



REVIEW OF NATIONAL AGED CARE QUALITY REGULATORY PROCESSES

Ms Kate Carnell AO

Professor Ron Paterson ONZM

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The Hon Ken Wyatt MP
Minister for Aged Care
Parliament House
Canberra ACT 2600

Dear Minister Wyatt

We present to you our report on the Review of National Aged Care Quality Regulatory Processes.

While Commonwealth aged care quality regulatory processes work well in most cases, the Review examined why they failed to adequately detect the longstanding failures in care at the Oakden Older Persons Mental Health Service prior to its sanction on 17 March 2017.

The response to the Review was overwhelming. We received more than 400 submissions and conducted over 40 consultations with consumers and their families, advocates, peak bodies, service providers, health and aged care workers, academics and regulatory experts. We also held three consumer forums in Brisbane and Melbourne.

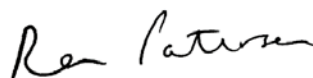
The Review was informed by analysis of peer-reviewed and grey literature that examined how the operation of Australia's aged care regulatory system compares to those in other developed countries facing similar challenges. We also assessed the extent to which Australia's regulatory system conforms with established best-practice regulatory principles.

Our consultations and research highlighted the need for better coordination of regulatory functions, expanded intelligence-gathering capacity and a better system for sharing information on provider performance with the public and aged care service providers, to promote service improvement. We have also recommended changes to accreditation, compliance monitoring and complaints-handling processes to make them more responsive to emerging issues with care quality.

Our recommendations represent an important step towards ensuring that the Commonwealth's aged care regulatory processes protect older Australians.

We thank you for the opportunity to contribute to building a stronger aged care system.

Yours sincerely



L-R: Professor Ron Paterson ONZM,
Minister for Ageing, the Hon Ken Wyatt AM,
MP, and Ms Kate Carnell AO (Chair)

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Executive summary

Introduction

The community expects the Commonwealth's regulation of aged care to be able to assure it that people in residential aged care facilities are safe, well cared for and have a good quality of life.¹

This statement of community expectations lies at the heart of our Review. We were asked to examine whether the community can justifiably have such assurance on the basis of current Commonwealth quality regulatory processes. A similar question is asked by England's regulator of residential aged care, the Care and Quality Commission (CQC). Does care meet the 'Mum Test' — is it good enough for my Mum or any other member of my family?²

Despite reforms to improve the quality of residential aged care, our Review has identified that current regulatory mechanisms do not consistently provide the assurance that the community expects.

Oakden Older Persons Mental Health Service (Oakden) had significant failures of care, and the Commonwealth's regulatory framework failed to detect them. Many aged care residents, including some of the most vulnerable and unwell in the aged care system, received poor-quality care and suffered as a consequence.

While the situation at Oakden is not typical, the circumstances that led to it are certainly not unique. Oakden is a sentinel case and highlights areas for improvement in the regulatory system.

The role of regulation

Considered in an international context, the regulatory system governing aged care in Australia performs relatively well. While complex, Australia's current regulatory system aligns well with some accepted best-practice regulatory principles.

However, in an era when consumer choice and competition are frequently invoked as the best means to improve quality, some may question the role of government as a regulator of this sector.

In our view, the rationale for regulation of residential aged care quality is that the market is an inadequate mechanism to ensure the safety and well-being of highly vulnerable residents. Elderly citizens living in care facilities, many of whom suffer from disabilities and dementia associated with ageing, are especially in need of protection.

¹ The Hon Ken Wyatt AM, MP, 1 May 2017, 'Federal aged care minister to commission review of aged care quality regulatory processes', Media release.

² Care Quality Commission, 2017, *The state of adult social care services 2014 to 2017*, p. 2; Kapp, M.B., 2003, 'At least Mom will be safe there: the role of resident safety in nursing home quality', *Quality & Safety in Health Care*, Vol. 12, pp. 201–204.

Quality assurance is vital in a sector where residents (and prospective residents) and their families are poorly placed to compare the quality of facilities. Despite their motivation to find a suitable, good-quality facility, people find it very difficult to obtain current, reliable information, and rely on recommendations from friends and (if they have the financial means) commercial aged care navigators.

Thus, we see the primary role of quality regulation as consumer protection. The Commonwealth needs to know that any residential aged care provider that it licenses and (partly) funds meets at least minimum standards of safety, quality of care and quality of life. Rigorous accreditation is a means of checking that core standards are met. As part of its safety oversight role, the Commonwealth can also protect residents by requiring reporting of serious incidents and mandating compliance with guidelines limiting the use of restraint and antipsychotic medication.

A further dimension of the Commonwealth's consumer protection role in aged care is ensuring that residents have access to an independent statutory complaints commissioner to assess and investigate complaints raised by residents and their representatives. An effective complaints commissioner provides answers and redress for individuals, shares lessons that providers can use for quality improvement, and acts as a public watchdog, notifying oversight agencies of 'red flag' information about patterns of concern or serious incidents evident in complaints.

A secondary role for regulation in the aged sector is to encourage quality improvement. While it is important that government does not stifle innovation by prescriptive regulation or burden providers with unnecessary red tape and costs that detract from care provision, regulation can help lift quality beyond a minimum standard. For example, regulation can mandate publication of comparative quality information, require participation in agreed quality indicator programs, and promote education of consumers and providers about the rights of care recipients.

Regulation should complement and support other quality levers. Ultimately, responsibility for the provision of high-quality care lies with the provider. Professionalism of aged care workers, a commitment to care and compassion, and effective clinical governance in the residential homes in which they work, are critical to ensuring that residents are well cared for.

Transparency of comparative information about quality is also an important means of improving quality. Consumers and providers in the aged care sector are calling for clear, accessible quality information. Despite the commitment to better information through the My Aged Care website, there is currently little meaningful quality information available to the public, and Australia is falling behind other countries in this area.

Meaningful input from residents, families, community visitors and advocacy groups is also essential to ensuring that the consumer's voice is heard by facilities. No one has a greater stake in the quality of residential aged care than the residents themselves and their families and advocates. They are the first to identify issues of concern and areas for improvement. We agree with the view expressed by Council on the Ageing Australia (COTA) in its submission:

*The aged care sector needs to increase the transparency of accreditation for residents and their family or friends, and much more effectively gather and incorporate their views about and experience of the facility in which they or their loved one lives ...*³

Key elements of an effective regulatory system for aged care quality

We have identified the following key elements of an effective regulatory system for aged care quality.

1) An integrated safety and quality regulator

The current regulatory system is fragmented. The point is well made in a submission from a major aged care services provider:

*... [T]he current split of responsibilities between the Department of Health, the Quality Agency and the Complaints Commissioner creates opportunity for miscommunication or discoordination between the three organisations ... It would ... be more efficient if a single agency looks at all aspects of an issue.*⁴

A single agency, as originally proposed by the Productivity Commission,⁵ would enable integration of accreditation, compliance and complaints handling in an independent body.

We propose establishment of an Aged Care Quality and Safety Commission. We recommend that the new Commission comprise an Aged Care Quality Commissioner, an Aged Care Complaints Commissioner and an Aged Care Consumer Commissioner. An Aged Care Commission Board would govern the Commission. Within the new Aged Care Commission, a Chief Clinical Advisor will provide clinical leadership.

We are conscious that, in relation to setting standards for safety and quality, there are some parallels between our proposed new Aged Care Commission and the Australian Commission on Safety and Quality in Health Care. However, residents of aged care facilities have special needs and vulnerabilities, different from those of patients and health care consumers – and the agency we propose will be a regulator, overseeing an area of high and discrete community concern.

2) Information on care quality for consumers and providers

The absence of reliable, comparable information about care quality in residential aged care is a striking feature of the current system. It is especially surprising given the ready access to comparative information about other consumer goods and services. It is also concerning, given the vulnerabilities of the elderly. The need for better, comparable quality information emerged as a theme in many submissions and in our consultation meetings. Alzheimer's Australia submitted:

³ COTA Australia submission (ID#743548634) p. 4.

⁴ BUPA submission (ID#95926361) pp. 12–13.

⁵ Productivity Commission, 2011, *Caring for older Australians*, Volume 2, chapter 15.

... [W]e need a new approach to the accreditation of aged care in Australia that gives consumers greater input into the process and results in outcomes that can then be reported to consumers in an accessible form.⁶

The Aged Care Sector Committee, in its 2016 *Aged Care Roadmap*, identified transparent information as essential for achieving quality:

To make informed choices about their care, [consumers] need improved information on safety and quality and My Aged Care should publish information about provider's performance against current standards for each service.⁷

We envisage the publication of clear, readily intelligible information that includes some form of star rating against core standards. The simple and readily understandable rating information published by the CQC in England provides a useful example.

3) Supporting consumers and their representatives to exercise their rights

The United Nations 'Principles of Older Persons' affirm:

Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care, or treatment facility, including full respect for their dignity, beliefs, needs and privacy and the right to make decisions about their care and the quality of their lives.⁸

These principles find expression in the Charter of Care Recipients' Rights and Responsibilities—Residential Care, legislated for in the *Aged Care Act 1997*.⁹ Specified rights include the right to "quality information appropriate to his or her needs", "to be treated with dignity and respect", "to complain and to take action to resolve disputes", "to have access to advocates and to other avenues of redress" and "to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights".¹⁰

Awareness of the Charter and of consumers' rights appears to be low. Not enough has been done to ensure that consumers know their rights and are encouraged to exercise them.

We have made recommendations to ensure that greater prominence is given to the rights of consumers of aged care residential services. Leadership in education should be provided by the new Consumer Commissioner within the proposed Aged Care Commission, working alongside the Aged Care Complaints Commissioner to educate the public and providers about consumers' rights.

⁶ Alzheimer's Australia submission (ID#11395657), text accompanying recommendation 2.

⁷ Aged Care Sector Committee, 2016, *Aged Care Roadmap*, p. 13.

⁸ United Nations, 1991, General Assembly resolution 46/91, Principles for Older Persons, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>

⁹ *Aged Care Act 1997*, s 9 and Schedule 1, User Rights Principles 2014.

¹⁰ Charter of Care Recipients' Rights and Responsibilities, Care Recipient Rights (b), (d), (s), (t), (u).

4) More effective accreditation and compliance monitoring

The need for improvements in the rigour of the accreditation system was a persistent theme in submissions made to this review. The Australian Aged Care Quality Agency has recognised the need to move to a risk-based approach to accreditation, to take proper account of relevant history and current risk profile of a facility, to do a better job of seeking the views of residents and their representatives, and to ensure that quality surveyors have skills appropriate for the facility whose care quality they assess.

Clearly, the accreditation processes that permitted the Makk and McLeay wards at Oakden to pass all 44 outcomes under the Accreditation Standards in February 2016 were inadequate. This was a deeply concerning failure. All too often, the Review heard about accreditation by the Quality Agency that was focused on processes rather than outcomes, and appeared to be a ‘tick-the-box’ exercise.

Many critics of the current system pointed to the weaknesses of knowing the timing of accreditation visits. One aged care worker commented:

Any audit that gives you two months’ notice they’re coming and is conducted by non-clinicians is farcical. It’s known as the ‘pre-accreditation shuffle’: give the walls a fresh coat of paint, buy some new outdoor furniture, roster extra staff on the audit day, go back and fill in all the blanks on your paperwork and don’t serve the cold party pies until the next week.¹¹

We recommend that the new Care Quality Commissioner (within the new Aged Care Commission) develop a more effective risk-based approach to accreditation, using information from a single integrated database and from unannounced visits (after the initial accreditation visit) to ensure that providers meet core standards for safety, quality of care and quality of life.

We recommend discontinuing planned accreditation visits and replacing them exclusively with unannounced visits. High-performing residential services with a low risk profile will have fewer visits so the Care Quality Commissioner can focus on facilities with higher risk.

It is also important that the capability of assessment teams is strengthened, and that assessment against standards is consistent and objective, reflecting attainment of specified outcome measures for all core standards.

Polypharmacy and medication errors were frequently raised in our consultations. We recommend conducting resident medication management reviews on admission to a nursing home, after any hospitalisation, upon any worsening of medical condition or behaviour, or on any change in medication regime. We also recommend limits on the use of restrictive practices in residential aged care, and recording and reporting when such practices are used.

5) Enhanced complaints handling

Submissions to the review reported widespread dissatisfaction with complaints handling by facilities and by the Aged Care Complaints Commissioner. We appreciate the importance of differentiating dissatisfaction with complaint outcomes from concerns about complaints processes, such as lack of

¹¹ Submission (ID#617437173).

timeliness, clarity and fairness. However, we regard effective complaints handling as a key aspect of the regulation of quality in aged care, and consider that the current model needs some improvements.

All residential aged care providers must have well-publicised, clear, prompt and fair complaint-handling processes. The new Complaints Commissioner within the new Aged Care Commission must be an exemplar of prompt and fair complaint handling.

We recognise the achievements of the current Aged Care Complaints Commissioner since it became an independent agency in 2016. It is essential that the autonomy of the Complaints Commissioner, as an independent ombudsman-like office, be maintained in the new Aged Care Commission.

We believe that the Complaints Commissioner needs increased statutory powers, to enable the Commissioner to share information and to publicly name non-compliant providers (subject to due process protections). We recommend that the Commissioner develop an online register with information about the nature of complaints received and how they have been resolved (including investigation outcomes).

Conclusion

The extensive feedback to our Review, and our analysis of the performance of Australia's aged care quality regulatory processes compared with systems in similar developed countries, confirms that further reform is necessary.

We believe that implementation of the recommendations of this Review will help prevent a repeat of the regulatory failures that occurred at Oakden with such tragic consequences.

Recommendations

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

Actions

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

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

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

Actions

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

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

Actions

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

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

Actions

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

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

Actions

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

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

Actions

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

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

Actions

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

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

Actions

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

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

Actions

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

10. Enhance complaints handling.

Actions

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

PART 1 Aged care quality regulation in Australia

Chapter 1: Introduction

When we enter residential aged care, we expect it to be a safe home, and a place of good quality care. We rely on the Commonwealth's regulation of aged care to ensure that people in residential aged care facilities know they are safe, well cared for and have a good quality of life. With over a quarter of a million¹² Australians using residential care each year, including some of the most vulnerable in our community, it is essential that it delivers quality care and that confidence among the community is maintained.

In general, residential aged care facilities provide a high standard of care to older Australians. Nevertheless, reports in early 2017 of care failures in the Makk and McLeay wards at the Oakden Older Persons Mental Health Service in South Australia (Oakden), and in a number of other residential care facilities, have demonstrated serious flaws and dented public confidence. Headlines such as "Oakden nursing home abuse and secrecy creates crisis in confidence amid ongoing government secrecy"¹³ and allegations of abuse and poor care of nursing home residents are damaging to public confidence and raise questions that need to be answered. Poor care in some facilities also risks undermining the efforts of the majority of residential aged care providers that are committed to providing good-quality services. As noted by Aged Care Crisis in its submission, "aged care is a sector where trust and trustworthiness are vitally important".¹⁴ People must be able to enter residential aged care and know 'this place is right for me'.

Failures such as those at Oakden can have catastrophic consequences for residents, including potentially resulting in illness, injury or death. They can be traumatic for staff, who lose confidence in their ability to perform their roles properly, and confronting for professionals in regulatory roles, who take their responsibility to make services as safe as possible seriously.

It is important for everyone that we use a critical incident such as events at Oakden to stop and reflect on what has happened, what the contributing factors might be, and how to prevent a recurrence. In some fields, such as clinical care and transportation, analysis of critical cases is a core

¹² Around 235,000 using permanent residential care, plus those using residential respite care.

¹³ Miles Kemp, 10 June 2017, Adelaide Now (online), <http://www.adelaidenow.com.au/news/south-australia/oakden-nursing-home-abuse-and-secrecy-creates-crisis-in-confidence-amid-ongoing-government-secrecy/news-story/5fb80be611b92d57bfa29f364b581da3>

¹⁴ Aged Care Crisis submission (ID#341409579).

strategy for improving safety and quality.¹⁵ We must analyse Oakden and use this sentinel case to understand how safety and quality in aged care can be improved.

In the wake of the failures at Oakden, the Australian Government commissioned an independent review of the Commonwealth's aged care quality regulatory processes to determine why they did not more quickly identify the extent of the failures of care at Makk and McLeay wards. On 11 May 2017, we were appointed as joint reviewers to undertake this important project. We were asked to examine what happened at Oakden, and to propose any necessary reforms to the regulation of aged care generally that might prevent a repeat of such incidents and raise quality and confidence in the residential aged care system.

Context

Like every developed country, Australia is facing the challenge of demographic change that is driving growth in demand for aged care. The number of Australians aged over 65 is rising and, over the next three decades, the proportion of the population aged over 85 will more than double.¹⁶ This demographic change is driving significant growth in demand for aged care. People prefer to be cared for in their homes, and policy changes over the last decade have significantly expanded the availability of home care packages.¹⁷ This also means that the population moving into residential aged care is older, frailer and has more complex care needs.

There have been many reviews of Australia's aged care system as it has evolved over time. Many have been broad in scope, such as the Productivity Commission's wide-ranging inquiry in 2011, which examined the whole aged care system, or the Legislated Review of Aged Care, which examined the effects of legislative changes in 2012–13 that ranged across access, pricing, equity issues and workforce matters.¹⁸ This Review is narrower, focusing specifically on the regulation of quality in residential care.

There are broader health reform initiatives that also address issues relevant to older Australians, particularly integration of care provided across health and ageing services. In August 2017, Health Ministers endorsed the *Fifth National Mental Health and Suicide Prevention Plan 2017–2022* and its Implementation Plan. The Fifth Plan is focused on improvements across eight targeted priority areas and calls for ongoing collaboration and engagement across jurisdictions to achieve meaningful reform.

Aged care and mental health are also priority areas for Primary Health Networks. These were established in 2015 to improve coordination of care to ensure patients receive the right care in the right place at the right time. We hope that over time these reforms will coordinate what is often fragmented and disjointed health services and place the consumer at the centre of care.

¹⁵ Woloshynowych, M., et al., 2005, 'The investigation and analysis of critical incidents and adverse events in healthcare', *Health Technology Assess*, Vol. 9(19), pp. 1–143.

¹⁶ Tune, D., 2017, *Legislated review of aged care*, p. 38.

¹⁷ Tune, D., 2017, *Legislated review of aged care*, pp. 49–51.

¹⁸ Productivity Commission, 2011, *Caring for older Australians*; Tune, D., 2017, *Legislated review of aged care*.

Commonwealth legislation establishes processes for the regulation of care delivered to all aged care residents. Its goal is to ensure providers deliver appropriate care that meets expected standards. The legislative framework includes processes for accreditation, monitoring, reviewing and investigating compliance with standards, and resolving complaints. The performance of Australia's accreditation and complaints systems has been favourably compared with other Organisation for Economic Co-operation and Development (OECD) countries.¹⁹ However, like other countries, while aspects of Australian aged care regulation are strong, some parts show room for improvement.

As Australia's aged care system has grown and evolved, it has undergone significant reform across most aspects of its operation. Over the past two decades, the reforms initiated under the *Aged Care Act 1997*—including the creation of the Australian Aged Care Quality Agency in 2014 and the Aged Care Complaints Commissioner in 2016—have seen significant improvements in the quality of residential aged care. The reforms sought to make changes such as creating consumer choice and control in home care, independence from government in complaints handling, changing how aged care is funded and, most recently, the proposed introduction of care indicators.

Care involves not only people's health, but also "support and care activities undertaken to ensure people with loss of function and capacity are able to maintain their wellbeing."²⁰ The National Aged Care Alliance described as 'quality care' services that are:

*consumer-driven, have a wellness and reablement focus, are affordable for the community and individuals, sustainably provided, and are inclusive of the diversity of older people according to their needs.*²¹

Regulation for quality is intended to ensure that quality of care is provided to every person in aged care, regardless of circumstance. It seeks to achieve this by focusing on the needs of consumers, on outcomes, and on improving systems, not only on protecting individual people.²² Effective aged care delivers quality of *life* for care recipients, not simply quality of *care*. It is important, therefore, that regulation is built on an understanding of consumer needs and experiences. Current reforms, such as piloting of quality-of-life indicators,²³ and developing a Single Quality Framework,²⁴ are directed to ensuring quality regulation has a strong consumer focus.

¹⁹ OECD/European Commission, June 2013, *Country note: Australia—a good life in old age*, <https://www.oecd.org/els/health-systems/Australia-OECD-EC-Good-Time-in-Old-Age.pdf>

²⁰ Milte, R., et al., 2017, 'Evaluating the quality of care received in long-term care facilities from a consumer perspective: development and construct validity of the Consumer Choice Index—Six Dimension instrument', *Ageing & Society*, pp. 1-23.

²¹ National Aged Care Alliance, 2015, *Blueprint series: enhancing the quality of life of older people through better support and care*, p. 3.

²² See, for example, Paterson R, Review of Future Governance Arrangements for Safety and Quality in Health Care, 2005, *National Arrangements for Safety and Quality of Health Care in Australia*, p. 1.

²³ KPMG, 2017, Department of Health – key findings and outcomes – National Aged Care Quality Indicator Program – consumer experience and quality of life pilot outcomes for residential care.

²⁴ Department of Health, Single quality framework: focus on consumers, <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers>.

Oakden—a critical incident

Oakden provided specialised residential care to older people with complex mental health care needs and people with severe dementia. The residents represented some of the most vulnerable people in our community. Oakden was run by the Northern Adelaide Local Health Network, part of the South Australian Government’s health care service. Since becoming a Commonwealth-funded accredited aged care service, Oakden had experienced significant challenges in delivering quality care. At one point in 2008, its problems were so severe that it briefly lost accreditation and was penalised by Commonwealth sanctions; its operators struggled to bring it back to compliance and delivery of quality care.

By late 2008, it was again accredited and sanctions were lifted. For many years thereafter, accreditation of Oakden proceeded routinely. However, a complaint by a family in 2016 about the care experienced at Oakden triggered a series of events that ultimately uncovered care systems so flawed, management so deficient and facilities so inadequate, that the South Australian Government decided to shut the facility down, and multiple staff members were referred to the regulator of health practitioners or the police.

The Oakden case is dramatic and significant. When it was reviewed in early 2017 by the South Australian Chief Psychiatrist, he and his three co-reviewers observed “a system that gave all members of the Review little comfort. For each of us, we saw aspects of a mental health system that we had thought confined to history. Sadly, this was not the case.”²⁵ His report, and this Review, reflect on this critical incident, use it as a lens through which to view Australia’s regulation of residential aged care, and consider how regulation might be improved.

This Review

Our Review has identified that current regulatory mechanisms do not consistently provide the assurance of quality that the community needs and expects. We have made a series of recommendations in this report that build on good regulatory practice and the lessons of Oakden. They include changes to how the regulators are structured, what their goals are and how they do their work.

We believe that implementation of the recommendations of this Review will help remedy “deficiencies in the Commonwealth’s aged care regulatory system which might have prevented the early detection and swift remediation” of failures in care such as those at Oakden.²⁶ Our consultation meetings and the 436 submissions we received—from families, community groups, aged care workers and residential aged care facility providers—confirm our conclusion that reform is necessary.

²⁵ Groves, A., et al., 2017, *The Oakden report*, South Australia Department for Health and Ageing, p. 115.

²⁶ The Hon Ken Wyatt AM, MP, 1 May 2017, ‘Federal aged care minister to commission review of aged care quality regulatory processes’, Media release.

We thank the many individuals and organisations that assisted us. Through interviews, meetings, submissions and advice, they have provided information, increased our understanding and supported our analysis. We trust that, through learning the lessons of Oakden and adopting our recommendations, better regulation and support will be provided to residential aged care, and the care received by each of us who uses those services will be better as a result.

Chapter 2: Australia's current regulatory system

Introduction

The Australian Government has an extensive regulatory system in place aimed at ensuring that people in residential care homes receive quality care. This regulatory framework has evolved over the last two decades, and continues to do so.

The *Living Longer Living Better* reforms of 2013—the government's response to the Productivity Commission's 2011 report *Caring for older Australians*—made changes to the regulatory system governing the quality of care received by consumers of aged care in both home and residential care.²⁷ The reforms signal an increased emphasis on being cared for in the home, and a shift to a 'consumer-directed' model of home care.²⁸

The reforms have also given consumers more control over their care, whether in their own homes or in a residential home, providing more information, choice and avenues of complaint, while aiming to ensure they receive a high quality of care. The goal of the reform has been described as an aged care system that is more consumer-driven, more market-based and less regulated.²⁹

The *Aged Care Act 1997* (the Act) provides the basis for Commonwealth-subsidised home care packages and residential care, including financing that care. It sets out the requirements for approval as a provider of government-funded aged care, the allocation of aged care places, approval and classification of care recipients, the rights of consumers and the subsidies paid by the government.

The Act has been amended many times in an effort to establish a regulatory framework that protects consumers and promotes quality of care (and continuous quality improvement), to meet the needs and expectations of consumers.

The Act in its current form has mechanisms to regulate for quality, including accreditation and monitoring of approved providers, managing non-compliance, complaints mechanisms and advocacy services for consumers. It is a complex piece of legislation, with subordinate legislation that details 17 Principles of Aged Care, many with additional schedules.

The aged care principles that are especially relevant to the provision and regulation of quality residential care are:

- Approved Provider Principles
- Accountability Principles
- Quality of Care Principles (including the Accreditation Standards, which form a sub-set)
- Sanctions Principles

²⁷ Productivity Commission, 2011, *Caring for older Australians*.

²⁸ Department of Health, Why is aged care changing? www.agedcare.gov.au. From 27 February 2017, funding for a home care package follows the consumer.

²⁹ Aged Care Sector Committee, 2016, *Aged Care Roadmap*.

- User Rights Principles
- Complaints Principles

Providers of residential aged care are expected to adhere to the provisions of the Act, and can be penalised if they fail to do so.

In addition, there is separate legislation, the *Aged Care Quality Agency Act 2013*, which establishes one of the regulators, the Australian Aged Care Quality Agency. This Act also has a set of principles in subordinate legislation.

The two Acts and their subordinate legislation, including the 17 Principles, inform the work of the three key players in the regulatory environment of aged care: the Australian Government Department of Health (the Department), the Australian Aged Care Quality Agency (the Quality Agency) and the Aged Care Complaints Commissioner (the Complaints Commissioner). The three arms of the regulatory system evaluate the performance of providers against the Act and Principles.

Consumers of aged care have rights under the Act and the Principles, and can expect to receive care in line with the standards the legislation embodies. The three regulators are increasingly making information available to consumers to help them make more informed choices relating to their care. However, as noted later in this Report, this process is in its early stages.

These three organisations form a kind of ‘tripartite’ regulation of aged care and are the focus of this report, but they are not the only regulators involved. Other agencies have significant involvement, including the Australian Health Practitioner Regulation Agency, state and territory health departments (for example, South Australian Department of Health, which provided aged care at Oakden), and law enforcement bodies, particularly in situations such as alleged assault or fraud.

A tripartite system

Each of the three main regulatory agencies plays a part in regulating the delivery of quality residential aged care. While the three regulatory agencies have distinct functions, the work of the Department and the Quality Agency, in particular, overlaps as they both monitor providers’ compliance with their responsibilities under the Act.

In summary, the responsibilities of the three regulatory arms are:

- The Department of Health administers funding to all aged care providers, including residential aged care homes. It regulates the ‘gateway’ for providers to enter the system where they become eligible to receive government funding, by approving providers for the type of care they provide—residential, home care or mixed.³⁰ It also has the power to enforce compliance with the Act and to remove providers from the system by revoking their approval. The Department supports residential care providers in their efforts to comply with their obligations under the Act through education. The Department publishes compliance

³⁰ ‘Mixed’ care refers to the small number of providers that operate across residential and home care. Four out of five providers operate only one type of care. See Aged Care Financing Authority, 2016, *Annual Report on the Funding and Financing of the Aged Care Sector*, p. xii.

decisions on the My Aged Care website,³¹ which is the window to the aged care system for consumers.

- The Quality Agency accredits residential aged care facilities against the Accreditation Standards that are legislated in the Quality of Care Principles. It monitors compliance with expected standards of care through audits and site visits. It notifies the Department of non-compliance with the Accreditation Standards by providers, and both the Department and the Quality Agency have processes to deal with non-compliance. Results of the Agency's reviews are publicly available to inform consumer choice.
- The Complaints Commissioner deals with complaints from individuals about aged care services, including about the quality of care residents are receiving, and attempts to resolve those with the provider. If a complaint indicates that a provider may be non-compliant, the Commissioner can refer a provider at any time to the Quality Agency or the Department for compliance action, depending on the type and seriousness of the complaint.

There are formal referral arrangements among the three agencies, detailed in memorandums of understanding. These apply if one agency identifies systemic risks or issues appropriate to the jurisdiction of a different agency, or in the event of providers not complying with their responsibilities to provide quality care in accordance with the Accreditation Standards. These arrangements, along with general information sharing, are intended to result in a coordinated approach to protecting the safety and well-being of older Australians receiving care.

This tripartite system has existed in various forms for nearly two decades, but has altered significantly since 2014. The Quality Agency was established as a statutory authority from 1 January 2014, under the *Aged Care Quality Agency Act 2013*. Its predecessor, the Aged Care Standards and Accreditation Agency Ltd, had been an independent company established by the Commonwealth Government under the *Aged Care Act 1997*.³² The period of care under scrutiny at Oakden, examined in chapter three, traverses the time of both the Accreditation Agency and the Quality Agency.

The Complaints Commissioner was established as a separate entity in its current form on 1 January 2016. Previously, consumer complaints had been processed by the Complaints Investigation Scheme (later known as the Aged Care Complaints Scheme), which had been in operation since 1 May 2007, administered within the Department.³³ Prior to 2016, only *reviews* of complaints were considered by an Aged Care Complaints Commissioner outside the Department, whereas now all complaints are handled independently by the Complaints Commissioner.

³¹ www.myagedcare.gov.au

³² Senate Community Affairs References Committee, 2005, *Quality and equity in aged care*, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/aged_care04/report/c03. The Agency was appointed as the 'accreditation body' for residential care services and the Accreditation Grant Principles 1999, made in accordance with the Aged Care Act, specified its functions and procedures.

³³ From Guidelines for the Aged Care Complaints Commissioner, May 2016, p. 1, <https://www.agedcarecomplaints.gov.au/raising-a-complaint/aged-care-complaints-guidelines/>

Provider approval

To enter the government-subsidised system, providers of residential aged care must first seek approval from the Department. They must be approved for the particular type of aged care services they are providing (home, residential or mixed). As at June 2016, there were 949 approved residential aged care providers.

The provider seeking approval is not the specific aged care facility, but its owner and / or operator. The requirements that providers need to meet to be approved are set out in the Act and in the Approved Provider Principles 2014, which dictate what should be considered in assessing an applicant's suitability to provide residential aged care.

The approval of providers for Commonwealth subsidies is largely dependent on the Department examining their financial management records, governance, structure and staffing. Applicants must meet a number of criteria relating to financial management and governance. They must demonstrate their experience in providing relevant types of care, an understanding of their responsibilities (such as compliance with standards), and that they have the appropriate systems to meet those responsibilities. In practice, the regulation of approved provider status appears to place emphasis on financial and governance aspects, but these are only part of what the Act says approval requires.³⁴

The Department has the power to revoke approved provider status if the suitability criteria are no longer met, or in the rare case where a provider is found to have given false or misleading information.

Approved provider responsibilities

The responsibilities of approved providers are set out in Chapter 4 of the Act, and the associated Quality of Care Principles, User Rights Principles and Accountability Principles.

Quality of Care Principles

Provider responsibilities to deliver quality care are detailed in the Quality of Care Principles,³⁵ which cover general care and services that need to be provided to all residents in aged care homes. The principles cover everything from furnishings and meals to assistance with daily living, therapy and nursing services and emotional support. In residential homes, this includes maintaining sufficient appropriately skilled staff to meet the needs of care recipients.

³⁴ Aged Care Act 1997, section 8-3. See also chapters 4.1, 4.2 and 4.3 of the Act. See Section 2.4 of the application form, and 2.6.2. See 2.16 in Department of Health, Guidance for applicants seeking approval to provide aged care, <https://agedcare.health.gov.au/funding/the-guidance-for-applicants-seeking-approval-to-provide-aged-care>

³⁵ Quality of Care Principles 2014, made under section 96-1 or the *Aged Care Act 1997*, Schedule 1.

The Accreditation Standards form Schedule 2 of the principles. They are “standards for quality of care and quality of life for the provision of residential care”.³⁶ Although located under the Aged Care Act, they form the reference standard for the primary work of the Quality Agency.

User Rights Principles

The User Rights Principles provide information on the rights of residents. They spell out the practical aspects of their rights, such as security of tenure, access to consumer representatives and advocates, complaint resolution mechanisms and the information they must be given. Schedule 1 of the principles, called the Charter of Care Recipients’ Rights and Responsibilities, also covers quality-of-life aspects, such as the rights to quality care, to be treated with dignity and respect, to have privacy and security, to have cultural and religious views respected, and to have input into decision-making that affects care recipients.³⁷

Accountability Principles

The Accountability Principles cover providers’ responsibilities to comply with the conditions regarding, for instance, the allocation of places and assessment of care needs. In addition, the principles include a specific provision that providers must report alleged assaults directly to the Secretary of the Department of Health.³⁸

Provider accreditation

As well as seeking approval from the Department of Health, the provider must apply to the Quality Agency for accreditation of its residential care services.

The Quality Agency assesses the performance of approved residential care providers against the Accreditation Standards. The Quality Agency Principles, made under the Aged Care Quality Act, describe the processes the Quality Agency uses to accredit an approved provider’s service and monitor their compliance with all aged care standards.³⁹

There were 2,678 accredited residential aged care facilities in 2015–16.⁴⁰

Accreditation Standards

The key Quality Agency function is to accredit residential aged care homes that receive funding from the Commonwealth, and to monitor their compliance with standards of care. The Quality Agency’s approach is to engage actively with the sector and support providers to meet expected standards of care.⁴¹ Promoting high-quality care, innovation in quality management and continuous improvement by providers are specific functions of the Quality Agency. To fulfil those functions, the Quality

³⁶ Quality of Care Principles, Part 2, Division 2.

³⁷ Charter of Care Recipients’ Rights and Responsibilities.

³⁸ Aged Care Act, Division 64; Provider Approval Application form section 2.4,

<https://agedcare.health.gov.au/application-for-approval-to-provide-aged-care-new-applicant-form>

³⁹ Quality Agency Principles 2013, made under Section 53 of the Australian *Aged Care Quality Agency Act 2013*.

⁴⁰ Australian Aged Care Quality Agency (AACQA), *Annual report 2015–16*.

⁴¹ AACQA, Corporate Plan 2017 to 2021, <http://www.aacqa.gov.au/about-us/CORPORATEPLAN2017to2021V6.6.pdf/view>

Agency offers targeted education services and workshops, as well as standardised training packages for providers.⁴²

For a facility to be accredited, it must meet four Accreditation Standards, relating to:

1. the facility's management systems, staffing and organisational development
2. the health and personal care the home provides to its residents
3. the lifestyle residents can lead
4. the physical environment, including the safety of that environment.

Within those four standards, there are 44 outcomes providers aim to meet. The Accreditation Standards establish minimum quality standards against the 44 outcomes. In 2016, nearly 98 per cent of providers met all 44 outcomes across all four standards.

Providers are not assessed on a sliding scale against each outcome, but are simply determined either to have met or not met the particular outcome. One outcome under each standard the provider needs to meet is "continuous improvement"; providers must have in place a plan for continuous improvement.⁴³

The standards are not intended to be prescriptive, but to guide the delivery of quality care. They are:

*...intended to provide a structured approach to the management of quality and represent clear statements of expected performance. They do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its care recipients. It is not expected that all residential care services should respond to a standard in the same way.*⁴⁴

Accreditation process

Initial accreditation of newly approved providers involves the Quality Agency conducting a desk audit to ascertain the residential home's standards, which happens before residents move in (Figure 1).⁴⁵ The Quality Agency visits the site (an assessment contact, explained in more detail below) between one and two months after accreditation has been granted.⁴⁶ When a provider is accredited for the first time, the accreditation period lasts for one year. The Quality Agency makes available a suite of training and other tools to explain the accreditation process to providers.⁴⁷

⁴² AACQA, Education, <http://www.aacqa.gov.au/providers/education>

⁴³ Quality Agency Principles 2013.

⁴⁴ Quality of Care Principles, Division 2 – Accreditation Standards, 11 – Application of Accreditation Standards.

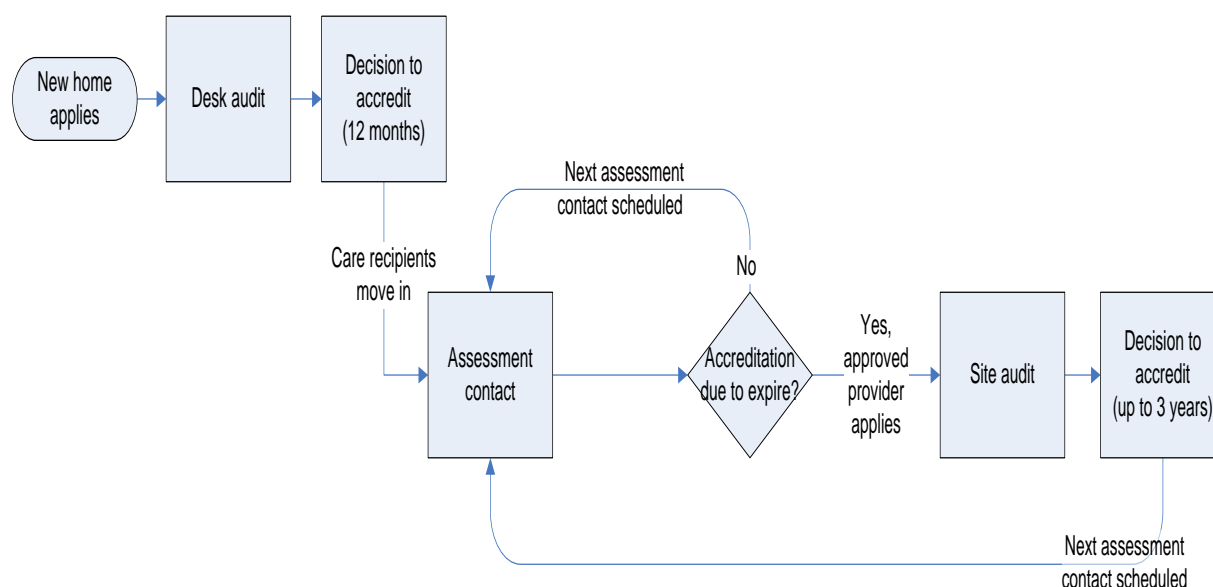
⁴⁵ Quality surveyor handbook, August 2017, p. 15.

⁴⁶ Quality surveyor handbook, August 2017, p. 15.

⁴⁷ AACQA, Courses and workshops, <https://www.aacqa.gov.au/providers/education/courses-and-workshops/one-day-workshops>

Residential care facilities must apply for re-accreditation six months prior to the expiry of their current accreditation.⁴⁸ Re-accreditation is usually for three years, although if the Quality Agency considers the provider to pose a higher risk of non-compliance with any of the standards, the period can be less than three years.

Figure 1. Residential aged care facility accreditation cycle⁴⁹



The accreditation and assessment activities are undertaken by quality surveyors whom the Quality Agency trains and registers. As at 4 September 2017, there were 318 surveyors across Australia.⁵⁰

Monitoring compliance with the Accreditation Standards

The Quality Agency uses three types of visits to accredited aged care homes to monitor and support providers in meeting the quality of care Standards: site audits, assessment contacts and review audits.

Quality surveyors can offer assistance during assessments to help providers make improvements, including informing them about alternative ways of providing services and care, and possible causes of any problems observed.⁵¹

During site visits, quality surveyors discuss their findings with the provider, including any gaps they observe, and give the provider an opportunity to supply further information about their service delivery and performance.⁵²

⁴⁸ The provider has to submit an application form, together with payment:

https://www.aacqa.gov.au/providers/residential-aged-care/copy_of_processes/accreditation-fees. The form explains they need to apply six months before the current accreditation expires.

⁴⁹ Source: Quality surveyor handbook, August 2017, p. 15.

⁵⁰ Register at <https://www.aacqa.gov.au/surveyor-register-6-09-17-1>

⁵¹ Quality surveyor handbook, August 2017, pp. 40-41.

Site audits

After a home has applied for re-accreditation, the Quality Agency audits the facility's operations. This includes a site audit, an announced site visit to assess performance against all 44 outcomes of the Accreditation Standards. Each of the outcomes is assessed as met or not met. As part of the process, providers complete a self-assessment of their performance against each outcome, which they can submit during, or prior to, the site audit.⁵³

The intention is that through assessing their own performance, providers discern their own strengths and areas for improvement. Self-assessment is an internal review against the standards, intended to culminate in the residential home creating plans for improvement. Developing their own performance assessment also assists providers to prepare for both announced and unannounced contact visits by quality surveyors.⁵⁴

Assessment contacts

In addition to a comprehensive site audit, the Quality Agency conducts assessment contacts to examine the provider's performance and assist the home's process of continuous improvement.⁵⁵

There is considerable variation between assessment contacts, depending on the type of service and the reason for the assessment, but their scope is always narrower than the scope for audits, focusing only on specific aspects of care.⁵⁶

The Quality Agency decides on the form and frequency of assessment contacts on a case-by-case basis, considering the particular circumstances of the home and any indicators of risk of poor performance.⁵⁷ It also takes into account information from the public, consumers or their representatives, and the media.⁵⁸ Assessment contacts are also used to assist a provider with continuous improvement, provide further information and education, monitor progress in cases where a provider has not met any of the outcomes and is working towards re-establishing compliance with that standard, and identify the need for further visits.⁵⁹

The Quality Agency can initiate assessment contacts at any time, and they may be announced or unannounced. It is government policy that each residential facility receives at least one unannounced assessment contact every year.⁶⁰ The Quality Agency may also initiate assessment contacts based on referrals from the Department or the Complaints Commissioner.

⁵² Quality surveyor handbook, August 2017, p. 41.

⁵³ Self-assessment tool, Introduction, https://www.aacqa.gov.au/providers/residential-aged-care/copy_of_processes/processes

⁵⁴ Quality surveyor handbook, August 2017, Appendix 1, p. 79.

⁵⁵ AACQA, Assessment contacts, http://www.aacqa.gov.au/providers/residential-aged-care/copy_of_processes/assessment-contacts/assessment-contacts

⁵⁶ Quality surveyor handbook, August 2017, p. 24.

⁵⁷ Quality surveyor handbook, August 2017, p. 24.

⁵⁸ Quality Agency Regulator Performance Self-Assessment Report 2015-16, p. 20.

⁵⁹ Quality surveyor handbook, August 2017, p. 25.

⁶⁰ AACQA, Assessment contacts, https://aacqa.gov.au/providers/residential-aged-care/copy_of_processes/assessment-contacts/

Review audits

In cases of suspected non-compliance, the Quality Agency may also perform a review audit, which can be undertaken at any time, on an announced or unannounced basis.⁶¹

For a review audit, a review team can be on site for up to a week to assess the home's performance against all 44 outcomes of the Accreditation Standards. The team interviews staff, residents or their representatives, reviews documentation and observes the practices in the home.⁶²

A review audit may be triggered by concerns identified during an assessment contact. Alternatively, like an assessment contact, the Quality Agency may choose to conduct a review audit following a referral from the Complaints Commissioner or the Department, or based on any other information it has received.

The Quality Agency is required to conduct an immediate review audit if requested by the Secretary of the Department.⁶³ This happens when the Department has identified or suspects a breach of compliance with the standards of such nature and / or severity that it justifies a full review of the facility's accreditation status.⁶⁴

In accordance with the Quality Agency Principles 2013, the Quality Agency has the power to refuse re-accreditation following a review audit, or to revoke a service's accreditation.⁶⁵ The Quality Agency Chief Executive Officer (CEO) may also decide to vary the duration of accreditation. Loss of accreditation means loss of Commonwealth subsidies for that facility.⁶⁶

In the 2015–16 financial year, quality surveyors conducted 4,251 visits to the 2,678 accredited facilities,⁶⁷ made up as follows:

- 858 site audits
- 13 review audits (following concern that the Accreditation Standards were not being met)
- 3,380 assessment contacts, including
 - 2,866 unannounced visits
 - 515 assessment contacts to monitor performance.⁶⁸

As these figures show, most visits are unannounced assessment contacts, while review audits are seldom conducted. Decisions not to re-accredit, or to revoke accreditation, are rare.

⁶¹ AACQA, Review audits, www.aacqa.gov.au/providers/residential-aged-care/copy_of_processes/review-audits/review-audits

⁶² AACQA, *Annual Report 2015-2016*.

⁶³ Quality Agency Principles 2013, 2.35, within 3 business days.

⁶⁴ This is a Type 4 referral. Type 1 is for information, Type 2 for consideration at the next visit and Type 3 is for urgent consideration to alert the agency to more serious concerns. *Aged Care Aged care compliance operations manual*, September 2014, p. 94.

⁶⁵ Quality Agency Principles, 2.42.6.

⁶⁶ *Aged Care Aged care compliance operations manual*, September 2014, pp. 93-94.

⁶⁷ The number of accredited facilities has stayed relatively stable for the last five years, with a slight reduction from 2718 in 2012–13 to 2768 in 2015–16.

⁶⁸ AACQA, *Annual report 2015–16*, p. 11.

Consumer involvement

Feedback from residents and their experience of the quality of care and services they receive is an integral part of site and review audits. Residential homes must inform consumers about a site audit and tell them that they will have an opportunity to meet with the assessment team.⁶⁹ As part of a site audit, the assessors must interview a minimum of 10 per cent of residents and representatives, such as family, a guardian or clinical representatives.⁷⁰

Surveyors speak to over 50,000 residents and their families or representatives each year about the quality of care the resident receives.⁷¹ Quality surveyors use the information from residents and their representatives to support their assessment of management practices, systems and processes.

In June 2017, the Quality Agency implemented a set of core interview questions for a random sample of residents during site audits.⁷² A random sample of 12 to 17 residents (depending on the size of the aged care home) rate their experience for ten core questions. Response options (on a ratings scale from never, sometimes, most of the time, always) are accompanied by visual analogues to elicit responses from residents who may have communication difficulties or cognitive or sensory impairment, and enable participation of a greater breadth of residents.⁷³ The Quality Agency uses this information to supplement the interviews surveyors already conduct with residents, and to be able to report in a consistent way on findings. The results are released in a consumer experience report, published on the Agency's website with information on how residential aged care residents and their representatives experience the quality of care.⁷⁴

Managing non-compliance with the Standards

If an approved facility does not meet one or more of the 44 outcomes of the Accreditation Standards, the Quality Agency sets a timetable for improvement that outlines a plan for the provider to demonstrate that their performance is improving. During 2015–16, timetables for improvement were issued to 70 facilities.⁷⁵

Generally, a timetable for improvement gives the provider three months to improve, and progress is monitored during this period through assessment contact visits to the facility.⁷⁶ In addition to a timetable for improvement the Quality Agency can support the provider through education.⁷⁷

⁶⁹ Quality Agency Principles, 2.12.

⁷⁰ Quality Agency Principles, 2.15.

⁷¹ AACQA, September 2017, Quality Standard, <https://www.aacqa.gov.au/providers/education/the-standard/september-2017/consumer-report-to-cover-2018all-aged-care-homes2019>

⁷² AACQA, Consumer experience reports, <https://www.aacqa.gov.au/publications/consumer-experience-reports>

⁷³ Wells, Y., Herd, A., Fetherstonhaugh, D., 2017, *Developing a consumer experience report: Pilot Stage*, Australian Institute for Primary Care & Ageing, La Trobe University, pp. 14–15.

⁷⁴ Quality Agency, Consumer experience reports, <https://www.aacqa.gov.au/publications/consumer-experience-reports>.

⁷⁵ AACQA, *Annual report 2015–16*, p. 23. Of the 70, 68 were resolved within the timeframe. This includes homes that were on an existing timetable at the start of the financial year.

⁷⁶ AACQA response to the submission by Combined Pensioners and Superannuants Association of NSW to the Senate Committee investigating the future of Australia's aged care sector workforce (2016).

If the provider fails to rectify the issues with its performance by the end of the period of the timetable for improvement, the Quality Agency may conduct a review audit and may vary or revoke the facility's accreditation. In addition, the Department may take separate action.⁷⁷

If the Quality Agency identifies what the Act calls "serious risk" to the safety, health or well-being of residents as a result of any unmet outcomes under the standards, the Agency contacts the provider and requests a response to the issue within a very short timeframe. The Quality Agency considers the provider's response when determining whether the failure to meet the applicable standards has placed, or may place, the safety, health or well-being of care recipients at serious risk.⁷⁹

Determining whether "serious risk" exists is a separate statutory decision, and can be a consequence of failure in just one expected outcome. Conversely, multiple 'not met' outcomes do not necessarily lead to a decision of serious risk to a care recipient.⁸⁰ The Quality Agency may also decide that the failure has placed a care recipient at serious risk even if the failure has subsequently been addressed by the provider.⁸¹

Under the Quality Agency Reporting Principles, the Agency must inform the Department when it has made a decision that a serious risk to residents has been identified, so that the Department can review information from the Agency and decide whether to take immediate action to ensure the safety of residents.⁸² The Agency noted this was an area for potential improvement:

*The Department and the Quality Agency have been working together to streamline the exercise of their respective functions in this area, however, this is constrained by the current legislation. Risk of harm to care recipients is subject to two different threshold tests, one by the Quality Agency and another by the Department (both appealable to Administrative Appeals Tribunal). The respective responsibilities and tests in dealing with this aspect of non-compliance are not well understood by the sector.*⁸³

Reports to the Department of Health

In addition to reporting serious risk, the Quality Agency must advise the Department of all accreditation decisions. This includes:

- advice about aged care services that do not meet the Accreditation Standards
- if and when a timetable for improvement has been given to the provider
- if, at the end of that process, there has not been sufficient improvement in the provider's performance according to the Standards.⁸⁴

⁷⁷ Quality Agency response to the submission by Combined Pensioners and Superannuants Association of NSW to the Senate Committee investigating the future of Australia's aged care sector workforce (2016).

⁷⁸ AACQA, Failure to meet the Standards, https://www.aacqa.gov.au/providers/residential-aged-care/copy_of_processes/failure-to-meet-the-standards/failure-to-meet-the-standards

⁷⁹ Quality Agency Principles, Part 5, 2.63.

⁸⁰ Quality Agency Regulatory Bulletin, Issue 1, August 2017, p. 2.

