, specific examples were raised by some stakeholders in relation to the improvements in certain aspects of care delivery which relate to certain consumer cohorts. For example, some providers described adapting architectural styles associated with cultural backgrounds to accommodate the cultural needs of their consumers. In comparison, some stakeholders including both consumers and care experts perceived that there had been limited improvements in the support provided to consumers with dementia or cognitive impairment to communicate their needs and preferences.

Impact on providers

The impact on providers was varied. Some providers indicated that the new Standards had posed minimal impact to their organisation, while other providers described a range of impacted areas such as cost associated with regulatory burden, innovation, workload and retention of staff and training and development. These domains are presented below.

Table 15: Areas of impact for providers

Area of impact	Description
Cost and regulatory burden	Some providers and other stakeholders such as peak bodies reported that the Standards had introduced a significant regulatory burden on providers. Providers conveyed that the introduction of the Standards had required staff, particularly registered staff, to complete additional care documentation and assessment, and other 'tick box' regulatory requirements.
Innovation in service delivery	Whilst there were varying views expressed in relation to innovation in the sector, some providers expressed the view that the Standards had impacted their ability to focus on innovation opportunities in service delivery. Other stakeholders raised that, for providers who were 'high performing' and were more advanced in their understanding and application of the Standards, the Standards had 'empowered

	staff' within a service to pursue initiatives to improve service delivery and drive innovation.
Workforce attrition	Stakeholders and particularly providers raised that they believe the regulatory burden placed on services had further increased attrition rates of the aged care workforce including in management levels. However, stakeholders communicated that a range of factors external to the Standards had also contributed to workforce attrition rates in the sector, including the Royal Commission and broader workforce gaps.
Workforce learning and development opportunities	Stakeholders consulted raised that training and development of the workforce had been an overall improvement since the Standards were implemented.

Source: KPMG.

Whilst a number of varying challenges to implement Standards were identified across different service types and settings, no significant difference in ongoing impact was identifiable through the Evaluation. The challenges to implementation based on service setting are highlighted in Section 5.3. Home care providers raised their own specific challenges which are addressed throughout this report.

Impact on the Commission

Commission stakeholders reported that the impact of the new Standards on the Commission was significant. Activities related to sector education, conducting assessments and monitoring of home care services were specific areas of impacts identified, as described below.

Sector education delivery

The Commission (formerly the AACQA) was responsible for the development and delivery of training and resources to support the implementation of the Standards. The Commission undertook extensive activities to support implementation of the Standards in the aged care sector (as described in Section 5).

Demand for workshops on the Standards remained high post 1-July 2019 from both new entrants into the market (especially in home care) and new staff at providers related to ongoing attrition of the workforce. In response to ongoing demand, the Commission continued to host workshops and webinar series and delivered specific training courses for providers in relation to accreditation, quality reviews and the management of accreditation performance.

In relation to preparation for future education delivery, the Commission is responding to the Australian Government announcement to engage an Assistant Commissioner for Sector Capability and Education from December 2021.[62] The Assistant Commissioner will be responsible for leading a transformational change program, informed by regulatory intelligence, to build sector capability.

Assessment Workforce and Activity

The introduction of the Standards was significant for the Commission. In particular, it significantly extended the assessment activities and other implementation activities of the Commission. The key impacts to the Commission were found to be:

- Increased assessment workload. The introduction of the Standards increased time on site as well as increased preparation for assessment activities. The introduction of Standards also significantly increased report writing time.
- Demand for assessment activities. Due to increased non-compliance of the sector, increased scheduling of Review Audits and relevant risk assessment activities was required. Similarly COVID-19 impacted the quality and assessment monitoring program at this time.
- Continued recruitment, development and training of the existing and new members of the quality assessment workforce was required. The workforce was impacted and needed to grow as a response to the

[62] P. 23, Aged Care Quality and Safety Commission, Corporate Plan (2020-2021), www.agedcarequality.gov.au/sites/default/files/media/acqsc-corporate-plan-2021-22.pdf

increased workload demands for assessment activities, as well as continued attrition as a potential result of increased work demands. The education and training activities for the workforce were significant but also required continued cover of basic development for new member of the assessment workforce.

