Regulating to propel positive change

(Looking under the bonnet of the ACQSC)

Janet Anderson PSM, Commissioner

National Aged Care Provider Conference 2023 – 8 and 9 June

'Working together – our journey through aged care reform and regulation'

Australian Government
Aged Care Quality and Safety Commission

The marvellous Mrs Love, grande dame of Surry Hills

Grit, grace, generosity and good-naturedness have defined this centenarian's greatness

HELEN TRINCA

This week, the world's media celebrated Henry Kissinger as he turned 100, one of a relatively small cohort of humans to make it that far. On Sunday, he will be joined by Marjorie Love, my neighbour. Hers is not a name generally mentioned in the same paragraph as that of one of the world's most controversial statesmen. But in our street Mrs Love is also the stuff of legend, her life as deserving of headlines as that of the former diplomat, political theorist and US secretary of state.

The world Mrs Love – Marge, Mum, Grandmother, Granny – created around family and friends, work and neighbours is small compared with Henry's world.

Born and reared in Sydney's Darlinghurst, she has never lived far from the inner-city 'hood she loves. Forty years ago this month – well before the suburb became something of a hipster's mecca, Marge and her husband John moved into a small terrace in Surry Hills. Shortly after, I moved next door. For the past 20 years since John died, Marge has lived alone and it was only a few weeks ago that she decided it was time for residential care a few streets away.

As a kid, she'd lived just off Oxford Street, a pre-war childhood in which she was able to skip down to the city shops or just play in the open paddocks near her home. She has marvellous stories of a world in which the tram ran up Oxford Street out to Bondi; in which electricity was just taking over from gas; in which she and her sisters sat on their front porch on Saturday afternoons, blonding

Marjorie Love

their hair with Lux soap powder. She was only five or six when her parents separated. Her father, who worked the nightshift as a conductor on the Bondi tram, brought up his brood as a single parent.

Smart as a tack, Marge couldn't wait to leave school and go to work. She loved those teenage jobs in printing and mail order firms and, an efficient and committed worker, was still working well into her 60s.

But Marge's real job was mothering. She has five children, but even when they were young wanted more – indeed, to this day she regrets not having twins. Those five children have provided her with a multitude of grandchildren, great-grandchildren and great-great-grandchildren.

Keeping track of birthdays, knitting endless jumpers and scarfs, dusting the dozens of their framed photographs in her living room; collecting the great-grandchildren after school kept her alert and engaged as she headed for 100.

She has maintained a strong interest in local as well as her own family history and till her eyesight faltered was a keen reader. Unlike Kissinger, she hasn't spent much time worrying about the State of the World, lamenting the collapse of Western civilisation or wondering how she can sort it all out.

She has, however, spent a great deal of time thinking about family and friends, about how to be there for them when they needed support, about how not to bother her kids too much but fend for herself; about staying cheerful and positive even as her body finally began to let her down.

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Grit, grace, generosity and good-naturedness have defined Marge's greatness and they are the qualities we will recall as we help her celebrate her 100th on Sunday.

Getting to 100 in relatively good nick physically and mentally is partly about accidents of geography and genetics. It's also about the access to healthcare that eluded earlier generations – although Marge's preference for chocolates over greens rather defies the experts on that one.

Ultimately, though, it's also about one's stance, one's disposition, one's capacity to practice optimism, one's willingness to look for the best in others, to try to never speak ill of the neighbours, to delight in hearing about any new baby in anyone's extended family.

Marge, like Kissinger and all the other centenarians, has seen extraordinary changes across her lifetime but in so many ways she has held to a few basic beliefs – the value of loving and accepting others, of getting up every day and getting on with it, of holding on and living your life with as much energy as you can muster. As more and more of us live longer and longer, we're likely to have to call on all of the above to get through our later years in a way that makes living worthwhile.

It's an opportunity for an extended, good-quality life denied many who suffer debilitating physical conditions as they age or the particularly cruel blight of Alzheimer's.

During the past couple of years Marge has often said that if she got to 100 – with that telegram from the King, thanks very much – she planned to throw away all her meds and ask her GP to remove her stent on the basis that, well, life is good but enough is enough.

She has not mentioned it so much lately. Perhaps like many of us, the closer she gets to the end of her life the less enamoured she is with the idea of leaving it. Whatever. When she does make her exit, Mrs Marjorie Love will not attract the obituaries that will rain down upon the world when Henry goes. She will not, however, be forgotten.

Postscript: On Friday, Marge's much-loved younger sister, 95-year-old Mrs Betty Best, moved into the room next door in her residential home.

Mrs Marjorie (Marge) Love has just celebrated her 100th birthday.

She has always lived in inner-city Sydney. In the 1980s, she and her husband moved into a small terrace in Surry Hills. She has lived alone since John died 20 years ago.

As a child before WW I, Marge lived just off Oxford St, from where she was able to skip down to the city shops or just play in the open paddocks near her home.

She and her sisters – brought up by their father as a single parent – used to sit on their front porch on Saturday afternoons, blonding their hair with Lux soap powder.

Marge left school to join the workforce as soon as she was allowed to, and loved her first jobs in printing and mail order firms. She was still working well into her 60s.

rs Love,
urry Hills

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But Marge's real job was mothering. She has 5 children, and multitudes of grand-, great-grand, and great-great-grand children. And they put the sparkle in her eyes.