⁸¹ AACQA, Serious risk, <http://www.aacqa.gov.au/providers/news-and-resources/serious-risk>

⁸² Quality Agency Reporting Principles, Part 2, 13 (2).

⁸³ Quality Agency, personal communication.

⁸⁴ Quality Agency Principles.

The National Aged Care Compliance Program

The Department of Health runs the National Aged Care Compliance Program, under Chapter 4 Part 4.4 (consequences of non-compliance) of the Aged Care Act.

The emphasis of departmental compliance work is similar to that of the Quality Agency, focusing on bringing providers back into compliance with the Act and the Accreditation Standards.

The Department's *Aged care compliance operations manual* details the steps it takes to bring providers back to complying with their responsibilities in relation to the quality of care they provide, accountability for that care and the rights of consumers.⁸⁵ The manual also provides a step-by-step guide to the processes the Department uses in deciding on a particular course of action.

According to the Department, the paramount consideration throughout the compliance process is the health, welfare and interests of both current and future aged care consumers.⁸⁶ The manual states that compliance responses are determined on the basis of a process of risk assessment:

*A systematic, risk-based program of compliance monitoring, assessment and action ensures that the Department targets its available resources at the highest risks, and proactively responds to changing and emerging risks.*⁸⁷

The Department encourages compliance through education as well as enforcement measures, including sanctions. The goal is to encourage providers to voluntarily comply with their responsibilities, with matters only escalated where necessary.⁸⁸

Monitoring compliance with provider responsibilities

While the Quality Agency monitors providers' compliance with the Accreditation Standards within each residential aged care home, the Department's role focuses on compliance by the approved provider; in other words, the company or organisation that owns the aged care homes. The Department's compliance activities are also broader, and extend to other obligations approved providers need to meet, including their financial responsibilities.

According to the Department, a key element of the risk-based model is identifying and monitoring providers considered to be at a higher risk of compliance failure. The Department gains relevant information via formal and informal means, both from within the Department and from external sources.⁸⁹ For instance, the Department receives regular compulsory reports to monitor providers' suitability to provide aged care, including their financial responsibilities, financial management and appropriate claims for subsidies.⁹⁰

⁸⁵ *Aged Care Act 1997*, ss 4.1, 4.2 and 4.3.

⁸⁶ Department of Social Services, Aged Care Compliance Policy Statement 2015-2017, p. 5; *Aged care compliance operations manual*, September 2014, p. 7.

⁸⁷ *Aged care compliance operations manual*, September 2014, p. 6.

⁸⁸ *Aged care compliance operations manual*, September 2014, p. 9.

⁸⁹ *Aged care compliance operations manual*, September 2014, p. 8.

⁹⁰ *Aged care compliance operations manual*, September 2014, pp. 13, 15.

Both the Complaints Commissioner and the Quality Agency may refer to the Department particular issues relating to providers' general suitability that have been identified during their processes, but that are out of scope of their respective roles.

The Department may also become aware of concerns in residential care homes from external parties. These may come from a range of sources such as consumer advocacy groups, health complaint bodies, media reports, direct contact from consumers, and letters to the Minister for Health and Members of Parliament.⁹¹

In practice, the Department relies heavily on information from the Quality Agency and the Complaints Commissioner to raise concerns about possible non-compliance. Both the Quality Agency and the Complaints Commissioner refer cases of provider non-compliance with quality-of-care issues to the National Aged Care Compliance Program. The memorandums of understanding among the three bodies detail their roles and responsibilities and set out specific operational protocols for formal cooperation in possible instances of non-compliance, as well as for general communication.

The Department does not appear to have memorandums of understanding or agreements with other bodies, including the Australian Health Practitioner Regulation Agency, or state and territory governments or statutory authorities.

The only instances where referrals do not come from the Quality Agency or the Complaints Commissioner relate to compulsory reports; under the Act, approved providers must advise the Department directly within 24 hours of incidents of alleged assaults reported to the police.⁹² They must also report to the Department within 24 hours if a resident is missing and the absence has been reported to the police.⁹³ These cases are not investigated by the Department, as they are police matters.

It should be noted that providers need only report the alleged assault to the Department, not the outcome of any investigation. In its recent report, *Elder abuse—a national legal response*, the Australian Law Reform Commission recommended that the government introduce a new serious incident response scheme where providers are required to notify the outcome of an investigation of a serious incident, and that the definition should be broadened to cover serious incidents of abuse and neglect. This would include, for example, physical, sexual or financial abuse, cruel treatment, unexplained serious injury or an incident that is part of a pattern of abuse.⁹⁴

⁹¹ Department of Health, 2017, Review of National Aged Care Quality Regulatory Processes: Background Paper, p. 4, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-national-aged-care-quality-regulatory-pr/>

⁹² Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p.11: the previous Aged Care Complaints Investigation Scheme, which was administered by the Department, had responsibility for compulsory reporting for alleged assaults. The compulsory reporting function remained with the Department and did not transition to the Complaints Commissioner.

⁹³ Department of Health, 2015–16 *Report on the Operation of the Aged Care Act 1997*, 10.4.

⁹⁴ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, Recommendations 4.1 and 4.3. "Reportable assaults" are specified in the Accountability Principles.

Managing provider non-compliance

In managing non-compliance, the Department's focus is always on returning the provider to compliance as soon as possible. It assesses the risk to residents posed by non-compliance and determines the most appropriate action to address the non-compliance following assessment of the risk posed.

The legislative framework governing the Department's management of non-compliance, and the procedures that guide the process, are involved and complex. The Department has several options available to address non-compliance, from education and support through to the regulatory actions available under Part 4.4 of the Act.⁹⁵

In cases of potential non-compliance, the Department engages with the provider and gathers further information through correspondence or meetings and active monitoring. In practice, the Department relies heavily on the Quality Agency to visit sites to assess compliance issues against the standards and collect information. Other forms of non-compliance can rely on information from the Complaints Commissioner and the Department's own investigations. The Department can request the provider to submit regular reports.⁹⁶

Underpinning the decision to use a particular strategy is the Department's assessment of the level and immediacy of the risk posed to residents, the nature and reasons for non-compliance, and the provider's willingness and / or ability to rectify the non-compliance.

If the Department assesses risk to residents as minor, it will usually attempt to resolve the non-compliance through education and support. A regulatory response drawing on its legislated powers may be considered more appropriate if the risk to the residents is potentially more serious.⁹⁷

The Department's compliance monitoring activities closely track and to a large extent rely on those of the Quality Agency. Agency progress reports on providers' performance against a timetable for improvement inform the Department's risk assessment and decision-making process about which strategy to use in cases of non-compliance.

Administrative response

In some cases of non-compliance with low risk to residents, the Department may focus on educating and informing providers of their responsibilities.⁹⁸ In cases where the Quality Agency has issued a timetable for improvement to a provider, the Department monitors the provider's progress through

⁹⁵ Department of Health, 2017, Review of National Aged Care Quality Regulatory Processes: Background Paper, p. 4, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-national-aged-care-quality-regulatory-pr/>

⁹⁶ *Aged care Aged care compliance operations manual*, September 2014, pp. 19–24.

⁹⁷ *Aged care Aged care compliance operations manual*, September 2014, p. 30.

⁹⁸ Department of Health, 2017, Review of National Aged Care Quality Regulatory Processes: Background Paper, p. 4, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-national-aged-care-quality-regulatory-pr/>

the reports from the Quality Agency's assessment contacts during the timetable period.⁹⁹ The Department would usually contact or meet with the provider to discuss the issues.¹⁰⁰

Regulatory response

If breaches of the Accreditation Standards are more serious, or the provider fails to address the Department's concerns appropriately, placing residents at greater risk, the Department may enforce compliance through its legislated powers. If the Department considers that the non-compliance by the provider poses a severe and immediate risk to the safety, health or well-being of the residents, the Department is able impose sanctions on the provider immediately.¹⁰¹ The most common way to identify such a risk is through a "serious risk" report from the Quality Agency.¹⁰²

However, under the Act and the Sanctions Principles, the Department has other options available that do not require sanctions to be applied immediately, but may ultimately lead to sanctions being imposed on the provider in cases of serious non-compliance.

The Department starts a process aimed at managing the provider back to complying with all relevant standards of care as quickly as possible.

At each step, the provider is given an opportunity to demonstrate how they are addressing the issues. The Department's monitoring of the provider generally aligns with the Quality Agency's activities. For instance, if the Department issues a 'notice of non-compliance', providers need to show they have lodged a plan for continuous improvement with the Quality Agency. If the Department is satisfied, it issues a 'notice to remedy' and the provider signs an 'undertaking to remedy', with an expiry date usually corresponding with the expiry of the Quality Agency's timetable for improvement.¹⁰³

If the provider does not achieve the specified outcomes, the Department may impose sanctions, but may first give the provider a 'notice of intention to impose sanctions'. The Department may also give the notice of intention if the provider has not made any submission in response to a notice of non-compliance.¹⁰⁴ In evaluating a provider's response to such a notice, the Department takes into account the Quality Agency's assessment visit report at the end of the timetable for improvement.¹⁰⁵

To impose sanctions on a provider, the Department must provide them with a sanctions notice, which is also published on the My Aged Care website.

The most common sanctions imposed are:

- restricting subsidies for new care recipients

⁹⁹ Department of Health, 2017, Review of National Aged Care Quality Regulatory Processes: Background Paper, p. 4, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-national-aged-care-quality-regulatory-pr/>

¹⁰⁰ *Aged care compliance operations manual*, September 2014, p. 33.

¹⁰¹ *Aged care compliance operations manual*, September 2014, p. 34 – referred to as the 'short pathway'.

¹⁰² *Aged care compliance operations manual*, September 2014.

¹⁰³ *Aged care compliance operations manual*, September 2014, pp. 42, 44.

¹⁰⁴ *Aged care compliance operations manual*, September 2014, p. 47.

¹⁰⁵ *Aged care compliance operations manual*, September 2014, p. 49.

- revoking provider approval unless the provider agrees to end the non-compliance, appoints an administrator or adviser to assist the provider to manage a return to compliance, or implements specific training.¹⁰⁶

The Department monitors the facility closely, and providers must notify residents and their representatives about the imposition of sanctions and answer their questions.

If a clinical advisor or administrator is appointed, the Department receives reports directly from them, which means the Department has a direct link to the facility's progress, in addition to reports from visits by the Quality Agency.¹⁰⁷

During 2015–16, the Department issued six notices of decision to impose sanctions to four providers. Five sanctions were imposed due to non-compliance in providing quality of care, while the sixth was in relation to prudential matters.¹⁰⁸

Complaints

The aged care legislation puts the rights of consumers at the centre of aged care regulation, through the of Care Recipients' Rights and Responsibilities. The Charter specifically lists the right of care recipients to complain and take action to resolve disputes, and to have access to advocates and other avenues of redress.¹⁰⁹

Providers are required to give a copy of the Charter to residents,¹¹⁰ and to have complaints management processes in place.¹¹¹ In addition to the Charter, one of the 44 outcomes under the Accreditation Standards is that care recipients have access to internal and external complaints mechanisms.¹¹²

When people are unable to resolve complaints directly with the provider, the Aged Care Complaints Commissioner is the primary external mechanism for resolution of concerns.¹¹³ The Complaints Commissioner handles complaints in accordance with the process described in the Complaints Principles 2015.¹¹⁴

Role of the Aged Care Complaints Commissioner

The work of the Aged Care Complaints Commissioner completes the tripartite regulatory framework that aims to ensure consumers receive quality aged care.

¹⁰⁶ *Aged care compliance operations manual*, September 2014, p. 57.

¹⁰⁷ *Aged care compliance operations manual*, September 2014, p. 67.

¹⁰⁸ Department of Health, *2015–16 Report on the Operation of the Aged Care Act 1997*, p. 90.

¹⁰⁹ *Aged Care Act 1997*, Schedule 1 User Rights Principles 2014, 1(s) and 1(t).

¹¹⁰ User Rights Principles, Division 3, 11 (1). Department of Health, Legislated rights and responsibilities of providers and consumers, <https://agedcare.health.gov.au/programs-services/home-care/legislated-rights-and-responsibilities-of-providers-and-consumers>

¹¹¹ Under the Quality of Care Principles, see Guidelines for the Aged Care Complaints Commissioner, version 2.0, p. 75, <https://www.agedcarecomplaints.gov.au/raising-a-complaint/aged-care-complaints-guidelines/>

¹¹² Quality of Care Principles 2014, Schedule 2, Accreditation Standards.

¹¹³ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 4.

¹¹⁴ Complaints Principles 2015.

The Commissioner's complaints process seeks to protect the individual consumer whose care is the subject of the complaint, but the process also supports compliance monitoring to ensure standards of care are being met. The work of the Complaints Commissioner can give an 'early warning' of deficiencies in care, and identify potential system failure and opportunities for improvement.¹¹⁵ While the Complaints Commissioner has a proactive education function, the role is largely reactive and starts when concerns are raised.¹¹⁶

The work of the Complaints Commissioner

Anyone, not only care recipients or their family, can lodge a complaint about the quality of care being delivered to consumers receiving aged care subsidies from the government.¹¹⁷ The Complaints Commissioner receives more than 4,500 complaints per year, and more than 10,000 contacts (including referrals from other organisations and matters out of the Commissioner's jurisdiction).¹¹⁸

There are 150 complaints-handling staff, located in offices in Adelaide, Brisbane, Canberra, Hobart, Melbourne, Perth and Sydney. They deal with complainants over the phone, by email or letter, or by visits to residential homes. Complaints officers may announce visits to residential homes—and do so in most circumstances—but have the power to conduct unannounced visits if the circumstances warrant it.

The Complaints Commissioner has the power to refer complaints or issues to external organisations as part of complaints handling and investigation, such as public health units, the police, the coroner, health care complaints bodies and the Australian Health Practitioner Regulation Agency.¹¹⁹

Responsibilities of the provider in the complaints process

Providers of aged care services are required to engage actively and cooperatively with the complaints process and address the concerns that have been raised. If resolution of a complaint is not possible or appropriate through facilitation or more informal processes, the Complaints Commissioner has the power to direct a service provider to demonstrate that it is meeting its responsibilities under the Act. The Commissioner must give notice to the provider before issuing a direction.¹²⁰

If a provider fails to take action in response to a direction, the Complaints Commissioner refers the provider to the Department for potential compliance action. The Commissioner relies on the Department to enforce compliance with the direction.¹²¹

According to the Complaints Commissioner, notices and directions are not required often because "simply knowing these powers are there is usually enough to ensure providers respond appropriately to complaints".¹²² During 2016–17, the Complaints Commissioner gave notices in

¹¹⁵ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 4.

¹¹⁶ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 1.

¹¹⁷ Guidelines for the Aged Care Complaints Commissioner, p. 28.

¹¹⁸ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 4.

¹¹⁹ Guidelines for the Aged Care Complaints Commissioner, p. 59.

¹²⁰ Complaints Commissioner, *Annual report 2016–17*, p. 23.

¹²¹ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 7.

¹²² Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 7.

relation to 30 complaints.¹²³ Twenty-seven were finalised without leading to directions. Of these, two were finalised when the provider complied with the directions and addressed the issues to the satisfaction of the Commissioner. Three were ongoing at the end of the reporting year. One direction issued the previous year was referred to the Department following non-compliance by the provider.¹²⁴

Referral

As an integral part of the Commonwealth regulatory framework for aged care, the Commissioner can refer complaints to the Quality Agency and / or the Department, depending on the type of non-compliance and on the level of risk. During 2016–17, the Commissioner referred 468 issues to the Quality Agency, and 33 to the Department.¹²⁵ These figures reflect the Quality Agency's responsibility for overseeing standards of care, which are the most frequent causes of complaints.

Through investigation of complaints, the Commissioner may become aware of broader issues with the operations of a residential facility, and refer this to the Quality Agency. Referrals range from recommending that the Quality Agency prioritise the issue in its plans, to the Commissioner requesting the Agency to urgently undertake a comprehensive assessment against all relevant standards. In the latter case, the Complaints Commissioner will always also inform the Department.¹²⁶ The Commissioner can also refer any complaint to the Department and vice versa.¹²⁷

Education and support for consumers

The regulatory framework aims to promote consumer choice and control by raising awareness of provider performance, and encouraging them to ask the 'right' questions and demand quality of care, which in turn encourages provider performance.

The Quality Agency publishes performance information on the quality of care and services provided at the residential homes it has accredited. To inform consumer choice, its website lists all decisions to accredit, re-accredit or revoke the accreditation of residential aged care homes. Audit reports on each residential facility, which include detailed observations from surveyors, are also published on the Quality Agency website.

¹²³ Most of the notices related to complaints about residential care – personal communication, Complaints Commissioner.

¹²⁴ Complaints Commissioner, *Annual report 2016–17*, p. 23.

¹²⁵ Complaints Commissioner, *Annual report 2016–17*, p. 24. Most of the referrals related to residential care – personal communication, Complaints Commissioner.

¹²⁶ MOU between Complaints Commissioner and Quality Agency, p. 6.

¹²⁷ MOU between the Department and the Complaints Commissioner. When the Aged Care Complaints Scheme was still in operation, providers were required to notify that Scheme in certain cases, including reportable assaults and unexplained absences of people in care. The Department no longer handles complaints but this requirement remains. The Complaints Commissioner will, however, be involved if someone other than a provider makes a complaint in relation to assaults or unexplained absences. See Guidelines for the Aged Care Complaints Commissioner, p. 32.

The My Aged Care website, administered by the Department, also publishes the Accreditation Standards and other information, and provides links to the Quality Agency website and to the Complaints Commissioner.¹²⁸

Other regulators of quality in aged care

While the Department, the Quality Agency and the Complaints Commissioner are the principal regulators of aged care quality, other agencies play a significant role in the complex system of aged care regulation.

Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency (AHPRA) implements the National Registration and Accreditation scheme, which regulates 14 health professions. The professions it regulates play important roles in the aged care workforce, including all staff responsible for clinical assessment and medical care. They include registered and enrolled nurses, as well as physiotherapists, occupational therapists and certain other allied health staff. Together, they make up around 14 per cent of the workforce in residential aged care homes.¹²⁹ In order to practice in Australia they must be registered with the relevant National Board, meet registration standards and follow the codes and guidelines for their profession.¹³⁰ AHPRA investigates complaints about the conduct or performance of individual practitioners, including complaints passed on by the Complaints Commissioner, who has no jurisdiction in relation to actions of individual registered health practitioners.¹³¹

The states and territories

Regulation by state and territory governments, as well as by local governments, impacts aged care services across the country. State and territories have building and fire safety regulations and set the minimum community standard for safety, health, and amenity of buildings.¹³²

State and territory governments also own and operate residential aged care homes. These make up 4.6 per cent of all residential facilities in Australia.¹³³ The proportion of government-run facilities

¹²⁸ See My Aged Care, Accreditation standards, <https://www.myagedcare.gov.au/quality-and-complaints/accreditation-standards>

¹²⁹ According to the National Aged Care Workforce Census and Survey (NACWCS) there are 236,000 employees in residential care homes. 70 per cent are personal care attendants, 10 per cent are nurses and 4 per cent are allied health professionals. Allied health services include physiotherapy, speech pathology, occupational therapy, dietetics, podiatry, and music therapy. NACWCS, 2016, p. XV, p. 13 and Tables 3.3 and 5.3.

¹³⁰ Other aged care staff are currently not regulated. The NSW Parliamentary inquiry into registered nurses in NSW nursing homes recommended the establishment of a licensing body for aged care workers.

¹³¹ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 7.

¹³² Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F15.

¹³³ At 30 June 2016: not-for-profit providers were responsible for 56.3 per cent of operational residential care places, for-profit providers were responsible for 39.1 per cent, and government providers were responsible for 4.6 per cent. Department of Health, *2015–16 Report on the Operation of the Aged Care Act 1997*, p. 44.

increases with increasing remoteness, and in remote and very remote regions of Australia, government-run organisations manage a much larger percentage of aged care services.¹³⁴

Facilities owned by state and territory governments need to meet responsibilities and obligations for quality care in relation to the particular government's aged care and health policies. The requirements differ from jurisdiction to jurisdiction and some have implemented additional regulations to ensure quality care. In addition, some aged care providers are also health care providers regulated under the Australian Health Service Safety and Quality Accreditation Scheme. The Makk and McLeay wards at Oakden were an example of this.

Other developments in quality care

National Aged Care Quality Indicator Program

While the regulatory system prescribes minimum standards, the National Aged Care Quality Indicator Program aims to promote continuous quality improvement using evidence-based performance measures. This is a voluntary program, under which providers of residential care can compare their performance on a number of quality indicators against national data.

The program commenced on 1 January 2016 for residential care facilities, with three quality-of-care indicators: pressure injuries; use of physical restraint; and unplanned weight loss. The My Aged Care website will publish the quality indicator data when the data has been established as reliable.¹³⁵ The Department is also currently trialling consumer-focused quality-of-life indicators to broaden the focus of the program and to bring objective assessment to areas of importance to consumers. A report on the pilot of this work was published in March 2017.¹³⁶

The *Aged Care Roadmap* proposes that indicators should be in place across both home and residential care by 2018, and should be published on the service finder (on My Aged Care) in the years thereafter. The use of indicators is touched on in chapter three and in part two of this report. As the KPMG report on the National Quality Indicator Program consumer experience and quality of life pilot study notes, there will be issues if the program remains voluntary.¹³⁷

¹³⁴ Australian Institute of Health and Welfare, Explore services and places in aged care, <https://www.gen-agedcaredata.gov.au/Topics/Services-and-places-in-aged-care/Explore-services-and-places-in-aged-care>. In remote and very remote areas, the private sector manages only 2 per cent, and the remainder is managed by the not-for-profit sector. It should be noted that these figures relate to all aged care services, not only residential facilities.

¹³⁵ Department of Health, About the National Aged Care Quality Indicator Program, <https://agedcare.health.gov.au/ensuring-quality/quality-indicators/about-the-national-aged-care-quality-indicator-programme>.

¹³⁶ KPMG, 2017, Department of Health – key findings and outcomes – National Aged Care Quality Indicator Program – consumer experience and quality of life pilot outcomes for residential care.

¹³⁷ KPMG, 2017, Department of Health – key findings and outcomes – National Aged Care Quality Indicator Program – consumer experience and quality of life pilot outcomes for residential care, p. 15.

Single Quality Framework

In consultation with consumers, approved providers and the community, the Department has been working towards developing a single set of aged care quality standards for all aged care services. The new standards will replace the Accreditation Standards and, subject to government approval, will take effect from 1 April 2018. According to the Department, the aim is to streamline the way performance of providers is assessed and monitored against quality standards, and increase the focus on quality outcomes for consumers.¹³⁸

Work on the standards is continuing, following submissions to a consultation paper released in March 2017.¹³⁹ The proposed quality standards comprise eight individual standards, each having several requirements that organisations would be required to demonstrate. The proposed standards are:

1. Consumer dignity, autonomy and choice
2. Ongoing assessment and planning with consumers
3. Delivering personal care and clinical care
4. Delivering lifestyle services and supports
5. Service environment
6. Feedback and complaints
7. Human resources
8. Organisational governance.¹⁴⁰

Each of the draft standards includes a consumer outcome (eg, “I am treated with dignity and respect”), an organisation statement (eg, “The organisation has a culture of inclusion, acceptance and respect for consumers”) and a set of requirements (eg, “The organisation demonstrates that each consumer’s identity, culture and diversity is respected”).¹⁴¹

Community engagement to promote quality

This chapter has noted ways consumers of aged care and other members of the community are able to engage in the aged care system to improve its quality, and what is being done by the government to expand that engagement.

¹³⁸ Department of Health, Single quality framework: focus on consumers, <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers>.

¹³⁹ Department of Health, 2017, *Single Quality Framework: draft Aged Care Quality Standards consultation paper*, <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft-standards/>. The paper was released on 9 March and submissions were due by 21 April 2017.

¹⁴⁰ Department of Health, 2017, *Single Quality Framework: draft Aged Care Quality Standards consultation paper*, p. 5.

¹⁴¹ *Report on the outcome of consultations on the Single Aged Care Quality Framework*, July 2017, p. 5, <https://agedcare.health.gov.au/report-on-the-outcome-of-consultations-on-the-single-aged-care-quality-framework>

There are committees and services that contribute to the overall improvement in the quality of aged care, whether through assisting care recipients in navigating the system and making complaints, or providing feedback to the regulatory agencies.

Aged care advocacy services

Funded by the Commonwealth, aged care advocacy services are provided free through the Older Persons Advocacy Network (OPAN), a national network of nine state and territory organisations that deliver advocacy, information and education services to older Australians.¹⁴²

Aged Care Quality Advisory Council

Set up under the *Aged Care Quality Agency Act 2013* to advise the Quality Agency in relation to its functions, and to advise the Minister on the performance of the Quality Agency, the council consists of between 7 and 11 members. Members represent providers, clinicians and consumers. They must have experience in, and knowledge of, either evaluating quality management systems, or aged care provision, consumer issues, geriatrics, gerontology, aged care nursing, psychiatry, adult education, public administration, law, health consumer issues or other appropriate expertise.

Aged Care Sector Committee

The Aged Care Sector Committee brings together key stakeholders in the aged care sector, including providers, peak bodies such as Alzheimer's Australia, National Seniors Australia and the National Aged Care Alliance, plus consumers, workforce representatives and regulators. It has a key role in advising the Minister for Health on the government's reform process and its future direction. The committee was tasked by the government to develop the *Aged Care Roadmap*. The Roadmap represents the committee's views on the short-, medium- and long-term actions required to transform the current aged care system into a sustainable, consumer-driven and market-based system. The Roadmap was delivered to the Minister for Health and Aged Care in April 2016. The government has shown support for the Roadmap and will use it as a guide for future reforms.¹⁴³

Aged Care Complaints Commissioner Consultative Committee

The Aged Care Complaints Commissioner established the Aged Care Complaints Commissioner Consultative Committee to support the Commissioner's education and complaints functions. The committee gives advice, feedback and ideas, and includes representatives of at least three of the special needs groups identified in the *Aged Care Act 1997*, as well as broader service provider and service user representatives.¹⁴⁴

¹⁴² Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 4, footnote 15.

¹⁴³ Department of Health, Aged Care Sector Committee, <https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee>

¹⁴⁴ Aged Care Complaints Commissioner Consultative Committee, <https://www.agedcarecomplaints.gov.au/aged-care-complaints-commissioner-consultative-committee>. The Committee met for the first time on 10 May 2016.

Conclusion

The regulatory system governing aged care in Australia is a complex arrangement of responsibilities across several agencies. There are structures to support coordination and cooperation among some of the main players, though not all. The system gives the impression of being the result of multiple incremental changes, rather than system-based design to achieve the most efficient and effective regulation of quality in aged care. Chapter three examines how the system performed at Oakden, and chapter four reviews the performance of Australia's aged care regulation more broadly.

Chapter 3: What went wrong at Oakden?

Introduction

This inquiry is not a review of the care provided at the Makk and McLeay wards, the two wards at Oakden Older Persons Mental Health Service (Oakden).¹⁴⁵

Our examination of what went wrong at Oakden is about why, prior to its sanction on 17 March 2017, Commonwealth aged care regulatory processes did not adequately identify the systemic and longstanding failures of care at the Makk and McLeay wards documented in South Australia's Chief Psychiatrist's report of April 2017. That report was prepared by Dr Aaron Groves, along with three colleagues, Professor Nicholas Procter of the University of South Australia, Dr Duncan McKellar from Central Adelaide Local Health Network, and Ms Del Thomson, the Clinical Risk Manager for the Office of the Chief Psychiatrist. It is referred to here as the Groves report.

We have sought to understand why significant concerns about care at Oakden were not adequately reflected in the Commonwealth's regulatory processes, so that lessons can be learned and processes improved where necessary.

There are two dimensions to analysis of what happened at Oakden. The first is understanding what occurred at this facility and why. The second is to ask whether Oakden was an isolated instance. This is an important question, because the breadth of any proposed reforms turns on whether Oakden is an outlier, or instead represents a wider pattern of concern.

Oakden—a story in three parts

The events at Oakden, culminating in the closure of the Makk and McLeay wards on 14 June 2017, can be understood in three phases. The first phase covers the period up to March 2010, during which Oakden received numerous short accreditation periods and was subject to intense scrutiny because of failures of care. The second phase begins in March 2010, when Oakden was accredited for three years—the first time this length of accreditation had been granted to Oakden—and extended to the end of 2016. The third phase begins with the establishment of the inquiry by the Chief Psychiatrist in December 2016 and a media report about an alleged failure of care at Oakden, published on 17 January 2017, culminating in the South Australian Government's decision to close the facility.

Oakden until 2010: close supervision

Prior to 1998, the facilities at Oakden were state-funded psychogeriatric facilities, administered as a health care service. In that year, however, accreditation as nursing home beds (as they were then known) was sought for two of the four 'wards' at the facility, Makk and McLeay. As the Groves report notes:

¹⁴⁵The Oakden facility includes a third ward, Clements House. Clements House is not an aged care facility, and not covered by this Review. In this report, the term 'Oakden' refers only to the Makk and McLeay wards.

*This was a key turning point. From that time, what had been an entirely State funded Specialist [Older Persons Mental Health Service] was now an entirely Commonwealth funded service, for these two units that were attempting to provide the same range of specialist services with a lower level of overall funding. It is unknown what happened to the State recurrent funding of Oakden from that time onward.*¹⁴⁶

From this point, Oakden was operating in an unusual regulatory environment, because of dual involvement by both state health and Commonwealth aged care regulators. As a specialist facility, Oakden was caring for older people with particularly complex mental health needs. Good practice would dictate that it met both aged care and health care standards. However, it seems that this was not the case.

It appears that right from the beginning of Oakden's time as a Commonwealth-subsidised facility, there were issues with the care it was providing to consumers. For example, an external review of care was initiated by the state health care service in 1999, in response to concerns about the service.¹⁴⁷ Between 2001 and 2007, Oakden was mostly only accredited¹⁴⁸ for one-year periods, which again suggests there were quality issues,¹⁴⁹ since the large majority of facilities nationwide received three-year accreditation.

Oakden, operated by Central North Adelaide Health Service, was experiencing significant problems meeting the Accreditation Standards during 2007, based on a site audit conducted by the Aged Care Standards and Accreditation Agency (the Accreditation Agency)¹⁵⁰ in February 2007. That audit, though it resulted in a recommendation that the facility be re-accredited, also identified non-compliance with some standards, the last of which was not resolved until September that year. The Accreditation Agency gave Oakden one year of accreditation to May 2008.

Despite remedying the non-compliance, the Commonwealth Department of Health received information that further issues existed at Oakden, triggering further investigation by the Department's complaints investigation team of the care received by residents at the facility and on 6 December 2007, the Department made a Type 4 referral (the most serious) to the Accreditation Agency. In response, an Accreditation Agency assessment team conducted a review audit of the site for nine days in that December.

The Accreditation Agency's review audit found that Oakden complied with only 18 of 44 expected outcomes under the Accreditation Standards, and that there was "serious risk to residents in relation to the living environment and behavioural management".¹⁵¹ This information was provided to the Department, which determined that there was an immediate and severe risk to care recipients. On 12 December 2007, the Department placed sanctions on the facility, which included a requirement

¹⁴⁶ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 24.

¹⁴⁷ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 24.

¹⁴⁸ Under Commonwealth aged care standards.

¹⁴⁹ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 25.

¹⁵⁰ This would be superseded in 2014 by the Australian Aged Care Quality Agency. The term "Accreditation Agency" is used in this chapter to refer to both.

¹⁵¹ Nancy Morelli, State Manager, Accreditation Agency, 'Decision Not to Revoke Accreditation Makk & McLeay Nursing Home', undated, following the review audit of 1 to 5 March 2008.

to appoint nurse advisers to assist the provider with delivery of care and services. Two nurse advisers commenced at Oakden on 21 December 2007.

From 15 December 2007, an assessment team from the Accreditation Agency was on site nearly every day until the start of January to supervise the addressing of the most urgent issues. By 4 January 2008, the Accreditation Agency could advise the Department that the two areas of serious risk that had prompted the Type 4 referral had both been rectified.

The Accreditation Agency had to determine whether to continue Oakden's accreditation. The facility clearly had serious problems, because the assessment team that had conducted the evaluation recommended that the facility not be accredited. The Accreditation Agency weighed its own team's recommendation against other factors, including actions the provider had undertaken and the provider's response to the assessment report. On 7 January 2008, setting aside the team's recommendation, the Agency described its decision:

*The assessment team also recommended that the Agency revoke the home's accreditation. In making its decision, the Agency considered the home's level of noncompliance, compliance history and the home's remaining period of accreditation. While the home still has non-compliance, the Agency is satisfied that the home is continuing to make improvements to ensure the health, safety and well-being of residents.*¹⁵²

The Accreditation Agency placed the facility on a timetable for improvement, requiring Oakden to rectify non-compliance by 28 February 2008. This involved making at least 139 improvements across the 26 outcomes the facility did not meet.

When the Agency's timetable for improvement was put in place, Oakden's accreditation had four months to run. However, the situation appeared to deteriorate, when on 16 January 2008 the nurse advisers resigned over concerns about the willingness of the facility and its staff to make the changes necessary to meet the Accreditation Standards. The Accreditation Agency's assessment team's recommendation, the Department's imposition of sanctions, and the resignation of the first nurse advisers, may all have contributed to the decision of the site's operator (the South Australian Government) to initiate an external review.¹⁵³

The Accreditation Agency continued to make regular contact visits while the provider was still non-compliant with the Standards and under departmental sanctions. On 26–28 February, the Agency also conducted a three-day audit.

However, just as the audit was being completed, there was a significant incident at Oakden. On 28 February 2008, a resident at Oakden died following an incident involving another resident, who was charged with murder but died before trial. The incident was reported immediately to the police and the Department, as required under legislation. Within 24 hours, the Department had issued a second Type 4 referral – the most serious – to the Accreditation Agency requiring a review audit.

¹⁵² Accreditation Agency, attachment to letter to Mr Sexton, Acting General Manager, Central Northern Adelaide Health Service, 7 January 2008, 'Decision not to Revoke Accreditation Makk & McLeay Nursing Home'.

¹⁵³ Stafrace, S., Lilly, A., 1 April 2008, *Final report on the review of the Makk & McLeay nursing home*.

Within a further 24 hours, the Agency was on site, conducting a full-scale audit, which ran from 1 to 5 March 2008.

During the review audit, the Accreditation Agency found extensive non-compliance with the Accreditation Standards, and advised the provider and the Department that its timetable for improvement had not been met.

A letter from the Agency to Oakden on 13 March 2008 suggests that a further timetable for improvement may have been put in place, and (though the documentation is not completely clear) the accreditation period of the facility may have been shortened, sending a clear signal that unless there was improvement, Oakden was on track to lose accreditation:

*The timetable in which the improvements were required to be made has now ended. I am not satisfied that the level of care provided by the home complies with the Accreditation Standards.*¹⁵⁴

Despite this apparently serious failure to improve, the letter continued:

We will continue to conduct support contacts to monitor your compliance with the Accreditation Standards.

The home must take immediate action to rectify the non-compliance with the Accreditation Standards. If non-compliance continues the Agency may decide to conduct a review audit, following which your accreditation period could be shortened or your accreditation revoked.

However, later documentation (the site audit accreditation decision of 9 September 2008) states in part: "In March 2008, the home's accreditation was revoked, and following a reconsideration of that decision, in April 2008, the home was granted a 6 month period of accreditation."¹⁵⁵

Based on information provided by the Accreditation Agency following its March audit, on 10 April 2008 the Department issued a notice of non-compliance to Central North Adelaide Health Service, which was the official approved provider.

While the situation at Oakden remained unsatisfactory, the Accreditation Agency found that compliance with the expected outcomes under the standards was improving, with compliance having risen to 30 of 44 outcomes. Perhaps of more significance was a change in the assessment team's advice regarding accreditation, contained in its report on the March audit:

The assessment team recommends that The Aged Care Standards and Accreditation Agency Ltd not revoke accreditation of Makk & McLeay Nursing Home. The assessment team recommends that the period of accreditation not be varied. The assessment team

¹⁵⁴ Virginia Matthews, Acting Assessment Manager, Accreditation Agency, letter to Mr Sexton, Acting General Manager, Central Northern Adelaide Health Service, 13 March 2008.

¹⁵⁵ Ann Wunsch, State Manager, Accreditation Agency, 'Site Audit', Makk & McLeay Nursing Home RACS ID: 6010, 9 September 2008.

*recommends that there should be six support contacts during the period of accreditation and the first should be within one week.*¹⁵⁶

The Accreditation Agency, in its “Decision not to revoke accreditation Makk & McLeay Nursing Home” (undated, but following the review audit of 1 to 5 March 2008), stated:

*The home’s period of accreditation remains unchanged and will expire on 18 October 2008...The Agency has found that the home complies with 30 of the 44 expected outcomes of the Accreditation Standards...Extensive non-compliance was identified at the review audit. However, following the audit, ACH Group, which has extensive experience in aged care, has entered into a partnership with the approved provider in relation to the management of the home. In addition, the home is being assisted through the appointment of a nurse adviser. ACH is implementing new management systems to improve care for residents and to address the non-compliance identified at the review audit. The remaining short period of accreditation means the home will be subject to another full audit which will assess the sustainability of the improvements being made. The approved provider has been advised of matters in respect of which improvements would be necessary to recommend continuation of the home’s accreditation. The Agency will undertake support contacts to monitor progress with these improvements and compliance with the Accreditation Standards.*¹⁵⁷

During the ensuing five months, the support contacts were conducted. A report by the assessment manager after a contact on 7 July 2008 indicated that it had “provided evidence that the home has made improvements and I am satisfied the home has rectified the non-compliance”.¹⁵⁸

The next Accreditation Agency site audit was over three days in August 2008, and found compliance with all 44 outcomes under the Standards. The assessment team recommended a year of accreditation, but on 9 September 2008, the Agency decided to accredit for a shorter period, from 19 October 2008 to 30 April 2009. In February 2009, the re-accreditation audit, over a three-day period, again found compliance with all 44 expected outcomes. The assessment team recommended two years’ accreditation, but on 30 March the Agency decided to keep Makk and McLeay wards under closer scrutiny, approving only one year, until April 2010.

The decision to keep Oakden under relatively close scrutiny seems consistent with other evidence that it was not yet running completely smoothly. During 2009, there were three separate referrals of matters from the Department’s Complaints Investigation Scheme to the Accreditation Agency, and five complaints-based unannounced visits to Oakden. Compared to the oversight of Oakden after 2010, this still represented a relatively high degree of scrutiny of the service.

¹⁵⁶ Accreditation Agency, Review audit report – not to revoke/to vary, ‘the report of a review audit of Makk & McLeay Nursing Home 6010S, 200 Fosters Road, Oakden SA 5086 from 1 March 2008 to 5 March 2008 submitted to The Aged Care Standards and Accreditation Agency Ltd on 11 March 2008’.

¹⁵⁷ Nancy Morelli, State Manager, Accreditation Agency, ‘Decision not to revoke accreditation Makk & McLeay Nursing Home’, undated, following the review audit of 1 to 5 March 2008.

¹⁵⁸ Virginia Matthews, Assessment Manager, Accreditation Agency, ‘Support contact advice’, Makk & McLeay Nursing Home RACS ID: 6010, undated (date of contact visit 7 July 2008).

Oakden 2010 to 2017: set and forget?

The approach of the Accreditation Agency appears to have changed in 2010. In February 2010, following a two-day accreditation audit in the lead-up to expiry of accreditation in April, and another assessment of compliance with all 44 outcomes under the standards, the assessment team made the same recommendation as had been made one year earlier, which was for a two-year accreditation. However, the Agency's decision was different to 2009. Instead of keeping Oakden under relatively intense scrutiny, it awarded accreditation for three years, to April 2013.

Engagement with Oakden from the start of 2010 rapidly reduced to a bare minimum. In 2010, the Department received two compulsory reports of incidents, but there was only a single complaint-based visit to Oakden, and just two support contacts by the Agency after accreditation.

In 2011, there was even less engagement. Although the Department received two more compulsory reports of incidents, these triggered no visits, while the Accreditation Agency made two contact visits. There were three Agency visits in 2012, and no other contact. Throughout this period, all Agency visits reported compliance with all assessed expected outcomes under the Standards.

Despite finding compliance with the assessed outcomes, substantive issues were regularly identified in the support contact visit reports. For example:

- In January 2011, medication issues were noted, as were several issues around care and staffing, with the contact team's report noting that "Information from observations on-site and residents / representatives' interviews indicated possible issues with staffing management."¹⁵⁹
- In July 2011, while full compliance was found, the examples of continuous improvement recorded in the report were mostly in response to incidents, some of them potentially significant, that had required rectification.
- In January 2012, medication issues were again noted in the context of care problems that were observed.
- In July 2013, an issue with pain management was noted.
- In September 2014, pain management was scrutinised more closely and there were numerous issues noted. This appeared to have been resolved by the January 2015 visit, but its appearance over consecutive contact visits could have raised a question about the effectiveness of management or staffing at the facility.

There had been a change in the way the audit process worked by the time of the next accreditation audit in February 2013. For the first time, the report that the assessment team prepared for the Accreditation Agency did not contain an explicit recommendation about whether or not to re-accredit. This reflected a change in administrative processes within the Agency. Therefore, it is not possible to discern whether the assessment team held a different view from the Agency's final accreditation decision.

The assessment team undertook a two-day site audit at Oakden on 11 and 12 February 2013. It reported compliance with all 44 expected outcomes. Three further years of accreditation were given

¹⁵⁹ Accreditation Agency, 'Support contact report', undated, support contact 18 January 2011.

by the Agency. The only contact for the rest of the year was one unannounced visit, representing the minimum possible contact under government policy. In 2014, there was again almost no contact—the minimum single unannounced visit from the Agency,¹⁶⁰ and one visit by the Complaints Investigation Scheme. 2015 was the same.

Finally, in February 2016, the Quality Agency (as it had now become, following the *Living Longer Living Better* changes) conducted another two-day accreditation audit, and found compliance with all expected outcomes. Oakden was re-accredited for three years. There had now been six years of minimal oversight.

2017: scrutiny reveals failure

In early 2016, Bob Spriggs, a resident at Oakden, was given ten times the amount of a prescribed medication and was left with unexplained bruises that resulted in his hospitalisation. His family was very concerned about the care he received at Oakden. While not naming Mr Spriggs in his report, this is how Dr Groves recounts subsequent events:

He did not return to Oakden.

In June 2016, the family of this consumer made their concerns about his care known to the Principal Community Visitor and then to the [Northern Adelaide Local Health Network] NALHN Mental Health Service.

Subsequently the family's concerns about the level of his clinical care were raised with Ms Jackie Hanson, the CEO of NALHN, who then met with them in December 2016 to hear their concerns and to respond.¹⁶¹

These events were the trigger to scrutiny that would lead ultimately to national news stories and a decision by the South Australian Government to close Oakden. In his report, Dr Groves began by explaining:

On 20 December 2016, the Chief Executive Officer (CEO) of the Northern Adelaide Local Health Network (NALHN), Ms Jackie Hanson contacted the Chief Psychiatrist raising concerns about the level of clinical care provided at the Oakden Older Persons Mental Health Service (OPMHS). Ms Hanson requested the Chief Psychiatrist undertake an external independent review of the Oakden Facility as a matter of urgency with the intention of providing a report in April 2017.¹⁶²

It appears that, despite these serious concerns, and the formal commissioning of a review of a facility that included Commonwealth-accredited and -funded aged care, Commonwealth regulatory agencies were unaware of this activity. On 17 January 2017, ABC Adelaide carried a news story about the care of Bob Spriggs. This was the first time that Commonwealth aged care regulators became aware of the concerns of Mr Spriggs' family and, through them, of the possibility that there would again be questions about the quality of care at Oakden.

¹⁶⁰ From 2014, the regulatory responsibilities of the Accreditation Agency were transferred to the new Australian Aged Care Quality Agency but the term Accreditation Agency is used throughout this chapter.

¹⁶¹ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 2.

¹⁶² Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 1.

The incident involving Mr Spriggs, or the issues that might have contributed to it, were not identified in either the Quality Agency's re-accreditation audit in February 2016, or the unannounced assessment contact visit in November 2016, in which the facility had met all assessed expected outcomes.

On 28 February 2017, the Department briefed the Commonwealth Minister for Health and the Quality Agency conducted an assessment contact visit on the same day. It is not clear why this occurred a month and a half from the date of the media report. By this stage, Dr Groves' investigation was well underway.

The November 2016 assessment contact visit had been undertaken by a single accreditation team member; the February 2017 visit was undertaken by two assessors. Whereas the November 2016 contact visit report indicated no issues, the February 2017 contact report, which included examination of incident reports and medication charts, raised several issues.

The February 2017 assessment contact report, which outlined the extent of issues at Oakden, was provided to the Department. The report set out a range of problems identified through examination of incidents, including those involving Mr Spriggs. The report also indicated the extent of staff performance issues at the facility and that the Australian Health Practitioner Regulation Agency (AHPRA) was now involved:

- o The clinical staff (two registered nurses) involved in the medication error have been stood down and reported to AHPRA and no longer work at the facility.*
- o The Medical officer has also been stood down pending an investigation.*
- o A clinical director was relinquished from duties late last year [2016] relating to concerns regarding governance and responsibilities. This is now being overseen by the current Nursing Director and acting Clinical Service Coordinator (CSC).¹⁶³*

The February 2017 assessment contact visit found other issues, such as internal audits not conducted, and staff appraisals and education not yet completed.

The issues identified by the Quality Agency instigated an extensive review audit in March 2017. As noted in chapter two of this report, review audits are relatively rare, and indicative of potentially serious issues at a facility that require attention. The review audit was conducted by three Agency assessors and spanned nearly a fortnight (from 6 to 17 March). Towards the end of the audit, the Quality Agency released information to the Department that noted significant quality-of-care issues at Oakden. These demonstrated starkly that residents were not being provided with adequate care.

From this point, the process moved rapidly, with the Department determining an immediate and severe risk to residents, placing sanctions on the facility, while the Agency conducted at least 17 assessment contacts and visits to Oakden over the next two months. On 10 April, Dr Groves and his colleagues handed their report on Oakden to the South Australian Minister for Mental Health. It was a sharply critical and comprehensive indictment of the Makk and McLeay wards. The South

¹⁶³ Australian Aged Care Quality Agency, 'Assessment contact report', undated, assessment contact 28 February 2017.

Australian Government announced it would accept all the report's recommendations, and that the facility would be closed. According to the South Australian Government:

*At 8 August 2017, a total of 12 staff were suspended pending further investigation, three staff members' employment had been terminated and two had resigned. Nine matters have been referred to South Australia Police and 34 staff have been referred to Australian Health Practitioner Regulation Agency (AHPRA).*¹⁶⁴

The Makk and McLeay wards ceased operation on 14 June 2017.

It emerged during this Review that there appeared to be some ambiguity about the regulatory oversight of Oakden. The facility is part of the Northern Adelaide Local Health Network, which is part of the South Australian Health portfolio. It is also a separately incorporated entity. Northern Adelaide Local Health Network's service level agreement with the South Australian Department for Health and Ageing states, in part, that the Local Health Network's CEO's responsibilities include:

*Implementing the National Safety and Quality Health Service (NSQHS) Standards and ensuring that all hospitals are accredited under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.*¹⁶⁵

However, it appears that Makk and McLeay wards were not assessed against the NSQHS standards in 2016 (though Clements ward was). The Australian Commission on Safety and Quality in Health Care advised this Review:

*That all health services where patients have a severe form of dementia should be cared for in health services where the NSQHS Standards are in place and that these health services should be routinely assessed for accreditation by approved accrediting agencies along with other mental health services of the Local Health Network.*¹⁶⁶

Understanding Oakden

The final paragraph of the Groves report states:

*At the very heart of the intent of this report's recommendations is that Oakden must close and that it must be replaced by a range of contemporary services that aspire to excellence in care to the most vulnerable people in South Australia. But more fundamental should be the lesson that the failings of Oakden should never happen again.*¹⁶⁷

For the Commonwealth's regulatory system, this requires consideration of two questions: what can the government do to foster excellence in care for vulnerable people; and what needs to change to

¹⁶⁴ Government of South Australia, Submission to the Senate Community Affairs References Committee inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised, p. 4.

¹⁶⁵ Service Level Agreement for the period of: 1 July 2016 – 30 June 2017. Agreement between: Chief Executive, Department for Health and Ageing and Chief Executive Officer, Northern Adelaide Local Health Network, p. 10.

¹⁶⁶ Letter from ACSQHC to Reviewers, 21 September 2017.

¹⁶⁷ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 115.

avoid failures such as those that occurred at Oakden? The remainder of this chapter focuses on learning from the Oakden experience to avoid repeats of another such disturbing case. We focus on these questions:

- What circumstances were unique to Oakden or to a small number of cases, and what might be a system-wide problem?
- Is accreditation effective?
- Is accreditation structured according to risk?
- Are the necessary relationships and communication in place?

Was Oakden unique?

A view sometimes expressed to this Review was that the Oakden case can be considered a rare, if not unique, situation. The two main lines of argument put forward that Oakden should be considered as exceptional are that:

- Oakden's structure was atypically complex, as were the needs of its consumers, and therefore Oakden is of limited relevance to the rest of the aged care system.
- Evidence suggests that the residential aged care system as a whole is one of relatively high-quality care.

There is truth in both those propositions, but both risk understating the significance of the systemic issues that Oakden demonstrates. We set out each of these cases and elaborate on the relevant issues below.

The complexity of Oakden

The Makk and McLeay wards at Oakden were a rare type of facility: one that was simultaneously a state health care facility regulated as such, and an aged care facility accredited under the Commonwealth's *Aged Care Act 1997*. It was the only facility of its kind in South Australia and one of only a handful among the over 2,500 residential facilities across the country.

As the Groves report notes:

*The services provided at Oakden comprise the only Specialist Mental Health Service for Older People in South Australia that are provided as a State-wide service on behalf of all [Local Health Networks].*¹⁶⁸

One of the purposes of specialised facilities is to provide care for people with the most extreme behavioural symptoms of dementia. They represent a very small proportion of people with dementia. For example, the prevailing model estimates there would be only 25 to 35 people in the whole of South Australia requiring the most intensive type of care.¹⁶⁹

Several stakeholders, in their submissions to this Review, drew attention to the unusual governance and funding arrangements at Oakden. Aged and Community Services Australia, for example, said that:

¹⁶⁸ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 14.

¹⁶⁹ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 17.