- Ongoing review and development of assessment methodology to assess new Standards. This has increased prescriptiveness of sampling and continues to be revised and embedded.
- Impact to embed and upgrade existing IT and business systems, operational support to support both transition and increased scheduling requirements.

Impact on other stakeholders

Peak bodies and consultants confirmed they had engaged heavily with aged care providers to support training and implementation of the Standards. They also confirmed a sustained and ongoing demand for consulting services to support providers to understand quality implementation.

7.3 What other factors may have contributed to or hindered the achievement of the outcomes?

This Evaluation found some overlap between the factors which impacted the initial implementation of the Standards (discussed in Section 5.3) and the factors which continue to impact the ongoing achievement of the outcomes intended within the Standards. Specific factors which reported to have either contributed to or hindered the achievement of outcomes are presented below.

Workforce challenges

The challenges facing the aged care sector in terms of workforce are well recognised and were highlighted as a priority area to address by the Royal Commission. The sector faced challenges related to the workforce prior to implementation of the Standards, as the country continued to move towards an increasingly ageing population. Since implementation of the Standards, the impact of COVID-19 has further increased workforce challenges due to loss of immigration flow.

The 2020 Workforce Census highlighted that whilst the workforce was growing in 2019 – 2020, providers reported that 29% of their workforce left during the year, highlighting an ongoing trend of attrition. The resulting recruitment and retention issues means that providers have faced difficulties delivering the outcomes of Standard 7, but outcomes for all the Standards are impacted by this challenge, as was raised by providers and peak representatives.

Financial viability of the sector

Providers face continuing financial challenges and suggested there was has been an ongoing cost to meeting the regulatory requirements under the Standards. Whilst the scope of compliance costs could not be independently verified, recent financial trend data highlights that the financial position of the sector has worsened in the last two years. The most recent Aged Care Financing Authority (ACFA) report highlights that there has been a recent trend in deterioration of financial performance, particularly in regional and remote settings.[63] This does not necessarily demonstrate that the introduction of the Standards has added financial pressure to providers, but rather confirms an ongoing trend that increasing financial pressures are not being met by the funding available. Previous research also found that there was a weak correlation between care

[63] ACFA (2021), Ninth Report on the Funding and Financing of the Aged Care Industry, /www.health.gov.au/sites/default/files/documents/2021/08/ninth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2021.pdf

indicators and financial metrics across aged care services.[64] Nonetheless, some providers communicated that financial pressures were impacting their ability to meet the Standards, for example by limiting ability to increase staffing and staff time for training and update to systems and processes. Financial viability of the sector was identified as an urgent priority by the Royal Commission[65]. In response, the Australian Government committed additional funding for residential aged care services as part of the 2021-22 Budget which will be rolled into the new Australian National Aged Care Classification (AN-ACC) funding model.

COVID – 19

Stakeholders, in particular providers reported that COVID-19 both contributed to and hindered the achievement of the outcomes. Providers reported that COVID-19 had required providers to rapidly adapt their systems, policies, and processes in response to the pandemic, resulting in improved and strengthened responses to infection control.

However, due to the measures providers were required to put in place in response to COVID-19, providers' ability to gather feedback from consumers as part of service delivery was impacted. Restrictions on workforce availability due to state-based infection control measures, lockdowns and restrictions on movement have continued to impact the ability of providers to deliver a number of aspects of care. Additionally, COVID-19 has affected the experience of consumers who face limitations on various individual freedoms in line with the rest of the population.