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The aged care sector, 2023

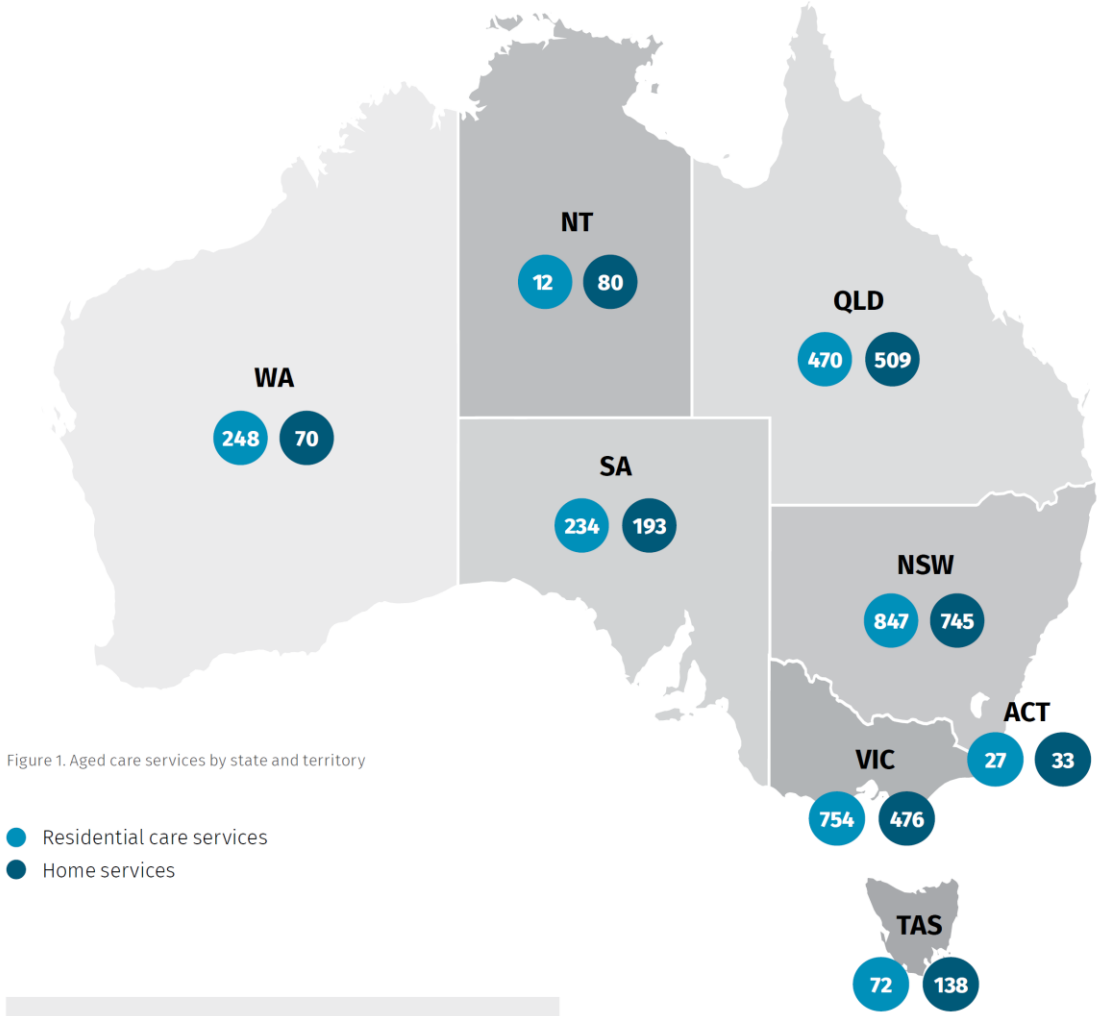

Figure 1. Aged care services by state and territory

Number of providers of residential care	789
Number of residential care services	2,664
Number of aged care residents	**188,877**
Number of home services *(includes HCP, CHSP, and flexi care in the home setting)*	2,244
Number of home care packages (and consumers)	**249,429**
Number of Commonwealth Home Support Programme consumers	**818,228**

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Aged care reforms with regulatory implications

Reform initiative	Commenced/commencing
Serious Incident Response Scheme (SIRS)	1 April 2021 for residential aged care, 1 December 2022 for home services
Financial and prudential monitoring, compliance and intervention framework	1 July 2021 (phase 1), 1 September 2022 (phase 2) and 1 August 2024 (phase 3)
Modified consent provisions for restrictive practices	December 2022
Code of Conduct	1 December 2022
Provider governance obligations	1 December 2022, or some elements from 1 December 2023 (existing providers)
Star ratings	December 2022
New pricing caps for home care packages	1 January 2023
Additional mandatory Quality Indicators	1 April 2023
24/7 registered nurse cover	1 July 2023
Mandatory care minutes	1 October 2023
Annual provider submission on operations	31 October 2023
New Aged Care Act	1 July 2024
Strengthened Aged Care Quality Standards	1 July 2024
New regulatory model	1 July 2024
Support at Home Program	1 July 2025

Why do regulators exist?

- Regulators exist primarily **to control risks to society**; to protect the public interest and safeguard citizens
- The public expects regulators to be effective in tackling risks, harms, problems or threats to people or things that matter to people
- Depending on the nature of the risk, that might mean:
  - eliminating it, or
  - preventing it, or
  - reducing its likelihood / probability or scale, or
  - mitigating its consequences.
- Regulation is a means to an end (a safer society). It is not an end in itself. **Outcomes matter.**

What outcomes are we collectively seeking in aged care?

- a great aged care experience for every older Australian using these services
- a thriving aged care sector that accepts and delivers on the social license that comes with being an aged care provider
- a regulator that has impact and delivers value for older Australians, providers and the wider community

We need to talk about risk

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Risks are inherent in the provision of aged care

- Providing any form of social care comes with risks
- **Risk is present at different levels of the aged care system**
- These risks cannot be eliminated but they must be controlled, managed and mitigated

- **System or sector-wide** (e.g. models of care, distribution of care and availability, workforce supply and competence, funding and financial sustainability)
- **Provider cohorts** (risks associated with different service types [residential care, home care packages, CHSP, transitional care, NATSIFACP] and market segments [service type by size, location, corporate entity])
- **Provider** (e.g. governing body capabilities and accountability, appropriate business and clinical expertise, workforce strategy, suitability of key personnel, fit-for-purpose infrastructure and corporate enablers)
- **Service** (e.g. management capabilities and accountability, operating systems, processes and procedures, workforce supply, competence and oversight, equipment, physical environment)
- **Individual older person** (e.g. person-centred care built around the individual's values, goals and preferences, and protecting and promoting the person's safety, health, wellbeing and quality of life)

How do regulators “control” risks to society?

- **The principal project of regulators is to modify the behaviour of regulated entities** so that their behaviour accords with agreed norms (as set out in, for example, legislated standards and principles):
- Regulators are therefore vitally engaged with **processes of organisational change and responses to change.**
- This understanding significantly expands the regulator’s potential field of play.
- **For the Commission**, it opens up and legitimises activities such as:
  - helping consumers to understand their rights, and providers to understand their legal obligations
  - supporting the sector on the reform journey
  - sharing how we understand risk
  - identifying sector-wide performance challenges and providing insights, practical strategies and tools to help providers respond to those challenges
  - working with key stakeholders (providers and consumers) to build capability across the sector
  - detecting and responding in a proportionate and timely way to non-compliance and possible or actual harm to older Australians; calling out underperformance
  - pointing providers in the direction of “better” performance.

Keeping our eyes on the prize

The Commission's regulatory strategy has to address two pivotal questions:

1. What is the **desired behaviour** by an aged care provider that will deliver the best possible experience of care and outcomes for every older person?