*the specific and unique situation with Oakden (i.e. state government ownership (and therefore atypical expectations around accountability); joint funding and specialist nature) may have been an important factor.*¹⁷⁰

The Aged Care Guild argued:

*the Makk and McLeay wards were established as a specialist mental health facility and so are not reflective of the care provided by the wider sector. The residents, staffing, relationship with the South Australian government and specific care provided are fundamentally different to the wider sector...It might be that the aged care regulatory system is not geared for facilities such as Oakden, which was a mental health facility and as such atypical in [the] sector.*¹⁷¹

HammondCare wrote:

*The fact that Oakden was subject to both state and Commonwealth regulatory systems suggests it was more likely to be ill-suited to both. By properly aligning Commonwealth regulatory processes with services providing Commonwealth programs, we believe many of the issues that occurred at Oakden could be avoided.*¹⁷²

All of these things are true, and they mean that Oakden was in a different situation than many aged care services. However, there are two main reasons why the distinctive nature of Oakden should not be overstated.

First, as the analysis in the Groves report and in this chapter has shown, there were failures of care for consumers at Oakden that lay entirely within the scope of the Commonwealth's regulatory system, and were not caused by the extra layer of state health system regulation and control. They were issues that any service could experience. The Groves report did identify some issues that related to the regulatory circumstances at Oakden, such as funding adequacy. However, most of the issues were attributable to failures that any service could be vulnerable to.

Second, while Oakden cared for people with particularly complex mental health needs, there are many consumers with complex needs in the aged care system. We know from the Aged Care Funding Instrument, for example, that around half of residential care consumers have symptoms of mental illness.¹⁷³ This group overlaps with the approximately half who have dementia.¹⁷⁴ We know that frailty is increasing,¹⁷⁵ and that the number of people in care with dementia (and therefore with severe dementia) is increasing.¹⁷⁶ Oakden is not unique, because the characteristics and needs of its residents were not unique.

¹⁷⁰ Aged and Community Services Australia submission (ID#603497857) p. 5.

¹⁷¹ Aged Care Guild submission (ID#1032742486).

¹⁷² HammondCare submission (ID#253951248).

¹⁷³ Australian Institute of Health and Welfare, People's care needs in aged care, <https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care>

¹⁷⁴ Department of Health, 2015–16 Report on the Operation of the Aged Care Act 1997, p. 45.

¹⁷⁵ E.g. The Hon Sussan Ley MP and The Hon Ken Wyatt MP, 'Stronger Compliance to Protect Integrity of Aged Care Sector', media release, 16 December 2015.

¹⁷⁶ Brown, L., Hansnata, E., and Anh La, H., February 2017, *Economic cost of dementia in Australia 2016–2056*, Alzheimer's Australia, p. ix.

The regulatory system must be designed to respond to the profile of consumers in a service. Had that been the case ten years ago, Oakden—and other facilities with more vulnerable consumers—could have been supported and monitored more closely.

The quality of care across the aged care system

The second argument that Oakden is an unusual case, is that care across the aged care system is generally regarded as of good quality. COTA Australia stated:

*COTA Australia is pleased to note however that in its experience, cases such as Oakden are not a common occurrence amongst the 2,681 residential aged care facilities in Australia. Indeed, they are isolated and rare.*¹⁷⁷

Provider representatives took a similar view. The Aged Care Guild submitted:

*Broadly, the Guild considers the individual regulatory activities and processes of government agencies to be robust and meet their intended purpose. The Guild believes the regulatory framework, when applied appropriately, provides a very comprehensive protection and assurance that residents in aged care facilities are receiving a high level of care.*¹⁷⁸

The Quality Agency reported that the accreditation system has delivered increases in compliance with standards. In 2000, only 64 per cent of agencies met all 44 standards. By 2006, shortly before the main problems with Oakden were identified, that had risen to 92 per cent. By 2015 it was 97.8 per cent.¹⁷⁹

However, we know from Dr Groves' investigations at Oakden that the quality of care there was not accurately represented in the Agency's evaluations. If this is true at Oakden, it could well be the case elsewhere, a possibility raised with this Review by stakeholders. Accordingly, it is not possible to rely solely on the level of reported compliance with the Accreditation Standards as a robust indicator of quality in the residential care system.

But there is other evidence to indicate that the care in Australia's system is good overall. Complaints data give some indication that the serious issues at Oakden are unusual, without being unique. The issues at Oakden were of a kind that, had they been brought to the attention of the Aged Care Complaints Commissioner, would have required referral to one of the regulatory agencies.

In 2016–17, the Complaints Commissioner received 3,656 complaints about residential care and made 501 referrals of matters to either the Department or the Quality Agency.¹⁸⁰ Put in the perspective of the care system, complaints raising serious issues can be seen to represent a small proportion of aged care, as Figure 2 shows.

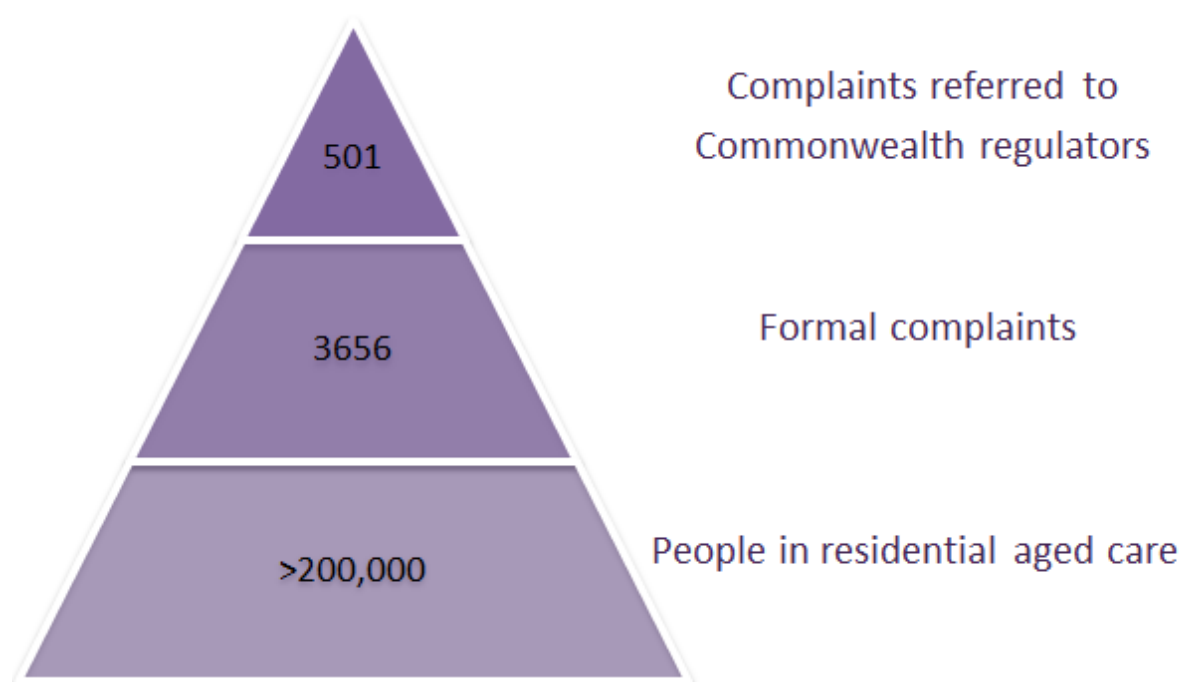
¹⁷⁷ COTA Australia submission (ID#743548634).

¹⁷⁸ Aged Care Guild submission (ID#1032742486).

¹⁷⁹ AACQA, *Annual report 2015–16*, p. 7.

¹⁸⁰ Complaints Commissioner, *Annual report 2016–17*, pp. 18, 24. Most of the referrals related to residential care – Complaints Commissioner, personal communication.

Figure 2. Aged care complaints¹⁸¹



While more serious issues are uncommon, there are other patterns in the complaints data that indicate that Oakden is not dramatically different to the sector more generally. In particular, the large majority of complaints handled by the Complaints Commissioner relate to residential aged care rather than home care, and the most common complaints relate to areas of aged care similar to those that were problematic in the Oakden case. Regarding the 3,656 complaints received about residential care in 2016–17, the Commissioner’s annual report states:

The most common complaints about residential care were about medication administration and management (559), falls prevention and post fall management (382), and personal and oral hygiene (365).¹⁸²

This list includes many of the issues identified at Oakden by Groves, and by families and professionals who raised issues about care.

Other sources of data that might give more insight to Australia’s quality of care were not available to this Review. Unlike some other countries, Australia does not have a mature quality indicator system. We also lack good-quality consumer experience information. We return to these issues in our recommendations.

Overall, the limited data available suggest that residential care is, in general, of a good standard, but that the circumstances at Oakden should not be considered unique.

¹⁸¹ Sources: Complaints Commissioner, *Annual report 2016–17*; Aged Care Financing Authority, *Annual report 2017*.

¹⁸² Complaints Commissioner, *Annual report 2016–17*, p. 19.

In summary, it appears that the degree of seriousness of failures to care for residents that were reported at Oakden may be relatively rare, but the types of issues found at Oakden have much in common with the types of issues that arise for aged care consumers whenever there are quality-of-care challenges.

Accordingly, Oakden should not be treated as a unique case, but as a type of service that operated towards one end of the spectrum of complexity of care, from which the entire aged care system can learn, and with reform implications for the system as a whole.

Was accreditation effective?

The Oakden case raises serious questions about the accreditation system. The assessment of Oakden by Dr Groves and his colleagues found information and practices not at all consistent with the standards of care that accreditation is designed to foster. The Groves report covers these issues in more detail. In this section, we consider what that report indicates about compliance with the standards that the Agency is responsible for monitoring. As outlined in chapter two, there are currently 44 expected outcomes under four standards against which accreditation occurs. Box 1 illustrates examples of findings and issues discussed by Dr Groves against some of the outcomes in the Commonwealth's accreditation framework.

Box 1. Examples of accreditation outcomes and failures at Oakden

Accreditation outcome	What Dr Groves observed and found
1.1 The organisation actively pursues continuous improvement.	Dr Groves found at Oakden a culture that was hostile to learning, improvement or adoption of contemporary clinical practice. For example, in relation to the use of pelvic restraints, he found: "A number of previous attempts to have Oakden consider this evidence was met with rejection of such ideas and re-iteration that their approach was appropriate. This is a feature of organisations that are closed to new evidence, and cannot incorporate new approaches when they are challenged about the prevailing norms in their practice." (p. 84)
1.2 Management and staff have appropriate knowledge and skills to perform their roles effectively.	Dr Groves found training at Oakden was inadequate and poorly focused. His findings included: "Staff were not provided with adequate opportunity to meet their mandatory training requirements, let alone access desirable training to assist them in caring for and improving services for the consumer cohort. While just over 50% of staff had completed a Performance Review and Development, what may have been included as 'Development Activities' is not clear." (p. 65)
1.5 The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.	Dr Groves documented numerous leadership issues before concluding simply by quoting the saying: "'the fish rots from the head'. This is an apt view of the collective organisational leadership as it related to Oakden." (p. 75)

Accreditation outcome	What Dr Groves observed and found
2.2 The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.	Dr Groves' report devoted a chapter to the use of seclusion and restraint, identifying shocking practices and a lack of leadership. Among his conclusions was: "There has been ongoing, repeated use of restrictive practices at Oakden that has contravened legislation, national standards, state policy and local procedures and likely implemented for staff convenience and or used as punishment." (p. 113)
2.4 Care recipients receive appropriate clinical care.	Dr Groves' report described many care issues, including detail of an example of poor care, that his report stated directly was not consistent with accreditation: "The Review found multiple clinical entries that referred to various terms such as 'tends to lie on the floor', 'puts themselves on the floor' and 'floor time'. The Review could not understand what this meant. On direct questioning, the Review was informed of a very disturbing account of what constituted 'Floor time'. It occurred when during staff interactions with certain consumers, the staff would leave the consumer on the floor in considerable distress if they had formed a view that intervening to assist the person was not needed immediately, for whatever reason. This is among the most abhorrent approaches to providing care to severely disturbed consumers that any of the Review had encountered in well over 110 years of collective practice. It simply lacks any humanity. This was an example of the type of issue that no accrediting body would ever endorse, if it was aware of its occurrence." (p. 78)
2.7 Care recipients' medication is managed safely and correctly.	Dr Groves observed many issues around medication. For example: "The Review also examined files in which the combination of certain medications, doses and even the clinical indication for the use of the medication was questionable. These issues would be addressed by the inclusion of Clinical Pharmacy services within the Clinical model for the services at Oakden." (p. 86)
2.13 The needs of care recipients with challenging behaviours are managed effectively.	Dr Groves reported "a widespread view, held by the staff, which the Review heard repeatedly, that Oakden (in particular Makk and McLeay Nursing Home), is a place for the rest of the consumer's life. This resulted in an attitude among staff that there was less effort and emphasis that needed to be placed on managing the consumer's challenging behaviours as there was little prospect that any improvement would help facilitate their discharge." (p. 30)

An effective accreditation process, raising questions about both clinical practice and care for residents with challenging behaviour, should have identified cases such as that noted above, where a view was "widespread" and expressed "repeatedly". If the National Safety and Quality Health Service standards were being implemented at Oakden, they should have caused the Local Health Network responsible for Oakden to be alert to risks at the facility. It appears, however, that these health standards were not being applied. Dr Groves' overall view was that there were:

*unacceptably high levels of challenging behaviour; worrying data on increased use of restraint, falls and other injuries; medication errors; and as shown elsewhere assaults and poor clinical outcomes.*¹⁸³

It is not possible to reconcile the findings of Groves' review with the Agency's finding in February 2016 that Oakden met all 44 expected outcomes, and its subsequent assessment contact findings in November 2016 of full compliance with the outcomes that were assessed.

The Groves report observed that there was a focus on getting through accreditation, and considered that the organisation had acted specifically to ensure it made it through that process:

*The Review found that Oakden has developed a culture of making periodic attempts to meet different accreditation standards, even if these were barely met, rather than embracing a culture of continuous quality improvement that is seen as one of the core features of good clinical governance....The Review heard and saw evidence that Oakden became better at knowing how to produce documents and records that Accrediting Bodies and Surveyors wanted to and expected to see; and better at ensuring staff knew what to say. However, it became no better at providing safe or better quality care.*¹⁸⁴

It is also clear from the analysis of Oakden that the shortcomings at Oakden were not transient, or isolated. They were persistent and widespread, and should have been detected:

Having made a detailed review of clinical records...that in some cases go back as far as 2005, the Review did not find an appreciable difference in the overall level of clinical outcomes over that entire period. Put another way, the problems in 2016 are seen as far back as one looks.

*The Review heard from many sources, including some through the media, that significant problems were known as far back as 2007 at Oakden when it first failed to meet certain Commonwealth Standards. At that time, the external review by Stafrace and Lilly pointed to some of the reasons for these problems. This Review has confirmed that these problems remain... [by and large] they have been present throughout the last 10 years.*¹⁸⁵

We conclude that there are at least three issues with accreditation evidenced by the Oakden case that need to be addressed.

Some of the expected outcomes under the standards are inappropriate. The current Accreditation Standards have been in place for a long time and place excessive emphasis on processes, with insufficient focus on consumers and outcomes. Two examples illustrate this problem: leadership, and restrictive practices.

In a complex field like aged care, effective leadership cannot possibly be evidenced by documenting a corporate vision, values, philosophy, objectives and commitment to quality, which is what the standard currently says. These things need to be evidenced, not merely written down. The standards need to better reflect what is actually expected of aged care services and their leadership. The emphasis in the standards on whether things are documented, while acceptable in some situations,

¹⁸³ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 75.

¹⁸⁴ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 77.

¹⁸⁵ Groves A., et al., 2017, *The Oakden report*, South Australian Department for Health and Ageing, p. 77.

can prevent surveyors from considering whether care activities and management systems are good enough and implemented well enough (rather than just adequately recorded).

Restrictive practices, such as the use of physical restraints or sedation, are a different example. They are known to risk violating consumers' rights and to deliver poor outcomes in many care settings (not only aged care), and are the subject of significant human rights concerns and calls for law reform nationally. They have been, and continue to be, a concern across aged care. Despite this, there is no regulation that explicitly addresses their use. Regulation should target the things that are important and the problems that are known. The standards do not do this adequately in the area of restrictive practices.

Accreditation needs to look deeply into a service, to understand the experience of residents. There is evidence that some Agency visits did this effectively. Critical examination of medical charts and resident records by an experienced eye can successfully determine the quality of clinical care being provided. Observation of care and activities in a service can often determine a great deal about the service.

The experience of Oakden suggests that there was uneven depth in the examination of services. Too many Agency visits appeared either not to detect issues within the service, or did not report them in a way that triggered effective follow-up, or rectification by Oakden.

The most likely causes of this problem are that some surveyors lacked sufficient skills or training, including in conducting investigations,¹⁸⁶ to conduct the necessary analysis, surveyors were not spending enough time at facilities to look at matters in sufficient detail, or the processes and materials supporting surveyor work were not fit for purpose.

Services may be preparing for accreditation rather than focusing on continuously providing high-quality care. Services are becoming adept at providing the Agency with the information it wants to hear, especially at the time of re-accreditation. This is actively encouraged by the system of planned re-accreditation visits, where all parties know when they will occur and what will be required. The heavy reliance on planned re-accreditation has a further negative effect, drawing significant resources away from the two activities that should be the backbone of Agency quality assurance activities: education; and thorough, unannounced visits.

The inappropriateness of the accreditation cycle

The problem of services preparing for accreditation highlights concerns around the way in which accreditation activities are targeted and undertaken.

There is a longstanding expectation and practice in aged care that, unless there is a serious problem in a facility, it will be accredited for three years, regardless of other risk factors. This is clear from Quality Agency data about accreditation. In 2016, less than two per cent of facilities were accredited

¹⁸⁶ Such as the requirements for investigators set out in the Australian Government Investigations Standards 2011.

for any period other than three years.¹⁸⁷ This has remained broadly unchanged across the history of the system; in 2002–03, the former Aged Care Standards and Accreditation Agency was accrediting fewer than five per cent of facilities for anything other than three years.¹⁸⁸

Oakden had a history of non-compliance with the Accreditation Standards, multiple complaints investigations, and the visiting Accreditation Agency assessment team recommended accreditation for only two years. Yet, in 2010, Oakden was given three years' accreditation. There were regular surveyor concerns about medication management and staff culture, identified over successive site visits, which did not result in further action. These factors suggest that questions need to be asked not only about examination of this residential aged care facility, but about the accreditation system itself.

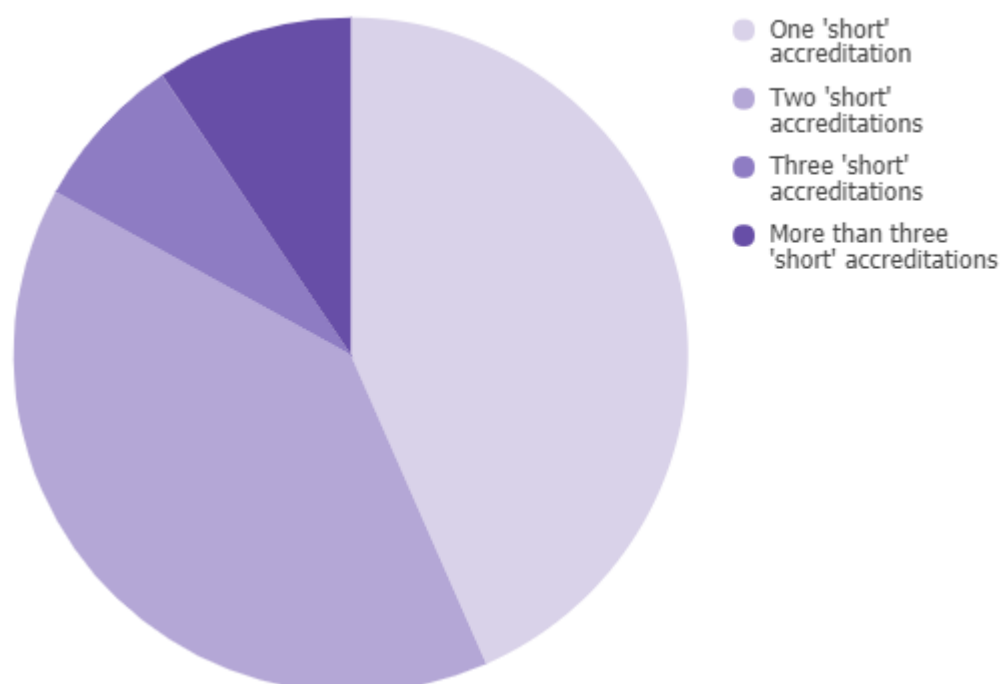
To understand how Oakden compares with the management of quality concerns in aged care generally, the Review analysed the accreditation pattern for those services that were placed under sanction by the Department at some point in the last decade. We considered only those cases for which there were at least two accreditation decisions made post-sanction. There are 57 facilities that have an accreditation history matching this description. The analysis is limited in that the Review did not determine the reason for the sanctions. We recognise that in some cases, they may not have related to quality of care; however, as all these cases have at least one period of accreditation of less than three years (implying that the Agency had some concerns), it is likely that care quality issues were relevant, as they were at Oakden.

This analysis has allowed the Review to develop a picture of what accreditation pattern was 'normal' over time for a facility that may have had a significant compliance issue. This picture can be compared with the accreditation history at Oakden prior to 2017. Figure 3 shows how long it took to return to three-year accreditation for all providers who experienced sanctions at some stage in the last decade.

¹⁸⁷ AACQA, *Annual report 2015–16*, 21 (not counting new facilities and facilities involved in a pilot scheme in South Australia).

¹⁸⁸ Aged Care Standards and Accreditation Agency, *Annual report 2002–03*.

Figure 3. Number of accreditation periods before providers re-attain three-year accreditation



This analysis shows two key facts. First, it demonstrates the overwhelming logic of the regulatory system that three-year accreditation is the goal, and that every service is placed on a path to achieve it. Of the 57 services examined, all but three returned at some point to three-year accreditation, in some cases despite a long history of issues and more than one application of sanctions by government. Even among the three that did not return to three-year accreditation in the period examined, one is too recent to tell whether it might return to three-year accreditation, while the other two services have closed. The evidence is clear that there is no risk assessment that leads to facilities being accredited on any different cycle. The target for both provider and regulator appears not only to be compliance, or quality of care, but a particular accreditation status.

Second, the analysis shows that the accreditation path for Oakden, from its sanctions in 2007 through to 2010 when it first received three-year re-accreditation, is consistent with Oakden's quality of care deficiencies being considered relatively serious. Put another way, by the standards of Australia's accreditation system, Oakden was placed under relatively extended scrutiny, with three short periods of accreditation (meaning accreditation of less than three years), before it was permitted a three-year term. The data show that well over 80 per cent of facilities that experienced sanctions returned to three-year accreditation faster than Oakden did.

Our view is that Oakden should never have been on a cycle of three-year accreditations. But the system treated Oakden consistently with how accreditation is set up. By the standards it appeared to have set for itself, the Accreditation Agency did not 'fail' by providing three-year accreditation. The regulatory architecture failed, by signalling to the Agency and the sector that three-year accreditation was appropriate. It follows that the problem is not the Oakden case. The problem is the system design.

The default three-year accreditation period creates numerous pressures that undermine the goals of accreditation and the protection of resident safety and quality of care, including:

- Services set a goal of seeking three-year accreditation as a proxy for being quality carers, instead of focusing on care.
- At the other end of the spectrum, accreditation for less than three years is taken to represent a penalty and can raise significant questions in the minds of prospective residents and families, even though it may not indicate any ongoing quality of care issues.
- A standard accreditation period is inconsistent with a risk-based approach to accreditation, as some services—of which Oakden is a prime example—care for highly vulnerable consumers with particularly complex needs and will therefore always have higher risks.

Not holding three-year accreditation should not be seen as a criticism of the service. Facilities that work with older people with severe mental illness, for example, are vital to providing an equitable and compassionate aged care system. However, they will always be higher-risk services, regardless of their quality of care. This is not because of their quality as services, but because of the population they service. The system needs to reflect this.

Three-year accreditation is inefficient and not risk-based. The Oakden case demonstrates that it can place higher-risk services and vulnerable consumers at unacceptable risk. It should be replaced with ongoing accreditation and a risk-based system of more rigorous monitoring, under updated standards. This is discussed further later in this Report.

Relationships and communication

There are several aspects of the Oakden case that illustrate the importance of effective communication pathways and relationships.

Throughout the regulation of Oakden, it appears that once one Commonwealth agency (whether the Department, Quality Agency or, since 2016, the Complaints Commissioner) identified a substantive issue at Oakden, in most cases there would then be a close partnership between them in addressing issues. The separation of accreditation and compliance activity does, however, require much inter-agency coordination, and there appears to be overlap in responsibilities.

There are some other aspects of the case that show areas where communication could be improved. This is most apparent in three areas:

- Resident and family complaints
- Government-to-government relations
- Sharing and interpreting information between regulating agencies.

When concerned about Mr Spriggs' care, his family first approached the Principal Community Visitor, a statutory officer under South Australia's *Mental Health Act 2009*, appointed to manage a scheme for people to regularly visit and inspect treatment centres and meet individuals receiving treatment. The family then approached the Northern Adelaide Local Health Network's Mental Health Service,

and from there the complaint was escalated to the Network's CEO. The family did not contact the Aged Care Complaints Commissioner and there is no evidence that they were advised to do so. None of the state services referred their concern, or any actions taken in relation to it, to any Commonwealth regulator.

The most important thing for a resident or their family is that any problems are acknowledged and addressed. Their concern is not who they should approach about it—they want a result. They do not want to repeat the whole complaint-making process, if they can do it once and get a response. It is also important that their privacy and choices are respected.

In a facility that has two regulatory frameworks in place, such as Oakden, it is important that complaints are addressed by appropriate bodies. This means that both the operators of these facilities and all regulators involved must ensure that information about a serious complaint finds its way to all relevant bodies, and not just one possible handler of the complaint.

The second area where there were issues was in government-to-government communication. It is of some concern that the issue raised by Mr Spriggs' family was never brought to the attention of the Commonwealth regulators. Under existing memorandums of understanding, had one of the Commonwealth bodies been contacted with this complaint, its severity would have triggered sharing of relevant information. However, with no such formal arrangements between SA Health and the Commonwealth, there was no established pathway for this to occur.

It is also a concern that a formal inquiry into care at Oakden could be initiated by SA Health without communication with the Commonwealth, which SA Health would have known was a funder and regulator of the service.

The third area of communication in which the Oakden case is relevant concerns the flow of information into and between regulatory organisations. It appears that prior to August 2016, there was not full sharing of information about mandatory reports among the three Commonwealth bodies. These reports concern unreasonable use of force or assault on a care recipient or unlawful sexual contact with a care recipient.¹⁸⁹ They do not necessarily require action by one of the Commonwealth agencies, generally being matters for police investigation. However, provided they contain sufficient detail, they are important potential sources of insight into whether there might be underlying quality-of-care issues that contributed to the situation that prompted the compulsory report.

There were also numerous instances, identified in Accreditation Agency reports or noted in the Groves report, where incidents at a facility were not documented or incidents that should have been reported to various agencies or databases outside the facility, were not.

Conclusion

Oakden had significant failures of care, and the Commonwealth's regulatory framework failed to detect them. As a result, many aged care residents, including some of the most vulnerable and

¹⁸⁹ *Aged Care Act 1997*, s. 63-1AA.

unwell in the aged care system, received poor-quality care and suffered as a consequence. On the evidence assembled by the South Australian Chief Psychiatrist, the failures of care at Oakden were longstanding. Accordingly, so was the failure of Commonwealth regulatory framework to detect them.

While the situation at Oakden is far from typical, the circumstances that led to it are certainly not unique. Oakden is a sentinel case and highlights areas for improvement in the regulatory system. Several areas for potential improvement have been identified, particularly in relation to the structure of the regulators and the accreditation system, the implementation of accreditation 'on the ground', and the flow of information and communication among regulatory stakeholders. These are central to the areas of improvement outlined in part two of this Report.

Chapter 4: Performance of Australia's aged care regulatory system

Introduction

This chapter assesses the Australian Government's current aged care regulatory system against best-practice regulatory principles. Adherence to best-practice principles is a reliable way to ensure that government is:

*adopting approaches that minimise the regulatory burden, using risk-based approaches in the targeting of their compliance activities, being accountable for, and transparent in, decision-making, and monitoring and evaluating both their own performance and the achievement of regulatory outcomes.*¹⁹⁰

The performance of regulators must be aligned with public expectations, and regulators need to operate consistently with their powers.¹⁹¹ This chapter also considers the performance of the Australian aged care regulatory system in comparison with other countries. While regulatory practice is necessarily nuanced in light of the context in which regulation is delivered, comparison with countries with similar systems illustrates Australia's overall performance and areas where improvement can be made.

A framework to analyse regulatory performance

There is an extensive body of literature and expertise regarding best-practice regulation. The principles used are different in language, but common in features and intent. For the purposes of this Review, the best-practice principles published by the Productivity Commission in its 2011 report on aged care have been adopted,¹⁹² with the addition of 'role clarity' from the most recent OECD principles of good governance.¹⁹³ The resulting framework used to assess the performance of Australia's system is shown in Box 2.

International comparisons were made against these principles, where relevant information assisted our analysis. Seven countries were selected for comparison: New Zealand, Canada, England, Germany, the United States, the Netherlands and Norway. These countries were considered primarily because they are all developed countries facing similar challenges in maintaining the

¹⁹⁰ Australian National Audit Office (ANAO), 2014, *Administering regulation: achieving the right balance*, p. i, https://www.anao.gov.au/sites/g/files/net3241/f/2014_ANAO%20-%20BPG%20Administering%20Regulation.pdf

¹⁹¹ Organisation for Economic Co-operation and Development (OECD), 2012, *Recommendation of the Council on Regulatory Policy and Governance*, OECD Publishing.

¹⁹² Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F.1. The Productivity Commission identified four best-practice principles for residential aged care regulation. The fourth is 'streamlined reporting arrangements', which is considered by the Review as part of the other principles.

¹⁹³ OECD, 2014, *OECD best practice principles for regulatory policy, the governance of regulators*, OECD Publishing. http://www.oecd-ilibrary.org/governance/the-governance-of-regulators_9789264209015-en

quality of aged care services for a growing ageing population. Childcare and health regulatory systems in Australia were also considered.

In practice, while it is possible to describe the regulatory systems of other countries and sectors, and how they align with good-practice principles, little has been published evaluating how these systems have performed. For some criteria, this meant that we did not rely significantly on international comparisons.

For each criterion, we conclude with an assessment of whether the current aged care regulatory system is broadly aligned with best practice, partly aligned or not well aligned. These assessments are reflected in our recommendations in the second part of this report.

Box 2. Best-practice regulatory principles for residential aged care

Principle 1: Good governance

- Clarity in jurisdictional responsibilities
- Role clarity
- Separation of policy advice from regulation
- Well-structured complaints handling and a right of independent appeal
- Freedom for advocacy
- Effective and regular review mechanisms

Principle 2: Appropriate choice of standards

Principle 3: Responsive regulation to encourage and enforce compliance

Principle 1: Good governance

Good governance is:

*the set of responsibilities and practices, policies and procedures, exercised by an agency's executive, to provide strategic direction, ensure objectives are achieved, manage risks and use resources responsibly and with accountability.*¹⁹⁴

A well-governed regulatory system should be carefully designed to allocate responsibilities clearly and to define the roles of regulatory agencies. Good governance ensures that stakeholders using that regulatory system, whether consumers or providers, have confidence in it and have avenues to engage with the regulators and to appeal decisions they believe to be unfair. Good governance also incorporates processes for review and improvement of the performance of the regulatory framework.

Clarity in jurisdictional responsibilities

A lack of clarity in jurisdictional responsibilities of governments or agencies involved in a regulatory system can lead to important issues such as 'falling through the cracks', confusion for the regulated entities, duplication of function and a reduction in confidence by consumers.

¹⁹⁴ ANAO and Department of the Prime Minister and Cabinet, 2006, *Implementation of programme and policy initiatives: making implementation matter*, Better Practice Guide, Commonwealth of Australia, p. 13.

Performance of the Australian system

The regulation of aged care is primarily the responsibility of the Australian Government. In general, there are few issues with jurisdictional responsibilities between tiers of government. However, as demonstrated at Oakden, this is not the case for those facilities that are also regulated as health services, under different standards, for different purposes, by different tiers of government.

Multi-level regulatory tracks create administrative complexity and, as noted in chapter three, contributed to failures at Oakden. For example, the Quality Agency's 2015–16 annual report stated:

*During 2015 to 2016 we teamed up with the Australian Council of Healthcare Standards (ACHS) in a pilot audit project. The project aimed to test an approach to reduce the regulatory burdens on services that are subject to both the Accreditation Standards and the National Safety and Quality Health Service (NSQHS) Standards.*¹⁹⁵

However, it is not clear whether any progress has been made on this issue, nor in cases where a state government is an approved provider. In its submission to this review, the Quality Agency did not mention the pilot project, and said:

*there is little to no information sharing between state governments and the Quality Agency. Nor are there arrangements to share information with Australian Council on Health Care Standards who were responsible for the accreditation of the health services provided by Oakden or any other accrediting agencies for the Australian Commission on Safety and Quality in Health Care.*¹⁹⁶

For aged care facilities that are also health facilities, Australia lacks jurisdictional clarity in its regulatory system. Where facilities are state-run, they are also obliged to comply with any state-based directives. In Victoria, for example, public residential care services are required to report on their performance against the Victorian quality indicators for residential aged care.¹⁹⁷ The Oakden case has shown that this creates potential complications around responsibility, with an apparent failure to maintain all forms of regulatory oversight.

In relation to complaints and compulsory incident reports, multiple agencies might be involved in a regulatory response. An agency (such as the Australian Competition and Consumer Commission, the Australian Health Practitioner Regulation Agency, state and territory regulators or ombudsmen) may refer a complaint to the Complaints Commissioner. In other cases, referrals might be between the Department, the Quality Agency and Complaints Commissioner. Police might also be involved in cases of elder abuse allegations or fraud.

NOT WELL ALIGNED: Reform is needed to move towards best-practice regulation for clarity around jurisdictional responsibilities.

¹⁹⁵ AACQA, *Annual report 2015–16*, p. 16.

¹⁹⁶ AACQA, personal communication.

¹⁹⁷ Department of Human Services, 2006, *Beyond compliance*, Government of Victoria, <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/beyond-compliance>, <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/quality-indicators-psracs>

Role clarity

Best practice dictates that roles and responsibilities of regulatory agencies need to be clearly defined and delineated in legislation and procedures. This avoids overlaps, complexity and confusion among the regulators, consumers and those being regulated:

*For a regulator to understand and fulfil its role effectively it is essential that its objectives and functions are clearly specified in the establishing legislation. The regulator should not be assigned objectives that are conflicting or should be provided with management and resolution mechanisms in case of conflicts. The legislation should also provide for clear and appropriate regulatory powers in order to achieve the objectives and regulators should be explicitly empowered to cooperate and coordinate with other relevant bodies in a transparent manner.*¹⁹⁸

Performance of the Australian system

As described in chapter two, there are currently three main organisations with regulatory functions and responsibilities relating to quality in residential aged care: the Commonwealth Department of Health, the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

The Productivity Commission's 2011 report noted the inefficiencies in the system:

*[M]any features of best practice 'responsive regulation' are difficult to achieve when one aspect of regulatory responsibility (that is, accreditation and the assessment of performance against Quality Standards) is structurally separated from compliance investigations and enforcement decisions surrounding quality. Regulatory behaviour would be enhanced by locating quality assessment within the same organisation that receives consumer complaints, monitors compliance, provides information on ways that providers could improve the quality of their care services and makes the enforcement decisions.*¹⁹⁹

The Productivity Commission went on to recommend that it is better to limit potential confusion and increase the efficiency of regulation through establishing a single entity responsible for investigations of non-compliance.

Responsibilities and powers in the Australian regulatory system regarding quality of care are defined in the *Aged Care Act 1997*. However, as described in chapter two, relevant Acts and subordinate legislation form a complex framework that can be difficult for stakeholders, including consumers, to navigate.

Despite efforts to ensure clarity in roles among the regulators through their memorandums of understanding, providers express confusion over the delineation of roles between the Quality Agency and the Department in managing compliance with the Standards. There is overlap between the requirement, implemented by the Department, for approved providers to deliver adequate care, and the requirement, implemented by the Quality Agency, for providers to meet the Accreditation

¹⁹⁸ OECD/Korea Development Institute, 2017, *Improving regulatory governance: trends, practices and the way forward*, OECD Publishing, p. 25.

¹⁹⁹ Productivity Commission, 2011, *Caring for older Australians*, p. 402.

Standards. Despite the Productivity Commission's recommendations, the situation remained largely unchanged with the Living Longer Living Better reforms. Simplifying this complexity should be considered in future reforms.

Benchmarking Australia with other systems

Like Australia, regulation of aged care in other countries is tied to supply and funding of residential aged care services.

In Australia, the regulation of providers is carried out at the national level by the Australian Government, so it is consistent across all states and territories.²⁰⁰ Unlike Australia, in almost half of the international schemes considered, part of the administration or regulation is embedded in a state or regional body. For example, in the US, licensing of providers for aged care is covered under state-based licensing frameworks, which vary from state to state. The regulation of health and hospital services in Australia is similar, in that all states and territories licence private health facilities, although there are National Safety and Quality Health Service Standards against which services are assessed.

However, the organisational structure of Australia's aged care regulatory scheme is similar to that of other countries in that it contains multiple organisations that are required to work together. England is an exception, with all regulatory functions consolidated into a single agency, the Care Quality Commission (though complaints handling is separate),²⁰¹ which is important for reasons set out below. Placing all regulatory functions in the one agency is considered best regulatory practice as it supports more seamless handling of cases.²⁰² In this aspect, Australia does not achieve best practice.

In Australia, sharing information is a particular challenge in the tripartite organisational structure. Memorandums of understanding have been negotiated and published, to foster cooperation among the three agencies. This is good practice as the roles and responsibilities of each agency are set out in a way that provides transparency and accountability. However, while the approach is sound, it is not clear that enough information is being shared under the arrangements.

In most of the international systems considered, the objectives of the law and the powers provided to regulators are set out clearly in law and are similar to those in Australia. An exception is the presence of specific laws and powers to protect consumers from neglect and abuse, which only occur in England and Ontario, Canada. Other than the limited protection offered by the mandatory reporting of assaults and the Charter of Rights and Responsibilities, such specific protections are not yet present in Australia. It is clear from the review of literature that mechanisms to detect and respond to elder abuse are a priority for aged care globally, and a report by the Australian Law

²⁰⁰ There are residential aged care providers in Australia that are not funded under this scheme. They are outside the scope of this Review as the funding and regulation of these parts of the sector is not under the *Aged Care Act 1997*.

²⁰¹ Which? Making a complaint about a care provider, <http://www.which.co.uk/elderly-care/your-relatives-needs/dealing-with-unsatisfactory-care/343077-making-a-complaint-about-a-care-provider>

²⁰² Productivity Commission, 2011, *Caring for older Australians*, Appendix F.

Reform Commission has made recommendations for significant change to national aged care laws to combat elder abuse.²⁰³

PARTLY ALIGNED: Further improvement possible to achieve best-practice regulation for clarity of roles and powers.

Separation of policy advice from regulation and interactions with individual recipients

Regulators should not be assigned conflicting or competing functions or goals unless there is a clear public benefit in combining them.²⁰⁴ Conflict can occur because a statutory decision-maker tasked with determining an appropriate response to non-compliance is required to make a trade-off between outcomes. For example, the Secretary of the Department may have to decide whether to impose a sanction that would have the effect of closing a facility if the provider does not return to compliance. This decision would remove the provider from the funding allocation for the system, which in turn reduces the number of places available in government-accredited facilities.

Conflict can also occur when an agency that deals directly with consumers is also tasked with decisions regarding the distribution of funds. Where government provides substantial funding or subsidies to individuals and families, emerging best practice points to governance arrangements that separate the policy agency from the 'consumer interface' agency.²⁰⁵

The other broad lesson from the history of regulation is that best-practice governance arrangements should separate the policy advice agency from the independent regulator or the body that administers the law.²⁰⁶ Making regulators independent from the changing agendas of governments generally increases consistency and transparency in the regulatory approach, and confidence in the regulator.

Performance of the Australian system

There is partial separation of functions in the Australian aged care regulatory system, but it is incomplete. Accreditation against the standards is undertaken by the Quality Agency. This agency is independent from the Department, which sets the policy and approves a residential aged care provider for funding under the aged care system. This is in line with best practice to ensure the independence of regulators.

However, monitoring compliance with the Act, including enforcement action against breaches in quality of care, is largely undertaken by the Department. The Department is also responsible for decisions to approve providers to deliver aged care, funding of approved providers, and for policy development in relation to residential aged care. This means that regulatory responsibility is not functionally separated from either policy development or funding of services.

²⁰³ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia.

²⁰⁴ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia.

²⁰⁵ Productivity Commission, 2011, *Caring for older Australians*, Appendix.

²⁰⁶ Productivity Commission, 2011, *Caring for older Australians*.

Benchmarking Australia with other systems

Across many regulatory schemes in Australia and internationally, there is generally greater movement towards the separation of policy and regulation functions, which is regarded as good practice. As noted above, Australia has partial separation of regulatory and policy functions through the establishment of an independent accreditation agency. In most countries considered by the Review, these functions are separated. In some cases, this is because policy work is done at the national level and regulation is carried out by states or regional governments. In others, including England,²⁰⁷ there is full separation, in that case between the Department of Health and the Care Quality Commission. Ontario, Canada²⁰⁸ is one of the few places that does not separate the policy and regulatory arms of government in relation to its residential aged care schemes.

The Australian schemes for quality of care in private hospitals and childcare also separate the policy and regulatory arms of government.

NOT WELL ALIGNED: Reform is needed towards best-practice regulation for separation of policy advice from regulation.

Well-structured complaints handling and a right of independent appeal

Well-structured complaints handling involves all stakeholders in the improvement of care quality. Timely and appropriate response to complaints empowers consumers to be involved in regulation. A transparent complaint-handling scheme will inspire trust and confidence in a regulatory scheme.²⁰⁹

Complaints management supports regulators by ensuring all relevant information is received, recorded and responded to appropriately. This is an essential element of any regulatory scheme because, in between monitoring and compliance visits, complaints are a critical source of information about facility quality, potential non-compliance and risk.

A well-structured complaint-handling scheme for residential aged care requires three distinct tiers of complaint-handling processes. The first is within the aged care facility, since the most efficient way for complaints to be handled in the first instance is usually by the facility itself. The second is complaint escalation to a body that is external to and independent of the provider (for example, in cases where the consumer is unhappy with the provider's response to the initial complaint, where the consumer or a staff member does not want the provider to know about a complaint,²¹⁰ or where another agency or third party wishes to provide information to the independent body). The third tier is to provide for complaints about the actions of the second tier independent body. Best-practice

²⁰⁷ Care Quality Commission, 2015, *CQC Corporate governance framework*, http://www.cqc.org.uk/sites/default/files/20151111_Corporate_Governance_Framework_August_2015.pdf

²⁰⁸ The system is different in each Canadian province, and the Review's focus was on Ontario as the province with the largest population; Meadus, J., 2010, *A brand new world: Ontario's new Long-Term Care Homes Act*, Advocacy Centre for the Elderly Newsletter, Toronto.

²⁰⁹ Bismark, M.M., et al., 2011, 'Remedies sought and obtained in healthcare complaints', *BMJ Quality & Safety*, Vol. 20(9), pp. 806–810.

²¹⁰ For example, out of fear for personal safety, where a complaint to the provider has not elicited an appropriate response or effected the desired change, or where the issue is deemed out of the control of the supplier of the service.

governance ensures that the second and third mechanisms are independent from the funding and regulatory arms of government.

Performance of the Australian system

The Australian system for handling complaints about residential aged care aligns with best practice in relation to independence and right of appeal.

Client surveys provide evidence of consumer and industry confidence in the current complaints scheme. Overall satisfaction with its operation is high with 86 per cent of service users (complainants and providers) satisfied or very satisfied.²¹¹

The Complaints Commissioner has power to investigate complaints, but does not have powers to enforce compliance. The latter is the role of the Department. Resolution is the key focus of the Complaints Commissioner, to protect care recipients from harm and ensure that the provider meets obligations under law. Where scope for improvement is identified, the Commissioner provides relevant information to the provider so that it may take appropriate steps to improvement. In cases where this involves non-compliance, the Department or Quality Agency is also informed. The Department and the Quality Agency determine appropriate steps to bring the provider back into compliance.

The Australian scheme provides appropriate review mechanisms through the Commonwealth Ombudsman for decisions made under the scheme. Appeals in relation to the regulator's or the decision-maker's determinations are transparent and at arm's length from both the policy and regulation agencies. Australia is meeting best-practice principles in this respect.

Benchmarking Australia with other systems

Germany, New Zealand and Australia are the only countries considered by the Review with a single complaint mechanism that is independent from the regulatory and funding arms of government. Almost all other countries still have multiple avenues for making complaints about residential aged care quality.

Australia, Canada and England all have established mechanisms for the right of appeal on complaints handling and appropriate mechanisms for appeal of the regulator's decisions.

BROADLY ALIGNED: Australia is aligned with best-practice regulation for well-structured complaints handling and right of appeal.

Freedom for personal and policy advocacy

It is considered best practice for all regulatory schemes to provide consumer protection through free access to personal and policy advocacy. This is particularly relevant for government services like health and disability services and aged and childcare, where people may not be able to speak for themselves:

²¹¹ Complaints Commissioner, *Annual report 2016–17*, p. 37.

*Personal advocacy involves standing alongside a person and speaking on their behalf in a way that represents the best interests of that person. Advocacy agencies provide an independent, free and confidential service to consumers through the delivery of information, referral, support, advice and/or representation to both individuals and groups.*²¹²

Appropriate government involvement includes funding such services and establishing appropriate governance arrangements to ensure that they are independent of government, including any regulator. According to the Productivity Commission, there is also a broader role for both industry and consumer organisations to advocate for their constituencies to influence policy development.²¹³

Performance of the Australian system

Australia has established mechanisms to provide freedom of access to advocacy services for residential aged care residents and their families. Personal advocacy is supported through government-funded advocacy services.

Individual confidential advocacy services have been identified as fundamental in supporting older people through the aged care system, particularly with the move towards consumer-directed care.²¹⁴ Advocacy services are delivered through the National Aged Care Advocacy Program, which supports the rights of consumers and aims to empower them to make informed decisions about their care. A single provider, the Older Persons Advocacy Network, was engaged from 1 July 2017 to deliver independent and free advocacy, education and information for consumers. The government is also developing a National Aged Care Advocacy Framework with input from advocacy providers and organisations representing both aged care providers and consumers.²¹⁵

As noted in chapter two, Australia actively involves the industry and community in policy development for residential aged care, for example, through stakeholder engagement by the Department and the Quality Agency in the development of the Single Quality Framework.²¹⁶ Policy advocacy is also supported through several committees with stakeholder representation that facilitate advocacy and are involved in co-design of aged care policy.

Benchmarking Australia with other systems

Limited information about advocacy services in other countries was available to this Review. New Zealand has a Health and Disability Advocacy service, which also provides advocacy services to the

²¹² Productivity Commission, 2011, *Caring for older Australians*, Appendix F, pp. F5-F6.

²¹³ Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F6.

²¹⁴ Department of Health, National Aged Care Advocacy Program Guidelines, p. 4, <https://agedcare.health.gov.au/support-services/national-aged-care-advocacy-program-guidelines>.

²¹⁵ Department of Health, The National Aged Care Advocacy Program, <https://agedcare.health.gov.au/support-services/the-national-aged-care-advocacy-program>.

²¹⁶ AACQA, Consultation: guidelines for new draft quality standards under Single Aged Care Quality Framework, <https://www.aacqa.gov.au/providers/education/the-standard/june-2017/quality-agency-developing-guidelines-single-aged-care-quality-framework>.

elderly in residential homes.²¹⁷ A Director of Advocacy is contracted to provide a nationwide advocacy service.²¹⁸ The free service operates independently of government and funding bodies.

While the US has ombudsmen to resolve complaints and offer assistance and support, advocacy in the context described above is performed by citizen advocacy groups located in each state²¹⁹ but generally not supported by public funds. The groups range from small collections of concerned citizens working within their community, to structured organisations with budgets and staff.²²⁰

In Ontario, the Ministry of Health encourages residents and their families to form councils and support groups. Such groups are supported by the Ontario Association of Residents Councils, which is partly funded by the provincial government and partly through provider fees.²²¹ The United Kingdom has several organisations that advocate on behalf of older people, including the national Older People's Advocacy Alliance and Age UK, which advocate on behalf of older people and are charity-funded.²²²

BROADLY ALIGNED: Australia is aligned with best-practice regulation for freedom for personal and policy advocacy.

Effective and regular review mechanisms

An evidence-based policy approach means providing the best possible evidence to inform the development and implementation of sound public policy. Reliable and accessible data and quality research are essential components of such review. Without data, review mechanisms cannot effectively improve schemes and maintain their alignment with the needs of consumers, providers and the public interest.

Performance of the Australian system

Building review periods and mechanisms into law is one way to ensure that stakeholders and governments can consider and improve regulation over time.²²³ There was a one-off review of reforms to the Aged Care Act created during the *Living Longer Living Better* reforms of 2012–13,

²¹⁷ Health and Disability Commissioner, Rest home, <http://advocacy.hdc.org.nz/case-studies/residential/rest-home>

²¹⁸ Health and Disability Commissioner, Background of the Advocacy Service, <http://advocacy.hdc.org.nz/about-us/background-of-the-advocacy-service>

²¹⁹ The National Consumer Voice for Quality Long-Term Care, How to solve problems in a nursing home, http://theconsumervoice.org/uploads/files/long-term-care-recipient/9._How_to_Solve_Problems_in_a_Nursing_Home.pdf, p. 2

²²⁰ National Consumer Voice for Quality Long-Term Care, Citizen advocacy groups, <http://theconsumervoice.org/issues/for-advocates/citizen-advocacy-groups>

²²¹ Ontario Association of Residents' Councils, OARC Objectives, Richmond Hill, 2017; Ontario Association of Residents' Councils, OARC funding, <http://www.ontarc.com/Funding.html>

²²² Older People's Advocacy Alliance, Our history, <http://opaal.org.uk/about-us/about-us-sub-page-2/> and Age UK, We provide advice, <http://www.ageuk.org.uk/no-one/we-provide-advice/>

²²³ For example, the *Fuel Quality Standards Act 2000*, s. 72; *Dental Benefits Act 2008*, s. 68; *Product Stewardship Act 2011*, s. 109.

which was recently completed.²²⁴ However, there are no periodic review requirements built into either the Aged Care Act or the Quality Agency legislation.