Technology barriers

Some provider and government stakeholders raised the fact that technology barriers facing the sector affected the ongoing ability of providers to meet the Standards. These challenges range from internet connectivity issues to the cost and training needs of deploying digital systems to support care practices and risk monitoring. The Royal Commission agreed that technological barriers were a significant challenge facing the sector and that this needed to be addressed as a priority into the future.[66]

Sector maturity and governance

During consultations, some provider, peak and government stakeholders raised that a key factor for the achievement of outcomes under the Standards was the organisational maturity, governance and management of a service. Related to this was the organisational design and setting of a service, such as the size of a service and its access to external corporate support. One example provided was that regional and remote services faced increased challenges to recruit appropriately skilled and qualified volunteer board members for their services.

Providers, peak bodies and care delivery experts reported that some home care providers who had purchased franchised service models trusted franchise supplied tools/resources with limited awareness regarding their own responsibility. This included acceptance of standardised policies and procedures which may limit their ability to tailor their governance to needs of their service and consumers and so limit their potential to achieve the outcomes of Standard 8.

Broadly, stakeholders reported varied experiences in implementation and adherence to the Standards and noted this was largely reflective of both organisational leadership and varying sector maturity. Reflecting these challenges, the sector is demonstrably disjointed with no major market shareholders providing majority care. The residential aged care sector remains highly fragmented in its make up, with over 60% of providers only operating a single residential home. Additionally, no one provider maintains a market share of more than 3%. Collectively, the top 10 providers maintain 23% of the market share.[67]

[64] P. 6, Royal Commission into Aged Care Quality and Safety (2020), Report on the Profitability and Viability of the Australian Aged Care Industry, www.agedcare.royalcommission.gov.au/sites/default/files/2020-09/research-paper-12-report-on-profitability-and-viability-of-australian-aged-care-industry.pdf

[65] P. 154-155, Royal Commission into Aged Care Quality and Safety (2021), Final Report Executive Summary, www.agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf

[66] P. 148, 253 Recommendation 68, Royal Commission into Aged Care Quality and Safety, Final Report Volume 1, www.agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf

[67] AIHW Gen Data (2020), Analysis adapted from the Aged Care Service List: 2020, www.gen-agedcaredata.gov.au/resources/access-data/2020/october/aged-care-service-list-30-june-2020

8. Conclusion and considerations for the review of the Standards

Conclusion and considerations for the review of the Standards

This section presents key considerations for the future review and changes to the Standards.

8.1 Conclusions

The implementation of any new set of standards is intentional and transformational for a sector or industry. The development and implementation of the Standards can require a significant amount of investment from government, providers and the broader sector to test, refine, review, implement and adjust to newly introduced Standards.

The introduction of the Standards was a significant change for the aged care sector. The Standards were the first single set of standards to apply across all Commonwealth funded aged care service types in Australia. The Standards introduced new themes and requirements centred on consumer outcomes. The framing of the new Standards introduced more complex dimensions to meeting specific requirements which were less binary in nature. As such, a high proportion of providers experienced challenges with implementing the Standards and further guidance on the expectations of the Commission and how they assess performance against the Standards would be beneficial.

The Royal Commission highlighted a range of improvement areas for the Standards which were consistent with stakeholder perspectives provided during this Evaluation. There was support for the 'consumer' focus of the Standards, but the Royal Commission was critical of specific gaps within the Standards and the measurability of the Standards. Despite having these concerns, the Royal Commission noted that 'the current Aged Care Quality Standards have only relatively recently come into effect and were the result of an extensive process of consultation', and as such did not recommend introducing a new set of Standards at this time.

While it is too early to make a conclusive statement as to whether service providers are achieving consumer outcomes, feedback received from stakeholders during the consultation indicates that the Standards have contributed to some improvements in the quality and safety of care delivered within the sector. There is opportunity to enhance the current set of Standards in the short to medium term to address concerns raised during the Royal Commission and this Evaluation. In the longer term there is opportunity to pursue greater alignment of standards between sectors. Any changes to the Standards need to be considered and designed within the context of broader changes occurring within the aged care sector (as articulated in Section 5) including those that directly relate to the Standards, and with consideration of the significant investment to implement. This includes relevant reform commitments by the Australian Government such as:

- QI Program and introduction of further indicators should be aligned with/or inform measuring performance against the Standards
- Review and amendments to the Clinical Standard by ACQSHC
- Introduction of new measures to monitoring the quality and safety of aged care, including a new star ratings system.