2. What can or should we, as the regulator, do to help **elicit that behaviour** from providers, and for it to be sustained?

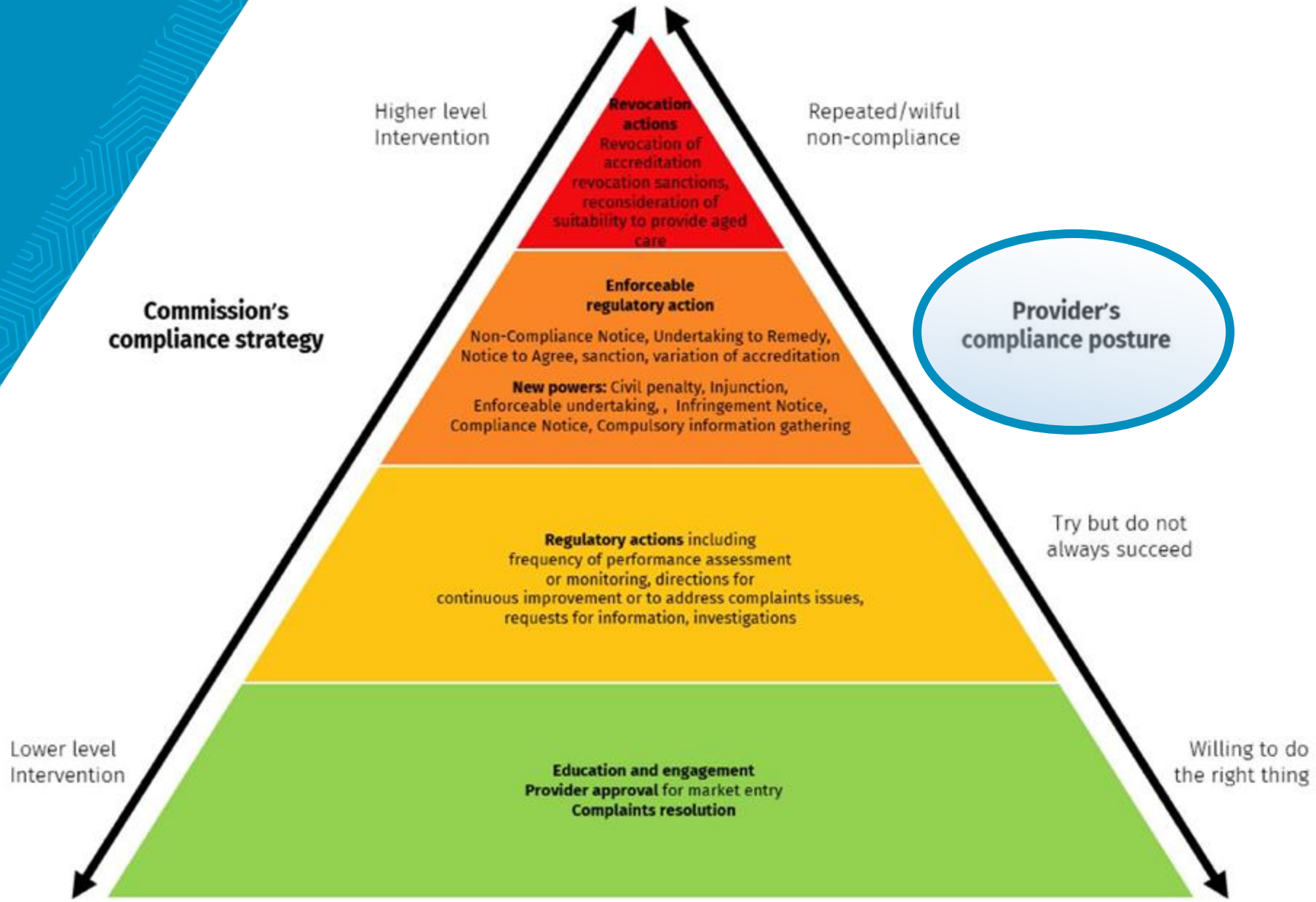
   In other words, how can we help providers to see the **desired behaviour as logical, necessary, feasible and rewarding** for them to pursue, and how can we create the most favourable conditions for them to pursue it (preferably consistently and over the long-term)?

Answering these questions is not something we can do by ourselves.

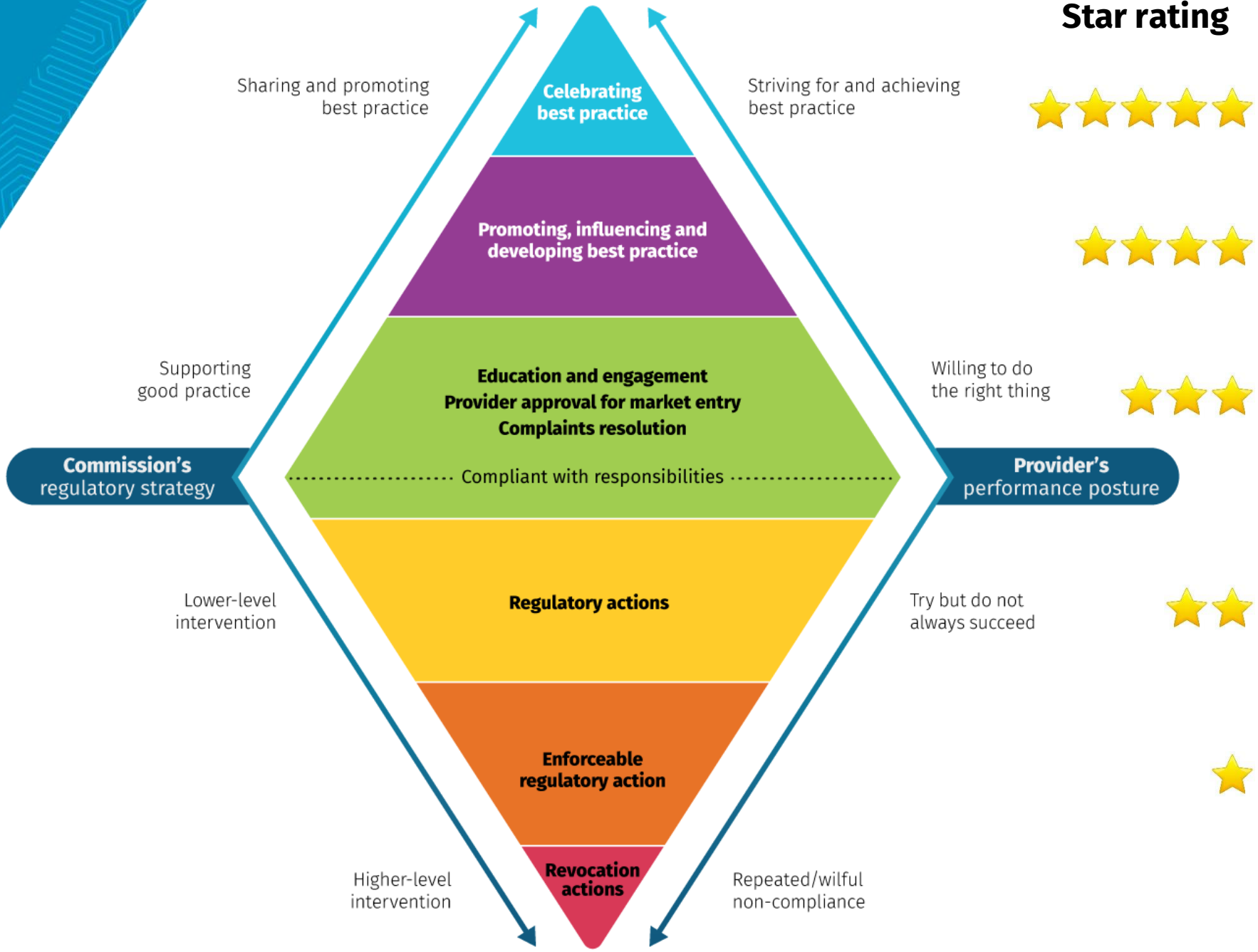
Developing and implementing an effective regulatory strategy requires us to engage in an ongoing way with:

a. ***older people receiving aged care (and their representatives)***
b. ***providers of aged care***

Responsive regulation – Aged care regulatory pyramid



Aged care regulatory diamond



Fundamentals of responsive regulation

- **Prevention is better than cure**. There is a heavy presumption in favour of starting at the centre of the diamond (base of the pyramid) because engagement between the Commission and providers at this level (e.g. communications, guidance, education) is a relatively low-cost and time-efficient strategy for:

    a) maintaining or obtaining compliance, and

    b) building sector capability.

- The responses of a regulated entity to engagement at the centre of the diamond determine if, how far and when the regulator moves down the diamond. In other words, **providers have agency and can exercise choice**.

- The Commission moves down the diamond in response to a failure to elicit reform and remediation from a provider. Movement back up the diamond is prompted when/if these actions are forthcoming.

- The **diamond/pyramid is therefore firm yet forgiving** in its demands for compliance.

- Responsive regulation also **incentivises providers to undertake self-assurance and self-correction** in order to either (proactively) *"get out ahead of"* or (defensively) *"stay out of trouble with"* the regulator.

Five motivational postures of regulated entities

Postures of accommodation

1. **Commitment** – Believes in the regulator's mission and feels duty bound to support its work
2. **Acceptance or acquiescence** – acknowledges the regulator's legitimacy and wants to stay out of trouble but is less enthusiastic about what the regulator does

Postures of defiance

3. **Resistance** – signals dissatisfaction with how the regulator is doing its job; is a plea to the regulator to be fair and respectful
4. **Disengagement** – involves neither attending nor responding to the regulator, but rather, continuing business as usual
5. **Game playing** – takes place in an adversarial space where the objective is winning against the rules; involves searching for loopholes and ways around the regulator, undermining its effectiveness and its legitimacy.

Provider positioning is a dynamic process. Postures of accommodation and defiance ebb and flow over time depending on an entity's experiences, and present for regulators a complex, ever changing set of signals to decipher.

Reflections for the regulator

Acknowledging the various motivational postures that characterise providers at various points in time requires the Commission to **reflect on our own regulatory practice**.

As we pursue our statutory responsibility to hold providers to account for their performance, and to protect consumers from risk of, or actual harm, **we must also ask ourselves**:

- whether we have all the pieces in place to have earned provider postures of **commitment** and **acceptance**;
- if we have the organisational mechanisms/arrangements in place for hearing **resistance** and responding respectfully and constructively to it (e.g. by ensuring procedural fairness); and
- if we have accurately assessed the root causes of **disengagement** and **game playing**.

And now we need to talk some more about risk

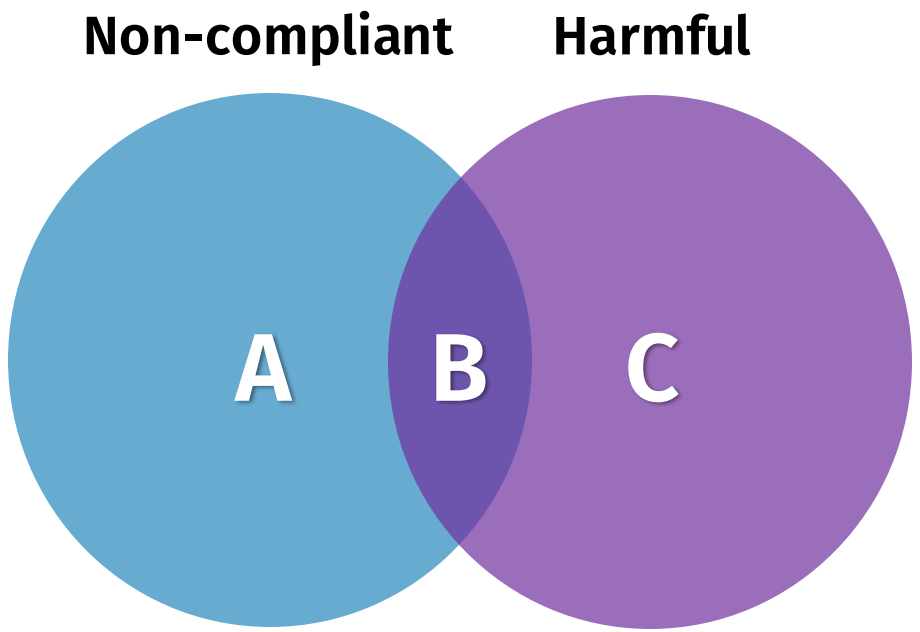
What the Commission focuses on – an integrated view of risk

There are two different but intersecting domains of risk with which regulators have to engage:

1. Risk of non-compliance with legal requirements/obligations
2. Risk of harm to individual older people receiving aged care

These domains are neither mutually exclusive nor entirely overlapping.