While the Aged Care Financing Authority, a statutory body, has a standing brief to review the financing of the aged care sector, there is no equivalent body that is specifically mandated to examine quality, compliance, or regulation more generally.

Historically, there has been a significant lack of publicly available data²²⁵ and policy-relevant evidence on residential aged care. This has limited the scope for comprehensive and independent assessment of the system.

The regulatory scheme for residential aged care in Australia collects a large volume of information for accreditation, approval, complaints handling, and compliance and enforcement functions; however, data published by the regulators tend to be high-level process data, which limits its utility in review of system performance.

NOT WELL ALIGNED: Further reform is needed to move towards best-practice regulation for effective review mechanisms.

Principle 2: Appropriate choice of Standards

Best-practice regulation involves choosing the right kinds of standards and regulating the right kinds of things to deliver an effective system. Standards should enable the proper assessment of quality and risks for clients, and focus on outcomes rather than inputs or activities.

The Productivity Commission observed that:

*The appropriate standard is one that matches the circumstances of the policy in terms of how clearly the goals and objectives are defined. For example, where goals can be clearly defined then it can be assumed that the regulated party knows the objective and less prescriptive, performance based standards can be implemented.*²²⁶

The residential aged care sector globally has generally moved to establish measures that set out a minimum set of standards against which compliance can be measured. There has been criticism of this approach from industry and consumers both in Australia and overseas. The argument is that it results in regulators only checking processes and policies, rather than being genuinely able to consider and measure the quality of care being delivered by the facility.

The effectiveness of a standard is linked to its ability to achieve the desired outcome. However, it is also generally considered important that the regulatory design allow for innovation,²²⁷ so that providers may both meet the standards and continue to improve service delivery.

²²⁴ The review was required by section 4 of the *Aged Care (Living Longer Living Better) Act 2013*. A single review such as this is more common in legislated review provisions than regular periodic reviews.

²²⁵ Productivity Commission, 2011, *Caring for older Australians*, p. xcii.

²²⁶ Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F6.

²²⁷ Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F7.

According to the Productivity Commission, performance standards are attractive because they focus on the outcomes to be achieved rather than the means of achieving them. And while they do not provide an incentive for continuous improvement or best practice, they do not preclude it.²²⁸ However, the Productivity Commission also observed that too much emphasis on process and documentation adds to cost and can detract from quality-of-care outcomes.²²⁹

Performance of the Australian system

Do the Accreditation Standards lead to quality of care?

It is generally agreed that accreditation of approved providers in Australia has had a positive impact on the quality of care for residents in aged care facilities. How much of this positive impact relates to the use of the Accreditation Standards is not clear in evaluations to date.

It is argued that accreditation has removed underperforming aged care homes, raised the standards of quality across the sector, established a degree of consistency, developed a focus on continuous improvement and resident-focused care, and set a minimum standard for quality.²³⁰ However, there is evidence to suggest that accreditation may not be adequate in delivering quality care outcomes for consumers. This is discussed in greater detail in part two of this Report.

Process versus outcome

Despite general agreement that accreditation is positive, the Standards have been criticised for providing limited incentives to improve quality. Concerns have been raised that standards are assessed on documentation, rather than evidence relating to what residential care providers are actually doing.²³¹ For some providers, passing accreditation might be an end in itself, rather than focusing on quality improvement and outcomes for consumers.²³²

The outcomes under the standards tend to be process-driven. This is most evident in Standard 1, which is intended to be an umbrella standard for improving quality across all the outcomes, but focuses on management systems and processes—human resources, education and staff development, regulatory compliance and information systems.

Minimums, scales, and improvement

The accreditation system states that continuous improvement is meant to be achieved under the Standards, with outcomes relating to this specified under each Standard.²³³ However, there is little incentive to achieve above the minimum standards, as there is no grading system or sliding scale in place. Providers are assessed as having met or not met each outcome.

²²⁸ Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F7. See also Chapter 10, especially pp. 215–216 and p. 218.

²²⁹ Productivity Commission, 2011, *Caring for older Australians*, p. 218.

²³⁰ Australian Aged Care Quality Agency, *Annual report 2015–16*; The Standard. September 2007, the Aged Care Standards and Accreditation Agency.

²³¹ NSW General Purpose Standing Committee, No 3, 2015, Registered nurses in NSW nursing homes.

²³² Groves, A., et al., 2017, *The Oakden report*, South Australia Department for Health and Ageing.

²³³ There is also a separate requirement that providers have a plan for continuous improvement in place.

The Productivity Commission argued that some operators survive in the current system because the system requires only minimum standards; they would fail in a more competitive market.²³⁴ If operators were assessed on sliding scales against the outcomes, consumers could be better informed about the performance of providers against the outcomes. This in turn could encourage providers to improve performance.

Are the Standards appropriate?

Ensuring compliance with standards is different from ensuring that those standards meet consumer expectations. Stakeholders have identified a range of areas in which the standards may need improvement or more explicit targeting to consumer needs, such as end-of-life care and limiting the use of restraints. In addition, the Australian Law Reform Commission's investigation into elder abuse found that many incidences of alleged abuse and neglect may not be reported as they do not come under the assault definition in the Aged Care Act.

The design of some standards to focus on processes and documentation can take the focus away from outcomes. This was a significant issue in the Oakden case. Standards need to be designed with an outcome focus.

These issues are addressed in more detail in chapters seven and eight.

Quality of life

Australia's Accreditation Standards have always included some quality-of-life outcomes under Standard 3, Care recipient lifestyle.

The concept of the importance of quality of life as an indicator of quality of care was recognised with the introduction also of a legislated Charter of Care Recipients' Rights and Responsibilities.²³⁵ While the Charter does cover much the same material as Standard 3 of the Accreditation Standards, it is more expansive and better oriented to the individual care recipient. The extent to which providers adhere to the Charter is not measured.

Putting the care recipient experience at the centre of measuring quality of care in a home can best be done through engaging directly with consumers and their families. The Quality Agency's introduction of the consumer experience report as an integral part of the site audit process and compliance measurement goes some way towards a consumer-centric evaluation of compliance. However, this is in its early stages.

The development of the Single Quality Framework, described in chapter two, is intended to make a range of improvements to aged care, including an increased focus on the quality of consumers' lives.²³⁶ The standards,²³⁷ framed from a consumer perspective, incorporate several types of regulatory design, as they include statements about outcomes for consumers, value statements for providers, and some guidance about pathways for compliance (through their sets of requirements).

²³⁴ Productivity Commission, 2011, *Caring for older Australians*, Overview, p. XLIV.

²³⁵ Under the User Rights Principles 2014.

²³⁶ Department of Health, Single quality framework: focus on consumers, <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers>

²³⁷ Department of Health, 2017, *Single quality framework—draft aged care quality standards consultation paper*, p. 5.

Benchmarking Australia with other systems

To the extent that Australia's Accreditation Standards include aspects relating to quality of life and the dignity of older people, they reflect good regulatory practice.²³⁸ However, previous reviews and submissions to this Review have noted that the vague descriptions of the standards, outcomes and guidance material contribute to inconsistency in assessment.

In most OECD countries, the starting points for quality assurance in residential care are development of minimum standards, licensing or accreditation of facilities, and training requirements for workers. Like Australia, most regulatory systems use some form of accreditation to authorise aged care providers. Two-thirds of OECD countries have compulsory accreditation or certification as a condition for receiving government funds. For that reason, accreditation standards are perceived, and used, as the minimum standards with which providers must comply.²³⁹

However, some countries add extra standards or indicators to improve quality of care. For example, the US has a set of national standards that indicates the 'minimum standard' of long-term care services; there are additional state standards aimed at prompting quality in service delivery.

Government-funded facilities in the US must participate in a quality assurance and performance improvement program, which features a system of star rating to enable comparison of providers.²⁴⁰

In most overseas jurisdictions (except New Zealand), quality-of-life and quality-of-care indicators are used to guide quality improvement, in conjunction with the accreditation standards. They are generally implemented in addition to the minimum accreditation or certification standards; participation in quality improvement programs is mandatory in several countries.

More recently, elements have been added to address the quality of life of recipients, basic human rights, as well as human dignity (in the Netherlands, England, the US, and Ireland), individualised care planning processes, and reporting systems for adverse events and complaints (Ireland, US and England). Standards specific to dementia care are getting more attention, for example in Ireland and England.

An increasing focus on the experience of consumers is becoming evident in several OECD countries. The standards in many jurisdictions emphasise the experience of the resident and their family as a key component of determining the quality of aged care. The English standards, in particular, are built around person-centred care including standards related specifically to safeguarding residents from abuse, safety, dignity and respect, as well as practical standards related to food and drink, and premises and equipment. Australia's Accreditation Standards feature some similar outcomes.

²³⁸ OECD/European Commission, 2013, *Better policies for better lives, Country note: Australia. A good life in old age*, OECD <https://www.oecd.org/els/health-systems/Australia-OECD-EC-Good-Time-in-Old-Age.pdf>

²³⁹ Scrivens, E., 2002, 'Accreditation and Regulation of Quality in Health Services' in Saltman, R. et al, (eds), *Regulating entrepreneurial behaviour in European health systems*, Open University Press, p. 94.

²⁴⁰ American Health Care Association, *Improving Lives by Delivering Solutions for Quality Care*, Facility Resources, Survey and Regulation (Five-Star Quality Rating System, 2017) https://ahcancal.org/facility_operations/survey_reg/Pages/FiveStar.aspx

Ontario also has standards that more directly reflect quality outcomes for residents, including standards related to continence care, falls prevention, use of restraints, nutrition and pain management. They include more stringent approaches to restraints than in Australian regulation.

The OECD has noted that translating quality-of-life concepts into indicators can be challenging.²⁴¹ There is an effort to incorporate them through collection of information from care recipients directly. Indicators focus on user experience or satisfaction, as well as social aspects of the long-term care (LTC) experience:

For example, Denmark, Spain, the Netherlands, England, and the United States survey patient and user experience. In England, a National Adult Social Care Survey has used ASCOT to survey all LTC users. ASCOT is a tool designed to capture information about LTC outcomes from the perspective of the LTC recipients, which focuses on items such as cleanliness and comfort, good nutrition, safety, control over daily life, social interaction, occupation, accommodation and dignity. Denmark, Austria, Finland, and the Netherlands are starting to use ASCOT, too. In the Netherlands, legislation requires all LTC facilities to carry out surveys of users' experience based on the national quality framework for "responsible care".²⁴²

England is noteworthy, because the minimum quality standards that need to be met for registration already incorporate residents' experience, and the monitoring and compliance process aims to assess the extent to which residents have quality of life, as well as quality of care.²⁴³

While Australia is aligned with other countries in mandating minimum standards of care through its accreditation system, and moving towards greater consumer input in measuring quality of care, there are areas where reform is needed as an impetus to future quality improvement. A number of countries reviewed are implementing reforms in relation to the way in which performance is measured, as well as what is being measured, to improve quality of aged care. Childcare and hospital services in Australia also provide some guidance in these areas.

Reform in measuring performance against standards could include sliding-scale assessment against expected outcomes, further expansion of consumer input to assessment, or mandated quality improvement programs.

Reform in what is being measured needs to focus on standards that measure quality of care through genuinely targeting outcomes, rather than only processes. More work also needs to be done to include specific indicators that reflect consumer needs, and the overall quality of life residents in aged care facilities experience.

PARTLY ALIGNED: Further improvement possible to achieve best-practice regulation for appropriate standards.

²⁴¹ OECD/European Commission, 2013, *A good life in old age? Monitoring and improving quality in long-term care*.

²⁴² OECD/European Commission, 2013, *A good life in old age? Monitoring and improving quality in long-term care*, OECD/European Commission, p. 19.

²⁴³ Care Quality Commission, Registering and Monitoring Services, <http://www.cqc.org.uk/what-do-we-do/how-do-we-do-our-job/registering-monitoring-services>

Principle 3: Responsive regulation to encourage and enforce compliance

Responsive regulation is the use of the appropriate regulatory tool in response to the circumstances at hand. It can influence behaviour and attitudes of regulated entities to compliance:

*A person that experiences responsive regulation will as a result have a more positive assessment of their experience of the investigation and enforcement process, more positive attitudes towards the regulator and compliance, and, crucially, better compliance behaviour, than a person that does not experience responsive regulation.*²⁴⁴

Responsive regulation has two key components:

1. Enforcement or rewarding action escalates or de-escalates according to the conduct of the regulated entity. “By credibly asserting a willingness to regulate more intrusively, responsive regulation can channel marketplace transactions to less intrusive and less centralized forms of government intervention... [It supports] both a hierarchy of sanctions and a hierarchy of strategies of varying degrees...”²⁴⁵
2. A means by which regulators can prioritise their supervision of those they regulate: to determine where on the pyramid (Figure 4) a stakeholder sits and therefore what kind of regulatory scrutiny or action they require.

Responsive regulation does not define what implementation tools should be used, instead focusing on the relationship between degrees of compliance and the degrees of support or enforcement they require. In different regulatory settings, different tools will be used. Figure 4 is taken from the Aged Care Compliance Policy Statement of the Australian Government, and shows how the concept has been adopted in aged care.²⁴⁶

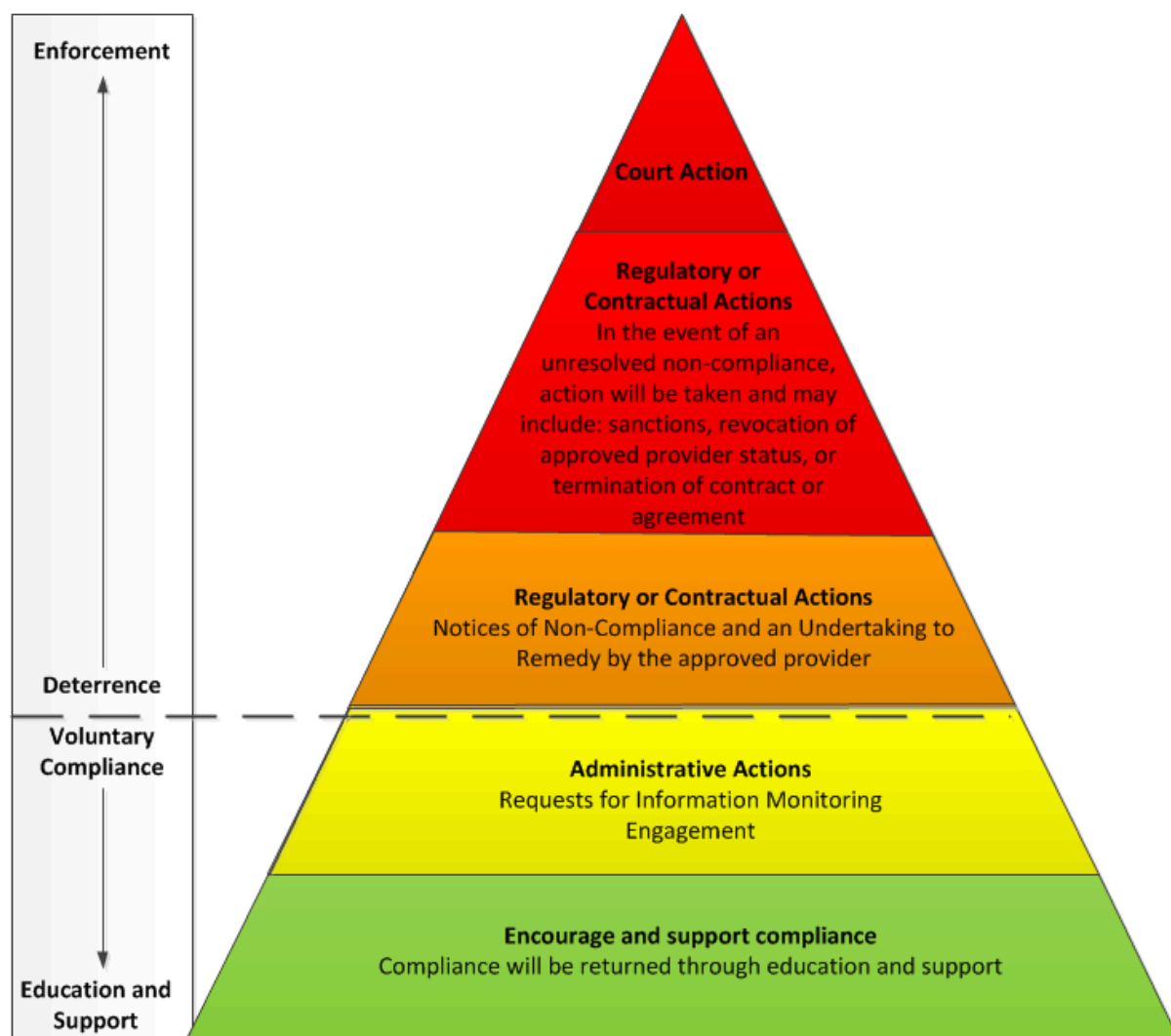
²⁴⁴ Nielsen, V., Parker, C., 2009, ‘Testing responsive regulation in regulatory enforcement’, *Regulation & Governance*, Vol. 3, pp. 376–399.

http://law.unimelb.edu.au/__data/assets/pdf_file/0011/1675064/NielsenandParkerTestingResponsiveRegulationinRegulatoryEnforcementPreprintformat1.pdf

²⁴⁵ Ayres, I., Braithwaite, J., 1994, *Responsive regulation: transcending the deregulation debate*, Oxford University Press, pp. 4–6.

²⁴⁶ Aged Care Compliance Policy Statement 2015–2017, Australian Government Department of Social Services.

Figure 4. Australian Government aged care responsive and risk-based regulation strategy



Responsive regulatory principles need to be implemented according to the regulatory setting.²⁴⁷ Recent reviews of responsive regulation discuss how the theory has developed and been modified and embedded into regulatory practice in several sectors.²⁴⁸ It remains a dominant regulatory strategy globally.²⁴⁹

²⁴⁷ There are nine principles of effective implementation that guide responsive regulation. These are set out in detail at Braithwaite, J., 2011, 'The essence of responsive regulation', *UBC Law Review*, Vol. 44(3), pp. 475–520.

²⁴⁸ Special issue, 'Twenty years of responsive regulation: an appreciation and appraisal', 2013, *Regulation and Governance*, Vol. 7(1).

²⁴⁹ Wood, C., et al., 2010, *Applications of responsive regulatory theory in Australia and overseas*. RegNet Occasional Paper 15; RegNet Research Paper No. 2015/72. http://regnet.anu.edu.au/sites/default/files/publications/attachments/2015-05/ROP15_0.pdf; Ivec, M., Braithwaite, V., 2015, *Applications of responsive regulatory theory in Australia and overseas: update*, RegNet Occasional Paper 23; RegNet Research Paper No. 2015/72. SSRN: <https://ssrn.com/abstract=2586888> or <http://dx.doi.org/10.2139/ssrn.2586888>

The responsive approach to sanctions

Knowledge that a regulation exists is usually enough for most entities in an industry to comply voluntarily.²⁵⁰ For this reason, under a responsive regulation model, regulators spend the larger proportion of their time educating the industry and its stakeholders about their responsibilities and the objectives of the regulations. At the other extreme are entities that will try to gain an advantage by purposefully not complying. The most significant penalties and strongest compliance actions exist in regulation to provide appropriate punishment for this minority of players.

In between these two extremes there may be circumstances leading to non-compliance that are not entirely intentional. Examples include a lack of clarity in the laws, emergence of a new risk or niche within the industry, an inexperienced employee or manager, the loss of critical expertise, a change in technology, or a change in the practices of the business. Tools designed to encourage or support a return to compliance are usually used to respond to this middle range of non-compliance.

The pyramid in Figure 4 illustrates that most of the industry is represented by the base, and recognises that only the extreme cases will require the enforcement response at the pinnacle. However, this pyramid describes the degree of regulatory action needed to achieve (or return to) compliance. It does not describe how widespread non-compliance might be and does not necessarily mean that significant breaches are rare, just that it is rare that forceful regulatory action will be necessary to correct them.

The responsive approach to supports

The escalation to sanctions as a means of enforcing compliance needs to be complemented by activities that reward positive behaviour and contributions. This has led to the addition of a 'pyramid of supports':²⁵¹ a hierarchy of strategies that build on strengths within a system to achieve performance that moves beyond compliance.²⁵²

The pyramid of supports is different because it aims to push industry towards the pinnacle through supporting strategies, incentives and non-regulatory tools. The pyramid of supports places compliant industry members at the base of the pyramid and the pinnacle represents only those that are leading and operating above minimum standards.

Regulation is no longer the default position of government.²⁵³ Regulatory agencies are using more non-regulatory tools like incentives, service support and behavioural insight-led nudges to support industry sectors to go beyond compliance. Non-regulatory tools can form part of the responsive strategy in a pyramid of supports.

²⁵⁰ Ivec, M., Braithwaite, V., 2015, *Applications of responsive regulatory theory in Australia and overseas: update*, Regulatory Institutions Network, Australian National University, p.5.

²⁵¹ Healy, J., 2011, *Improving health care safety and quality: reluctant regulators*, Ashgate.

²⁵² Borck, J.C., Coglianese, C., 2011, 'Beyond compliance: explaining business participation in voluntary environmental programs' in Parker, C., Nielsen, V.L., (eds), *Explaining compliance: business responses to regulation*, Edward Elgar, p. 139.

²⁵³ *The Australian Government Guide to Regulation*, Commonwealth of Australia, 2014, p. 2.

An understanding of the risks and the challenges

A mature assessment of risk is necessary for a regulatory scheme to support a responsive model of regulation. This is because there need to be mechanisms by which a regulator understands where in the regulatory pyramid a regulated entity might sit, and therefore what kind of response is called for. It is also desirable when there are a lot of regulated entities, so that there is an efficient way to make those assessments. Residential aged care, with nearly 200,000 residents, 2,500 services, and nearly 1,000 providers, will be more effectively regulated if the regulator can assess where risks lie in the system.

The Department of Industry describes risk assessment as the:

*process of analysis to determine the extent and likelihood of occurrence of undesirable events or situations as compared against benchmarks or standards.*²⁵⁴

For risk assessment to be effective in a regulatory environment, it requires two things: an understanding of what factors can contribute to undesirable events; and use of the results of that assessment to influence regulatory activity.

Performance of the current Australian system

A responsive approach to sanctions

Australia's current system for regulation of the residential aged care sector is effective in its delivery of a responsive approach to sanctions. It uses the tools available, including some non-regulatory tools, to work with industry to bring individual facilities back into compliance. An international comparative assessment of Australia's regulatory framework from 2007 stated:

*Australia relies on a consultative relationship between providers and regulators. Education rather than directive regulation is a major focus of the government's activities. Regulations are, as a matter of principle, very broad and not specific.*²⁵⁵

The tools used mostly relate to the provision of support through fostering collaboration between approved providers or through the provision of experts such as carers, nurses, medical practitioners or specialists. Sanctions are typically paired with a non-regulatory tool to assist the facility to return to compliance.

Research by the OECD indicates that enforcement is often not strong enough in the regulation of aged care quality generally across OECD countries, and that services are only terminated or have their funding cut in the most blatant cases, while other less serious cases are treated leniently.²⁵⁶ In our Review, we considered this in the context of responsive regulation, by looking at the history of

²⁵⁴ Department of Industry, Innovation and Science, July 2016, *Best practice guide to using standards and risk assessments in policy and regulation*, p. 2, <https://industry.gov.au/industry/IndustryInitiatives/PortfolioRegulationReform/Documents/Best-practice-guide-to-using-standards-and-risk-assessments-in-policy-and-regulation.pdf>

²⁵⁵ Weiner, J., et al., Feb 2007, *Quality assurance for long-term care: the experiences of England, Australia, Germany and Japan*, Public Policy Institute Issues Brief 2007-05, p. 8.

²⁵⁶ OECD/European Commission, 2013, *A good life in old age? Monitoring and improving quality in long-term care*, European Commission.

the strongest regulatory intervention normally used in the Australian system: revocation of approved provider status.

Only a small number of aged care facilities have faced revocation of approved provider status. The evidence on whether escalating compliance action is used, so that severe penalties follow on from incrementally staged measures, is mixed. In the last decade, of the ten facilities that have had approval revoked by the Department, all but one came following a full three-year accreditation. On the other hand, of those ten, seven had experienced limited accreditation periods or variations *prior* to the three-year accreditation that they held at the time their approved status was revoked. So, most had at some point in the past experienced closer attention from the Quality Agency around their standard of care.

It is not clear whether this means that escalation of compliance measures is not often used, or that it cannot be used because the emergence of significant quality-of-care problems necessitates more immediate regulatory action. In any case, severe compliance action is very seldom used in the Australian aged care system.

There is some evidence that the use of an escalating approach to sanctions has also had a positive impact on compliance in the sector. A study of data on accreditation activities and outcomes from 1999–2000 to 2007–08 attributed the low incidence of penalty-based sanctions to the effectiveness of measures that precede the imposition of sanctions.²⁵⁷

Independent research and formal reviews have credited the introduction of the 1997 Aged Care Act with addressing some of the problems with achieving continued quality improvements in the sector.²⁵⁸ The available data indicate that the accreditation scheme has been relatively effective at encouraging compliance with the minimum standards. However, the experience of Oakden indicates that this is not always successful.

A responsive approach to supports and innovation

Australia's aged care regulatory system does have some features that provide a responsive approach to innovation and increased quality. The government has developed some non-regulatory tools to support consumer choice in residential aged care. Examples include the Quality Indicator Program and consumer experience reports, discussed previously in this chapter. The Quality Agency has annual 'Better Practice Awards' that promote quality and encourage innovation, although the effect of these on the overall improvement of care is yet to be measured.

The Australian system is beginning to test and adopt some of the supportive strategies that have been employed in other countries. Currently, they appear to be uncoordinated because they are not presented as an overall strategy that aims to improve quality and drive the industry to perform beyond compliance. Thought needs to be given to how these tools fit with the pyramid of sanctions

²⁵⁷ Ellis, J.M., Howe, A., 2010, 'The role of sanctions in Australia's residential aged care quality assurance system', *International Journal for Quality in Health Care*, Vol. 22(6), pp. 452–460.

²⁵⁸ O'Reilly M., Courtney M., Edwards H., 2007, 'How is quality being monitored in Australian residential aged care facilities? A narrative review', *Int J Qual Health Care*, Vol. 19, pp. 177–182; Australian National Audit Office, *Managing residential aged care: the Aged Care Standards and Accreditation Agency Ltd.* 2003ANAO Canberra Audit report No 42. 2002–03.

and how they are to be promoted to empower elements of self-regulation and drive change in behaviour across the sector.

Risk-based allocation of resources

Regulatory enforcement and inspections should be based on evidence and measurement: deciding what to inspect and how should be grounded on data and evidence, and results should be evaluated regularly.²⁵⁹ A regulator should not undertake a regulatory activity unless there is a reason for that activity. As the Senate Economics Committee commented:

*Regulators need to make decisions about how to use their limited resources to address conflicting priorities.*²⁶⁰

In deciding when to intervene, government regulators in Australia may use risk-based tools and analysis of available data, taking into account the need to distribute resources effectively and remain aware of areas of risk within the industry and areas of likely non-compliance.²⁶¹

As noted in chapter two, the Australian residential aged care regulatory scheme currently contains elements of risk assessment as part of the compliance response.²⁶²

Since late 2014, the Quality Agency has had a visit prioritisation and risk ratings policy. The policy combines several risk-related concepts, including risk rating, risk factors and likelihood of event, to arrive at what it refers to as a risk profile. However, the policy is difficult to apply, and the assessment of risk is also overlaid with other considerations. The policy's purpose is to "manage and prioritise planning of visits to residential aged care homes". Elsewhere in the policy it appears risk rating is only one of four factors that affect the "form and frequency of assessment contacts" under case management.²⁶³

Risk factors may not be sufficiently aligned with outcomes for consumers. Of the 23 risk factors listed in the policy, only one relates to the care needs of consumers (number 17 "high-risk-demographic care recipients"), and while one of the factors identifies *new* facilities as a possible source of risk, none addresses risks that might be associated with facilities being *old*, or with low levels of investment. Finally, the full range of risk assessment has only a minor impact on the proposed frequency of visits, with the very highest risk rating resulting in only "at least two

²⁵⁹ OECD, 2014, *Regulatory enforcement and inspections, OECD best practice principles for regulatory policy*, OECD Publishing.

²⁶⁰ Senate Standing Committee on Economics, 2013, *The performance of the Australian Securities and Investments Commission*.

²⁶¹ For example, New South Wales Environmental Protection Authority, Risk-based licensing, <http://www.epa.nsw.gov.au/licensing/assessprocess.htm>; Australian Tax Office, Risk-differentiation framework <https://www.ato.gov.au/Business/Large-business/In-detail/Risk-Differentiation-Framework/Risk-differentiation-framework-fact-sheet/>; NSW Department of Education and Training, Childcare regulatory framework, <https://www.det.nsw.edu.au/media/downloads/what-we-offer/regulation-and-accreditation/early-childhood-education-care/regulatory-framework/enforcement/eccec-compliance-policy.pdf>; Australian Government Department of the Environment and Energy, Compliance monitoring program 2016–17, <https://www.environment.gov.au/system/files/resources/75aae702-cebb-46e1-8ff9-bf0c4f216d82/files/compliance-monitoring-program-2016-17.pdf>

²⁶² Department of Health, Aged care compliance operations manual, September 2014; AACQA, Visit prioritisation and risk ratings policy.

²⁶³ AACQA, personal communication.

assessment contacts within the financial year in addition to their annual unannounced assessment” .²⁶⁴

Recent cases, including Oakden, raise questions about whether underlying risk factors (such as the complexity of care) and longer-term sanctions and accreditation history are not sufficiently considered in the current risk assessment. The links between risk assessment and periods of accreditation are also not clear.

The findings of this Review suggest that current decision tools:

- are not being adequately used to determine which facilities and residents might be higher risk
- are not being used across all regulatory interventions.

A reformed, risk-based accreditation system should better protect care recipients from harm. This is discussed further in chapter eight.

Benchmarking with other schemes

All the international schemes considered in this Review use elements of responsive regulation. However, it was difficult to obtain good information about those schemes and their performance.

A responsive approach to compliance and sanctions

Responsive approaches to accreditation and compliance actions, such as sanctions, require both rules that allow incremental action and practices that show that regulators make use of the incremental actions that the rules allow. The length of accreditation and certification periods appears to be more variable in some jurisdictions than it is in Australia. New Zealand applies different certification periods dependent on the apparent risks identified during the previous certification audit. The certification acts as an entry point to the scheme and the longest period without re-certification is four years. Like Australia, the shortest certification period is one year.

Unannounced visits and spot checks are part of the compliance monitoring system in all countries considered, however the triggers and length varies considerably. Some regulators undertake surprise or unannounced visits to carry out checks. The Joint Commission is the US’s oldest and largest standards-setting and accrediting body in health care. The Joint Commission accredits and certifies nearly 21,000 health care organisations and programs in the US. In 2006, it moved to a program of exclusively unannounced visits,²⁶⁵ since scheduled visits allowed hospitals to make a big effort for the site visit and thereafter return to their usual ways of working.²⁶⁶

A responsive approach to supports and innovation

There is a range of approaches to applying responsive regulation through positive supports and innovation. Quality improvement through the use of indicators has been a significant trend, as is public reporting.

²⁶⁴ AACQA, personal communication.

²⁶⁵ The Joint Commission, Facts about the unannounced survey process, https://www.jointcommission.org/facts_about_the_unannounced_survey_process/

²⁶⁶ Healy, J., 2011, *Improving health care safety and quality: reluctant regulators*, Ashgate Publishing.

Most countries are developing systems, often separate from compliance regulation, to support improvement in the aged care sector. These are often systems designed to support consumer choice. They include quality-of-care and quality-of-life indicators, and frequently involve direct consultation with consumers within the facility.

In the Netherlands, the CQ Index, a standardised system for measuring, analysing and reporting client experience, is used to indicate the quality of long-term care from the resident's perspective.²⁶⁷ Norway moved to a system of indicators in 2014 to enable annual reports on the relative quality of health services and change in quality over time.

Unlike Australia, most schemes use some sort of scale to assess and describe a facility's compliance with certification or accreditation standards. The US uses star ratings, and New Zealand uses a risk or traffic light (red, amber, green) system linked to its risk assessment framework.

The New Zealand traffic light system is coupled to its risk assessment process and to the determination of the length of the certification (their equivalent to accreditation) period. The certification standard reports become part of their online audit report, which can be used by consumers in assessing the current state of a facility. The online report is updated between certifications, for example when a facility comes back into compliance.

England is using ratings embedded within its accreditation regime rather than as a separate system. It is taking advantage of technological improvements to present data in a more accessible way to consumers. This reflects problems England had previously experienced with its star-rating system, which consumers found difficult to use and which was not having a strong impact.

NOT ALIGNED: Reform is needed to move towards best practice in the use of responsive regulation to encourage and enforce compliance.

Conclusion

Considered in an international context, the regulatory system governing aged care in Australia is far from a poor performer. While complex, Australia's current regulatory system aligns well with some accepted best-practice regulatory principles. Specific areas that can be strengthened, and where reforms can draw on the better-practice examples of other countries, include: improved clarity and reduced overlap in the roles of regulatory authorities; clearer distinction between regulators and policy agencies and improvement in associated information-sharing processes; embracing and embedding standards that reflect a consumer-centred approach to aged care; and adopting a risk-based approach to accreditation and compliance monitoring.

This overall assessment of the performance of Australia's current aged care regulatory system is no comfort to the individuals, families and friends who have suffered appallingly in circumstances such as those in the Makk and McLeay wards at Oakden. It is scant reassurance to a community and public that is aware of instances of substandard quality of care. The next chapters of this report turn

²⁶⁷ Van der Veen, R., Mak, S., 2010, *Developing and ensuring quality in long-term care. Netherlands National report*, Interlinks, p. 10, http://interlinks.euro.centre.org/sites/default/files/WP4_NL_final.pdf

to a central question for this review. Having reviewed what went wrong at Oakden, the question is what needs to happen in Australia's aged care regulatory environment to avoid such failings in the future?

PART 2: How can we improve quality regulatory processes?

The decision to enter, or place a loved one in, residential aged care is one of the most difficult decisions most people face in their lifetime. In many cases, the decision is precipitated by a sudden decline in the health and independence of a parent or family member, adding additional stress.

When choosing a home, consumers and their families want assurances that the care provided will be personalised, safe and meet their needs. While considerable reform has occurred over the past 20 years with the goal of improving the safety of care and the information available to consumers to inform their choice of provider, the issues identified at Oakden and in submissions to this Review highlight that more needs to be done.

This part of the Report explores options to adjust regulatory processes to better protect residents and ensure they receive good care. Key priorities in our proposed reform of aged care quality regulation are:

- Place consumer rights and safety first
- Ensure that the regulatory system can quickly identify and remedy poor-quality or unsafe care
- Make clear, comparative information about care quality available to consumers and providers, to enable informed choice and quality improvement
- Establish a regulatory culture that ensures core standards are met, while encouraging high-quality care
- Acknowledge and reward providers that consistently provide high-quality care.

An issue raised during consultations was staffing in residential aged care, with the majority of comments related to mandating staff ratios. Feedback also referred to improving conditions (particularly remuneration) for aged care workers, auditing staffing levels as part of accreditation, or ensuring a registered nurse is on duty at all times.

We acknowledge and appreciate the important role of aged care workers in ensuring that residents are safe, well-cared for and have a good quality of life. However, the workforce issues raised in submissions are broader than aged care quality regulatory processes. We note that the Government has established an industry-led taskforce to develop an aged care workforce strategy. The taskforce is where these issues would be most effectively considered.

Based on the feedback from the Review consultation process and research into best-practice regulation, we identify key elements for a more effective aged care regulatory system and propose measures to facilitate transition to a new model.

Key elements of a more effective quality regulatory system

Integration of the regulatory system

- Centralise accreditation, compliance and complaints handling under a single independent agency.
- Develop a centralised database for real-time information sharing.

Information for consumers and providers on care quality

- Report provider performance against an expanded list of evidence-based quality indicators.
- Implement a star-rated system for public reporting of provider performance.

Support consumers and their representatives to exercise their rights

- Promote and protect consumers' rights through education, advocacy and engagement with consumers, their families and carers.
- Develop a serious incident response scheme.
- Limit the use of restrictive practices through guidelines, and monitor compliance.

Effective accreditation and compliance monitoring

- Develop an effective, risk-based approach to accreditation that supports early identification of poor-quality care and rewards high performing providers.
- Ensure that assessment against the Accreditation Standards is consistent, objective and reflective of current expectations of care.

Enhanced complaints handling processes

- Develop strong complaints-handling processes and powers of the Aged Care Complaints Commissioner.

Chapter 5: Integration of the regulatory system

An independent regulatory commission

In the past 20 years, steps have been taken to improve regulation of the quality of residential aged care and the regulatory governance arrangements that support it. These changes were designed to transition core regulatory functions away from the Department and to separate responsibility for policy development from accreditation and compliance functions.

What are the problems with the current approach?

Complexity of regulatory governance arrangements

Part one outlined the complexity of aged care quality regulation. Service providers are subject to regulation managed by Commonwealth, and by state and territory governments. Compounding this, there have been many iterative changes to the Act and subordinate legislation. It is difficult for consumers and providers to understand their rights and responsibilities, the roles played by the different regulatory agencies and how to navigate the system to resolve issues.

The complex segregation of regulatory functions adds to this confusion for consumers and providers. For example, the Quality Agency has the authority to revoke accreditation of a facility; however, where serious incidents of non-compliance are detected, the Department of Health has sole authority to impose sanctions against the service provider managing the facility. In such cases, the Department relies on written reports developed by the Quality Agency to gauge the severity of non-compliance and seriousness of the risk posed to residents.

Current arrangements, where the Department retains both policy and compliance responsibilities, represent an inherent conflict of interest not in line with best-practice regulation.²⁶⁸

Ineffective data capture and sharing

The Aged Care Guild noted:

*Our members have observed that inconsistencies and a lack of coordination by the Department of Health, the Quality Agency and Complaints Commissioner sees these regulatory agencies consider facilities and single issues with only a limited insight and perspective.*²⁶⁹

Fundamental to an agile regulatory system that responds quickly to care failures is a strong intelligence gathering and analysis capability. This involves integrated information systems, cooperation across agencies and with providers. While the three regulators have developed memorandums of understanding that describe processes and timeframes for information sharing, the segregation of function generally limits data sharing.

²⁶⁸ Productivity Commission, 2011, *Caring for older Australians*.

²⁶⁹ Aged Care Guild submission (ID#1032742486).

These issues with regulatory data management have been noted in several reviews of Australia's aged care quality regulatory system spanning more than 15 years^{270,271}.

Improving integration of the regulatory system: the new Aged Care Commission

The Productivity Commission proposed the establishment of an independent regulatory commission to consolidate quality regulatory functions. This Review supports that recommendation for a centralised organisation. However, we present a different model for the make-up and function of this organisation, which we propose should be called the **Aged Care Quality and Safety Commission (the Aged Care Commission)** to more clearly denote its purpose.

The principal objectives for centralising aged care quality functions under a single independent Commission are to:

- Provide more effective regulation of quality and safety
- Provide greater clarity around regulatory roles and responsibilities
- Improve real-time intelligence sharing
- Facilitate better information sharing with consumers
- Enhance the role for consumers in guiding regulatory processes.

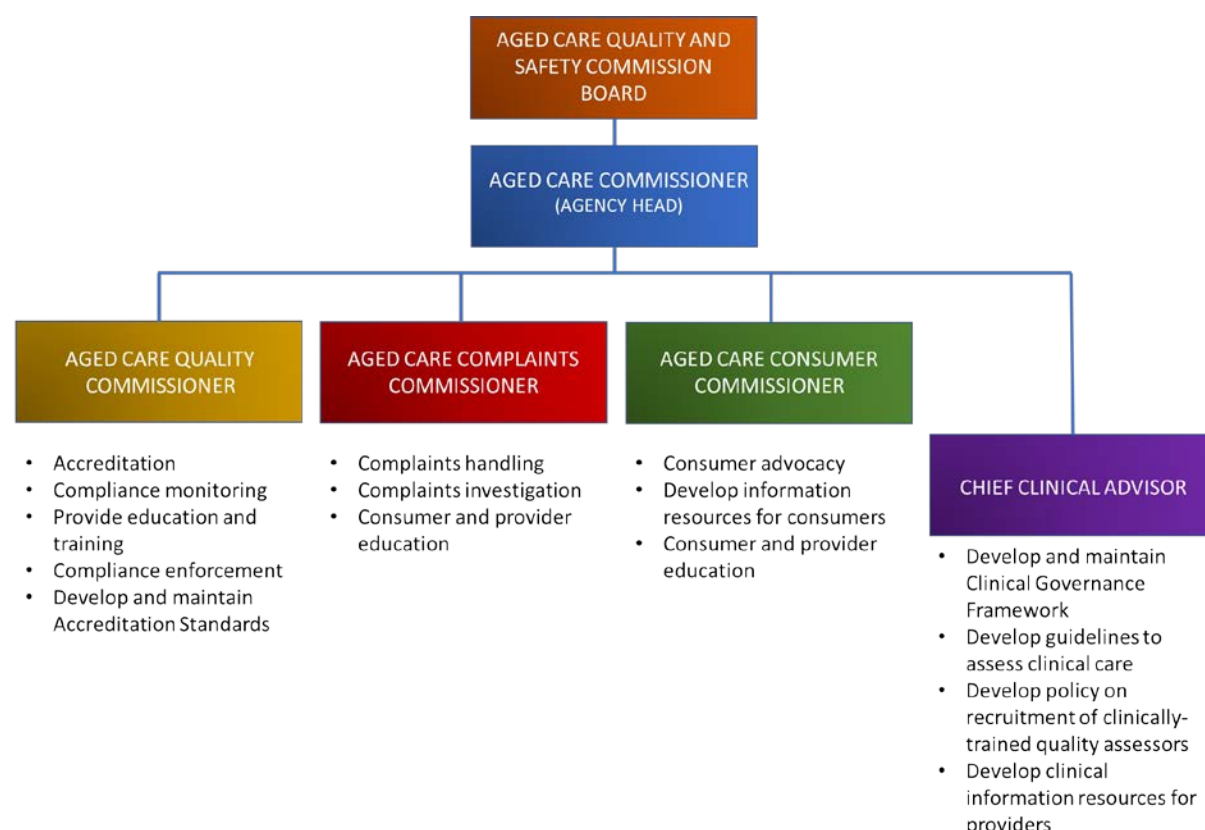
This chapter deals with the ways in which the design of regulatory governance arrangements for the Aged Care Commission can help achieve these objectives. The recommendations that follow in later chapters of this Report build on these arrangements and outline a vision for implementation of these guiding principles.

The proposed governance structure and function of the Commission is depicted in Figure 5.

²⁷⁰ ANAO, 2011, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*, Audit Report No.48 2010–11.

²⁷¹ Productivity Commission, 2011, *Caring for older Australians*.

Figure 5. Governance structure and functions of the Aged Care Quality and Safety Commission



The Aged Care Quality and Safety Commission Board

A board should be appointed by government to govern the Aged Care Commission and meet its responsibilities under legislation. The board should comprise individuals with relevant experience and skill sets drawn from health, aged care and disability services. The board will report to the Minister for Aged Care in relation to performance of the Commission's functions.

The Aged Care Commissioner

*The aged care system needs an overarching, independent, Aged Care Commissioner that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.*²⁷²

A new Aged Care Commissioner should be appointed to manage the day-to-day operation of the Commission and work with the other commissioners to ensure the effective stewardship of quality regulation and information sharing.

The Aged Care Commissioner will be responsible for core Commission functions and report directly to the board. This will include responsibility for corporate services that provide key operational support, including data management and technology services, strategic communications and media and human resource management.

²⁷² The Australian Medical Association submission (ID# 833514879).

It is further recommended that appeals against decisions made by the Aged Care Complaints Commissioner or the Aged Care Quality Commissioner be handled by the Aged Care Commissioner in the first instance. If the matter is not resolved to the satisfaction of the complainant, the matter could then be referred to the Administrative Appeals Tribunal.

The Aged Care Quality Commissioner

In accordance with the Productivity Commission's model, we recommend that the Quality Agency will become a statutory function within the Commission.

The newly designated Aged Care Quality Commissioner will oversee the functions currently managed by the Quality Agency, including:

- accreditation
- compliance monitoring
- delivery of training and education to support providers to understand their responsibilities under the Act
- development of information resources
- management and publication of data.

To simplify arrangements for compliance enforcement, it is recommended that the Department of Health's responsibility for imposing sanctions on providers determined to have breached the Standards be transferred to the new Aged Care Quality Commissioner. This makes that agency solely responsible for their enforcement. This approach streamlines the decision-making process and reduces confusion for providers.

The Aged Care Quality Commissioner will work closely with the Department, the Australian Commission on Safety and Quality in Health Care and other stakeholders to periodically review the Standards, outcome measures and assessment guidance material.

The Aged Care Complaints Commissioner

The Aged Care Complaints Commissioner will also become a statutory role within the Aged Care Commission. The current functions and independence of the Aged Care Complaints Commissioner would be retained under this model. However, we recommend increased powers, which are described in chapter nine.

The Aged Care Consumer Commissioner

*The community, the repository of our social values and our humanity [which is] so important in this sector, has been marginalised and has little input.*²⁷³

The *Aged Care Roadmap* places the consumer at the centre of care.²⁷⁴ To achieve this objective, consumers must have a direct role in shaping regulatory processes governing the care that they receive. While consumer representatives participate on advisory bodies, including the Aged Care Sector Committee and the Aged Care Quality Advisory Council, it is critical that consumers also have

²⁷³ Aged Care Crisis submission (ID# 341409579).

²⁷⁴ Aged Care Sector Committee, 2016, *Aged Care Roadmap*.

a voice on the Aged Care Commission to ensure that consumer perspectives help shape Commission policies and processes.

The Aged Care Consumer Commissioner will engage broadly with consumers, their families and carers, as well as consumer peak bodies and advocates, and feed this intelligence into operational policy and process design. This Commissioner will also work collaboratively with consumer groups to develop accessible, plain English information and educational resources, and help consumers understand quality regulation, provider responsibilities, consumer rights and how to exercise those rights.

Chief Clinical Advisor

Clinical care and clinical leadership is a vital component of services delivered in residential aged care facilities. The growing incidence of chronic disease and co-morbidities will only increase the demand on this role. In 2016, the majority (56.1 per cent) of people in permanent residential care were rated as having high care needs. Between 2009 and 2016, the proportion of high-care residents with complex health care needs rose from 13 per cent to 61 per cent.²⁷⁵ Continued growth in the incidence of mental disorders and diabetes within the community are likely to continue to place strain on limited clinical resources in nursing homes.²⁷⁶

Clinical care, including medication administration and management, remains the main source of complaints received by the Aged Care Complaints Commissioner.²⁷⁷ Issues with the quality of clinical care were also raised as core reasons for sanctions imposed against providers managing the Makk and McLeay wards at Oakden.²⁷⁸

It is proposed that the appointment of a Chief Clinical Advisor to the Aged Care Commission will provide clinical leadership, support the Commission to adapt its processes to better align with changes in clinical practice in aged care facilities, and collaborate with the Australian Commission on Safety and Quality in Health Care to improve alignment of clinical care practice with other health care settings.

The Chief Clinical Advisor will provide guidance on the development of clinical outcome measures and guidance material for accreditation. They will champion the development of a clinical governance framework for residential aged care facilities (described in detail in chapter eight) and provide information to nursing staff on best practice in clinical care. The Chief Clinical Advisor will also support the review of facilities found to be delivering ineffective or unsafe clinical care.

The role of the Department of Health

Under the recommended changes, the Department will retain responsibility for policy formulation, but will no longer have responsibility for imposing sanctions against providers failing to meet the Accreditation Standards.

²⁷⁵ Australian Institute of Health and Welfare 2017, GEN, <http://www.gen-agedcaredata.gov.au>, retrieved 7 September 2017.

²⁷⁶ Goss, J., 2008, *Projection of Australian health care expenditure by disease, 2003 to 2033*. Cat. No. HWE 43. Australian Institute of Health and Welfare.

²⁷⁷ Complaints Commissioner, Submission to the Senate Community Affairs References Committee; Aged Care Complaints Commissioner, *Annual report 2016–17*, p. 19.

²⁷⁸ Groves, A., et al., 2017, *The Oakden report*, South Australia Department for Health and Ageing.

The Department would continue to be responsible for granting providers approved provider status. While the Productivity Commission recommended transferring this function to the new Commission, we consider the approval process to be more of a prudential function. Given that the Australian Government acts as guarantor for bonds paid by residents to providers on entering residential care, it is appropriate that the Department retain the function of assessing the prudential risk posed by a new provider.

While the Review sees compelling arguments for transferring the control of price setting for subsidies to an independent authority, akin to the Independent Hospital Pricing Authority, this is outside the scope of this Review.

Recommendation 1. Establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling.

Actions

Establish an Aged Care Commissioner who chairs an umbrella regulatory body with:

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

An integrated data management system

Intelligence gathering and effective data management is critical to ensure that the regulatory system is responsive, both to support the mitigation of risk and to rapidly detect and address poor-quality care. According to the Australian National Audit Office (ANAO):

*The ultimate test of the regulatory framework is its ability to respond to issues in a timely and appropriately calibrated manner. Past incidents in the sector serve as a reminder of the potential impact of non-compliance on frail and elderly residents, and the importance of adopting a proactive and flexible approach to the administration of the framework, including the timely reporting and assessment of information collected by the Department and Agency staff.*²⁷⁹

The frequency of surveyor visits to a nursing home is based on the assessed risk of provider non-compliance. This approach is in line with the Organisation for Economic Co-operation and Development's (OECD) Best Practice Principles for Improving Regulatory Enforcement and Inspections,²⁸⁰ which note that:

²⁷⁹ ANAO, 2011, *Monitoring and compliance arrangements supporting quality of care in residential aged care homes*. Audit report No.48 2010–11.

²⁸⁰ OECD, 2014, *Regulatory enforcement and inspections, OECD best practice principles for regulatory policy*, OECD Publishing.

Enforcement needs to be risk-based and proportionate: the frequency of inspections and the resources employed should be proportional to the level of risk and enforcement actions should be aiming at reducing the actual risk posed by infractions.