Specific considerations on this are presented below.

Enhance the current Standards

As the introduction of a set of Standards is a significant change for the sector, the process to change the Standards could occur in a staged approach, as follows:

Short to medium term

There is opportunity to enhance the current set of Standards in the short to medium term to address concerns raised during the Royal Commission and this Evaluation. This is likely to require more focused attention and refinements to the requirements statements within the Standards. This could include revisions to existing requirements or the introduction of some more detailed or prescriptive requirements, both of which could address the issues raised by the Royal Commission related to measurability and meet provider demand for clarity of expectations of the Commission in relation to each Standard. More significant changes in architecture may provide a first step in alignment of standards between care sectors, and lessen the extent of future changes required to achieve convergence.

However, the introduction of new requirements needs to be balanced with a range of factors including the consequences for the length of the Standards, potential regulatory impact on providers and the regulator, the diverse maturity of providers within the sector and the need to strengthen clarity and measurability. The advantages of making more moderate changes to the Standards initially is that it will enable government to collect more data on provider performance against the Standards and to observe overall outcomes that have been achieved and allow more time for providers to embed requirements into practice.

For Standards that are a less prescriptive or detailed in nature, regulators in other sectors often use guidance material or other supporting documents such as the publication of accreditation guidelines to support provider understanding of how to meet a Standard. Similarly, stakeholders consulted as part of this Evaluation identified a preference for more detailed information on requirements to meet the Standards. As such, there is potential for more detailed or clarifying statements, some of which were raised as 'gaps' by stakeholders during this Evaluation, to be contained in supporting guidance material, such as through a sub-layer of indicators, rather than within the text of the Standards.

Specific areas for consideration include:

- **Addressing gaps** identified by the Royal Commission and supported by stakeholders as part of this Evaluation.
- **Removing perceived repetition within specific Standards** through the inclusion of more detailed requirements under existing Standards to distinguish between requirements under different Standards where there are common elements or perceived repetition.
- **Expanding requirements statements with multiple concepts** into separate requirements statements.
- **Improving measurability of the Standards** through amendments to existing requirements or the introduction of new, more detailed requirement statements.

In the short term, the Commission or the Department could also consider publishing guidance material for HCP providers similar to that available for CHSP providers to address concerns raised regarding understanding of the Standards, their relevance and application to the home care setting. This could include case study examples for some of the more complex themes and domains identified in this Evaluation. The Commission could also amend or provide additional guidance material surrounding the assessment framework and methodology to support provider understanding of decision making and expectations of the Commission. However, decisions on the development of such guidance material should be considered in the context of timing with broader reforms occurring within the sector such as the introduction of a new Aged Care Act and a new Single In-Home Care Program. Decisions to introduce new guidance material should also consider resourcing implications for the Commission and the relative benefit of developing new guidance material if changes are to be made to the Standards in the medium term.

Longer term

As part of the 2021-22 Budget, the Australian Government announced its intention to progress better regulatory alignment across the aged care, disability and veterans' care sectors. In the longer term there is opportunity to pursue greater alignment of standards between aged care, disability and veterans' care sectors.

The majority of stakeholders during the Evaluation that discussed harmonisation supported further harmonisation of the Standards.

A consequence of harmonised standards observed in other sectors is that there can be a decreased level of relevance for specific types of services delivered within the sector. One route that could be explored as part of harmonisation to mitigate this issue is by using a modular structure, which has a baseline set of standards that all providers are required to meet followed by modules with specific standards that apply to certain service types. Such is the approach used by the NDIS and the New Zealand standards.

