A literature review and description of the regulatory framework to support the project for the 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

November 2005
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Terms and acronyms

Key definitions

For the purposes of the project, the following definitions have been adopted.

**Accreditation** refers to a system where an external, independent authorised body assesses an organisation’s compliance with a set of defined standards or criteria.

Approved provider is a person or body in respect of which an approval under Part 2.1 of the *Aged Care Act 1997* is in force, and, to the extent provided for in section 8–6, includes any state or territory, authority of a state or territory or local government authority.

**Certification** is a status given to residential aged care homes based primarily on their ability to provide quality accommodation.

**Residential aged care** refers to care provided to older people, where the care is:

‘…personal care or nursing care, or both personal care and nursing care that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation.’

**Residential aged care homes** refers to organisations providing residential aged care. (These are still commonly referred to as ‘nursing homes’ and ‘hostels’. The latter term is used when referring to earlier legislation and residential aged care homes in the USA and the UK.)

**Residents of aged care homes** are persons residing in residential aged care homes. (‘Recipient of care’ is used to refer to residents where the Act or other documents are quoted.)

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<td>ACAT Aged Care Assessment Team</td>
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<td>ACHS Australian Council on Healthcare Standards</td>
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<td>ACOVE Assessing Care of Vulnerable Elders</td>
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<td>BPSD</td>
<td>Behavioural and Psychological Symptoms of Dementia</td>
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<td>CAM</td>
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<td>CINAHL</td>
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<td>EFQM</td>
<td>European Foundation for Quality Management</td>
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<td>Global Assessment Scale</td>
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<td>MEDLINE</td>
<td>A medical literature search facility</td>
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<td>MMSE</td>
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<td>MOPS</td>
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<td>MOS SF-36</td>
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<td>MRSA</td>
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<td>NATA</td>
<td>National Association of Testing Authorities</td>
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<td>OBRA</td>
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<td>OECD</td>
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<td>PsycINFO</td>
<td>A psychological literature search facility</td>
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<td><strong>QWB</strong></td>
<td>Quality of Well Being</td>
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<td><strong>RACASP</strong></td>
<td>Residential Aged Care Advocacy Services Program</td>
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<td><strong>RAI</strong></td>
<td>Resident Assessment Instrument</td>
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<td><strong>SAM</strong></td>
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<td><strong>TWiST</strong></td>
<td>Time Without Side Effects of Treatment</td>
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Executive Summary

The project to evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in residential aged care homes (the project), was commissioned by the Department of Health and Ageing (the Department) in November 2004. The project is being undertaken by Campbell Research & Consulting, who have formed a consortium with Phillips Fox Lawyers and Monash University. The broad objectives of the project are to:

• Assess the impact of accreditation on the quality of care and quality of life of residents in residential aged care homes; and
• Having regard to the findings of the project and other performance and benchmarking assessment systems, identify options for the measurement of quality improvement in the future provision of world class care.

The project comprises two main stages. The first stage entails developing a foundation of evidence from analysis of existing literature, the current legislative framework, and key stakeholder consultations.

The second stage of the project will comprise development of a survey of residential aged care homes to empirically assess key influences on quality of care and life for residents and identify performance measures to monitor future improvement.

Older Australians and the use of residential age care

The population of Australia is ageing. Both the number of older Australians and the proportion of older persons relative to the total population are projected to increase over the next 40 years. Although the great majority of older Australians are experiencing unprecedented levels of life expectancy, health status, employment, family support and community participation, meeting the future needs of an ageing population is the cause of much economic, health, welfare and social debate.

The Australian Government, through the Department of Health and Ageing, has recognised the importance of an ageing population, and placed the health and well being of older Australians as one of their six key strategic objectives in order to ensure:

‘...choice and access to appropriate community based and residential aged care homes for older Australians, support for carers and industry, and a whole-of-government approach to the challenges of an ageing Australian population.’

Specific government strategies aimed at enhancing the quality of life for older Australians are articulated under a specific portfolio outcome, reported by the Department.
The regulatory framework

For more than 40 years, the Australian Government has provided a financial subsidy to support the cost of care delivery, and for almost 40 years Government grants towards the capital costs of providing residential aged care have also been available.

In 1997, the legislation governing residential aged care in Australia was substantially reformed. Building on previous regulatory approaches, the Aged Care Act 1997 (the Act) established a sophisticated regulatory framework that creates significant compliance obligations for aged care service providers and makes the availability of public funding (both operational and capital) contingent on compliance by service providers with a comprehensive range of requirements.

The need for government intervention to promote the quality of residential care for the aged and the protection of consumer interests has been justified for the following reasons:

- There are information asymmetries which result in parties to a transaction having unequal access to relevant information;
- Residents of aged care may be vulnerable and in some need of guardianship or protection; and
- For social equity reasons, government manages all or some aspects of the availability and access to services.

It is recognised that the Australian Government has no direct constitutional power to regulate the activities of residential aged care homes. However, the Australian Constitution incorporates a number of heads of power that support aged care legislation, and the Government has used these powers to establish the regulatory framework for residential aged care. The Act, together with a range of principles and other regulatory instruments that comprise the aged care regulatory framework, establishes the scheme by which the Australian Government currently provides financial support for aged care (including residential aged care) and the conditions under which that financial support is provided.

The Act replaced the provisions in the National Health Act 1953 (the National Health Act) and the Aged or Disabled Persons Care Act 1954, under which nursing homes and hostels had been administered previously. It changed the regulatory framework and some of the financial arrangements but essentially left intact the user rights introduced in the late 1980s and early 1990s.

In broad overview, the Act and subordinate instruments are designed to protect and foster quality of care and quality of life of residents of residential aged care homes by:

- Focusing on the accountability of approved providers rather than on approval of premises as applied under the previous scheme regulated through the National Health Act 1953;
- Limiting access to residential care subsidies to approved providers, and ensuring that only people assessed as suitable to provide aged care are approved as providers;
Specifying in the Act and in the *Quality of Care Principles 1997*, the *User Rights Principles* and the *Accountability Principles* (the Principles), many of the legitimate rights and expectations of residents and the responsibilities of providers;

- Providing for the application of sanctions if approved providers fail to comply with their responsibilities;
- Providing for a process of certification of physical facilities, with financial incentives available for certified facilities; and
- Providing for a process of accreditation of residential aged care homes, with the availability of residential care subsidies contingent on the service being accredited.

The Secretary to the Department has a role in imposing sanctions in cases where approved providers have breached their responsibilities and in generally ensuring that approved providers meet their other obligations under the Act. If a sanction is to be imposed, the Secretary must give the approved provider a notice setting out the nature of the non-compliance, the sanction to be imposed, the consequences of the imposition of the sanction, the sanction period and the reasons for the sanction's imposition.

It is important to recognise that the Act establishes a comprehensive framework which is designed to assure the achievement of minimum standards of care as well as stimulate continuous improvement. An accreditation requirement is only one element of this framework. The Act and the *User Rights Principles* also provide the authority for the following:

- A Charter of Residents’ Rights and Responsibilities;
- Independent advocacy services, which operate in each state and territory;
- The Community Visitors Scheme (CVS), which is available to all residents of aged care services (not just residential aged care); and
- The Department’s Aged Care Complaints Resolution Scheme (the Scheme).

**Frameworks for understanding quality of care and quality of life**

Quality of care and quality of life are overlapping concepts that have originated in separate spheres of the literature. Neither term is defined in the Act or its subordinate instruments, although both the Act and the Principles refer frequently to the concept of ‘quality of care’.

Typically, quality in health care is a multidimensional concept, encompassing a broad range of domains including:

- Access, referring to the capacity of all individuals to receive the same standard of service provision;
- Appropriateness, referring to the extent to which the benefits of an intervention outweigh the risks associated with the same intervention;
- Technical proficiency (as distinct from technical *efficiency*), referring to the clinical application of current best practice in skills and knowledge;
• Continuity, referring to the extent to which a specific episode of service provision is integrated into an overall care plan;
• Safety, referring to risk avoidance and harm minimisation in care delivery;
• Acceptability, referring to the degree to which a given service addresses the ‘expectations of informed … consumers’;
• Efficiency, referring to the maximisation of benefits or outputs (e.g. health) for a given level of inputs (e.g. costs); and
• Effectiveness, referring to the impact of a particular intervention upon clinical outcome. Importantly, key elements of clinical outcome have been noted to range from survival to the quality of life of the survivor.

By contrast, the term ‘quality of life’ is synonymous with concepts of well-being and is being increasingly adopted as a summary measure of longer-term outcome, against which particular programs or services can be evaluated. Three major approaches to understanding and measuring quality of life can be identified from the research literature:

• Subjective indicators involving measurement of an individual’s level of well-being (e.g. overall life satisfaction, and satisfaction with specific areas of their lives) which assume that quality of life may be reflected by an individual’s personal values and judgement of their own life experience.
• Social indicators involving objective measurements of a range of social conditions (e.g. health statistics, crime statistics, education statistics, etc.), which assume that quality of life may be reflected by understanding a range of ‘typical’ (or normal) experiences encountered by an individual.
• Economic indicators involving measurement of a range of economic conditions (e.g. economic growth, inflation, interest rates, unemployment, consumer confidence, housing sales, etc.) which assume that quality of life may be reflected in an individual’s ability to receive the goods or services that they desire.

**Key influences upon quality of care and quality of life**

Many health-related factors have been identified in the literature to have major implications upon the monitoring, measurement and improvement of quality of care and quality of life in residential aged care homes. Broadly, these factors may be divided into four general domains, comprising:

• Health management, including:
  – Management of dementia;
  – Identification and management of depression;
  – Nutrition;
  – Management of pressure ulcers;
  – Management of pain;
Ambulation/bed fast/prevention of contractures;  
Management of incontinence; and  
Medication management.

- Behavioural management, including:  
  - The management of challenging behaviours; and  
  - The use of physical restraint.

- Care planning and coordination, relating to:  
  - Coordination of complex care requirements; and  
  - Loss of function/decline in medical condition.

- Illness and injury prevention activities, including:  
  - Falls and balance;  
  - Environments contributing to injury; and  
  - Infection control.

A wide range of other social and environmental factors have also been identified to have a major impact upon the quality of care and quality of life experienced by residents of aged care homes. These factors can broadly be described under domains relating to:

- Physical environment;  
- Level of functional ability;  
- Management arrangements and management ‘style’;  
- Process of care;  
- Resident and carer satisfaction, including life satisfaction and sense of autonomy and control;  
- Staff satisfaction and psychological well-being;  
- Measuring social outcomes;  
- Staff management; and  
- The ownership of residential aged care homes.

Measuring and improving quality

Methods of measuring quality in health and aged care have progressed through a number of stages since their inception and inspiration from the manufacturing industry. Initially, ‘quality assurance’ aimed to ensure that lower levels of performance improved towards the average. Components of quality assurance included standard setting, the delineation of minimum standards and quality inspection against defined standards. Next, ‘quality improvement’ aimed to improve the performance of all providers, thereby increasing the overall average level of performance. This involved ‘quality control’ mechanisms to reduce deficient processes leading to variations (not necessarily adverse outcomes) in care. It
recognised the need for continuous processes where the quality or standard to be met was redefined within a repeating cycle of analysis, action and review. More recently, the concept of ‘patient safety’ has provided a broader focus whereby error prevention and improved outcomes are promoted through the development of structures, processes and systems, rather than focusing on the performance of individuals.

Within these paradigms, a number of different perspectives and quality enhancement strategies have emerged. Broadly speaking, three general approaches are presented, together with examples of specific techniques used to measure and improve quality, including:

- Approaches that focus upon external regulation, including litigation, quality measures or benchmarks and regulatory frameworks that adopt certification, licensing, registration or chartering;
- Approaches that may be used for the purposes of self-regulation, such as clinical auditing, clinical governance, best practice guidelines, complaints monitoring, performance management and others; and
- Approaches to quality that focus upon external and/or self-regulation such as accreditation (amongst others).

Current issues and approaches to accreditation

Accreditation of health care organisations can be traced back to 1917 in the USA where it was used for the recognition of surgical training posts. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) then evolved and similar, although not identical, models were adopted in Canada and Australia with the establishment of the Australian Council on Healthcare Standards (ACHS) in the 1970s. Accreditation of health care organisations was adopted in Europe in the 1980s and is now prevalent in the UK, Spain, Portugal, the Netherlands, Finland, Italy, France, Sweden and Germany. JCAHO remains the leader in the development, innovation and review of accreditation, quality measurement and improvement practices. It is also the model upon which other international systems have been based.

While the overall principles underlying accreditation remain the same, different accreditation programs tend to delineate different themes upon which to base the development and assessment of standards. Commentators have observed several common features shared by all international accreditation programs, namely:

- The establishment of a regulatory body that grants accreditation and formulates standards;
- The establishment and operation of a program that is independent of government;
- A spirit of collaboration rather than competition between organisations within the accreditation program;
- The use of on-site reviews to evaluate compliance with standards;
• The formulation of multidisciplinary standards;
• The involvement of health care professionals in both the development of standards and the evaluation (surveying) of health care organisations;
• Formal feedback processes following on-site reviews;
• Systematic follow-up after reviews; and
• The awarding of an accreditation certificate valid for a prescribed period.

According to the Australian Council for Safety and Quality in Health Care:

‘Accreditation is widely recognised as having played an important role over the past three decades in improving safety and quality in the Australian health care system.’

Although research into the specific benefits of accreditation remains forthcoming, World Health Organisation (WHO) reports have also reflected a significant degree of consensus that accreditation systems are achieving quality outcomes:

‘There is, at the moment, no scientifically documented evidence to indicate that standards and accreditation programs result in a higher level of quality of care but several countries are now beginning to study how such documentation may be produced. However, in the absence of such documentation, there seems to be clear consensus amongst those countries who have been involved in national standard setting and accreditation for some time that these programs have been tremendously influential in creating and maintaining care of a certain standard, as well as in introducing new concepts for national achievement.’

However, despite the widespread application of accreditation systems, several limitations have also been reported in the literature and should be borne in mind when evaluating the benefits of this approach to quality improvement, including:

• A lack of evidence that accreditation improves outcomes and quality, despite the intuitive sense that it does;
• Accreditation programs that focus on minimum standards will not encourage excellence. Minimum standards are unlikely to challenge practice and stimulate performance improvement;
• Withholding of accreditation is punitive and inconsistent with a blame-free, continuous quality improvement approach which emphasises how to do things better and learn from system errors; and
• Accreditation is costly in terms of money, time, effort, resources and often requires the effort of volunteers to develop standards and perform inspections and surveys.

There is significant unresolved debate about whether it is possible to achieve two distinct purposes with an accreditation system— on the one hand, encouragement of continuous improvement within a supportive, peer-based environment in which participation is based on a commitment to improve, and on the other hand, assurance to external stakeholders of compliance with minimum standards.
This debate typically arises when Governments and/or other stakeholders impose requirements on service providers (either directly or indirectly) to achieve and maintain accreditation status. Such requirements are applying increasingly in the acute health care sector. For example, accreditation is now a requirement of the vast majority of private hospitals that seek to access private health insurance funding via contracts with health insurance funds, and approval for the purposes of access to Medicare benefits for pathology services is linked to the accreditation status of the pathology laboratory.

Some stakeholders believe that:

- The primary objective of accreditation is to stimulate quality improvement in an environment of openness and transparency with organisational or professional peers; and
- Achievement of this objective is incompatible with the objective of assuring an external funder (Government) or the community of compliance with minimum standards of safety and quality.

This perspective is based on the belief that the (usually) catastrophic nature of the consequences associated with failure of accreditation necessarily will prevent frank and open disclosure by providers to their peers of areas in which they are experiencing challenges or difficulties in providing quality care. From this perspective, therefore, combining ‘accreditation’ objectives with ‘compliance’ objectives is likely to impair achievement of the primary objective of accreditation, which is stimulation of quality improvement.

**Accreditation of residential aged care homes in Australia**

The Aged Care Standards and Accreditation Agency (the Agency) was appointed the ‘Accreditation Body’ under Part 5.4 of the Act in 1997. The functions of the Accreditation Body include:

(a) managing the accreditation process using the Accreditation Standards; and

(b) promoting high quality care, and helping industry to improve service quality, by identifying best practices and providing information, education and training to industry; and

(c) assessing, and strategically managing, services working towards accreditation; and

(d) liaising with the Department of Health and Ageing about services that do not comply with the standards applicable to them (the Residential Care Standards or the Accreditation Standards, as appropriate).”
The Accreditation Standards and their predecessors, the Residential Care Standards, were based on the standards previously defined in the *National Health Act*, but were updated to incorporate new knowledge and expectations. The Accreditation Standards now apply to all residential aged care homes. There are four standards:

- Management Systems, Staffing and Organisational Development (Standard 1);
- Health and Personal Care (Standard 2);
- Resident Lifestyle (Standard 3); and
- Physical Environment and Safe Systems (Standard 4).

For each standard, there is:

- A statement of Principles underlying the standard;
- A series of Matter Indicators; and
- An expected outcome for each Matter Indicator.

There are 44 Expected Outcomes across the four standards. The purpose of the accreditation process is to gather information to assess a service's performance against each of the 44 Expected Outcomes.

The majority of services are awarded three years' accreditation, but a lesser period may be awarded if a residential aged care service is assessed to be not performing well or has a history of non-compliance with the Accreditation Standards. The legislation does not specify a maximum period of accreditation. The common three year duration is consistent with overseas accreditation systems, including that conducted by JCAHO.

State or territory legislation concerning other matters such as medication management, occupational health and safety, building or food standards, continues to apply to residential aged care homes in that state or territory. Apart from such legislation addressing specific areas, however, the approach of the states and territories in recent years has been not to implement specific regulatory requirements for residential aged care homes, but to leave such specific regulation to the Commonwealth alone.

**Evaluating the impact of accreditation upon the quality of care and life for residents of aged care homes**

Determining the impact of accreditation is a challenging exercise because:

- Achievement of specific desirable outcomes identified as regulatory objectives is unlikely to be influenced solely by the accreditation requirements; and
- There are many factors that are likely to influence quality of life of residents of aged care homes that are independent of the quality of care provided to them.
The accreditation requirement established by the Act is the focus of this project. Clearly, however, there are other significant features of the regulatory environment and the client population that may have a significant impact on the quality of care and/or the quality of life of residents of aged care homes. These include, for example:

- The direct legislative requirements of approved providers that are independent of the accreditation process;
- Regulatory requirements and financial incentives for the provision of suitable facilities and amenity for residents of aged care homes;
- The availability and effectiveness of responses to concerns about quality of care and quality of life. These concerns may arise as a consequence of the accreditation process or through other formal or informal mechanisms;
- The effectiveness of the Aged Care Complaints Resolution Scheme; and
- The specific characteristics of the client population that may impact on their quality of life in any setting, independent of the quality of care provided to them. These may include diverse factors, such as for example the presence of debilitating and untreated symptoms of physical and/or mental illness, the degree of general infirmity experienced by the individual and the presence or absence of effective social networks and family support. Many aged care residents have underlying conditions that make them extremely vulnerable to experiencing a poorer quality of life. Even exceptional quality of care may fail to overcome the influence of those factors (e.g. physical ill health, depression or physical frailty).

Identifying the impacts of factors other than accreditation, and separating them from those impacts that are attributable to accreditation will be a significant challenge for this project. For this reason, the project has adopted a multi-dimensional methodology, focusing on structural and process features of the accreditation system and their consistency with known good practice, as well as outcomes where reliable data are available.
1. Introduction

This report is the first of a series of reports to be delivered for the project to ‘evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in residential aged care homes’ (the project), which was commissioned by the Department of Health and Ageing (the Department) in November 2004.

The project is being undertaken by Campbell Research & Consulting, who have formed a consortium with Phillips Fox Lawyers and Monash University. The objective is to:

‘... develop an evaluation methodology and evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in residential aged care homes and to identify improvement and performance and benchmarking assessment systems to take the provision of world class care for Australian residential aged care into the future.’

The broad purpose of the project is to:

- Assess the impact of accreditation on the quality of care and quality of life of residents of aged care homes; and
- Having regard to the findings of the project and other performance and benchmarking assessment systems, identify options for the measurement of quality improvement in the future provision of world class care.

1.1 Background to the project

In May 2003 the Australian National Audit Office (ANAO) completed a Performance Audit of the Aged Care Standards and Accreditation Agency (the Agency), the objective of which was:

‘... to form an opinion on whether the Agency’s management of the residential aged care accreditation process is efficient and effective.’ (The Auditor General 2003)

The ANAO concluded that the Agency had successfully assessed all aged care homes as required by the Aged Care Act 1997 (the Act) and that it had identified its legislative responsibilities and implemented an adequate process to meet them. The ANAO noted, however, that:

‘... one of the Agency’s objectives ... is to “enhance quality of life for residents”. While a number of factors and entities contribute to the quality of care provided to residents, the Agency does not yet have a way to assess the outcome of its accreditation and monitoring work on the residential aged care industry.’

The ANAO made a number of recommendations relevant to the internal mechanisms of the Agency, which are being addressed by the Agency. The ANAO also recommended that an evaluation should be planned of the impact of accreditation on the quality of care in the residential aged care industry.
In August 2003, the Joint Committee of Public Accounts and Audit (the Committee) held a public hearing to examine the ANAO Report. The Committee recommended that the Agency should ‘broaden the focus of the quality assessment data currently used for accreditation purposes to include quality-of-life information experienced industry wide by residents of aged care homes’ with a data collection mechanism that does not impose additional costs on the residential aged care homes nor further complicate the accreditation system. The project is consistent with that recommendation.

The project is also consistent with the recommendations of the Two Year Review of Aged Care Reforms (the Gray Review), in which Professor Len Gray undertook a comprehensive assessment of the impact of the major legislative reforms implemented in 1997 on the residential aged care system. In the Gray Review, Professor Gray concluded that:

‘There is evidence of acceptance of the new system by stakeholders, of considerable progress towards the targeted improvements in quality of care and accommodation and of optimism for the future of the sector generally.’ (Gray 2001b).

The Gray Review recommended that the Department and the Agency:

‘… undertake to give further consideration to processes and outcomes of accreditation following the first round of assessments to assist in the development of future monitoring of quality of care.’ (Gray 2001b, p. 93).

1.2 Structure of the project

The project is being conducted in two major stages. Stage 1 entails a review and analysis of:

- The literature relevant to quality of care and quality of life, and the role of accreditation, performance measures and benchmarks, in ensuring and/or promoting safety, quality and quality improvement in aged care and related settings;
- The regulatory framework that applies to residential aged care;
- Selected systems of regulation and/or accreditation of safety and/or quality in other industry settings, including centre-based long day child care, the food industry and the acute health care sector, with the objective of identifying differences in approaches and their known strengths and weaknesses; and
- The structure, processes and known outcomes of the residential aged care accreditation system.

Consultation with key experts, organisations and ‘grass roots’ stakeholders will also be conducted during Stage 1.

Stage 2 will build on the work of Stage 1, and will entail development and implementation of comprehensive surveys to ascertain resident and other stakeholder experiences of and views about the factors that contribute to quality of care and quality of life in residential
aged care, and the impact of accreditation on those factors. The surveys will test the extent to which the issues and perspectives identified in the qualitative consultation in Stage 1 are held by the broader population of stakeholders.

Stage 2 will also involve consideration of the potential form and utility of performance indicators relevant to quality of care and quality of life in the residential aged care sector, and their relationship to the accreditation system.

The project is not an evaluation of the work of the Agency. As noted above, the Agency’s work has been the subject of an ANAO audit, and it is neither necessary nor appropriate to repeat that audit. Rather, the focus will be on regulatory approaches, the structure and application of the accreditation system, and the suitability of the accreditation system to promote achievement of the objective of world class care for residents of aged care homes.

In the context of the completion of two rounds of accreditation in the residential aged care sector, the focus will be on looking ahead and making recommendations on practical ways to measure quality improvement and performance that will support the future provision of world class care.

1.3 Scope of and context for this regulatory analysis and literature review

A wide range of matters are relevant to accreditation in residential aged care. During Stage 1 these matters will be addressed systematically and a number of reports will be developed. Each report will be written as a ‘stand alone’ document, addressing specific issues relevant to the project.

In aggregate, the reports from Stage 1 will present a thorough description and comparative analysis of, and identify issues relevant to, the accreditation system used for Australian Government subsidised aged care homes and the measurement of quality of care and quality of life in residential aged care.

This literature review is the first report for Stage 1. It focuses on accreditation issues relevant to residential aged care. Its purpose is to:

- Provide an historical setting for the current residential aged care regulatory framework;
- Assist to define concepts that will be considered during the project;
- Describe the regulatory framework for residential aged care, including the objectives and intention of the Act;
- Describe how accreditation fits with other Government strategies to assure and improve the quality of care and quality of life in residential aged care; and
- Investigate the national and international literature relevant to accreditation.
Future reports developed during Stage 1 will complement this review, assisting to build up a comprehensive description and understanding of:

- Regulatory approaches to assuring quality and/or stimulating quality improvement in selected human service environments;
- The detailed structure and application of the aged care accreditation system, including the content of the standards and their relevance to quality of care and quality of life, the processes of review of Australian government subsidised aged care homes and the options that are available to the Agency and Government to manage accreditation outcomes;
- The way in which accreditation systems are structured and applied in other selected human service environments, for the purposes of comparative analysis;
- The known outcomes of aged care accreditation to date; and
- Any issues and/or opportunities that have been identified relevant to the aged care accreditation system.

### 1.4 Approach to this regulatory analysis and literature review

The regulatory analysis incorporated within this report was developed following a thorough review and analysis of:

- Expert commentary relevant to the regulatory framework for aged care that preceded the passage of the Act;
- Extrinsic material relevant to the passage of the Act and subsequent amendments, including explanatory memoranda, parliamentary speeches and parliamentary committee reports;
- The structural relationships defined by the Act that establish the rights and responsibilities of stakeholders (Government, the Agency and approved providers) relevant to accreditation, and the features of the regulatory framework established by the Act that are likely to impact on quality of care and quality of life in the residential aged care setting; and
- Relevant case law.

An extensive search of the published literature also was undertaken to identify and describe existing national and international residential aged care:

- Accreditation programs;
- Quality of care measurement systems;
- Quality of life measurement systems;
- Performance measurement processes; and
- Benchmarking programs.

In addition, relevant literature from outside the residential aged care sector was reviewed.
The identification of relevant literature was facilitated by a comprehensive standardised protocol involving combinations of the following search terms:

- Accreditation;
- Quality of care;
- Quality of life;
- Benchmarking;
- Performance measures;
- Residential aged care;
- Nursing home;
- Elderly;
- Quality; and
- Health care.

Electronic searches of MEDLINE, the Cochrane Library, FullText Clinicians Health Channel Journals@Ovid, PsycINFO and CINAHL databases were conducted.

Further information was sought via the Internet and involved searches of government departments, public and private sector agencies and leading accreditation and health care agency websites.

In addition, government departments, universities, health care organisations and other professional organisations were contacted by telephone or e-mail for information and reports where necessary.

Material was included on the basis of scientific validity, relevance and interest to the topic and has been critically appraised throughout the review. A number of other sources have been included where useful insights have been identified, particularly in relation to residents’ perspectives on quality in residential aged care homes. While there is a considerable body of scientific research related to the views of residents, the literature has had a stronger focus on clinical drivers of quality. For this reason, literature from a range of other sources has been included, and identified in the text, to ensure a balanced presentation of the issues.

A large number of references relate to work conducted in the USA. This reflects the leadership demonstrated within the USA in the field of quality measurement and improvement in health care.

There is a vast range of literature relevant to accreditation in the Australian aged care sector. The inclusion in this literature review of such work has been restricted because of its limited capacity to contribute to an evidence-based understanding of accreditation.

The limitations and generalisability of work cited is referred to throughout the review.
1.5 Structure of this regulatory analysis and literature review

As in any broad review of the literature, some degree of trade-off must be considered between the comprehensiveness with which issues are covered and the depth to which they are addressed individually. The approach to the current review has been to focus upon a comprehensive overview of key areas of the literature and to provide a description of the regulatory framework governing residential aged care in Australia. It should be noted by the reader that this review will be the subject of ongoing supplementation as the project progresses, taking into account other key areas that emerge from consultation and empirical investigation.

The key areas covered by the regulatory analysis and literature review are as follows:

- Section 1 introduces the purpose, approach and structure of the regulatory analysis and literature review;
- Section 2 outlines the characteristics of older Australians and the demand for residential aged care;
- Section 3 describes the regulatory framework for residential aged care in Australia, including the rationale for regulation, the evolution of the current approach, the constitutional basis for regulating residential aged care, the structure of the Act, the quality framework established under the Act, the characteristics and responsibilities of approved providers, other regulatory strategies that enhance user rights, the process of approval and classification of residents of aged care homes, the process of certification of aged care homes, and regulation through accreditation;
- Section 4 describes frameworks for defining and measuring quality of care and quality of life in residential aged care settings;
- Section 5 describes key clinical measures that have been identified from the literature to assess quality of care and quality of life for residents of aged care homes;
- Section 6 describes key socio-cultural measures that have been identified from the literature to assess quality of care and quality of life for residents of aged care homes;
- Section 7 outlines the general approaches to measuring quality in health and residential aged care to provide a perspective of accreditation as one of a number of approaches to regulation;
- Section 8 outlines current issues and approaches to accreditation in the health and aged care sectors focusing upon: the historical application of accreditation; differences and similarities between international approaches to accreditation; and the limitations observed in accreditation systems;
- Section 9 outlines the approach to accreditation in the aged care sector in Australia, including: the regulatory requirements for accreditation; the responsibility of approved providers to comply with the Accreditation Standards; the accreditation requirement, the structure and role of the Agency; the Australian Accreditation Standards and process; sanctions able to be imposed under the Act; and other regulatory requirements of residential aged care providers;
• Section 10 explores further issues relating to the current evaluation of the impact of accreditation as a regulatory approach upon the quality of care and quality of life experienced by residents of aged care homes; and
• A reference list with the literature referred to in the report.

1.6 Disclaimer

Please note that, in accordance with our Company’s policy, we are obliged to advise that neither the Company nor any member or employee undertakes responsibility in any way whatsoever to any person or organisation (other than the Australian Government Department of Health and Ageing) in respect of information set out in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.
2. Older Australians and Residential Aged Care in Australia

2.1 The population of older Australians

The number of Australians aged over 65 years is expected to increase by 50 per cent over the next 10–15 years. The number of Australians aged over 80 years is expected to double over the next 20 years (Australian Government Department of Health and Ageing 2002). Whilst the great majority of older Australians are experiencing unprecedented levels of life expectancy, health status, employment, family support and community participation (AIHW 2004a), meeting the future needs of an ageing population is the cause of much economic, health, welfare and social debate.

The Australian Government, through the Department, has recognised the importance of an ageing population and placed the health and well being of older Australians as one of their six key strategic objectives in order to ensure:

‘… choice and access to appropriate community base and residential aged care homes for older Australians, support for carers and industry, and a whole-of-government approach to the challenges of an ageing Australian population.’ (Department of Health and Ageing 2002)

In the 2001 National Health Survey, older Australians reported ‘overwhelmingly’ that they experienced good, very good or excellent health. For those older Australians experiencing ill health, 54 per cent aged 65 and older in 1998 had a long-term disability and 21 per cent had a severe or profound disability. Of the conditions causing disability, dementia, mental health conditions, diseases affecting eyesight, stroke and arthritis were the most prevalent and gave rise to the core activity restriction (which refers to difficulty or need for assistance with self-care, mobility or communication) that tends to require residential supportive care (AIHW 2004a).

The Australian Government has developed a National Strategy for an Ageing Australia which provides ‘a broadly based strategic framework to address emerging issues associated with an ageing population’ (Australian Government Department of Health and Ageing 2002). This strategy covers both community and residential aged care.