Different but intersecting risks



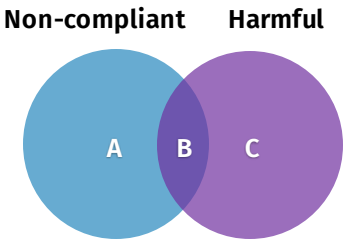
The **left-hand circle** represents organisations/services breaking the law, rules or regulations. Here lies non-compliance with agreed standards.

The **right-hand circle** represents organisations/ services behaving in ways that are risky or harmful, or potentially so, and some (but not all) of those risky behaviours are non-compliant.

Two overlapping sets give us three areas where the regulator might operate: domains A, B and C. The question is: ***"Which of these areas is/are the Commission's business, and in what order of priority?"***

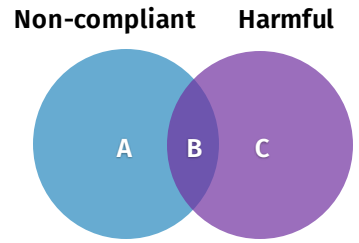
This is not a trivial question, because empirical research has demonstrated that in any sector:

- The circles invariably are not closely aligned
- Domains A and C are substantial



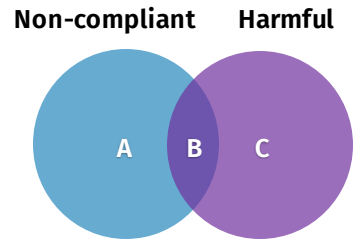
Contacts (complaints and enquiries)

	2021-22	2022-23 (to 31 March)
Complaints		
Received	10,323	6,774
About residential care	6,404	3,791
About home services	3,825	2,896
About flexible care	89	77
Not classified by service type	5	10
Finalised *(finalised complaints may have been received in a different period)*	9,466	7,367
Enquiries		
Received	12,811	8,479
Out of Scope and Other Contacts		
Received	3,485	2,420
Other contacts received (*Other contacts contain reviewed processes, own motion and undetermined case types)*	24	37
Total Contacts		
Received	26,643	17,711
Finalised	25,764	18,371



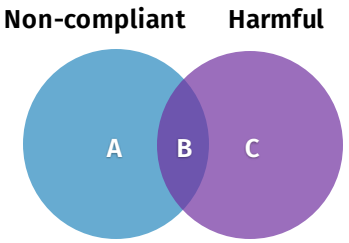
Residential care
- Top five complaint issues received, by number and proportion of total

Issue	2021-22	2022-23 (to 31 March)
Health Care - Medication administration and management	5%	**6%**
Personal Care - Personal and oral hygiene	5%	6%
Personnel - Number/sufficiency	**6%**	5%
Health Care - Falls prevention and post fall management	4%	5%
Consultation and Communication - Representative/family consultation and communication	4%	4%



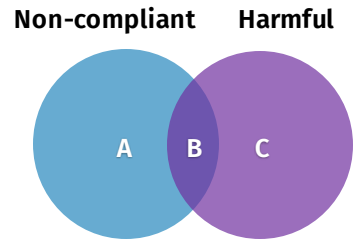
Quality monitoring and assessment activities

Residential	2021-22	2022-23 (to 31 March)
Site visits	**1,732**	**2,454**
Site Audits	710	1,232
Review Audits	5	2
Assessment Contacts	1,017	1,220
Discrete services visited	1,386	2,024
Non-site activities	**6,630**	**1,253**
Assessment Contacts	6,630	1,253
Total regulatory activities	**8,362**	**3,707**



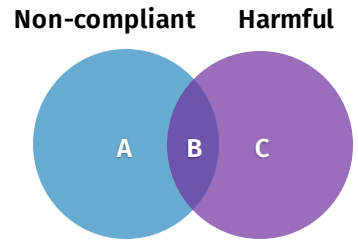
Residential care
- Requirements of the Aged Care Quality Standards most frequently cited in NCNs

Number of Non-Compliance Notices issued - Top 5 Quality Standard Requirements	2021-2022	2022-23 (to 31 March)
3(3)(a): Safe and effective personal and clinical care	119	137
8(3)(c): Effective Governance systems	70	106
3(3)(b): High impact or high prevalence risks managed effectively	112	98
8(3)(d): Risk management systems and practices	91	97
2(3)(a): Assessment and planning informs safe, effective care and services	78	74
7(3)(a): Number and mix of workforce	87	68
2(3)(e): Regular reviews of care and services	79	73



Compliance and enforcement actions

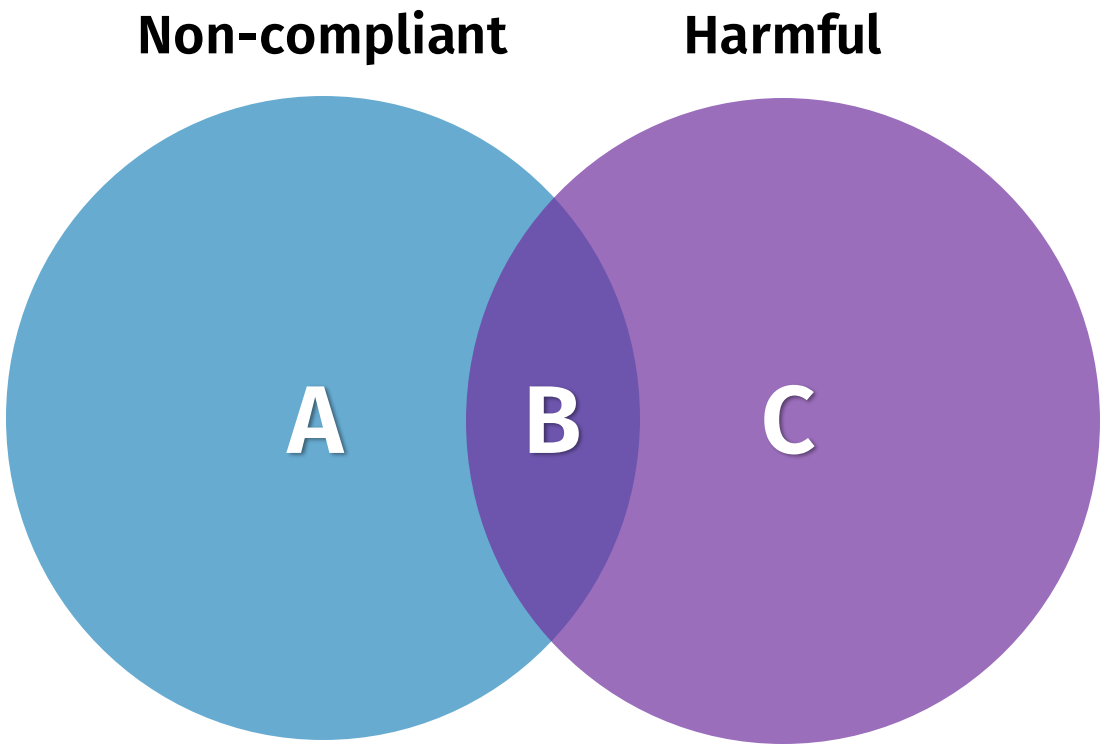
Regulatory activities	2021-22	2022-23 (to 31 March)
TOTAL ISSUED	**584**	**656**
Directions to revise Plan for Continuous Improvement (PCI)	281	308
Compliance Notices	**24**	**31**
Incident management & restrictive practices compliance notice (IMCN/RPCN)	5	3
Incident management compliance notice (IMCN)	19	28
Non-Compliance Notices (NCN)	**198**	**268**
Notices to Agree (NTA)	**56**	**36**
Sanctions (NDIS)	**25**	**13**