Activities to support the design and development of enhancements to the Standards

While the design and development process for the Standards was out of scope for this Evaluation, stakeholders provided perspectives on areas for government consideration. Additional areas were identified as part of conducting this Evaluation that may support future implementation and evaluation activities. These include:

- **Undertake modelling and analysis of the impact of changes to the Standards:** To support decision making on changes to the Standards, the Department could consider undertaking analysis and modelling of different options proposed for revision. This could include estimation of potential costs and broader impacts both on government, the regulator and consumers, including workforce implications and impact for different types of providers.
- **Sector-wide consultation:** The Royal Commission recognised that the current Standards were the result of an extensive process of consultation. As such it will be important for any changes to the Standards to be supported by sector-wide consultation on the design and potential impact of any changes to the Standards.

Implementation process for the Standards

It is recognised that the Commission and the Department undertook a range of activities to support the implementation of the Standards. The level of additional investment to support future changes to the Standards will depend on the extent and intent of change that occurs to the text of the Standards. There are however lessons that can be learnt from the implementation of the current Standards that can support future revisions to the Standards. This includes:

- Conducting an initial needs analysis of sector need to understand learning needs and preferences of the sector, including any new or enhanced themes or concepts that require clarification or support to understand and apply in practice
- Use of engagement activities that support two-way dialogue between providers and the Commission to enhance learning
- Provision of additional clarification guidance material (as described under Item 1) and resources for different audiences, including provider types, settings and consumers.

Appendices

Appendix A: Program Logic

			Outcomes		
Input	**Activities**	**Output**	**Short-Term**	**Intermediate**	**Long-Term**
• Existing four sets of Aged Care Quality Standards • Project manager • Project team • Quality Program Board • Funding • Standards Technical Advisory Group (TAG) • Partnership with Australian Aged Care Quality Agency • External Inquiries • Outcomes of the pilot of the draft Aged Care Quality Standards	• Collect evidence • Engage stakeholders and experts through consultations • Co-design new Aged Care Quality Standards • Stakeholder communication and messaging • Test draft Aged Care Quality Standards through stakeholder consultation • Refine draft final Aged Care Quality Standards • Conduct information sessions on the draft Aged Care Quality Standards	• Preliminary draft Aged Care Quality Standards • Consultation paper • Report on the outcome of consultations for the Aged Care Quality Standards • Final draft Aged Care Quality Standards • Legislative amendments • Application of the draft final Aged Care Quality Standards by service type • Transition plan	• Acceptance of the Standards by stakeholders • Standards are clear, valid and reliable • Standards are sufficiently flexible and can be applied across all service types and settings • Service providers understand the Standards • Service providers make changes to meet the new Standards • Service providers have an increased focus on quality outcomes for consumers • Consumer awareness of the Standards • Greater consistency in assessment of quality across aged care service types	• Standards are clear, measurable, valid and reliable • Consumers increase their understanding of outcomes they can expect from aged care • Consumers are decision makers in their care • Service providers embed the Standards in everyday practices • Service providers sustain their performance against the Standards • Outcomes of quality assessment against the Standards are used to drive Government policy	• Consumers make informed choices about their care and are partners in their care • Culture of continuous quality improvement in the aged care sector • The Standards support innovation within the aged care sector • Improved quality of care and service outcomes for consumers • Improved confidence in the aged care quality regulatory framework

Implementation of the Standards	**External factors**
Transition to the Standards commenced from 1 July 2018 Aged care services assessments against the Standards commenced 1 July 2019 Aged Care Quality and Safety Commission (and former Australian Aged Care Quality and Safety Agency) work developing guidance material and implementing the new Aged Care Quality Standards	Hearings and outcomes of external inquiries, including Royal Commission and impact on public perception of the quality of aged care within Australia Aged care sector economic climate Establishment of new Aged Care Quality and Safety Commission from 1 January 2019 COVID-19 and its impact on aged care recipients and providers Reforms in response to the Royal Commission recommendations

Appendix B: Stakeholder Participation

The tables below provide a breakdown of participation in consultations and the online survey by stakeholder group.