Information systems and data management are critical to underpin this risk-based approach to resource allocation. The OECD also notes that:

Information technology is essential in order to achieve major effectiveness and efficiency improvements in regulatory enforcement and inspections. It is the indispensable basis for risk-based planning, and for effective co-ordination of inspections. At the same time, if there is no comprehensive view of the information system across all types of inspections, the result can be duplicated expenses and work, incompatible systems, lack of information sharing. To ensure that information technology can deliver its full benefits, governments should develop and adopt a coherent vision of the development of information systems in enforcement and inspections – this vision should aim at ensuring co-ordination and data sharing.

We consider that this comprehensive vision of data management is currently missing in aged care quality regulation in Australia.

The Quality Agency draws on various intelligence to support risk-based profiling of providers. This information falls into two broad categories:

- (a) Prospective risk indicators—factors that the Quality Agency finds through analysis of compliance data are frequently associated with provider non-compliance. These risk indicators include the loss of key personnel at a nursing home, changes in management, relocation of premises, and sudden changes in the complexity of care that the service manages. The Quality Agency uses such information to predict the likelihood of non-compliance and allocates resources accordingly.
- (b) Performance data—information on the actual quality of care delivered by a provider, which may include information gained from site visits, provider non-compliance history, complaints and incident referrals, and experiences of care reported by consumers, their families, carers, and staff at nursing homes.

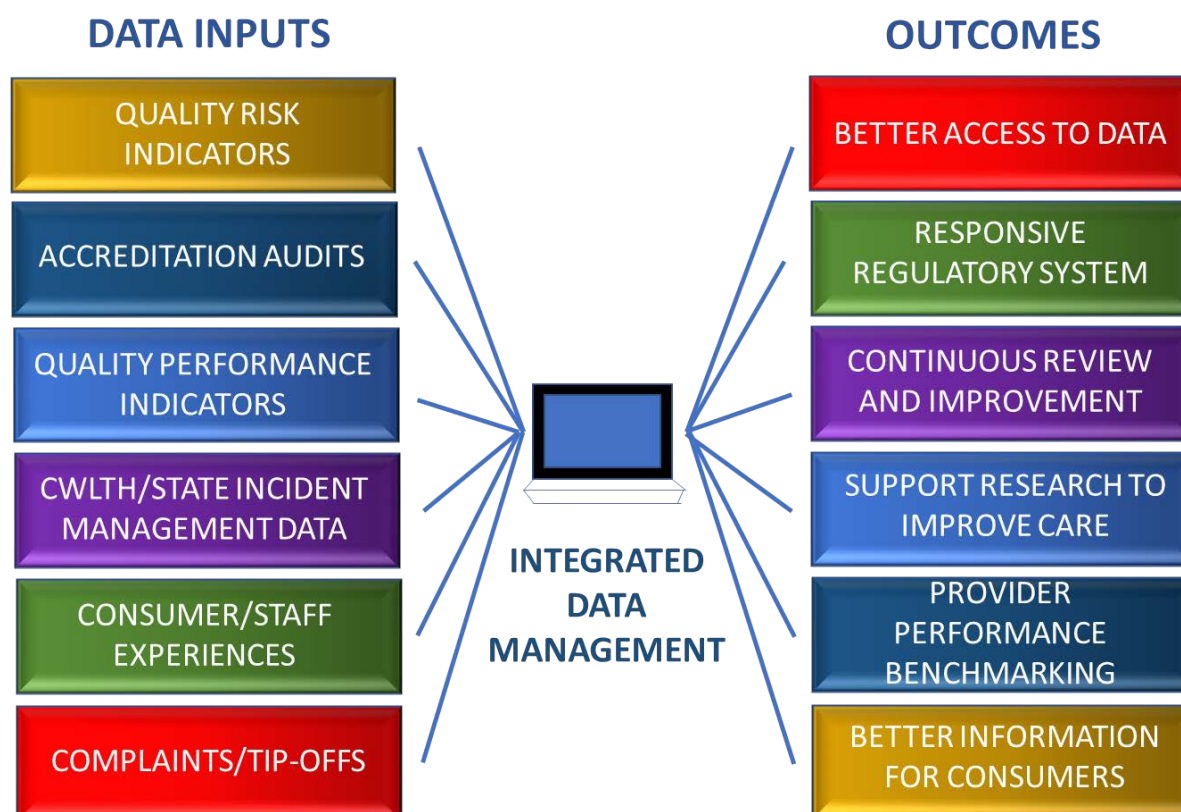
What are the problems with the current approach?

In our view, for aged care quality regulation to function effectively, data management must reflect the following principles:

- Timely access to quality data from all relevant sources
- Effective processes for data analysis to guide regulatory policy and processes
- Ongoing evaluation of the effectiveness of data management
- Refinement of data management
- Transparency of regulatory performance

Figure 6 depicts key data inputs and outcomes for effective management of aged care quality regulatory data.

Figure 6. Data inputs and outcomes for management of aged care quality data



It became clear during this Review that the current approach to data management fails to meet these objectives. This undermines risk-based profiling, compliance monitoring, continuous quality improvement and consumer choice. For the benefits of the new Aged Care Commission to be realised, the current deficiencies in data management outlined below must be addressed.

Poor integration of data

Despite the importance of ongoing data sharing by regulators with co-dependent functions, there is currently no connectivity between the databases used by the Department, the Quality Agency and the Complaints Commissioner. Ironically, the Department and the Complaints Commissioner both use the National Complaints and Compliance Information Management System database, yet neither agency can access the data held by the other. The Quality Agency uses different systems.

The ANAO noted in its 2011 review of monitoring and compliance arrangements,²⁸¹ that the Department's National Approved Provider system does not directly interface with the Quality Agency's Better Business Program system. Consequently, data on key risk indicators, such as changes to key personnel in residential aged care homes, are relayed manually by the Department. The ANAO noted that this increased the risk of the system not being updated with the new information.

²⁸¹ ANAO, 2011, *Monitoring and compliance arrangements supporting quality of care in residential aged care homes*. Audit report No.48 2010–11.

Criteria for transmittal of information among the agencies mean that only a fraction of the data collected by each one is available to the other regulators. Between July 2016 and June 2017, less than 15 per cent of complaints received by the Complaints Commissioner were relayed to the Quality Agency.²⁸² While many complaints may not be directly relevant to the Quality Agency or warrant further investigation, collectively they may paint a picture of emerging issues in the care delivered at a facility, which may guide surveyor investigation.

Likewise, more detailed information on issues identified during site visits by the Quality Agency may inform decisions by the Complaints Commissioner on whether subsequent complaints on related aspects of care merit further investigation.

Poor communication between Commonwealth and state and territory agencies

As described in chapter three, the tragic incidents at Oakden are partly attributable to the lack of formalised communication processes between the Commonwealth and state and territory agencies responsible for the management and oversight of aged care facilities in their jurisdictions.

Serious complaints about medication mismanagement and unexplained bruising on a resident at Oakden were raised with the Principal Community Visitor²⁸³ in June 2016 and then with Northern Adelaide Local Health Network (NALHN). This led the CEO of NALHN to request South Australia's Chief Psychiatrist to undertake an extensive review of clinical care within the Oakden facility in December 2016 and appoint a senior nurse manager on 9 January 2017 to oversee delivery of clinical care. Inexplicably, the Commonwealth aged care quality regulators were not advised of these issues and instead found out about them through a media report on 18 January 2017.

The Department and the Complaints Commissioner are the only agencies with which the Quality Agency has formalised communication arrangements, greatly limiting information sharing with Commonwealth, state and territory agencies that regulate or monitor other aspects of service delivery in residential aged care homes relevant to quality of care. This includes state- and territory-operated mental health visitor schemes and the managers of multi-purpose facilities.²⁸⁴

There is also an untapped capacity for private and state-based health professionals to report suspicions of poor care to Commonwealth regulators for further investigation. A study published in 2014 revealed that 11 out of 12 Newcastle residential aged care homes reported greater than 50 hospital transfers for every 100 residents each year.²⁸⁵ This significant interface with medical professionals could provide valuable information to the Commission on possible inappropriate care.

Inefficient processes for gauging consumer, family and staff views on care

A number of submissions to the Review commented on the importance of relevant, timely and transparent reporting of consumer experiences to assist consumers to make appropriate choices and effect cultural change. In its submission, COTA Australia said:

²⁸² Complaints Commissioner, *Annual report 2016-17*, p 24 – 468 referrals to the Quality Agency. Note that some referrals are likely to be of complaints received in 2015-16.

²⁸³ Groves, A., et al., 2017, *The Oakden report*, South Australia Department for Health and Ageing, p. 77.

²⁸⁴ Multi-purpose facilities include nursing homes that are co-located with hospitals. This arrangement is more common in regional and remote areas and are frequently publicly-operated.

²⁸⁵ Arendts, G., Howard, K., 2010, 'The interface between residential aged care and the emergency department: a systematic review'. *Age and Ageing*, Vol. 39(3), pp. 306–312.

*COTA believes that for consumer experience reports to be effective, an annualised collection of views should occur. Three years old views about a facility do not provide the relevant transparency of consumer experience required to effect cultural change or assist consumers make choices between facilities.*²⁸⁶

The perspectives on care shared by consumers, family and aged care staff through interviews with quality surveyors during site audits are an important source of information of areas for provider improvement. The collection of this information only during three-yearly accreditation audits reduces the currency of this intelligence and its value to risk profiling.

Current approaches to gathering this information also limit its value. As discussed further in chapters seven and nine, many consumers, family members and staff noted that fear of retribution is a deterrent to raising criticisms of provider performance with surveyors during site visits.²⁸⁷ Furthermore, since only 10 per cent of consumers, their family and representatives are interviewed during site visits, key information may be missed.

Ineffective risk profiling of providers

In the wake of the Groves report, the Quality Agency commissioned the Nous Group to provide independent advice on opportunities to improve its approaches and processes. The Nous Group found significant issues with the Quality Agency's approach to risk profiling. The report noted that "there was an expectation (by the Quality Agency staff and providers' staff) that all Expected Outcomes would be met at accreditation audits".²⁸⁸ The key findings were that:

- The accreditation process for the Makk and McLeay wards at Oakden did not allow the earlier history of the facility to be understood and applied to the assessment of risk and compliance monitoring. The Quality Agency did not consider the inherent risk of the Makk and McLeay wards as part of a facility for residents with highly complex mental health support needs and severe behavioural symptoms.
- The various visits to Makk and McLeay wards identifying issues did not result in a decision to escalate to a review audit. The review audit in 2017 was triggered by external information.
- As noted in chapter four, the Quality Agency's risk framework, including its risk assessment approach, does not sufficiently differentiate the risk profiles of facilities the Quality Agency accredits and monitors, or adequately guide the required levels of resource allocation.

We agree that improvement of the Quality Agency's risk-profiling methods is critical to ensuring that regulatory compliance is more responsive and can better anticipate issues with high-risk facilities such as Oakden. We identify additional weakness in the Quality Agency's risk-profiling strategy, as described in Box 3.

²⁸⁶ COTA Australia submission (ID#743548634).

²⁸⁷ Submissions (ID#459100113) and (ID#591055944).

²⁸⁸ The Nous Group, External independent advice: Australian Aged Care Quality Agency (2017).

Box 3. Weaknesses in the existing risk-profiling strategy

Findings	Description
Delayed access to risk indicator data	Many of the prospective risk indicators used by the Quality Agency to profile provider risk and allocate support are not regularly reported by providers. Instead, the Quality Agency collects these data largely through site visits to facilities, which can in some instances be almost two years apart. This greatly limits the capacity of the Quality Agency to prospectively identify providers at risk of non-compliance.
Limited consideration of the value of individual risk factors during risk profiling	The Quality Agency does not weight individual risk factors in its risk assessment of provider non-compliance based on the reliability of each indicator's association with provider non-compliance. Likewise, there is no mechanism for assessing the relative importance of specific indicators as prognostic markers of more serious non-compliance. This may reduce the reliability of risk profiles.
Insufficient use of complaints data	Only a small proportion of complaints are transmitted to the Quality Agency, limiting its ability to identify trends that may signal a need for further investigation.
Insufficient differentiation of the risk posed by providers	The Quality Agency currently rates provider risk according to three rating levels. This is insufficient to effectively support regulatory resource allocation.
A lack of transparency around processes for review of the risk profiling methodology	Processes for ongoing analysis of the effectiveness of risk indicators and the risk-profiling methods are not described and the results of reviews are not published.
Limited information available to providers about risk indicators and strategies for addressing them	While the Quality Agency provides some information to providers during site visits, limited data are available on the association of risk indicators with non-compliance, and limited information on how providers can address these risks as they arise.

Poor accountability of regulatory performance

In his submission²⁸⁹ to the Review, Professor Joe Ibrahim noted:

There is a paucity of empirical research into [residential aged care facilities], regulatory mechanisms and quality of care. This is related to a number of factors: a lack of dedicated funding to support research into quality of care in RACFs; the small number of researchers or academics engaged in the field and; restricted access to, as well as high costs in obtaining data essential to this type of research.

Research and data are critical both to assess the performance of the regulatory system and to identify emerging issues in care that warrant greater focus from regulators. While the proportion of residential aged care homes found to comply with all 44 outcome measures has increased steadily since 2000, this statistic does not give a clear impression of the quality of care delivered. Moreover,

²⁸⁹ Professor Joe Ibrahim submission to the Senate Community Affairs References Committee.

the high compliance rate makes it difficult to ascertain what areas of care should be improved. Complaints data plays a vital role in identifying issues, but is inevitably subjective and may provide an incomplete view of issues with care.

We see the value in using regulatory data to assess regulatory performance. We consider that data from other sources, including independent, peer-reviewed research, is essential to ensure that regulators are accountable and that findings on their performance are contestable.

The OECD noted:

*The reliability of the data used is of particular importance. As a rule, data that is directly the result of an agency's processes (e.g. number of prosecutions or sanctions, which is a number the agency can directly influence based on changes in enforcement policy) should never be used to assess compliance levels, because it is by no means "independent" data, and it creates negative incentives.*²⁹⁰

We did not find any formalised processes for capture of independent research findings in compliance process review and re-design. The application of research data to inform regulatory practice is covered in more detail in chapters five and eight.

Poor transparency of performance data

Data on performance is critical to enable providers to better understand how they perform relative to similar services, and to understand what aspects of their service they deliver effectively and what needs to be improved.

Publishing performance data also assists consumers to understand the quality of available services and exercise choice. This in turn drives competition between providers, which can improve care quality.

Currently, very little performance data is published. Improving the quality of published performance data is an important consideration of this Review and is dealt with in detail chapter six.

Improving information gathering and analysis

Improving the capture, management and publication of data is a core theme of this Report. We recommend changes that will improve the collection and use of data by the new Aged Care Commission, with processes for sharing that data outlined in subsequent sections.

Improve access to data

We recommend establishing a shared database for management of all data on accreditation, compliance and complaints handled by the new Aged Care Commission. This will give access to a broader set of data on other regulatory functions to inform the work of the Complaints Commissioner and the Quality Commissioner. The database will also be a repository for data obtained from other sources including consumer experience reports, intelligence from state and territory government agencies, reportable assaults, and other mandatory reporting data.

²⁹⁰ OECD, 2014, *Regulatory enforcement and inspections, OECD best practice principles for regulatory policy*, OECD Publishing.

Consideration should be given to the development of automated systems to better manage the larger dataset and raise ‘red flags’ to draw regulators’ attention to changes in providers’ circumstances that warrant further investigation.

Communication with state / territory government agencies

There is a clear need for better communication between the Commonwealth and state and territory government agencies for timely notification of incidents occurring in Commonwealth-funded nursing homes. State and territory governments have systems that collect data and report on patient incidents and complaints in state-operated health services. Some of these systems track investigation of these matters and record any outcomes reached. This information could provide the new Aged Care Commission with early warning of concerns with care delivered in public residential aged care homes.

There is also solid justification for establishing formalised reporting arrangements with local hospital networks that manage care in state-operated nursing homes, multi-purpose facilities and specialised care facilities, and with managers of the state-based mental health visitors schemes.

The Review suggests that the Australian Government refer these matters for consideration to the Australian Health Ministers’ Advisory Council.

Intelligence gathering from consumers, families and aged care staff

The Nous report noted that the Quality Agency depends largely on external sources of information to provide an indication that poor care is delivered in a nursing home.²⁹¹

We recommend that the Quality Agency launch the consumer experience report questionnaire online so that consumers, their families and carers can provide information year round. Furthermore, online surveys should be developed for staff to provide similar feedback on residential aged care home performance. This will help to address the existing sporadic engagement with these stakeholders through the accreditation process. It is further proposed that the new Aged Care Commission and advocacy groups provide education on the new instrument, to support better engagement.

These surveys should complement, rather than replace, interviews with consumers, families and staff. However, consideration should be given to conducting interviews by phone, off-site meetings or email, where practical, to address the significant concerns raised in submissions to this Review about fear of retribution for adverse comments.

We also recommend that engagement with informants be increased with interviews being conducted with 20 per cent of consumers or their representatives, to ensure a more representative sampling of views and experiences.

Develop a more responsive regulatory system

The Nous report proposed several changes to the Quality Agency’s approach to profiling the risk posed by providers of non-compliance. The recommendations relating to risk profiling are described in Box 4.²⁹²

²⁹¹ The Nous Group, External independent advice: Australian Aged Care Quality Agency (2017).

Box 4. Changes proposed by the Nous Group to Quality Agency risk-profiling processes

- Revise the risk framework to ensure the assessment of higher-risk services and the more extensive capture of information from sources of key indicators of risk are used to inform case management, visit planning and resource allocation
- Identify services that are inherently higher risk or have an ongoing history of issues to consider how these should be monitored under case management, including a watch list of high-risk facilities
- Expand the case management to monitor high-risk services
- Revise the existing risk framework, and re-design policies and procedures to improve the identification and management of higher-risk facilities and to address the specific risks in different types of services. Under the strengthened risk-based model, more frequent compliance monitoring and targeted approaches would be applied to higher-risk facilities than those with low risk. The risk framework should provide the Quality Agency:
 - (i) Revised risk stratification model that identifies the characteristics of low, medium and high-risk facilities
 - (ii) Process for determining the causes behind any significant change in compliance status (e.g. from many 'not met' expected outcomes to none in a short timeframe)
 - (iii) Process for a compliance monitoring watch list for the highest risk facilities, whether or not they have non-compliances recorded
 - (iv) Process for tailoring the audit plan to address specific risks relating to certain services and applying to site visits for high-risk facilities, and ideally all services.
- Regularly review the regulatory performance of the Quality Agency to ensure that the risk stratification of services, compliance outcomes of diverse types of audits, emerging sector risks and quality improvements in the sector are correlated. This would involve regulator analysis of facilities that have regular or significant non-compliance with the Accreditation Standards or determination of 'Serious Risk' findings to identify trends or common characteristics.
- Develop and resource a more established approach to external intelligence gathering on services including determining arrangements to support the better exchange of information in services where multiple parties are involved in regulation and quality monitoring to ensure pertinent information is shared and reduce unnecessary regulation burden.

We endorse these recommendations. In addition to the changes to data capture and integration recommended above, we propose that the following actions be taken to increase the effectiveness of risk profiling:

- Providers should be required to update information on key risk indicators whenever their circumstances warrant reporting this information to ensure that risk profiles are current and accurate.
- Risk indicators should be weighted to reflect their reliability as markers of non-compliance.

²⁹² The Nous Group, External independent advice: Australian Aged Care Quality Agency (2017).

- There should be more extensive use of complaints data to gauge emerging issues with the quality of care in residential aged care homes.
- The levels of the risk rating scale used to assess provider risk of non-compliance should be increased from three to at least five to ensure that high-risk providers are more clearly differentiated and compliance monitoring is appropriately stratified.
- The processes for ongoing evaluation of the effectiveness of risk profiling and individual risk indicators should be published.
- The Aged Care Commission should publish information on the relationship between risk indicators and non-compliance, ongoing performance of risk profiling, and strategies to help providers address risks as they arise.

In our view, a strengthened risk profiling methodology is critical to improving the responsiveness of the regulatory system to emerging issues with care quality. Chapter 8 explores how this tool can be used to assign regulatory resources where they are most needed.

Continuous review and improvement

The Review recommends that the Aged Care Commission develop and publish information on more rigorous processes for reviewing regulatory performance. It should include an explanation of how information obtained from performance reviews and acquired from other sources is used to refine regulatory processes.

While trends in compliance and provider satisfaction are important and should form part of this process, the Aged Care Commission should use external data to contextualise and validate assumptions made about the effectiveness of regulation drawn from internal process statistics. This more expansive appraisal should be published.

There is a key role for independent research to inform this review process. Despite the high compliance rates reported by the Quality Agency, peer-reviewed literature reveals several concerning aspects of residential aged care that require greater focus.²⁹³ The Commission should provide greater clarity around how issues with care quality identified through academic studies guide compliance and education activities.

Research on the quality of residential aged care faces many barriers, principally the lack of targeted funding and access to regulatory data. A review of the literature and information indicated that investment in aged care research is limited to a few areas, notably including neurodegenerative disorders and population-based studies. The Review recommends that additional funding be allocated to support research into quality of care in residential aged care, including clinical and quality-of-life determinants of care.

We also recommend that the integrated regulatory data management system proposed in this chapter be designed to provide researchers with better access to de-identified data. Consideration should be given to how these data can be linked to datasets held by the Department, including data on aged care subsidies.

²⁹³ Morphet et al., 2014, 'Shortfalls in residents' transfer documentation: Challenges for emergency department staff' *Australasian Emergency Nursing Journal*, Vol. 17, pp. 98-105; Somers M. et al., 2010, 'Quality use of medicines in residential aged care', *Aust. Fam Physician*, Vol. 39: pp. 413-6.

Recommendation 2. The Aged Care Commission will develop and manage a centralised database for real-time information sharing.

Actions

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

Chapter 6: Better information on quality for consumers and providers

The *Living Longer, Living Better* reforms were designed to ensure that aged care service delivery was focused on consumer needs and preferences. The *Aged Care Roadmap*, developed by the Aged Care Sector Committee in 2016, proposed that as the market matured, consumer expectations of care would drive quality improvement, enabling a commensurate relaxation of regulation.

However, one of the most fundamental underpinnings of a more consumer-focused aged care market—access to quality information on provider performance—is largely absent in Australian aged care. This is despite the clearly established relationship between the public availability of quality information and consumer welfare.²⁹⁴

We appreciate that addressing these issues is not a simple matter. For example, there is misunderstanding about the uses and limitations of quality indicators and significant risk in using small sets of indicators to guide consumer choice and performance improvement. This chapter discusses issues with collecting and sharing performance data and proposes a more nuanced approach to data sharing that better addresses the objectives described above.

Evidence-based quality indicators

Objective measures of care quality in Australian nursing homes are lacking. We recognise that quality of care is complex to define, encompassing an array of different aspects of service provision and consumer perspectives on the care that they experience. Establishing measures that adequately address this complexity is challenging and, as outlined in chapter four, much attention has been focused on the development and use of quality indicators in other countries.

Due to the narrow focus of individual quality indicators, suites of indicators are required for a complete picture of the factors that may contribute to a problem in care quality. The aim of quality indicator sets is therefore to identify the aspects of care that can benefit from improvement of the care process and to define performance of individual providers.²⁹⁵

Leading quality of health care researcher Donabedian defines three dimensions of care quality indicators:²⁹⁶

- structure—the context in which care is delivered, including buildings, staff, financing, and equipment (e.g. staffing levels)
- process—the processes of care (e.g. how many medication reviews are conducted)

²⁹⁴ Akerlof, G., 1970, 'The Market for "Lemons": Quality Uncertainty and the Market Mechanism', *The Quarterly Journal of Economics*, Vol. 84(3), pp. 488-500.

²⁹⁵ Frijters, D. et al., 2013, 'The calculation of quality indicators for long term care facilities in 8 countries (SHELTER project)', *BMC Health Services Research*, Vol.13, p. 138.

²⁹⁶ Donabedian, A., 1988, 'The quality of care: How can it be assessed?', *JAMA*, Vol. 260 (12), pp. 1743-8.

- outcomes—the impact of care on patients / residents (e.g. prevalence of dehydration among residents).

While outcome measures are desirable because they measure the actual impact of care on residents, there has been a tendency for health and aged care to focus on the use of process-based quality indicators because they are comparatively easy to measure.

There has also been a tendency for clinical quality indicators to be adopted over quality-of-life indicators, despite the latter being more meaningful to many residents. The inherent complexity of defining care quality may explain why regulators focus on “tangible, material, quantifiable components and overlook the more subjective aspects of service life or ‘what it’s like’ to live in a service”.²⁹⁷ One study demonstrated an association between provider performance against clinical quality indicators, including hydration, falls and depression, and resident perceptions of quality of life.²⁹⁸

The US experience with quality indicators

As chapter four outlined, a number of countries have implemented quality indicators to measure care quality in aged care, but the approach is generally in its infancy. Information on the value of quality indicators in aged care is largely drawn from the US, which has almost 16 years’ experience with nursing home quality indicators.

In the US, long-stay nursing home performance against 13 quality indicators is publicly reported on the Nursing Home Compare website. Performance information is drawn from routine data collected at regular intervals through the minimum data set.²⁹⁹

Much interest in the US experience with quality indicators has centred around whether reporting performance measures impacts on care outcomes. Research across nine nursing homes in Mississippi showed a significant impact on resident outcomes and the nursing process through the introduction of 15 clinical care quality indicators.³⁰⁰ One study also showed that the actions taken by nursing home administrators in response to publication of quality indicators resulted in improvement in two of five measures assessed.³⁰¹ Another study reported that nursing homes made small improvements in their quality measure scores.³⁰²

²⁹⁷ Marquis, R., 2002, ‘Quality in Aged Care: A Question of Relational Ethics?’, *Australasian Journal on Ageing*, Vol. 21(1), pp. 25–9.

²⁹⁸ Courtney et al., 2009, ‘Measuring and supporting quality of life’, In Nay, R. & Garratt, S. (eds), *Older People: Issues and Innovations in Care*, Elsevier, pp. 351–371.

²⁹⁹ Nursing home quality measure resource manual. New England Quality Innovation Network. http://www.healthcarefornewengland.org/wp-content/uploads/QM-ManualV1-4_042815.pdf

³⁰⁰ Fitzgerald, Shiverick B.N., Zimmerman, D., 1996, ‘Applying performance measures to long-term care’, *Jt Comm J Qual Improv*, Vol. 22(7), pp. 505–517.

³⁰¹ Mukamel, D. et al., 2008, ‘Publication of Quality Report Cards and Trends in Reported Quality Measures in Nursing Homes’, *Health Serv. Res*, Vol. 43(4), pp. 1244–62.

³⁰² Castle N.G., Liu D., Engberg J., 2008, ‘The association of Nursing Home Compare quality measures with market competition and occupancy rates’, *Journal of Healthcare Quality*, Vol. 20(2), pp. 4–14.

However, several studies failed to detect significant improvement in care associated with the collection of quality indicator data. The reasons for variation in the impact of quality indicators are explored in more detail below.

Quality indicators in Australian aged care homes

In Australia, there has also been strong consensus support for the implementation of quality indicators to measure aged care quality and to gauge the performance of quality regulation. Several critical national reports³⁰³ and policy documents³⁰⁴ have recommend the adoption of quality indicators. There was also support for their adoption in submissions to this Review.

Alzheimer's Australia submitted:³⁰⁵

Quality indicators should be published on the 'My Aged Care' website and should include relevant information to aid informed decision-making about use of restraint, psychotropic medications as well as information about staffing and skills mix.

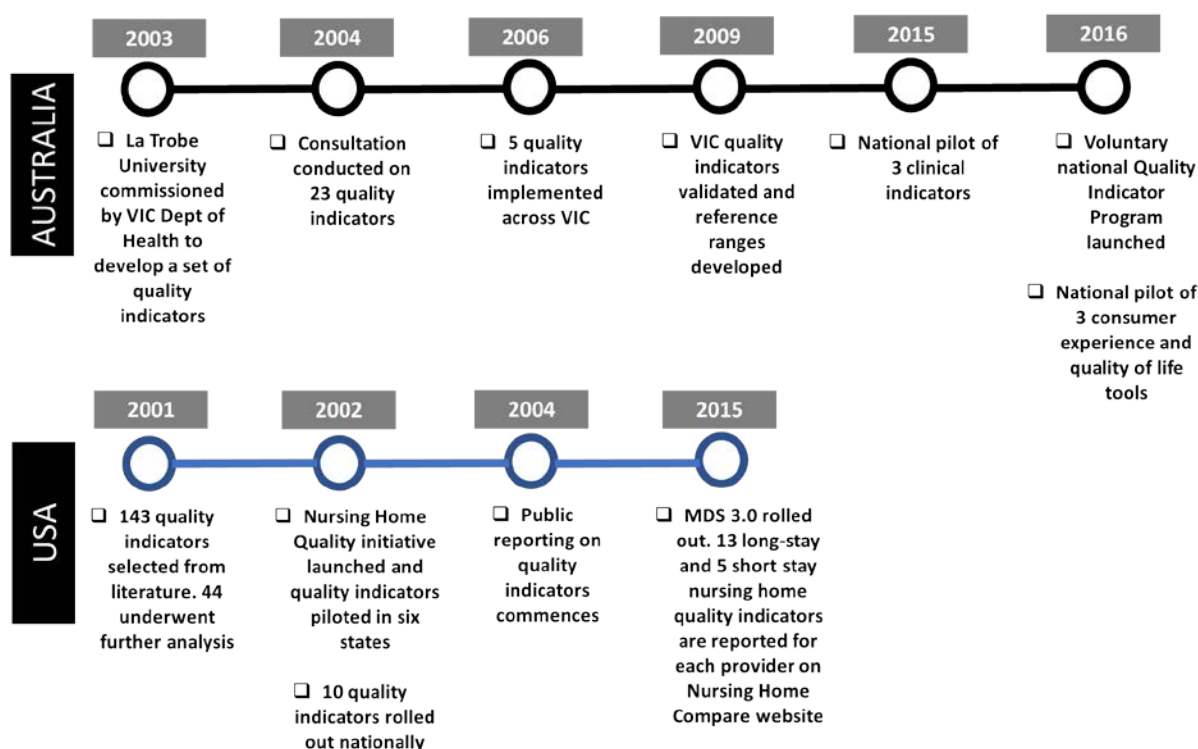
Yet progress on the adoption of quality indicators nationally in Australia has been slow, relative to the US (Figure 7).

³⁰³ Campbell Research & Consulting and Department of Health, 2007, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes*; ANAO, 2011, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*, Audit Report No.48 2010–11, p. 32; Productivity Commission, 2011, *Caring for Older Australians*.

³⁰⁴ National Aged Care Alliance, 2012, *Blueprint for Aged Care Reform*; Aged Care Sector Committee, 2016, *Aged Care Roadmap*.

³⁰⁵ Alzheimer's Australia submission (ID#11395657).

Figure 7. Adoption of quality care indicators in Australia vs the US



In 2016, the Department commissioned KPMG to pilot three consumer experience and quality-of-life tools. The trial enrolled 290 nursing homes and received 1,732 consumer responses.³⁰⁶

KPMG's report noted that while the tools were validated, it will take some years before use of the preferred tool will be adequately implemented in the sector. This delay results from the need to identify factors that may influence quality indicator measurements (e.g. variation in care complexity), adjust for these influences, and develop reference thresholds for benchmarking.

A handful of studies paint an encouraging picture of the use of quality indicators in Australia. For example, a survey of residents and staff of public nursing homes in Victoria in 2010–11³⁰⁷ found that:

- residents perceived improvement in care, safety and outcomes when a more proactive approach was taken by the provider
- managers and staff observed improvements in awareness of clinical risk factors and staff skills, increased awareness of the importance of risk assessments, perceived improvements in quality of care and a more holistic approach to care.

Another study illustrated the capacity for performance benchmarking against a panel of quality indicators to identify issues with care quality. The study, benchmarking providers on 23 quality

³⁰⁶ KPMG, 2017, Department of Health – key findings and outcomes – National Aged Care Quality Indicator Program – consumer experience and quality of life pilot outcomes for residential care.

³⁰⁷ Balding, C. and Ibrahim, J., 2009, *Quality in Public Sector Residential aged care: Where to from here?* Integrated Quality Projects report, Victorian Department of Health.

indicators for 107 residents in four Brisbane nursing homes, found that 60 per cent of residents assessed in one facility showed signs of dehydration.³⁰⁸

Barriers to the effective application of quality indicators

Research has identified a number of issues that will need to be addressed to ensure the effectiveness of quality indicators in residential aged care in Australia.

A key determinant of the impact of performance measurement is the attitude of aged care home management and staff to quality improvement. Several factors are relevant to this, including:

- providers and staff see the benefits of the quality indicators that they measure³⁰⁹
- aged care homes take a proactive approach to innovation and teamwork³¹⁰
- facility administrators must not dismiss poor-quality indicator scores.³¹¹

Other factors that have been shown to influence the responsiveness of providers to issues identified in care are:

- Competition between providers in a local area has been shown to be a strong driver for aged care homes to improve their performance following publication of quality indicators.³¹²
- Poor understanding of quality indicators or how to address poor performance can also influence providers' responsiveness to quality indicator outcomes. Studies have demonstrated that expert clinical support can help underperforming facilities achieve improvement against quality indicators.³¹³

Technical issues with collecting and reporting quality indicators

A number of difficulties complicate the collection and application of performance data. They need to be addressed to ensure that the performance data accurately reflects the care being delivered by a provider. For example:

- Quality indicator scores are sensitive to a variety of external factors, including the complexity of resident care needs and demographic factors, making risk adjustment and benchmarking difficult.
- Collecting data on some quality indicators can be time-consuming for aged care home staff. The tendency to select quality indicators that make use of existing data, or require minimal time to collect, can limit the range and value of quality indicators.

³⁰⁸ Courtney M., et al., 2010, 'Benchmarking clinical indicators of quality for Australian residential aged care facilities', *Australian Health Review*, Vol. 34, pp. 93–100.

³⁰⁹ Mannion, R., and Goddard, M., 2001, 'Impact of published clinical outcomes data: case study in NHS hospital trusts', *BMJ*, Vol. 323, pp. 260–263.

³¹⁰ Berlowitz, D., et al., 2003, 'Quality improvement implementation in the nursing home', *Health Services Research* Vol. 38(1), pp. 65–83.

³¹¹ Popejoy L., et al., 2000, 'Improving quality of care in nursing facilities. Gerontological clinical nurse specialist as research nurse consultant', *Journal of Gerontology Nursing*, Vol. 26(4), pp. 6–13.

³¹² Castle, N.G., Liu, D., Engberg, J., 2008, 'The association of Nursing Home Compare quality measures with market competition and occupancy rates', *Journal of Healthcare Quality*, Vol. 20(2), pp. 4–14.

³¹³ Rantz, M., et al., 2001, 'Randomized clinical trial of a quality improvement intervention in nursing homes', *Gerontologist*, Vol. 41(4), pp. 525–538.

- Interpreting quality indicators can be complicated and occasionally the outcomes can be counter-intuitive. It was observed in the US, for example, that rather than reflecting poor quality, a high prevalence of pain recorded among aged care home residents was associated with better pain assessment and treatment care processes.³¹⁴
- Data reliability may be questionable due to reporting errors, as well as poor understanding among staff of quality indicators and how data is to be collected.³¹⁵

Insufficient quality indicators in use in Australia

The suite of three clinical quality indicators available through the National Quality Indicator Program, described in chapter two, is inadequate to provide an accurate assessment of care quality. As discussed previously, individual clinical indicators examining specific elements of care provide limited insight into the quality of aged care, with its complex intersection of clinical and psychosocial requirements. Several commentators have noted the importance of using larger numbers of measures to assess quality, given the inherent complexity of this subject.³¹⁶

Over-reliance on a small set of quality indicators can create unintended problems that undermine performance measurement. Some providers may seek to fix the aspects of service that are reported, but not address broader issues with service quality that quality indicators are intended to identify. This phenomenon was observed with the UK National Health Service Performance Assessment Framework.³¹⁷ There is also a risk that focusing on a small number of quality indicators may inadvertently result in providers being selective about which residents they accept into a nursing home.³¹⁸

There is a risk that providing a narrow snapshot of provider performance may misrepresent the standard of care delivered in an aged care home. A US study benchmarking the performance of 92 homes against 23 quality indicators found that no facility had quality indicator scores consistently in the good, average or poor ranges, for all indicators assessed. Moreover, the study found inherent instability in provider performance against quality indicators, with only 45 per cent of facilities classified into the same group using two consecutive, six-month periods.³¹⁹ This means that sampling bias with a smaller number of quality indicators may portray a false impression of provider performance.

³¹⁴ Cadogan, M., et al., 2004, 'A minimum data set prevalence of pain quality indicator: is it accurate and does it reflect differences in care processes?' *J Gerontol A Biol Sci Med Sci*, Vol. 59(3), pp. 281–285.

³¹⁵ KPMG, March 2016, *National Aged Care Quality Indicator Program—residential care pilot outcomes*.

³¹⁶ Zimmerman D., et al., 1995, 'Development and testing of nursing home quality indicators', *Health Care Financial Review*, Vol. 16, pp. 107–127; Sainfort, F., Ramsay, J., Monato, H., 1995, 'Conceptual and methodological sources of variation in the measurement of nursing facility quality: an evaluation of 24 models and an empirical study', *Med Care Res Review*, Vol. 52, pp. 60–87; Spector, W., Mukamel, D., 1998, 'Using outcomes to make inferences about nursing home quality', *Eval Health Prof.*, Vol. 21, pp. 291–315.

³¹⁷ Bevan, G., Hood, C., 2006, 'What's measured is what matters: Targets and gaming in the English public health care system' *Public Administration*, Vol. 84(3), pp. 517–538.

³¹⁸ Mor, V., 2005, 'Improving the quality of long-term care with better information', *The Milbank Quarterly*, Vol. 83(3), pp. 333–364.

³¹⁹ Rantz, M., et al., 2004, 'Stability and sensitivity of nursing home quality indicators', *Journal of Gerontology*, Vol. 59A(1), pp. 79–82.

Improving the measurement of provider performance

The development of a robust set of objective quality indicators should be a priority for future reform activity.

We note the lack of clarity around the intended scale of the National Quality Indicator Program and the timeframe for benchmarking and public reporting. If, as has been stated, quality indicators are intended to serve both as barometers for provider performance and as signals of where problems in service delivery lie, a much larger set of quality indicators is required. Given the considerable time required to validate and implement quality indicators, it is essential for a larger panel of indicators to be piloted now if they are intended to be part of information reporting on care quality in the foreseeable future.

The Review acknowledges the challenges in obtaining agreement from the aged care sector on which quality indicators to select and how they will be measured. However, it was noted that participants in the National Quality Indicator Program pilot expressed interest in expanding the number of quality indicators being reported; indicators on falls, infections and use of chemical restraints were proposed.³²⁰

We also received feedback that some providers already collect a broader array of quality data as part of their quality improvement programs. This corroborates an earlier survey of 27 Australian nursing homes, that found that more than 50 per cent of facilities routinely collect data on rates of infection, falls, skin integrity, polypharmacy, pressure ulcers, continence and doctor's visits.³²¹

This list of priority areas for data collection aligned closely with information gathered in a previous study of the views of aged care staff and managers regarding the most important aspects of clinical care to measure.³²² Furthermore, three indicators — falls, hydration and depression — were commonly associated with poor resident quality of life. Collectively, this data supports further examination of other clinical indicators.

We acknowledge that, in some cases, the outcomes of care are not solely within the control of providers. For instance, pharmacists and general practitioners contribute to medication errors within aged care homes. However, the judicious use of process- and outcomes-based indicators may help to address these concerns. For example, measurement of the proportion of residents taking more than five medications who receive residential medication management reviews would help to assess medication management, while minimising the impacts of performance risks outside provider control.

While some providers already collect and analyse data on performance, in our opinion the development of a standardised approach to measuring performance against key clinical and

³²⁰ KPMG, March 2016, *National Aged Care Quality Indicator Program—residential care pilot outcomes*.

³²¹ Courtney M., et al., 2007, 'Development of a systematic approach to assessing quality within Australian residential aged care facilities: the Clinical Care Indicators Tool', *Aust Health Rev.* Vol. 31(4), pp. 582–591.

³²² Courtney B.M., Spencer L., 2000, 'What's best? Clinical indicators of quality in residential aged care facilities', *Collegian*, Vol. 7, pp. 14–19.

psychosocial risk factors is an important step towards reliably assessing the quality of care provided to aged care residents across the country. This approach will have broader benefits, including supporting analysis of the impact of new policy initiatives aimed at addressing broader issues with the quality of residential aged care.

Publication of performance against quality indicators

In our view, quality indicators should not be published as stand-alone performance data or alongside current accreditation audit reports. The prominence of data on such a limited pool of quality indicators, in the absence of any other metrics for gauging provider performance, would be misleading. Instead, we recommend that quality indicator data be published with a broader set of performance data obtained during accreditation audits. This will provide context to the information derived from the quality indicators. An approach to expanding information reported on accreditation outcomes is discussed in further detail in the next section of this chapter.

We acknowledge the need to ensure that quality indicators have been thoroughly validated, data has been risk-adjusted, and reference thresholds for comparison of provider performance have been rigorously assessed, before the performance of individual providers is published. Consequently, in the next three to five years, the principal use of this data will be to inform providers on performance issues. Work to establish reference thresholds and benchmarking criteria for existing quality indicators needs to continue in parallel with the validation of additional quality indicators.

Mandatory participation in the National Quality Indicator Program

Continuous quality improvement is a critical aspect of Australia's aged care accreditation system. The Review heard from many providers that consumer-driven competition should drive quality improvement, and that there should be a corresponding reduction in regulatory control to promote service innovation. This view is consistent with the *Aged Care Roadmap*. For this to occur, providers must furnish the information needed to better inform consumers. Many providers have long accepted this; however, others see data collection and reporting as onerous. We see a compelling case for mandatory participation in an expanded quality indicator program, to enable consumer choice and promote competition. While it is appropriate that pilots of quality indicators involve voluntary participation of providers, once the value and reliability of these indicators has been validated, providers should be expected to collect and report data against them.

Education and support to use quality indicators

Studies in the US highlight the need for support for providers and consumers to enable them to understand quality indicator data.³²³ Support was also shown to be important in the pilot of three clinical quality indicators in Australia.³²⁴ Once a broader suite of clinical indicators is established, consideration should be given to the support provided to aged care homes. This should include establishing a dedicated telephone hotline to answer providers' questions about interpreting, measuring and reporting quality indicators.

³²³ Rantz M.J., et al., 2012, 'Randomized multilevel intervention to improve outcomes of residents in nursing homes in need of improvement', *J Am Med Dir Assoc.*, Vol. 13, pp. 60–8.

³²⁴ KPMG, March 2016, *National Aged Care Quality Indicator Program—residential care pilot outcomes*.

Recommendation 3. All residential aged care services in receipt of Commonwealth funding must participate in the National Quality Indicators Program.

Actions

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

A star-rated system for reporting of provider performance

Ensuring that information for consumers about provider performance is available in a format that is easily understandable is critical to supporting their choice of a service provider. At present, information on the quality of care in aged care homes does not achieve this objective.

The Quality Agency publishes summary reports of the accreditation audits that it conducts at each residential aged care home. These provide information on whether the home was accredited, whether each of the 44 outcome measures were met or not met, and a brief summary of the reasons for the decision. However, this approach to reporting does not enable consumers to easily compare the quality of residential aged care services.

In its submission to this Review, Alzheimer’s Australia noted:

*Although the accreditation status of a residential aged care facility is publicly available, consumers often report to us that they find the documents difficult to interpret and that there is a lack of transparency as to how that relates to quality of care...Ultimately, it is vital that accreditation and quality mechanisms span consumer experience and quality of life within aged care services and that they are reported in a way that is both accessible and meaningful to consumers.*³²⁵

To improve the accessibility of information on the quality of care, the Quality Agency recently launched a new consumer experience report. The report is being used to collect the views of consumers and their families on aspects of care including food, safety, emotional and physical care, support for independent living, follow-up by staff, communication and respectful care.³²⁶ Respondents are asked to indicate whether each aspect of care meets their expectations ‘always’, ‘most of the time’, ‘some of the time’ or ‘never’. These reports are published along with

³²⁵ Alzheimer’s Australia submission (ID#11395657).

³²⁶ AACQA, ‘New report focuses on the resident experience in aged care’. Media release 18 August 2017. <https://www.aacqa.gov.au/about-us/mediarelease18August2017final.docx>

accreditation reports on the Quality Agency's website. However, the new reports do not include information captured during audits.

Providing data in a format that consumers are able to use effectively can influence provider behaviour, creating incentives for performance improvement.

Lessons from the US

A number of countries, including Germany, Korea, Sweden and the US, publish reports on aged care providers along with grading of their performance. The US has grappled with similar challenges with performance reporting as Australia over the past two decades. Research on the impacts of the US approach is instructive in considering how to manage information sharing in Australia.

The publication of performance data has had a significant impact on provider behaviour in the US. Studies have demonstrated the improvement of care outcomes following publication of report cards on quality indicators on the Nursing Home Compare website.³²⁷ The results in the US mirror improvements in performance outcomes in German nursing homes after the introduction of report cards on care quality.³²⁸

A modest additional effect on provider behaviour has been observed following the transition, in 2008, by the Centre for Medicare and Medicaid to a 5-star graded reporting system about provider performance. One study found that after its introduction, there was a significant decrease in the use of physical restraint by nursing homes that had received lower performance ratings.³²⁹

The graded reporting system also influenced consumer choice. One study observed that, not surprisingly, the introduction of the 5-star reporting system led to a significant decrease in consumer demand for 1-star homes and a commensurate increase in demand for 5-star facilities.³³⁰

However, it is not clear to what extent reported data on provider performance reflect consumer views of the care delivered in each facility. A 2012 study reported that there was no correlation between family experiences of care and scores for quality outcomes captured in the National Home Care report cards.³³¹ Likewise, another study found poor correlation between star ratings and

³²⁷ Fitzgerald, R.P., Shiverick, B.N., Zimmerman, D., 1996, 'Applying performance measures to long-term care', *Jt Comm J Qual Improv*, Vol. 22(7), pp. 505–517; Mukamel D.B. et al., 2008, 'Publication of Quality Report Cards and Trends in Reported Quality Measures in Nursing Homes', *Health Serv. Res*, Vol. 43(4): pp. 1244–62; Castle, N.G., Liu, D., Engberg, J., 2008, 'The association of Nursing Home Compare quality measures with market competition and occupancy rates', *Journal of Healthcare Quality*, Vol. 20(2), pp. 4–14; Zinn, J. et al., 2005, 'Do trends in the reporting of quality measures on the nursing home compare web site differ by nursing home characteristics?' *Gerontologist*, Vol. 45(6), pp. 720–30.

³²⁸ Herr, A., Nguyen, T., Schmitz, H., 2016, 'Public reporting and the quality of care of German nursing homes', *Health Policy*, Vol. 120(10), pp. 1162–70.

³²⁹ Clement, J., Bazzoli, G., Zhao, M., 2012, 'Nursing home price and quality responses to publicly reported quality information', *Health Serv Res*, Vol. 47(1 Pt 1), pp. 86–105.

³³⁰ Werner, R., Konetzka, R., Polsky, D. et al., 2009, 'Impact of public reporting on quality of postacute care', *Health Serv Res*; Vol. 44(4), pp. 1169–1187.

³³¹ Çalıkoglu, Ş., Christmyer, C., Kozlowski, B., 2012, 'My eyes, your eyes--the relationship between CMS five-star rating of nursing homes and family rating of experience of care in Maryland', *J Healthc Qual.*, Vol. 34(6) pp. 5–12.

consumer satisfaction scores in Ohio.³³² Also, use of the Nursing Home Compare site³³³ and similar health websites³³⁴ has been impacted by poor awareness of their existence and distrust of the data.

Issues with Australia's performance reporting system

Unlike the US, Australia's performance reporting system does not consolidate data from accreditation audits, quality indicators and consumer feedback to provide a simple-to-understand appraisal of provider performance. The segregation and complexity of information makes it difficult for people to compare residential aged care homes.

There are also significant issues with the currency of data used to inform selection of a home:

*COTA believes however that with changing of staff the culture of facilities can change within a very short timeframe. Accordingly, COTA believes there should be an annualised collection of the consumer experience report for each residential facility, to ensure the views are current and of relevance to consumers looking to understand the views of other residents prior to entering a residential aged care service It is clear to us that potential residents will heavily discount information that is not perceived as current.*³³⁵

Accreditation audit data is also generally collected on a three-year schedule, which compromises its currency.

Improving performance reporting in Australia

We believe that better use can be made of the extensive data captured through accreditation audits and consumer feedback. We commend the work done by the Quality Agency to develop consumer experience reports that collect graduated responses from residents and their families against questions that align with key topics of interest to consumers. However, we note the missed opportunity to supplement this with similar information from accreditation reports.

We propose the development of a star-rated reporting system for performance data that incorporates the results from accreditation audits and consumer experience reports. We envisage scores against each Accreditation Standard, with an overall score provided for each facility.

To support this system, accreditation audit reports should include graduated scores against all outcome measures. This approach will provide richer data on provider performance that differentiates high-performing providers and incentivises quality improvement.

The new Aged Care Commission should also develop a web tool that enables consumers to quickly compare the performance of aged care homes in a chosen area.

³³² Williams, A., Straker, J., Applebaum, R. 2016, 'The nursing home five star rating: how does it compare to resident and family views of care?' *Gerontologist*, Vol. 56(2), pp. 234-42.

³³³ Konetzka, R., Perrallion, M.C., 2016, 'Use of nursing home compare website appears limited by lack of awareness and initial mistrust of the data', *Health Aff. (Millwood)*; Vol. 35(4), pp. 706-13.

³³⁴ Marshall, M., et al., 'The public release of performance data: What do we expect to gain?' *JAMA*, Vol. 283(14), pp. 1866-74.

³³⁵ COTA Australia submission (ID#743548634).

Once quality indicators have been validated, they could be incorporated into this reporting structure. If reported as part of a broader set of data, quality indicator data can provide context to the findings of audit reports and consumer experience reports. This approach will also serve to mitigate the risks of publication of data on small numbers of quality indicators.

We recommend that the Aged Care Commission undertake a review of the new system within three years of its implementation by surveying consumer and provider views on the usefulness, comprehensibility and reliability of the data presented. The review should also investigate the extent to which performance scores align with resident and family experiences of care.

Recommendation 4. The Aged Care Commission will implement a star-rated system for public reporting of provider performance.

Actions

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

Chapter 7: Better support and protection for consumers

It is essential for aged care consumers to have confidence in the regulatory system and to be aware of, and able to exercise, their rights. We believe more needs to be done to empower consumers and their representatives.