2.2 The international perspective

Australia is not alone in facing the issue of providing services for the needs of an ageing population. Internationally, the Organisation for Economic Cooperation and Development (OECD) has reported on the rising demand for residential care services to meet the needs of increasingly ageing populations and the community expectation for high quality services which provide residents with choices and autonomy.
The World Health Organisation (WHO) adopted the term ‘active ageing’ to describe the process of ‘optimising opportunities for health, participation and security in order to enhance quality of life as people age’. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care (AIHW 2004a). After the UN International Year of Older Persons in 2000, the WHO stated that regional and international cooperation was required to ‘secure older persons’ independence, participation, care, self-fulfilment and dignity’.

However, while a number of international strategies have been initiated to improve delivery of care to the elderly in long-term care and promote consumer direction and choice (OECD 2005), internationally and within Australia, older people receiving residential care services face a number of issues including:

• Inadequate accommodation and lack of privacy (OECD 2005);
• A complex array of medical issues including depression, bed sores and inadequate pain management (OECD 2005);
• Functional disabilities and progressive functional decline;
• Inappropriate use of chemical or physical restraints (OECD 2005);
• Poor social relationships (OECD 2005);
• Increased use of medical (particularly hospital) and social resources (Bergman et al. 1997);
• Risk of fragmented care in multiple settings and poor outcomes (Bergman et al. 1997; Ma et al. 2004); and
• A shortage of trained geriatricians, family medicine practitioners, nursing and allied health professionals with experience in aged care (Chiang 1998).

2.3 Defining ‘residential aged care’

‘Aged care’ is a generic term that covers a wide range of inter-related services for older people delivered across the continuum of care from acute services to community and residential care. For the purposes of this report, the concept of ‘residential care’ encompassed within the Act has been adopted. The Act specifies that residential care includes:

‘… personal care or nursing care, or both personal care and nursing care that:

(b) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation.”
Inherent in this definition is the recognition that a service providing residential aged care is both a health care organisation and a social welfare organisation.

The Act also regulates aged care homes that relate to:

- Community care; and
- Flexible care (The Aged Care Act 1997, Schedule 1).

### 2.4 Influences on the demand for residential aged care

In 2005 the OECD reported that the future demand for long-term residential care will not only be driven by a growth in numbers within relevant age groups, but could be mitigated by a number of other factors which potentially influence the demand for care. These broad-ranging factors which include levels of informal care, levels of health, rates of disability, life expectancy, policy and legislative reforms, could improve the capacity of ageing people to live independently or within their community and consequently change the current demographic projections for future needs. However, based on current projections it is predicted that by 2040 one person in four may be 65 years or older in OECD countries.

The WHO has indicated that long-term residential care will always be required for a proportion of frail elderly people (Fox & Kalache 2000). Furthermore, the number of persons requiring such care is likely to increase in the future as the population ages and family and work patterns change (Productivity Commission 2005).

According to current USA figures, 60 per cent of people aged over 85 years and 2–5 per cent of people aged over 65 years require long-term residential care. Australian estimates are comparable, with Mason and colleagues reporting that there is a 0.42 probability of females and 0.24 probability of males requiring residential aged care over their lifetime (Mason, Lui & Braun 2001).

The demand for residential aged care in Australia is anticipated to increase more than threefold by 2045 (Productivity Commission 2005).

In the past, concerns have been raised in Australia about:

- Inappropriate admissions to residential aged care homes of people who could receive care in other settings; and
- A lack of access for those who do require a high level of care.

For example:

- In 1968 the Federal Government introduced a supplementary benefit of $3 per day for patients requiring and receiving intensive nursing care in residential aged care homes, to address the lack of willingness of providers to admit such patients; and
- In 1972 the National Health Act was amended to control the industry’s size and cost, both of which were perceived to have escalated inappropriately in response to the introduction of government subsidies.
The appropriateness of admissions to residential aged care homes is an important issue for all stakeholders. The Australian Government’s policy is that aged and disabled people should be supported by residential services only where other support systems are not available to meet their needs (Commonwealth Department of Health and Ageing 2002, p. 11). This policy position is consistent with community expectations. A recent USA study found that 30 per cent of seriously ill hospitalised adults would prefer not to be placed in a nursing home (Mattimore et al. 1997), despite the fact that for some it would be unavoidable. Ensuring that residential aged care homes are accessible to those who need them but are not used inappropriately for those who could be supported in other settings has been and will continue to be an important policy and regulatory consideration.

Current approaches to managing requirements for residential aged care and ensuring that services are used appropriately include:

- Health promotion and disease prevention strategies, such as screening and management of health risk factors;
- Improvements in diagnosis, treatment, rehabilitation and recovery programs;
- The Aged Care Assessment Program, incorporating delegation to Aged Care Assessment Team (ACAT) members of the Commonwealth power to approve entry to residential aged care homes (Commonwealth Department of Health and Ageing 2002, p. 13); and
- The provision of community care and other services to enable living at home independently or with support assistance (Fox & Kalache 2000), for example,
  - Extended Aged Care at Home (EACH) packages;
  - Community Aged Care Packages (CACPs); and
  - Services provided under the Home and Community Care (HACC) program (including Linkages Packages). (AIHW 2004a).

The importance of enhanced community programs is highlighted in the recently released statement of action by the Commonwealth Department of Health and Ageing: The Way Forward – A New Strategy for Community Care: Consultation Paper. This document aims to facilitate specific reforms in community aged care in 2004–05 and beyond (2003).

Although an older person’s need for residential aged care is determined largely by progressively declining physical or cognitive functional abilities, such declines are not necessarily irreversible and may be amenable to interventions designed to slow the rate of decline. Residential aged care should seek to maintain the highest quality of life of a person according to ‘his or her individual preferences with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity’ (Fox & Kalache 2000). This principle was ratified in the landmark USA Nursing Home Reform Act 1987, known as the Omnibus Budget Reconciliation Act (OBRA), where it was mandated that a residential aged care service must maximise each resident’s physical, psychological and social functioning or slow the inevitable decline. That legislation established a ‘sweeping reform of nursing home regulation’ as a response to reports of poor nursing home quality in the 1970s (Prochoda 2002).
Despite these legislated ideals, evidence indicates that further research is required to identify successful interventions that improve quality of life for residents living in residential aged care (Kane 2003). To assist service delivery and research, the WHO has identified a range of key factors it considers crucial to the delivery of residential aged care:

- Maintenance of community, social and family life with attention to the spiritual, emotional and psychological needs of residents;
- Use of assistive devices and housing structures to accommodate diminished function;
- Adequate assessment of social and health status with explicit care plans involving health professionals where necessary;
- Programs to reduce disability and prevent further deterioration;
- Provision of palliative care and bereavement support where necessary;
- Provision of support for family and other informal care givers; and
- Provision of culturally sensitive care. (Fox & Kalache 2000).

These factors highlight that when assessing quality of care and life in residential aged care, the focus must include psychological, social and cultural dimensions alongside the more traditional clinical factors that tend to dominate health care quality measurement programs.

The WHO has proposed the following principles to guide residential aged care policy:

- Attention to personal and public values;
- Delineation of private and public sector roles and responsibilities;
- Provision of public information and education;
- Provision of formal and informal care with training to formal and informal care givers;
- Long-term care systems that provide both social and health care services;
- Provision of income security and residential aged care financing;
- Attention to best use of current and future technology;
- Attention to research data collection; and
- Attention to quality of care measurement and enhancement to satisfy residents and care givers (Fox & Kalache 2000).

### 2.5 Provision of residential aged care in Australia

A diverse range of private for-profit, private not-for-profit and public providers offer residential aged care homes to older Australians. Residential aged care is a competitive industry. The Australian Government subsidises residential aged care (Braithwaite 2001), and residential aged care places are formally allocated to providers through Australian Government Approval Rounds. Whether or not people can access residential aged care homes (or community-based aged care services) depends on a formal assessment of their physical and cognitive functioning by an ACAT. However, this assessment does not guarantee that a place will be provided in a residential aged care service of the individual.
or family’s choice (AIHW 2004a). In this context, the Australian residential aged care industry bears many similarities to its UK (Turrell, Castleden & Freestone 1998) and USA counterparts (Scott & Elstein 2004).

There was an increase of 19 per cent in total expenditure on aged care services over the four years prior to 2001 (AIHW 2004a). The majority of the Australian Government’s financial support for aged care is directed towards the residential care sector: in 2003–04 the Australian Government spent $5.1 billion on residential care, amounting to approximately 0.6 per cent of Gross Domestic Product (GDP) (Productivity Commission 2005), from within a total aged care expenditure budget of $6.5 billion (Australian Government Department of Health and Ageing 2004a, Table 5). By 2045, expenditure by the Australian Government on residential aged care is projected to increase to 1.59 per cent of GDP (Productivity Commission 2005).

At 30 June 2004 there were 2933 residential aged care services in Australia: 174,657 residential aged care places had been allocated, and 156,056 residential aged care places were operational (Australian Government Department of Health and Ageing 2005b, p. ix). The total number of residential aged care places is anticipated to increase to 478,286 by 2045 (Productivity Commission 2005).

On average, the number of operational residential aged care places has been increasing by 1 per cent per year. However, this growth has not matched the rate of growth in the aged population, meaning that residential aged care is progressively catering for a smaller proportion of the elderly (AIHW 2004a).

Together with growth in the number of places available in residential aged care homes, there has been an increase in Community Aged Care Packages from 26,425 in 2002 to 27,881 in 2003. These packages are aimed at providing home care to those requiring low-level residential care and the increase in the number of Community Aged Care Packages available is consistent with the targeting of residential care towards a more dependent group of people (AIHW 2004c).

Residential aged care provides both permanent and respite care for a predominantly older, female, highly dependent, single population (Table 2). It operates on a high occupancy rate with permanent residents staying an average of almost three years.
**Table 2: AIHW – Demographic features of residents of aged care services for 2002–03 (2004c)**

<table>
<thead>
<tr>
<th>Demographic feature</th>
<th>2002–03 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average occupancy rate</td>
<td>96%</td>
</tr>
<tr>
<td>Age equal to or greater than 85 years</td>
<td>51%</td>
</tr>
<tr>
<td>Age less than 65 years</td>
<td>4%</td>
</tr>
<tr>
<td>Gender</td>
<td>72% Female</td>
</tr>
<tr>
<td>Pension status</td>
<td>74% Centrelink pension</td>
</tr>
<tr>
<td></td>
<td>16% Department of Veterans Affairs pension</td>
</tr>
<tr>
<td>Identifies as Indigenous</td>
<td>0.6%</td>
</tr>
<tr>
<td>Culturally and linguistically diverse background</td>
<td>49.8/182.3 per 1000 persons aged 75–84 years per 1000 persons aged 85 years and over</td>
</tr>
<tr>
<td>Marital status</td>
<td>59% Widowed</td>
</tr>
<tr>
<td></td>
<td>24% Married or de facto relationship</td>
</tr>
<tr>
<td></td>
<td>11% Never married</td>
</tr>
<tr>
<td></td>
<td>6% Divorced or separated</td>
</tr>
<tr>
<td>Respite care</td>
<td>47% of admissions (45,445 residents)</td>
</tr>
<tr>
<td>Length of stay (permanent residents)</td>
<td>19% &lt; 3 months</td>
</tr>
<tr>
<td></td>
<td>20% 3 months to 1 year</td>
</tr>
<tr>
<td></td>
<td>42% 1–5 years</td>
</tr>
<tr>
<td></td>
<td>19% &gt; 5 years</td>
</tr>
<tr>
<td></td>
<td>Average: 143 weeks</td>
</tr>
<tr>
<td>Length of stay (respite residents)</td>
<td>Average: 3.1 weeks</td>
</tr>
<tr>
<td>Dependency levels</td>
<td>64% High care (RCS* 1–4)</td>
</tr>
<tr>
<td></td>
<td>36% Low care (RCS 5–8)</td>
</tr>
<tr>
<td>Discharges (permanent care)</td>
<td>84% Died</td>
</tr>
<tr>
<td></td>
<td>4% Returned to community</td>
</tr>
<tr>
<td></td>
<td>5% Moved to other residential aged care service</td>
</tr>
<tr>
<td></td>
<td>6% Discharged to hospitals</td>
</tr>
</tbody>
</table>

* RCS  Resident Classification Scale (RCS) indicates resident dependency levels across eight levels of care in descending order of need. The level of care need represented by each RCS category determines the Australian Government care subsidy.
3. The Regulatory Framework for Residential Aged Care in Australia

3.1 Introduction

For more than 40 years, the Australian Government has provided a financial subsidy to support the cost of residential aged care; and for almost 40 years Government has also provided grants towards the capital costs of providing residential aged care.

The quality of care and quality of life of residents of aged care homes is of considerable interest and concern to government and the community:

‘While there are many initiatives in place to promote and support good health throughout life, it is also important that when care services are required they are accessible, appropriate and of high quality. Australia has a world class care system that is in a strong position to respond to the ageing of the Australian population. This is not to say, however, that demographic changes, combined with changes in patterns of morbidity, in consumer expectations, in technology and a range of other factors, will not require a series of strategic responses across all sectors of the care system.’ (Australian Government Department of Health and Ageing 2002).

Government’s financial support enables it to exert considerable influence over the residential aged care sector. The degree of Government regulation of residential aged care has increased considerably since subsidies were first introduced.

In 1997, the legislation governing residential aged care in Australia was substantially reformed. Building on previous regulatory approaches, the Act established a sophisticated regulatory framework that creates significant compliance obligations for aged care service providers and makes the availability of public funding (both operational and capital) contingent on compliance by service providers with a comprehensive range of requirements.

The Australian Government’s commitment, during parliamentary debate prior to the passage of the Act, to undertake an ongoing review of the reform policy and its implementation will be progressed through this project.

3.2 The rationale for regulating residential aged care

For the purposes of this report, we have adopted the OECD concept of regulation, which defines three categories of regulation: economic regulation, social regulation and administrative regulation (1997).

- Economic regulations intervene directly in market decisions such as pricing, competition, market entry or exit. Reform aims to increase economic efficiency by
reducing barriers to competition and innovation, often through deregulation and use of efficiency-promoting regulation, and by improving regulatory frameworks for market functioning and prudential oversight.

• Social regulations protect public interests such as health, safety, the environment and social cohesion. The economic effects of social regulations may be secondary concerns or even unexpected, but can be substantial. Reform aims to verify that regulation is needed and to design regulatory and other instruments, such as market incentives and goal based approaches, which are more flexible, simple and effective at lower cost.

• Administrative regulations are paperwork and administrative formalities – so-called ‘red tape’ – through which governments collect information and intervene in individual economic decisions. They can have substantial impacts on private sector performance. Reform aims at eliminating those no longer needed, streamlining and simplifying those that are needed, and improving the transparency of application.

Regulatory action is only justified when the harms that are being addressed are substantial and no other effective form of intervention is available.2 The potential benefits of regulation must be considered in light of the substantial risk of regulatory failure, which may manifest itself either in the regulation failing to achieve its intended outcomes or in the generation of significant unanticipated costs due to unforeseen regulatory impacts. Such costs may be direct (e.g. the costs of regulatory enforcement) or indirect (e.g. the opportunity costs resulting from the stifling of innovation).

The need for government intervention to promote the quality of residential care for the aged and the protection of consumer interests has been justified for the following reasons:

• There are information asymmetries which result in parties to a transaction having unequal access to relevant information;

• Residents of aged care homes may be vulnerable and in some need of guardianship or protection; and

• For social equity reasons government manages all or some aspects of the availability and access to services (Hogan 2004, chapter 12).

Regulation of the residential aged care industry in Australia currently comprises both economic regulation (where the objective is to intervene in market decisions such as pricing, competition, market entry and exit) and social regulation (where the objective is to promote public interests such as health, safety and social cohesion).

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2 Regulatory reform is used in the OECD work to refer to changes that improve regulatory quality, that is, enhance the performance, cost-effectiveness, or legal quality of regulations and related government formalities. Reform can mean revision of a single regulation, the scrapping and rebuilding of an entire regulatory regime and its institutions, or improvement of processes for making regulations and managing reform. Deregulation is a subset of regulatory reform and refers to complete or partial elimination of regulation in a sector to improve economic performance.
3.3 The constitutional basis for regulating residential aged care

The Australian Government has no direct constitutional power to regulate the activities of residential aged care homes. The Australian Constitution incorporates a number of heads of power that support aged care legislation, however, and the Australian Government has used these powers to establish the regulatory framework for residential aged care.

The relevant heads of constitutional power have been described by the Australian Law Reform Commission and include:

‘… the appropriations power, the power to make grants to the States, the Territories power, the corporations power and the external affairs power. Perhaps the strongest source of constitutional power is the social welfare power, which provides that the Commonwealth may make laws regarding the provision of maternity allowances, widows’ pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services ... benefits to students and family allowances.

‘This would include providing services for people who, because of their age, experience some degree of incapacity or an inability to provide adequately for their own health care needs.’ (Australian Law Reform Commission 1995).

The constitutional basis for provisions in Parts V, VA and VC of the National Health Act 1953 that created the regulatory framework relevant to ‘approved nursing homes’ was challenged in Alexandra Private Geriatric Hospital Pty Ltd v The Commonwealth (Alexandra Private Geriatric Hospital Pty Ltd v The Commonwealth 1987). According to the plaintiff, the collective effect of the detailed regulation and control imposed on the management of a private nursing home stamped the law with the character of a law with respect to private nursing homes and that this was sufficient to place the law outside the scope of its enabling body.

The plaintiff argued that the law was:

‘… well outside the limits of any law which could properly be characterised as a law with respect to the provision of sickness or hospital benefits, because as a matter of practical reality the law conferred on the Commonwealth power to assume control of the entire nursing home industry including the number of premises, the number of beds, the selection of patients, the number of nurses and the wages paid to them, the quality and nature of the services provided, the gross fees that may be charged and the bookkeeping arrangements.’

The High Court rejected this challenge, however, noting that:

‘As a matter of practical reality, it may be true to say that the Commonwealth has this degree of control over the industry because there would be few proprietors who would find it profitable to conduct a nursing home without the benefit of the very substantial government subsidy. But as a matter of law it is only if and when the proprietor of a
nursing home obtains approval for his premises as such that he becomes subject to the provisions of the Act … his participation in the scheme is ultimately a matter of his own choice.’

The Court held that:

‘The Parliament having resolved to legislate with respect to the provision of sickness and hospital benefits to patients in nursing homes, some kind of scheme was essential to ensure both that the provision would be effective in meeting the needs of such patients and capable of being held within reasonable budgetary limits.’

Accordingly, the constitutional basis for regulating the residential aged care services industry as a consequence of the Government funding directed to the industry is clear.

3.4 The evolution of residential aged care funding and regulation

The structure of the current regulatory framework for residential aged care should be considered in the context of the challenges that confronted regulators of the residential aged care sector from the early 1960s.

Until the 1960s, the Australian Government played no direct role in the regulation of the sector.

The introduction in 1962 by the Menzies Government of an amendment to the National Health Act enabled the Australian Government to commence payment of 20 shillings per day nursing home benefit per patient in approved nursing homes, and to link access to that funding with compliance with specific conditions.

Until the Act was completely revised in 1997, regulation of aged care evolved incrementally. Various regulatory initiatives were implemented in response to concerns that emerged over time about a range of issues including equity of access, inappropriate service provision, poor quality of care, high cost of care and inadequate attention to residents’ rights. Some of these initiatives were effective in addressing the problems that had been identified, and have been retained in the framework established by the Act.

A brief description of the major issues that arose, and Government’s response, is provided below, with the objective of establishing for the reader the factors that have influenced the form of the current Act (Le Guen 1993):

- In 1966 the Government announced changes to the administration of the Aged Persons Homes Act 1954 to allow, for the first time, payment of a subsidy towards the capital costs of nursing home beds;
- In 1968, in response to a situation where private nursing homes were reluctant to admit patients whose disabilities rendered them virtually bedridden or those who were wholly or substantially dependent on nursing care, the Federal Government introduced
a supplementary benefit of $3 per day for nursing home patients requiring and receiving intensive nursing care;

• In 1972, in response to the rapid growth in size and cost in the industry that had occurred as a consequence of the introduction of government subsidies, the National Health Act was amended to control the industry size and cost;

• Between 1972 and 1975 the Federal Government pursued a strategy of encouraging alternatives to nursing home admissions and also attempted to shift the balance of nursing home provision away from private enterprise to the voluntary sector, by providing new capital subsidies and entering deficit-financing arrangements with charitable and voluntary organisations; and

• In 1977 the National Health Act was amended to place private health insurance providers under an obligation to pay a benefit equivalent to the Commonwealth nursing home subsidy to those nursing home patients who were insured with them. This scheme experienced considerable administrative difficulties and was reversed in 1981.

Major reforms to regulation of the aged care sector were commenced in the mid-1980s in response to a series of public scandals and parliamentary inquiries. There were concerns at that time about excessive cost to the public and individuals of residential aged care, inappropriate admissions, poor levels of accountability and inadequate quality of care (McLeay 1982; Senate Select Committee on Private Hospitals and Nursing Homes 1985).

• In 1985, the Report of the Select Committee on Private Hospitals and Nursing Homes (the Giles Report) raised considerable concerns about the quality and cost of residential aged care, and recommended the development of new Federal Government standards for residential aged care homes and the establishment of a Federal Government nursing homes and hostels inspectorate;

• In 1986, the Federal Government completed its nursing home and hostels review (Australian Department of Community Services) and announced a strategy to reform residential aged care which included the monitoring of adverse outcomes for residents. Prior to that, the Federal Government had only undertaken financial, medical and status inspections involving the assessment of benefit levels, classification of residents of aged care homes and essentially checking the physical facilities of a service, cleanliness and staffing levels (Braithwaite et al. 1993);

• In 1986 the Commonwealth-State Working Party on Nursing Home Standards was established to formulate national standards of care for nursing home residents and to develop a funding system for uniform nursing home staffing standards throughout Australia. A draft national standards paper was released and agreement on uniform national standards was reached in July 1987. The Working Party developed 31 outcomes which were incorporated into gazetted Standards. The Standards specified the minimum standard of care that was to be provided to residents. They differed for nursing homes and hostels. For nursing homes, physical safety and maintaining health were included in the Standards, and for hostels, the meeting of identified care needs was included (Gray 2001b). For both sectors, the Standards related to:
- Maximising social independence;
- Freedom of choice and exercising of rights;
- Creating a home-like environment;
- Privacy and dignity; and
- Providing for participation in a variety of experiences;

• Compliance with the Standards was monitored through visits conducted by Standards Monitoring Teams which were generally comprised of a departmental representative and a nursing officer (Gray 2001b). Proprietors of approved nursing homes were obliged to comply with the Standards or face sanctions ranging from the cessation of funding to the suspension or revocation of approval. There were no specific penalties in relation to hostels that failed to comply with the Standards;  

• In 1987 a new formula (the Standard Aggregated Module, SAM) was introduced to subsidise the infrastructure costs of non-government nursing homes;  

• In 1988, a new resident classification instrument (RCI) was introduced for the purpose of determining the level of funding to be provided for resident care according to an instrument called the Care Aggregated Module (CAM);  

• In 1988, legislation was introduced to limit the charges that could be made directly to nursing home residents;  

• In 1988 review panels were set up in all States to enable nursing home proprietors who believed that the Commonwealth had treated them unfairly to obtain a review of the standards monitoring process;  

• In 1989 a consultant report entitled Residents’ rights in nursing homes and hostels was released, resulting in three developments:  
  - Government endorsement of a ‘user rights’ philosophy and the development of a Charter of Residents’ Rights and Responsibilities;  
  - The development of better advocacy services; and  
  - The development of the CVS (Ronalds, Goodwin & Fiebig 1989); and  

• In 1990 the Charter of Rights for Nursing Home Residents was added as a Schedule to the National Health Act 1953. It enshrined the rights that formed the basis of the legal contract (Resident’s Agreement) between the nursing home resident and the home proprietor. Signing the agreement and compliance with it were conditions of Commonwealth funding.

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3 A nursing officer was not necessarily required for hostel visits.  
4 Section 45E of the National Health Act 1953.  
5 The evolution of the actual process of standards monitoring in Australia is described in some detail in a report prepared for the Department of Community Services and Health in 1990 (Braithwaite et al. 1993).
The user rights reforms that were introduced remain in place today, including the Charter of Residents’ Rights and Responsibilities, Resident Agreements, a complaints scheme, CVS6 and advocacy services.

- In 1993, the final report of a major project assessing the standards monitoring process was released (Braithwaite et al. 1993). It concluded that:
  ‘… these disparate sources of evidence constitute an overwhelming case that the standards monitoring process has been a success in improving the quality of life for nursing home residents. At the same time, the consultants absolutely agree with those nursing home employees, residents and consumer advocates who believe that the improvements are comparatively minor compared with what remains to be done.’
- In 1993 the Review of the Structure of Nursing Home Funding Arrangements Stage 1 report by Professor Bob Gregory was released. Professor Gregory’s report documented major deficiencies in capital works and was critical of the nursing home funding system which, in his view, provided neither the funding nor incentive for providers to maintain their capital stock; and
- In 1997 significant statutory reform was effected through the passage of the Act, addressing both the quality of the infrastructure of residential aged care homes and the quality of care provided.

The aged care reforms package legislated in 1997 was, therefore, the culmination of an ongoing regulatory response, spanning more than a decade and two Federal Governments. During that period, various concerns about the provision of residential aged care were identified, and an understanding developed about the way in which the industry was likely to respond to different regulatory strategies. In addition, the concept of standards was introduced to the industry and a government role in monitoring compliance with those standards was introduced.

While some commentators considered that the standards monitoring process had been a success (albeit noting that there was much room for further improvement) (Braithwaite et al. 1990), others considered that there were a number of difficulties with the Outcome Standards that applied at the time:

‘It was also held that the Outcome Standards could not distinguish between one-off events and systemic problems, did not properly address cases of poor care and failed to promote continuous improvement. There was a strong feeling that the standards monitoring process was intrusive and rigid.’ (Gray 2001b).

The history of challenges managing the accessibility and appropriateness of supply and the quality of residential aged care places over many years supports the necessity for continuation of a comprehensive regulatory regime, through the Act, that addresses the quality of both capital infrastructure and services provided.

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6 The Community Visitors' Scheme is funded by the Federal Government and managed by approved auspices in each State and Territory. It helps to establish links between people living in an aged care home and their local community. The Scheme aims to improve the quality of life of residents who have limited family and social contact, and may be at risk of isolation from the general community for social or cultural reasons, or through disability (Residential Care Manual, section 10 – User Rights, Department of Health and Ageing, January 2002).
3.5 The Aged Care Act 1997

The Act, together with a range of principles and other regulatory instruments that comprise the aged care regulatory framework, establishes the scheme by which the Australian Government currently provides financial support for aged care (including residential aged care) and the conditions under which that financial support is provided.

The Act replaced the provisions in the National Health Act 1953 and the Aged or Disabled Persons Care Act 1954, under which nursing homes and hostels had been administered previously. It changed the regulatory framework and some of the financial arrangements but essentially left intact the user rights introduced in the late 1980s and early 1990s.

As well as introducing significant changes to the funding for aged care, the Act was said to:

‘… provide(s) strategies for ensuring the rights of aged care recipients and the quality of care are maintained and strengthened. The legislation is based on the premise of helping to ensure aged care recipients enjoy the same rights as all other Australians … also includes a range of sanctions for the small numbers of providers who do not meet their clearly defined responsibilities. These are responsibilities in relation to meeting user rights, quality of care and accountability requirements imposed in relation to Commonwealth funding.’ (Moylan 1997).

The Act details a series of objectives, the first of which is to provide for funding for aged care. Underscoring the importance of quality of care and resident outcomes, this first object of the Act links the provision of funding to the quality of care and the outcomes for residents of aged care homes. The first object also makes direct reference to the accountability of providers under the Act.

‘…

To provide for funding of aged care that takes account of:

(i) The quality of care;

…

(iv) Appropriate outcomes for recipients of care;

(v) Accountability of the providers of care for the funding and outcomes for recipients.’

Section 2.1.
The Act has a number of additional objects that are relevant to the quality of care and quality of life of residents of aged care homes, including, among other things, requirements:

(b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;

(c) to protect the health and well-being of the recipients of aged care services;

... 

(d) to encourage diverse, flexible and responsive aged care services that:

(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and

(ii) facilitate the independence of, and choice available to, those recipients and carers;

(e) to help those recipients to enjoy the same rights as all other people in Australia.  

The objectives of the Act and its numerous subordinate instruments have been summarised as follows:

• Promoting a high quality of care and accommodation that meets the needs of individuals and protects their health and well-being by encouraging diverse, flexible and responsive residential aged care homes that facilitate the independence of, and choice available to, care recipients and carers;

• Facilitating access to residential care by those who need it, regardless of race, culture, language, gender, economic circumstance or geographic location and to help care recipients to enjoy the same rights as all other people in Australia;

• Planning effectively for the delivery of aged care homes by targeting services to areas of greatest need and people with the greatest need, avoiding duplication of services and improving the integration of the planning and delivery of residential aged care homes with the planning and delivery of related health and community services; and

• Providing funding in such a way as to take account of the quality and level of care provided, to hold providers of care accountable for the funding they receive and for the outcomes for the recipients of care they provide, and to ensure care is affordable for the people who need it (Hogan 2003, p. iv).
The meanings of the terms ‘care’ and ‘health and well-being’ have been subject to broad legal interpretation. For example, the Administrative Appeals Tribunal has declared that:

‘… in relation to “care”, its meaning will be coloured by its context. Its relevant ordinary meaning is to “provide for, look after, take care of” (The New Shorter Oxford English Dictionary, 3rd Edition, 1993). Care does not necessarily entail the constant physical presence of the carer in the life of the person cared for. A child, for example, remains in the care of a parent even though the child is at school for a significant portion of the day or staying with relatives for a period (Secretary, Department of Social Security v Lowe (1999) 92 FCR 26 at 30) (Burchett, Kiefel and Hely JJ). “Health” requires no explanation other than to note that it encompasses in its ordinary meaning not only the sound condition of the body but also its “spiritual soundness” (The New Oxford English Dictionary, 3rd Edition, 1993). “Well-being” means the “healthy, contented, or prosperous condition; moral or physical welfare” (The New Shorter Oxford English Dictionary, 3rd Edition, 1993) …’ (Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003, para. 227).

The Act authorises the Australian Government to give financial support through payment of subsidies for the provision of aged care and through payment of grants for other matters connected with the provision of aged care.9 Subsidies are paid to providers rather than residents of aged care homes, but before a subsidy can be paid a number of approvals and similar decisions are required, relating to the provider, the aged care service in question and the resident.10

Specifically, the Act authorises the payment of subsidies for residential aged care to a provider, on any given day, if that provider has been approved by the Secretary of the Department of Health and Ageing (the Secretary) and if the Secretary is satisfied that, during that day:

(a) the approved provider holds an allocation of places for residential care subsidy that is in force under Part 2.2 (not being a provisional allocation);11 and

(b) the approved provider provides residential care to a care recipient in respect of whom an approval is in force under Part 2.3 as a recipient of residential care; and

(c) the residential aged care service through which the care is provided meets its accreditation requirement (if any) applying at that time (see section 42.4).12

The process of approval of a provider requires the Secretary to consider a range of issues which are discussed in more detail later in this paper. A central issue for the Secretary’s consideration, however, is whether the applicant is ‘suitable’ to provide aged care.

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9 Section 3.1.
10 Section 3.2.
11 The Act establishes a scheme whereby a determination is made for each financial year of the number of places to be made available in each State or Territory (Division 12). An approved provider is entitled to apply for an allocation of places to provide aged care (section 13.1).
12 Section 42.1.
The Act details specific responsibilities of approved providers, and enables the Secretary to impose sanctions on an approved provider who fails to comply with those responsibilities. The Act also provides for a process of certification – the status given to a residential aged care service based primarily on its ability to provide quality accommodation for residents – and establishes financial incentives for providers to seek and maintain certification.

