CPSA COMBINED PENSIONERS & SUPERANNUANTS ASSOCIATION

Submission to the Australian Aged Care Quality Agency on the Draft Guidance Aged Care Quality Standards

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Combined Pensioners & Superannuants Association of NSW Inc (CPSA)

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CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 100 branches and affiliated organisations with a combined membership of over 25,000 people living throughout NSW. CPSA's aim is to improve the standard of living and well-being of its members and constituents. CPSA receives funding support from the NSW Government Departments of Family & Community Services and Health and the Australian Government Department of Social Service.

CPSA welcomes the opportunity to provide feedback on the draft guidance material for the new aged care quality standards. CPSA represents pensioners of all ages and low income retirees. As such, CPSA is interested in ensuring that the aged care system is able to deliver high quality, person centred care to all those who need it, regardless of their geographical location and their capacity to pay.

In an increasingly market-based aged care system, the accreditation standards and how they are interpreted and implemented is critical in ensuring that all residents have access to safe care that meets their needs. This submission focuses on how the guidance material can be improved to ensure that the realities of care experiences are properly being captured through the auditing process, particularly in residential aged care.

13. How clear is the guidance material overall?

14. Are there any gaps in the guidance material?

CPSA acknowledges that the strategies employed by aged care providers to achieve the quality standards will vary in type, complexity, scope and scale. Aged care organisations provide different types of services, they cater to consumers with different needs and their size, resources and locations vary. However, the purpose of a single quality framework is to ensure providers understand the expectations of aged care services and drive improvements in the quality of care. This is reliant on the capacity of the assessment process to accurately capture the care reality of consumers, which in turn is reliant on providers having appropriate evidence and quality assessors making sound judgements about that evidence.

The existing system for regulating the quality of aged care services has a limited capacity to detect systemic failures in care. In 2016-17, the Australian Aged Care Quality Agency conducted 3,964 visits to Residential Aged Care services and only 79 services were assessed as having 'Not Met' expected outcomes[1]. This suggests that 98 per cent of nursing homes are delivering high quality care. However, CPSA regularly receives complaints about nursing homes that once aggregated point to systemic deficiencies in the quality of care.

[1] Australian Aged Care Quality Agency (2017) 'Annual Report' accessed at: http://www.aacqa.gov.au/about-us/annual-reports/AACQAAnnualReport2017PRINTED.pdf

There is a myriad of evidence suggesting that the accreditation process is not accurately picking up on poor quality care. A discussion paper released by the Department of Health estimated that the prevalence of pressure sores among aged care residents was between 26% and 42%[2]. A recent study estimated that there has been a 400% increase in premature deaths among nursing home residents since 2000[3]. Additionally, the South Australian Oakden facility which was shut down early 2017 following revelations of long term/widespread staffing deficiencies and mistreatment of residents was fully accredited and assessed as meeting all 44 outcomes just a year earlier. The failure of accreditation to identify non-compliance is due in large part to a disconnect between the accreditation process and the actual care outcomes experienced by consumers. This disconnect stems from a lack of transparency and a process oriented assessment methodology.

CPSA welcomes the consumer centric focus of the new standards and believes it is essential for the consumers' voice to be a part of any quality assessment process. It is also essential that the consumer experience is combined with reliable evidence of measurable care outcomes. CPSA is concerned that the guidance material lacks sufficient detail about some of the standards and is in parts too vague about what is considered acceptable evidence to prove compliance. In this way the material is insufficient to ensure that residents receive safe care that aligns with clinical best practice.

Objectivity and measurability

CPSA acknowledges that aged care providers require a degree of flexibility in the types of evidence they can use to demonstrate compliance. However, the standards must provide clear and concise information about the specific types of acceptable evidence and ensure that the standard is not too open to interpretation by the quality assessors or providers. Currently, in some areas the guidance material on the draft standards is very broad and does not provide enough detail about what evidence is required to enable them to be achievable.

In many cases, the organisation statements and requirements are too vague and cannot be objectively measured. In the absence of objectively measurable indicators or more specific standards, the system is overly reliant on the judgement of individual quality

[2] Department of Health (2017) 'Single Aged Care Quality Framework: Draft Aged Care Quality Standards Consultation Paper' pp.22 Available: https://consultations.health.gov.au/aged-care-access-and-quality-
[3] Ibrahim, J. et al (2017) 'Premature deaths of nursing home residents: an epidemiological analysis' Medical Journal of Australia, 206(10), pp1-5

assessors. Quality assessors are diverse in their skills and experiences with some coming from clinical backgrounds but others from administration and business backgrounds, therefore some may be ill-equipped to make uniform judgements on some of the standards. For example, an assessor with a business background may have a different interpretation than an assessor with a clinical background on Standard 7, which refers to the organisation having a sufficient skilled and qualified workforce to provide safe care.