We also need better protection of residents in aged care facilities. This includes improved systems to prevent abuse and neglect, and to report serious incidents and the response to them. As Australian Human Rights Commissioner Brian Burdekin noted in 1993: “[The] system often ignores elderly people who are mentally ill, or assigns them the lowest priority... Neglecting the physical health needs of old people is a form of elder abuse.”³³⁶

The use of restrictive practices does, in some circumstances, constitute elder abuse. Restrictive practices can deprive people of their liberty and dignity. Standards need to provide safeguards to limit restrictive practices and allow them to be used only when absolutely necessary.

Support for consumers to exercise their rights

In 1991, the United Nations General Assembly adopted 18 principles for older persons.³³⁷ The principles include:

- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives (Principle 14).
- Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse (Principle 17).

These principles find expression in the Charter of Care Recipients’ Rights and Responsibilities in residential care, legislated for in the Aged Care Act. Specified rights included the right to “quality information appropriate to his or her needs”, “to be treated with dignity and respect”, “to complain and to take action to resolve disputes”, “to have access to advocates and to other avenues of redress” and “to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforces his or her rights”.

Awareness of the Charter appears to be low. Unlike parts of the health sector, a culture of ‘provider knows best’ continues to prevail in the aged care sector, with many people unaware of their rights or too afraid to exercise them.

³³⁶ Burdekin, B., 1993, *Human rights and mental illness*, Australian Government Publishing Service.

³³⁷ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>

Aged care residents have the same general consumer rights as everyone has in the broader economy, protected under consumer law and contract law. In aged care, this is particularly important, as most residents are cared for under a resident agreement, which is a legal contract. As with the Charter, there is a lack of awareness of the legal right to appropriate treatment conferred by resident agreements.

We agree with the observation of one respondent, that it was “confronting” to read the Oakden report in 2017, and that it “shares aspects with the Burdekin Report” from nearly a quarter of a century earlier.³³⁸ The abuse and neglect of basic human rights detailed in the Oakden report has many disturbing echoes of the treatment of mental health patients recorded by the Australian Human Rights Commission in the Burdekin report in 1993.

The Aged Care Commission should include advocacy on behalf of consumers to protect and advance their rights in the functions of the Consumer Commissioner. This has several dimensions:

- Systemic advocacy
- Provider awareness and training
- Individual advocacy.

Systemic advocacy involves advocating across the aged care system for reforms that promote consumer rights. The role of the Consumer Commissioner can build on the experience of other advocacy systems undertaken by organisations in different fields. For example, the Public Advocate in the ACT undertakes systemic advocacy. This means it works to:

*introduce and influence positive long-term changes to systems that support and respond to the needs of the community, including: the legislative, policy and practice environments that they operate in, ensure that the rights and interests of people experiencing vulnerability are upheld, promote improved opportunities and outcomes, ensure the issues and experiences of individuals inform the focus of our work.*³³⁹

Similarly, the national Children’s Commissioner performs functions that include:

*to promote discussion and awareness of matters relating to the human rights of children in Australia; to undertake research, or educational or other programs, for the purpose of promoting respect for the human rights of children in Australia, and promoting the enjoyment and exercise of human rights by children in Australia.*³⁴⁰

Promotion and protection of the rights of consumers in aged care will include some of these kinds of activities. In addition, the new role can draw on the model for systemic advocacy used by the Age Discrimination Commissioner, whose brief “includes research, policy advice and education initiatives that tackle the attitudes and stereotypes that can lead to age discrimination”.³⁴¹

³³⁸ Submission (ID#805671192).

³³⁹ ACT Human Rights Commission, Systemic advocacy, <http://hrc.act.gov.au/public-advocate/systemic-advocacy/>

³⁴⁰ Australian Human Rights Commission Act 1986, s. 46MB(1).

³⁴¹ Australian Human Rights Commission, About age discrimination, <https://www.humanrights.gov.au/our-work/age-discrimination/about-age-discrimination>. The Consumer Commissioner will have a brief that is

Systemic advocacy to support consumer rights will be strengthened through partnership with the Complaints Commissioner, bringing together data and analysis from different areas of consumer engagement by the Aged Care Commission, to identify areas where consumer rights need support.

A second dimension to protecting consumer rights is that aged care providers need to be aware of those rights, and to support their residents in exercising them. The Consumer Commissioner can lead education and awareness in this area. OPAN noted in its submission:

*The introduction of [an] education program actively promoting the roles and responsibilities of the ACCC, AACQA and the National Aged Care Advocacy Program (NACAP) so that both consumers and service providers understand the continuum of safeguards available to address concerns in an appropriate and timely manner. In OPAN's experience, service providers, consumers and their carers/representatives are often confused about the varying roles of each of these organisations and how they interact with one another.*³⁴²

Existing aged care legislation contains provisions that require providers to inform consumers about aspects of their rights, such as the requirement under the User Rights Principles that the provider “must give a care recipient information about the care recipient’s rights and responsibilities in relation to the service under the Charter”.³⁴³ However, residents must be able to exercise their rights in practice.

Training can help staff understand residents’ rights (including the right to advocacy) and staff responsibilities. Access to this training should be supported by government, so it is not a cost to aged care providers.

A third dimension to effective protection of consumer rights is individual advocacy. As noted in chapter four, an effective regulatory system needs to provide advocacy services for individuals who need support to exercise their rights in the aged care system. Our analysis concluded that Australia has a relatively effective individual advocacy system, operating under the National Aged Care Advocacy Program. Advocacy provider OPAN explained:

*The services focus on supporting older people and their representatives to raise and address issues relating to accessing and interacting with Commonwealth funded aged care services...OPAN organisations offer advocacy services that are rights based. They seek to ensure that aged care consumers understand and exercise their rights and participate, to the maximum degree possible, in the decisions affecting their care. OPAN organisation advocates...act at the consumer's direction.*³⁴⁴

We have made recommendations to ensure that greater prominence is given to the rights of residents in aged care residential homes. Leadership in education should be provided by the new

narrower than that of the Age Discrimination Commissioner, who responds specifically to complaints about age discrimination under the *Age Discrimination Act 2004*. The Age Discrimination Commissioner deals with all age-related discrimination, including for example in relation to children; the Consumer Commissioner’s brief is obviously only for older Australians, and only on issues within the aged care system. However, we envisage a broader role, advancing all the rights of people in aged care, not only the right to be free of discrimination.

³⁴² OPAN Submission (ID#1721685255).

³⁴³ User Rights Principles 2014, s.11.

³⁴⁴ OPAN Advocacy Services, http://www.opan.com.au/advocacy/#what_is_advocacy

Consumer Commissioner within the Aged Care Commission, working alongside the Complaints Commissioner to educate the public and providers about consumers' rights. Residential aged care facilities should be required to educate residents and their representatives about consumers' rights, and to ensure that all staff undertake OPAN training on consumers' rights regularly.

Recommendation 5. The Aged Care Commission will support consumers and their representatives to exercise their rights.

Actions

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

Protecting aged care residents from abuse and neglect

Evidence to this Review and previous inquiries suggests that the current regulatory environment does not adequately protect the residents of aged care homes from abuse and neglect. The accreditation system does not appear to be sufficiently robust, and the requirement for compulsory reporting is restrictive and of limited value in improving the safety of residents.

In 2016–17, there were 2,853 notifications of 'reportable assaults' to the Department. Of these, 2,463 were recorded as alleged or suspected unreasonable use of force, 348 as alleged or suspected unlawful sexual contact, and 42 as both. This represents an incidence of reports of suspected or alleged assaults of 1.2% of people receiving permanent residential care during that period.³⁴⁵

Providers are obliged to report allegations or suspicions of reportable assaults to the Department. The reporting requirement was enacted through amendments to the Act³⁴⁶ and commenced on 1 July 2007.

The Department, the Quality Agency and the Complaints Commissioner have separate responsibilities in relation to reports of alleged or suspected assault in aged care services. The Department and the Quality Agency are responsible for monitoring provider compliance with their reporting responsibilities and ensuring that providers have systems and processes in place to respond appropriately to reports of alleged assault. The Complaints Commissioner is responsible for resolving complaints in relation to assault and ensuring that providers have responded appropriately.

³⁴⁵ Department of Health, *2016–17 Report on the operation of the Aged Care Act 1997*.

³⁴⁶ Part 4.3, s. 63-1AA.

Requirement to report allegation or suspicion of a reportable assault

As mentioned in chapter two, providers of residential care are required to report all allegations or suspicions of reportable assault to the police and the Department within 24 hours of receiving the allegation or from when they start suspecting, on reasonable grounds, a reportable assault. This includes unlawful sexual contact or unreasonable use of force.³⁴⁷ The report to the Department provides information about the incident.

Reporting requirements are designed to protect vulnerable residents from unlawful sexual contact from a person who is not another resident, not to restrict their sexual freedoms. Reports are sometimes made on the basis that a third party or relative is uncomfortable with the sexuality or sexual freedom of a resident. These situations are difficult for providers, but where there is a consensual relationship between a resident and another person who is not a carer, it is not considered assault. It is particularly difficult in cases involving residents with cognitive impairment that may impinge the ability to give consent.

Unreasonable use of force ranges from deliberate and violent physical attacks on residents to the use of unwarranted physical force. The latter may include hitting, pushing or kicking a resident, regardless of whether this causes visible harm.

Providers are not obliged to report to the Department an allegation or suspicion of a reportable assault, if they meet the following four requirements:³⁴⁸

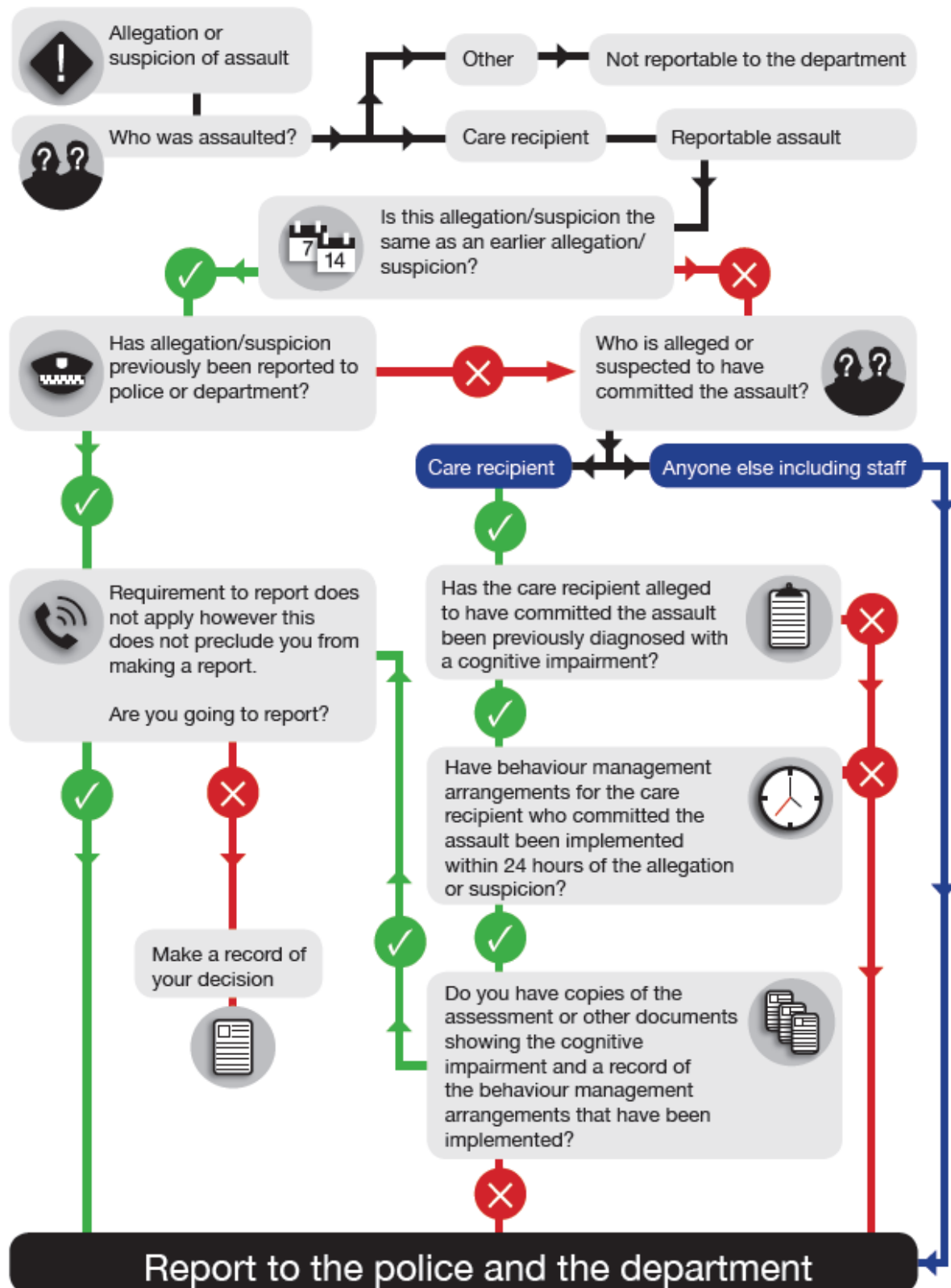
1. Within 24 hours of the provider becoming aware of the allegation or the suspicion, the provider forms an opinion that the assault was committed by a resident to whom they provide care.
2. That prior to receiving the allegation or suspicion of assault, the resident who committed or is alleged to have committed the assault was assessed by appropriate health professionals as suffering from a cognitive or mental impairment.
3. Within 24 hours of the receipt of the allegation or suspicion of assault, the provider has put in place effective arrangements to manage the resident's behaviour.
4. Records are held to support the assessment of the resident's cognitive or mental impairments, and to show the arrangements put in place to manage the resident's behaviour.

In such cases, providers are instead required to put in place responses that focus on effective behaviour management. This approach enables cases involving residents with a cognitive or mental impairment to be clinically managed, where this is the most appropriate response.

³⁴⁷ Department of Health, Guide for reporting reportable assaults, <https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportable-assaults>

³⁴⁸ As described in the reportable assault report form: <https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/compulsory-reporting-for-approved-providers/reportable-assaults-report>

Figure 8. Reportable assault flowchart for residential aged care³⁴⁹



³⁴⁹ Department of Health, Reportable assault flowchart, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/07_2017/reportable_assault_flowchart_july.pdf

Regulatory response to compulsory reports

The information provided to the Department in relation to a reportable assault is recorded and may be used as part of the Department's ongoing regulatory functions under the Act. The Department may take compliance action where approved providers do not meet the compulsory reporting requirements under the Act. The investigation of alleged or suspected assault is the responsibility of the police.

The Quality Agency assesses a residential home's compliance with the Accreditation Standards through its usual monitoring and accreditation processes. This includes an approved provider's compliance with its regulatory responsibilities, specifically:

- that processes are in place to encourage staff to report allegations or suspicions of incidents of assault on a resident
- that the provider is keeping records of all incidents of assault
- whether the provider met the conditions for not reporting an incident of assault.

The Quality Agency uses this information in conjunction with existing intelligence to determine whether an assessment contact visit is warranted, and to review whether systems and processes are appropriate to safeguard resident safety and appropriate actions have been taken. The Department may take compliance action where approved providers do not meet the Accreditation Standards.

The Department shares monthly data on all reports of alleged or suspected assault with the Quality Agency and the Complaints Commissioner. This data enables the agencies to build intelligence in relation to a provider's response and compliance with reporting requirements.

Does the compulsory reporting scheme provide adequate safeguards?

While some may argue that the legal requirement to comply with aged care Accreditation Standards is enough to demonstrate appropriate responses to serious incidents, our enquiries during this Review suggest this is not the case. The events at Oakden indicate that the current accreditation system is not sufficiently robust to provide adequate safeguards for residents who may have been subject to abuse and neglect. This is alarming considering significant investments by all governments to secure the human rights of people living with mental illness in light of the Burdekin report in 1993, which noted that "dementia, like other mental illnesses, can be managed successfully without compromising protection of human rights".³⁵⁰

The Aged Care Act is a weak framework for promoting the rights of older people, including the right to be free from abuse and exploitation, since it only provides for the reporting of serious physical and sexual assaults. The requirement of reporting to police can lead to a belief that nothing more needs to be done, since the matter is in the hands of the police. There is a sense from individual submissions that the process following on from the obligatory report is flawed. People are left in the dark.

³⁵⁰ Burdekin, B., 1993, *Human rights and mental illness*. Australian Government Publishing Service.

In its June 2017 report into elder abuse, the Australian Law Reform Commission (ALRC) pointed out that the reportable assault provisions place no responsibility on the provider other than to report an allegation or suspicion of an assault.³⁵¹ Significantly, there is no legislative obligation on the provider to record any actions taken in response to an incident.

Submissions to the ALRC inquiry were critical of the existing compulsory reporting scheme, claiming there is little evidence that the reporting requirements to the Department are effective in protecting residents. This view was corroborated in submissions to this Review:

*With the Department of Health the cryptic reporting on reportable assaults should be replaced with substantial information on what happened following the reporting of an alleged assault such as what action was taken, how many were substantiated and did any penalties result. If there were nearly 3,000 alleged assaults against primary school children we would not accept a couple of lines in an annual report as the limit to public information on the matter.*³⁵²

And:

*CPSA urges the reviewers to consider the recommendations for change in the aged care space made by the ALRC's part of the inquiry into Elder Abuse. In particular, CPSA is keen to see reform of the reportable assaults scheme...*³⁵³

Improving the response to serious incidents of abuse and neglect

Peak aged care consumer groups support the ALRC recommendation for a new serious incident response scheme (SIRS) for aged care with oversight by an independent body.³⁵⁴

We endorse this, and propose that the new Aged Care Commissioner oversee the new SIRS. This scheme should replace the current responsibilities in relation to reportable assaults in the Act.

We propose that the Aged Care Commission keep under scrutiny the systems of aged care providers for preventing, handling and responding to reportable incidents involving residents in aged care services. An aged care provider must give the Aged Care Commissioner notice as soon as possible, or within 28 days, of a reportable incident of which the provider becomes aware. The Aged Care Commissioner will determine whether appropriate action has been taken. as a result of the investigation.

Replacing the current statutory scheme with a new reportable incidents scheme would contribute to a strengthened legal framework and allow the provider to take a proportionate, considered response to the incident.

³⁵¹ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, p. 112.

³⁵² Elder Care Watch submission (ID#322319626).

³⁵³ Combined Pensioners and Superannuants Association (CPSA) submission (ID#360932844).

³⁵⁴ COTA Australia submission (ID#743548634); Alzheimer's Australia submission (ID#11395657); Combined Pensioners and Superannuants Association (CPSA) submission (ID#360932844); Elder Care Watch submission (ID#322319626).

To further enhance the transparency and accountability of providers in responding to reportable incidents, consideration should be given to requiring providers to report the number of alleged or suspected reportable incidents that have occurred in their service on a monthly or quarterly basis to residents and their representatives, and to making the information publicly available.

Defining a serious incident

The ALRC recommends broadening the types of incidents to be reported in residential care to mean, when committed against a resident:³⁵⁵

- (i) physical, sexual or financial abuse
- (ii) seriously inappropriate, improper, inhumane or cruel treatment
- (iii) unexplained serious injury
- (iv) neglect.

The ALRC also recommends that incidents of violence between residents in residential aged care should be treated as serious incidents, whether or not the person committing the act is cognitively impaired:

*This approach better calibrates the level of oversight appropriate to the management of violence between residents, and is consonant with a sector-wide commitment to ensuring that aged care recipients live in an environment free of violence and abuse. Responses to such incidents should be contemporaneously monitored, particularly where such responses may involve the use of restrictive practices.*³⁵⁶

Alzheimer's Australia supports this approach, noting:

*...aggression exhibited by people with dementia does not constitute criminal abuse; but the challenges posed by these situations are acknowledged. We recommend that all incidents of assault, including assaults perpetrated by a person with cognitive impairment be reported within 24 hours.*³⁵⁷

A draft report released by Monash University's Health, Law and Ageing Research Unit recommends extending the current mandatory reporting requirements to include all types of aggressive incident regardless of the cognitive status of residents involved:

*As the number of RACS residents with dementia in aged care rises, it is not practical to continue to exclude these cases in reporting. Targeted prevention strategies to reduce [resident to resident aggression] require accurate information on the incidences and the residents involved.*³⁵⁸

³⁵⁵ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, pp. 119–120.

³⁵⁶ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, p. 123.

³⁵⁷ Alzheimer's Australia submission (ID#11395657).

³⁵⁸ Ibrahim, J., (ed.), 2017, *Recommendations for prevention of injury-related deaths in residential aged care services [draft]*, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University.

Overall, we consider the ALRC extended definition of ‘serious incident’ appropriate, but note that there would need to be clear definitions to assist providers to understand any expanded reporting requirements. We note that fraud and financial abuse is not an area for which the Health portfolio currently has responsibility, and that the nature of investigations that could be conducted by the Aged Care Commission would need to be considered.

We also agree that all incidents of assault, including those committed by a resident with a cognitive impairment, should be reported to help ensure appropriate actions are being taken to provide care for and protection of residents, including those with severe dementia.

The Aged Care Commission should develop guidance with appropriate definitions, in consultation with experts and stakeholders, to assist residential aged care homes to understand what constitutes abuse. We believe that the overarching aim is to build organisational cultures that do not condone abusive conduct. We support the ALRC suggestion to model this guidance on the NSW Ombudsman Guide for Services.³⁵⁹

Recommendation 6. Enact a serious incident response scheme (SIRS) for aged care.

Actions

(i) The SIRS will require approved providers to inform the Aged Care Commission of:

- (a) an allegation or a suspicion on reasonable grounds of a serious incident; and**
- (b) the outcome of an investigation into a serious incident, including findings and action taken.**

(ii) The Aged Care Commission will monitor and oversee the approved provider’s investigation of, and response to, serious incidents, and will be empowered to conduct investigations of such incidents.

Protecting aged care residents from restrictive practices

The current use of restrictive practices to manage difficult behaviours within residential aged care facilities is a matter of grave concern to this Review. Using restrictive practices on residents, whether physical or chemical, is a human rights issue, and the use of alternative means for behaviour management should become the norm in aged care facilities.

We recommend that the Aged Care Commission work closely with the residential aged care sector to significantly reduce the use of all restrictive practices. The elimination of restrictive practices is a goal that both government and providers should aspire to.

Most people with dementia experience some behavioural or psychological symptoms of dementia (BPSD) of varying severity at some time during the course of their illness.

³⁵⁹ NSW Ombudsman, 2016, *Guide for services: reportable incidents in disability supported group accommodation*.

People may suffer mild symptoms of BPSD, such as apathy and repetitive questioning, or moderate symptoms such as calling out, disturbed sleep, socially inappropriate behaviour, hallucinations and delusions. More serious symptoms can include marked agitation and aggression. A small minority of people have very severe acute psychiatric disturbance and may be dangerously aggressive.³⁶⁰ The cause can be varied, with most behaviours transient in nature, although some behaviours, including agitation, can persist.

The use of restrictive practices to manage challenging behaviours of residents in aged care services has been described as a human rights issue in Australia.³⁶¹ In this context, restrictive practices can mean physical or mechanical restraint (e.g. tied to a chair, restrained to bed by bed rails), chemical restraint (e.g. use of antipsychotic medication), and seclusion. Other forms of restraint include restricted access to objects, or electronic forms of restraint (fitting tracking bracelets, camera surveillance or restrictions on media devices).³⁶²

The Oakden report confirmed that the current regulatory mechanisms failed to protect residents, many whom had dementia with severe or very severe BPSD, from excessive use of restrictive practices. Among other things, Groves found heavy reliance on medication and mechanical restraint to manage behaviours. The ALRC notes that “...the use of restrictive practices will, in some circumstances, be elder abuse. [It] can deprive people of their liberty and dignity—basic legal and human rights.”³⁶³

In its 2016 report on indefinite detention in Australia of people with cognitive and psychiatric impairment, the Senate Community Affairs References Committee discussed the use of involuntary treatments and restrictive practices, noting that such use “can be viewed as indefinite detention in the disability and aged care context.”³⁶⁴ In its concluding comments, the Committee noted:

*It is clear from the evidence provided that indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context, occurring both within external facilities and private homes. It is also clear this detention is often informal, unregulated and unlawful.*³⁶⁵

The stark reality is that restrictive practices are often used in human service settings on the most vulnerable and disempowered people. This is explained and justified as protecting the restrained person or others from harm during episodes of ‘challenging behaviours’, such as striking themselves or other people or wandering. However, it may also be being used as a “means of coercion,

³⁶⁰ Brodaty, H., Draper, B., Low, L.F., 2003, ‘Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery’, *Med J Aust.*, Vol. 178, pp. 231–234.

³⁶¹ ALRC, Queensland Office of the Public Advocate, 2017, *Legal frameworks for the use of restrictive practices in residential aged care: an analysis of Australian and international jurisdictions*.

³⁶² ALRC, Queensland Office of the Public Advocate, 2017, *Legal frameworks for the use of restrictive practices in residential aged care: an analysis of Australian and international jurisdictions*.

³⁶³ ALRC: ‘Elder Abuse – A National Response’; 2017 p.251

³⁶⁴ Senate Community Affairs References Committee, 2016, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, p.153.

³⁶⁵ Senate Community Affairs References Committee, 2016, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, p.169.

discipline, convenience or retaliation by staff or others providing support, when aged care facilities are understaffed.”³⁶⁶

There are many studies indicating that the use of restrictive practices is an ineffective method to manage challenging behaviour and may cause physical or psychological harm.³⁶⁷ A recent study reported that there were five deaths as a result of physical restraint in Australian residential aged care facilities over a 13-year period.³⁶⁸ However, the absence of a central reporting body collecting information on the prevalence of restraint use means we do not know the proportion of serious injuries from restraint practices. To put it simply:

*We need to know how many people are actually restrained in any way and talk about whether that's acceptable, rather than turning a blind eye or rationalising by saying that we're acting in the person's interest, and their best interest is to stop them walking because they might fall.*³⁶⁹

Inappropriate use of antipsychotic medicines

The use of antipsychotic drugs as a restrictive practice to control behaviour in residents with dementia may be inappropriate for several reasons. First, there is evidence of their limited effectiveness in treating certain symptoms of dementia. Second, there is at times an over-reliance on using antipsychotics as a first line of response, missing other needs of the resident. Overuse of antipsychotic drugs may be the result of a ‘quick-fix’ mentality, reflecting an organisational culture that is not centred on the resident, or lack of training, qualified staff or other resources. There is also evidence that antipsychotic drugs are administered without informed consent in some cases.

Limited effectiveness of antipsychotic drugs

In any discussion about the use of antipsychotics in residential care, it is important to acknowledge that some residents with dementia may have severe mental health conditions, while others have a long-term mental illness where the use of antipsychotics is appropriate and important to their treatment.

There is evidence that some drugs are effective for treating psychosis or agitation and aggression in people with dementia and severe BPSD.³⁷⁰ However, antipsychotics have been shown to be of limited effect in treating most behavioural and psychological symptoms of dementia.³⁷¹ For every 100 people with dementia given an antipsychotic, only 20 will derive some clinical benefit.

³⁶⁶ Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, 2016, *Elder abuse in New South Wales*, p. 71.

³⁶⁷ Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, 2016, *Elder abuse in New South Wales*, p. 71.

³⁶⁸ Bellenger, E., et al., 2017, ‘Physical restraint deaths in a 13-year national cohort of nursing home residents’, *Age and Ageing*, Vol. 46(4), pp. 688–693.

³⁶⁹ MJA Insite 30 January 2017, https://www.doctorportal.com.au/mjainsight/2017/3/harms-of-restraints-outweigh-benefits/?utm_source=MJA+InSight&utm_campaign=4ddd788e60-EMAIL_CAMPAIGN_2017_01_27&utm_medium=email&utm_term=0_7346f35e23-4ddd788e60-42211297

³⁷⁰ National Health and Medical Research Council Cognitive Decline Partnership Centre Guideline Adaptation Committee, 2016, *Clinical practice guidelines and principles of care for people with dementia*.

³⁷¹ Best Practice Advisory Centre, 2011, ‘Prescribing atypical antipsychotics in general practice’, *Best Practice Journal*, Vol. 40, pp 14–23.

Moreover, there will be one extra death and one extra stroke,³⁷² and current evidence does not support their use for the prevention or treatment of delirium.³⁷³

The 2016 *Clinical practice guidelines and principles of care for people with dementia*³⁷⁴ provide an up-to-date and comprehensive summary of the evidence and recommended actions that provide alternatives to antipsychotics.

Non-pharmacological interventions are increasingly being shown to be effective without side effects, but with challenges implementing and identifying methods with sustained effects.³⁷⁵

The 'quick fix' of antipsychotics

In 2015, the Australian Commission on Safety and Quality in Health Care (ACSQHC) released the *Atlas of healthcare variation* (the Atlas), which examined dispensing rates of antipsychotic medicines for people aged 65 and over from the Pharmaceutical Benefits Scheme.³⁷⁶ Prescription rates were particularly high for this age group, with a rate of 27,043 prescriptions per 100,000 people.

Studies have highlighted the high, variable and increasing levels of prescribing antipsychotics for use in the management of BPSD in Australia,³⁷⁷ particularly in residential care facilities, where over half the residents have a formal diagnosis of dementia. Data suggest up to one third of residents are prescribed antipsychotics.³⁷⁸

The figure may be even higher:

³⁷² Banerjee, S., 2009, *The use of antipsychotic medication for people with dementia: time for action*. A report for the Minister of State for Care Services.

³⁷³ Kishi, T., 2016, 'Routine use of antipsychotics to prevent or treat delirium is not recommended'. *Evidence-Based Mental Health*, Vol. 9(4), p. 123.

Neufeld, K.J., et al., 2016, 'Antipsychotic medication for prevention and treatment of delirium in hospitalized adults: a systematic review and meta-analysis', *Journal of the American Geriatrics Society*, Vol. 64, pp. 705–714.

³⁷⁴ National Health and Medical Research Council Cognitive Decline Partnership Centre Guideline Adaptation Committee, 2016, *Clinical practice guidelines and principles of care for people with dementia*.

³⁷⁵ Richter, T., 2012, 'Psychosocial interventions for reducing antipsychotic medication in care home residents', *Cochrane Database of Systematic Reviews*, Issue 8, Article No. CD008634; Chenoweth, L., et al., 2009, 'Caring for aged dementia care resident study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial', *Lancet Neurol*, Vol. 8, pp. 317–325; Brasure, M., et al., 2016, *Nonpharmacologic interventions for agitation and aggression in dementia*, Comparative Effectiveness Reviews, No. 177, Agency for Healthcare Research and Quality (US), Rockville (MD).

³⁷⁶ <https://www.safetyandquality.gov.au/atlas/atlas-2015/>. Private prescriptions were not included. The data are not linked to diagnosis, do not categorise prescribers and do not include dispensing in hospitals. Further analysis would be required to determine the relationship between dispensing rates and the proportion of older adults living in residential and community settings.

³⁷⁷ Pharmaceutical Benefits Advisory Committee. Drug Utilisation Sub-Committee, Outcome Statement 6-7 June 2013.

³⁷⁸ Snowdon, J., Galanos, D., Vaswani, D., 2011, 'Patterns of psychotropic medication use in nursing homes: surveys in Sydney, allowing comparisons over time and between countries', *Int Psychogeriatr*, Vol. 23, pp. 1520–1525; Hollingworth, S.A., et al., 2011, 'Psychiatric drug prescribing in elderly Australians: time for action'. *Australian and New Zealand Journal of Psychiatry* Vol. 45, pp. 705–708; Westbury, J., et al., 2010, 'An effective approach to decrease antipsychotic and benzodiazepine use in nursing homes: the RedUse project', *Int Psychogeriatr* Vol. 22, pp. 26–36; Nishtala, P.S., et al., 2010, 'Determinants of antipsychotic medication use among older people living in aged care homes in Australia', *Int J Geriatr Psychiatry*, Vol. 25, pp. 449–457.

*It is estimated that about half of people in aged care and about 80% of those with dementia are receiving psychotropic medications, although this varies between facilities. There is evidence to suggest that in some cases these medications have been prescribed inappropriately.*³⁷⁹

Prescribers, aged care staff and family members appear to lack knowledge about antipsychotics' limited effectiveness, their potential for serious side effects and the success of non-pharmacological, person-centred approaches. There are pressures on all sides that promote antipsychotics as a 'quick fix', and once commenced, a 'set and forget' mentality can result.

Over-reliance on antipsychotics as a first line of response, primarily to control behaviour and sedate people with BPSD,³⁸⁰ may mean other unmet needs can be missed, such as pain and delirium. This reflects a lack of adherence to guidelines.³⁸¹

In addition, antipsychotics are often prescribed without appropriate consent,³⁸² which is potentially a key factor contributing to the high levels of use. Coupled with lack of knowledge, non-adherence to guidelines or resource issues, the results can be dire:

*My mother was incorrectly given antipsychotics which were never prescribed. After spending 10 days in hospital due to an overdose she returned to her aged care home and within two days she was once again give[n] a non prescribed antipsychotic drug and another Alzheimer drug which had been ceased. The aged care home did not follow DBMAS recommendations. Also our concerns of mothers medical issues were ignored and it lead to our mother being again hospitalised with delirium due to UTI, bowel impaction and polypharmacy issues.*³⁸³

Strategies to reduce inappropriate use of antipsychotics—research

Efforts to reduce inappropriate use of antipsychotics in Australia and overseas have included regulatory reforms, guidelines, safety warnings, education, policy, and funded interventions. In the US, the over-prescription of antipsychotics to the elderly in nursing homes is addressed first by regulation specific to nursing facilities, such as the Federal Nursing Home Reform Amendments, part of the *Ombudsman Budget Reconciliation Act of 1987*, and through the Centers for Medicare and Medicaid Services (CMS) guidelines.³⁸⁴ In 2012 CMS released quality indicators to measure performance that include antipsychotic use.³⁸⁵

³⁷⁹ Alzheimer's Australia submission (ID#11395657)

³⁸⁰ NPS MedicineWise, 2013, *Antipsychotic overuse in dementia: is there a problem?* Health News and Evidence.

³⁸¹ Australian Commission on Safety and Quality in Health Care, 2015, *The Australian atlas of healthcare variation 2015*.

³⁸² Rendina, N., et al., 2009, 'Substitute consent for nursing home residents prescribed psychotropic medication', *Int J Geriatr Psychiatry*, Vol. 24, pp. 226–231.

³⁸³ Submission (ID#27635086).

³⁸⁴ Levin, C., 2011, *Lifting the fog: the problem of antipsychotic drug use in nursing facilities*. <https://dash.harvard.edu/bitstream/handle/1/8822193/LevinF%26Dpaper.pdf?sequence=1>

³⁸⁵ Description of Antipsychotic Medication Quality Measures on Nursing Home Compare, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/AntipsychoticMedicationQM.pdf>

In 2010, England's Department of Health commissioned a national dementia and antipsychotic prescribing audit to collect demographic and prescribing information on people with dementia from general practitioners' practices. It included any prescription of antipsychotic medicines or any alternative medicines, including drugs for dementia, hypnotics and anxiolytics and anti-depressants. There was a reported 52 per cent reduction in antipsychotic prescriptions for people with dementia between 2008 and 2011.³⁸⁶

Apart from nurse education, single strategies on their own have had limited success in reducing inappropriate prescribing. Research has shown that interdisciplinary and multi-faceted strategies hold more promise with a focus on education and review.

Two successful research examples in Australia include the Reducing Use of Sedatives (RedUSE) program and the Halting Antipsychotic use in Long Term Care (HALT) study, both of which were funded by the Department. Both studies emphasise the importance of education about the limited benefit and increased harm of antipsychotics, the potential causes of BPSD, and encourage the use of non-pharmacological and person-centred approaches to management.

Some residential aged care services are leaders in this field. They demonstrate that improved outcomes are possible. The challenge lies in the introduction of mechanisms to ensure that all services can provide safe and quality care for people with dementia and BPSD.

Current regulation in aged care

The use of restrictive practices in aged care is not explicitly regulated. However, residential aged care providers are required to comply with the quality standards, which, as detailed previously, include expected outcomes requiring residential aged care homes to provide a safe and comfortable environment and to comply with all relevant requirements and standards. Meeting these requirements means that they must be able to protect residents' basic legal and human rights while at the same time maintaining their duty of care to all residents and staff.

The Quality Agency's *Results and processes guide* contains advice to assist quality surveyors to identify and consider whether the Standards are met, including specific items relating to restraint:³⁸⁷

- How behavioural management is carried out and communicated to the relevant staff as per the general care process. For example, how does the home ensure the need for physical and chemical restraint (if used) has been assessed, has been deemed to be the last resort, is authorised and administered at a minimum form and level required, and in accordance with strict safety standards.
- When using pharmacological interventions, the aim is to settle distress, without affecting clarity of consciousness or compromising quality of life. Chemical restraint should only be used when all other options have been exhausted.
- Homes should be able to demonstrate that all other options and alternatives for managing a resident's behaviour have been exhausted before any form of restraint is employed.

³⁸⁶ Health and Social Care Information Centre, National Dementia & Antipsychotic Prescribing Audit 2012.

³⁸⁷ AACQA, Results and processes guide, <https://www.aacqa.gov.au/providers/residential-aged-care/resources/other-resources/resources>, pp. 55–57, p. 93.

- How does the home regularly review its practices for providing a safe and comfortable environment needs? For example, does the home monitor and review environmental strategies for avoiding restraint of care recipients and ensuring that care recipients with challenging behaviours (such as wandering) are safe.

The Department does not directly monitor the use of restrictive practices, although if approved providers are found not to be compliant with the expected outcomes the Department may take compliance action.

The evidence available to this Review suggests that the regulatory framework is not sufficient to protect the rights of residents. The Office of the Public Advocate in Queensland submitted that features of the legal and service quality framework should include:

*...establishing principles ... that restrictive practices may only be used in instances where a person is at risk and when all other less restrictive measures have been attempted.*³⁸⁸

The ALRC recommends that they be used only to prevent serious physical harm, to further raise the threshold for justification for their use.³⁸⁹

The ALRC has previously discussed the use of restrictive practices in Australia, highlighting the ‘patchwork’ of federal, state and territory laws and policies governing restrictive practices, and set out stakeholder calls for reform.³⁹⁰ The Queensland Office of the Public Advocate recommended (as did the ALRC in 2014) that Commonwealth, state and territory governments “develop a national approach to the regulation of restrictive practices”, including in the aged care sector. Calls for reform, including for nationally consistent legislated regulation, were repeated in the ALRC’s recent report on elder abuse, which recommended that aged care legislation regulate the use of restrictive practices in residential aged care facilities.³⁹¹

Barriers to best practice

Notwithstanding concerns about the current legal framework, there are factors that may inhibit minimising or eliminating the use of restrictive practice in aged care facilities, including:

- Lack of knowledge of guidelines, and guidelines not promoted or easily accessible or tailored.
- Residential service characteristics³⁹² such as nursing and care skills, staffing levels, staff turnover and time pressure that work against implementing person-centred care.
- Funding and care models and organisational culture.³⁹³

³⁸⁸ Submission (ID#769301094) p. 15.

³⁸⁹ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, p. 251.

³⁹⁰ ALRC, 2014, *Equality, capacity and disability report*.

³⁹¹ Australian Law Reform Commission, 2017, *Elder abuse—a national legal response*, ALRC report 131, Commonwealth of Australia, p. 251.

³⁹² Frankenthal, D., et al., 2016, ‘The impact of facility characteristics on the use of antipsychotic medications in nursing homes: a cross-sectional study’, *Israel Journal of Health Policy Research*, Vol. 5, pp. 1–6; Rodriguez-Monguio, R., Seoane-Vazquez, E., 2014, ‘Potentially inappropriate antipsychotic use in a nationally representative US nursing homes sample: a safety concern’, *Journal of Pharmaceutical Health Services Research*, Vol. 5, pp. 215–223.

- Constraints on the residential aged care facility workforce, including lack of time and awareness of guidelines, complex patient population and pressure from family members and / or other residential care staff.
- Limited collaboration among general practitioners, residential care staff and pharmacists.
- Lack of access to mental health and allied health professionals' expertise for assessment, guidance on behavioural interventions and appropriate use of medicines, particularly in rural and remote areas.
- Lack of assessment skills, including pain assessment.
- View of medication as a first and quick response to behavioural issues, along with a lack of awareness of the risks of harm and the limited benefits of antipsychotics.
- Lack of the knowledge, skills and time to implement non-pharmacological interventions.

Limiting the use of restrictive practices in aged care – developments

It is clear that aiming to eliminate, or at least reduce, the use of restrictive practices requires a multi-pronged approach to address the barriers to best practice—a combination of regulatory mechanisms, monitoring and education and support for improvement. According to Alzheimer's Australia:

*All staff in residential aged care facilities need to receive high quality training in dementia care, including a social model of care and alternatives to physical and chemical restraint. Quality standards and assessment processes for aged care services should aim to end inappropriate use of physical and chemical restraint and provide information to consumers about their use; and the Aged Care Complaints Commissioner should escalate complaints which relate to use of restraint or assault.*³⁹⁴

Building on evidence of high rates of antipsychotics use in the Atlas, the ACSQHC held two roundtables in 2016 and 2017 to discuss strategies to reduce inappropriate use of antipsychotics among older people in the community, hospitals and residential aged care homes. This work is ongoing. Regarding residential aged care homes, the ACSQHC recommends the following strategies:

1. Include dementia, BPSD and antipsychotics in the new aged care standards
2. Monitor appropriate use of antipsychotic prescribing
3. Further define good practice to include informed consent
4. Balance compliance with initiatives that support quality improvement.³⁹⁵

Work in other sectors, notably disability and mental health, is instructive for aged care. In 2014, Commonwealth and state and territory disability ministers endorsed the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (the National Framework). The National Framework focuses on the reduction of the use of restrictive practices in disability services that involves restraint (including physical, mechanical or chemical) or seclusion. It outlines key principles to guide work in this area and core strategies to reduce the use of restrictive

³⁹³ Chen, Y., et al., 2010, 'Unexplained variation across US nursing homes in antipsychotic prescribing rates', *Arch Intern Med*, Vol. 170, pp. 89–95.

³⁹⁴ Alzheimer's Australia submission (ID#11395657) p. 3.

³⁹⁵ ACSQHC, internal briefing paper.

practices in the disability service sector.³⁹⁶ An example of how these principles could be adapted for aged care is in Box 5.

Box 5. Core strategies for reducing and eliminating the use of restrictive practices

Person-centred focus: including the perspectives and experiences of people with disability and their families, carers, guardians and advocates during restrictive practice incident debriefing, individualised positive behaviour support planning, staff education and training, and policy and practice development.

Leadership towards organisational change: leaders need to make the goal of reducing use of restrictive practices a high priority, and provide support to their staff to achieve it.

Use of data to inform practice: mechanisms—such as periodic review of behaviour support plans containing a restrictive practice, provider reporting on use of restrictive practices, reporting client assessments and individual / positive behaviour support plans—should be used to assess whether restrictive practices are still needed, and to consider possible alternatives. Data is also important to determine what factors are effective in reducing or eliminating the use of restrictive practices.

Workforce development: key needs include understanding positive behaviour support and functional behaviour assessment, and skills for trauma-informed practice, risk assessment, de-escalation, and alternatives to restrictive practices.

Use within residential aged care services of restraint and seclusion reduction tools: use of evidence-based assessment tools, emergency management plans and other strategies integrated into each individual's positive behaviour support plan.

Debriefing and practice review: aged care service providers should undertake regular review processes of their use of restrictive practices to identify areas for practice and systemic improvement.

The National Mental Health Commission's Seclusion and Restraint project in 2015 looked at the operation of restrictive practices in mental health and made recommendations on safeguards to the Council of Australian Governments.³⁹⁷

In December 2016, the Australian Health Ministers' Advisory Council's Safety and Quality Partnership Standing Committee endorsed National Principles to Support the Goal of Eliminating

³⁹⁶ Department of Social Services, National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector>.

³⁹⁷ National Mental Health Commission. *A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services*. May 2015. www.mentalhealthcommission.gov.au/our-work/definitions-for-mechanical-and-physical-restraint-in-mental-health-services/our-position-paper-a-case-for-change.aspx

Mechanical and Physical Restraint in Mental Health Services. The principles are intended to apply to all mental health services in Australia.³⁹⁸

We suggest it is time for similar principles to be adopted for aged care. We also recommend that the Aged Care Commission's Chief Clinical Advisor be required to approve the use of antipsychotic medications in nursing homes.

Support for aged care providers

Approved providers of aged care are required to have sufficient appropriately skilled and qualified staff to ensure that they operate in accordance with legislation and expected standards of care, including protecting residents' rights. They are also required to address the education and development of staff to ensure they have the knowledge and skills to perform their roles effectively.

In our view, meeting expected standards of care and having the appropriate staff and resources to do so should mean that barriers to best practice can be overcome. It means committing to minimise or eliminate the use of restrictive practices to protect residents' human rights in ways that maintain providers' duty of care to all residents and staff.

The government offers support to help providers meet requirements in relation to qualified staff. For instance, the government funds the Dementia Training Program (DTP),³⁹⁹ which offers a national approach to accredited education, upskilling, and professional development in dementia care. The DTP currently provides:

- dementia-specific continuing professional development training to acute and primary health and allied health professionals
- free accredited dementia care vocational training courses to eligible care workers
- tailored onsite training to aged care providers who request assistance
- a training needs assessment service
- an environmental consultancy to provide on-site education, assessment and advice to managers, staff, project managers and architects who are keen to create more enabling environments.

In addition, service providers can access more tailored support through the Dementia Behaviour Management Advisory Services and the Severe Behaviour Response Teams. These services are funded by the Australian Government and delivered by Dementia Support Australia (DSA). Providers of residential aged care and family carers can access advice 24 hours a day. As part of the service, DSA provides capacity-building resources and specific strategies for carers and organisations to improve the care of people living with dementia in the longer term and minimise the use of restraints.⁴⁰⁰

The Australian Government also funded the development of the *Decision-making tool: supporting a restraint free environment in residential aged care*, to guide residential aged care homes, residents

³⁹⁸ Australian Health Ministers' Advisory Council - Safety and Quality Partnership Standing Committee, December 2016, National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services.

³⁹⁹ Dementia Training Australia, <https://www.dementiatrainingaustralia.com.au/>

⁴⁰⁰ Dementia Centre, Dementia Support Australia (DSA), <http://www.dementiacentre.com.au/services/dsa>

and their families in this decision-making process, to identify alternatives to the use of restrictive practices, and to promote a restraint-free environment.⁴⁰¹

Monitoring appropriate use of antipsychotic prescribing

As an additional strategy to work towards eliminating restrictive practices, we recommend public reporting on antipsychotic rates. This is in line with Recommendation 13 of the 2014 Senate Community Affairs References Committee on care and management of younger and older Australians living with dementia and BPSD. The committee recommended reporting on circumstances where antipsychotics have been used for more than six months, together with the reasons and any steps taken to minimise the use of the drugs, as well as general usage patterns in each facility.⁴⁰² There is now an enhanced capacity to do such reporting. From 1 July 2017 the use of Pharmaceutical Benefits Scheme (PBS) medicines within residential aged care directly from PBS data provides a mechanism to monitor usage of antipsychotics such as risperidone,⁴⁰³ Through the collation of this data, the Department will be able to quantify the use of antipsychotics by residential services. Good models of care will be able to be identified, analysed and published. The identification of homes with high rates of prescribing will allow the Aged Care Commission to target these facilities for more attention as having a high risk of breaching the Accreditation Standards.

Informed consent

The lack of informed consent in current practice is potentially a key factor that contributes to the high levels of use of antipsychotics. This could be addressed by further tightening the PBS clinical criteria restrictions to include the need for documented informed consent. It could also be included in compliance monitoring by the new Aged Care Quality Commissioner.

While ideally, informed consent should be obtained from the resident, it is likely that in many cases where restraints are used, the resident lacks the capacity to consent. Consent should then be obtained from a substitute decision-maker. Enforcing the requirements for obtaining informed consent promotes shared decision-making and greater effort to explain benefits versus harm and possible alternatives.

Family members and carers should be involved as partners in care as early as possible. They need to be educated, empowered and supported in their role. We see a role for the Aged Care Quality Commission to lead the development of relevant shared decision-making tools to support informed consent.

⁴⁰¹ Department of Health, Decision Making Tool: Supporting a Restraint-Free Environment, <https://agedcare.health.gov.au/publications-articles/resources-learning-training/decision-making-tool-supporting-a-restraint-free-environment>. There is a companion guide for community aged care.

⁴⁰² Senate Community Affairs References Committee, 2014, Report of the inquiry into care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD), http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Dementia/Report/index

⁴⁰³ Department of Health, Revised dispensing for nursing home residents, www.pbs.gov.au/info/news/2017/06/revised-dispensing-for-nursing-home-residents-july-2017

Are restrictive practices ever truly necessary?

Some have argued that, although they should be a last resort, restrictive practices are sometimes necessary to protect other care recipients and staff. However, we believe that the use of restraints—whether physical or chemical—is not a solution when a person is exhibiting behaviours of concern. The application of restrictive practices usually escalates, rather than calms, a person’s behaviour. According to Alzheimer’s Australia, there should instead be a focus on the ‘environmental or service factors’ that cause problematic behaviour.⁴⁰⁴ Instead of using restraints, aged care staff need to be supported and given adequate time to provide responsive and flexible and individualised care.

There are also different views about how restrictive practices could be reduced or eliminated. Some echo the ALRC’s call for legislative regulation of restrictive practices. Others propose non-regulatory means as a better approach to achieving a reduction or elimination of their use.

The key elements set out in Recommendation 7 are intended to discourage the use of restrictive practices and set a clear and high standard to move towards their elimination. Restrictive practices must be subject to proper safeguards and used only when strictly necessary. Through regular review and continuous improvement, it is intended that over time their use will be eliminated.

We support the concept of the National Disability Insurance Scheme Quality and Safeguarding Framework. It provides a nationally consistent approach to help empower and support scheme participants to exercise choice and control, while ensuring appropriate safeguards are in place and establishing expectations for providers and their staff to deliver high-quality supports.⁴⁰⁵ A senior practitioner and required reporting on the use of restrictive practices are features of the *National framework for reducing and eliminating the use of restrictive practices in the disability service sector*. We note that the ALRC also recommended consideration of these additional oversight mechanisms as part of any regulation of such practices in aged care.

We recommend that professional guidance to reduce the use of restrictive practices be developed by the Chief Clinical Advisor in the new Aged Care Commission, who must approve the inclusion of restrictive practices in a person’s behaviour support plan before they can be used on a person. These additional measures may assist in providing leadership and expertise in reducing and eliminating the use of restraint.