The requirement that funding can only be provided in relation to residential aged care for ‘a facility which has met its accreditation requirement’ is central to the quality framework established by the Act.

The Act does not define the term ‘accreditation’, but it establishes a system whereby a service meets its accreditation requirement if it is assessed by the accreditation body as compliant with all 44 Expected Outcomes defined in the ‘Accreditation Standards’.

The Accreditation Standards are:

‘… standards for the quality of care and quality of life for the provision of residential care on or after the accreditation day.’

They are incorporated within the Quality of Care Principles 1997, which are disallowable instruments under the Act.

In addition, capital funding is allocated on a competitive basis between residential aged care service, and access is contingent on, among other things, a service having:

‘… a very good record in meeting its responsibilities and obligations under the Act and other legislation relating to the provision of Australian Government funded aged care.’ (Australian Government 2004).

As well as making the availability of the operating and capital funding contingent on compliance by approved services with a range of specific requirements directed towards enhancing the quality of care and quality of life of residents, the Act establishes a range of direct legislative requirements of approved services that have a similar objective, together with a range of sanctions that can be imposed if those requirements are not met.

The Act incorporates, therefore, a complex range of direct and indirect strategies, of which the accreditation requirement is only one, that are aimed at assuring and enhancing the quality of care and quality of life for residents of aged care homes.

The effectiveness of the regulatory framework established by the Act, particularly those elements that establish accreditation requirements for residential aged care homes, has been widely debated and analysed. Professor Len Gray, in his report Two Year Review of Aged Care Reforms concluded that while it was too early to comment definitively on the
new quality assurance arrangements, the industry had accepted the changes, building activity had increased and more public information was available on the quality of care (Gray 2001b). On the other hand, some stakeholders have been critical of the regulatory framework, one substantial criticism being that it has imposed excessive and unnecessary ‘paperwork’ requirements on providers. For example:

‘Support services for older people have increasingly been required to perform along business lines despite increasing recognition that the principles of a perfect market do not apply in human services. This has resulted in an overwhelming contractual and regulatory demand for paperwork. While the intention was to improve the efficiency of service provision, this result is actually reducing the amount of time providers can spend with clients. This is exacerbated for providers that receive funding from a number of different sources, with different reporting requirements.’ (NSW Aged Care Alliance 2004)

3.6 Principles established under the Aged Care Act 1997

The Act authorises the Minister to make 23 sets of principles providing specific detail on the application of the legislative requirements. Known collectively as the Aged Care Principles those that are of particular relevance to the quality of care and quality of life of residents of aged care homes include:

- Accreditation Grant Principles;
- Approved Provider Principles;
- Quality of Care Principles;
- User Rights Principles;
- Accountability Principles;
- Certification Principles;
- Committee Principles; and
- Sanctions Principles.

The Principles established under the Act are disallowable instruments.15

3.7 The quality framework established under the Aged Care Act 1997

In broad overview, the Act and subordinate instruments are designed to protect and foster quality of care and quality of life of residents of aged care homes by:

- Focusing on the accountability of approved providers rather than on approval of premises as applied under the previous scheme regulated through the National Health Act 1953;

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15 Section 96.1(2).
Limiting access to residential care subsidies to approved providers, and ensuring that only people assessed as suitable to provide aged care are approved as providers;

Specifying in the Act and in the Quality of Care Principles, the User Rights Principles and the Accountability Principles many of the legitimate rights and expectations of residents and the responsibilities of providers;

Providing for the application of sanctions if approved providers fail to comply with their responsibilities;

Providing for a process of certification of physical facilities, with financial incentives available for certified facilities; and

Providing for a process of accreditation of residential aged care homes, with the availability of residential care subsidies contingent on the service being accredited.

These regulatory features are complemented by various additional strategies that reinforce the independence of residents, their right to receive quality care, and the responsibilities of providers. For example:

- Section 81.1 enables the Secretary on behalf of the Commonwealth to make grants for specified purposes, including encouraging understanding of and knowledge about the rights of residents of and potential residents, enabling residents to exercise those rights, and providing advocacy services. The Government funds advocacy services in each Australian state and territory;

- Section 82.1 enables the Secretary on behalf of the Commonwealth to make grants for facilitating contact with the community by care recipients, helping residents maintain independence through contact with people in the community, and assisting residents to maintain contact with people from similar linguistic or cultural backgrounds;

- Section 91.1 enables an authorised officer to enter a residential aged care service, with consent, to assess compliance with regulatory responsibilities; and

- Section 96.3, together with the Committee Principles, provides for the appointment of the Complaints Commissioner and the operation of the Complaints Resolution Scheme.

The features of the regulatory framework that appear to impact most directly on quality of care and quality of life of residents of aged care homes are presented in the following sections, which focus upon:

- Characteristics of approved providers;
- Responsibilities of approved providers;
- Other strategies enhancing resident rights;
- Approval and classification of residents of aged care homes; and
- Certification of residential aged care homes.
3.8 Characteristics of approved providers

An approved provider is:

‘A person or body in respect of which an approval under Part 2.1 is in force, and to the extent provided for in Section 8.6, includes any State or Territory, authority of a State or Territory or Local Government authority.’¹⁶

The Act provides that the Secretary must approve a person as a provider of aged care if:

(a) the person … makes an application under section 8.2; and
(b) the Secretary is satisfied that the applicant is a corporation; and
(c) the Secretary is satisfied that the applicant is suitable to provide aged care; and
(d) the Secretary is satisfied that none of the applicant’s key personnel is a disqualified individual.¹⁷

The Secretary must take a number of issues into account in deciding whether an applicant is suitable to provide aged care including, among other things:

(a) the suitability and experience of the applicant’s key personnel; and
(b) the applicant’s ability to provide, and its experience (if any) in providing, aged care; and
(c) the applicant’s ability to meet (and, if the applicant has been a provider of aged care, its record of meeting) relevant Standards for the provision of aged care (see Part 4.1); and
(d) the applicant’s commitment to (and, if the applicant has been a provider of aged care its record of commitment to) the rights of recipients of aged care; and
(e) the applicant’s record of financial management, and the methods that the applicant uses, or proposes to use, in order to ensure sound financial management; and
(f) if the applicant has been a provider of aged care, its record of financial management relating to the provision of that aged care; and
(g) if the applicant has been a provider of aged care, its conduct as a provider and its compliance with its responsibilities as a provider and its obligations arising from the receipt of any payments from the Commonwealth for providing that aged care; and
(h) any other matters specified in the Approved Provider Principles.¹⁸

The Approved Provider Principles, established under the Act, contain further detail about the matters to which the Secretary must have regard in determining the suitability of an applicant.

¹⁶ Schedule 1.
¹⁷ Section 8.1. A disqualified individual is defined in section 10A.1 as an individual who has been convicted of an indictable offence, or an individual who is insolvent under administration, or an individual who is of unsound mind.
¹⁸ Section 8.3.
3.9 Responsibilities of approved providers

Approved providers are required to comply with a range of specific responsibilities, set out in Chapter 4 of the Act, encompassing quality of care, user rights and accountability. While these responsibilities are comprehensive, the following brief description covers responsibilities that are likely to have the greatest impact on the quality of care and quality of life of residents of aged care homes.

3.9.1 Quality of care

Schedule 1 of the Quality of Care Principles provides a comprehensive list of facilities, care and services that must be provided to residents of aged care homes.

The Quality of Care Principles also contains the Accreditation Standards which are:

‘… standards for quality of care and quality of life for the provision of residential care on and after the accreditation day (which was 1 January 2001).’

The specific quality of care responsibilities of an approved provider which are likely to be most relevant to the quality of care and quality of life of residents of aged care homes include:

(a) to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;
(b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;
(c) to provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles for the purposes of paragraph 56.1(l), 56.2(i) or 56.3(j);
(d) if the care is provided through a residential aged care service after the accreditation day – to comply with the Accreditation Standards made under section 54.2; and

…
(h) such other responsibilities as are specified in the Quality of Care Principles.

It should be noted that a number of requirements established by the Act, are distinct and separate from the accreditation requirement, which must be fulfilled if residential care subsidy is to be payable. These include those established by:

• section 54.1, requiring approved providers to comply with the Accreditation Standards made under section 54.2; and
• section 63.1, requiring approved providers to allow people acting for accreditation bodies to have such access to the service as is specified in the Accountability Principles.

19 Section 54.2.
20 Section 54.1.
If an approved provider fails to comply with these, or other specified responsibilities including compliance with the User Rights and Accountability Principles, the Secretary may impose sanctions. The rights and responsibilities of the various parties with respect to the imposition of sanctions are discussed later in this review.

3.9.2 User rights

All are required to have an internal complaints system. If, however, a complainant is uncomfortable discussing a problem directly with the service provider, or a provider’s internal complaints system is ineffective in resolving a complaint, the consumer or advocate is entitled to lodge a formal complaint with the Department’s Aged Care Complaints Resolution Scheme.

The specific user rights responsibilities of an approved provider which are likely to impact most directly on quality of care and quality of life of residents include the following requirements:

(e) to provide such security of tenure for the care recipient’s place in the service as is specified in the User Rights Principles;

... 

(g) to offer to enter into a resident agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement (see Division 59);

... 

(i) to comply with the requirements of section 56.4 in relation to resolution of complaints;

(j) to allow people acting for care recipients to have such access to the service as is specified in the User Rights Principles;

(k) to allow people acting for bodies that have been paid advocacy grants under Part 5.5 to have such access to the service as is specified in the User Rights Principles;

(l) not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles; and 

(m) such other responsibilities as are specified in the User Rights Principles.

3.9.3 Accountability

The specific accountability responsibilities of an approved provider which are likely to impact most directly on quality of care and quality of life of residents of aged care homes include requirements:

21 Section 56.4(1).
22 Section 10.38(2) of the Committee Principles provides that ‘the affected care recipient or their representative, or anyone else (the complainant) may make a complaint to the Secretary about anything that (a) may be a breach of the relevant approved provider’s responsibilities under the Act or the Aged Care Principles; and (b) the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.’
23 Section 56.1.
(g) to allow people authorised by the Secretary access to the service, as required under the Accountability Principles, in order to review the certification of the service under section 39.4;

(k) to comply with any agreement the approved provider makes under paragraph 66.2(1)(b) and with any undertaking the approved provider gives for the purposes of section 67.4;

(l) to allow people acting for accreditation bodies to have such access to the service as is specified in the Accountability Principles; and

(m) such other responsibilities as are specified in the Accountability Principles.24

3.10 Sanctions under the Aged Care Act 1997

The Secretary has a role in imposing sanctions where approved providers have breached their responsibilities and in generally ensuring that approved providers meet their other obligations under the Act. The Secretary has discretion in responding to an approved provider’s non-compliance25 and may impose sanctions if:

(a) the approved provider has not complied, or is not complying, with one or more of its responsibilities under Part 4.1, 4.2 or 4.3; and

(b) the Secretary is satisfied that it is appropriate to impose sanctions on the approved provider; and

(c) the Secretary complies with the requirements of Division 67.26

In deciding whether or not to impose sanctions in respect of an approved provider’s non-compliance with his, her or its responsibilities, the Secretary must consider:

(a) whether the non-compliance is of a minor or serious nature;

(b) whether the non-compliance has occurred before and, if so, how often;

(c) whether the non-compliance threatens the health, welfare or interests of care recipients;

(d) whether the approved provider has failed to comply with any undertaking to remedy the non-compliance;

(e) any other matters specified in the Sanctions Principles.27

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24 Section 63.1.
26 Section 65-1 of the Aged Care Act 1997.
27 Section 65-2 of the Aged Care Act 1997.
The sanctions that may be imposed by the Secretary are to:

(a) revoke or suspend the approved provider’s approval under Part 2.1 ... as a provider of aged care services;

(b) restrict the approved provider’s approval under Part 2.1 as a provider of aged care services to aged care services that are being conducted by the approved provider at the time the sanction is imposed;

(c) restrict the approved provider’s approval under Part 2.1 as a provider of aged care services to either:
   (i) care recipients to whom the approved provider is providing care at the time the sanction is imposed; or
   (ii) care recipients other than those to whom the approved provider commenced providing care, through one or more specified aged care services, after the time the sanction is imposed;

(d) revoke or suspend the allocation of some or all of the places allocated to the approved provider under Part 2.2;

(e) vary the conditions to which the allocation of some or all of those places is subject under section 14-5;

(f) prohibit the further allocation of places under Part 2.2 to the approved provider;

(g) revoke or suspend the extra service status of a residential care service, conducted by an approved provider;

(h) prohibit the granting of extra service status in respect of residential care services, or distinct parts of residential care services, conducted by the approved provider;

(i) revoke or suspend the certification of a residential care service in respect of which the approved provider has not complied with its responsibilities;

(j) prohibit the charging of accommodation bonds or the accrual or accommodation bond charges, for the entry of care recipients to one or more specified residential care services, or all residential care services, conducted by the approved provider;

(k) require repayment of some or all of any grants paid to the approved provider under Chapter 5 in respect of an aged care service in respect of which the approved provider has not complied with its responsibilities;

(l) such other sanctions as are specified in the Sanctions Principles.\(^28\)

The Sanctions Principles 1997\(^29\) set out the steps that a provider must take to ensure suitability of key personnel\(^30\) and the circumstances in which the Secretary might approve the appointment of an administrator to an approved provider instead of revocation of approval.\(^31\)

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\(^28\) Section 66-1.
\(^29\) Came into operation on 1 October 1997 and have since been amended by the Sanctions Amendment Principles 2001.
\(^30\) Part 1A
\(^31\) Division 2
The procedure for the imposition and lifting of sanctions is the subject of Division 67 of Part 4.4 and Part 3 of the Sanctions Principles. The Secretary must not impose sanctions on an approved provider for non-compliance with one or more of its responsibilities under Part 4.1, 4.2 or 4.3 unless the Secretary has completed each of the steps set out in section 67-1(1), including giving the approved provider notice of non-compliance, a notice of intention to impose sanctions or to remedy the non-compliance, or both and notice of the Secretary’s decision whether to impose sanctions. If the Secretary determines there is an immediate and severe risk to the health safety or well-being of residents, sanctions may be imposed immediately without completing the steps set out in section 67-1.

The Secretary is required to consider any submissions made by the provider. If the Secretary considers that the submissions propose appropriate action to remedy the non-compliance, set out sufficient reason for the non-compliance or are otherwise satisfactory, the Secretary may give the provider a notice to remedy the non-compliance. That notice must inform the approved provider that, within 14 days after receiving the notice, or within a shorter period specified in the notice, it must give the Secretary a written undertaking to remedy the non-compliance. It must also inform the approved provider that the Secretary may impose sanctions on the approved provider if the undertaking is not given or complied with.

If a sanction is to be imposed, the Secretary must give the approved provider a notice setting out the nature of the non-compliance, the sanction to be imposed, the consequences of the imposition of the sanction, the sanction period and the reasons for the sanction’s imposition. The notice may be dispensed with if:

‘... the Secretary is satisfied that, because of the approved provider’s non-compliance, there is an immediate and severe risk to the safety, health or well-being of care recipients to whom the approved provider is providing care.”

In Riverside Nursing Care Pty Ltd v Honourable Bronwyn Bishop, the Full Court of the Federal Court held that section 67-1(2), when read with sections 67-1, 67-2 and 67-3, clearly excludes the rules of natural justice when the Secretary is satisfied that there is an immediate and severe risk to the safety, health or well-being of residents of aged care homes (Riverside Nursing Care Pty Ltd v Honourable Bronwyn Bishop 2000). Their Honours went on to explain why that should be so:

‘There are good policy reasons why, in the circumstances contemplated by s67-1(2), the right to be heard should be excluded. The exclusion takes place only if the secretary is satisfied that there is an immediate and severe risk to the safety, health or well-being of care recipients. The object of excluding the steps referred to in s67-1(1) in such circumstances is to ensure that the taking of those steps does not occasion a

32 Section 67-4(1) of the Aged Care Act 1997
33 Section 67-5(2) of the Aged Care Act 1997. If the Secretary decides not to impose a sanction, the notice must specify the nature of the approved provider’s non-compliance and the reasons for not imposing a sanction (section 67-5(3)).
34 Section 67-1(2). For a good discussion of when there is an immediate and severe risk to the safety, health or well-being of care recipients, see the judgment of the Administrative Appeals Tribunal in (Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003).
delay which might imperil the safety, health or well-being of care recipients. Any delay resulting from allowing an approved provider to exercise a common law right to be
heard could jeopardise the safety, health or well being of care recipients. There would be no utility in excluding the steps contemplated by s67-1 (1) if a common law right to be heard remained.’

The length of any sanction period is determined by the Secretary having regard to any matters specified in the Sanctions Principles, including:

(a) whether the non-compliance is of a minor or serious nature; and
(b) whether the non-compliance has happened before, and, if so, how often; and
(c) whether the non-compliance threatens or threatened the health, welfare or interests of care recipients; and
(d) whether the approved provider has failed to comply with any undertaking to remedy the non-compliance; and
(e) the period likely to be needed to establish whether any improvement in compliance can be sustained.35

Under the Sanctions Principles, the Secretary must have regard to these matters in deciding whether it is appropriate to lift a sanction and the requirements that must be met to lift a sanction.36 In addition, the Secretary must have regard to what the provider has done to remedy the non-compliance for which the sanction was imposed, any assessment carried out while the sanction has been in effect, staffing and organisational development against the Accreditation Standards, consultations with staff and carers of residents of aged care homes or their relatives and the provider’s proposals for sustaining its compliance with its responsibilities.

The Department publishes information on its website about sanctions imposed, including:

• The names and addresses of residential aged care homes where sanctions are in place;
• The names of the approved providers (operators) of the residential aged care homes;
• Sanctions action taken under the Act and the reasons for that action; and
• The status of the services (Australian Government Department of Health and Ageing 2005a).

According to some commentators, the hierarchy of sanctions under the Act is not credible (Braithwaite 2001, pp. 443–6). Braithwaite argues that an effective regulatory regime requires the capacity to move up a pyramid of enforcement sanctions, and suggests that more graduated sanctions that reflect the severity of a problem are needed.37

36 Sections 22.18 and 22.19 of the Accreditation Grant Principles 1999.
37 For an interesting discussion of the quality of ‘regulatory dialogue’ and the need for sanctions-based strategies only when ‘respectful dialogue’ fails, see (Braithwaite 1998).
‘... doubts as to whether the sanctions prescribed in the Act and used by the Secretary are likely to achieve the desired result of helping a service provider provide an adequate standard of care. It seems that by imposing additional burdens and sanctions which result in reduced funding to nursing homes, which are already over burdened and under staffed, decision makers may in fact be making worse the situation they are intending to remedy.’

Concerns about the sanctions regime also were expressed by the Administrative Appeals Tribunal in *Neviskia Pty Ltd and Secretary, Department of Health and Aged Care*:

‘There is much repetition in the documentation and one review audit can give rise to a number of separate decisions at different times each of which can result in sanctions.’

The question of whether the sanctions available to the Secretary are optimal in terms of promoting compliance with the Accreditation Standards and achievement of the objectives of the accreditation process will be assessed during this project.

The Administrative Appeals Tribunal identified some tensions inherent in the current structural framework for accreditation in the residential aged care sector:

‘On the one hand, it leaves at risk the nursing home’s residents while the Agency assessments are undertaken, reports prepared and decisions made by the Department. On the other, it does not provide “hands on” guidance to a nursing home as to how it may rectify its non-compliance. In other words, the system that has been put in place is not directed to accreditation as that word is generally understood by accreditation bodies or in the Manual issued by the Department. Accreditation as it is generally understood is directed to assisting the public, the users and the government that they will have a service of an appropriate quality. The standard setting authority, the accrediting authority, the payment authority and the inspecting or compliance authority are separate bodies operating independently so that each can carry out its function appropriately and the system as a whole can ensure that the public receives services of an appropriate quality. Having heard from Ms Bowman and considered the various documents to which we have referred, we have formed the view that the necessary separation of the four functions is absent.’

The tensions created when an approved provider who is adjudged to have not complied with their responsibilities is denied access to a portion of their funding, and the potential ‘spiralling’ effect on quality of care, were also the subject of recent comment by the Administrative Appeals Tribunal (*Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003*):

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38 The case concerning an application for review of two decisions made by the delegate of the Secretary of the Department of Health and Ageing which revoked Riverside’s approval as a provider under the Aged Care Act and revoked all places allocated to the provider under the Act (*Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003*).
'The focus of the Act only upon the accountability of the provider of aged care services and not upon the financial interests of an approved provider does not necessarily mean that its financial position is irrelevant. There are instances in which there may be a tension between an approved provider's accountability and the Act's object of protecting the health and well-being of the recipients of the aged care services and that tension is as a result of the approved provider's financial position. That tension may arise in instances in which a sanction is imposed and the outcome of the imposition of that sanction is effectively to reduce the total amount of subsidy payable to an approved provider. A reduction could occur, for example, if a sanction restricted an approved provider's approval as a provider of aged care services to care recipients to whom it was providing care at the time the sanction was imposed but not to those to whom it subsequently provided care. If it should come to pass that the number of recipients in relation to whom it was an approved provider fell below the level at which an approved provider's business is viable and if the approved provider cannot recover from other sources the amount that would otherwise be paid to by way of subsidy under the Act, then there must be a very real possibility that the health and well-being of the recipients of aged care services may be compromised …'

Similar concerns have been echoed in other cases before the Administrative Appeals Tribunal (Neviskia Pty Ltd and Secretary. Department of Health and Aged Care 2000):

'… the evidence has also raised doubts as to whether the sanctions prescribed in the Act and used by the Secretary are likely to achieve the desired result of helping a service provider provide an adequate standard of care. It seems that by imposing additional burdens and sanctions which result in reduced funding to nursing homes, which are already overburdened and under staffed, decision makers may in fact be making worse the situation they are intending to remedy.'

Overall concerns regarding the complexity of the legislation have also been expressed:

‘… Justice Weinberg described the system as a “somewhat convoluted legislative scheme”. We can only agree.’

These issues will be explored fully during the course of this project.

### 3.11 Other strategies enhancing quality of care and user rights

It is important to recognise that the Act establishes a comprehensive framework which is designed to assure the achievement of minimum standards of care as well as stimulate continuous improvement.

The accreditation requirement is only one element of this framework. The definition of responsibilities of approved providers (as described above) is a further element. The Act and the User Rights Principles also provide the authority for the following:
• A Charter of Residents’ Rights and Responsibilities;\textsuperscript{40}
• Independent advocacy services, which operate in each state and territory;\textsuperscript{41}
• The CVS, which is available to all residents of aged care homes (not just residential aged care),\textsuperscript{42} and
• The Department’s Aged Care Complaints Resolution Scheme.\textsuperscript{43}

The issues related to residents’ rights and the need for systematic responses to address the advocacy needs of residents were acknowledged previously by the Australian Government and a number of strategies had been initiated to address these issues prior to the introduction of the Act.

In 1989 the Australian Government commissioned a report by Ronalds which highlighted a number of factors which impacted on residents’ capacity to discuss concerns related to where they live. This report recognised the impact of factors such as: feelings of isolation from family and friends; inability to participate in decision making; lack of knowledge about the aged care system and consumer rights; loss of independence and consequent loss of self-esteem; and fear of possible retribution. Two of the key recommendations of the report were the introduction of a Charter of Residents’ Rights and Responsibilities and the establishment of an independent, community based advocacy agency for people in receipt of aged care homes in each State and Territory.

In 1989-90, the Residential Aged Care Advocacy Services Program (RACASP) was formed as part of the Commonwealth Government’s strategy to reform the residential aged care program. It responded directly to the issues raised in the Ronalds report and put into place a strategy for the establishment of the advocacy services in each state and territory to uphold residents’ rights.

Following on from these developments, legislative recognition of residents’ rights was enshrined in the Act and \textit{User Rights Principles 1997} (Part 4.2). Amendments made to the Principles in 2000 and 2004 sought to strengthen the recognition that residents of aged care homes have the responsibility to exercise their individual rights in ways that do not adversely affect other residents’ rights, and that a person’s rights are should not be diminished when he or she moves into an aged care home.

\textsuperscript{40} Section 23.14 of the \textit{User Rights Principles} provides that information about the care recipient’s rights and obligations in relation to the service under the Charter must be provided to a care recipient upon entering a service.

\textsuperscript{41} Part 5.5 of the Act provides for Advocacy Grants. Through the National Aged Care Advocacy Program, the Department funds Advocacy Services in each State and Territory to provide independent advocacy services to residents, potential residents and their families.

\textsuperscript{42} See part 5.6 of the Act for Community Visitors’ Grants.

\textsuperscript{43} Section 10.38(2) of the Committee Principles provides that ‘… the affected care recipient or their representative, or anyone else (the complainant) may make a complaint to the Secretary about anything that (a) may be a breach of the relevant approved provider’s responsibilities under the Act or the Aged Care Principles and (b) the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.’
3.11.1 Charter of residents’ rights and responsibilities

The *User Rights Principles 1997* made under the *Aged Care Act 1997* includes a Charter of Residents’ Rights and Responsibilities. Recognising that a person’s rights are not diminished when he or she moves into an aged care home, the *Charter of Residents’ Rights and Responsibilities* details the personal, civil, legal and consumer rights of all residents. The Charter also outlines residents’ responsibilities in relation to other residents, staff and the residential aged care service community as a whole. The Act specifies that providers should inform residents and their nominated representatives should be informed about these rights and responsibilities. These rights include the right:

- to personal, civil, legal and consumer rights;
- to quality care appropriate to his or her needs;
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to privacy;
- to continue his or her cultural and religious practices and to retain the language of his or her choice;
- to freedom of speech;
- to make decisions about the personal aspects of his or her daily life, financial affairs and possessions;
- to have access to services and activities which are available generally in the community;
- to have access to information about his or her rights, care, accommodation;
- to complain and to take action to resolve disputes; and
- to have access to advocates and other avenues of redress.

Responsibilities specified in the Charter include the responsibility:

- to respect the rights and needs of other people within the residential care service;
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment; and
- to care for his or her own health and well-being, as far as he or she is capable.

3.11.2 Independent advocacy services

In accordance with the Act, Advocacy Grants are provided to fund independent Advocacy Services in each State or Territory through the National Aged Care Advocacy Program. Services provided through the Program are free and confidential.

Advocacy Services recognise that recipients of aged care homes may be particularly vulnerable and require the support of an advocate to exercise the rights provided to them in the *Aged Care Act 1997* and *User Rights Principles 1997*. People who are eligible to access Advocacy Services include all recipients of Commonwealth aged care homes.
3.11.3 The Community Visitors Scheme
The CVS is funded by the Federal Government and is managed by approximately 160 approved community-based organisations in each state and territory. The Scheme is available to all recipients of aged care homes, not just residential aged care. It provides funding for the training of volunteers (who act as Community Visitors), and the local delivery of the Scheme.

The Scheme recognises the importance of maintaining community connectedness between people living in aged care homes and members of their local community. It aims to improve the quality of life of recipients of aged care homes, in particular those who have limited family and social contact, and may be at risk of isolation from the community for social or cultural reasons, or as a result of disability. While the Scheme extends beyond residential aged care homes, by encouraging community interaction within residential aged care homes the Scheme assists in ensuring that the community expectations of residential aged care homes are maintained.

3.11.4 The Aged Care Complaints Resolution Scheme
The Aged Care Complaints Resolution Scheme is operated by the Australian Department of Health and Ageing to provide a free, accessible independent system for the resolution of complaints about Commonwealth funded aged care homes (including residential services, aged care homes, hostels and community aged care packages).

The Scheme was designed to promote continuous quality improvement of aged care homes by ensuring that both internal as well as external systems of complaints resolution are established. As such, the Scheme provides a process for complaints to be firstly addressed through internal processes with the provider, and then to proceed to the external Scheme, if this first stage internal ‘negotiation’ is unable to resolve the issue.

This approach acknowledges that the best way to resolve complaints is at the local level, directly with the aged care service. This is seen as the most efficient and expedient approach to resolving an issue in a way which encourages aged care providers to be aware of, and responsive to both residents’ and community expectations. The Scheme recognises, however, that in some cases people may choose not to seek internal resolution as their first option, so it has provisions to enable any person who is concerned about any aspect of the care to complain directly to the external Scheme. This may be done either before or after using the internal complaints process.

The Scheme provides information to people wishing to make a complaint as well as a ‘Complaints Handling Kit’ to providers. The Kit has been designed to assist providers in the development of effective, accessible complaints management processes which reflect Accreditation Standard 1.4 ‘Comments and Complaints’ (Management Systems, Staffing and Organisational Development) while ensuring that they meet their legal responsibilities under the Aged Care Act 1997 (see especially Division 56) and Aged Care Principles (in particular the Aged Care Committee Principles under the User Rights Principles).
In September 2000, the Australian Government also established (under the *Committee Principles 1997*) the independent Office of the Commissioner for Complaints to oversee the Complaints Resolution Scheme.

The Scheme is available to anyone who wishes to make a complaint (if required, confidentially and anonymously) about an aged care service. The process functions are broadly that:

- The provider is notified of the general nature of a complaint and a written response is requested (described as ‘negotiation’ in the *Committee Principles*);
- If ‘negotiation’ fails, the complainant may then choose to go on to a mediation with the provider (subject to the willingness of the provider to mediate); and
- The complainant may go to a determination hearing by a Complaints Resolution Committee (the four committee members being drawn from a pool of experienced people contracted by the Department). The provider is compelled to participate in the determination hearing and to abide by the determination (subject to a right of review by a Determination Review Panel[^44]). If the provider does not abide by the determination, the Secretary may take compliance action under section 65.1 of the Act.

Protocols allow for the sharing of information with the Department and also between the Department and other complaints bodies to which the Department can refer particular issues (for example, the Victorian Health Services Commissioner). The Department can make inquiries about systematic matters within a service and, if necessary, refer them to the Agency.

### 3.12 Approval and classification of residents of aged care homes

As previously noted, payment of a residential care subsidy is only made to an approved provider under Part 2.3 of the Act[^45]. The Secretary has the power to approve a person as a recipient of residential aged care. This power generally is delegated to nominated positions on ACATs.

Section 21.2 of the Act provides that a person is eligible to receive residential care if:

(a) the person has physical, medical, social or psychological needs that require the provision of care; and

(b) those needs cannot be met more appropriately through non-residential aged care services; and

(c) the person meets the criteria (if any) specified in the *Approval of Care Recipient Principles* as the criteria that a person must meet in order to be eligible to be approved as a recipient of residential care.

[^44]: See further the *Committee Principles*. The Panel consists of the Commissioner for Complaints and one person drawn from a panel of potential chairpersons of the Complaints Resolution Committees. The Panel reviews the original determination on the papers only and will either confirm, vary or set aside. Reasons for seeking the review must include more than ‘mere dissatisfaction’. The legislation does not specify what is relevant but it would seem that issues of procedural fairness would be relevant.

[^45]: Section 20.1(1).
ACATs assess the person’s medical, physical, psychological and social circumstances and approve persons as requiring either high level or low level care. ACATs are guided by the Commonwealth’s ‘Aged Care Assessment and Approval Guidelines’ which identify the main considerations they should address when approving persons for specified types of care.

A Commonwealth subsidy will only be paid for people who have been approved to receive care, and only for the type of care provided in accordance with any limits set by the approval. A decision to approve or not approve a person to receive care, and to set limitations to an approval, is a ‘reviewable decision’ and, following a request for internal review, can be referred to the Administrative Appeals Tribunal.

Once a person has been approved as a recipient of care, the approved provider must appraise the level of care needed by the residents of aged care homes, relative to the needs of other residents (unless the approved provider has been suspended under section 25.4 from making appraisals, in which case another authorised person must make those appraisals). The amount of subsidy payable to an approved provider depends, among other things, on the classification level of the recipient(s) of care.