Residential SIRS by Incident type

Incident type (Priority 1 and Priority 2 only)	2021-22	2022-23 (to 31 March)
TOTAL	**34,435**	**36,772**
Unreasonable use of force	21,525	22,657
Neglect	4,991	5,995
Psychological or emotional abuse	2,803	3,110
Unlawful sexual contact or inappropriate sexual conduct	1,781	1,805
Unexplained absence from care	1,674	1,279
Unexpected death	693	683
Stealing or financial coercion by a staff member	481	681
Inappropriate use of restrictive practices	487	562

Different but intersecting risks

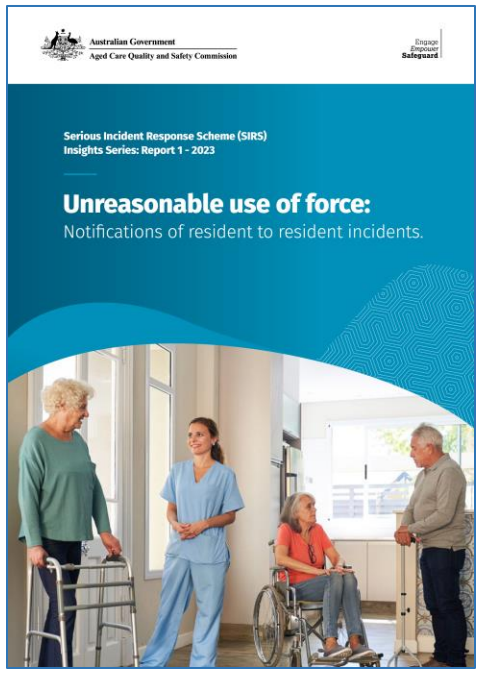


Domain A – focus is on compliance and non-compliance

Domain C – focus is on risks of or actual harms

Domain B – combines important ends with available means

- The **ends** are important because they relate to genuine harms (C)
- The **means** include relevant powers and the resources required to exercise them effectively (A)



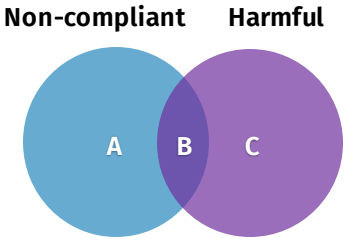
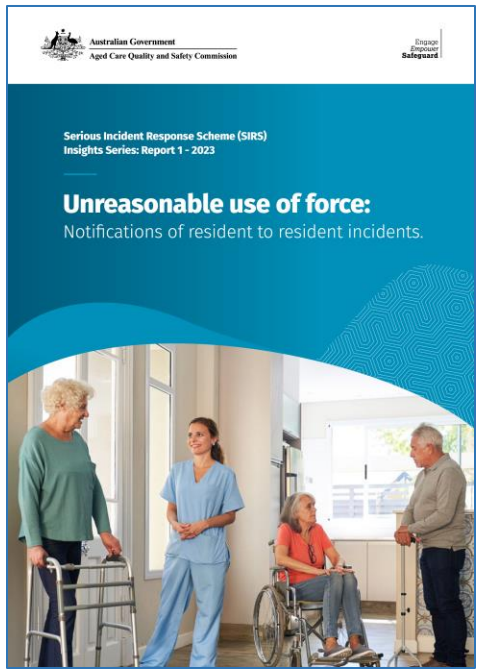


Table 1: Overview of SIRS notifications by incident type for 1 April 2021 to 30 June 2022

	1 Apr–30 Sep'21	1 Oct'21–30 Jun'22			
Incident Type	**Priority 1**	**Priority 1**	**Priority 2**	**Total**	**% of total notifications**
Unreasonable use of force	5,033	6,209	13,195	24,437	62%
Neglect	1,260	2,445	2,082	5,787	15%
Psychological or emotional abuse	424	536	2,092	3,052	8%
Unlawful sexual contact or inappropriate sexual conduct ^	655	1,080	388	2,123	5%
Unexplained absence from care *	734	1,237	85	2,056	5%
Unexpected death *	374	517	12	903	2%
Stealing or financial coercion by a staff member	172	256	161	589	1%
Restrictive practices	75	200	247	522	1%
Total notifications	**8,727**	**12,480**	**18,262**	**39,469**	**100%**



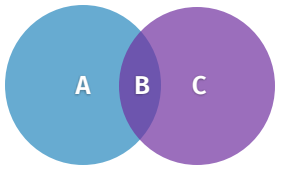
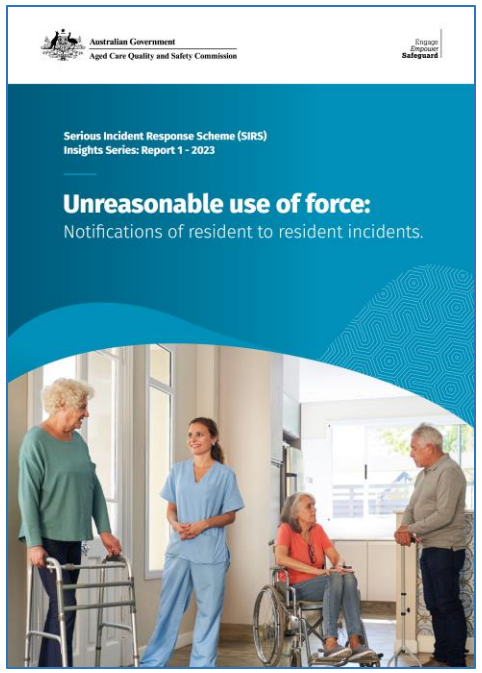


Table 2: Unreasonable use of force - Subject of Allegation Type for 1 April 2021 to 30 June 2022