Table 16: Consultations held by stakeholder group:

Stakeholder group	Count of workshops	Count of stakeholder consulted
Aged care service provider	11	113
The Department of Health and representatives from program areas	5	34
Consumer, family member, carer or representative of a consumer	4	37
Special Interest Groups	5	62
Provider peak body	2	18
Consumer peak body	1	12
Department of Social Services, Department of Veterans' Affairs & NDIS	1	8
The Aged Care Quality and Safety Commission	3	12
Australian Commission on Safety and Quality in Health Care	1	3
Other	2	25
Grand Total	**35**	**323**

Source: KPMG.

Table 17: Analysis of survey respondents, by stakeholder group

Stakeholder group	Response count	%
Aged care service provider	471	29%
Consumer, carer or family member of a consumer	393	24%
Aged care worker, including volunteer	348	22%
Health professional	232	14%
Consumer peak body	30	2%
Provider peak body	25	2%
Other	112	7%
Total	**1611**	**100%**

Source: KPMG.

Appendix C: Consumer Outcome Statements of the Standards

Figure 21. Aged Care Quality Standards, consumer outcome statements

Standard 1: I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

Standard 2: I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

Standard 3: I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

Standard 4: I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

Standard 5: I feel I belong and I am safe and comfortable in the organisation's service environment.

Standard 6: I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

Standard 7: I get quality care and services when I need them from people who are knowledgeable, capable and caring.

Standard 8: I am confident the organisation is well run. I can partner in improving the delivery of care and services.

Appendix D: Additional information on the Commission's assessment methodology

Additional information provided by the Commission as part of this evaluation in relation to the assessment methodology is provided below. More information on the Commission's assessment processes can also be found on the Commission's website[68].

About the assessment methodology

The Commission has adopted the following principles for the conduct of assessments against the Quality Standards, based on the ISO19011 International Standard for auditing management systems:

- Integrity
- Fair representation
- Diligence and judgement in assessment
- Independence
- Evidence based approach
- Risk-based assessment, and
- Transparency and accountability.

The assessment methodology guides the Commission's overall approach to assessing aged care provider performance against the Standards and supports quality assessors to reach similar conclusions about performance against the Standards in similar circumstances and provides clarity for stakeholders about the conduct of quality assessment.

How the Commission's assessment methodology supports consistent assessment of performance against the Standards

The Commission's assessment methodology supports consistent assessment of performance against the Standards through the following activities:

- Quality assessors obtain and evaluate sufficient relevant evidence that is collected through observations, interviews and review of documented evidence of the quality of care and services delivered to determine the approved provider's performance against the Quality Standards, in relation to the service
- Evidence collection is enabled through a sampling approach that is purposeful. The sample size will depend on the scope of the assessment (which Quality Standards are being assessed), the size and nature of the service, the composition of the consumer population using the service, the risks and issues identified in assessment planning, opening questions about risk and consumer interviews.
- In assessing the service's performance against the Quality Standards, the Assessment Team will focus on the intended outcome of the Quality Standard in relation to each requirement.
- The Assessment Team will consider the range of evidence sources relevant to the scope of each requirement. This means that depending on the requirement being assessed different forms of evidence may be relevant. The totality of evidence, in the context of the consumer outcome, will be considered in reaching a recommendation of whether a Quality Standard is met.
- Aged care providers are required to submit self-assessment information against the Quality Standards as part of accreditation and re-accreditation application. Self-assessment is an important part of the continuous improvement cycle for aged care providers. It provides an opportunity for providers to evaluate their own performance against the Quality Standards, to review the results for aged care consumers, to

[68] www.agedcarequality.gov.au/providers/assessment-processes

assess the effectiveness of any improvements, and to support processes for ongoing quality improvement and risk management.

- The self-assessment process provides an excellent opportunity for an organisation to increase its understanding of how it delivers care and services to improve outcomes for consumers. Before completing a self-assessment, providers should familiar themselves with the Quality Standards and the Guidance and Resources for Providers to support the Aged Care Quality Standards (published on the Commission). A Self-Assessment Tool template for the Quality Standards has been developed to assist providers, however this is not a prescribed template and providers may complete a self-assessment in any preferred format. The Commission has extensive guidance on its website to support providers in conducting self-assessment.