The initial classification appraisal process entails comprehensive assessment and documentation of each resident’s care abilities and care needs, together with the development of a care plan and submission to the Department for approval of the classification. There are 20 questions on the Resident Classification Scale (RCS).

For existing residents, re-classification depends on an evaluation of the resident’s care plan including the adequacy of strategies on the plan, and submission to the Department. All existing residents are required to undergo an annual reappraisal and an application for re-classification can also be submitted if a resident’s care needs have changed by two or more classification levels. The Department validates appraisals retrospectively through a targeted audit program based on document review.

The Australian Government announced in the 2004 Budget that it intends to introduce a new funding model for residential aged care in 2006. The new system will rationalise the current funding classification system from eight down to three categories and introduce new supplements to target existing funds towards the care of residents with dementia exhibiting challenging behaviours and complex nursing, including palliative care needs.

The Department has recently advertised a Request for Tender (Australian Government 2005), with the objectives of the project being to:

- Test options for the introduction of a new funding mechanism for residential aged care by conducting a national trial of the draft Aged Care Funding Instrument, using it to classify residents for residential aged care; and

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46 Section 25.3.

47 The Secretary may suspend an approved provider from making appraisals if the Secretary is satisfied that the approved provider, or a person acting on the approved provider’s behalf, gave false, misleading or inaccurate information in a substantial number of appraisals reviewed under subsection 19.1(3) and the classifications made in connection with those appraisals were changed under section 29.1 and the Secretary is satisfied that, after those classifications were changed, the approved provider continued to give false, misleading or inaccurate information in other appraisals (section 25.4).

48 Section 44.3(3)(a).
• Collect relevant data and conduct detailed comparative analysis of specified funding models for residential aged care based on a comprehensive analysis of the relevant data, including those collected during the national trial.

The process for approval and classification of residents of aged care homes is not directly linked in the Act to the quality of care, user rights or accountability responsibilities of approved providers, and does not have a direct relationship to the quality of care or quality of life of residents. However, it is an integral aspect of the overall funding and regulatory framework for residential aged care, and it imposes on approved providers and staff accountability and administrative requirements that may become confused with, or appear to duplicate, requirements related to the Quality of Care, User Rights and Accountability Principles.

In addition, it has clearly been demonstrated that a comprehensive care plan is an important element of quality care. While the requirement to develop a care plan is associated with classification of residents rather than the quality framework, it has an important association with the quality framework established by the Act.

3.13 Certification of residential aged care homes

Certification is a status given to residential aged care homes based primarily on their ability to provide quality accommodation to residents. Certification is mandatory for approved providers who charge accommodation bonds\(^49\) or accommodation charges\(^50\) or receive concessional resident supplements\(^51\) in respect of a residential aged care service.

The certification standards and assessment instrument were developed in consultation with the industry through the Committee for the Quality of Aged Care Accommodation. The certification measures are aimed at raising the standards of safety and comfort for older Australians and bring continuous improvement in building infrastructure.

A certification assessment is conducted by an independent person (Certification Principles 1997, section 8.12(a)) using the 1999 Certification Assessment Instrument. Scores are given for each of the following areas:

- Safety;
- Hazards;
- Privacy;
- Access;
- Mobility;
- Occupational Health and Safety;
- Heating/cooling; and
- Lighting/ventilation and security.

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\(^49\) Section 57.2(1)(a).
\(^50\) Section 57A(8).
\(^51\) Section 44.6(2)(c).
An overall score is then awarded (Australian Government Department of Health and Ageing 2003).

Although the Act addresses certification as an issue discrete from accreditation, there are direct and indirect legislative links between the two requirements. Whilst the requirements for each process and the relationship between them are clearly defined in the Act, early stakeholder comment suggests that views may differ about how that relationship should be developed in the future to achieve optimal administrative efficiency and quality of accommodation.

The quality of accommodation of residents of aged care homes is likely to make a major contribution to their quality of care and quality of life. For example, maintenance of resident privacy and a home-like environment clearly, to a large degree, will be influenced by the physical facilities within which care is delivered.

Apart from this indirect relationship between certification and quality of care/quality of life, the Act establishes a direct link between the certification process and the standard of care that is provided. For example, in considering an application for certification, the Secretary must also have regard to:

- The standard of residential aged care being provided;
- The approved provider’s conduct and compliance with its responsibilities and obligations arising from the receipt of any payments from the Australian Government; and
- Any other matters specified in the Certification Principles. 52

Likewise, Accreditation Standard 4 addresses ‘Physical Standards and Safe Systems’, with Expected Outcomes relating to the safety and comfort of the working environment.

These links between certification and accreditation will be examined during the current project.

In July 1999 a ten-year forward plan for certification was agreed by industry representative groups. The plan incorporated a December 2003 target for fire safety and a 2008 target for privacy and space. The forward plan gave approved providers a clear framework of targets that would enable them to plan for and implement improvements in accommodation.

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52 Section 38.3.
3.14 Annual Reports on the Aged Care Act 1997

The Act establishes an important public accountability mechanism in its requirement that the Minister presents to Parliament annually a report on the operation of the Act. The Minister is required to report on a large range of matters, including:

(a) The extent of unmet demand for places;
(b) The adequacy of the Commonwealth subsidies provided to meet the care needs of residents;
(c) The extent to which providers are complying with their responsibilities under the Act;
(d) The amounts of accommodation bonds and accommodation charges charged;
(e) The duration of waiting periods for entry to residential care;
(f) The extent of building, upgrading and refurbishment of residential aged care homes; and
(g) The imposition of any sanctions for non-compliance under Part 4.4, including details of the nature of the non-compliance and the sanctions imposed.53

A number of changes have been introduced into the Act and User Rights Principles 1997 since 2000 to improve the legislative protection afforded to residents. Key amendments to the Act over time have incorporated54:

- The capacity for the Agency to charge fees for accrediting residential aged care services (1998);
- The capacity for revocation of approved provider status to occur in stages, allowing appropriate time to make alternative arrangements for the care of residents (1999/2000);
- Formalisation of accommodation charges and appropriate protection measures for residents (1999/2000);
- The capacity to act upon provider breaches which occurred under previous legislation (1999/2000);
- The capacity to defer (or progressively apply) sanctions, allowing residents to become aware of the impact of any sanctions upon their care (2000/01);
- The introduction of appropriate standards for ‘key personnel’ as approved service providers (2000/01);
- The establishment of a panel of advisers, and administrators to assist facilities under sanction in relation to the provision of appropriate standards of care (2000/01);
- The extension of the Criminal Code to the regulation of providers under the Act (2001/02);

53 Section 53.2.
54 There were no amendments to the Aged Care Act 1997 during 2002/03.
• The removal of ACAT reassessment requirements for residents who move from low to high care within the same facility (2003/04); and
• The removal of the maximum five year period that a resident could be charged, allowing the provider to levy accommodation charges for the entire period that a resident remains in a facility (2003/04).

3.15 Regulation and quality of life

Regulation of aged care homes generally is intended to foster improved quality of care and quality of life for residents who are a vulnerable segment of the population. The intention of regulation is to achieve levels of care and quality of life that are acceptable to the community, carers, health professionals and residents. The legislative reform process has focused on this outcome.

The following sections review the international literature relating to measuring quality of care and quality of life.
4. Frameworks for Understanding Quality of Care and Quality of Life for Residents in Residential Aged Care

Quality of care and quality of life are overlapping concepts that have originated in separate spheres of the literature. Neither term is defined in the Act or its subordinate instruments, although both the Act and the Principles refer frequently to the concept of ‘quality of care’.

Understanding both concepts is critical to this project. Accordingly, this section will:

- Describe the concept and measurement of quality of care; and
- Describe the concept and measurement of quality of life.

4.1 Understanding quality of care

Typically, quality in health care is seen as a multidimensional concept encompassing domains of accessibility, coordination, comprehensiveness, effectiveness, efficiency, patient satisfaction, safety, technical proficiency, appropriateness and acceptability (Boyce et al. 1997; Caper 1988; Irwig 1993). Many of these domains apply to elements of the residential aged care sector as they do to the acute health care sector, although their application may differ and their relative importance may vary considerably between the sectors.

Following the working definitions proposed by Boyce and colleagues (1997) each element of health care quality may be understood as follows:

- Access refers to the capacity of all individuals to receive the same standard of service provision;
- Appropriateness refers to the extent to which the benefits of an intervention outweigh the risks associated with the same intervention;
- Technical proficiency (as distinct from technical efficiency) refers to the clinical application of current best practice in skills and knowledge;
- Continuity refers to the extent to which a specific episode of service provision is integrated into an overall care plan;
- Safety refers to risk avoidance and harm minimisation in care delivery;
- Acceptability refers to the degree to which a given service addresses the ‘expectations of informed … consumers’;
- Efficiency refers to the maximisation of benefits or outputs (e.g. health) for a given level of inputs (e.g. costs) and may be further broken down into:
  - Technical efficiency which is concerned with minimising the level of inputs or resources required to achieve a given benefit or output; and
  - Allocative efficiency which is concerned with maximising the distribution of outputs or benefit obtained from a particular level of input or resource; and
• Effectiveness refers to the impact of a particular intervention upon clinical outcome. Importantly, key elements of clinical outcome have been noted to range from survival, to the quality of life of the survivor.

4.2 Understanding ‘quality of life’

4.2.1 Quality of life in the international research literature

‘Quality of life’ can be best understood as a descriptive term for an individual’s relative experience of well-being. The term ‘quality of life’ is synonymous with concepts of well-being and forms a useful and effective summary measure of longer-term outcome, against which particular programs or services can be evaluated. As such, measures of an individual’s quality of life hold a great deal of personal and political currency in describing the impacts of government policies and programs.

The research literature examining quality of life is expansive and beyond the scope of this review. There is no clear consensus about the definition of quality of life. Accordingly, a targeted summary of key concepts within the literature is provided to inform readers and enable them to locate specific reading to inform discussion and future exercises in measuring quality of life.

Three major approaches to understanding and measuring quality of life can be identified from the research literature:

• Subjective indicators involving measurement of an individual’s level of well-being (e.g. overall life satisfaction, and satisfaction with specific areas of their lives), that is held to represent personal judgements and emotional responses to their particular life circumstances. These indicators have typically been measured by large national surveys (Andrews FM & B 1976; Campbell, Converse & Rodgers 1976; Headey 1981). The underlying assumption of this approach is that quality of life may be reflected by an individual’s personal values and judgement of their own life experience;

• Social indicators involving objective measurements of a range of social conditions (e.g. health statistics, crime statistics, education statistics, etc.), that are held to represent the actual circumstances experienced by individuals in any specified geographic or cultural area. The underlying assumption of this approach is that quality of life may be reflected by understanding a range of ‘typical’ (or normal) experiences encountered by an individual; and

• Economic indicators involving measurement of a range of economic conditions (e.g. economic growth, inflation, interest rates, unemployment, consumer confidence, housing sales, etc.) that is held to represent the standard of living enjoyed by individuals in a specified geographic or cultural area. The underlying assumption of this approach is that quality of life may be reflected in an individual’s ability to receive the goods or services that they desire.

55 For an informed overview of the literature the interested reader is referred to (Diener & Suh 1997).
4.2.2 Quality of life in the international health care literature

Within the health care literature, an additional term has been introduced, focusing upon ‘health-related quality of life’. Citing the foundations of health-related quality of life in the constitutional definition of health determined by the World Health Organisation (1947), this is described as:

‘… not only the absence of infirmity and disease but also a state of physical, mental and social well-being’

Most commentators acknowledge that there has been limited agreement on a unified definition of the concept of ‘health-related quality of life’ (Jenkins 1992; McSweeny & Creere 1995; Spitzer 1987). Notwithstanding a lack of formal agreement, three general approaches have emerged in the health-related quality of life literature, and these can be seen to reflect the three major approaches in the broader research literature, including:

- The use of subjective ratings of health status, which started to emerge in the 1970s as an accompaniment to objective ratings of health status and, evolved in the 1990s as independent measures of health-related quality of life. These instruments also typically assess key areas relating to self-perceived physical, psychological and/or social functioning, in addition to other areas of health status that may be affected by particular health states, or individuals' overall health or satisfaction with life as a whole. This approach is analogous to the measurement of subjective indicators of well-being in the broader research literature. More recently-developed instruments have progressed to gathering large amounts of population data in order to understand ‘typical’ levels of health status reported by the general population, and by specific population sub-groups. Two of the most rigorously developed instruments in this area are the Medical Outcomes Study Short Form-36 Health Survey (MOS SF-36) (Ware 1993), and the World Health Organisation's Quality of Life Assessment (WHOQOL) (1998);

- The use of objective measures of health status, which were among the first cited as measures of health-related quality of life. Typically these measures involved some assessment of an individual's physical, psychological and/or social functioning, and may also have included a range of other areas that may be affected by specific disease states. This approach is analogous to the objective measures targeted by social indicators researchers, and has been reflected in the development of a wide range of outcome measures from the Karnofsky Scale in 1948, to the Katz Activities of Daily Living Scale in 1960s, the Sickness Impact Profile (SIP) in the 1970s, and the Functional Independence Measure in 1980s; and

- The development of economic indicators relating to health status is a more recent development in the health-related quality of life literature. Economic approaches to health-related quality of life attempt to measure and estimate individuals' preferences or choices towards the experience of particular health states against an experience of ‘normal’ health, in order to estimate the broader costs involved in living with particular...
health conditions. Such measures are used to estimate the impact of particular disease states upon the individual and the community. The application of these techniques has resulted in new measures including (for example) Quality Adjusted Life Years (QUALYs), Disability Adjusted Life Years (DALYs), and Time Without Side Effects of Treatment (TWiST) (Jenkins 1992; Kaplan, Feeny & Revicki 1993) that can be applied to understand the relative costs of particular health conditions and interventions designed to ameliorate their impacts upon individuals and the community.

Thus, the research literature within health care and the broader community has incorporated three general approaches to understanding and measuring the quality of life of individuals, based upon:

- Subjective judgements of an individual’s unique experience;
- Objective measurement of an individual’s ‘typical’ experience; and
- Individual choices and preferences to select particular products or services.

Each of these approaches represents the outcomes of an individual’s experience of their community, and provides unique and overlapping information about the quality of that experience on a day-to-day basis. Accordingly, the current evaluation must adopt a multi-dimensional approach to quality of life assessment in order to obtain a balanced approach to understanding the short and longer-term outcomes of residents of aged care homes.

4.2.3 Key areas of focus for future quality of life measurement

In relation to specific areas for quality of life evaluation, it can be seen that many approaches have adopted an overall evaluation of health and/or well-being, in addition to a range of other key life areas or domains. Reflecting on the 1947 WHO definition of health, most studies have incorporated the key areas of physical health, psychological health and social health. Subsequent conceptualisations of individuals’ health resulting from the impact of disease by the WHO (1980) introduced concepts of impairment\(^57\), disability\(^58\) and handicap\(^59\) to measures of treatment outcome and health-related quality of life. More recently, these concepts have been the subject of further revision by the WHO (2001) and an emphasis upon personal capability (‘activity limitation’) and community engagement (‘participation restriction’) have been suggested as a more positive health-related focus for future measurement.

Recent large scale multi-national studies by the WHO into the quality of life experienced by ‘sick’ and ‘well’ population groups have confirmed the basic structure of self-reported quality of life revolving around:

- Overall health and well-being;
- Physical capability;
- Psychological capability;

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\(^57\) Defined as ‘any loss or abnormality of psychological, physiological or anatomical structure or function’.

\(^58\) Defined as ‘any ... lack of ability to perform an activity in the manner ... considered normal for a human being’.

\(^59\) Defined as ‘a disadvantage, resulting form an impairment or disability, that limits or prevents the fulfilment of a role ... that is normal for that individual’.
• Social relationships; and
• Environmental concerns, including (among other things) considerations of physical surroundings, financial resources, and levels of community participation.

In light of these sources of evidence, any future consideration of the quality of life for residents of aged care homes should include each of these key areas of concern.

4.3 Quality in residential aged care

Issues relating to the quality of residential aged care have been highlighted by a number of authors (Braithwaite 2001; Harrington 2001, 2004; Kapp 2003; Rosen et al. 1999) and have been the subject of many government reports in the USA and Australia (Braithwaite 2001; Harrington 2001). Many have been driven by the concern that poor quality of care was being provided and the quality of life of residents was diminished. In the USA, Harrington described residential nursing home quality as ‘one of the nation’s most serious problems’ (Harrington 2001). In Australia, Braithwaite has referred to residential aged care as ‘a crisis in the quality of care and crisis of political confidence’ even though he noted that regulation has been successful in raising standards over time (Braithwaite 2001).

USA Federal Government reports in 1998 and 1999 revealed that:
• 25–33 per cent of residential aged care services had ‘serious or potentially life threatening problems’ and were causing harm to residents;
• 26 per cent had poor food hygiene;
• 21 per cent provided ‘inadequate’ care;
• 19 per cent had ‘environments that contributed to injuries in residents’; and
• 18 per cent showed ‘improper’ management of pressure ulcers (Harrington 2001).

While these figures do not necessarily apply to Australian residential aged care services, there appears to be an international consensus that a strong focus on quality within these services is required.

The OECD (2005) reported that the quality of aged care is variable and does not meet the expectations of the public, users of services and their families. Internationally, there is mounting evidence of inadequate quality in aged care provided from multiple sources such as reports by advocacy groups, media reports, public reviews, monitoring of provider accreditation and outcomes of quality assurance processes. This is further evident when recipients of long-term care interface with the acute healthcare system where mortality data and studies using forensic medicine have allowed for increased scrutiny of the consequences of quality deficits in long-term aged care (OECD 2005).

In a Dutch study of the cost of quality management in residential aged care, Wagner and colleagues estimated that only 0.8–3.5 per cent of overall budgets were devoted to quality management in the residential aged care sector. The authors concluded that it was impossible to speculate on the cost-effectiveness of quality management in the sector as
there was little information about the actual cost of poor quality (Wagner, van Merode & van Oort 2003). The OECD (2005) reported that the initial resources required to establish quality monitoring and improvement strategies are considerable and should not be underestimated.

However, even if a cost-effective rationale is not substantiated, humanitarian reasons alone provide a sound basis for increasing the attention to quality in residential aged care.

Influences upon quality of care and quality of life may be broadly considered in two categories:

- Health related influences impacting upon daily life are requirements which are best measured through clinical indicators; and
- Broader social and environmental influences that may exert an impact on daily experience which are best measured through socio-cultural indicators.

The following two sections focus on each of these areas.

### 4.4 Relationship between quality of care and quality of life for residents of aged care homes

Mattiasson and Andersson eloquently articulate the difficulty in separating the constructs of quality of care and quality of life in residential aged care in the following quotation:

> ‘Caring has been subjected to considerable attempts of defining and theorizing in order to adequately specify the term quality of care. Caring incurs meeting human needs … meeting psychological needs, security needs, “belongingness” needs and needs for self-actualization have been identified as fundamental determinants for quality of care. Seen from another perspective, quality of care for patients includes, among other things, the right to govern one’s life under conditions which support individual autonomy.’ (Mattiasson & Andersson 1997).

Clearly *quality of care* and *quality of life* are not interchangeable or synonymous terms. Whilst high quality of care may indeed contribute to quality of life in public health terms, it is not a necessary or sufficient cause of quality of life but logically, it may go some way to enhancing it. Table 3 provides a comparison of the traditional domains examined within the quality of care and quality of life literature.
<table>
<thead>
<tr>
<th>Domains of quality of care</th>
<th>Domains of quality of life</th>
<th>Overlapping themes</th>
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<td>Access</td>
<td>Economic standard of living (ability to receive the goods or services desired)</td>
<td>Physical health and success of health care interventions</td>
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<tr>
<td>Appropriateness</td>
<td>Social activity (typical experiences encountered)</td>
<td>Psychological health</td>
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<tr>
<td>Technical proficiency</td>
<td>- Level of well-being (overall life satisfaction and satisfaction with specific areas of life)</td>
<td>Social health</td>
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<td>Continuity</td>
<td>Health related quality of life (health status):</td>
<td>Personal capability</td>
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<td>Safety</td>
<td>- Sensory abilities</td>
<td>Community engagement</td>
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<td>Acceptability</td>
<td>- Mobility and functional deficits</td>
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<td>Efficiency</td>
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<td>Effectiveness</td>
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<td>- Self care ability</td>
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<td>- Pain</td>
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<td>- Medical symptoms and side effects</td>
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The quality of care literature has tended to focus on a medical model of care, which emphasises the provider’s point of view, and in the acute care sector especially, is largely concerned with health care interventions and their availability, safety and outcomes. In comparison, the quality of life literature is more sociologically based and includes broader psychosocial and cultural considerations from the consumer’s viewpoint. The need to integrate these two perspectives in the residential aged care sector is mandatory, since these facilities are not just health care providing facilities, but also facilities that determine the overall lifestyle of the resident because of the permanency of the stay. In residential aged care, quality of care and its traditional domains should be seen as contributory components of quality of life but not exclusive determinants of quality of life.
5. Clinical Measures of Quality of Care and Quality of Life in Residential Aged Care Homes

Many health related factors have been identified in the literature as having major implications upon the monitoring, measurement and improvement of quality of care and quality of life in residential aged care homes. Broadly these factors may be divided into four general categories that encompass clinical domains including:

- Health management;
- Behavioural management;
- Care planning and co-ordination; and
- Illness and injury prevention.

A detailed description of each of these areas from a clinical viewpoint (where ‘clinical’ is defined as relating to direct health care interventions and health care provider characteristics) is presented in this section of the report. Section 6 will focus on non-clinical influences (that is, the sociocultural features) on quality of care and quality of life in residential aged care homes.

5.1 Health management

Factors relating to illness prevention and health management that have been identified as impacting upon quality of care and quality of life in residential aged care include:

- Management of dementia;
- Identification and management of depression;
- Nutrition;
- Management of pressure ulcers;
- Management of pain;
- Ambulation/bed fast/prevention of contractures;
- Management of incontinence; and
- Medication management.

5.1.1 Management of dementia

The impact of progressive dementia upon individuals, their families, care givers and others can be profound, and is often associated with family decisions to consider the need for residential aged care homes.

Dementia is the term used to describe the symptoms of a large group of illnesses which are characterised by a progressive decline in mental functions including language, memory,
perception, personality and cognitive skills. This leads to significant difficulties with work, social activities and relationships with others (Morris 2003). Typically the symptoms of dementia are classified into three main areas:

- **Cognitive impairment:** Symptoms may include memory impairment, impairment of speech or language, and an inability to recognise objects in addition to a wide range of other difficulties processing daily information (Access Economics 2003).

- **Psychiatric and behavioural characteristics:** This group of symptoms is also increasingly becoming known as behavioural and psychological symptoms of dementia (BPSD) (Brodaty, Draper & Low 2003b). This includes any of a number of psychiatric symptoms such as depression, visual and/or auditory hallucinations, delusions, personality changes that range from passivity to hostility, decreased emotional reactivity, stubbornness, decreased initiative and heightened suspiciousness or paranoid delusions that lead to false accusations of those around them (Geldmacher & Whitehouse 1996). Behaviours can include wandering, incessant walking, agitation, repetition (Access Economics 2003), rummaging, disinhibition, and/or aggression. A small percentage of individuals may progress to exhibit more serious symptoms including physical violence towards staff and other residents, verbal abuse towards staff and other residents, self harm, nocturnal wakefulness, screaming, frequent and unnecessary toilet requests, or refusal to eat (Proctor *et al*. 1999).

- **Dysfunction in activities of daily living:** In the early stages of dementia these may take the form of difficulties with shopping, driving or handling money and general life management planning. In the later stages of dementia more basic tasks are affected such as dressing, eating or bathing.

Alzheimer’s disease is the most common form of dementia, estimated to be responsible for 70 per cent of dementia cases (AIHW 2004b). Primarily affecting older people, the impact of dementia varies between individuals and may vary according to the neurological impact of the condition, the characteristics of the individual, the specific disease involved, and the stage to which the condition has progressed (Access Economics 2003). Notwithstanding the individual symptom profile experienced by different individuals, the overall burden of dementia upon individuals, families and services within Australia remains considerable. An examination of the ten leading causes of disease burden in Australians in 1996 revealed that dementia was ranked as the third highest cause of disease burden for women, and the fifth highest for men. It is predicted that by 2016 dementia will the highest source of disease burden for women and will remain the fifth highest for men (Jorm 2001).

Studies of the incidence and prevalence of dementia demonstrate a growing demand for services, including residential aged care homes, to meet the needs of individuals and families affected by this condition. It was estimated that in 2002 around 167,000 Australians were affected by dementia, with almost two-thirds being aged 80 years and over. Among people aged 65 and over, currently 6.5 per cent are estimated to have dementia (AIHW 2004b). Although women are more likely to develop dementia than are men, it should be kept in mind that this is also influenced by the greater longevity of women compared...
with men in the general population. In 2002 it was estimated that the number of women with severe or profound core activity restriction (that is, requiring assistance with mobility, communication and or self-care) was about double the number of men in the same position (AIHW 2004b).

Current Australian estimates indicate that the incidence of dementia doubles every 5.1 years of age after the age of 65, affecting 24 per cent of those aged 85 and over (AIHW 2004b). Coupled with this are predictions that the disproportionate increase in the ageing of the Australian population will see a rapid growth in the proportion of the population aged 65 years or older. While this group accounted for 12 per cent of the population in 1997 it is projected to increase to between 21 per cent and 22 per cent by 2031 (Australian Bureau of Statistics 2000). Thus, current estimates suggest that the fastest growing segment of the Australian population will also be the most at risk for dementia. Based upon these projections, by 2041 Australia’s population will be 25 million with an estimated 460,000 people with dementia (Jorm 2001). The implications of this are a considerable concern for governments and communities with the responsibility of providing care and support to people affected by dementia.

Although a cure for dementia is not currently available, commentators urge early and accurate diagnosis, claiming that ‘all types of dementia are treatable, at least with psychosocial interventions’ (Geldmacher & Whitehouse 1996). Arguably the greatest challenges facing those who care for people with dementia in residential aged care environments are those people with psychiatric and behavioural characteristics. People with psychiatric and behavioural characteristics can be physically and emotionally destructive. They can contribute to increased staff stress levels and diminish the quality of life of the affected individual and their co-residents. A number of behavioural, psychological, medical and other strategies have been proposed to assist in management of people with psychiatric and behavioural characteristics.

Commentators emphasise that goal planning focusing on the strengths and abilities of each resident, can enable the setting of achievable and appropriate behavioural goals, minimising the influence of disruptive behaviour. Outreach psycho-geriatric teams appear to be especially helpful in this area (Proctor et al. 1999). Other researchers propose that many behavioural problems may reflect normal reactions to disturbing situations such as physical restraints, excessive medication, boredom and frustration, excessive daytime sleeping or other medical conditions causing pain or delirium. These individuals advocate the need to consider full medical assessments, and the introduction of a variety of other behavioural interventions (Coons & Mace 1999).

People with psychiatric and behavioural characteristics associated with dementia are demanding upon residential aged care staff. In a recent survey, staff in residential aged care homes indicated that they had difficulty coping with residents who were aggressive/hostile, had little control over their difficult behaviour, were stubborn/resistive and deliberately difficult or unpredictable (Brodaty, Draper & Low 2003b). Brodaty and his colleagues argued that there is a lack of comprehensive planning for managing and preventing psychiatric
and behavioural characteristics. The resources provided for optimal care of people with psychiatric and behavioural characteristics are inadequate and unevenly divided (Brodaty, Draper & Low 2003a). They propose a seven tiered model to assist in planning services. According to the model, people with psychiatric and behavioural characteristics are provided with strategies to assist them in managing their behaviours within one of the seven tiers in ascending order of symptom severity. Intervention aims to prevent patients moving to the higher levels of behavioural disturbance but instead to move them to more moderate levels of behaviour. The International Psychogeriatric Association has published an education pack titled ‘Behavioural and Psychological Symptoms of Dementia,’ providing detailed pharmacological and non-pharmacological ways to manage the behavioural disturbances of patients with dementia (International Psychogeriatric Association 2005).

More broadly, it is recognised that operators of aged care homes will need to increasingly consider how their facilities will meet the transitioning needs of residents with dementia as they progress through the various stages of the condition (Alzheimer’s Association Australia 2004) and provide environments that support the retention of functional abilities, independence and the promotion of quality of life.

5.1.2 Identification and management of depression
Residents of aged care homes have rates of depression three to five times that of their community dwelling counterparts. In the USA, Brown and colleagues found that only 55 per cent of residents in aged care settings received antidepressants (2002). Amongst those who did receive antidepressants the dose was often sub-optimal. In a report to the Australian Government Department of Health and Ageing, the Hammond Care Group described the results of the Challenge Depression Project examining the management of depression in residents of aged care homes in Australia (2004c). Findings were similar:

- 51 per cent of high care and 30 per cent of low care residents who were able to complete the Geriatric Depression Scale were depressed; and
- 38 per cent of high care and 26 per cent of low care residents who were able to complete the Cornell Rating Scale (for the severely cognitively impaired) were depressed.

Furthermore, the report stated that ‘under normal circumstances a significant proportion of depressed residents go unnoticed. Staff were often not aware of information that would help them to notice and understand the depression in the people around them. When staff are obliged to look at residents in a systematic way their recognition of the symptoms of depression improves.’ (Australian Government Department of Health and Ageing 2004c)

Larger residential aged care homes have been found to be less likely to treat depression with antidepressants (Lapane & Hughes 2004). The apparent paradox that antidepressant use in residential aged care is low and antipsychotic use higher, can possibly be explained by the different effects of depressed versus psychotic or disturbed behaviour. Whereas the former may be easily missed, the latter tends to be more disruptive and demanding of action.
The Assessing Care of Vulnerable Elders (ACOVE) project indicator set includes identification of depression (Wenger & Shekelle 2001) including prevalence of symptoms of depression and prevalence of symptoms of depression with antidepressant therapy (Center for Health Systems Research and Analysis 2005).

The set of national quality indicators developed by the USA Centers for Medicare and Medicaid Service includes the per cent of residents who become increasingly depressed or anxious (Castle 2004).

5.1.3 Nutrition
Residents of aged care homes may be at risk for insufficient oral food and fluid intake. This may be particularly evident where swallowing or cognitive difficulties are present. However, oral intake can be improved with adequate feeding assistance and monitoring (Simmons & Schnelle 2003).

The USA Provider Initiative Project (Center for Health Systems Research and Analysis) includes nutrition and eating in its quality indicator set (Bryant et al. 2004) with the following indicators:

• Prevalence of weight loss;
• Prevalence of tube feeding; and
• Prevalence of dehydration (Center for Health Systems Research and Analysis 2005).

The Centers for Medicare and Medicaid Service set of national quality indicators also include the percentage of residents who lose too much weight (Castle 2004).

5.1.4 Management of pressure ulcers
A large body of evidence reveals that pressure ulcers are a major quality problem in residential aged care (Harrington 2004). The Provider Initiative Project (Center for Health Systems Research and Analysis 2005) includes the domain of skin care in its quality indicator set (Bryant et al. 2004) with the following indicator:

• Prevalence of Stage 1–4 pressure ulcers (Center for Health Systems Research and Analysis 2005).

The Centers for Medicare and Medicaid Services’ set of national quality indicators includes the percentage of high risk and low risk residents who have pressure ulcers (Castle 2004).

5.1.5 Management of pain
The prevalence of pain in residential aged care has been found to be as high as 70-80 per cent, exacerbated by high rates of chronic musculoskeletal conditions, peripheral vascular disease, cancer, surgical procedures, cardiovascular disease and other painful medical diseases. Furthermore, pain in the elderly is often complicated by the presence of multiple conditions, multiple locations and varying causes. It is often associated with depression, withdrawal, sleep disturbances, poor mobility, decreased activity, functional decline, falls, malnutrition and lack of engagement in rehabilitation (Ferrell, B 2004; Ferrell, B R & Ferrell BA 1996; Horgas, McLennon & Floetke 2003).
Poor pain management may be exacerbated by under-recognition of pain, staff beliefs that pain is normal for the elderly, and fear of addiction to and adverse effects from pain medication (Horgas, McLennon & Floetke 2003).