	Notification	
Subject of Allegation Type*	**Number**	**Percentage**
Another care recipient	20,914	86%
Staff member	2,268	9%
Other	305	1%
Unknown	713	3%
Family/friend of care recipient	130	1%
Blank	107	<1%
Total	**24,437**	**100%**



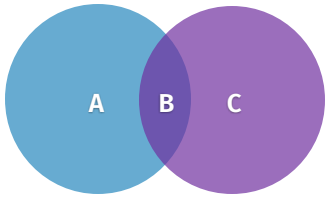
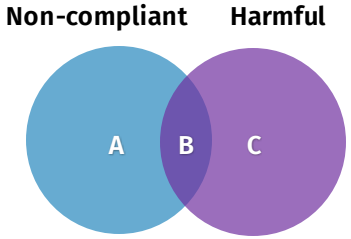


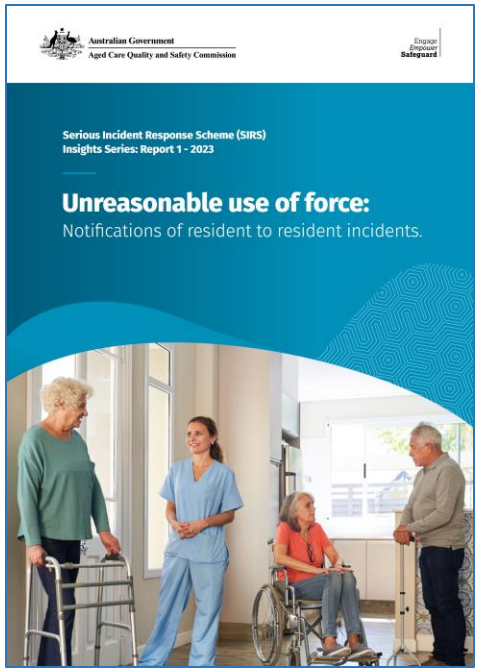
Table 5: SIRS notifications by the reported cognitive impairment level of the subject of allegation, where the subject of allegation was reported to be another consumer, by incident types, for 1 April 2021 to 30 June 2022

	Subject of allegation – Reported Level of cognitive impairment (% of row total)						
Incident Type*	**Severe**	**Moderate**	**Mild**	**None**	**Unknown**	**Blank**	**Total**
Unreasonable use of force	62%	29%	6%	2%	1%	<1%	20,914
Psychological or emotional abuse	37%	37%	16%	9%	1%	<1%	1,861
Unlawful sexual contact or inappropriate sexual conduct	41%	35%	16%	6%	2%	1%	1,542
Total	**59%**	**30%**	**7%**	**3%**	**1%**	**<1%**	**24,317**

Unreasonable use of force: key take-aways

- Resident-to-resident incidents usually have a component of cognitive impairment and behaviour management issues in one or both parties.
- Many incidents are provoked, and this is key to understanding and prevention. The person using force often also needs support, and their needs may have been dismissed or neglected leading up to the incident.
- Psychological harm and distress must be assessed and predicted.
- For residents living with dementia, being unable to recall the incident or articulate their feelings should not be taken to mean there is no impact.
- Many incidents are recurrent, with the same individuals involved. Repeat incidents involving the same residents suggest that the response to the first incident was insufficient.
- Blame and punishment of residents must be avoided. Staff must be helped to understand a resident's behaviour in the context of the setting, the resident's underlying conditions and how they might be feeling.
- Predicting incidents by understanding risks and introducing preventive and proactive behaviour support should be part of a service's incident management process with clear governance protocols.
- Assessment of impact should not be confined to the immediate physical harms. Physical impact can be delayed or hidden and can include, for example, deep tissue injury, internal bleeding and joint injury. Psychological impact always needs to be considered and may not be obvious.
- There are potential intersections between unreasonable use of force and sexual contact issues where detail, intent and perception need careful thought when responding to the incident and selecting the correct incident type for reporting purposes.
- There are potential intersections between unreasonable use of force and neglect, where neglect of a person's needs may be the cause of the force incident. Again, careful thought must be given to how best to respond to the incident and to selecting the correct incident type for reporting purposes.
- If a response to an incident involves consideration of use of restrictive practices, then early attention must be given to behaviour support and fulfilment of all the legislative requirements.
- If a resident poses serious ongoing risks to others, urgent intervention (including escalation to expert advice) should occur.





Questions for boards and governing bodies to ask when investigating an incident

Providers have a responsibility under the *Quality of Care Principles 2014* to manage incidents. This includes assessing whether the incident could have been prevented and what actions could be taken to improve the prevention, management and resolution of similar incidents.

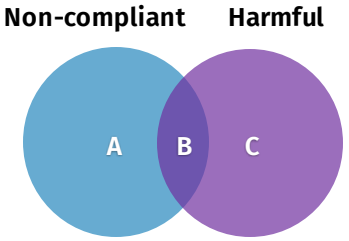
As indicated in the Quality Standards, providers must use an open disclosure process when things go wrong. This means that providers should facilitate an open discussion with consumers (and their representatives) when something goes wrong that has harmed or had the potential to cause harm to a consumer. Providers are expected to practise open disclosure in their prevention and management of any incidents impacting consumers.

Questions to ask include:

- Was the response to the incident appropriate?
- How was this incident able to occur?
- Could this have been predicted?
- What are the factors that could have triggered, caused or contributed to the incident?
- Could these factors have been prevented or modified?
- Could this happen again to this person or to others?
- What actions will be taken to reduce risk and prevent reoccurrence?
- How and when will we check that these actions are implemented, effective and sustained?
- Are we confident that our service is actively engaging in open discussions with affected residents for each incident?
- Does our incident management system enable us to identify trends, issues and areas for improvement?
- Is there a trend in our service which, if identified, would have prevented this incident?
- Is our team recording near misses - incidents that have the potential to cause harm but do not do so?
- Could this incident have been prevented if the service was actively recording near misses that happened prior to this incident occurring?
- Are our responses to an incident reflective of the principles of consumer dignity and choice?

What works for you?

If you have some examples of how you have effectively managed similar scenarios, please email us on SIRSinsights@agedcarequality.gov.au



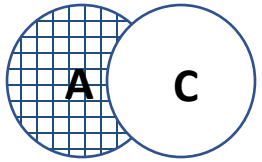
Does the choice of domain matter?