The Australian Aged Care Quality Agency also does not have a specific methodology that assessors can use to determine sufficiency of staffing levels. Unless there is a clear model linking consumers' needs to staffing levels and skill mixes, then the idea of 'sufficient' is not measurable or evidence based and relies too much on subjective judgement. A set of standards which leave too much room from subjective judgements will not produce standardised high quality care conditions. Accordingly, it is not clear that standards without measurable outcomes will have any meaningful impact on the aged care provider or drive changes required to promote a culture of high quality care.

There are a number of standards which can be measured by asking consumers directly. For example, Standard 1 requires that consumers are treated with dignity and respect, this standard is clearly about whether an individual feels a certain way or not. In this case the methodology for assessment is relatively straightforward. However, there are a number of standards which are not as easily measurable, where wording is ambiguous and open to interpretation.

Examples include:

- **Standard 2, Requirement 2.2**: 'Assessment and planning informs the delivery of safe and effective care services.' There are many different types of assessment and planning and many different ways it can inform care services. In this case it is unclear which assessments and what planning is relevant, it is also unclear to what degree assessment and planning has to inform the delivery of care to comply with the standard. Additionally, the guidance material also doesn't clarify over what period of time assessment and planning needs to inform care services for this standard to be met. Does the quality assessor need to witness evidence that this is happening daily, weekly or just sporadically?

- **Standard 3, Requirement 3.5:** 'Deterioration or change of a consumer's function, capacity or condition is recognised and responded to in a timely manner.' The term 'timely manner' is ambiguous and not measurable. It is also possible for a provider to have trained staff to recognise and respond to deterioration and to have processes and documentation in place but fail to respond to deterioration in a 'timely manner'. For example, if there are not enough to staff on a shift to monitor all residents then it is not necessarily possible for those staff to respond, even if they are trained and know the procedure. In this situation a provider may have plenty of evidence that they comply with the standard but in reality may not be ensuring the conditions for this requirement to be fulfilled.

- **Standard 6, Requirement 6.1:** 'Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.' Complaints handling is a very delicate process for consumers, their family, friends and staff, particularly in residential aged care. Current internal and external complaints systems do not adequately address inherent power imbalances between providers and those making a complaint. Many consumers are unlikely to feel free to make a complaint as they are dependent on their providers to look after them and are fearful of retribution. Consumers may be visibly encouraged to make complaints, there may be policies and documents in place to enable this and consumers may even report that they can provide feedback, however, these forms of evidence may not be adequate to uncover problems with complaint handling in aged care. For this kind of care standard it might be appropriate to draw upon more evidence or different types of evidence, which should be indicated in the guidance material.

- **Standard 7, Requirement 7.1:** 'The workforce is planned and the number and mix of staff deployed enables the delivery and management of safe and quality care and services.' This requirement relies on using rosters and other schedules to identify whether staffing levels and mixes are 'sufficient' to provide safe and quality care. But how is 'safe and quality care' measured? If any consumer ends up in hospital due to a fall, pressure sores or other indicators of neglect is an aged care provider delivering safe and quality care? Without a measurable definition of safe and quality care, an assessor has to rely on their own judgement of whether an aged care service is adequately staffed.

The intent of many quality standards in the guidance material is clear, however, the use of ambiguous words which are not measurable and are open to interpretation must be replaced by measurable statements and definitions that can be assessed by audit. There is a need to include a greater layer of specificity in order to ensure that the assessment of compliance is consistent and to minimise the influence individual assessors or providers have over the assessment process.

Process vs. Outcome

The current assessment arrangements are overly process driven and have come to be viewed as a tick the box exercise for aged care providers and quality assessors alike. A quality system that assesses processes and systems is not actually assessing quality at all, as these processes and systems are not necessarily tied to the care outcomes which consumers' experience. Identical processes and systems can lead to vastly differing outcomes for two different consumers based on their own needs and other variables. For example, to look at menus, food preparation and ordering processes is not an indicator of consumer nutrition, because if a consumer needs assistance with eating and isn't receiving that support then they are not actually accessing the nutritional benefits the process alludes to.

The new draft standards have improved on the previous standards, however, there are still many examples where the standards may be over-reliant on documentation and procedure, rather than outcome based measurements, for example, Standard 3 personal care and clinical care. The guidance material doesn't provide much detail about the types of evidence appropriate to demonstrate compliance. In this case providers may overemphasise systems and procedural evidence at the expense of outcomes and consumers' experiences.

CPSA strongly asserts that it is incumbent upon the Australian Aged Care Quality Agency to ensure during audits that the analysis of care outcomes relating to the delivery of care is performed by expert clinicians and incorporates clinical indicators. For example, all coronial cases that are relevant to consumers receiving aged care services should be reviewed by experts and included in assessments. It is also important that data on medical incidents and transfers to hospitals are included in all assessments. This will assist with expert person led care and outcome based monitoring.

Lastly, the guidance material is unclear about how much weight a consumer's experience and other outcomes based evidence will be given in context to process based documentation, particularly in the case where they have conflicting messages. It is critical that the guidance material for the new standards communicates a bigger emphasis on outcomes and consumer experiences than processes and procedures. Otherwise the system does not evaluate the actual care and support consumers receive.