Although many elderly patients die in residential aged care homes, the lack of access to palliative care and hospice facilities for these patients has been highlighted as a major problem by Horgas and colleagues, leading to higher rates of untreated pain and poor levels of social and spiritual support for residents and their family members (Zerzan, Stearns & Hanson 2000).

In an Australian study, Llewellyn-Jones and colleagues (Llewellyn-Jones et al. 2003) advocated multidisciplinary approaches to pain management which include psychological and physical support in addition to a singular focus on pharmacological intervention. They also highlighted the need for additional resources to conduct pain management programs in residential care (given that many older people are unable to access community-based programs) and to change the attitude that pain is an inevitable part of old age. In one study they found evidence that pain may be linked to depression, suggesting that effective pain management could reap additional psychological benefits.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) recommends pain be seen as ‘the fifth vital sign’ and requires systematic assessment of pain in hospitalised patients through compliance with regulatory guidelines on pain management. However, the JCAHO standards do not extend to residents of aged care homes (Horgas, McLennon & Floetke 2003).

There are a number of pain management protocols that are specific to the elderly (e.g. American Geriatrics Society, American Pain Society, Weiner and Hanlon pain management overview) (Horgas, McLennon & Floetke 2003).

Pain assessment in residential aged care settings needs to incorporate verbal self-reports of pain and non-verbal behaviours that indicate pain. The Brief Pain Inventory and the McGill Pain Questionnaire are appropriate for patients without dementia. The Visual Analogue Scale in which patients rate pain on a 0–10 scale or verbal descriptor scale has been found to be useful for non-cognitively impaired patients as well as those with mild to moderate cognitive impairment. For more severely cognitively impaired patients, structured assessments of pain behaviours such as facial grimacing, physical movements such as bracing, guarding, vocalising, sighing and screaming are required (Horgas, McLennon & Floetke 2003).

The Centers for Medicare and Medicaid Service’s set of national quality indicators includes the percentage of residents who have moderate to severe pain (Castle 2004).

The Provider Initiative Project (Center for Health Systems Research and Analysis) includes the indicator of prevalence of pain in its indicator set (Center for Health Systems Research and Analysis 2005).
5.1.6 Ambulation/bed fast/prevention of contractures
Leaving residents in bed all day has been identified as a major quality problem in residential aged care (Harrington 2004). This may occur for multiple reasons. For example, low staff levels, poor physical mobility, or poor motivation from dementia or depression may all contribute. As a consequence, contractures (frozen joints due to shortening of surrounding ligaments and tendons) from lack of ambulation are major quality problems (Harrington 2004). Studies support the use of exercise interventions designed to increase aerobic power, muscle strength, balance and flexibility in nursing home residents (Applegate & Pahor 1997). These can be monitored through process measures.

The Centers for Medicare and Medicaid Services’ set of national quality indicators includes:
- Percentage of residents who spent most of their time in bed or in a chair during the assessment period; and
- Percentage of residents whose ability to move about in and around their room became worse (2004).

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the following indicators relating to ambulation:
- Prevalence of bed fast residents;
- Incidence of decline in late-loss activities of daily living;
- Incidence of decline in range of movement; and
- Prevalence of little or no activity (2005).

5.1.7 Management of incontinence
Incontinence is a significant factor in decisions regarding admission to aged care homes, particularly with admission to high care. Incontinence is seldom the sole contributor to these decisions and has its greatest effect when combined with other problems, particularly dementia or cognitive impairment and mobility. Incontinence has been identified as a major quality problem in residential aged care throughout the world, and is associated with the ageing process and the typical co-morbidities in this patient population (Harrington 2004). It affects at least two-thirds of residents (Cotton 1993). High rates of catheter use are associated with negative outcomes, higher infection rates and poorer quality of life (Cotton 1993).

Ouslander (1989) has identified a number of effective interventions for urinary incontinence. For instance, prompted voiding can reduce the number of wet episodes from three per day to one or less in the 25–33 per cent of patients who are responsive to this intervention. Ouslander has trialled computerised quality control charts where those deemed to be responders are checked for wetness at random times. If the responders are found to be wet more often than statistically predicted, they have either not been toileted appropriately or their condition has worsened.

The USA National Medicare Resident Assessment Protocols (RAPs) do not condone catheter use for the sake of staff convenience or family request and restrict long-term catheter use to:
• Bladder outlet obstruction;
• Wound management of a Stage 3 or Stage 4 ulcer affected by continuous skin moisture;
• Terminal illness, for comfort; and
• Short-term monitoring of intake and output (Prochoda 2002).

The Centers for Medicare and Medicaid Services’ set of 24 validated quality indicators includes three related to urinary incontinence:
• Prevalence of bowel or bladder incontinence;
• Prevalence of occasional or frequent urinary or bowel incontinence without a toileting plan; and
• Prevalence of an in-dwelling catheter.

Performance in the 75th percentile or above immediately flags to surveyors that further review is indicated (Prochoda 2002).

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the domain of elimination and continence in its quality indicator set (Bryant et al. 2004) and includes the following indicators:
• Prevalence of bladder or bowel incontinence;
• Prevalence of bladder or bowel incontinence without toileting plan;
• Prevalence of indwelling catheter;
• Prevalence of faecal impaction; and
• Prevalence of urinary tract infections (Center for Health Systems Research and Analysis 2005).

5.1.8 Medication management

Inappropriate antipsychotic drug use has been identified as a major quality problem in residential aged care (Harrington 2004). Lower rates of psychotropic drug use have been linked to improved care (Hughes, Lapane & Mor 2000).

Several studies have demonstrated that antipsychotic drugs are more likely to be used in larger residential aged care homes. Services with higher staffing levels and drug intervention teams have fewer deviations from appropriate drug prescribing criteria (Hughes, Lapane & Mor 2000; Schmidt et al. 1998). A study by Oborne and colleagues found that although 24 per cent of nursing home residents received benzodiazepines, only 7 per cent were found to receive them appropriately (Oborne et al. 2003).

Medication errors and mismanagement were identified as a priority issue in residential aged care by the Australian Pharmaceutical Advisory Council and the Pharmaceutical Health and Rational Use of Medicines Committee (Roughead, Semple & Gilbert 2003). Furthermore, the Australian Pharmaceutical Advisory Council has published Guidelines for Medication Management in Residential Aged Care, which makes recommendations in the following key areas:
• Medication Advisory Committees (that each residential aged care service should establish or have direct access to a Medication Advisory Committee to facilitate the quality use of medicines);
• Medication charts (that appropriate procedures and documentation of medication administration be followed via the use of medication charts);
• Medication review (that residents’ medications should be reviewed by members of the health professional team);
• Administration of medications (that medication administration be undertaken by qualified or suitably qualified staff if not self administered);
• Standing orders (that standing orders for new medication should not be used);
• Nurse initiated medication (that nurse-initiated medication be from a defined list of drugs in accordance with protocols);
• Self administration (that a resident may choose to administer their own medication where it has been assessed that this can be safely carried out);
• Alteration of oral formulations (that each facility should have procedures for the alteration of dosage forms e.g. the crushing of tablets or opening of capsules);
• Dose Administration Aids (that a dose administration aid only be used for overcoming potential problems with compliance or confusion);
• Information resources (that the facility has resources on medicine information available for staff, residents/carers and health professionals);
• Storage of medicine (that all medication be securely stored);
• Disposal of medicines (that the facility have a mechanism for the disposal of returned, expired and unwanted medicines);
• Complementary, alternative and self-selected medications (that written policies be developed for the management of complementary, alternative and self-selected medications within the facility); and
• Emergency supplies of medications (that the medication advisory committee determine the circumstances under which emergency medications may be used and any required documentation and stock control) (Australian Pharmaceutical Advisory Council 2002).

Indicators have been developed to monitor the appropriateness of prescribing certain medications and combinations of medications to nursing home patients (Oborne et al. 2003).

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the domain of psychotropic drug use in its quality indicator set (Bryant et al. 2004) with the following indicators:
• Use of nine or more different medications;
• Prevalence of antipsychotic use in absence of psychotic and related conditions;
• Prevalence of anti-anxiety/hypnotic use; and
• Prevalence of hypnotic use more than two times per week (Center for Health Systems Research and Analysis 2005).

In the USA, state surveyors monitor use of antipsychotics and other psychotropic medication (Hughes, Lapane & Mor 2000).

Interventions found to improve medication management and that are easily monitored include:
• Clinical pharmacy services in aged care homes (reduces use of benzodiazepines, laxatives, Non-Steroidal Anti-Inflammatory Drugs [NSAIDs] and antacids); and
• Dose-administration aids (Roughead, Semple & Gilbert 2003).

5.2 Behavioural management

Factors relating to behaviour management that have been identified to impact upon quality of care and quality of life in residential aged care have focused upon:
• The management of challenging behaviours, and
• The use of physical restraint.

5.2.1 Management of challenging behaviours

Behaviour problems in residents of aged care homes may be due to the dementia process or other physical and psychiatric conditions and can include:
• Physical violence towards staff and other residents;
• Verbal abuse towards staff and other residents;
• Restlessness and wandering (e.g. ‘sundowning’);
• Self-harm;
• Nocturnal wakefulness;
• Screaming;
• Frequent and unnecessary toilet requests; or
• Refusal to eat (Proctor et al. 1999).

Behaviour problems may be emotionally destructive and impact significantly upon the capacity of staff and co-residents to experience a warm and friendly atmosphere in residential aged care homes.

Some commentators maintain that violence in long-term care is ‘inevitably caused by a negative environment and is therefore treatable’. They propose that many behavioural problems are normal reactions to disturbing situations such as physical restraints, excessive medication, boredom and frustration, excessive daytime sleeping or other medical conditions causing pain or delirium. Possible remedies therefore include full medical assessment, spontaneous activities that are distracting and light hearted, elimination of
rigid schedules and positive reinforcement and rewards for desired behaviours (Coons & Mace 1999). Proctor and colleagues also suggest goal planning that emphasises the strengths and abilities of each resident to enable setting of achievable and appropriate behavioural goals for each resident, taking into account the factors that influence behaviour. They also advocate the use of outreach psychogeriatric teams (1999).

The International Psychogeriatric Association has also published an educational pack titled *Behavioural and Psychological Symptoms of Dementia*, providing detailed pharmacological and non-pharmacological ways to manage the behavioural disturbances of patients with dementia (2005).

### 5.2.2 Use of physical restraint

Physical restraint is a serious intervention that can compromise patient autonomy and dignity. When used improperly, it may be associated with death, injury or pressure ulcers. The USA 1987 *Nursing Home Reform Act* mandated reduction in physical restraint use and declared that residents have the right to be free from any physical restraint imposed for disciplinary or convenience purposes (Castle 2000).

Restraint use in residential aged care homes has been reported to be as high as 84 per cent in some residential aged care service. Many restraint standards have been developed, of which the JCAHO restraint standard is the most widely used (Anonymous 2001).

The Australian Government Department of Health and Ageing has released a decision-making tool responding to the issues of restraint in aged care homes. Although not a guideline, this publication provides information to assist in the evaluation of triggers, causes, care plans, use of alternatives to restraint, use of different restraint measures, communication with patients, staff, relatives and other caregivers, review and observation processes, documentation and future prevention of restraint (Australian Government Department of Health and Ageing 2004b).

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the indicator prevalence of daily restraints (2005).

### 5.3 Care planning and co-ordination

Clinical factors relating to care planning and care co-ordination that have been identified as impacting upon quality of care and quality of life in residential aged care include:

- Coordination of complex care requirements; and
- Loss of function/decline in medical condition.

#### 5.3.1 Coordination of complex care requirements

Systematic, standardised comprehensive geriatric assessment with direct links to care planning protocols has been found to improve quality of care by improving the thoroughness and adequacy of the assessment and treatment plan (Schroll 1997).
In response to the complexities of ensuring and monitoring the quality of care of residents of aged care homes, the USA introduced the National Resident Assessment Instrument (RAI) in all nursing homes that participated in the publicly funded Medicare and Medicaid programs. In recent times, it has been estimated that virtually all nursing homes in the USA complete RAI s on residents. The instrument is now also used in Europe, Canada and Japan. The RAI contains a minimum data set and certain items or combinations of items will trigger particular RAPs that cover cognitive loss, incontinence and pressure ulcers. The RAP provides formal guidelines for care planning, problem solving and preventing decline (Schroll 1997). A before-after study showed that use of the RAI was associated with improved outcomes in daily living, urinary incontinence, bowel incontinence, being understood, understanding others, cognitive performance, social engagement and rate of transfers to hospitals (Schroll 1997).

Compliance with standardised comprehensive geriatric assessment tools and associated clinical pathways can be readily monitored through process indicators.

5.2.2 Loss of function/decline in medical condition
Decline in functional status, or the loss of independence in activities of daily living, has been recommended as a quality indicator in residential aged care, although there are multiple definitions of ‘functional status’. In a study by Rosen and colleagues, six measures of functional status outcome were compared in a large sample of Veterans Affairs facilities in the USA. Declines in functional status ranged from 77 per cent to 31.5 per cent, depending on the definitions used. The authors conclude that careful selection and consistent application of the definition of functional status is required (Rosen et al. 1999).

The ACOVE project indicator set includes identification of dementia and functional decline (Wenger & Shekelle 2001).

The Centers for Medicare and Medicaid Service’s set of national quality indicators includes the percentage of residents whose need for help with daily activities has increased (2004).

The Institute of Medicine has recommended the following outcome measures be used as a component of quality assurance, with attention to appropriate risk adjustment:

- Deterioration in functional status during the first six months following admission;
- Deterioration in pressure ulcer stage over six months; and
- Mortality within six months of the last nursing home live record irrespective of the place of death (Mukamel & Spector 2000).

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the domains of clinical management, physical functioning and cognitive patterns in its quality indicator set (Bryant et al. 2004).

Reliable measures of functional status in long-term care settings include heart rate, timed chair rise and sit, timed stands, walking speed and five minute walking distance (Zabel 2000).

The MOS SF-36 and its more recently developed shorter forms are widely used to easily measure health status cross-sectionally and over time for both clinical and research purposes (Bryant et al. 2004).
The Australian Aged Care Standards and Accreditation Agency includes the standard Health and Personal Care in its Accreditation Standards which includes a number of Expected Outcomes (2004a).

### 5.4 Prevention of injury and illness

Factors relating to environmental management that have been identified as impacting on quality of care and quality of life in residential aged care include:

- Falls and balance;
- Environments contributing to injury; and
- Infection control.

#### 5.4.1 Management of falls and balance

Every year, around 75 per cent of residents of aged care homes are reported to sustain a fall (Bail 2004). In a 2003 report to the Commonwealth Department of Health and Ageing under the National Falls Prevention for Older People Initiative titled: *Projected costs of fall related injury to older persons due to demographic change in Australia*, it was estimated that by the year 2051, the total health cost attributable to fall related injury in Australia will increase to $1375 million and that an additional 3320 residential aged care places will be required as a result (Moller 2003). While most falls are injury free, 10–25 per cent are associated with hospital admission and/or fractures (Vu, Weintraub & Rubenstein 2004).

The prevention of falls in residential aged care may involve a range of activities including:

- Fall-risk assessments at the time of admission and periodically thereafter using one of the readily available standardised objective measures. This enables an individual's risk factor for falling to be identified and managed;
- Post-fall assessments to identify the preventable causes of the fall (Bail 2004);
- Environmental assessments of hazard and modification of risks (e.g. removal of rugs, loose electrical cords, wet floors, uneven flooring, inappropriate furniture height, poor lighting and patient restraints);
- Evaluation and optimisation of the use of assistive devices (e.g. walking frames);
- Medication reviews to identify and prevent excessive sedation and postural hypotension;
- Gait assessments and training;
- Staff education of risks;
- Exercise programs to maintain flexibility and mobility;
- Management of visual impairment;
- Hip protector use; and
- Blood pressure evaluation (Vu, Weintraub & Rubenstein 2004).
Although elderly patients in the community have been found to respond to fall prevention interventions, there is less evidence to support the efficacy of fall prevention interventions in residential aged care (Vu, Weintraub & Rubenstein 2004). This has been attributed to falls in residential aged care homes being due to ‘multiple coexisting risk factors acting synergistically’. Furthermore, there are significant differences between community dwelling older people and residents of aged care homes including increased frailty, co-morbidity and decreased functional capacity (Vu, Weintraub & Rubenstein 2004). Nevertheless, it makes intuitive sense that aged care homes require coordinated and concerted, multidimensional approaches to the prevention and management of falls.

5.4.2 Environments contributing to injury

Physical environments are important contributors to accidents and injuries in a poorly mobile, frail elderly population. Reduction in environmental hazards such as the removal of mats and other tripping obstacles is likely to lead to improvements in the form of declining rates of falls and other injuries.

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the domain of accidents in its quality indicator set (Bryant et al. 2004) with the following indicators:

- Incidence of new fractures; and
- Prevalence of falls (Center for Health Systems Research and Analysis 2005).

The Australian Aged Care Standards and Accreditation Agency includes the standard of Physical Environment and Safe Systems in its Accreditation Standards (2004a).

5.4.3 Infection control

Figures derived from UK studies estimate that a 36-bed nursing home experiences between 50–80 acute infections per year, with 5–6 residents affected at any one time. Nursing homes are said to be responsible for 78 per cent of infective diarrhoea and have a methicillin-resistant Staphylococcus aureus (MRSA) colonisation rate of up to 27 per cent.

The UK Public Health Laboratory Service has identified 16 standards of infection control for residential aged care that incorporate hand-washing, use of isolation, catheter care, skin care and wound care, and the Service recommends linking compliance with these standards to accreditation (Stone et al. 2001).

While showing a trend towards an association with quality of care, actual infection rates may have a poor association with quality of care because of the patient factors that also contribute to infection (Ibrahim et al. 1998). Process infection control indicators are likely to be of more benefit.

The Provider Initiative Project (Centre for Health Systems Research and Analysis) includes the domain of infection control in its quality indicator set (Bryant et al. 2004).
6. Socio-Cultural Influences of Quality of Care and Quality of Life in Residential Aged Care Homes

In addition to clinical factors, many non-clinical socio-cultural factors have been identified as impacting on residents’ quality of care and quality of life in the residential aged care sector. Measurement and exploration of non-clinical, social, cultural and psychological factors impacting on residents’ views of quality of care and quality of life has tended to lag behind the extensive scientific literature on clinical drivers of quality (Chou, Boldy & Lee 2003; Curtis et al. 2005; Sikorska 1999). Traditionally, research in aged care has predominantly focused upon health-related quality of life and clinical care indicators. However, there has been increasing recognition of the importance of including consumer perspectives in assessments of quality, as the demands for holistic approaches to care with a resident focus emerge (OECD 2005). This has also been driven by the increased recognition that while aged care homes provide vital health care and physical support, they also contribute to residents’ social and psychological well-being as well as the residents’ overall lifestyle.

The following section begins by presenting some of the issues involved in the measurement of residents’ views and then presents an overview of the range of Australian and international literature related to socio-cultural factors influencing views on quality of care and life in residential aged care homes.

6.1 Issues in measuring residents’ views

While there has been considerable consumer satisfaction research carried out with acute healthcare services (Chou, Boldy & Lee 2003), research on the role of consumer satisfaction and its relationship to quality of care and quality of life is at an early stage of development (Lowe et al. 2003), particularly in the residential aged care sector (Curtis et al. 2005).

Consumer satisfaction research is widely appreciated as a means of empowering consumers and assessing the more psychosocial and cultural acceptability of care (Chou, Boldy & Lee 2002a). The Department of Veterans Affairs in the USA has mandated that residential aged care homes conduct patient satisfaction surveys (Van De Water et al. 2003). Many USA states are also developing legislation to mandate consumer satisfaction reports in residential licensure and accreditation programs in the aged care sector (Lowe et al. 2003).

Measurement of older people’s views has presented special problems that have inhibited the development of research in the aged care sector.

6.1.1 Resident attributes

Resident attributes can impact on research in the aged care sector. These attributes include levels of physical and mental fragility and preparedness to accept relatively low standards (Boldy, Chou & Lee 2004; Byrne & MacLean 1997). Differences have been noted in the way
frail older people in residential care tend to score services when compared to healthier counterparts (Courtney et al. 2003; Frytak 2000) and when compared to scores of older people residing in the community (Byrne & MacLean 1997; Kane, R. A. 2001).

Health and cognitive status can also limit the participation of residents. The literature indicates that as many as 40 per cent of residents of aged care homes may be unable to be interviewed for satisfaction/quality of life studies because of cognitive deficiencies (Kane, R A 2003). This impacts on sampling strategies, making random sampling inappropriate (Courtney et al. 2005) and can contribute to research bias because selection strategies generally exclude representation of residents with higher care needs due to cognitive or sensory impairment (Bravo et al. 1999). Related to this, diverse resident characteristics can result in different care experiences and impact on consistency of assessments of quality (Bravo et al. 1999). Other mental health problems such as depression, which has been commonly reported in people residing in aged care homes (Cummings 2002), can impact on results of satisfaction studies and be misinterpreted as a cognitive impairment.

In an Australian study of nursing home resident satisfaction, where there was a high percentage of positive responses, the authors found that the positive responses did not correlate with observations of the research assistants, suggesting that while the residents were able to assess care, they were often reluctant to criticise (Pearson et al. 1993). Older residents in particular have been found to be more satisfied with care (Chou, Boldy & Lee 2003), which may indicate a greater reluctance to complain in this age group.

6.1.2 The need for appropriate measuring instruments

The lack of appropriate measurement tools specific to residential aged care has also inhibited research in residential aged care (Courtney et al. 2003; Frytak 2000). The psychological, physical or social factors that contributed to a person moving into residential aged care not only distinguishes them from other aged people living in the community but also may require additional care to maintain quality of life (Gerritsen et al. 2004). Consequently, standardised instruments may not adequately address the issues facing older adults living in residential services and only a limited range of specialist tools with utility in residential aged care settings have been developed (Courtney et al. 2003; Tester, Hubbard & Downs 2001). However, the Short Form Resident Satisfaction Questionnaire developed by Chou and colleagues for use in residential aged care settings includes questions relating to room, home, social interaction, meals service, staff care and resident involvement (Chou, Boldy & Lee 2002a).

While there are a number of measuring tools developed by individual organisations, these tools have generally been developed for a specific organisation and have not been tested to identify levels of reliability and validity that would to enable them to be used more extensively (Berg et al. 2002).

The frailty of older people in residential services has resulted in a tendency toward the use of health related quality of life measurement tools which have a strong focus on health status and physical functioning (Philp 1996). This can be problematic as such tools can result
in the appearance that residents in a nursing home have a poor quality of life (Courtney et al. 2003). A more valid result may be achieved when appropriate subjective and objective measures are selected albeit from a range of different instruments (Philp 1996). Kane suggested that there is a need to develop an approach using observations and proxies for measuring quality of life for residents who cannot be interviewed (Kane RA 2003).

Van de Water and colleagues found that residents of aged care homes might be capable of reliably answering specifically developed satisfaction surveys (2003). The difficulty lies in developing the survey and identifying who is able to complete it (Van De Water et al. 2003). Mozley and colleagues found that 77.5 per cent of people who scored 10 or over on the Mini-Mental State Examination (MMSE) (indicating the presence of significant cognitive deficits) were able to answer the majority of questions in the Lancashire Quality of Life Profile (Residential) Scale. The capacity to be interviewed was most strongly associated with orientation to place, language and attention (Mozley et al. 1999).

6.1.3 Organisational or institutional factors
Life in residential aged care is considerably different to life in the community. Consequently, research within the residential aged care sector takes into account a number of factors which may not be relevant to older people living within the mainstream community (Courtney et al. 2005). These factors could include:

- Diversity and lack of consistency across services (i.e. size, level of care offered etc.) (Curtis et al. 2005);
- Residents’ concerns about reprisals for criticising staff or the organisation (Boldy, Chou & Lee 2004);
- Differences between residents (levels of acuity, cognition, dependency); and
- Difficulties in gaining permission and consent to access residents (Curtis et al. 2005).

6.1.4 Resident inclusion in research
It is generally acknowledged that ideally all residents should be included in the assessment of resident satisfaction or quality of life (Brown 1995; Gerritsen et al. 2004; Gurland & Katz 1997). However, for practical reasons, most large scale studies of quality of care and quality of life endeavour to include resident input but recognise the need to involve residents with the cognitive and sensory capacity to respond independently (Courtney et al. 2005).

While a number of family member satisfaction instruments have been developed for use in nursing homes (Castle 2004), Lowe and colleagues report that it is well established that data provided by residents about quality of care is different from that provided from ‘clinical indicators, family members, nursing home staff or regulatory practices and evaluations’ (Lowe et al. 2003). Lavizzo-Mourey and colleagues found that the family or other associates are often unreliable surrogates for resident satisfaction surveys with correlations on specific items of care ranging from 0.1–0.55 (Lavizzo-Mourey, Zinn & Taylor 1992).

Research is beginning to suggest that inclusion of residents with impairments should not automatically be precluded. A number of studies support the ability of people with
dementia to reliably respond to structured questionnaires about quality of care and quality of life issues (Brod et al. 1999; Kane 2003; Kane & Kane 2000; Logsdon et al. 1999). Reliable results have also been found in studies which have used alternative formats on quality of life instruments, allowing for use of binary response formats instead of Likert Scales (Kane & Kane 2000) and in studies using specialist instruments such as the Dementia Quality of Life Instrument (DQoL) (Logsdon et al. 1999).

Where the residents’ impairment is too severe to allow inclusion or would result in distress, observation, proxies, audits and objective assessment may provide some useful data (Bowling 2005; Epstein, Hall & Tonetti 1989; Kane 2003) about institutional practices and the perceptions of staff and professionals.

6.1.5 Measurement tools used in residential aged care
The vast array of instruments which purport to measure quality of life were generally designed for use with people who have a chronic disease and as such are highly health focused (Berzon et al. 1995; Burckhardt & Anderson 2003), or were designed as measures of global quality of life for use with people living within the mainstream community. Currently, only a limited number of instruments measure the quality of care and quality of life of elderly persons (Bowling 2005). It has been argued that too often these instruments do not define the construct from the perspective of the elderly person but weight it according to the judgement of others and, as such, the definitions too frequently reflect the conceptual bias of the researcher hampering cross-study comparisons (Courtney et al. 2003; Philp 1996).

The need to develop customised instruments from existing tools is not uncommon and can be far more sensitive and responsive than using an intact instrument that contains items which are not relevant to the population under study (Gething, Fethney & Blazely 1998; Gill & Feinstein 1994).

Social outcome indicators that have been developed and used in residential aged care are the:

- ACOVE project indicator set which includes themes of proportionate care, informed consent and end-of-life issues (Wenger & Shekelle 2001);
- Provider Initiative Project (Center for Health Systems Research and Analysis) which includes the domains of behavioural and emotional patterns and quality of life in its quality indicator set (Bryant et al. 2004); and
- Australian Aged Care Standards and Accreditation Agency which includes the standard of Resident Lifestyle in its Accreditation Standards which includes a number of Expected Outcomes (2004a).

Qualitative and quantitative methods have been used to assess resident satisfaction in residential aged care. Quantitatively, quality of life measurement instruments such as The Lancashire Quality of Life interview have been used to measure quality of life in community residential settings. Health-related quality of life is a component of overall quality of life. There are five commonly used health-related quality of life tools that have demonstrated reliability and validity in several types of residential care settings:
Common parameters examined in health related quality of life tools include:

- Sensory abilities;
- Mobility and functional deficits;
- Emotional disorders;
- Cognitive impairment;
- Self care ability;
- Pain; and
- Medical symptoms and side effects (Wodchis, Hirdes & Feeny 2003).

These tools have limited use within severely disabled populations whose scores may be adversely influenced by cognitive impairment, poor health, prognosis, functional and sensory deficits, and pain (Shepherd et al. 1996).

With regard to quantitative measures of food quality, the FoodEx-LTC is the only instrument developed to examine food quality in nursing homes. It has been shown to be a reliable and valid measure of resident food and food service satisfaction in nursing homes (Crogan, Evans & Velasquez 2004).

There is debate as to whether tools designed to measure satisfaction in residential aged care reflect quality of care (Lowe et al. 2003). Ejaz and colleagues maintain that quality of care is one component of quality of life in nursing homes and that consumer satisfaction measures are therefore important subjective measures of both (2003). Others contend that an understanding of resident satisfaction can provide important insights into understanding service and care attributes which promote quality of life for residents (Chou, Boldy & Lee 2002a).

### 6.2 Socio-cultural factors influencing quality of care and quality of life

A number of complex social, cultural and psychological factors can influence quality of care and quality of life in residential aged care homes. These include:

- Physical environment;
- Level of functional ability;
- Meals and food service;
- Social interaction, activities and community;
• Management and organisational factors;
• Residents’ sense of autonomy and control;
• Involvement of families and carers;
• Relationships with staff;
• Accessibility of staff; and
• The regulatory environment.

These areas will be discussed in more detail in the following sections.

6.2.1 Physical environment

The physical environment has been found to be an important factor in residents’ assessments of quality and expectations particularly in relation to the degree to which buildings allow for privacy and personal space (OECD 2005).

Edwards (2003) found that the maintenance of personal property contributed to residents’ sense of homeliness, while individual rooms also contributed to residents’ well-being because they allowed for privacy, provided opportunities for residents to express their own lifestyle choices and enabled personalisation of the environment. Private bathrooms were identified as very important in addressing resident expectations in relation to privacy, hygiene and dignity (Edwards, Courtney & O’Reilly 2003). The design of the physical environment was an important contribution to residents’ feelings of safety and security (Edwards, Courtney & O’Reilly 2003).

Timko and Moos (1990) found that comfort of the physical amenities, social and recreational aids and the amount of personal and communal space was associated with the development of a sense of social cohesion and belonging.

Facility size was found to have a negative impact on resident involvement with others (Chou, Boldy & Lee 2003) with residents in larger facilities feeling more isolated and less involved. Consistent with this, higher levels of satisfaction have been associated with smaller facility size, a moderate level of physical amenities and greater personal space (Sikorska 1999).

Where residents were responsible for the selection of the home, a USA study found that a number of factors including many physical factors influenced resident perception of quality and choice of home. These included clean, pleasant surroundings, location, homelike character, compatibility or familiarity with the setting and privacy (Hedrick et al. 2003).

In a USA study of residents in long-term residential care (Abt Associates Inc 1996) residents linked adequacy of personal space with privacy, opportunities to exercise freedom of choice, ability to be alone, ability to entertain others and opportunities to hold private conversations.

6.2.2 Level of functional ability

Residents of aged care homes commonly require supported accommodation as a result of diminished function and inability to maintain an independent life in the community (Edwards, Courtney & O’Reilly 2003; Reberger, Hall & Criddle 1999). Residents with the greatest levels of impairments, either cognitive, physical or sensory, have been considered
to have the greatest risk of having poor quality of life (Kane, R A 2003; OECD 2005) and are most likely to be excluded from attempts to measure resident satisfaction with quality (Bravo et al. 1999).

Chou and colleagues (2002a) found that highly dependent residents were less satisfied with social interaction and with the meal service. They were also more likely than independent residents to be confined to certain areas within the home (Chou, Boldy & Lee 2002a) suggesting that the functional abilities of residents impacted on their interaction with the environment and with others.

Shepherd and colleagues (1996) used the Global Assessment Scale (GAS), the MMSE and the Daily Living Skills Questionnaire (which assesses cooking, budgeting and basic self-care tasks) to provide comparisons of functional abilities in residents across different types of residential care settings. They found that higher levels of disability were associated with poorer quality of care, worse residential conditions, more institutionalised care and higher levels of resident dissatisfaction. Similarly, Bravo and colleagues found that the presence of cognitive deficits was the strongest determinant of poor quality care in long term care facilities (1999).