We envisage that the Aged Care Commission will oversee guideline implementation and lead the development of decision-making tools to support the limited, appropriate use of restrictive practices.

⁴⁰⁴ Alzheimer’s Australia submission (ID#11395657).

⁴⁰⁵ Department of Social Services, 2016, NDIS quality and safeguarding framework, https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_final.pdf

Recommendation 7. Aged care standards will limit the use of restrictive practices in residential aged care.

Actions

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

Chapter 8: Better accreditation and compliance monitoring

This chapter considers how to improve the effectiveness of accreditation and compliance monitoring in regulating the quality of residential aged care.

It is widely accepted that aged care is highly regulated.⁴⁰⁶ The Commonwealth Government has outlined a process of reform to transition the system towards one in which consumers and their families exercise choice and the needs of consumers become the focus and the principal driver for quality improvement. This is a worthy objective and many of the recommendations in this Report are designed to facilitate transition to a market-driven regulatory model, by increasing consumer knowledge and choice.

However, the market needs to mature considerably before a truly consumer-driven model can be achieved. Currently, the government caps supply of beds in residential aged care facilities with average occupancy rates across the sector of approximately 92 per cent.⁴⁰⁷ This operates as a significant constraint on competition and choice as drivers for quality.

The average time that residents stay in permanent residential aged care is three years.⁴⁰⁸ Less than three per cent of residents changed facilities in 2015–16, and only a portion of these would be for reasons connected with consumers exercising a choice between providers.⁴⁰⁹ These statistics do not point to a market in which consumer choice flourishes.

More than 53 per cent of people living in permanent residential aged care have dementia⁴¹⁰ and 49 per cent of these residents are classified as having severe cognitive skills impairment.⁴¹¹

For consumer-based competition to effectively drive quality improvement, there needs to be significant structural and cultural change. This will take time to implement across the sector.

Even in a mature market, there will always need to be appropriate protections for more vulnerable consumers who may not have the capacity to advocate for themselves or have family support to advocate on their behalf.

⁴⁰⁶ De Boer, R., 2010, 'Challenges of an ageing population', *Parliamentary library briefing book*, www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook43p/ageingpopulation.

⁴⁰⁷ Australian Institute of Health and Welfare, 2017, GEN. Canberra: AIHW. <http://www.gen-agedcaredata.gov.au>.

⁴⁰⁸ Australian Institute of Health and Welfare, 2017, GEN. Canberra: AIHW. <http://www.gen-agedcaredata.gov.au>

⁴⁰⁹ Australian Institute of Health and Welfare, 2017, GEN. Canberra: AIHW. <http://www.gen-agedcaredata.gov.au>

⁴¹⁰ Australian Institute of Health and Welfare, 2011, 'Dementia among aged care residents: first information from the Aged Care Funding Instrument', *Aged care statistics series no. 32*, Cat. no. AGE 63.

⁴¹¹ Australian Institute of Health and Welfare, 2011, 'Dementia among aged care residents: first information from the Aged Care Funding Instrument', *Aged care statistics series no. 32*, Cat. no. AGE 63.

Consequently, this Review is focused on what needs to be done to make accreditation more effective in the current context. The proposed model can be revised progressively to adapt to evolving changes in the marketplace towards a more consumer-driven model.

We caution the government not to establish a regulatory system around a consumer-driven market before the market is ready to take on this role.

A risk-based approach to accreditation

The objective of accreditation is to ensure that providers meet basic standards for the quality and safety of care, and to provide assurance to consumers, families and the community. The intention of aged care quality regulation is not to 'catch providers out'. Many instances of non-compliance result from providers not understanding their responsibilities or how to demonstrate compliance with the Standards. Ideally, regulatory checks should identify where care needs to be improved and support facilities to achieve this.

What are the problems with the current approach?

Announced site visits are ineffective tools

The focus (of Oakden) was on ensuring staff knew what to say during accreditation, rather than knowing how a service should provide high quality care...

The review heard and saw evidence that Oakden became better at knowing how to produce documents and records that accrediting bodies and surveyors wanted to and expected to see; and better at ensuring staff knew what to say. However, it became no better at providing safe or better care.⁴¹²

There was a strong view expressed by consumers, their families, advocates and aged care workers in aged care homes that announced visits are staged. It is understandable that facilities want to perform well during accreditation visits. However, this approach to monitoring care places emphasis on passing accreditation rather than delivering high-quality care all the time.

There was strong support in submissions to this Review for increased use of unannounced visits as a way of seeing the real picture of care and being able to determine what support providers need.

All audits should be unannounced: The current process of alerting facilities to an upcoming accreditation encourages bandaid practices and window-dressing to ensure the facility presents itself in the best possible light. ... It's known as the 'pre-accreditation shuffle': give the walls a fresh coat of paint, buy some new outdoor furniture, roster extra staff on the audit day, go back and fill in all the blanks on your paperwork and don't serve the cold party pies until the next week.⁴¹³

Some submissions also noted the stress caused to staff and residents in preparing for announced re-accreditation visits:

⁴¹² Groves, A., et al., 2017, *The Oakden report*, South Australia Department for Health and Ageing, p. 77.

⁴¹³ Submission (ID#617437173).

*I think a lot of the evidence which has to be supplied is all very well but speaking for myself I spend 80% of my time collecting data that will never be looked at but is done in case it is. I would much rather spend my time monitoring the actual care being given.*⁴¹⁴

Annual unannounced visits are a major element of the current approach to monitor provider performance. Quality Agency data over the past five years demonstrates that unannounced site visits are more effective than announced site visits at identifying non-compliance (Table 1). However, currently, most unannounced visits are conducted over one day and not all outcome measures are assessed, limiting their capacity to identify issues with care quality.

Table 1. Percentage of responsive* visits where new non-compliance was found at a facility⁴¹⁵

Financial year	Assessment contact, unannounced	Assessment contact, announced	Review audit, unannounced	Review audit, announced
2013	7%	2%	67%	33%
2014	3%	1%	83%	43%
2015	2%	1%	80%	57%
2016	1%	1%	50%	63%
2017	4%	1%	70%	58%

*Responsive refers to a visit triggered in response to information received about a service (e.g. complaint, referral from the Department of Health or the Complaints Commissioner, information from a media report), identification or monitoring of non-compliance, or reasonable grounds a facility may not be complying with the Standards.

There has been criticism that unannounced visits are disruptive for facilities. However, feedback received by the Quality Agency following site visits indicates that “the level of disruption is not as extensive as some commentators have suggested”.⁴¹⁶ In a survey of views from 62 per cent of providers following site visits, 92 per cent rated assessment teams conducting unannounced visits excellent or very good in relation to allowing staff to conduct their work.⁴¹⁷

Insufficient time for site audits

A re-accreditation site audit typically includes entry and exit meetings, documenting and recording, interviews with residents and representatives, managers, direct care staff and others (such as volunteers), observation of practices and the general environment of the facility, and review of complaints.

⁴¹⁴ Submission (ID#322970458).

⁴¹⁵ Source: Data provided by the Australian Aged Care Quality Agency, 27 July 2017.

⁴¹⁶ AACQA, *Annual report 2015–16*.

⁴¹⁷ AACQA, *Annual report 2015–16*.

Meeting these requirements within a two-day re-accreditation site visit limits the time that can be spent investigating whether the care delivered matches the paperwork. The current approach, which pays insufficient attention to the risk of non-compliance of the service, also means that quality surveyors do not always have the time or resources on the ground to conduct further investigation when they suspect issues may exist. As one surveyor commented:

*The main change the assessment and monitoring process desperately needs is to have more surveyor resources allocated on visits. The current level of staffing resources – and by this I mean our time on site, as well as the number of surveyors on most visits – is too low for us to be able to do a good job of checking whether the home is meeting the standards. The current allocated staffing only allows us to skim the surface on what is happening at a home and so, unless a problem comes up and bites us on the nose, it can easily be overlooked.*⁴¹⁸

Indeed, limited time and resources might make quality surveyors risk averse. According to National Seniors Australia:

*Given the short time-frame allowed, quality assessors may be reluctant of a negative finding toward a provider as it implies that residents will be subject to detrimental outcomes, when this may or may not be the case.... This responsibility is likely to weigh heavily on assessors, who may act in a risk averse manner if they are unable to adequately substantiate negative findings in the short time frame provided.*⁴¹⁹

Several submissions highlighted the benefits of extended visits:

*Surveyors should come onsite and be placed in a facility for a length of time to understand, observe work practices that occur. This would be beneficial to impart consistency of practice in an everyday setting. It would enable surveyors to be at the coal face, not just viewing documentation.*⁴²⁰

However, it appears difficult for surveyors to get authorisation from the Quality Agency to extend visits. The Nous Group, which conducted an internal review of the Quality Agency processes, noted that at Oakden:

*The reaccreditation visit resource allocation was insufficient to conduct an assessment of a high risk facility, find non-compliance and determine Serious Risk because of the breadth of work required, and the inappropriate interaction of staff and residents within the facility would have been apparent only over a longer timeframe.*⁴²¹

Rather than the re-accreditation being an effective instrument for identifying poor care, the Nous Group commented:

Data provided by the Quality Agency demonstrates that it is rare to find failure of care during an accreditation audit. There has been an expectation (by the Quality Agency staff and Providers' staff) that all Expected Outcomes would be met at accreditation audits, where the

⁴¹⁸ Submission (ID#346790910).

⁴¹⁹ National Seniors Australia submission 504028734

⁴²⁰ Submission (ID#426849911).

⁴²¹ The Nous Group, External independent advice: Australian Aged Care Quality Agency (2017).

*service has three to six months to prepare for demonstration of Standards on a specified date, and the self-assessment prepared by the provider provides the guide for the audit.*⁴²²

Improving the effectiveness of accreditation

Implement more effective processes for monitoring care quality

Currently, when an approved provider applies for initial accreditation of its residential care service, an announced site audit is conducted against all 44 expected outcomes within months of the facility commencing operations. It is proposed that this approach continue, with an emphasis on supporting the provider to understand and meet the Standards, help solve problems and strengthen the service's performance. Establishing a constructive working relationship between the new Aged Care Commission and the service supports a responsive regulatory approach where punitive strategies are less often needed.⁴²³

It is recommended that in place of scheduled re-accreditation visits on a fixed accreditation cycle, a more robust system of unannounced visits be introduced, with investigation of provider performance against all 44 outcome measures under the Standards and a minimum of two days allocated to each site visit.

Greater emphasis on unannounced visits will address the issues identified in this Review, in Groves' examination of Oakden, and in regulatory good practice, of shifting the emphasis in the residential aged care system towards ongoing delivery of quality care and away from passing a test at a single point in time.

Shifting from a standard accreditation cycle to ongoing accreditation with regular monitoring will have other advantages. It would free providers from diverting resources to prepare for a fixed accreditation event, which was raised as an issue with this Review. It would allow the Aged Care Commission to better manage resources, by evening out peaks and troughs in its workload. Most importantly, it would support a regulatory framework that is fully responsive and fully risk-based, to better protect consumers and better support providers.

It is further proposed that changes to the way that experiences of consumers, family and staff are collected (described in chapter five) will give quality surveyors more time to spend monitoring care.

Under the proposed model, assessment outcomes from unannounced visits will be published, providing consumers with up-to-date information on provider performance. Reports and decisions should be presented in plain language on the My Aged Care website.

More effective allocation of regulatory resources

The current system needs to transition to a responsive regulatory model.

The expanded risk profiling of providers described chapter five should be applied to determine the frequency and duration of unannounced visits, so that surveyors can focus on supporting providers at greatest risk of non-compliance.

Consistent with this risk-based approach, we propose that the current prescriptive system of annual unannounced visits for all providers be changed so that high-performing facilities receive fewer unannounced visits. This rewards high-performing providers for the investment made in delivering

⁴²² The Nous Group, External independent advice: Australian Aged Care Quality Agency (2017).

⁴²³ Productivity Commission, 2011, *Caring for older Australians*, Appendix F, p. F9.

quality care. Conversely, the frequency, duration and staffing of unannounced visits should be greater for providers in higher-risk circumstances, to ensure that surveyors are able to properly investigate care quality.

As we argued in chapter three, higher risk is not determined solely based on the risk of provider non-compliance. It also relates to the complexity of care that the service provides, and the vulnerability of the residents cared for. There are many consumers whose care is more complex to deliver or who may have fewer supports, for example:

- people with severe dementia
- people with mental illness
- people under guardianship
- people with disabilities requiring specialised supports
- people who are homeless or at risk of homelessness.

The Quality Agency has also already established that there are other risk factors that do not reflect on a provider's expertise or willingness to comply with the Standards. These include a service being in a rural or remote area, or operating in locations prone to extreme weather events.⁴²⁴

Risk-based assessment of providers under a system of ongoing accreditation would ensure that the Aged Care Commission would engage more closely with providers who experience any risk factors. The emphasis would continue to be on strongly supporting providers in their ongoing provision of quality care, rather than on taking compliance action.

By way of example, Oakden cared for numerous consumers in the first three of the categories in the list above, and on this basis, would have received closer support and supervision from the Quality Agency, not because it had problems or needed to be threatened with compliance action, but because the accreditation system recognised the inherent demands in offering high-quality care to people with complex needs.

Announced support contacts would continue under this model and would play a significant role in educating providers.

Through the elimination of re-accreditation audits and the re-distribution of resources according to risk, this model is designed to minimise cost increases for government. Existing provider payments for re-accreditation visits and the annual contribution for an unannounced visit should be rolled over into an annual contribution under the new model, with no net increase to provider contributions.

Since the revised process allocates visits based on potential risk of non-compliance, it is proposed that provider contributions to the cost of visits be based on the number of beds in each facility and not on the number of visits conducted. This means there would no longer be a direct link between provider contributions and unannounced visits.

⁴²⁴ AACQA, personal communication.

Recommendation 8. Ongoing accreditation, with unannounced visits, to assure safety and quality of residential aged care.

Actions

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

Assessment against Accreditation Standards

The previous section of this chapter outlined the first important step in more effective monitoring of compliance with the Standards: developing a more effective, risk-based approach to accreditation.

Several other steps are also necessary to improve assessment:

- Recruit fit-for-purpose assessment staff and provide the right training
- Ensure guidance material for outcome assessment reflects best practice
- Review Standards over time
- Improve and assess clinical governance

Each step is discussed below.

Assessment staff: quality and training

Assessment teams need the capacity to engage expertly with providers to assess, support and, where necessary, improve providers' practices.

In the reformed regulatory arrangements outlined in this Review, it will be particularly important that quality surveyors have the skills to look deeply into a service's care and management systems. They need to be able to distinguish good documentation from good care, and to see that management-speak translates into good practice. Most of the time, most providers are doing the right thing and doing it competently. Effective regulation relies on assessment teams having the skills to detect and respond in situations when this is not the case.

The capability of assessment teams needs to match the increasingly complex care needs of residents in aged care facilities. Assessment teams need a strong understanding of, and the skills to assess, a diverse range of care services.

Ensuring quality surveyors have the skills and / or experience to assess all residential services will require diversity of skills and careful management by the Aged Care Commission because of the range of provider sizes, complexity and service models.

The integration of regulatory functions in a single authority, together with reforms to the accreditation model, will require adjustment in the assessment workforce. While it is impractical to expect each quality surveyor to have breadth of experience that traverses all service types, the

balance of skills possessed by the assessment teams contributes to the rigour of assessment and should be commensurate with the type and complexity of care in the facility being assessed. Additionally, detailed guidance material with clearly defined outcome measures will ensure consistency of assessment.

We heard from providers and experienced staff, who argued that further development of the workforce is needed:

*The current accreditation standards are too 'vague' and open to interpretation and assessors are very often not appropriately qualified and experienced enough to make sound judgements.*⁴²⁵

Peak body, Aged Care Guild, indicated that it:

*considers the wide variation in approaches to, and application of, the Standards and how homes are assessed and monitored as evidence of an inconsistent approach and variation of the skills set and interpretation of the Standards. Despite the assurances of the Quality Agency, this is a common experience of Guild providers and facilities. Ultimately, this will see different approaches and interpretation of the Standards applied in different geographic regions.*⁴²⁶

Submitters expressed concerns about a range of aspects of skills, with some mentioning surveyors' qualifications, others identifying relevant experience as significant, and others commenting on the importance of a clinical background:

*The (assessment) team must also include at least one Registered Nurse (RN) with a background in aged care, but unaffiliated with any aged care provider or regulating body. Those who are not nurses should be very familiar with nursing professional standards and the application of these standards to the delivery of nursing services in the aged care setting. Non-clinician assessors should only assess those aspects of the aged care service that are non-clinical.*⁴²⁷

The feedback from public consultation on the Single Quality Framework also emphasised "the need for quality surveyors to be appropriately qualified and with expertise in the type of service being reviewed".⁴²⁸ As we argue later in this report, the non-clinical aspects of standards and assessment are critical and need to be given greater prominence, while ensuring that good clinical practice and governance are embedded in aged care and assessment.

The Quality Agency provided information about the experience, skill base, training and support for the Quality Agency workforce.⁴²⁹ While over half of surveyors (53 per cent) have nursing qualifications and experience, the currency (including maintenance of professional registration and

⁴²⁵ Submission (ID#101503685).

⁴²⁶ Aged Care Guild submission (ID#1032742486).

⁴²⁷ Qld Nurses and Midwives Union submission (ID#950941010).

⁴²⁸ Department of Health, 2017, *Report on the outcomes of consultations on the Single Aged Care Quality Framework*, p.14.

⁴²⁹ Quality Agency information provided for the review regarding experience, skill base and training of Quality Assessors, received 8 September 2017.

the associated mandatory continuing professional development requirements) and relevance to aged care of their experience is unclear.

The Quality Agency's surveyors are supported through a program of continuing professional development.⁴³⁰ The Agency provides:

*ongoing training of assessors about contemporary audit techniques and methodologies, as well as general industry developments, government policy and legislative updates.*⁴³¹

However, training appears not to include a strong focus on issues that directly impact on consumer outcomes.

At Oakden, the failure of assessment teams to identify problems with care and clinical governance highlights the importance of assessors having a good understanding of these areas. As the Quality Agency itself notes:

*Following the Oakden report the Quality Agency is also taking steps to develop the workforce to ensure it is equipped to respond to the increasingly complex residential aged care environment. This includes a renewed focus on the surveyors, through training and recruitment, as well as developing and maintaining a skills audit to enable the right resources to be matched to assessment of higher risk facilities.*⁴³²

There is also evidence that Oakden was not an isolated case. Despite almost 98 per cent of residential care facilities complying with the Accreditation Standards, including outcomes relating to clinical care, dissatisfaction with clinical care, particularly medication administration and management, remains the top source of complaints received by the Aged Care Complaints Commissioner.⁴³³

The importance of having an expert assessor to assess clinical governance and clinical care has been highlighted by the ACSQHC. In its recent review of the Australian Health Services Safety and Quality Accreditation Scheme, the commission proposed the introduction of expert assessors to improve the effectiveness and expertise of the assessment team.⁴³⁴ As part of this strategy, it will specify qualification and training requirements and develop a training program for expert assessors.

The Review acknowledges the work of the Quality Agency to develop its workforce to respond to the increasingly complex residential aged care environment. However, strategies must be implemented to further strengthen the capabilities of assessment teams.

⁴³⁰ Quality Agency information provided for the review regarding experience, skill base and training of Quality Assessors, received 8 Sept 2017.

⁴³¹ AACQA, *Annual report 2015-16*, p. 72.

⁴³² Quality Agency information provided for the Review regarding experience, skill base and training of Quality Assessors, received 8 Sept 2017.

⁴³³ Complaints Commissioner, *Annual Report 2016-17*.

⁴³⁴ Australian Commission on Safety and Quality in Healthcare, April 2017, *Revision of the Australian Health Services Safety and Quality Accreditation Scheme to improve the reliability of health service organisation accreditation processes*.

The assessment workforce can make greater use of the expertise of people experienced in the use of aged care. England's Care Quality Commission uses a program of 'experts by experience' to support the commission's program of inspections, including in aged care:

*During inspections, Experts by Experience speak to people using services and their family or organisations that support them. They may also observe how the service is delivered and speak to staff. Their findings are used to support the inspectors' judgments on services and may be included in inspection reports.*⁴³⁵

The use of consumer expertise is similarly developed in other sectors, such as mental health.⁴³⁶ This approach could also support the stronger focus on quality of life, not just clinical care, to meet consumer expectations.

It is important that quality surveyors have the skills to thoroughly investigate compliance with standards, under the integrated model of the new Aged Care Commission. As the OECD's best-practice guide on regulatory enforcement argues, it is important for regulatory staff not only to have technical competence in the fields relevant to the type of risk being addressed, but also specific inspection skills.⁴³⁷

Part of the Aged Care Commission's role will be investigation and analysis when there are concerns about whether a service is meeting the Accreditation Standards. For agencies that conduct investigations where it is possible that there will be civil penalties or administrative sanctions, the Australian Government Investigations Standards are relevant.⁴³⁸ They recommend specific training for staff with these functions:

*Certificate IV in Government (Investigation), or its equivalent, as set out in the Public Services Training Package (PSP04). This qualification should be obtained before an officer is primarily engaged as an investigator; otherwise the officer should be under the supervision of a qualified investigator.*⁴³⁹

The Aged Care Commission's team will need some of its surveyors to meet this standard.

Appropriate guidance material to assess outcomes

As outlined in the Quality Agency Principles 2014, the Standards do not provide instructions on how to meet expected outcomes, as it is recognised that residential services will have different ways to achieve quality based on the individual service and the needs of care recipients. The Quality

⁴³⁵ Care and Quality Commission, Experts by experience, <http://www.cqc.org.uk/about-us/jobs/experts-experience>.

⁴³⁶ See for example SA Health, Experts by Experience Initiative—Mental Health, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/country+health+sa+local+health+network/engaging+with+chsa/experts+by+experience+initiative+-+mental+health+-+country+health+sa>.

⁴³⁷ OECD, 2014, *Best practice principles for regulatory policy: regulatory enforcement and inspections*, p. 47.

⁴³⁸ Australian Government Investigations Standards, August 2011.

⁴³⁹ Australian Government Investigations Standards, August 2011, p. 2.

Agency's Results and processes guide identifies key areas where positive outcomes are expected to be seen, without being prescriptive.⁴⁴⁰

Several factors support flexibility of the Standards. As described by the Productivity Commission, the Standards:

*specify the outcome of the improvement or desired level of performance but leave the concrete measures to achieve them open for the 'duty holder' to adapt to varying local circumstances.*⁴⁴¹

Researchers from US advocacy organisation AARP Foundation compared Australia's aged care system with several other countries. They described the Australian aged care standards as "very broad and non-specific to allow providers considerable latitude in demonstrating how they achieve quality goals".⁴⁴² This approach is intended to promote innovation in how providers deliver care. They argued that flexible standards allow a "focus on broad issues of facility quality rather than compliance with detailed regulations".⁴⁴³ This encourages dialogue among surveyors, providers and consumers to establish if and how expected outcomes have been met.⁴⁴⁴

While this flexibility in standards can be appropriate, it can create issues for both the assessing regulator and providers in determining how care can best be provided, and what counts as failure to meet the standards. In flexible standards, the criteria for compliance are more difficult to define:

*For some standards, a flexible approach is adequate, as different services have different capabilities and capacities. However, this may lead to inconsistencies between each assessor, or the assessment process not picking up on vital signs of incompetence.*⁴⁴⁵

Common criticisms of the Accreditation Standards raised in submissions to this Review are that they lack specificity, the language used is unclear, and they are too open to interpretation.⁴⁴⁶ It was argued that this leads to variation in assessments and inconsistency in decision-making, and that accreditation needs to be more objective and evidence-based.

The need for more specific assessment criteria was consistent with consultation feedback on the Single Quality Framework. Stakeholders noted the need for guidance materials that "draw out the requirements of the standards and describe how requirements will be monitored and measured".⁴⁴⁷ As noted by the Victorian Department of Health and Human Services:

⁴⁴⁰ Quality Agency Principles 2013. <https://www.legislation.gov.au/Details/F2017C00136>

⁴⁴¹ Productivity Commission, 2011, *Caring for older Australians*.

⁴⁴² Weiner, J.M., et al., 2007, *Quality assurance for long-term care: the experiences of England, Australia, Germany and Japan*, Public Policy Institute Issues Brief 2007-05, AARP, Washington, p. vi.

⁴⁴³ Weiner, J.M., et al., 2007, *Quality assurance for long-term care: the experiences of England, Australia, Germany and Japan*, Public Policy Institute Issues Brief 2007-05, AARP, Washington, p. ix.

⁴⁴⁴ Weiner, J.M., et al., 2007, *Quality assurance for long-term care: the experiences of England, Australia, Germany and Japan*, Public Policy Institute Issues Brief 2007-05, AARP, Washington, p. 12.

⁴⁴⁵ Australian Medical Association Submission 833514879.

⁴⁴⁶ Submissions (ID# 224160559, ID#685384744), Australian Aged Care Group (ID#101503685), Australian Nursing and Midwifery Federation (ID# 522721697).

⁴⁴⁷ Department of Health, July 2017, *Report on the outcomes of consultations on the single Aged Care Quality Framework*, p. 6.

*Expectations around standards of care need to be clear and specific so that: care recipients and providers understand these expectations; performance can be objectively measured and reported, and not open to broad interpretation by either providers or assessors and support more consistent care. This includes defining safety and quality and adverse events as they relate to aged care.*⁴⁴⁸

Broad or specific requirements for meeting the standards?

One issue raised in submissions concerned the broad requirements for addressing Standard 2: Health and personal care, which encompasses clinical care. A number of submissions noted the lack of clarity around best practice for clinical care, particularly issues related to administration of medicine, sterilisation standards and incident reporting protocols. It was argued that clinical care should not be subject to interpretation, but be very clear in terms of requirements.

The Australian Medical Association noted:

Standards that relate to medical care should not be subject to interpretation to ensure quality care is received and so RACFs are aware of their specific responsibilities.

and:

*The accreditation standards however give vague indications to RACFs on how to achieve adequate care. Regulations and standards in the aged care sector needs to be loose in areas that will improve innovation and quality in the sector, but not where medical care is involved. We hope to see standards refined through the development of a single set of aged care quality standards.*⁴⁴⁹

The Victorian Department of Health and Human Services also pointed out that:

*The aged care quality assessment and accreditation framework lacks adequate systems for monitoring the effectiveness of clinical and medical care.*⁴⁵⁰

On the other hand, some regulatory experts argue against increasingly prescriptive standards for quality and safety. Braithwaite and colleagues argue that greater prescription and compliance enforcement can work in cases where:

Such activities are tractable, meaning that the underlying principles are well understood, that problems are amenable to decomposition, that conditions of work are relatively well specified, stable and controllable, and that dependence on external events is limited.

Most healthcare activities however are intractable, because care settings are complex and unpredictable. This means that the underlying principles are incompletely known, that

⁴⁴⁸ Victorian Department of Health and Human Services, Submission to the Senate Community Affairs Reference Committee, p. 5.

⁴⁴⁹ Australian Medical Association submission (ID#833514879).

⁴⁵⁰ Submission by the Victorian Department of Health and Human Services to the Senate Community Affairs References Committee inquiry, p. 5.

*problems are complex and resist decomposition, that conditions of work are underspecified and unstable...*⁴⁵¹

The way the Standards are written polarises stakeholder views. Most submissions to this Review, and commentary in the public domain, recommends that the Standards either maximise flexibility in interpretation or be more defined to support objective decision-making and consistency. However, these views are not mutually exclusive.

The Productivity Commission noted that:

*It might be possible to develop a middle ground between broad standards and specific standards which allow the development of more systematic, quantifiable measures of the quality of care that could be used over time to compare facilities or to benchmark the whole system to track changes over time.*⁴⁵²

Evidence-based guidance to support care provision and assessment allows the standards to be flexible, but for good practice to be recognised and expected.

Where evidence-based best-practice care is well defined, the Standards should enable providers to deliver care that meets the Standards. There are existing guidance and best-practice materials for residential aged care such as those for medication management,⁴⁵³ use of restraint,⁴⁵⁴ preventing pressure injuries,⁴⁵⁵ end-of-life care⁴⁵⁶ and preventing falls.⁴⁵⁷ Assessment should include an expectation that consistent implementation of such guidance is necessary for providers to meet the Accreditation Standards.

An example of how this approach can be implemented can be seen in the draft National Safety and Quality Health Service (NSQHS) Standards (version 2). These address specific high-risk clinical areas of patient care⁴⁵⁸ and the accompanying guides include examples of suggested key tasks, strategies and resources that health service organisations can use to implement the NSQHS standards.⁴⁵⁹

⁴⁵¹ Braithwaite, J., Wears, R.L., Hollnagel, E., 2015, 'Resilient health care: turning patient safety on its head', *International Journal for Quality in Health Care*, Vol. 27(5), pp. 418–419.

⁴⁵² Productivity Commission, 2011, *Caring for older Australians*, p. 429.

⁴⁵³ Department of Health, October 2012, *Guiding principles for medication management in residential aged care facilities*.

⁴⁵⁴ Department of Health, August 2012, *Decision-making tool: supporting a restraint free environment in residential aged care*.

⁴⁵⁵ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan-Pacific and Pressure Injury Alliance, 2014, *Prevention and treatment of pressure ulcers: quick reference guide*. Cambridge Media, Perth, Australia.

⁴⁵⁶ Queensland Health, Residential aged care end of life care pathway, <https://metrosouth.health.qld.gov.au/raceolcp>; the National Palliative Care Standards are currently being finalised. See <http://palliativecare.org.au/policy-and-publications/the-national-standards/>.

⁴⁵⁷ Australian Commission on Safety and Quality in Health Care, 2009, *Preventing falls and harm from falls in older people: best practice guidelines for Australian residential aged care facilities*. ACSQHC, Sydney.

⁴⁵⁸ Australian Commission on Safety and Quality in Health Care, 2016, *Draft National Safety Quality Health Service Standards (version 2)*. Standard 4 – Medication safety standard and Standard 5: Comprehensive care standard address areas of clinical care relevant to residential aged care.

⁴⁵⁹ Australian Commission on Safety and Quality in Health Care, 2017, *Consultation Draft National Safety Quality Health Service Standards Guide for Hospitals*.

These resources were developed for use in the clinically-focused hospital environment, but illustrate how information could provide clarity to both quality surveyors and aged care service providers on what quality care looks like and how it should be delivered. Alzheimer's Australia endorsed consideration of this approach in aged care:

*What Alzheimer's Australia's consumers make clear to us is that there is a need to better link compliance with quality assurance... Another example of how this might work is provided in the health care sector by the ACSQHC, through the development and implementation of the NSQHS Standards. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.*⁴⁶⁰

The next section explores aspects of care that continue to present challenges to the quality of care in residential aged care and proposes how these could be addressed through accreditation. It also explores the need to plan for ongoing revision and improvement in the Accreditation Standards to ensure that accreditation adapts to address emerging issues in care quality and safety, and new evidence around best practice.

Two case studies

Despite almost all providers meeting Standard 2 on Health and personal care, complaints received by the Complaints Commissioner and independent peer-reviewed research continue to highlight issues with aspects of clinical care.⁴⁶¹ Some of the issues lie at the interface of residential aged care and health services.

Two areas in which ongoing issues have been noted are the coordination of resident transfers to hospital and medication management. Conspicuously, the existing *Results and processes guide*⁴⁶² refers to assessment of both of these aspects of clinical care, however little detail is provided on how this should be done.

Obviously, providers are not solely responsible for issues with medication management and communication between aged care facilities and hospitals. However, aspects of care within the control of facility staff could be more effectively managed to improve resident care outcomes.

Ineffective coordination between residential aged care and hospitals

Provider responsibility for clinical care extends to the information provided with a resident who is referred to see medical practitioners outside the residential care setting:

The communication of accurate medical information is fundamental to providing quality care to all patients as they transfer within the health care system. Standards for transfer of

⁴⁶⁰ Alzheimer's Australia submission (ID#11395657).

⁴⁶¹ Courtney, M., et al., 2010, 'Benchmarking clinical indicators of quality for Australian residential aged care facilities', *Australian Health Review*, Vol. 34, pp. 93-100; Morphet, J., et al., 2014, 'Shortfalls in residents' transfer documentation: Challenges for emergency department staff', *Australasian Emergency Nursing Journal*, Vol. 17: 98-105; Somers, M., et al., 2010, 'Quality use of medicines in residential aged care', *Australian Family Physician* Vol. 39(6):413-6.

⁴⁶² AACQA, 2014, *Results and processes guide*, pp. 36 & 41-43.

*information with the patient are being set within and on discharge from acute care settings both in Australia and internationally. Similar standards could be adopted for the transfer of aged care residents. ... The aged care quality assessment and accreditation framework could better support safe and continuing care between home, acute and aged services by setting information standards for resident/patient transfers.*⁴⁶³

Failure to provide clinical information with residents transferring to hospital adversely impacts patient outcomes, resulting in service duplication and medical services that are not required.⁴⁶⁴ One study found alarming failures in the provision of critical clinical information—clinically important documentation was frequently absent, including the reason for transfer to the emergency department (in 48.2 per cent of transfers), baseline cognitive function (in 59.7 per cent of transfers), and vital signs at the time of complaint (in 69.9 per cent of transfers).⁴⁶⁵

Ineffective medication management

Clarity around clinical practice is particularly relevant with respect to medication management. With aged care residents taking an average of 9.75 medications, polypharmacy (the concurrent use of five or more drugs) is commonplace.⁴⁶⁶ As stated previously, dissatisfaction with medication administration and management is the number one source of complaints received by the Aged Care Complaints Commissioner.⁴⁶⁷

The incidence of medication-related problems is well documented.⁴⁶⁸ For example, one study found that 96 per cent of aged care residents participating in the trial were considered to have at least one medication-related problem,⁴⁶⁹ while another study found 44 per cent of patients were prescribed at least one potentially inappropriate medicine.⁴⁷⁰ Several aspects of care under the control of residential care homes impact medication management, including nursing staff awareness of the adverse effects of medication, and ineffective medication incident reporting.^{471, 472}

⁴⁶³ Victorian Government submission to the Senate Community Affairs Reference Committee Inquiry, p.12.

⁴⁶⁴ Coleman, E.A., 2003, 'Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs', *J Am Geriatr Soc*, Vol. 51(4):549-55.

⁴⁶⁵ Morphett, J., et al., 2014, 'Shortfalls in residents' transfer documentation: challenges for emergency department staff', *Australasian Emergency Nursing Journal*, Vol. 17, pp. 98–105.

⁴⁶⁶ Somers, M., et al., 2010, 'Quality use of medicines in residential aged care', *Aust Fam Physician*, Vol. 39, pp. 413–416.

⁴⁶⁷ Complaints Commissioner, *Annual report 2016–17*, p.19.

⁴⁶⁸ Roughhead, L., Semple, S., Rosenfeld, E. and Australian Commission on Safety and Quality in Health Care, 2013, *Literature review: Medication Safety in Australia*; Community Affairs References Committee, 2014, *Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD) report*.

⁴⁶⁹ Nishtala, P.S., et al., 2011, 'A retrospective study of drug-related problems in Australian aged care homes: medication reviews involving pharmacists and general practitioners', *Journal of Evaluation in Clinical Practice*, Vol. 17(1), pp. 97-103.

⁴⁷⁰ Stafford, A.C., Alswayan, M.S. and Tenni, P.C., 2011, 'Inappropriate prescribing in older residents of Australian care homes', *Journal of Clinical Pharmacy & Therapeutics*, Vol. 36(1), pp. 33-44.

⁴⁷¹ Jokanovic, N., et al., 2016, 'Why is polypharmacy increasing in aged care facilities? The views of Australian health care professionals', *J. Eval. Clin. Pract.*, Vol. 22, pp. 677–682; Hansen, R.A., et al., 2010, 'Patterns in nursing home medication errors: disproportionality analysis as a novel method to identify quality improvement opportunities', *Pharmacoepidemiol Drug Saf.*, Vol. 19(10), pp. 1087–1094.

⁴⁷² Hansen, R.A., et al., 2010, 'Patterns in nursing home medication errors: disproportionality analysis as a novel method to identify quality improvement', *Pharmacoepidemiol Drug Saf.*, Vol. 19(10), pp. 1087–1094.

However, despite these issues, the number of claims for Residential Medication Management Reviews has decreased by approximately 18 per cent between 2008–09 and 2015–16.

Improving the effectiveness of accreditation guidance

Longstanding issues with coordination of resident transfer between residential aged care and acute care led the ACSQHC to pilot strategies to address this.⁴⁷³ The ACSQHC subsequently developed a toolkit to assist residential services to prepare standardised information.⁴⁷⁴

However, while resident transfers are mentioned in the *Results and processes guide*, which surveyors use to assess compliance with Outcome 2.4: Clinical care, compliance with this standardised approach to transmission of clinical information is not included in the guide.⁴⁷⁵ The ACSQHC, the Department of Health and the new Aged Care Commission should work collaboratively to review this guidance material to assess its applicability as guidance for the standardisation of clinical documentation for residents being transferred to hospital. Compliance with these approaches should then be embedded in accreditation.

Similarly, ongoing issues arising from polypharmacy and medication management need to be more effectively addressed in accreditation. The Department should revise the *Guiding principles for medication management in residential aged care* and the accreditation process should require providers to demonstrate how they conform with these principles.⁴⁷⁶ We recommend that a resident medication management review be conducted on admission for residents to a residential aged care facility, following hospitalisation, upon deterioration of medical condition or behaviour, or upon any change in medication regime.

Care coordination with hospitals and medication management are two examples of areas in which there are known concerns with quality of care, and for which more thorough adoption of existing detailed guidance to support the Standards should help improve outcomes. This approach can be applied in other areas where there is both clinical and non-clinical evidence-based good-practice guidance available.

Review and improvement of the Standards

Regular review of the Standards and their supporting guidance material is necessary for continuous quality improvement to occur system-wide. This should include engagement with consumers, review of complaints data, and incorporation of the latest academic research and evaluation as part of ongoing review of both the Standards and their supporting guidance documentation.

The accreditation process also needs to give greater emphasis to quality of life and to ensuring providers deliver care consistent with consumer expectations. Here it can be harder to measure

⁴⁷³ Australian Commission on Safety and Quality in Health Care, 2011, *External Evaluation of the National Clinical Handover Initiative Pilot Program: Final report*

⁴⁷⁴ Australian Commission on Safety and Quality in Health Care, 2011, *Implementation Toolkit for Clinical Handover Improvement*.

⁴⁷⁵ AACQA, October 2014, *Results and processes guide*, p. 36.

⁴⁷⁶ Department of Health, 2012, *Guiding principles for medication management in residential aged care facilities*.

compliance, but it should still be possible to recognise good performance and to identify and validate preferred models of care and staffing.

Systematic reviews of aged care quality consistently indicate that quality of life is a high priority for people in residential care. Relevant factors include the need for sufficient time with staff, importance of a home-like environment, and the development of relationships with staff.⁴⁷⁷

Recent studies highlight the need for consumer engagement in revision of the Standards:

*Stakeholders display strong support for consumer engagement as an overarching principle, while voicing resistance to the way it is currently mandated through accreditation programmes...Based upon our findings, it is clear that while the requirements of standards are vital, greater inclusion of consumers in standards revision processes, and the assessment of [health service organisations] performance against revised standards, may also be worth considering, to enhance credibility of programmes.*⁴⁷⁸

This advice is equally relevant to aged care. The Quality Agency has made progress in this area with its consumer experience reports. Work should continue to ensure that consumer preferences are translated into practice guidance to support compliance with the Standards.

Accreditation processes have remained generally unchanged over the past 20 years. Updating the accreditation process is crucial if it is to meet its objectives and improve its reliability:

*The Accreditation process has been a valuable addition to Aged Care and has greatly assisted in developing a continuous improvement culture. Given that customer expectations, control and awareness have changed over the past 20 years, it is time for the system to be modernised to better align with changes in the above, government policy and for residential care shorter lengths of stay of customers, the processes of review need to be more reflective of society's expectations.*⁴⁷⁹

The nature of aged care is changing rapidly, with an increase in frailty, dependence and complexity of health issues in people receiving residential aged care.⁴⁸⁰ As part of an evaluation of aged care accreditation, Campbell Research & Consulting recommended that the Standards include a process of regular review consistent with international best practice, to ensure they remain contemporary.⁴⁸¹ Periodic reviews of standards are commonplace in other systems. For example, Australian Health Ministers have charged the ACSQHC with maintaining the NSQHS standards and

⁴⁷⁷ O'Keeffe, V., 2014, *Client perceptions of quality care in aged care services*, Centre for Work + Life, University of South Australia.

⁴⁷⁸ Hinchcliff, R., et al., 2016, 'Levers for change: an investigation of how accreditation programmes can promote consumer engagement in healthcare', *International Journal for Quality in Health Care*, Vol. 28(5), p. 564.

⁴⁷⁹ Submission (ID#571698506).

⁴⁸⁰ Australian College of Nursing, *Position statement: The role of registered nurses in residential aged care facilities*, July 2016.

⁴⁸¹ Campbell Research & Consulting and Department of Health, October 2007, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes*, p. 95.

each version is reviewed within five years of introduction;⁴⁸² ISO International Standards also undergo a systematic review process at least every five years after publication to ensure they remain up-to-date and globally relevant.⁴⁸³

This Review supports the recommendation in the Campbell report. We believe it is imperative for there to be periodic review of the Standards, outcome measures and guidance material to ensure that they are fit for purpose and reflect changes in best practice. This should occur every five years.

Periodic review could be done as a comprehensive review of the Standards. An alternative model would be a rolling cycle of review of individual standards and of the good-practice guidance that is used to support them. This model could allow a more even workload for the Department and the Aged Care Commission, and allow deeper engagement with specialists in the relevant area.

Improve and assess clinical governance

Good clinical governance is essential to ensure that clinical care is delivered effectively and that staff are supported and receive appropriate training. It requires that systems are in place to detect poor clinical care within a residential aged care home, review the practices that contribute to it and drive improvement.

The Single Quality Framework consultation paper on draft standards described clinical governance as:

*An integrated component of corporate governance in organisations that provide clinical care. It encompasses the systems used by organisations, from Boards to the frontline clinical and other workforce, to account to consumers and the community for assuming the delivery of safe, effective, consistent, consumer-centred clinical care and for continuously improving the safety and quality of clinical care and services.*⁴⁸⁴

Despite its importance to the management of clinical care, the current aged care Accreditation Standards make no reference to clinical governance. The Victorian Government, in its submission to the Senate Community Affairs Reference Committee Inquiry, noted that:

*Organisational clinical governance requires strengthening to improve aged care providers accountability and consumer confidence. An appropriate clinical governance framework for aged care providers in Australia should be developed and agreed, drawing on the well-established frameworks elsewhere in health care.*⁴⁸⁵

⁴⁸² Australian Commission on Safety and Quality in Health Care, 2017, *National Safety and Quality Health Service Standards (second edition)*, <https://www.safetyandquality.gov.au/wp-content/uploads/2017/09/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

⁴⁸³ International Organization for Standardization (ISO), 2017, *Guidance on the Systematic Review Process in ISO*.

⁴⁸⁴ Department of Health, July 2017, *Report on the outcomes of consultations on the single Aged Care Quality Framework*, p. 35.

⁴⁸⁵ Victorian Government submission to the Senate Community Affairs Reference Committee Inquiry, 2017.

As the health care needs of residents in aged care are becoming more acute and complex,⁴⁸⁶ the importance of effective clinical governance is increasing. The previous section outlined evidence of poor resident outcomes resulting from ineffective clinical care managed, at least in part, by aged care services. There must be systems in place to ensure the delivery of safe, effective, high-quality clinical care and services.

What are the problems with the current approach?

Clinical care is a critical component of the care delivered in aged care homes. The Australian College of Nursing, for example, noted that registered nurses play an important clinical leadership role in aged care homes. This role includes high-level clinical assessment, clinical decision-making, nursing surveillance and intervention, service coordination, and clinical and managerial leadership required to meet desired outcomes and to ensure the provision of high-quality care.⁴⁸⁷

While the Review accepts that this role is undertaken at times under the direction of external health professionals, including an individual resident's general practitioner, registered and enrolled nurses provide an array of clinical functions in aged care homes, many of them self-directed, and without a clear clinical governance framework to guide them.

However, a view was also expressed during our consultations that increasing the rigour of clinical care standards would turn residents' homes into sterile, hospital environments. We do not accept that is a necessary consequence, and believe that the implementation of effective clinical governance and clinical care processes go on behind the scenes, and are critical to residents experiencing good-quality care.

Clinical governance needs strengthening

The Australasian College of Care Leadership and Management noted that while registered nurses identify with being trained expert clinicians, they may not necessarily see themselves as managers or leaders of people and resources, and some may be unprepared for the complex supervisory role in residential care.⁴⁸⁸ Registered nurses need to be supported by, and have input into, a clinical governance framework to enable them to deliver the highest level of care to residents.

The Oakden report illustrates the risks posed by ineffective clinical governance arrangements. The report noted that the absence of clinical governance at Oakden was a critical reason for the failures of care. Warning signs were not heeded, responsibility for clinical outcomes was not owned, leadership was poor, education, training and professional development were seriously deficient, there were no systems of continuous improvement, and important data was not used to drive change.⁴⁸⁹

Dr Groves noted:

⁴⁸⁶ Australian Institute of Health and Welfare, People's needs in aged care, Factsheet 2015–16, GEN Aged Care Data. <https://www.gen-agedcaredata.gov.au/Resources/Factsheets-and-infographics/Care-needs-factsheet.pdf?ext=>.

⁴⁸⁷ Australian College of Nursing, July 2016, *Position statement: The role of registered nurses in residential aged care facilities*.

⁴⁸⁸ Australasian College of Care Leadership & Management, Submission to the General Purpose Standing Committee No.3, Inquiry into Registered nurses in New South Wales nursing homes, pp. 18, 24.

⁴⁸⁹ Groves A., et al, 2017, *The Oakden Report*, South Australia Department for Health and Ageing, pp. 89–90.

Throughout the Review and from almost all we interviewed there was no consistent view of who was in charge of clinical outcomes in Oakden. The more we asked the more we heard people say it was someone else. The Review went around and around hearing that it was someone else who was at fault...

Within the current arrangements, clinical governance seems to be viewed as something separate to clinical practice and something that somebody else 'does' rather than being a system for supporting clinicians to engage in monitoring and improving their practice, and providing safe care; this has resulted in limited clinical leadership of and engagement in the safety and quality systems. There is no shared definition of what good care is or looks like; consequently, roles and responsibilities with respect to safety and quality are not clear, and functions are focussed on compliance activities (rather than improvement) and are fragmented and not well understood.⁴⁹⁰

Ensuring clinical governance requirements are clear

Ultimately, responsibility for the provision of good-quality care lies with the provider.

Professionalism in aged care workers, a commitment to care and compassion, and effective clinical governance of the organisations in which they work are critical to ensuring that residents are well cared for. We believe that the aged care sector needs better guidance on effective clinical governance.

It is encouraging that the draft standards released for consultation in early 2017 as part of the Single Quality Framework include clinical governance as part of Standard 8: Organisational governance.⁴⁹¹ This demonstrates the importance of clinical governance in the delivery of clinical care in residential services. While this is a positive step, there needs to be clarity for providers around what good clinical governance looks like.

When Dr Groves and his colleagues reviewed Oakden, they recommended that the service provider establish a new clinical governance system, and that it be:

informed by the National Model of Clinical Governance Framework developed by the ACSQHC and address each of its elements.⁴⁹²

The ACSQHC has developed a National Model Clinical Governance Framework for acute health service organisations that has five components: governance, leadership and culture; patient safety and quality improvement systems; clinical performance and effectiveness; safe environment for the delivery of care; and partnering with consumers.⁴⁹³ The framework is based on the NSQHS standards, in particular the Clinical Governance Standard and the Partnering with Consumers Standard, and is mandatory for health service organisations that need to meet the NSQHS standards.

⁴⁹⁰ Groves A., et al, 2017, *The Oakden Report*, South Australia Department for Health and Ageing, pp. 73, 75.

⁴⁹¹ Department of Health, 2017, *Single Aged Care Quality Framework: Draft Aged Care Quality Standards Consultation Paper*, p. 32.

⁴⁹² Groves A., et al, 2017, *The Oakden Report*, South Australia Department for Health and Ageing, p. 90.

⁴⁹³ Australian Commission on Safety and Quality in Health Care, 2017, *National Model Clinical Governance Framework*, p.11.

As described by the ACSQHC, a clinical governance framework needs to:⁴⁹⁴

- define clinical governance
- provide context about how clinical governance is an integrated component of corporate governance
- describe the key components of a clinical governance framework based on the NSQHS standards
- discuss the role of culture in supporting good clinical governance
- outline the respective roles and responsibilities of, and essential partnership between, patients and consumers, clinicians, managers, and governing bodies (such as boards) in implementing effective clinical governance systems in health service organisations.

A parallel framework needs to be developed for residential aged care, as well as other aged care providers that deliver clinical care services. The framework should address the roles, responsibilities and scope of clinical care delivered in these settings. This should be incorporated in the guidance material for the new aged care standards. The ACSQHC is an ideal partner to work with aged care regulators, the sector and consumers to develop a clinical governance framework.

Recommendation 9. Ensure that assessment against Standards is consistent, objective and reflective of current expectations of care.

Actions

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

⁴⁹⁴ Australian Commission on Safety and Quality in Health Care, 2017, *National Model Clinical Governance Framework*, p.4.

Chapter 9: Enhanced consumer-centred complaints processes

This chapter examines the effectiveness of the current system for handling complaints about the quality of residential aged care. The primary focus is the Aged Care Complaints Commissioner (the Complaints Commissioner), however the need for improvements in complaints handling by providers is also discussed.

The current legal and regulatory framework seeks to protect aged care consumers, including those in residential care, by ensuring that they and their representatives can complain directly to a care provider or to the independent Complaints Commissioner.

Effective complaints handling is a key mechanism for ensuring the voices of consumers and their representatives are heard, and for identifying and remedying care problems. Complaints to an independent agency may be ‘the canary in the coal mine’, serving as a warning that consumers are at risk, and that regulator intervention is needed, if a provider fails to fix an identified deficiency in care.

The Review’s discussion of complaints handling is based on recurrent themes expressed in submissions and during consultations, and is informed by the Complaints Commissioner’s published procedures, strategies and activity data.

Complaints and complaints-handling activity

The Complaints Commissioner’s 2016–17 annual report covers the first full year of complaints-handling data since the transfer of powers from the Department of Health to the Complaints Commissioner from 1 January 2016.⁴⁹⁵ Some of the Complaints Commissioner’s published data reflects an aggregate of all the aged care programs.