How to Commission's assessment methodology supports effective communication channels with aged care providers

The Commission's assessment methodology supports effective communication channels with aged care providers for the purpose of performance assessments through the following activities:

- Communication between the assessment team and the person in charge at a service during a performance assessment:
    - Every performance assessment commences with an entry meeting with the person in charge at the service (and those they choose to involve). The assessment team will outline the assessment process including the scope of the assessment, the evidence collection methods (through interviews, observation and review of documents through a purposeful sampling approach) and the expected length of the assessment. The assessment team will also establish an effective communication channel with the provider and discuss how and when the assessment team will communicate with the person in charge throughout the assessment.
    - If it becomes apparent that there is evidence of potential non-compliance with the Quality Standards, the assessment team will raise concerns regarding possible non-compliance and risk to consumers with the person in charge of the service. This will enable the service to address risks at the point of care and to take early action to ensure the safety, health and well-being of consumers.
    - Where the performance assessment is being conducted at the premises of a service, on each day of the assessment a member of the Assessment Team will meet with the person in charge at the service to discuss the progress of the assessment.
    - At the conclusion of a performance assessment an exit meeting is held with the person in charge at the service, and those they choose to involve. The Assessment team provides an overview of the assessment and communicates any key issues identified, including areas of concern, observations on some areas done well, and results of consumer interviews.
    - The assessment team will also provide an optional and confidential feedback questionnaire for the service provider regarding the assessment during the exit meeting. This information is independently managed and utilised by the Commission for continuous improvement of its assessment program.
- Communication between the Commission and providers in relation to the finalisation of the assessment report:
    - Following a performance assessment, the assessment team prepares an Assessment Report detailing a summary of the assessment findings at the Standard level, recommendations of met and not met against each assessed requirement of the Standards, and detailed findings and evidence from the assessment. The Assessment Team will also identify in the report any concerns about potential risk of harm to the safety, health and well-being of consumers.
    - The Commission provides the Assessment Report to the provider of the service so that they have the opportunity to understand the reasons, evidence and facts that the decision-maker is to rely on in identifying areas for improvement and making a decision regarding compliance; and provide a response to matters identified in the assessment report that may be relied on by the decision maker.

  - Once the provider has had the opportunity to respond to the assessment report, a delegate of the Commissioner considers the assessment team's report, the provider's response and other relevant information and develops a performance report. The performance report details the Standards and requirements as either compliant or non-compliant at the Standard and requirement level where applicable. The report may also specify areas where improvements must be made to ensure the Standards are complied with.

- Quality assessor registration/re-registration including specific training such as the Quality Assessor Training Program is a key quality and competency control utilised by the Commission to ensure consistent assessment approach:
  - Only a person registered as a quality assessor by the Commission in accordance with Part 6 of the Commission Rules can undertake performance assessments of aged care services against the Quality Standards.
  - A person applying to be registered as a quality assessor must successfully complete the Quality Assessor Training Program that covers the assessment methodology used by quality assessors when undertaking performance assessments under the Quality Standards. The Quality Assessor Training Program is currently accredited with ISQua against the Guidelines and Standards for Surveyor Training Programmes 3rd edition v1.1 until 2024.
  - A quality assessor must meet certain criterial if they wish to retain their registration. These include completing ongoing professional development including any mandatory training specified by the Commissioner and undertaking a minimum amount of performance assessments to ensure the quality assessor maintains the currency of their skills and knowledge of assessing the performance of services against the Quality Standards.
  - Quality assessors must observe the Quality Assessor Code of Conduct at all times given the high standards of performance and integrity that are required in all interactions with providers, carers, consumers and their representatives.
  - The Commission provides ongoing support to quality assessors with guidance material, and supporting policies and procedures and training. The Aged Care Quality Standards Guidance and Resources document is also available to support quality assessors and providers to understand the intent of each Quality Standard and ways in which evidence may be sought.

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