This suggests that high levels of low functional ability amongst residents of aged care homes could be a flag for possible poor quality of care and life, and warrants more stringent quality measurement, inspection and improvement interventions.

### 6.2.3 Meals and food services

Resident satisfaction with meals and food services has a number of significant social, health and quality of life implications for residents of aged care homes (Crogan, Evans & Velasquez 2004). It can also be an indicator of both quality of care (Crogan, Evans & Velasquez 2004) and quality of life (Davis, Sebastian & Tschetter 1997; Lengyel et al. 2004). International research suggests that malnutrition is a considerable health issue in relation to residents and as such has serious health and quality of life implications for affected residents (Crogan, Evans & Velasquez 2004).

Food and meals involve a complex array of attributes which go beyond the simple provision of nutritious food. While food quality and choice (Davis, Sebastian & Tschetter 1997; Lengyel et al. 2004) are known to be factors influencing resident satisfaction with meals (Crogan, Evans & Velasquez 2004), organisational factors can also have an impact on residents, particularly upon high care residents. These residents may require flexible options for meal delivery practices, relating to attributes such as timing of meals, amount and temperature as well as increased staff to assist with eating.

In a Canadian study, Lengyel and colleagues (Lengyel et al. 2004) found that satisfaction of elderly residents with meals and food services was related to a number of quality of life issues. They concluded that while residents expressed concern about food variety, quality, taste, appearance and the posting of menus, the autonomy of residents was the most important determinant of quality, particularly in relation to food choice and snack availability.
The food and meal services can also have broader social and emotional implications for residents. Satisfaction with meals has been found to be related to a number of complementary attributes such as the pleasantness of the physical environment in which meals are served and the atmosphere and the opportunities for social interaction associated with the meal service. Food and meals were also found to become a major part of the lives of dependent residents and had an influence on their assessments of other factors – becoming a symbol of security, as well as a vehicle for social integration and socialisation (Chou, Boldy & Lee 2002a).

6.2.4 Social interaction, activities and community
Sense of belonging to one’s community, social engagement and the ability to participate in meaningful activities are known to be factors which impact on the views of quality of life held by older people still residing in the community (Bowling 2005). Not surprisingly these are also important to older people residing in residential aged care homes.

Mitchell and Kemp found that positive social climate, measures of group cohesion, participation in social activities, monthly family contact and an environment low in conflict improved quality of life for residents of aged care homes (2000).

Similarly, Lawton and colleagues showed a congruence between mood (as measured by the Philadelphia Geriatric Center Positive and Negative Affect rating scale) and the quality of daily events involving health, family, and self-initiated and social events (Lawton, De Voe & Parmelee 1995).

An Australian study found that activities were important in residents’ quality of life (Edwards, Courtney & O’Reilly 2003). However, for activities to be valued by residents they needed to be seen as meaningful and suited to the needs of individuals. Residents required a range of activities which allowed them to exercise a degree of choice (Edwards, Courtney & O’Reilly 2003).

Wilhelmson and colleagues (2005) concluded that social relations, functional ability and activities may influence the quality of life of elderly people as much as health status.

Commenting on a number of frail and disabled younger people residing in aged care homes, Reberger and colleagues (1999) expressed concern at the inability of younger people to have their social and emotional needs met in an aged care environment, highlighting the importance of compatibility in emotional well-being.

In a study undertaken in Australia with Chinese immigrants in residential aged care, Tsang and colleagues (2004) found that a high self-rated quality of life was associated with a number of factors including a sense of strong ties to one’s ethnic community and family. Associated with this was the importance of cultural understanding and compatibility with others living in the aged care home.

6.2.5 Management and organisational factors
In addition to the challenges facing all older adults, residents of nursing homes can be affected by additional factors unique to their living environment. Components of quality of life
such as health, social supports and personality can be directly influenced by the nursing home through policies, practices and the environment, and indirectly through the approaches of the organisation towards family and community (Kane 2003). Timko and Moos (1990) found that the organisational policies and services were important in determining social climate within a facility, which was seen as contributing to resident satisfaction.

In their study of residential psychiatric facilities, Shepherd and colleagues examined organisational structures, operational policies, sources of referral, staff training and quality assurance procedures. The Homes Practices Index (HPI) was used to assess the degree to which care was ‘resident-oriented’ versus ‘institutionally-oriented’ and the extent of personal choice and freedom offered to residents. This instrument also compared staff and residents’ beliefs concerning the organisation of care (Shepherd et al. 1996). In this study, quality of care in community residential homes was largely determined by the personality and philosophical orientation of the managers and leaders of the service (Shepherd et al. 1996). Other studies have also emphasised the pivotal role of management and leadership in staff satisfaction and the resulting improvements in quality of care for residents (Chou, Boldy & Lee 2002b).

Commenting on the contribution which those in positions of leadership can make to the quality of life of residents, Kane and colleagues state that although aged care homes may not overcome extreme sensory impairment, high disease burden and cognitive impairment, there are many interventions available to those responsible for managing aged care facilities such as attention to comfort, autonomy, privacy, dignity, meaningful activity, relationships, food enjoyment, security, functional competence and spiritual well-being that can improve or maintain quality of life for residents (Kane et al. 1997).

6.2.6 Resident sense of autonomy and control

Australian (Byrne & MacLean 1997; Edwards, Courtney & O’Reilly 2003; Hudson & Richmond 2000) and international studies (Kane, R A 2001; Kane, R L 2000; Kane, R L & Kane, R A 2000) have indicated the importance of maintaining resident choice, autonomy, control and efficacy as important factors in residents’ quality of life.

In a USA study of quality of life in long-term residential aged care (Abt Associates Inc 1996), residents identified a number of attributes related to independence. This included self-sufficiency, freedom of choice over daily activities, living with fewer rules and controlling one’s immediate surroundings. Independence and its associated attributes were linked to the overall concept of dignity.

Vallerand and colleagues (1989) challenged the common assumption that residential aged care impacts negatively on life satisfaction per se. In a comparison of residents in community housing, high self-determination nursing homes and low self-determination nursing homes, they found that life satisfaction ratings of residents in high self-determination nursing homes were similar to those of elderly people living in the community.

The resident’s participation in the initial choice of facility was also important in ensuring that residents were able to match their individual needs with facility characteristics, rather than placements occurring on the basis of bed availability (Sales et al. 2005). Compounding
this, Edwards (2003) reported that because residents were often not driving the decision to move into the home, they experienced a significant sense of loss of control when moving into a home which could impact on their quality of life.

In order to facilitate maintenance of independence and autonomy, residential care homes need to be tailored to the residents’ levels of functioning (Hedrick et al. 2003; Timko, C et al. 1993). Supportive physical environments and living assistance services improve the quality of life of disabled residents, whilst independent, high functioning residents receive more benefit from interventions that allow them more control over their daily lives (Timko, C et al. 1993).

Shepherd and colleagues (1996) suggest that quality of life, personal choice and autonomy can be improved by simple interventions involving access to the ‘same facilities, which the rest of us would take for granted, such as being able to go into the kitchen at night and make a cup of tea.’ Similarly, Kane and colleagues (1997) report that cognitively intact residents of aged care homes attach importance to choice and control over everyday decisions such as bedtime, rising time, food, room-mates, care routines, use of money, use of the telephone, trips out of the facility and initiating contact with a doctor. However, whilst these authors found that residents and staff both viewed this control as important to residents, there was a perception within both groups that residents were not satisfied with their control and choice. Disappointingly, neither group was optimistic about being able to improve the levels of control and choice (Kane et al. 1997).

McAllister and Silverman (1999) stress that dementia and cognitive impairment are not barriers to community formation within institutional settings. Rather, they contend that community formation can be promoted by:

- Increasing resident independence and choice;
- Flexible and person-centred staff roles; and
- A physical environment that facilitates social interaction, autonomy and participation in the activities of daily living.

Regimented care delivered within a medical rather than a social model of care, in physical settings that do not promote resident interaction and social bonding and are detrimental to community formation whatever the level of cognitive ability of the residents (McAllister & Silverman 1999). In fact, Mattiasson and Andersson propose that ‘an ethics of intimacy’ should have priority in the care delivered in residential aged care settings. This would highlight the need for others to relate to and would make ‘chats’ part of the ‘real work’ of staff. It has also been suggested that assessments of residents’ degree of intimacy also include sexual intimacy and that social engagement also include parameters such as involvement in voting and other external community activities. Resident autonomy also extends to the opportunity for individuals to give informed consent to treatment or the refusal of treatment, especially in end-of-life issues, in accordance with basic medical ethics (Mattiasson & Andersson 1997).
6.2.7 The involvement of families and carers

Access to meaningful interaction with families and carers was identified as important in residents' quality of life and in contributing to the successful transition into residential aged care (Dellasega & Nolan 1997; Edwards, Courtney & O'Reilly 2003). It has also been seen as an important factor in the adjustment of carers and family members (Fleming 1998; Nay 1996, 1997).

Following the move into residential care, the family continues to be the most important outside source of support to the resident and is integral to the continuation of the resident's social relationships (O'Bren & Climo 1999). Consequently, their participation in the choice of home, its location and the timing of the decision to move (Nolan et al. 1996) can be vital in the successful adjustment of the older person to residential care.

Australian (Kellet 1996; Nay 1996, 1997) and international studies (Dellasega & Nolan 1997; Hedrick et al. 2003) suggest that the transition period when residents first enter residential care is emotionally stressful not only for the resident but also for their carers. Many relatives and carers have cared for their relative at home for an extended period and consequently experienced significant burden and stress (Kellet 1996; Nay 1996, 1997). Entry to residential aged care most commonly occurs at a time of crisis (e.g. following an acute illness and period of hospitalisation) rather than following a planned response to early warning signs (Clarke 1999) and is frequently associated with guilt and emotional turmoil in family members (Nolan et al. 1996). While it is often assumed that placing the relative into the nursing home will alleviate this stress, there is evidence that this is not necessarily the case. A different set of stressors can impact upon families and carers as a result of dealing with a new and unfamiliar system and from a sense having abandoned or relinquished their loved one into residential care (Nay 1996; Nolan et al. 1996). This can be exacerbated by the way relatives perceive the home, with some reporting feelings of being marginalised. This was generally linked to staff interactions and included instances where family members felt that they were: not fully informed about their relatives' condition; left waiting; expected to provide personal care such as toileting; or felt that staff expected them to provide more care than they could offer. Others reported feeling negative emotions as a result of the nursing home environment, or difficulties coping with the declining health of a loved one. The results of this were negative for all parties, as the visits of relatives to the home decreased (Nay 1997).

The positive attitude of carers and absence of carer guilt has been attributed with improving the morale and adjustment of residents. The support of staff and the organisation was seen as important in facilitating this adjustment and was pivotal in assisting carers to maintain ongoing meaningful relationships with residents (Dellasega & Nolan 1997; Nay 1996). Maintenance of positive relationships between staff and carers impacts on both the quality of care and quality of life of residents (Bower 1988; Kellet 1996) in addition to improving the carer's well-being (Nay 1996, 1997).

Some authors have argued that families should be viewed as co-clients, co-workers and resources (Nay 1996, 1997). Their role in assessing the quality of care and quality of life that their relative is experiencing is vital and is the subject of a large body of research (Clarke
In relation to caring for people with dementia, Clarke describes the family as experts on the ‘individual who now has dementia’ and health care professionals as ‘experts in managing the disease’ (Castle 2004).

In an Australian study Fleming (1998) found that family members and carers provide a special type of care which is different from the daily maintenance care provided by health care staff. This special care was directed at enhancing the quality of life of the resident and was seen as being the result of the care givers’ intimate and extensive knowledge of their relative. The opportunity to have meaningful involvement with their relative was seen as having reciprocal benefits both for the family member and the resident (Fleming 1998).

The recognition of the important reciprocal benefits to residents and family care givers resulting from increased opportunities for meaningful interaction together has brought calls for nursing homes to develop and implement family friendly policies and practices which enable family members and carers to engage in meaningful interactions with residents. This approach is seen as yielding positive results for all concerned (Fleming 1995, 1998; Nay 1997).

Carers Victoria (2003) describes a wide range of tangible benefits for the resident, staff and family members which can result from active inclusion of carers in the lives of residents. They support the view that carers are an additional resource to work in collaboration with the facility in bringing about positive outcomes for the resident including increased understanding of the resident’s behaviour, health status, personal history, language, cultural and spiritual needs. They advocate the involvement of carers in ways which continue to empower residents and with the permission of the resident.

### 6.2.8 Relationships with staff

Resident and staff relationships have been found to have an important impact on residents’ assessments of quality in residential aged care, not just as carers but also as companions and sources of social interaction (Abt Associates Inc 1996).

Buelow and Fee described the qualities of nursing home staff that residents value most highly (2000). These included genuine concern, kindness, respect, consistent attentiveness and pleasant disposition. The qualities of nursing home staff that family members valued most highly were knowledge regarding ageing, gentle assertiveness and commitment to long-term employment within the facility (Buelow & Fee 2000).

The quality of resident-staff communications was also found to be important, with residents reporting that they valued interactions in which staff spoke with them with respect, treated them as adults and made requests politely. Residents strongly associated positive communications with staff as a dignity issue (Abt Associates Inc 1996).

A small Australian qualitative study indicated that the quality of resident interactions with staff was important in residents’ sense of belonging and also their trust that they would receive care when it was required. Residents’ familiarity with staff was also important, with residents preferring to be cared for by people whom they knew and trusted (Edwards, Courtney & O’Reilly 2003).
The attitude of staff and the quality of their interactions with residents has been found to have a positive influence on the overall atmosphere of the home environment and residents' satisfaction. Chou and colleagues (2002a) found that the quality of staff interaction compensated for a less than desirable physical environment. For both high and low care residents satisfaction with staff was found to increase satisfaction with a broad range of other aspects of life in a nursing home – including a positive impact on resident satisfaction with involvement with others and social interaction. Age was also found to impact on satisfaction with staff with older residents more likely to be satisfied with staff care (Chou, Boldy & Lee 2003).

Residents’ relationships with nursing staff and personal care attendants as well as allied professionals were found to have a strong impact on the overall quality of an individual’s life (Tester, Hubbard & Downs 2001).

Mistreatment of residents of aged care homes by staff members has been documented as a problem within the residential aged care sector overseas. Although specific evidence of mistreatment has not been identified in the Australian literature, this issue requires continued monitoring. Credentialing represents the most appropriate means of protecting against this, with criminal background checks of employees, and maintenance of nurse and care-giver registries (Kapp 2003).

The significance of the relationship which staff have with family members and carers has also been recognised. Given the importance of resident–family interaction on the well-being of residents, the impact of staff attitude towards active family involvement and interaction is extremely important. Fleming (1995) has put forward the view that the purpose of family members’ visits extends beyond family obligation and serves a number of functional purposes for the resident. The broader functions of the visits, however, can be overlooked by staff who fail to recognise the important contribution being made to the resident as a result of family involvement. To counter this, Fleming suggested that family care givers should be viewed by the staff as co-clients, and their involvement in the home should be fostered by the policies and programs instituted at the home and would improve staff perceptions about the role of family members in the home.

### 6.2.9 Staff satisfaction

Staff satisfaction is strongly correlated to resident satisfaction in nursing homes (Chou, Boldy & Lee 2003; OECD 2005). In fact, Boldy and colleagues report that improving staff satisfaction (in the domains of personal satisfaction, satisfaction with workload, team spirit, training and professional support) provides the greatest potential for increasing the satisfaction of residents of aged care homes.

Shepherd and colleagues measured staff satisfaction using the Minnesota Satisfaction Questionnaire. These authors explored whether or not staff satisfaction is dependent on the nature of the work in residential aged care settings or organisational characteristics, or both. Interestingly it was found that staff satisfaction has a very small relationship with workload or resident dependency or working conditions and more to do with job context factors such
as management support, feeling in control of the working environment and the influence of bureaucracy (Shepherd et al. 1996). Similarly, Jenkins and Allen found that staff who reported higher levels of personal accomplishment (on the Maslach Burnout Inventory) had more staff–resident interactions. Staff who reported more involvement in decisions relating to their work (as measured on the Perceived Involvement Personal Questionnaire) had fewer negative staff–resident interactions. Distress and emotional exhaustion were not found to be related to the quantity or quality of staff–resident interactions (Jenkins & Allen 1998).

Hence, it would appear that attention to the organisational structures that facilitate staff satisfaction would be likely to lead to higher quality of care, less staff turnover and greater continuity of care and in turn improved quality of life.

In addition, Shepherd and colleagues measured the psychological well being of staff with the 28-item General Health Questionnaire and found that staff of residential care settings experience high levels of psychological distress. These authors reported that, paradoxically, staff members who scored low on distress levels were observed to have the most negative interactions towards residents (Shepherd et al. 1996).

Staff satisfaction has been identified as an important and statistically significant factor in determining resident satisfaction in nursing homes (Chou, Boldy & Lee 2003) and has been identified as a key factor which should be addressed in the development of strategies to increase resident satisfaction (Boldy, Chou & Lee 2004). In their discussion of the Australian residential aged care system, Hudson and Richmond (2000) commented that staff morale is dependent upon encouragement, support and education and that this in turn has an impact on the resident care.

### 6.2.10 Accessibility to quality staff

Low staffing levels have been found to be the single most important contributor to poor quality of nursing home care in the USA (Cotton 1993; Harrington 2004; Wells 2004). There is a general consensus that the problem is not one of staff recruitment, but one of retention. According to USA figures, three out of four nursing staff leave the industry every year, leading to lack of continuity and stability of care. Historically, levels of funding, skills maintenance and professional status have been issues within the residential aged care workforce, affecting trained nurses, nurses’ aides, patient care assistants and visiting medical practitioners (Harrington 2004).

Consistency of staff has been found to have a positive impact on resident satisfaction (Chou, Boldy & Lee 2003) and has been found to contribute to residents’ peace of mind and security related to the accessibility of care (Edwards, Courtney & O’Reilly 2003). Access to staff to assist with personal care in a timely fashion has been linked to residents’ views of quality of life, as well as dignity and self-esteem (Abt Associates Inc 1996).

There is a large body of research linking nurse-staffing levels and outcomes of residential aged care with staffing said to be the best predictor of good processes of care. Higher staffing levels have been linked with improvements in mortality rates, physical functioning,
antibiotic use, pressure ulcers, catheterisation rates, hospitalisation rates, weight loss and dehydration (Cotton 1993; Harrington 2004; Wells 2004).

The Institute of Medicine relates the quality of residential aged care to the performance of its workforce and proposes workforce development as one of its nine guiding principles in long-term aged care (Wunderlich & Kohler 2001).

Measurement of staffing levels has been found to be a better predictor of quality care processes than the following indicators:

• Weight loss;
• Bed fastness;
• Physical restraint use, pressure ulcers, incontinence;
• Loss of physical activity;
• Pain; and
• Depression rates (Harrington 2004).

Some State legislatures in the USA have adopted minimum ratios or hours of direct care per resident day. In general, mandatory staffing standards have not been widely adopted through legislation (Wells 2004). However, the Institute of Medicine has highlighted the need for minimum staffing levels (Wunderlich & Kohler 2001).

Stone and colleagues suggest monitoring of workforce development activities focusing on the attitudes, values, skills and knowledge of workers in residential aged care settings (Stone, Dawson & Harahan 2004). This is supported by the Institute of Medicine which also supports the need for development in leadership and management (Wunderlich & Kohler 2001).

The accessibility of high quality staff is an important factor in the care provided to residents. In their discussion of the Australian residential aged care system (Hudson & Richmond 2000) illustrated the importance of not just sufficiency of staffing levels but the education of staff to ensure that they have the required professional skills to deal with the complex range of issues that arise when working in environments where death is a reality of daily life. Staff need to have the training and expertise to ensure that care meets the residents’ physical, pastoral, cultural, physiological, spiritual and other needs. Staff also play a significant role in supporting families and require training and support to maintain their morale while undertaking these roles. Hudson and Richmond emphasise the need for open communication and collaboration between allied health staff and nursing staff in providing consistent informed care of a resident. They also emphasise the importance of access to specialist care staff, such as palliative consultants for residents, their families and staff.

The Australian Aged Care Standards and Accreditation Agency includes the standard of Management Systems, Staffing and Organisational Development in its Accreditation Standards which includes a number of Expected Outcomes (2004a).
6.2.11 The regulatory environment
The regulatory environment consists of factors that have been identified as impacting upon quality of care and quality of life in residential aged care, particularly factors relating to accreditation, inspection and regulation. Although the evidence linking accreditation programs with quality improvement is limited, in the USA serious federal citation against a nursing home after an inspection visit has been found to be associated with subsequent improved outcomes (Cotton 1993). However, other authors maintain that the USA Residential Aged Care Survey and Enforcement Program is ineffective. For instance, according to the USA General Accounting Office, surveyors have been found to be deficient in their ability to detect serious problems in quality of care. In particular, areas that have been difficult to detect include preventable hospitalisations, deaths, falls that led to fractures, infections, pressure ulcers, the inappropriate use of restraints, the failure to dress and groom residents, and malnutrition (Harrington 2001).

Furthermore, many argue that the increased administrative burden associated with recording and measuring quality can be counterproductive and divert attention away from direct patient care. However, opponents of this view generally cite the ‘Hawthorne effect’ which suggests that behaviour which is measured and monitored tends to improve.

Related to this, Marquis (2002) suggested that the multidimensional subjective and objective components of quality makes it a difficult concept to define and has resulted in evaluations of aged care homes being primarily aimed at tangible, material, quantifiable components of services, overlooking the subjective aspects of life within the service. Commenting on aged care homes in Australia, Marquis expressed concern that the focus on ‘paper’ measurement of quality of life, with an emphasis on management practices rather than the experiences of residents, can, in itself, detract from the quality of life of residents by depersonalising service provision and reducing residents to tasks to be completed.

Braithwaite and Makkai (1993) reported on the importance of ensuring that residential aged care inspection processes include some subjective resident-centred standards that are reliable and practical, no matter what the level of dependency and care the individual requires.

Accreditation programs involving the setting of standards and review of performance internally and by peers, consumers and other interested parties would appear to represent the most comprehensive method for quality of care and quality of life monitoring in residential aged care. While supported mostly by process indicators, it is feasible that more sophisticated outcome tools will become available to enable satisfaction and quality of life to be measured even for those residents who are cognitively compromised.
7. Measuring and Improving Quality in Health and Residential Aged Care

7.1 Introduction

Quality of care has become an increasingly important issue in both the acute health and aged care sectors. In both sectors, quality has increasingly commanded the attention of decision makers, and the need for more research and academic rigour in the area has become widely appreciated. Whereas debates in the past tended to focus on whether quality in health care could be measured, the question has now shifted to how to measure quality (Wagner, De Bakker & Groenewegen 1999).

It is important to recognise, however, that while there are undoubtedly similarities in many of the issues that face both sectors, there also are fundamental differences between the acute health and residential aged care sectors that necessitate considerable care when comparing and contrasting approaches to assuring quality and stimulating quality improvement.

In Australia both sectors:

- Are, in the main, publicly funded;
- Involve the provision of personal care of varying complexity, depending on patient/client need;
- Involve the provision of active health care interventions by health care professionals, particularly nurses and medical practitioners;
- Are structurally and functionally interrelated, with frail aged persons cared for in both sectors and a significant rate of transfer of patients/clients between the sectors (in both directions); and
- May be integrated from a management and governance perspective, in both the public and private sectors.

The primary focus of care in the residential aged care sector differs from that of the acute health sector, however. In residential aged care, the focus is on the provision of quality personal care, the creation of supportive environments that meet resident's personal needs and preferences and maximise their independence, and the provision of quality physical amenity. While active health care interventions to prevent or diagnose illness and to provide appropriate, safe, high quality care are essential elements of residential aged care, they are not the primary focus.

The primary focus of the acute health care system, in contrast, is on domains of accessibility, coordination, comprehensiveness, effectiveness, efficiency, patient satisfaction, safety, technical proficiency, appropriateness and acceptability of acute interventions (Boyce et al. 1997; Caper 1988; Irwig 1993). The quality of physical amenity and supportive care is an important element of an overall quality system, but is not the predominant focus.
The following sections of this report describe in detail issues relevant to quality of care. There is a focus on acute health services and the role of accreditation in assessing and promoting quality in acute health care, reflecting the areas in which academic debate and comment on quality and accreditation is most prominent. That debate and comment provides considerable useful content for the consideration of quality and accreditation in residential aged care.

The literature is presented in the context of an understanding that, while the principles relevant to quality and accreditation applying to both systems may be similar, the parameters of quality in residential aged care are likely to be quite different from those that apply in the acute health care sector. In future stages of the project, the features of other relevant systems will be presented for comparative analysis.

### 7.2 The evolution of the quality movement in health and aged care

The quality movement in health care has progressed through a number of stages since its inception and inspiration from the manufacturing industry. Initially ‘quality assurance’ aimed to ensure that lower levels of performance improved towards the average. Components of quality assurance included standard setting, the delineation of minimum standards and quality inspection against defined standards. Next, ‘quality improvement’ aimed to improve the performance of all providers, thereby increasing the overall average level of performance. This involved ‘quality control’ mechanisms to reduce deficient processes leading to variations (not necessarily adverse outcomes) in care. It recognised the need for continuous processes where the quality or standard to be met was redefined within a repeating cycle of analysis, action and review (Berwick 1991). More recently, the concept of ‘patient safety’ has provided a broader focus whereby error prevention and improved outcomes are promoted through the development of structures, processes and systems, rather than focusing on the performance of individuals (Shojania et al. 2002).

Within these paradigms, a number of different perspectives and quality enhancement strategies have emerged. Some strategies focus heavily on self-regulation whilst others focus more on external control organisations and individual practitioners (Grol 2001). Self-regulation occurs through internal assessments, self-directed learning and improvement, and tends to promote the realisation of maximum achievable standards. External regulation is generally linked to compliance with legal, licensing or funding models and tends to enforce minimum standards.

Internationally, it is anticipated that future approaches to regulating and improving quality in residential aged care will have a stronger emphasis on incorporating consumer views on quality and that mechanisms to facilitate consumer empowerment will enable consumers to play an increasingly active role in quality development (OECD 2005). This reflects a growing recognition of the importance of including the resident’s voice in determining quality in residential aged care (Chou, Boldy & Lee 2003; Kane et al. 1997; Larsson & Wilde Larsson...
which has been associated with the view that a fundamental objective of high quality service provision for the elderly should be improved quality of life. Over the past decade this is a trend which has been reflected in Australian aged care policy (Gething, Fethney & Blazely 1998) and appears likely to underpin future approaches to the development of quality in residential aged care.

7.3 Measuring the quality of care

Measuring quality of care is generally divided into structural, process or outcome measures (Donabedian 1988). Some commentators favour process measures as having greatest utility, as demonstrated in the Assessing Care of Vulnerable Elders (ACOVE) project. This large Rand Corporation project was commissioned to assess care in the elderly, and proposed that process measures were preferable to structure or outcomes measures because:

- Processes have been found to be more efficient in measuring quality, showing deficiencies earlier and require less data collection than outcomes;
- Outcomes are heavily influenced by differences in case-mix and there is a paucity of validated risk adjustment models to take this into account;
- For most conditions there is inadequate information in the medical record to determine outcomes; and
- Processes are more amenable to interventions and responsive action (Shekelle et al. 2001).

Linking process to outcomes and quality in aged care remains problematic, however, because few health care processes are supported by quality evidence from trials that are applicable to elderly patients (Shekelle et al. 2001). Accordingly, expert opinion is often required and was used in the ACOVE project that developed 236 process clinical indicators covering 22 conditions for vulnerable elders. This particular indicator set is designed to produce an aggregate score for quality at the health system level. Two hundred patients are required to detect meaningful differences in aggregate scores between health systems (Wenger & Shekelle 2001).

Other quality of care indicators that have been developed for residential aged care homes and identified in this review include: the USA Center for Health Systems Research and Analysis Provider Initiative Project (PIP) (Bryant et al. 2004), the USA Centers for Medicare and Medicaid Service National Nursing Home Quality Measures (Scott & Elstein 2004), and a project commissioned by the Aged Care Branch of the Victorian Department of Human Services to develop a set of quality-of-care performance indicators for the public sector residential aged care homes in Victoria, the Public sector residential aged care quality of care performance indicator project, reported in June 2004 (Nay et al. 2004). A list of the indicators in these programs is contained in Attachment 2. It is also noted that Queensland University of Technology and Blue Care are currently conducting a project to develop a suite of clinical care indicators for use within residential aged homes (Courtney et al. 2005). The Agency (2004a) has also done work in the area.
7.4 Specific approaches to improving and measuring quality

Table 4 provides an alphabetic summary of approaches to quality assurance, quality improvement, patient safety and measurement of quality developed over the last 15 years. The strategies highlighted are considered by the project team to demonstrate potential for application to residential aged care environments.

It can be seen from this list that the strategies differ markedly in specificity and in their clinical or managerial focus. No one particular strategy is all-encompassing or applicable to every sector within the health care system, and many strategies overlap and include elements of others. For example, accreditation programs generally include clinical indicators. Risk management programs generally include sentinel event monitoring and root cause analysis. Tissue audits tend only to apply to clinical surgical settings, and utilisation reviews and total quality management are largely management tools to monitor clinical practice. Generally, health care organisations use a combination of approaches in order to achieve a comprehensive quality program.

Table 4 illustrates that many of the approaches to measuring and monitoring quality standards in health care are also relevant to residential aged care settings. Importantly, each of these strategies can be seen to operate from one or more of the key paradigms discussed above. An overview of each of these strategies is presented below, grouped according to the nature of their regulatory focus.

7.4.1 Approaches focusing upon external regulation

Three primary strategies have been identified to promote quality standards through external regulation, including:

- **Litigation:** Operating within a quality assurance paradigm, this strategy involves claimants seeking legal redress to compensate for adverse events and poor outcomes in health care. This approach is more often cited as a driver for the quality in the health care movement rather than a strategy per se, with case resolution often based on patient outcome not on occurrence of negligence (Brennan et al. 1991). Such an approach often leads to ‘defensive medicine’ which is generally costly and may be associated with inappropriate care.

- **National/state development of reportable quality measures or benchmarks:** This strategy operates within quality assurance, quality improvement and patient safety paradigms. The Australian Health Care Agreements include provisions for reporting on quality and quality improvement initiatives (McLoughlin et al. 2001). Other national Australian initiatives include:
  - Establishment of the Australian Council for Safety and Quality in Health Care to promote national collaboration through expert-based representation and the commissioning of a number of nationally relevant projects;
  - Establishment of the National Institute for Clinical Studies (NICS), a body which aims to focus on bridging the gap between evidence and clinical practice; and
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Establishment of the National Health Performance Committee, responsible for developing a national performance measurement framework (McLoughlin et al. 2001).

In the USA, a recent Institute of Medicine Report recommended the establishment of standardised performance measures across government programs and public reporting requirements for providers and health plans (Corrigan, Eden & Smith 2003). The National Forum for Quality Measurement and Reporting has been established to promote development of common performance indicators throughout the USA health care sector (McLoughlin et al. 2001).

- Regulatory frameworks that adopt certification, licensing, registration or chartering:
  Operating from quality assurance and patient safety paradigms, licensing-type strategies refer to legal processes that permit ability to practice or operate within a particular field within the relevant state or national governing body. Such processes are based on attainment of and compliance with minimum standards (Retfalvi & Simon 1996).

7.4.2 Approaches focusing upon external and/or self-regulation
A greater number of strategies have been identified to promote quality standards through a mixture of external regulation and/or self regulation, including:

- Accreditation: Operating within quality assurance, quality improvement and patient safety paradigms, accreditation refers to a system where an external, independent authorised body assesses an organisation's compliance with a set of defined standards or criteria. These standards or criteria typically focus upon structures, processes and outcomes. If the organisation is deemed compliant, a certification is awarded that is endorsed by the credibility and reputation of the accrediting body (Bohigas et al. 1996).