The number of contacts received by the Complaints Commissioner in 2016–17 increased by ten per cent over the previous year.⁴⁹⁶ This may be indicative of a greater awareness of the Complaints Commissioner’s role and ability to assist consumers.

The Complaints Commissioner publishes complaints-handling data spanning the five most recent quarters on its website.⁴⁹⁷ A summary is included at Appendix D.

The usefulness of the data published by the Complaints Commissioner could be improved if all related activity measures were separated by care type. This would allow a more comprehensive appraisal of residential or other care type complaints activity. In addition, publication of other

⁴⁹⁵ Complaints Commissioner, *Annual report 2016–17*. The Excerpt from the Commissioner Principles 2015 [Appendix], sets out the activity the Commissioner must report on.

⁴⁹⁶ This includes the final six months of the Aged Care Complaints Scheme (July–December 2015) and the first six months of the Aged Care Complaints Commissioner (January–June 2016).

⁴⁹⁷ <https://www.agedcarecomplaints.gov.au/about/quarterly-reports/>

activity indicators could increase the level of transparency in reporting. The next section addresses this point in more detail.

More accessible information for consumers

The Complaints Commissioner has developed a range of information products to encourage and facilitate making complaints. They include a series of videos, brochures, posters and fact sheets in a range of different languages, including Indigenous languages, to better support special needs groups.

The Complaints Commissioner also publishes a range of resources for providers, including industry alerts, presentations and a complaints-handling guide, consistent with the Commissioner's role in educating the sector on rights and handling processes.

Several respondents to the Review indicated that access to complaints resources and information needs to be improved. One carer suggested:

*Make the process and the existence of the Aged Care Complaints Commissioner more publicly well-known, and publicly accessible and easier to use.*⁴⁹⁸

Many aged care residents have limited online access or familiarity with how to make a complaint, which suggests the need for complaints materials to be clearly visible within each residential facility. The size and positioning of complaints information within a facility contribute to their accessibility. An aged carer observed:

*More visible signs for residents, family/visitors should be on display in nursing homes with clear instructions on how to make a complaint through the proper channels. As it is, the tiny posters put in out of the way places are not helpful.*⁴⁹⁹

Improving the culture and transparency of complaints handling

Potential barriers to raising complaints

We examined potential barriers to raising complaints. The Aged Care Complaints Commissioner noted: “[M]any people who could complain don’t.”⁵⁰⁰

The decision by a consumer or representative not to complain is influenced by a range of factors, including the ease of raising complaints. Some respondents report being daunted by the process of making a complaint, and need help to lodge the complaint and identify the issues involved.

Consumers may also be concerned about:

⁴⁹⁸ Submission (ID#904826044).

⁴⁹⁹ Submission (ID#730234568).

⁵⁰⁰ Complaints Commissioner, Submission to the Senate Community Affairs References Committee inquiry, p. 8.

- how a complaint would be received—will it be taken seriously and help solve a problem?
- choosing the best person to complain to:
 - individual facility staff
 - provider management
 - an external body such as the Complaints Commissioner
 - police
 - an advocacy body
 - someone else?

For consumers who are older, frailer and more vulnerable, knowing where and how to complain may present a substantial or even insurmountable barrier:

*While complaints handling processes are improving they have remained reactive and reliant on informed consumers with the capacity and courage to complain.*⁵⁰¹

Red tape

A view was expressed in some submissions (from consumers and providers) that the complaints process involves onerous administrative requirements or ‘red tape’, which may be a deterrent. Bupa Aged Care Australia noted:

*The one size fits all approach to complaints, where the onus is on the provider to justify their actions, even when they are in line with Accreditation Standards, creates a great deal of administrative burden for all involved thereby taking providers away from delivering high quality care.*⁵⁰²

Many family members do not know how to make a complaint and / or find the process too onerous or too bureaucratic.

Fear of reprisals

By far the most frequent issue raised as a barrier to making a complaint was the fear of reprisals.

This was raised not just by residents and families, but also by residential aged care staff and professionals who have observed practices that they find inconsistent with the provision of quality care. One aged care advocate recalled being asked by a resident not to complain on their behalf:

The Veterans and War Widows who previously – when they were in their own home – had full access to all the DVA entitlements through the Rehabilitation Appliance Program. This included an unlimited supply of incontinence pads. Once in the RACF they are told they will only be supplied the same number as all the other patients. In the complaints lodged that number was 2 in a 24 hour period. This was regardless of need.

*The complainants were in fear of retribution and would not allow me to disclose their name or their location. This made it difficult to resolve.*⁵⁰³

⁵⁰¹ Victorian Government, Submission to the Senate Community Affairs References Committee, p. 10.

⁵⁰² Bupa Aged Care Australia submission (ID#95926361).

⁵⁰³ Australian Federation of Totally & Permanently Incapacitated Ex-Servicemen & Women Ltd submission (ID#152931135).

Two peak consumer bodies were among those expressing concerns about residents and their families' fear of adverse consequences should they voice complaints. Their concerns highlight the particular significance complaints have within the special needs groups, including in some cases, a culture of not complaining. According to the Multicultural Communities Council of Illawarra:

*It is not part of the culture within many CALD communities to make complaints. In addition many do not know how to go about making a complaint and will rely on others for assistance. Those that do know about the complaints process and how to go about it have commented about their fear of retribution for their loved one who needs to remain in care.*⁵⁰⁴

The Combined Pensioners and Superannuants Association also commented on fear of retribution:

*Many clients are fearful of speaking out or making a complaint due to fear of retribution from the aged care provider or a worker, or out of not wanting to rock the boat.*⁵⁰⁵

Staff are also limited in their capacity to blow the whistle or speak out when issues arise as they may face dismissal for doing so. There must be avenues available to clients, their supporters and aged care staff to provide feedback anonymously.

Of concern was the number of respondents highlighting the fear of reprisals by providers against aged care workers who raise complaints. Fifty-seven per cent of aged care workers who responded to this Review saying that they decided against making a complaint, cited fear of retribution as the reason.

The Complaints Commissioner readily acknowledges the difficulties that confront residents, families or staff, including their fear of reprisals, and has attempted to address this. Complainants can request that their concerns (all or in part) be treated with confidentiality or, alternatively, that the complainant remains anonymous. Those who choose anonymity can also elect to use a pseudonym.

While residents and staff who fear reprisal are encouraged to raise their concerns, the real problem lies within the culture of some provider organisations. This needs to change, as COTA indicates:

*Change the culture of complaints from 'fear of retribution' to 'a normal and welcome part of customer service'.*⁵⁰⁶

Unresponsiveness of providers

Some submissions gave examples of providers who appeared ambivalent to the concerns that were raised with them. One example was received from the son of an aged care resident, who is also a residential facility manager:

As I am a manager at a residential care facility I am aware of how I could make a complaint.

As a family we had been concerned about small things that had been missing from [my father's] care for a while and my sister who lives nearby and visits regularly had felt their concerns were not being met even after speaking to the RN and care staff.

⁵⁰⁴ Multicultural Communities Council of Illawarra submission (ID#312703087).

⁵⁰⁵ Combined Pensioners & Superannuants Association, submission (ID#360932844).

⁵⁰⁶ COTA Australia submission (ID#743548634).

*It was disappointing that I had to eventually make a complaint in writing instead of the facility looking at its practices and making changes before the written complaint.*⁵⁰⁷

Aged care providers with a genuine commitment to consumer-centred care and improvement recognise that mistakes happen and complaints matter. Rather than fear the consequences, they value learning from complaints, and embrace open disclosure, apology and careful attention to analysing and rectifying problems.

Aged care providers are ‘service’ businesses. They should expect that, from time to time, their consumers’ (residents’) expectations will not be met. How organisations react to residents’ complaints is telling. As discussed below, there is a case for naming unresponsive providers in certain circumstances.

Addressing the problem of unresponsive providers

A significant majority of aged care providers willingly accept their responsibilities to residents and their families.

However, not all providers are responsive to complaints or to interventions by the Complaints Commissioner. Some put barriers in the way of attempts by the Commissioner to investigate serious complaints:

*In a small number of cases approved providers are reluctant to assist with the resolution of a complaint. This does not happen often but it can take the form of delaying or refusing to provide documents or refusing to acknowledge failure and correct it and apologise for it.*⁵⁰⁸

Practices of this kind are inconsistent with the responsibilities of providers under the Act, which requires their compliance with directions received from the Complaints Commissioner. More broadly, they are inconsistent with a culture of openness and cooperation in complaints handling.

While existing legislation gives the Complaints Commissioner power to require a provider’s cooperation, it does not provide enforcement or compliance powers. As the Commissioner notes:

We cannot compel approved providers or other agencies and organisations to allow us on premises or to provide information. We rely on good will and co-operation to provide us with the information we need to examine a complaint thoroughly.

*If an approved provider fails to comply with a direction or directions, the Commissioner must notify the Department. The approved provider will be referred to the Department for consideration of compliance action and any further action is up to the Department. At this point, the Commissioner can do little else for the complainant.*⁵⁰⁹

Depending on the circumstances, the Complaints Commissioner’s referral to the Department will be accompanied by a substantial amount of documentation setting out the substance of the matter.

⁵⁰⁷ Submission (ID#979404399).

⁵⁰⁸ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 7.

⁵⁰⁹ Complaints Commissioner, Submission to the Senate Community Affairs References Committee, p. 7.

This then needs to be considered by the Department before a decision to act or not act can be made. The current processes appear slow and unwieldy, and unlikely to engender complainant and public confidence with the aged care regulatory system.

One way to improve the culture of appropriate and responsive complaints handling in aged care facilities would be to give the Commissioner the power to publicly name providers who create barriers to legitimate complaints handling as a non-compliant organisation.

In New Zealand, the Health and Disability Commissioner has the power to name a provider within a public report. The supporting policy for that Commissioner's power states that "in each case the key question is whether the public interest in naming outweighs the potential harm to the provider".⁵¹⁰

We propose that the Aged Care Complaints Commissioner be given a similar power to publicly name a provider who is not sufficiently responsive to, or will not comply with, a direction issued by the Commissioner in respect of a complaint.

It is anticipated that the Complaints Commissioner would develop a policy setting out relevant factors in deciding whether it is in the public interest to name a non-responsive or non-compliant provider. Clearly, fairness and due process will need to be accorded to any provider prior to publication. In most cases, the prospect of adverse publicity will be sufficient to deter behaviour that is not in keeping with placing the welfare of residents at the centre of our system.

An open disclosure statement

In December 2013, Australian Health Ministers endorsed the Australian Open Disclosure Framework (the Framework), developed by ACSQHC.⁵¹¹ The Framework is designed to enable health service organisations and clinicians to communicate openly with consumers when their health care does not go to plan.

We recommend that the Framework be adapted for the residential aged care setting. Many key elements of the Framework are relevant to aged care, including:

- open and timely communication
- acknowledgement
- apology and expression of regret
- supporting and meeting the needs and expectations of consumers, family and carers as well as those in the facility providing the care
- integrating risk management including clinical risk and systems management
- good governance
- confidentiality.⁵¹²

⁵¹⁰ Health and Disability Commissioner (New Zealand), 2008, *Policy document—naming providers in public HDC reports*, p. 2.

⁵¹¹ Australian Commission on Safety and Quality in Health Care, 2013, *Australian Open Disclosure Framework—better communication, a better way*.

⁵¹² Australian Commission on Safety and Quality in Health Care, 2013, *Australian Open Disclosure Framework—better communication, a better way*, pp. 12–13.

A new disclosure framework embedded within Accreditation Standards guidance material will enhance the rights of care recipients and their families, in addition to formalising a requirement for care providers.

The Review also notes the support for open disclosure within the proposed Single Aged Care Quality Framework. Draft Standard 6 – Feedback and complaints includes the following rationale for adoption:

*For example, the requirement to demonstrate open disclosure aligns the standard with contemporary practice regarding the principles of open communication and transparent processes, including acknowledgement and apology when failings are identified.*⁵¹³

The Complaints Commissioner also promotes the benefits of open disclosure:

For a service provider, saying sorry when something has gone wrong is the right thing to do morally, and it's the right thing to do for your organisation.

*A good apology is not an automatic admission of guilt and nor is it laying blame. It is simply a recognition that the service provided has not met expectations and things could have been done better.*⁵¹⁴

Increasing transparency and timeliness in reporting

A key message heard during the Review, from a broad range of stakeholders and experts, is the value of greater transparency in aged care information gathering and sharing. Leading international aged care expert Eilon Caspi notes:

*Greater transparency becomes possible by introducing a specific data system to report. The benefits of transparency are an increase in the accountability among individual nursing homes, providers and the sector as a whole. This should translate into improvements in the quality of care. An important property of public reporting is to have information that is user-friendly and easily accessible to consumers, care advocacy organisations, policy makers, legislators, and the media. This shared knowledge increases the likelihood for well-coordinated policy and preventive interventions.*⁵¹⁵

Increasing the transparency and timeliness of information should result in improved complaints handling.

⁵¹³ Department of Health, 2017, *Single Quality Framework draft aged care quality standards consultation paper*, p. 28.

⁵¹⁴ Aged Care Complaints Commissioner, 2017, *Rae's reflections—the power of an apology*, <https://www.agedcarecomplaints.gov.au/raes-reflections-the-power-of-an-apology/>.

⁵¹⁵ Caspi, E., 2017, 'Commentary – national register of events causing serious resident harm', *Victorian Institute of Forensic Medicine, Residential Aged Care Communique*, Vol. 12(3), p. 6.

The Complaints Commissioner already publishes a set of key performance indicators in addition to the required activity reporting. These indicators measure the effectiveness of internal processes and have been self-assessed by the Commissioner as met in 2016–17.⁵¹⁶

However, the Commissioner’s current reporting results in a minimal level of transparency. Other measures of the Commissioner’s activity could usefully be published to add to the level of understanding and discussion about quality of care and complaints in residential aged care.

We suggest that additional aggregated and de-identified activity measures be published by the Commissioner, which could include:

- the date the complaint was raised and registered with the Complaints Commissioner
- the type of process used by the Commissioner e.g. early resolution
- whether the complaint concerns a person with special needs
- whether an advocacy service has engaged with the complaint / complainant
- the subject e.g. clinical care / quality of life; and the substantive issue involved, e.g. the administration of medication / improvement in environment
- the status of the complaint (remains open / has been closed)
- whether the complaint has been referred to another agency and, if so, when the referred agency is responsible for finalisation of all or part of the complaint, the date it was finalised
- whether regulatory action has been imposed as a result of the complaint.

Greater transparency and utility of complaints data could be achieved with more frequent, accessible activity reporting. To this end, we suggest the Commissioner publish an online activity report, which is updated every month. The online report would provide both an easy-to-view summary of accessible complaints-related data and capture low-level resolution.

Strengthening consumer assistance and advocacy

The involvement of other organisations—referrals

The Complaints Commissioner has a primary responsibility for independently resolving complaints involving aged care services. However, in exercising this responsibility, the Commissioner may determine a need to involve another organisation that may be better placed to deal with the issue.

While referrals by the Complaints Commissioner to other organisations are appropriate in some cases, the complainant may receive inadequate feedback about the status of their complaint as a result. This statement is included within one of the Commissioner’s consumer fact sheets:

Sometimes we will not be able to discuss a referral to another organisation with you as information about the referral is protected information under the Aged Care Act 1997. While the feedback we provide you may be limited, please be assured that we have taken your

⁵¹⁶ Complaints Commissioner, *Annual report 2016–17*.

*concerns seriously and have referred your complaint to the organisation best placed to deal with it.*⁵¹⁷

Where other organisations become involved in complaints, they will usually provide the Complaints Commissioner with a letter advising the outcome of their review at the conclusion of their investigation.⁵¹⁸ However, for reasons that may include matters outside the Commissioner's scope, protected information and / or privacy considerations, there may be little detailed feedback provided to the Commissioner or that the Commissioner can pass to the complainant.

The Complaints Commissioner may encourage the complainant to take the matter directly to that other organisation. In such cases, the Commissioner may take no further action and end the resolution process.⁵¹⁹

Where possible, the Commissioner will attempt to link the complainant with an advocate or advocacy organisation. However, the Review heard that this may not always produce the desired outcome:

*The Complaints Commissioner referred a client to us when they did not have a clear understanding of ... our organisation's ability to assist the individual.*⁵²⁰

It is obviously important that care is taken in referring a complainant to another organisation, both to ensure an issue that properly lies with the Complaints Commissioner is not referred away, and that the recipient is an appropriate body to handle the referred matter. Having to deal afresh with new and unfamiliar organisations would be demotivating or stressful for residents and families.

Aged care consumers need to be confident that the Complaints Commissioner will assist them through to the conclusion of their complaint.

The Complaints Commissioner's policies and procedures should be reviewed and amended where necessary to reflect:

- that the Commissioner will link complainants with appropriate advocates where they are available, but will remain the complainant's primary contact in respect of the progress of their complaint where the complainant accepts that offer by the Commissioner
- that complainants who elect to have the Commissioner act as their primary contact receive appropriate information on the progress and finalisation of their complaint either from the Commissioner or from the organisation the complaint is referred to
- that the outcomes of referred complaints will be tracked and reported on, including when they are finalised by the organisation they are referred to.

⁵¹⁷ Aged Care Complaints Commissioner, 2017, *Fact sheet – referrals to other organisations*,

<https://www.agedcarecomplaints.gov.au/resources/factsheets/factsheet-referrals-to-other-organisations/>

⁵¹⁸ Protocols for information sharing are generally set out within individual memorandums of understanding between the Complaints Commissioner and other organisations.

⁵¹⁹ Australian Government, *Complaints Principles 2015, Explanatory Statement*, Section 8 – No further action on an issue and Section 14 – Ending resolution process,

<https://www.legislation.gov.au/Details/F2015L02125/Explanatory%20Statement/Text>

⁵²⁰ Advocare Inc submission (ID#1069639159).

Strengthening advocacy within the Community Visitors Scheme

The Australian Government's Community Visitors Scheme funds organisations referred to as 'auspices' to coordinate volunteers to visit the residents of aged care facilities and home care consumers. The scheme aims to support people who are socially isolated and whose quality of life would be improved by friendship and companionship. In 2016, the Department commenced a review of the scheme, which was completed in 2017. The final report presents a range of options to enhance the scheme and align it with other aged care support programs within the context of current and ongoing aged care reforms.⁵²¹ The government is currently considering these options.

The Community Visitors Scheme also incorporates state-based network members who play a significant role in facilitating collaboration, information sharing and training for the scheme's auspices in their jurisdictions.

According to Department of Health guidance material, the responsibilities of visitors include:

- notifying the scheme's auspice coordinator of any accident or incident that occurs while visiting
- reporting unsafe visiting environments
- exercising a duty of care at all times.⁵²²

A volunteer visitor cannot become involved in investigating or following up complaints. If a visitor becomes concerned about some aspect of a resident's care, they should seek advice from their scheme's auspice coordinator. The auspice is responsible for notifying the provider.⁵²³

While a visitor in the scheme has a responsibility to inform the auspice organisation of any concern they may have, there appears to be little guidance for how an auspice should respond to the visitor's concerns.

In some cases, for example when a visitor has not been informed of a resident's desire for confidentiality, it may be inappropriate for an auspice to report the visitor's concerns to the provider. In addition, the matter may be further complicated where the auspice organisation is also the provider of care.⁵²⁴

We note the findings of the ALRC report into elder abuse:

⁵²¹ Department of Health, 2017, *Review of the Community Visitors Scheme: final report*, <https://agedcare.health.gov.au/support-services/review-of-the-community-visitors-scheme-final-report>

⁵²² Department of Health, 2017, *Community Visitors Scheme frequently asked questions: visitors/auspices*. <https://agedcare.health.gov.au/older-people-their-families-and-carers/community-visitors-scheme/community-visitor-scheme-cvs-frequently-asked-questions-faqs>.

⁵²³ Department of Health, 2017, *Community Visitors Scheme frequently asked questions: visitors/auspices*. <https://agedcare.health.gov.au/older-people-their-families-and-carers/community-visitors-scheme/community-visitor-scheme-cvs-frequently-asked-questions-faqs>

⁵²⁴ The Department of Health advised the Review that a number of organisations funded to auspice the scheme are also aged care providers (Personal communication, 28 August 2017).

*The Department of Health (Cth) should develop national guidelines for the community visitors scheme. The guidelines should include policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients.*⁵²⁵

We note that a range of sectors in the states and territories also have official visitor schemes that focus on advocacy and rights protection for vulnerable people, such as people with disability, children in care, and people in mental health services.

A consumer peak body remarked on the value of visitors in providing a further safeguard for system quality, drawing the Review's attention to the ALRC report in respect of an official visitors scheme:

In terms of implementing a broader improvement to quality, COTA believes there is merit in exploring an official visitors scheme to achieve greater early warning systems in monitoring and indeed complaint handling.

*As the ALRC Discussion Paper said, the official visitors scheme would 'complement complaints and reportable incident schemes, by providing an additional opportunity to identify issues of concern, especially on behalf of those with cognitive or communication disabilities, and those with fewer social supports'.*⁵²⁶

The ALRC concluded that the current focus should be on continuing to support consumer advocacy services. However, it recognised that an official visitors scheme might be something to be considered in future, depending on a review occurring in the disability sector:

*The NDIS Quality and Safeguarding Framework intends to undertake an independent evaluation of state and territory visitors schemes to consider how such schemes might integrate with other oversight mechanisms. Results of this evaluation should inform future consideration of the utility of an official visitors scheme in aged care.*⁵²⁷

We note the ALRC findings and recommend that once established, the Consumer Commissioner, in partnership with the Complaints Commissioner, clarifies processes for reporting the concerns of visitors participating within the Community Visitors' Scheme including:

- setting out a clear policy and guidelines for organisations funded to auspice the scheme
- making clear the existing duty of care visitors and auspice organisations have under the scheme in raising and reporting concerns or complaints related to the provision of residential care for an individual or group of care recipients (and other forms of aged care)
- setting out, within policy and guidelines, the options available to the scheme's visitors and auspice organisations for raising concerns including by
 - the auspice making direct and early contact with the Complaints Commissioner
 - where the auspice is also an aged care provider, referring the visitor's concerns to the auspice network (state level) as soon as possible for the network's early referral to the Complaints Commissioner.

⁵²⁵ Australian Law Reform Commission (ALRC), 2017, *Elder abuse—a national legal response*, ALRC report 131.

⁵²⁶ COTA submission (ID#743548634).

⁵²⁷ Australian Law Reform Commission (ALRC), 2017, *Elder abuse—a national legal response*, ALRC report 131.

Recommendation 10. Enhance complaints handling.

Actions

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

Appendix A: Terms of reference

Terms of reference were established for the review of the Australian Government's regulatory activities applying to quality of care in aged care residential facilities.

The review was not to review the care provided at the Makk and McLeay wards at Oakden Older Persons Mental Health Service (Oakden) and relevant to Commonwealth aged care regulatory processes.

The review examined and advised on:

- why, prior to its sanction on 17 March 2017, Commonwealth aged care regulatory processes did not adequately identify the systemic and longstanding failures of care at the Makk and McLeay wards documented in the Oakden report.
- what improvements to the Commonwealth aged care regulatory system would increase the likelihood of immediate detection, and swift remediation by providers, of failures of care such as those identified in the Oakden report.

This could include changes to:

- the legislative framework for the provision of aged care in Australia, including the *Aged Care Act 1997* and the *Australian Aged Care Quality Agency Act 2013*
- the administrative policies and approaches of the Department of Health, the Aged Care Complaints Commissioner, and the Australian Aged Care Quality Agency
- reporting requirements, whether voluntary or mandatory, for residential aged care staff and any other care professionals involved in the provision of care in a residential setting
- engagement between the Commonwealth aged care regulatory agencies and other relevant regulatory agencies including those administering healthcare standards
- any other matter that the reviewers consider relevant to the purpose of the review, including any other measures in addition to current statutory arrangements that may strengthen the protection of residents.

Having regard to recent findings in respect of the Makk and McLeay wards at Oakden, the review will examine the processes managed by all Commonwealth agencies involved in regulating the quality of care in residential aged care facilities, as follows:

- the Department of Health
- the Aged Care Complaints Scheme, managed by the Department of Health until 1 January 2016
- the Aged Care Complaints Commissioner
- the Australian Aged Care Quality Agency.

Appendix B: Process of the review

An independent review of Commonwealth aged care regulatory processes was announced by the Minister for Aged Care, Hon Ken Wyatt MP, in response to the Oakden report which detailed failures in the quality of care delivered at the Oakden Older Persons Mental Health Service (Oakden) in South Australia.

The Review examined why regulatory processes did not adequately identify the systemic and longstanding failures of care at the Makk and McLeay wards documented in the Oakden report. The Review also identified improvements to the regulatory system that would increase the likelihood of immediate detection, and swift remediation by providers.

Independent reviewers

The Review was led by Ms Kate Carnell AO, a veteran public administrator and regulator, in conjunction with Professor Ron Paterson ONZM, an international expert on patients' rights, complaints, health care quality and the regulation of healthcare professions.

The Reviewers were supported by a Secretariat in the Department of Health.

The Review examined and reported on Commonwealth regulatory practices relating to monitoring the quality and standard of care in residential aged care facilities. The review was not intended to investigate and resolve individual cases—that is the role of the Aged Care Complaints Commissioner. However, individuals' experiences of care helped identify opportunities to improve Commonwealth regulatory processes.

Consultation strategy

The reviewers used several strategies to conduct the Review. They included a public consultation process and targeted consultation with key aged care stakeholders, including consumer and service provider peak bodies. Meetings were held with regulatory bodies, including the Department of Health, the Aged Care Quality Agency and the Aged Care Complaints Commissioner.

Information about the review was disseminated using:

- the Department of Health Ageing and Aged Care website⁵²⁸
- the Department of Health My Aged Care website⁵²⁹
- the Department of Health Aged Care Providers newsletter
- the Department's bulk information distribution message system
- the Department of Health's Twitter account
- Minister Wyatt's media releases: 1 May 2017, 11 May 2017, 20 June 2017 and 14 August 2017⁵³⁰
- a dedicated external-facing inbox: agedcarequalityreview@health.gov.au

⁵²⁸ <https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes>

⁵²⁹ <https://www.myagedcare.gov.au/latest-news>

⁵³⁰ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/the-hon-ken-wyatt-am-mp-media>

Literature review

The Department engaged with KPMG to undertake a literature review examining the regulatory processes that underpin the delivery of quality care in residential aged care facilities in Australia and overseas. The literature review examined the benefits and challenges posed by Australia's current regulatory model and key attributes of successful international and national regulatory systems.

Editing services

Hamilton Stone provided editorial and writing services for this report.

Appendix C: Consultation summary

Targeted consultation

A multi-faced consultation approach was undertaken to ensure that the review was informed by the collective and varied experience of policy-makers, regulators, academics, health and aged care service providers, care recipients and their families and carers. Face-to-face and teleconference meetings were held with:

Consumers and Aged Care workers

Families of former residents at the Oakden Older Persons Mental Health Service

Mr Shane Lyttle & Mrs Margaret Lyttle

Aged Care Regulators

Dr Nick Hartland, Valerie Spencer & Neil Callagher, Australian Government Department of Health: National Aged Care Compliance Programme

Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency

Ms Rae Lamb, Ms Shona Moloney & Ms Viv Daniels, Aged Care Complaints Commissioner

Aged Care Organisations

Aged Care Sector Committee

Ms Andrea Coote, Chair, Aged Care Quality Advisory Council

Mr Tim Dixon, HammondCare

Ms Netty Horton, Salvation Army

Ms Fiona May & Mr Geoff Rowe, Older Persons Advocacy Network

Ms Andrea Matthews, mpconsulting

Mr Cameron O'Reilly, Mr Ross Johnson & Mr Andrew Sudholz, Aged Care Guild

Mr Sean Rooney, Leading Age Services Australia

Ms Pat Sparrow & Mr Darren Matthewson, Aged and Community Services Australia

Professor Graeme Samuel & Ms Maree McCabe, Alzheimer's Australia

Mr Ian Yates, Council on the Ageing Australia

Academics and technical experts

Adj/Professor Debora Picone, Dr Robert Herkes, Dr Nicola Dunbar & Margaret Banks, Australian Commission on Safety and Quality in Health Care

Adj/Professor Mark Brandon OAM, Brandon Consulting

Professor Jeffrey Braithwaite, Australian Institute of Health Innovation, Macquarie University

Ms Robyn Coulthard, former Nurse Adviser to the Northern Adelaide Local Health Network

Emeritus Professor Rosalind Croucher, former Chair, Australian Law Reform Commission

Dr Stephen Duckett, Grattan Institute

Professor Joseph E Ibrahim, Health Law and Ageing Research Unit, Department of Forensic Medicine, School of Public Health and Preventive Medicine, Monash University

Ms Robyn Nolan, National Council of Women (WA)

Mr David Tune, Chair, Legislated Review of aged care

Ms Lisa Triggs, London School of Economics, United Kingdom

Dr Catherine Yelland, Geriatrician, Redcliffe Hospital

Professor Marilyn Walton, Professor of Medical Education (Patient Safety), University of Sydney

Professor Mike Woods, Centre for Health Economics Research and Evaluation, University of Technology Sydney

NOUS Group

Government officials

Australian Government Department of Health:

- Aged Care Access and Quality Division
- Aged Care Policy and Regulation Division
- Health State Network (NSW and SA)
- Dr Anthony Hobbs, Deputy Chief Medical Officer
- Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Dr Aaron Groves, former South Australian Chief Psychiatrist

Ms Michele McKinnon, Director, Safety and Quality, South Australian Department for Health

Victorian Department of Health and Human Services

As well as meeting with key stakeholders, the reviewers conducted three consumer forums in Brisbane and Melbourne.

Alzheimer's Australia and COTA supported the forums, helping to recruit a broad range of consumers, family members and carers who could share their experiences with aged care quality regulatory processes and provide their views on desired improvements.

We value the contribution every individual and organisation provided to the Review. We recognise the courage of people who told their personal stories. We are grateful for the skills and experience shared by peak organisations and academics. These contributions steered the direction of the report.

Public consultation

Formal feedback was sought through an online survey on the Department's consultation hub, which uses the Citizen Space platform designed with specific demographic questions to support analysis. Questions were directed to respondents to identify aspects of aged care regulatory processes that should be retained or changed. There were free-text boxes to ensure respondents had the opportunity to describe their experiences and identify opportunities for improvement. Public consultation opened on 19 June 2017 and closed on 24 July 2017.

To ensure that the process was comprehensive and accessible, people who had trouble using the online survey process could send hard copy submissions or via email. The review secretariat then manually entered these responses into Citizen Space on their behalf.

Notable features of the public consultation process were that:

- there was strong interest in the survey. A total of 423 submissions were received, with 399 responses provided through the online survey tool.
- 76 per cent (N = 321) of respondents indicated that they agreed for their submissions to be published.
- 69 per cent (N = 292) of responses came from individuals or organisations based in east coast states (NSW, VIC, QLD); only four responses came from NT and seven from TAS.
- 17.5 per cent (N = 74) of respondents were organisations and 81.7 per cent (N = 345) were individuals (three respondents did not respond to this question).
- 17.1 per cent (N = 72) of respondents live in rural or remote areas, 12.3 per cent identify as people from culturally and linguistically diverse backgrounds. 4 per cent (N = 17) were Aboriginal and / or Torres Strait Islander people. 2.4 per cent identified as lesbian, gay, bisexual, transgender or intersex and 12.3 per cent (N = 52) identified as being financially or socially disadvantaged.
- 37.7 per cent (N = 159) of respondents were aged care workers / professionals. 14.9 (N = 63) per cent were family and / or carers for an aged care resident, and only 2.8 per cent (N = 12) of responses came from aged care consumers.

What the submissions said

Focus of regulation

Retaining the practice of provider self-assessment against the Standards as part of the accreditation process was identified as important for provider engagement with the process and quality improvement. Providers also noted the importance of support from the Quality Agency, especially for providers who are non-compliant, to help improve their quality of care.

Providers encouraged the continuation of Quality Agency support through support visits to facilities:

*Extension of the accreditation period from 3 years to allowing for increased support visits to ensure homes are maintaining standards.*⁵³¹

*Sliding scale for accreditation periods can be based on previous record of compliance and rewards those who exceed by a longer accreditation period. This approach could then enable resourcing into services that need regular support.*⁵³²

Stronger focus on consumer outcomes

There was a strong view that the accreditation process is too 'paper focused' and there should be a greater focus on the engagement with consumers, families / carers and staff.

*I think a lot of the evidence which has to be supplied is all very well but speaking for myself I spend 80% of my time collecting data that will never be looked at but is done in case it is. I would much rather spend my time monitoring the actual care being given.*⁵³³

It was proposed that accreditation should focus on engagement with consumers, their families and carers and the 'staff on the floor'. One respondent noted that accreditation should focus on whether the provider was meeting the individual care needs of residents.

*Accreditation should be less paperwork-focused, and more practical, ie more focus on outcomes and consumer/carers involvement.*⁵³⁴

Forty-six per cent of respondents [N=84] who identified as having reason to make a complaint about aged care services, elected not to because of fear of retribution. A few respondents said that there should be more interviews conducted privately with consumers, family / carers and staff, to address this barrier to making complaints. One respondent also suggested that general practitioners should be involved in the interview process. There was a strong view that the surveyors should be randomly selecting whom they interview and residents' files to audit.

*GPs should be included in the accreditation process as clinical/medical leads.*⁵³⁵

⁵³¹ Submission (ID#308648982).

⁵³² Submission (ID#272875091).

⁵³³ Submission (ID#322970458).

⁵³⁴ Submission (ID#339723358).

⁵³⁵ Submission (ID#272875091).

The authenticity of input by residents and families into the accreditation process is a concern: interviews should be conducted in a non-threatening environment away from the provider, to allay any fears they may have of speaking candidly (additionally, interviews should not be conducted in multi-person rooms).⁵³⁶

The selection of resident files for audit should be made by the accreditor and not the aged care service, who could hand-pick only positive cases.⁵³⁷

Several respondents suggested that engagement with consumers and their family and carers should occur by phone or email. Another respondent proposed that discussions with consumers be conducted off-site.

Accreditation Agents should interview more residents or representatives at facilities for their feedback. This should include emailing representatives or speaking to them by phone. Perhaps interview some who have made complaints before or internal complaints for their feedback.⁵³⁸

It was proposed that if consumer experience reports are to drive cultural change in residential aged care, interviews with residents in each facility need to be conducted annually, rather than every three years. It was proposed that a higher percentage of residents should also be interviewed during site visits.

The newly introduced Consumer Experience Reports are not timely and do not offer providers the opportunity to respond to consumers' observations. Providers would like to be able to respond to consumers' experiences to demonstrate how they improved the quality in response to observations made by consumers.⁵³⁹

LASA Members suggest that more frequent collection of consumer experience data may be more meaningful than the current 3-yearly collection period.⁵⁴⁰

More effective performance monitoring

Forty-five per cent of respondents to the Review survey felt that current processes for the accreditation of aged care homes were not effective. Fifty-one per cent of respondents were also dissatisfied with processes for monitoring performance of aged care homes.

One aged care worker noted that scheduled visits created extensive stress for care staff who were required to prepare for assessments and that this may be reduced by conducting unscheduled visits instead.

The accreditation process should be retained but done on a basis whereby the Inspection is done WITHOUT the prior knowledge of the visit. I have witnessed the lengthy ongoing

⁵³⁶ Submission (ID#1069639159).

⁵³⁷ Submission (ID#1069639159).

⁵³⁸ Submission (ID#985883601).

⁵³⁹ Submission (ID#883559093).

⁵⁴⁰ Submission (ID#883559093).

*process by an [aged care facility], to prepare for the Accreditation inspection and of all the false equipment and cleanliness that the facility went through to make a good impression.*⁵⁴¹

It was suggested that unannounced visits should happen both day and night, as well as on the weekend to get a better sense of how care is delivered at contrasting times. The Quality Agency should have a 'mystery shopper' that could be conducted by nursing students. Expanding the Community Visitors Scheme to observe the quality of care delivered and report any incidents of poor care – was also suggested.

*... site visits by auditors who do not reveal their identity – such as a mystery agency worker, to get the real picture of what care is really like.*⁵⁴²

*More "unplanned" visits should be considered. Out of hours or weekend visits should be considered.*⁵⁴³

*Assessments should be carried out over a range of random time periods (evenings, nights and weekends). Assessors should involve themselves in the usual care routines so they can actually monitor care standards and resident health.*⁵⁴⁴

There was a strong view that unannounced site visits should be retained, with particular support from aged care workers.

*As an experienced quality surveyor I'm well aware that a lower risk provider can, sometimes almost overnight, become high risk due to changes in management, key staff, residents with escalating care needs, etc. For such reasons, it's essential we maintain the requirement for AT LEAST one unannounced visit per year.*⁵⁴⁵

*Many residents, relatives and staff (and sometimes even managers) over the years have told me stories about how providers put in temporary fixes (including extra staffing) for announced visits. Residents and relatives place their confidence much more in the process of unannounced visits and I think there would be an outcry if the Agency dropped this requirement.*⁵⁴⁶

*staff are under huge pressure from management at accreditation time some told what to say if accreditation team want to speak to them.*⁵⁴⁷

Supporting assessors to make objective assessments of quality

There was a strong view that accreditation visits should be longer, as surveyors may be reluctant to find a provider non-complaint due to time restraints. One aged care worker noted that providing insufficient time for thorough investigation during accreditation visits could undermine surveyors'

⁵⁴¹ Submission (ID#218218674).

⁵⁴² Submission (ID#673055120).

⁵⁴³ Submission (ID#504850188).

⁵⁴⁴ Submission (ID#617437173).

⁵⁴⁵ Submission (ID#346790910).

⁵⁴⁶ Submission (ID#346790910).

⁵⁴⁷ Submission (ID#124976532).

confidence in the defensibility of adverse findings about provider care, which may contribute to conservative decision-making. It was also stated that accreditation needed to be more objective and evidence-based.

*In the state I work in, our staffing allocations in relation to home size have remained unchanged over the years despite residents' care needs increasingly significantly over that time. This means we're having to review more and more complex clinical information (verbal and written) without having additional time or staffing to do so. In turn, this means we're doing more superficial and rushed assessments which unfortunately means we're missing problems and having less time to explore concerns, two factors clearly at play for Oakden.*⁵⁴⁸

It was noted that there should be mandatory reporting of quality indicators, with support for more quality indicators to be developed. Two respondents suggested that this information should be published on the My Aged Care website. Respondents showed support for the use of quality indicators for providers to benchmark their performance against similar services.

*More Bench marking quality indicators and improved records so Board and families can measure quality.*⁵⁴⁹

Several respondents felt that assessors should have clinical training to enable them to investigate the management of clinical care provided in facilities. They also suggested that a registered nurse should be on each assessment team. There was also support for assessors to have training in mental health, particularly for people living with dementia, and for more training generally.

*Assessors should be experienced and current clinicians that know what to look for and where to find it. Simply checking paperwork does not ensure a rigorous review of care standards and resident outcomes.*⁵⁵⁰

*Assessors need better training, and serious investigations need to be resourced with more medical authority and the capacity to gather first hand evidence. It should still be possible within a strengthened Government regime for better performers to earn a more light handed approach to their reaccreditation.*⁵⁵¹

More information for consumers on performance

There was a strong view that there is a lack of public information available about the rights, responsibilities, the meaning of quality of care and the performance of residential aged care facilities. The information that is available is not easy to understand.

A few respondents indicated that rather than simply defining minimum expectations for the quality of care, the Accreditation Standards should be used to differentiate performance of providers. They also proposed the adoption of a five-star rating system.

⁵⁴⁸ Submission (ID#346790910).

⁵⁴⁹ Submission (ID#1053395477).

⁵⁵⁰ Submission (ID#617437173).

⁵⁵¹ Submission (ID#991551124).

Better information to help providers meet their obligations

It was suggested that the Standards were too vague; the language is unclear and leads to subjective interpretation.

*Vague wording in the standards such as adequate staffing and adequate training should be replaced by a quantifiable description. Who judges what adequate means??*⁵⁵²

Compliance

There was a variety of suggestions as to how non-compliance could be managed better. It was proposed that sanctions should be harsher to encourage compliance with the Standards. However, it was also suggested that sanctions should be removed and replaced with more frequent visits to non-compliant providers:

*The Guild considers the use of sanctions as a penalty for extreme cases to be appropriate, if consistently and fairly applied, but notes the importance of a proportionate response by regulators. The Quality Agency could use a more collaborative approach to assist providers improve processes and procedures to complement the application of sanctions.*⁵⁵³

It was noted that it was important to maintain a proportionate, risk-based response to provider non-compliance with the Accreditation Standards:

*We also support moves toward a risk-based approach to regulation as we believe this will help drive service excellence, continuous improvement and reduce red tape. In other words, we call for a system not solely focused on technical compliance and enforcement, but one designed to drive innovative practice and subsequent improvements in quality.*⁵⁵⁴

Complaints handling

Many respondents felt there was a lack of clarity around the complaints-handling process. Fifty-two per cent of respondents to the Review survey indicated that they experienced difficulty finding information about the complaints handling process:

*Finding information when you are working as an advocate (no government funding in my case) is relatively easy. However relatives (residents' representatives) who I assist, or hear from, often lack an understanding of the process. Where they have acted on their own they typically have made a verbal complaint and they have either not been told, or have failed to understand, the process options available to them.*⁵⁵⁵

*It should also be easier to access information to make complaints and who we can talk to about the complaint.*⁵⁵⁶

⁵⁵² Submission (ID#339723358).

⁵⁵³ Submission (ID#1032742486).

⁵⁵⁴ Submission (ID#793278997).

⁵⁵⁵ Submission (ID#322319626).

⁵⁵⁶ Submission (ID#632417958).

Many respondents had no confidence in the complaints-handling processes:

After my complaint to the Aged Care Complaints hotline the Facility provided me with a report. It contained a number of assertions I knew to be incorrect, including the suggestion my mother had pulled curtains on herself.

*The Aged Care Hotline said as my initial complaint had been satisfied and my further complaint referred to a systemic staffing issue they were unable to help me.*⁵⁵⁷

*On both occasions the provider was given a gentle slap on the wrist. Initially it was noted that the provider would try alternative interventions and on the second occasion the provider agreed to remind staff of their obligations and hold a staff meeting to discuss the issue. The complainant felt let down, betrayed by the Complaints Scheme.*⁵⁵⁸

*It took ten days for the complaints officer to contact me. They showed little insight into the situation we were alerting them to and were reluctant to take any immediate action. The complaints scheme provided details of the complainant to the provider which resulted in us losing our service contract with the provider. Frustrated with the process, we withdrew our involvement in the case and the matter was not pursued further by the department.*⁵⁵⁹

Fear of reprisal was a common reason given for not making a complaint. Those fearing reprisals were principally aged care workers / professionals and family or carers of an aged care consumer:

*Every time we verbally complain to management about a situation we get bullied into accepting it as normal. This includes (at the moment) 2 staff dealing with 16 wandering and aggressive dementia residents with no supervisor on site.*⁵⁶⁰

*There is that fear factor of retribution present in many homes and I have found that if we try to make a complaint, we are often shut down by management. Complaints are often not treated as confidential which further complicates matters and I have personally experienced a manager who was the workplace bully.*⁵⁶¹

Respondents indicated that it was important to keep the ability for residents, families and staff to make anonymous complaints. However, it was also noted that providers usually do their best to resolve issues and that anonymous complaints should never be accepted. Individuals who provide an anonymous complaint do not receive feedback on the outcome of the investigation:

*"Informants" are told their names will be suppressed but they aren't and there are serious ramifications for dedicated carers trying to do the right thing for the elderly...also management are forewarned giving them time to have those who would be willing to talk truthfully off duty.*⁵⁶²

⁵⁵⁷ Submission (ID#16842646).

⁵⁵⁸ Submission (ID#16842646).

⁵⁵⁹ Submission (ID#322319626).

⁵⁶⁰ Submission (ID#617437173).

⁵⁶¹ Submission (ID#490060676).

⁵⁶² Submission (ID#23768430).

*There needs to be some way of ensuring that consumers/carers are not vilified for making complaints. Despite assurances to the contrary, there are repercussions for complaining, such as my experience of a DON writing to family members threatening them with a ban to enter the facility if they continued to put forward complaints.*⁵⁶³

Many people had trouble finding information on complaint processes. There is a need for better access to education programs promoting the roles and responsibilities of regulatory bodies and advocacy programs, so that consumers and service providers better understand the safeguards available to address concerns.

The need for more accessible, plain English information on complaint processes was also highlighted. There should be access to translation services for people from culturally and linguistically diverse backgrounds:

There is a need for a plain English brochure which sets out the options, especially their right not to accept the 'quick resolution' option.

Submitters thought that visits from independent advocacy organisations could improve understanding of complaints-handling processes.

Data sharing and communication between organisations

It was suggested that the communication and data sharing among regulators should be improved:

*A system enabling Australian Government authorities to be alerted to possible performance shortfalls in aged care facilities, including via reports by health professionals, local authorities and visitors, and via complaints from residents, families and consumer advocates.*⁵⁶⁴

It was noted that the Quality Agency's role should remain independent of the Department. Similarly, the Aged Care Complaints Commissioner should remain independent:

*My advice would be to re-structure and outsource Quality and Compliance using, for example the International Standard 1900 Series Quality Management (processes include Business Structure and Audit, including professional and external auditors) resulting in resident and family confidence in 'arms length' compliance review, complaints investigation, reduced political interference to appease Shareholder expectations, and businesses focussing on profit.*⁵⁶⁵

*The Government should hand over the entire process to an Independent and International Quality Management Organisation or similar.*⁵⁶⁶

⁵⁶³ Submission (ID#339723358).

⁵⁶⁴ Submission (ID#918059272).

⁵⁶⁵ Submission (ID#352779491).

⁵⁶⁶ Submission (ID#352779491).

There was support for the adoption of a single regulator, as recommended by the Productivity Commission, as a means to introduce a unified culture in aged care quality regulation and to achieve more efficient outcomes:

*A system for responding to verified shortfalls in performance, via methods including: education and assistance; notices of non-compliance; and sanctions” involving penalties culminating in loss of accreditation. Backed up by reinspections against the standards, and unannounced visits.*⁵⁶⁷

Aged care staffing

There was a strong view that the lack of staff was a major contributor to the number of complaints made around quality of care. It was noted that this situation negatively impacts staff morale:

*There are inadequate staffing levels, they are overworked, and the communication chain is not always maintained. Both these facilities have tried very hard over the years to meet our requests.*⁵⁶⁸

There was strong support for mandatory staff ratios in residential aged care facilities, to be audited as part of accreditation, and for a requirement that a registered nurse be on duty at all times in facilities:

*Registered nurse coverage 24/7 is essential for the appropriate nursing care to be given and monitored for residents who are increasingly debilitated and with multiple health issues. Having a nurse on call for the facility is not adequate – residents have a right to expect timely provision of things such as analgesia such as an S8 schedule medication which requires registered staff to administer, and having to call a nurse in from home during the night is unacceptable.*⁵⁶⁹

Another suggestion was that personal care workers should be required to earn qualifications to deliver services to residents. Staff should receive additional training, including specific training in delivering care to people with dementia:

*I think the required level of education personal care workers have is not enough, they are under educated and underpaid. With an overly demanding, stressful job on minimum wage it is somewhat understandable why care workers unwittingly participate in elder abuse day in, day out.*⁵⁷⁰

⁵⁶⁷ Submission ID#918059272).

⁵⁶⁸ Submission (ID#1045379818).

⁵⁶⁹ Submission (ID#371432381).

⁵⁷⁰ Submission (ID#673055120).

Appendix D: Complaints statistics

Aged Care Complaints Commissioner: summary of activity data

Contact type	Jul 2016–Jun 2017	Apr–Jun 2016	Jan–Mar 2016
Complaints	4,713	1,113	1,041
All other contact types*	6,294	1,384	1,728
Total	11,007	2,497	2,769

*Includes enquiries, own-initiative motions, reviewed processes and out of scope contacts.

All complaints by initiator type

Of the total number of complaints received by Complaints Commissioner for all care types in 2016–17, 2,838 (60 per cent) came from a representative or family member, 873 (19 per cent) from a care recipient, 574 (12 per cent) came from an anonymous complainant, 374 (8 per cent) from other interested person/s and 54 (1 per cent) from another initiator.

Complaints by care type

In 2016–17 there were a total of 3,656 complaints made in respect of residential care which accounted for 78 per cent of all complaints. The remaining 22 per cent were split between the home care packages (688 or 15 per cent) and the Commonwealth Home Support Program (339 or 7 per cent).

Most common residential complaints

Medication administration and management (559), falls prevention and post fall management (382) and personal and oral hygiene (365) accounted for the most common issues in residential care complaints in 2016–17.

Complaints finalised

The Complaints Commissioner reported a total of 4,617 finalised complaints in 2016–17 year, a 16 per cent increase over the previous period with 99 per cent finalised within 90 days.

Resolution processes

Wherever possible, the Commissioner's practice is to support the complainant to resolve their concerns quickly and directly with the service provider (early resolution process). In 2016–17, early resolution was achieved in 4,288 cases or 92 per cent, compared to 85 per cent of cases in the previous 12 months.

Site visits

For the 2016–17 year, the Complaints Commissioner reported a total of 50 site visits compared with 49 visits made in the six months to 30 June 2016 (all service types). Of those, 43 were announced (35 in 2015–16) and seven were unannounced (14 in 2015–16).

Notice of intention to issue directions (notice)

The Complaints Commissioner's processes include giving notice to a provider that the Commissioner is considering issuing the provider with a direction to undertake specific actions. This notice is given by the Commissioner following consideration of the provider's initial response to the complainant's concern.

The Complaints Commissioner reported that a total of 30 notices were sent during 2016–17 (compared to nine in the period January–June 2016) with five directions subsequently issued (nine in the preceding period). The directions issued in 2016–17 related to the charging of a capital refurbishment fee, infection control and security of tenure.

Referrals

Following an assessment of the issues raised by a complainant, the Complaints Commissioner may refer that complaint or matter to another more appropriate organisation. A total of 511 referrals were made in 2016–17:

- 468 to the Quality Agency
- 33 to the Department
- 10 to other organisations including one to APRHA.

Own-initiative processes

The Complaints Commissioner commenced 48 own-initiative processes in 2016–17 (29 in 2015–16) relating predominantly to fees, charges and care recipient health or personal care.

Residential care anonymous complaints

The Complaints Commissioner advised the review that there was a total of 542 anonymous complaints made in respect of residential care in the 2016–17 year.