(aka The regulator's dilemma)

Before answering this question, let's explore a related issue:

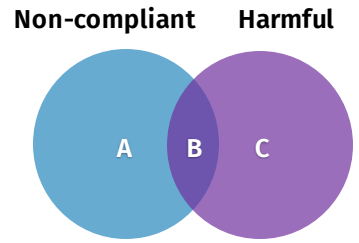
Q. What is the level of interest in, or tolerance for, a regulator's enforcement of rules that do not relate to substantial harm?

A. It depends on who you ask.



- The **regulated community** can get very irritated by this. They don't see the point and resent what they consider to be an unnecessary and avoidable regulatory burden. **… BUT …**
- **Consumers and members of the public** have the opposite concern. They can become **worried and suspicious** about any absence of a regulatory response to every instance of non-compliance because it indicates that the regulator is **exercising discretion** which then raises the possibility that the regulator might "let providers off" and bad things could go "unpunished" (aka the "slippery slope" argument).

In the worst case scenario, people **lose trust in the regulator** for what they see as its **indifference to rule infractions.** They become **fearful of experiencing harm** in aged care because they think that there are **few if any deterrents (ie. negative consequences) to providers getting things wrong**, including when they are wilfully non-compliant and providing unsafe, poor quality care that jeopardises consumers' wellbeing.



So … does the regulator's choice of domain matter?

Yes.

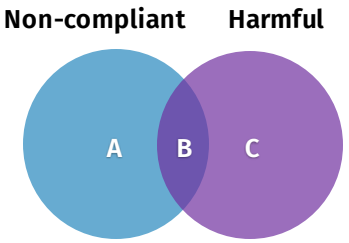
In order for the Commission to be effective in fulfilling our statutory obligations and regulatory purpose, that is, for us **to be successful in changing provider behaviour**, it is vital that at any point in time, we:

(a) recognise that **we have a choice to make** about what provider behaviour we pursue or prioritise (non-compliance, or risk of harm, or both);

(b) make the choice deliberately **with a particular purpose** / outcome in mind;

(c) are able to **justify and explain our choice** (i.e. why we are doing what we're doing);

(d) are **capable, effective and accountable** when operating in any of the three domains.



Working in Domain B – Risk-based regulation

- A risk-based regulator working in Domain B makes decisions about which non-compliance deserves priority attention on the basis of the degree of harm – actual or potential – that this non-compliance may cause.

- In short, **we use the harmfulness of consequences as the means for prioritising actions on non-compliance**.

- While this must always be heavily weighted in our decision-making, it may not be the only consideration. Other factors that can be taken into account can include, for example:

  - assessing degrees of culpability, deliberateness or criminality, or
  - paying more attention to repeat offenders, or
  - in responding to a provider demonstrating a particularly undesirable behaviour (e.g. wilful non-compliance), selecting and highlighting a compliance or enforcement action to serve as a general deterrent

The regulator must be skilful and judicious

Regulators should have access to a full toolkit AND demonstrate mastery of the entire toolkit AND exercise expert judgement about tool selection based on a clear understanding of task requirements and preferred outcomes.

What does a "full toolkit" comprise? Here are some examples relevant to the Commission's work:

- Engage in an ongoing way with, and listen carefully to, people using care and people responsible for providing care
- Pursue collaborative partnerships with bodies representing consumers, providers and workers
- Provide communications, guidance and education on rights, responsibilities, and best practice approaches to care
- Undertake sector surveillance and provider monitoring and assessment
- Gather, analyse and draw on data to inform engagement, intervention, priority setting
- Raise awareness of particular issues and risks through targeted campaign approaches
- Undertake or source research and disseminate findings
- Frame choices and decisions in ways which lead more providers to act more wisely (i.e. nudge providers into safer, better practices using approaches other than enforcement powers)
- Name providers/services that do not fulfil their responsibilities
- Use regulatory powers
- Use enforcement powers

The regulator must also be efficient

In choosing the most appropriate "means" to achieve a specific "end", that is, in selecting and deploying the right tool/s for the presenting circumstances, the Commission must not only be skilful and judicious, but also efficient.

Efficiency is important for the Commission in relation to:

1. our **budget** – being good stewards of public resources allocated to the agency

2. the **burdens** placed on the sector/individual providers – imposing no more cost and disruption than necessary to get the job done

3. (as far as possible) the **use of power** – opting for the approach ("right touch" regulation) that is least intrusive but still effective in prompting providers to modify their behaviour.

What the Commission is working on

The Commission has declared our ambition to become a world class regulator.

We are on that journey, which includes:

- Being more transparent about how we work and what we care about
- Understanding and improving the experience of engaging with us
- Improving our communication and education products to be more useful
- Developing our cultural competency and providing the right support to providers serving diverse communities
- Developing and sharing insights from our data that help providers to assess and manage their own performance
- Contributing to sector capability by incentivising and supporting continuous improvement
- Building our regulatory craftsmanship

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Aged Care Quality and Safety Commission

family.

Marge, like Kissinger and all the other centenarians, has seen extraordinary changes across her lifetime but in so many ways she has held to a few basic beliefs – the value of loving and accepting others, of getting up every day and getting on with it, of holding on and living your life with as much energy as you can muster. As more and more of us live longer and longer, we're likely to have to call on all of the above to get through our later years in a way that makes living worthwhile.

She has not mentioned it so much lately. Perhaps like many of us, the closer she gets to the end of her life the less enamoured she is with the idea of leaving it. Whatever. When she does make her exit, Mrs Marjorie Love will not attract the obituaries that will rain down upon the world when Henry goes. She will not, however, be forgotten.

Postscript: On Friday, Marge's much-loved younger sister, 95-year-old Mrs Betty Best, moved into the room next door in her residential home.

Closing observations

- Effective regulation is relational; it relies on ongoing constructive engagement between the regulator and regulated entities.
- Providers deliver vital care and services, and the Commission wants you to succeed - because older people are relying on you to do your job consistently well.
- We provide information, guidance and education to help you to (a) understand your responsibilities and obligations, and (b) take the necessary steps to ensure that you and your staff have the knowledge, skills and competencies you require to fulfil your responsibilities.
- We also hold you to account for your performance, including your compliance with your responsibilities and your management and mitigation of risks of harm to consumers.
- Providers must be **capable, effective and accountable** – and **you have agency and choice** in relation to the strategy you set, and the decisions and actions you take to achieve your goals and acquit your obligations
- The regulator must also be **capable, effective and accountable** – and **we have the same agency and choices** as you

✓ **At our mutually-reinforcing best, we can earn back the trust and confidence that the Australian public wants and deserves to have in its aged care system.**

✓ **Surely that's a worthwhile goal for all of us to work on together!**