  Given the relevance of this approach to the current project, a more detailed discussion of this approach is provided in subsequent sections of this report.

- Adverse event/incident monitoring: Operating within quality improvement and patient safety paradigms, this approach involves the monitoring of events that include ‘unintended injury that was caused by medical management and resulted in measurable disability’ (Brennan et al. 1991). Often a level of subjective judgement is required to identify events, potentially limiting the reliability of this approach. Limited adverse occurrence screening involves auditing medical records flagged by particular screening criteria (Wolff 1996; Wolff et al. 2001).

- Clinical indicators: Clinical indicators have evolved from a quality improvement paradigm, and comprise ‘a measurable element in the process or outcome of care whose value suggests one or more dimensions of quality of care and is theoretically amenable to change by the provider’ (Bernstein & Hilborne 1993). The reliability, validity and risk adjustment of specific indicators may be open to dispute.

- Clinical privileging: Clinical privileging has been adopted within quality assurance and patient safety paradigms, and involves the delineation of the scope of an individual’s
practice within the institution. Such delineation may be based on the credentials of particular individuals or the needs of the institution (Payne 1999).

- Credentialing: Operating within quality assurance, and patient safety paradigms, credentialing involves a process of obtaining, verifying and evaluating the qualifications and experience of a health care professional in order to define the specific care and treatment that can be provided by a particular professional at a certain point in time (Payne 1999). A main drawback of this approach is that detection of staff with emerging problems can be slow (Wolff 1994). The Australian Council for Safety and Quality in Health Care has recently undertaken a project to develop a national standard for credentialing and defining the scope of clinical practice for senior medical practitioners, and is developing an educational support package.

- Disease registers: Operating within a quality improvement paradigm, disease registers comprise large scale systematic computerised data collection at a population level, to ascertain information about the ‘product’ of health (i.e. short, medium and long-term outcomes). Disease registers have been effective in showing wide variations in health care resource utilisation rates (Wennberg & Gittelsohn 1973).

- Patient satisfaction surveys: With a focus upon quality improvement, satisfaction surveys can measure a wide variety of different components of care such as waiting times, interpersonal skills and hotel services (Dans 1993). Surveys conducted by the organisation delivering care may be limited by poor response rates and/or selection bias. Patients may not choose to comment on care because of confidentiality concerns and a fear of negative impacts of any feedback upon the care they may subsequently receive (Wolff 1994). Higher response rates and robust comment have been achieved in the Victorian patient satisfaction surveys.

- Peer review: Used within quality assurance and quality improvement frameworks, peer reviews focus upon personal attributes or actual performance of individuals by their professional peers (Ramsey et al. 1993). This approach may be also used as a form of external regulation by review from independent sources such as ‘expert witnesses’. The approach is based on the premise that fellow practitioners in a complex industry are often best able to understand the nuances of their care processes. Peer review can be based on clearly stated (explicit criteria) or implied standards (implicit criteria) (Brook & Appel 1973).

- Re-examination and re-certification: As a quality assurance and patient safety activity, this approach involves reviewing and re-awarding of professional qualifications based on proof of skill maintenance and development over time (Wolff 1994).

- Report cards: This approach has emerged from the quality assurance literature, and involves the use of standardised, publicly released reports focusing on the quality of care of an organisation or provider. The aim of this approach is to allow patients and referrers to select high quality providers and to motivate poorly performing providers to improve the quality of care and range of services offered (Longo et al. 1997; Schneider & Epstein 1996). Report cards have been used extensively in the USA and the literature has identified the following limitations:
- A tendency to be less than comprehensive, focusing on only a few aspects of care (Epstein 1995);
- Standardisation has proved difficult due to variation in data systems and data collection across organisations (Epstein 1995; Green & Wintfeld 1995; Green et al. 1997);
- Risk adjustment has proved difficult (Green & Wintfeld 1995);
- The approach may encourage ‘gaming behaviour’ where improvement occurs in measured areas at the expense of other factors that are not measured (Epstein 1995; Green & Wintfeld 1995);
- A limited body of empirical investigation to support their use (Marshall et al. 2000);
- They have not developed sufficient levels of reliability and validity to be implemented;
- Consumers and purchasers rarely search out report card information because of a lack of understanding and trust in the information (Marshall et al. 2000); and
- Some providers are sceptical of report card data (Marshall et al. 2000).

- Sentinel event monitoring: As a quality improvement and patient safety activity, sentinel event monitoring involves the monitoring and detailed investigation of rare events that have grave consequences (e.g. amputation of the wrong limb) (Department of Human Services Victoria 2003).

### 7.4.3 Approaches focusing upon self-regulation

The largest number of strategies identified to promote quality standards have utilised different forms of self-regulation, including:

- **Clinical governance:** Clinical governance requires the board and/or senior management to assume strong leadership and control of the safety and quality of clinical care. It emphasises the need for appropriate delegation of responsibility and effective systems of monitoring and accountability. Clinical governance may be defined as ‘the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (Scally & Donaldson 1998).

- **Clinical auditing:** Operating within a quality assurance (quality inspection) and quality improvement framework, clinical auditing is primarily a form of self-regulation but can be used as form of external regulation if sufficient resources are available. Clinical auditing involves a retrospective evaluation of medical care through the analysis of medical records (Lembcke 1956). The approach may utilise simple random or stratified sampling to achieve a proportional representation of cases. Statistically significant evidence of quality of care problems may be difficult to identify in typical sample sizes adopted for analysis (McGuire et al. 1992). Lembcke (1956) developed methods for...
medical record audit involving specific diseases or conditions that are audited against specific criteria. The Rand Corporation has furthered Lembcke’s methodology through the use of explicit case review series and structured review tools (Kahn et al. 1990).

• Clinical practice guidelines: As a quality improvement or patient safety activity, clinical practice guidelines aim to identify processes of care associated with good outcomes through evidence, or the consensus of experts, and place them in a pathway to assist clinical decision making (Kassirer 1993). Pathways more recently have been incorporated into computer/palmtop programs (computer-aided decision making) (Goldman 1990). Controversy exists over whether guidelines can be sufficiently detailed to cover patient variability and whether they can incorporate the latest research in a timely and effective manner (Kassirer 1993). At the current point in time there is limited evidence that implementation of clinical practice guidelines is associated with significant improvements in care (Grimshaw & Russell 1993).

• Complaints monitoring and management: As a quality improvement or patient safety activity, complaints monitoring focuses upon the specific analysis of consumer complaints. Unfortunately, only a small proportion of adverse patient events appear to be detected using this approach (Wolff 1994).

• Evidence based medicine: Operating within both quality improvement and patient safety paradigms, evidence based medicine involves ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett et al. 1996). The International Cochrane Collaboration was established in 1992 to prepare, maintain and disseminate systematic reviews of health care based on highest available evidence such as randomised controlled trials (Chalmers 1993).

• Patient empowerment: Also operating within both quality improvement and patient safety paradigms, patient empowerment involves actively addressing patient/consumer rights in organisational policies and procedures. For example, the Australian Council for Healthcare Standards defines patient/consumer rights as:
  − Access to appropriate equitable care;
  − Maintenance of personal dignity;
  − Privacy, confidentiality and consent;
  − Personal safety and security;
  − Knowledge of the identity and professional status of individuals providing service;
  − Participation in planning and decisions regarding their care and access to information;
  − The right to a second opinion or to refuse treatment; and
The JCAHO (USA) has implemented a ‘Speak Out’ campaign aimed at promoting the patient/consumer voice in error reduction. The ‘Open Disclosure’ project undertaken for the former Australian Council on Safety and Quality in Health Care in 2003 promoted early dissemination of information and involvement of patients in management of adverse events.

- Performance appraisal: As a quality assurance activity, performance appraisals involve a process of judging performance against specific job descriptions of individual service providers.
- Performance management: As a quality improvement and patient safety activity, performance management involves a process of setting performance expectations and professional development, through agreement between the employer/manager and the employee. This approach stresses the importance of a two-way interaction between both parties involving teaching, supervising, learning, problem solving, career development and feedback. It also links individual performance to organisational goals, objectives and values in order to build an organisational culture.
- Professional development/ MOPS/ Continuing medical education (CME): Operating from a quality assurance or quality improvement paradigm, professional development strategies – although typically undertaken as a form of self-regulation – can also be linked to external regulatory approaches. This approach generally involves a voluntary, self-assessment education program based on the accumulation of points through logbook records. Major problems with these approaches relate to the potential for variable levels of compliance and the potential difficulty in monitoring actual levels of compliance. The Royal Australian College of General Practitioners has been successful in linking CME to vocational Registration and Medicare Reimbursement Schedules (Newble, Paget & McLaren 1999).
- Risk management: Arising from the patient safety literature, risk management involves a process of identifying and assessing hazards that may lead to adverse events and poor care. It includes the development of structures and systems to avoid and limit the effects of adverse events and poor care, the analysis of serious adverse events and ‘near misses’ and the dissemination of lessons learnt (McNeil et al. 2000). Risk management incorporates key safety design concepts learnt from high risk industries and suggests that organisations:
  - Provide leadership to make patient safety a priority and everyone’s responsibility;
  - Respect human limits in process design (e.g. avoid reliance on memory and vigilance);
  - Standardise work processes;
  - Promote effective team functioning;
  - Anticipate the unexpected through a proactive approach; and
  - Create a learning environment with a blame free, non-punitive approach to reporting and examining errors and near misses (Kohn, Corrigan & Donaldson 1999).
• Root cause analysis: Root cause analysis is often utilised as a component of an overall risk management program. Root cause analysis is a hypothesis generating activity that involves detailed analysis of an adverse or sentinel event in order to identify key intervention points that could have prevented the sequence of actions leading to the event. This approach focuses on systems and processes as opposed to individual performance and aims to lead towards system modifications (Department of Human Services Victoria 2003).

• Tissue audit: Tissue audits refer to quality assurance (quality inspection) type activities that use histopathological diagnoses to confirm clinical diagnoses (e.g. for appendicitis) (Wolff 1994).

• Total quality management: Total quality management activities have arisen from the quality improvement literature adopted from the business sector. This approach involves the active implementation of an iterative quality improvement cycle that typically involves planning for systems improvement, implementation of quality improvement activities, a review to identify the effects of implementation and a determination of further courses of action (Kondo 1988).

• Utilisation review: Utilisation reviews are reported in the quality assurance literature and involve detailed analysis of the use of specifically identified resources (e.g. medications, places, surgery). This approach measures performance ‘in terms of quantity rather than quality’ (Wolff 1994).
8. Current Issues and Approaches to Accreditation

In chapter 7 ‘accreditation’ was defined as ‘a system where an external, independent authorised body assesses an organisation’s compliance with a set of defined standards or criteria, typically focusing on structures, processes and outcomes’. If the organisation is deemed compliant, a certification is awarded that is endorsed by the credibility and reputation of the accrediting body (Bohigas et al. 1996). Accreditation, therefore, is best viewed as a process whereby the standards and measurement systems are created followed by the judging of an organisations’ performance against these standards.

8.1 Historical development of accreditation in health care

Accreditation of health care organisations can be traced back to 1917 in the USA, where it was used for the recognition of surgical training posts. The JCAHO then evolved and a similar, although not identical, model was adopted in Canada, followed by Australia, with the establishment of the Australian Council on Healthcare Standards (ACHS) in the 1970s. Accreditation of health care organisations was adopted in Europe in the 1980s and is now prevalent in the UK, Spain, Portugal, the Netherlands, Finland, Italy, France, Sweden and Germany (Shaw 2000). JCAHO remains the leading agency in the development, innovation and review of accreditation, quality measurement and improvement practices. It is also the model upon which other international systems have been based.

8.2 International approaches to accreditation

While the overall principles underlying accreditation remain the same, different accreditation programs tend to delineate different themes upon which to base the development and assessment of compliance with standards. Table 5 compares the key accreditation themes of several major international accreditation programs. These programs have been chosen as examples because of their high standing and to illustrate differences rather than similarities in accreditation programs.

Based on a review of current literature, Wagner and colleagues report that the key areas of an organisation essential for delivering care of ‘consistently high quality’ that should be incorporated in an accreditation program are:

- Attention to quality assurance documents;
- The involvement of patients;
- Process control based on standards and protocols;
- Human resources management; and
- Process control by quality improvement procedures (Wagner, De Bakker & Groenewegen 1999).
Others have suggested five major aims of accreditation that focus upon:

- Improving the quality of care delivered by an organisation;
- Improving organisation-wide attention to quality;
- Promoting team building around quality in the organisation;
- Providing an educational tool for staff on quality; and
- Acting as a management tool allowing self-evaluation and objective external review of quality of care (Hayes & Shaw 1995).

Regardless of differences reported between individual accreditation systems, commentators have observed several common features shared by all international accreditation programs, namely:

- The establishment of a regulatory body that grants accreditation and formulates standards;
- The establishment and operation of a program that is independent of government;
- A spirit of collaboration rather than competition between organisations within the accreditation program;
- The use of on-site reviews to evaluate compliance with standards;
- The formulation of multidisciplinary standards;
- The involvement of health care professionals in both the development of standards and the evaluation (surveying) of health care organisations;
- Formal feedback processes following on-site reviews;
- Systematic follow-up after reviews; and
- The awarding of an accreditation certificate valid for a prescribed period (Ente 1999; Hayes & Shaw 1995).

The development of standards has been reported to be the most challenging aspect of accreditation programs. Tregloan (2000) emphasises the need for health care standards to be suitable, acceptable and credible. Similarly, Hayes and Shaw propose that standards for accreditation should be:

- Flexible to individual organisations;
- Relate to the structures, processes or outcomes associated with quality of care;
- Derived from consensus;
- Associated with clear objectives;
- Achievable; and
- Measurable (Hayes & Shaw 1995).
Table 5: Key accreditation themes of international accreditation programs

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<td>Access to &amp; continuity of care</td>
<td>Continuum of care</td>
<td>Main focus on administrative procedures rather than clinical results</td>
<td>Clinical results</td>
<td>Clinical practice</td>
<td>Management &amp; support services</td>
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<td>Patient &amp; family rights</td>
<td>Leadership &amp; management</td>
<td>Patient satisfaction</td>
<td>Administration &amp; staff management</td>
<td>Professional development</td>
<td>Professional management</td>
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<td>Assessment of patients</td>
<td>Human resources management</td>
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<td>Departmental management</td>
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<td>Patient care</td>
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<td>Philosophy &amp; objectives</td>
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<td>Patient &amp; family education</td>
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<td>Quality management &amp; improvement</td>
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<td>Facility safety &amp; management</td>
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<td>Management of information</td>
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Continuum of care
Leadership & management
Human resources management
Information management
Safe practice & environment
Improving performance
Main focus on administrative procedures rather than clinical results
Clinical results
Patient satisfaction
Administration & staff management
Clinical practice
Professional development
Service quality
Management & support services
Professional management
Departmental management
Philosophy & objectives
Management & staffing
Staff development & education
Policies & procedures
Facilities & equipment
Evaluation & quality assurance
The International Society for Quality in Health Care (ISQua) has recently outlined key principles for standard development. These include the following stages:

- Recruit key personnel who should be involved with planning and drafting the standard;
- Achieve a consensus on a process for the development of the standard;
- Decide on the key focus of the standard (e.g. client focus, safety focus, professional focus, continuum of care focus);
- Allow adequate time for standards to be developed and tested before final approval; and
- Develop a plan for the implementation and review of the standard (2000).

In assessing compliance with standards, measurement may take a variety of forms ranging from sophisticated numerical scales through to verbal reports. Self-assessment processes are often used in combination with surveyors. The reliability and validity of these different measurement systems varies widely, necessitating a clear description of the specific processes that are required (ISQua 2000).

Accreditation programs have been embraced by health care and other human service organisations ranging from acute care services, public health programs and departments, general practice and residential aged care. They have been developed in other industries, such as child care, food safety and education. In fact, there are now ‘accreditors for the accreditors’ such as the International Accreditation Forum (2005).

### 8.3 Structure of accreditation systems

According to the International Society for Quality in Health Care (ISQua), accreditation has certain characteristics, and is distinguishable from licensure, which is focused more on adherence to minimal standards:

> 'Accreditation is usually a voluntary program, sponsored by a non-governmental agency (NGO), in which trained external peer reviewers evaluate a health care organisation’s compliance with pre-established performance standards. Accreditation addresses organizational, rather than individual practitioner, capability of performance. Unlike licensure, accreditation focuses on continuous improvement strategies and achievement of optimal quality standards, rather than adherence to minimal standards intended to assure public safety.' (Shaw 2004)

It should be noted that under the International Organisation for Standardisation (ISO) system, the term ‘accreditation’ has a different meaning:

> 'In the ISO 9001:2000 or ISO 14001:2004 contexts, accreditation refers to the formal recognition by a specialized body – an accreditation body – that a certification body is competent to carry out ISO 9001:2000 or ISO 14001:2004 certification in specified business sectors. In simple terms, accreditation is like certification of the certification
It is interesting to note that some accepted definitions of accreditation, including the ISQua definition quoted above, identify the accrediting body as a non-governmental entity and emphasise the peer-basis and continuous improvement (rather than compliance) purpose of accreditation. Often, accrediting organisations are comprised of a membership reflecting the organisations that participate on a voluntary basis in the accreditation process. Examples of such membership-based structures include the ACHS, which is one of the major acute hospital accrediting bodies in Australia and the National Association of Testing Authorities (NATA, which accredits Australian pathology laboratories for the purposes of Medicare eligibility).

In some circumstances, however, Governments and/or third party funders rely on accreditation as a means of assuring themselves and/or the community that organisations in which there is a strong public interest, and/or in which significant public funds are invested, are operating at an acceptable level of quality. In some cases, including in residential aged care in Australia, accrediting bodies are relied on to assure compliance with standards established by government, as well as to verify that continuous improvement systems are in place.

It would be unusual for a Government to mandate accreditation of privately-owned entities. Increasingly, however, the achievement of accreditation or participation in an accreditation process is, while voluntary, a condition of access to Government funding. In the residential aged care sector, although participation in accreditation is a voluntary activity, it has become a practical necessity because of the link between achieving accredited status and access to the residential care subsidy.

Where Government relies on accreditation, it may seek to have a greater role in the membership and/or appointment of directors to the accrediting body, although this is not always the case. The accrediting bodies for residential aged care and child care in Australia are examples of organisations in which Government has ownership interests and/or appoints the governing body. On the other hand, the Australian Government relies on accreditation of pathology laboratories by NATA, but does not have a significant role in the organisation’s ownership or leadership. Nor does it have an ownership or leadership role in the ACHS.

Later in this project, we will examine in detail the accreditation arrangements for residential aged care, and the way in which they compare with other accreditation systems.

8.4 Benefits and limitations of accreditation systems


‘Accreditation is widely recognised as having played an important role over the past three decades in improving safety and quality in the Australian health care system.’
That report noted comments in a 1993 WHO report entitled *The Contemporary Use of Standards in Health Care*, prepared by EG Heidemann, which contained the following assertion:

‘There is, at the moment, no scientifically documented evidence to indicate that standards and accreditation programs result in a higher level of quality of care but several countries are now beginning to study how such documentation may be produced. However, in the absence of such documentation, there seems to be clear consensus amongst those countries who have been involved in national standard setting and accreditation for some time that these programs have been tremendously influential in creating and maintaining care of a certain standard, as well as, in introducing new concepts for national achievement.’

The Australian Council for Safety and Quality in Health Care concluded that there was an urgent need for research to elucidate the relationship between accreditation and health care safety and quality (Australian Council for Safety and Quality in Health Care 2003).

Despite their widespread application, several limitations of accreditation systems have also been reported in the literature, and must be borne in mind when evaluating the benefits of this approach to quality improvement, including:

- A lack of evidence that accreditation improves outcomes and quality, despite the intuitive sense that it does;
- Accreditation programs that focus on minimum standards will not encourage excellence. Minimum standards are unlikely to challenge practice and stimulate performance improvement;
- Withholding of accreditation is punitive and inconsistent with a blame-free, continuous quality improvement approach which emphasises how to do things better and learn from system errors; and
- Accreditation is costly in terms of money, time, effort, resources and often requires the effort of volunteers to develop standards and perform inspections and surveys (Buetow & Wellingham 2003).

With respect to the second point above, there is significant unresolved debate about whether it is possible to achieve two distinct purposes with an accreditation system – on the one hand, encouragement of continuous improvement within a supportive, peer-based environment in which participation is based on a commitment to improve, and on the other hand, assurance to external stakeholders of compliance with minimum standards.

This debate arises typically when Governments and/or other stakeholders impose requirements on service providers (either directly or indirectly) to achieve and maintain accreditation status. Such requirements are applying increasingly in the acute health care sector as well as in the residential aged care sector. For example, accreditation is now a requirement for the vast majority of private hospitals that seek to access private health insurance funding via contracts with health insurance funds, and approval for the purposes of access to Medicare benefits for pathology services is linked to the accreditation status of the pathology laboratory.
Some stakeholders believe that:

- The primary objective of accreditation is to stimulate quality improvement in an environment of openness and transparency with organisational or professional peers; and
- Achievement of this objective is incompatible with the objective of assuring an external funder (Government) or the community of compliance with minimum standards of safety and quality.

This perspective is based on the belief that the (usually) catastrophic nature of the consequences associated with failure of accreditation in these circumstances necessarily will prevent frank and open disclosure by providers to their peers of areas in which they are experiencing challenges or difficulties in providing quality care. From this perspective, therefore, combining ‘accreditation’ objectives with ‘compliance’ objectives is likely to impair achievement of the primary objective of accreditation which is stimulation of quality improvement.

Scrivens describes the issue:

‘A key distinction is that accreditation standards are set at what are described as optimal achievable levels, providing a target to strive for. Licensing, in contrast, uses minimum standards that have to be passed to designate the organisation fit to provide a service to the public … The JCAHO and CCHSA argue that accreditation is intended to perform a very different function from government regulatory systems.

The original clear distinction between licensing and accreditation has become confused as accreditation systems, particularly in the United States, have had to fight for their existence in the healthcare marketplace. In the United States, the JCAHO purports to be a vehicle for promoting the dissemination of good practice, yet is used in many states as a tool for public regulation. The Health Care Financing Administration, which is a pure instrument of regulation arguably to protect the general public, uses JCAHO findings in some states as part of, or as a substitute for, its licensing process … Medicare and Medicaid reimbursements can be made on the outcome of a JCAHO report.’ (Scrivens 2002)

Some regulatory systems appear to recognise and respond to this perspective by separating accreditation systems (the primary objective of which is quality improvement) from compliance systems (the primary objective of which is assuring Government and other stakeholders of compliance with minimum standards). A separate approach applies, for example, in centre-based long day childcare in Australia, where the states and territories are responsible for monitoring and enforcing compliance and the availability of child care subsidy is contingent on participation in a separate, national accreditation scheme. Other regulatory systems which impose (either directly or indirectly) an accreditation requirement appear to make efforts to overcome this potential inherent contradiction by incorporating standards for continuous improvement systems which define outcome-based standards that foster both provider flexibility and compliance.
The accreditation system for residential aged care in Australia is described in detail in the next section. Its objectives are relevant both to compliance and continuous improvement. These issues will be explored in detail later in the project, when the structure of various systems and their relative strengths and weaknesses are analysed.
9. Requirements for Accrediting Residential Aged Care Homes in Australia

9.1 The accreditation requirement

As noted earlier in this report, in addition to the provisions in the Act for sanctions to be applied if approved providers fail to comply with their Quality of Care, User Rights and Accountability responsibilities, section 42.1 provides that a residential care subsidy is only payable to an approved provider for a day if the Secretary is satisfied that, during that day:

- The approved provider holds an allocation of places for residential care subsidy that is in force under Part 2.2 of the Act;
- The approved provider provides residential care to a care recipient in respect of whom an approval is in force under Part 2.3 as a recipient of residential care; and
- The residential aged care service through which the care is provided meets its accreditation requirement (if any) applying at that time (our emphasis).

According to the Regulatory Impact Statement for the Accreditation Grants Principles 1999, the introduction of an accreditation-based quality assurance system is intended to result in the provision of better quality services and an industry standard by which to measure services (Productivity Commission 2003).

Section 42.4 of the Act provides that a residential aged care service meets its accreditation requirement at all times during which there is in force an accreditation of the service by an accreditation body, or there is in force a determination under section 42.5 that the service is taken, for the purposes of the Division, to meet its accreditation requirement.61 An approved provider does not meet its accreditation requirement if there is in force a determination by an accreditation body that the service does not comply with the Standards specified in respect of that specified day.62

The Accreditation Grant Principles define an ‘accredited provider’ as:

‘… an approved provider that:

(e) has an allocation of places in respect of a residential care service; and

(f) has been given a certificate of accreditation, under subsection 2.12(3), paragraph 2.29(3)(b) or subsection 2.39(3) for that service.”63

61 Subject to subsection 42.4(6), a residential care service meets its accreditation requirement at all times during the application period if the approved provider conducting the service had, before the start of the application period, applied to an accreditation body for accreditation of the service (Section 42.4(3)).
62 Section 42.2(6).
63 Section 1.3 Definitions.
Part 5.4 of the Act enables the Secretary to enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the purposes of accreditation of residential aged care homes in accordance with the Accreditation Grant Principles, and any other purposes specified in the Accreditation Grant Principles, including the performance of any of the function of the Secretary under the act that are specified in the Accreditation Grant Principles. An accreditation grant is a grant payable under Part 5.4, and an accreditation body is a body to which an accreditation grant is payable.64

9.2 The Accreditation Body

The Agency is the body corporate that is paid an accreditation grant under the accreditation grant agreement for the purposes set out in the Accreditation Grant Principles. The Agency was appointed the ‘accreditation body’ under Part 5.4 of the Act in 1997. Throughout this section of the report, when reference is made to the Agency in its role as the accreditation body, it will be referred to as the accreditation body.

The Agency is a Company Limited by Guarantee, established under the Corporations Act 2001 (Commonwealth) and, therefore, primarily is regulated by the Australian Securities and Investments Commission. It is wholly owned by the Australian Government and is also subject to the Commonwealth Authorities and Companies Act 1997 (The Aged Care Standards and Accreditation Agency 2004b, p. 8).

The functions of the accreditation body include:

(a) ‘managing the accreditation process using the Accreditation Standards; and
(b) promoting high quality care, and helping industry to improve service quality, by identifying best practices and providing information, education and training to industry; and
(c) assessing, and strategically managing, services working towards accreditation; and
(d) liaising with the Department of Health and Ageing about services that do not comply with the standards applicable to them (the Residential Care Standards or the Accreditation Standards, as appropriate).’ (Productivity Commission 2003)

Protocols are in place to regulate referrals, compliance monitoring processes and the exchange of data between the Department and the accreditation body.

To support its function of promoting high quality care, the Agency conducts educational activities and has processes in place for identifying examples of better practice.65

The Agency’s sources of revenue are accreditation fees paid by residential aged care homes when they apply for accreditation, the accreditation grant paid under the Act, and interest and income from educational activities.66

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64 Schedule 1.
65 According to a recent submission made by the Agency (2004c), those processes include identification by Agency staff, self-nomination by providers who consider they are providing outstanding ‘better practice’ and by people wishing to speak at the Agency Better Practice events as well as the higher awards arrangements.
66 In the 2004 Federal Budget the Australian Government provided a further $36.3 million over four years to enable the Agency to enhance its education, accreditation and monitoring roles: Press release, the Federal Minister for Ageing, Julie Bishop, 20 October 2004.
The Deed of Funding under which the accreditation body receives the accreditation grant requires the Agency to undergo an independent quality audit, and to report to the Department annually on progress against the recommendations made by the ANAO. The Agency recently achieved ISO 9001:2000 standards certification.67

Although the Agency is a company limited by guarantee, its sole member is the Minister for Ageing, who also appoints its board members.

9.3 The Accreditation Standards

The Accreditation Standards (the Standards) (and the Residential Care Standards which applied from the commencement of the Act until the date of accreditation or the accreditation day – 1 January 2001 – whichever was earlier68) are set out in Schedule 2 of the Quality of Care Principles.

Section 18.7 of the Quality of Care Principles defines Accreditation Standards as:

‘… standards for quality of care and quality of life for the provision of residential care on and after the accreditation day.’

Section 18.9 of the Quality of Care Principles states:

‘(1) The Accreditation Standards 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 residents. It is not expected that all residential care services should respond to a standard in the same way.

‘(2) The Accreditation Standards apply equally for the benefit of each resident of a residential care service, irrespective of the resident’s financial status, applicable fees and charges, amount of residential care subsidy payable, agreements entered into, or any other matter.’

The Accreditation Standards and their predecessors, the Residential Care Standards, were based on the standards previously defined in the National Health Act, but were updated to incorporate new knowledge and expectations (Gray 2001a). The Accreditation Standards now apply to all residential aged care homes. There are four standards:

- Management Systems, Staffing and Organisational Development (Standard 1);
- Health and Personal Care (Standard 2);
- Resident Lifestyle (Standard 3); and
- Physical Environment and Safe Systems (Standard 4).

67 ISO certification means that the Agency’s management system has been independently audited and confirmed as being in conformity with ISO 9001:2000.
68 Section 54.2 of the Act and Quality of Care Principles, section 18.7.
For each standard, there is:

- A statement of Principles underlying the standard;
- A series of Matter Indicators; and
- An expected outcome for each Matter Indicator.

There are 44 Expected Outcomes across the four standards.

The difference between the Accreditation Standards and the Residential Care Standards that previously applied is that the Accreditation Standards include an additional Standard – Management Systems, Staffing and Organisational Development. According to the Quality of Care Principles, that Standard is:

‘… intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.’

The Standards are reproduced in full in Attachment 1.

The Administrative Appeals Tribunal has previously considered the question of whether each of the 44 Expected Outcomes had to be complied with (Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003):

‘… Does each outcome have to be met? It seems to us that, if Riverside is to meet its responsibilities, it does have to do that. An examination of the [Accreditation Standards] reveals that the standards reflect the quality management and services expected of a nursing home. They are what is described as an “integrated matrix” and no standard can be considered in isolation from the others. Given that each standard is, in reality, no more than a grouping of outcomes that a nursing home is expected to achieve, it must follow that those outcomes also form an “integrated matrix” in which no expected outcome can be considered in isolation from the others. Furthermore, given that each expected outcome is assessed by reference to criteria that are expressed to be cumulative rather than in the alternative, it must also follow that those criteria also form part of that “integrated matrix” … if a nursing home fails to meet a criteria, it fails to meet an expected outcome and so fails to meet one of the standards and, ultimately, fails to comply with the Residential Care Standards. As it is required to comply with those Residential Care Standards, it then fails to meet one of its responsibilities under the Act.

‘This may seem a harsh interpretation but the practical consequences may be tempered by the manner in which the Secretary responds to an approved provider’s non-compliance. He or she is not obliged to impose sanctions but, pursuant to s.65.1, is given a discretion to do so …’

The continuous improvement philosophy that underpins the accreditation system requires that residential aged care homes continuously improve their service quality (Gray 2001b).
The Quality of Care Principles are not prescriptive about how a residential aged care service must achieve each outcome. According to the Agency, this approach aims to provide the opportunity for approved providers to tailor care and services in a way that best meets an individual resident’s needs and expectations, and encourages innovation (2004c, p. 8).

The Standards and Guidelines for Residential Aged Care Services Manual (Australian Government Department of Health and Ageing 1998) (the Department’s Guidelines) prepared by the Department provide greater detail about what is expected in terms of policy criteria and other considerations. These are not binding on a service, but specify criteria for each Expected Outcome and are intended to alert residential aged care homes to what might be relevant in relation to each standard.

The Administrative Appeals Tribunal has expressed some concern that the emphasis of the Department’s Guidelines is upon what it describes as practices and procedures which can be regarded as prescriptive and not simply as guidelines (Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003). The Tribunal commented that to regard them in that way would be contrary to section 18.9 of the Accreditation Care Standards which expressly states that ‘... it is not expected that all residential care services should respond to a standard in the same way’.

### 9.4 The accreditation process

All residential aged care homes must demonstrate how they comply with the Accreditation Standards through the process of assessment. The Accreditation Grant Principles 1999 set out in detail the accreditation process.

The Department’s Guidelines state that:

‘... Assessment for accreditation requires a service’s management to provide evidence to demonstrate that their system works to deliver effective outcomes.

The key assessment questions are:

(a) Is a system in place?

(b) Is the system used?

(c) Does the system work?

Quality management within each service underpins the system. Quality and continuous quality improvement are management and staff responsibilities in each service. This involves the careful management of every aspect of service at every level within the organisation.’

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69 Section 18.9 of Part 3 of the Quality of Care Principles makes this clear.
The introduction to the Department’s Guidelines stresses that there are no precise systems to be followed, stating that:

‘... it is not expected that all services should respond to a standard in the same way. The objective of an accreditation audit is to check that a service has systems in place – that those systems are being implemented and that they do, in fact, sustain quality outcomes in the service’s particular circumstances.

‘... The outcome of an assessment is based on service management and staff demonstrating the policies and practices have been implemented and are effective in supporting the standards.’

The Agency has published an Accreditation Guide for Residential Aged Care Services (1998) (the Agency’s Guide) to assist services prepare for, and better understand the accreditation process. Like the Department’s Guidelines, it is not binding on residential aged care homes and must be read subject to the terms of the Act and the Aged Care Principles. In the Agency’s guide, the accreditation process is outlined in eight main stages as follows:

(i) The approved provider and service conducts a self-assessment;
(ii) The approved provider submits an application, including the self-assessment report;
(iii) A team of at least two registered aged care quality assessors conduct a desk audit examining the application;
(iv) The same team conducts a two to three day site audit which includes interviews with residents, their families, staff and management;
(v) The Agency considers the assessment team’s findings, any submission from the approved provider and any other relevant information, including input from the Department. It decides whether or not to accredit the service, and if granted, the period of accreditation as well as the form and frequency of support contacts and whether the service must make improvements;
(vi) The Agency informs the provider of the decision;
(vii) The Agency publishes the team’s report and the Agency’s decision on the Agency’s website (2004a); and
(viii) The approved provider manages compliance with the Accreditation Standards and the Aged Care Act and ongoing continuous improvement to the service throughout the period of accreditation. At the same time, the Agency conducts support contacts to monitor compliance with the Accreditation Standards and the Act and, to assist the service to undertake continuous improvement (1998, p. 7).

The purpose of this process is to gather information to assess a service’s performance against each of the 44 Expected Outcomes. The accreditation process involves a team of at least two registered aged care quality assessors and the site audit includes interviews with residents, their families, staff and management (The Aged Care Standards and Accreditation Agency 2004c).70

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70 The assessors are obliged under section 2.23 of the Accreditation Grant Principles to consider any information about the quality of care provided by care residents or their families.
It is important to note that the legislation provides for the creation of an assessment team before the audit and the dissolution of the team at the conclusion of the audit. The accreditation body sees this as ensuring that assessment teams are independent of the accreditation body for the purposes of conducting the audit and reporting to it.

The Agency’s assessors used a four-level rating system, ranging from ‘commendable’ through ‘satisfactory’ and ‘unacceptable’ to ‘critical’ (1998, p. D3) in the first round of accreditation. Scores for each of the Expected Outcomes under each of the four standards were ‘rolled-up’ into an overall score for each standard. Services could receive a three year accreditation if they are graded commendable or satisfactory on each standard. These ratings allowed for minor deficiencies (The Aged Care Standards and Accreditation Agency 1998, p. D9). Since 2003, truly exceptional homes have been eligible for a four year accreditation.

In the second round of accreditation, a two tiered score of ‘compliant’ or ‘non-compliant’ was adopted for each of the 44 Expected Outcomes and there was no ‘rolling-up’ into overall scores for each standard. In addition, two higher awards of ‘Accreditation with Merit’ and ‘Commendable’ came into place in early 2003, providing for services committed to better practice (The Aged Care Standards and Accreditation Agency 1998, p. 24). This evolved from the first round of accreditation (The Aged Care Standards and Accreditation Agency 1998, p. 22). The higher ratings awards apply across the service, rather than to specific Expected Outcomes. Approved providers must apply for these higher ratings awards. The Agency then publishes higher ratings on its website.

If the accreditation body decides to accredit a residential aged care service it must decide on the period for which the service is to be accredited, whether there are any improvements which must be made to improve its compliance with the Accreditation Standards, and the form and frequency of support contacts for that service.

The majority of services are awarded three years accreditation, but a lesser period may be awarded if a residential aged care service is assessed to be not performing well or has a history of non compliance with the Accreditation Standards. The legislation does not specify a maximum period of accreditation. The common three year duration is consistent with overseas accreditation systems, including that conducted by JCAHO.

The accreditation body is required to carry out regular supervision of an accredited residential aged care service to ensure compliance with the Accreditation Standards and other responsibilities under the Act by means of support contacts.

If the accreditation body believes, on reasonable grounds, that an accredited residential aged care service may not be complying with the Accreditation Standards or its other

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71 Section 2.43, Accreditation Grant Principles 1999.  
72 Further, the Agency’s Accreditation Guide for Residential Aged Care Services (Issue 2.1, July 2004).  
73 For more information on the criteria against which higher ratings awards are assessed, see the Agency’s Accreditation Guide for Residential Aged Care Services.  
74 Section 2.28(1) of the Accreditation Grant Principles.  
75 Section 3.20 of the Accreditation Grant Principles.
responsibilities under the Act, it may arrange for a review audit. Following a review audit, the accreditation body may decide to revoke the accreditation of the service, to vary the period of accreditation or to make no change. The provider is given oral and written information about the findings of an audit and provided with an opportunity to make written submissions to the Agency before the decision is made.

If the accreditation body finds non-compliance with one or more Expected Outcomes and decides that non-compliance has placed, or may place the safety, health or well-being of persons receiving care through the service at serious risk, it must report immediately to the Department and make a recommendation on whether sanctions under the Act should be imposed on the provider.

There is provision for the accreditation body to reconsider decisions concerning the period of accreditation or a decision not to accredit a service. The Federal Court has held recently that a reconsidered decision concerns the status of the service at the time of the reconsidered decision. There is also provision for review of certain decisions by the Administrative Appeals Tribunal, including the decision of the Accreditation Body to refuse an application on reconsideration and a reconsidered decision itself.

If, following a review audit, the accreditation body maintains its finding of non-compliance, it may vary or revoke the period of accreditation and put in place a timetable for improvement. The timetable for improvement gives the provider a defined period within which to take corrective action and the Accreditation Body schedules a series of support visits to assess progress made by the service in making improvements.

The Department is notified and if, upon completion of the defined period, the provider remains non-compliant or there is evidence of ‘a serious risk to the health, safety or well-being of a person receiving care,’ the provider is referred to the Department for action. The case of *Saitta Pty Ltd v Commonwealth* [2001] illustrates the role of the Department in actioning sanctions under the Act.

In *Saitta Pty Ltd v Commonwealth* [2001] the applicants sought to persuade the Court that the *Accreditation Grant Principles 1999* are beyond the powers conferred by section 96-1 of the Act because they give to the Agency powers of enforcement which extend beyond matters of accreditation. In addition, the applicants claimed that the use of material gathered under powers contained in the *Accreditation Grant Principles 1999* for purposes of accountability was unlawful. Both arguments were based on the form of section 96-1,
and suggested that because of the arrangement of the table in that section, with separate items specified for accountability principles and accreditation grant principles, each set of principles must be entirely self-contained and segregated from any other set of principles, both in their terms and the uses made of them. The Court found, however, that the argument was bound to fail:

‘The Act clearly envisages that accreditation bodies will play a role in relation to accountability … It would be an absurd result if the accreditation body could not be authorised to accredit by reference to the accountability standards, or to report breaches of those standards.’ (Riverside Nursing Care Pty Ltd and Secretary, Department of Health and Aged Care 2003, para. 227)

There have been two full rounds of accreditation since the Act commenced in 1997. In that time, the Accreditation Grant Principles 199883 were replaced by the Accreditation Grant Principles 199984 which are more comprehensive. The Working Group of the National Aged Care Forum had identified areas for improvement relating to accreditation reporting and consumer information, the integrity of the accreditation process and quality management education (Working Group of the National Aged Care Forum 2002, p. 2). The following issues were addressed in the revised Principles (Regulatory Impact Statement: Accreditation Grant Principles 1999):

a) Provision for payment to cover the costs of accreditation for facilities with less than 20 places and a tapering subsidy for facilities with between 20 and 25 places;
b) Provision to allow the audit team to meet privately with residents or relatives;85
c) A requirement for providers to inform residents and relatives of the date of an impending audit within three days of being advised of the date by the accreditation body;86 and
d) A provision for a provider to appeal a decision of the accreditation body not to accredit a service.87

9.5 Other regulatory requirements of residential aged care homes

State or territory legislation concerning other matters such as medication management, occupational health and safety, building or food standards, continue to apply to residential aged care homes in that state or territory. Apart from such legislation addressing specific areas, however, the approach of the states and territories in recent years has been not to implement specific regulatory requirements for residential aged care homes, but to leave such specific regulation to the Commonwealth alone.

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84 And amended in December 2000.
85 Section 2.23 of the Accreditation Grant Principles 1999
86 Section 2.22 of the Accreditation Grant Principles 1999
87 Sections 2.38 and 7.1 of the Accreditation Grant Principles 1999
An example of one area that continues to be the subject of differential regulation by the states is professional nurse staffing levels.

The Act imposes a general obligation on approved residential aged care homes to ‘maintain an adequate number of appropriately skilled staff to ensure that the care needs of residents are met’. The Quality of Care Principles further specify that:

- Initial and ongoing assessment, planning and management of care for residents is carried out by a registered nurse;
- Nursing services are carried out by a registered nurse or other professional appropriate to the service; and
- Medications are administered subject to the requirements of State and Territory law.

In New South Wales, the Nursing Homes Act 1988 (NSW) which was recently repealed, required all nursing homes to obtain a State license to operate. The New South Wales Act did not apply to hostels. Nursing homes in New South Wales therefore were regulated directly by both State and Commonwealth law. This is in contrast to other States and Territories. For example, in Victoria the Health Services Act 1988 provides for minimum standards of care and the mandatory registration of certain supported residential services but does not apply to a service in respect of which a residential care subsidy or a flexible care subsidy is payable under the Aged Care Act.

Under the Nursing Homes Act 1988 (NSW) all licensed residential aged care homes were required to employ a chief nurse to be responsible for the overall care of the residents. Licensed nursing homes were also required to ensure that there was at least one registered nurse on duty at all times in the service. Following the repeal of the Nursing Homes Act, the New South Wales Parliament amended the Public Health Act to carry over the staffing requirements from the Nursing Homes Act.

The interaction between State and Commonwealth legislation is evident in Inspector Farrell v The Salvation Army (New South Wales) Property Trust (‘Re [2000] AATA 1152.’). A patient in a residential aged care service suffered first and second degree burns as a result of a hot shower. The patient died and a Coroner’s inquest determined that the cause of the incident was a faulty mixing valve. Proceedings against the provider for a breach of the Occupational Health and Safety Act 1983 were successful.

The practical impact of state and territory regulation on the accreditation of residential aged care homes and the quality of care provided to residents will be assessed during the course of this evaluation.

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88 Section 54-1(b) of the Aged Care Act 1997
89 3.8, Schedule 1.
90 3.8, Schedule 1.
91 3.10, Schedule 1.
9.6 The importance of effective regulatory design

An important aspect of the project will be consideration of whether the accreditation requirement is structured optimally to foster its espoused objectives of assurance and promotion of quality.

Central to the concept of ‘responsive regulation’ is the notion that effective regulation is dependent on achieving the optimal balance between deterrence and punishment. According to this model, compliance is best achieved through the use of an ‘enforcement pyramid’ consisting of a range of increasingly onerous actions by the regulator to enforce compliance. This ‘enforcement pyramid’ is an important concept in an environment where the community may react negatively to any enforcement measure that results in a valued service being unavailable to them. Catastrophic sanctions should only be contemplated as strategies of last resort, in circumstances where a service is valued and where replacement services are not available readily (Regulation Institutions Network 2004, p. 26).

Braithwaite and colleagues (1990) noted that there has been a shift in regulation from command and control to market-based incentives but argued, however, that in the domain of business regulation, regulatory rewards are less effective than punishment. He discussed the temptation of those who are regulated to implement inappropriate strategies simply to subvert regulatory incentives. By way of example, he discussed the Illinois Quality Incentives Program that was in place in the 1980s in which there were rewards for certain outcomes (e.g. the number of residents participating in activities). Braithwaite and colleagues (1990) found that sleeping residents were being wheeled out to activities to boost numbers to gain the rewards:

‘There is just one regulator to corrupt, capture or outwit. Hence the competitor mentality dominates the fixer mentality in the market place because there is more than one player to fix.’

Braithwaite suggested that approaches such as education, persuasion and restorative justice are normally better in the first instance as a more responsive means of regulating businesses. A form of reward that seems to have positive effects on compliance is informal praise. Makkai and Braithwaite in ‘Praise, Pride and Corporate Compliance’ (1993) found that when nursing homes were monitored by inspection teams that used an abundance of praise, subsequent compliance with quality of care standards improved. Braithwaite concluded that informal praise is compatible with co-operative problem solving at the base of a regulatory pyramid.

In relation to the Australian residential aged care sector, Braithwaite (2001, pp. 443–6) suggested that recent lessons from Australian regulation of aged care indicate that regulation is effective when:

- Outcome standards are few enough to be regulated conversationally;
- Standards empower residents;
- Records are audited locally;
• There are occasional inspections without notice;
• A graduated hierarchy of sanctions exists to deter negligent care without punishing residents;
• Praise is offered thus allowing best practice to be disseminated by acknowledging innovations in the provision of quality care;
• There is transparency, with reports being made available and discussed with committees of residents and their relatives; and
• Continuous improvement is used as a measure of outcome.

While the nature of the regulatory model itself is fundamental to the effective delivery of intended outcomes, a number of other factors need to be considered. Perceptions of the procedures and processes that underpin regulatory requirements may impact on compliance and therefore the extent to which desirable outcomes are achieved. Trust has been found to play an important role in influencing compliance with decisions and regulations. Braithwaite and Makkai (1994) found that where accreditation assessors were seen as both trustworthy and trusting, the quality of care in Australian residential aged care homes improved following the assessment.

Consistent with the view that perceptions of regulatory authorities and procedures can influence compliance, a number of international studies have found that processes that are perceived as procedurally fair can improve compliance and acceptance (Tyler 2001) of laws. This can extend to a willingness to accept the decisions of authorities and even nurture compliance (Murphy 2004).

Tyler (2001) has postulated that people comply not because they fear a sanction, which is frequently the basis of deterrence models of compliance, but rather because they are motivated by two key antecedents of compliance: legitimacy and morality. Legitimacy refers to the belief that an authority is entitled to compliance, while morality refers to the consistency between the law and the individual’s beliefs about right and wrong. According to this view, people are more likely to comply with procedures when they perceive the regulatory authority as fair and trustworthy. Even among groups where the policy could result in undesirable consequences or sanctions, Tyler (2001) found widespread support of procedures where they were seen as being developed and applied fairly.

Inclusiveness was also found to be an important factor in compliance and acceptability. Tyler (2001) found acceptance of procedures among culturally diverse groups and subgroups, where the groups felt that they had been represented by the authority responsible for developing and administering procedures.
10. Evaluating the Impact of Accreditation upon Quality of Care and Quality of Life

10.1 Recent reviews of aged care reforms

Since the implementation of the Act, there have been several reviews of the effectiveness of the reforms in achieving high quality care outcomes for the aged and of the management of accreditation by the Agency (Gray 2001b; Hogan, W P 2004; The Auditor-General 2002; Working Group of the National Aged Care Forum 2002). During the course of these reviews, some comments and concerns of industry and consumers about the regulatory framework have emerged. Some of these concerns are outlined below and will be addressed during the course of this project.

The accreditation process and the management of the accreditation process by the Agency have been refined since the inception of the Act. Areas for improvement of accreditation were identified by the Working Group of the National Aged Care Forum (Working Group of the National Aged Care Forum 2002, p. 2). The Agency is implementing these and the recommendations made by the ANAO in 2003.92

Professor Len Gray’s Two Year Review of Aged Care Reforms (Gray 2001b) sought to determine, among other matters, the extent to which quality in residential care had been affected by the reforms under the Act. He found there was general industry endorsement of the philosophical basis of the quality assurance system and clear improvements to processes of care, although it was premature to comment on the impact of the reforms on quality of care.

The 2004 Review of Pricing Arrangements in Residential Aged Care (the Hogan Review) also found that there is broad industry support for accreditation and a general acknowledgement that it has substantially improved standards of care and accommodation across the industry. However, a number of concerns about regulation have been identified by industry:

- Some providers perceived the regulatory requirements as limiting efficiency, innovation and flexibility to deliver an appropriate range of services;
- The associated sanctions were regarded by a few providers as disproportionate, at least where there is a lack of alternative accommodation should a facility be forced to close;
- The accreditation process was perceived by some to be adversarial and a significant resource cost to providers;
- The Accreditation Standards place insufficient emphasis on the needs of people with diverse languages and backgrounds, or the care of people with dementia; and
- The apparent overlap of complaints schemes results at times in providers being required to respond to the same complaint several times with several agencies, federal and state (Hogan 2004, pp. 239–40).

92 Those recommendations are outlined above.
The Hogan Review generally endorsed the Quality of Care Principles in encouraging flexibility so that services can adapt to individual needs and choices (Hogan 2004). It noted, however, the difficulty for consumers to compare the performance of services. It suggested that the Agency needed better strategies for supporting informed consumer choice and consumer input into accreditation and found that information provided by the Agency does not act as an incentive for providers to become more competitive in providing quality services. The development of a ‘star rating’ system to provide a measure of quality that was simple and accessible by consumers was recommended. The basis of such a system would be the relative performance of service providers against the Accreditation Standards.

The Hogan Review suggested that government will continue to play an important monitoring role in the aged care sector’s quality assurance and consumer protection while the sector matures, but ultimate responsibility for quality of care must be borne by aged care providers (Productivity Commission 2003).

Some commentators argue that consumer empowerment under the Act may not produce the desired results in the care of older people and that the current regulation of residential aged care has effectively transferred considerable responsibility for the enforcement of consumer rights away from government (and the aged care industry) to consumers themselves (McCullough 2002, p. 57). McCullough (2002) suggests that this has led to a culture of non-compliance among some providers and that there is room for a much more interventionist approach from Government in enforcing more actively the obligations of approved providers and consumer rights under the Act.

### 10.2 Methodological challenges in identifying the impact of accreditation upon quality of care and quality of life in residential aged care

Determining the impact of accreditation will be a challenging exercise because:

- Achievement of specific desirable outcomes identified as regulatory objectives is unlikely to be influenced solely by the accreditation requirements; and
- There are many factors that are likely to influence quality of life of residents of aged care homes that are independent of the quality of care provided to them.

The accreditation requirement established by the Act is the focus of this project. Clearly, however, there are other significant features of the regulatory environment and the client population that may have a significant impact on the quality of care and/or the quality of life of residents of aged care homes. These include, for example:

- The direct legislative requirements of approved providers, that are independent of the accreditation process;
- Regulatory requirements and financial incentives for the provision of suitable facilities and amenity for residents of aged care homes;
• The availability and effectiveness of responses to concerns about quality of care and quality of life. These concerns may arise as a consequence of the accreditation process or through other formal or informal mechanisms;
• The effectiveness of the Aged Care Complaints Resolution Scheme; and
• The specific characteristics of the client population that may impact on their quality of life in any setting, independent of the quality of care provided to them. These factors are diverse and may include, for example, the presence of debilitating and untreatable symptoms of physical and/or mental illness, the degree of general infirmity experienced by the individual and the presence or absence of effective social networks and family support. Many aged care residents have underlying conditions that make them extremely vulnerable to experiencing a poorer quality of life. Even exceptional quality of care may fail to overcome the influence of those factors (e.g. physical ill health, depression or physical frailty).

Other factors which reflect characteristics of human service delivery may also influence the intended outcomes of regulatory reform (e.g. a widely recognised dimension of the ‘quality’ of a service is its acceptability to the recipient of the service). Consumer and client needs and expectations may vary considerably and a standard of service which is very acceptable to a client in one setting or at one time may be quite unacceptable to another client who has different needs or receives the service in a different setting or at a different time. In such cases, the client’s circumstances may have a significant impact on the acceptability (and therefore the quality) of the service.

Identifying the impacts of factors other than accreditation and separating them from those impacts that are attributable to accreditation will be a significant challenge for this project.

In addition, the absence of any baseline data about the quality of care and quality of life of residents of aged care homes prior to the introduction of the accreditation system means that the project will need to rely on a range of objective and subjective information to reach a meaningful conclusion about the impact of accreditation per se.

For this reason, the project has adopted a multi-dimensional methodology, focusing on structural and process features of the accreditation system and their consistency with known good practice, as well as outcomes where reliable data are available.

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93 See, for example, the Quality Framework defined by the Victorian Quality Council, which defines the dimensions of care as safety, acceptability, appropriateness, effectiveness, efficiency and accessibility.
**ATTACHMENT 1:**
Australian Residential Aged Care Accreditation Standards

Standard 1: Management systems, staffing and organisational development

Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

<table>
<thead>
<tr>
<th>Matter Indicator</th>
<th>Expected Outcome</th>
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<tbody>
<tr>
<td>1.1 Continuous improvement</td>
<td>The organisation actively pursues continuous improvement.</td>
</tr>
<tr>
<td>1.2 Regulatory compliance</td>
<td>The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.</td>
</tr>
<tr>
<td>1.3 Education and staff development</td>
<td>Management and staff have appropriate knowledge and skills to perform their roles effectively.</td>
</tr>
<tr>
<td>1.4 Comments and complaints</td>
<td>Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.</td>
</tr>
<tr>
<td>1.5 Planning and leadership</td>
<td>The organisation has documented the residential care service’s vision, values, philosophy, objectives and commitment to quality throughout the service.</td>
</tr>
<tr>
<td>1.6 Human resource management</td>
<td>There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.</td>
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<tr>
<td>1.7 Inventory and equipment</td>
<td>Stocks of appropriate goods and equipment for quality service delivery are available.</td>
</tr>
<tr>
<td>1.8 Information systems</td>
<td>Effective information management systems are in place.</td>
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<tr>
<td>1.9 External services</td>
<td>All externally sourced services are provided in a way that meets the residential care service’s needs and service quality goals.</td>
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</tbody>
</table>

94 (The Aged Care Standards and Accreditation Agency 2004a)
**Standard 2:**
**Health and personal care**

Principle: Residents’ physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team.

<table>
<thead>
<tr>
<th>Matter Indicator</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Continuous improvement</td>
<td>The organisation actively pursues continuous improvement.</td>
</tr>
<tr>
<td>2.2 Regulatory compliance</td>
<td>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.</td>
</tr>
<tr>
<td>2.3 Education and staff development</td>
<td>Management and staff have appropriate knowledge and skills to perform their roles effectively.</td>
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<tr>
<td>2.4 Clinical care</td>
<td>Residents receive appropriate clinical care.</td>
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<td>2.5 Specialised nursing care needs</td>
<td>Residents’ specialised nursing care needs are identified and met by appropriately qualified nursing staff.</td>
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<tr>
<td>2.6 Other health and related services</td>
<td>Residents are referred to appropriate health specialists in accordance with the residents’ needs and preferences.</td>
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<tr>
<td>2.7 Medication management</td>
<td>Residents’ medication is managed safely and correctly.</td>
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<tr>
<td>2.8 Pain management</td>
<td>All residents are as free as possible from pain.</td>
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<tr>
<td>2.9 Palliative care</td>
<td>The comfort and dignity of terminally ill residents is maintained.</td>
</tr>
<tr>
<td>2.10 Nutrition and hydration</td>
<td>Residents receive adequate nourishment and hydration.</td>
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<tr>
<td>2.11 Skin care</td>
<td>residents’ skin integrity is consistent with their general health.</td>
</tr>
<tr>
<td>2.12 Continence management</td>
<td>residents’ continence is managed effectively.</td>
</tr>
<tr>
<td>2.13 Behavioural management</td>
<td>The needs of residents with challenging behaviours are managed effectively.</td>
</tr>
<tr>
<td>2.14 Mobility, dexterity and rehabilitation</td>
<td>Optimum levels of mobility and dexterity are achieved for all residents.</td>
</tr>
<tr>
<td>2.15 Oral and dental care</td>
<td>residents’ oral and dental health is maintained.</td>
</tr>
<tr>
<td>2.16 Sensory loss</td>
<td>residents’ sensory losses are identified and managed effectively.</td>
</tr>
<tr>
<td>2.17 Sleep</td>
<td>residents are able to achieve natural sleep patterns.</td>
</tr>
</tbody>
</table>
### Standard 3: Resident lifestyle

**Principle:** Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

<table>
<thead>
<tr>
<th>Matter Indicator</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong> Continuous improvement</td>
<td>The organisation actively pursues continuous improvement.</td>
</tr>
<tr>
<td><strong>3.2</strong> Regulatory compliance</td>
<td>The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about resident lifestyle.</td>
</tr>
<tr>
<td><strong>3.3</strong> Education and staff development</td>
<td>Management and staff have appropriate knowledge and skills to perform their roles effectively.</td>
</tr>
<tr>
<td><strong>3.4</strong> Emotional support</td>
<td>Each resident receives support in adjusting to life in the new environment and on an ongoing basis.</td>
</tr>
<tr>
<td><strong>3.5</strong> Independence</td>
<td>Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.</td>
</tr>
<tr>
<td><strong>3.6</strong> Privacy and dignity</td>
<td>Each resident's right to privacy, dignity and confidentiality is recognised and respected.</td>
</tr>
<tr>
<td><strong>3.7</strong> Leisure interests and activities</td>
<td>Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.</td>
</tr>
<tr>
<td><strong>3.8</strong> Cultural and spiritual life</td>
<td>Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.</td>
</tr>
<tr>
<td><strong>3.9</strong> Choice and decision-making</td>
<td>Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.</td>
</tr>
<tr>
<td><strong>3.10</strong> Resident security of tenure and responsibilities</td>
<td>Residents have secure tenure within the residential care service, and understand their rights and responsibilities.</td>
</tr>
</tbody>
</table>
**Standard 4:**  
**Physical environment and safe systems**  
Principle: Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

<table>
<thead>
<tr>
<th>Matter Indicator</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Continuous improvement</td>
<td>The organisation actively pursues continuous improvement.</td>
</tr>
<tr>
<td>4.2 Regulatory compliance</td>
<td>The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.</td>
</tr>
<tr>
<td>4.3 Education and staff development</td>
<td>Management and staff have appropriate knowledge and skills to perform their roles effectively.</td>
</tr>
<tr>
<td>4.4 Living environment</td>
<td>Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents’ care needs.</td>
</tr>
<tr>
<td>4.5 Occupational health and safety</td>
<td>Management is actively working to provide a safe working environment that meets regulatory requirements.</td>
</tr>
<tr>
<td>4.6 Fire, security and other emergencies</td>
<td>Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.</td>
</tr>
<tr>
<td>4.7 Infection control</td>
<td>An effective infection control program exists.</td>
</tr>
<tr>
<td>4.8 Catering, cleaning and laundry services</td>
<td>Hospitality services are provided in a way that enhances residents’ quality of life and the staff’s working environment.</td>
</tr>
</tbody>
</table>
Attachment 2: 
Example indicator programs and standards

Centers for Medicare and Medicaid Services (USA) National Nursing Home Quality Measures\textsuperscript{95}

**Measures for chronic care**
- Percent of residents whose need for help with daily activities has increased;
- Percent of residents who have moderate to severe pain;
- Pressure sores – Paired Measures:
  - Percent of high-risk residents who have pressure sores;
  - Percent of low-risk residents who have pressure sores; and
  - Percent of residents who were physically restrained.
- Incontinence and catheters – Paired Measures:
  - Percent of low-risk residents who lose control of their bowels or bladder;
  - Percent of residents who have/had a catheter inserted and left in their bladder;
  - Percent of residents who spent most of their time in bed or in a chair during the assessment period;
  - Percent of residents whose ability to move about in and around their room got worse;
  - Percent of residents with a urinary tract infection;
  - Percent of residents who have become more depressed or anxious; and
  - Percent of residents who lose too much weight.

**Measures for post-acute care**
- Percent of short-stay residents with delirium;
- Percent of short-stay residents who had moderate to severe pain; and
- Percent of short-stay residents with pressure sores.

\textsuperscript{95} (Centers for Medicare & Medicaid Services 2004)
Provider initiative project clinical indicators

- Incidence of new fractures;
- Prevalence of falls;
- Prevalence of behavioural symptoms affecting others;
- Prevalence of symptoms of depression;
- Prevalence of symptoms of depression with antidepressant therapy;
- Use of 9 or more different medications;
- Incidence of cognitive impairment;
- Prevalence of bladder or bowel incontinence;
- Prevalence of bladder or bowel incontinence without toileting plan;
- Prevalence of indwelling catheter;
- Prevalence of fecal impaction;
- Prevalence of urinary tract infections;
- Prevalence of weight loss;
- Prevalence of tube feeding;
- Prevalence of dehydration;
- Prevalence of bed fast residents;
- Incidence of decline in late loss ADLs;
- Incidence of decline in range of movement;
- Prevalence of antipsychotic use in absence of psychotic and related conditions;
- Prevalence of anti anxiety/hypnotic use;
- Prevalence of hypnotic use more than 2 times per week;
- Prevalence of daily restraints;
- Prevalence of little or no activity;
- Prevalence of Stage 1–4 pressure ulcers; and
- Prevalence of pain.

96 (Center for Health Systems Research and Analysis 2005)
ACOVE Indicators\textsuperscript{97}

Indicators according to condition:
- Continuity of care;
- Dementia;
- Depression;
- Diabetes mellitus;
- End-of-life care;
- Falls and mobility disorders;
- Hearing impairment;
- Heart failure;
- Hospital care;
- Hypertension;
- Ischaemic heart disease;
- Malnutrition;
- Medication management;
- Osteoarthritis;
- Osteoporosis;
- Pain management;
- Pneumonia and influenza;
- Pressure ulcers;
- Screening and prevention;
- Stroke and atrial fibrillation;
- Urinary incontinence; and
- Vision impairment.

Indicators according to domain of care:
- Screening;
- Prevention;
- Diagnosis;
- Treatment;
- Follow-up; and
- Continuity.

\textsuperscript{97} (Wenger & Shekelle 2001)
Indicators according to medical intervention:

- Assistive device;
- Counselling;
- Diet;
- Physical examination;
- Information continuity;
- History;
- Laboratory test;
- Medication;
- Nursing procedure;
- Referral;
- Surgery;
- Complex testing or procedure;
- Visit to physician; and
- Exercise.

Victorian public sector residential aged care quality indicators


This project recommended the following six indicators be implemented in a pilot phase:

- Incidence of stage 1–4 pressure ulcers;
- Incidence of new fractures as a proportion of falls;
- Incidence of daily physical restraints;
- Incidence of residents using nine or more different medications;
- Incidence of weight change (i.e. a significant increase or decrease from the norm); and
- Prevalence of symptoms of depression.

The following four indicators were suggested as requiring further refinement before implementation:

- Incidence of behavioural symptoms;
- Resident experiences of care;
- Health related quality of life of residents; and
- Staff experiences of care.
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