F Aged care regulation

This appendix provides an overview of the rationales for aged care regulation, the features of best practice regulation and the current regulatory arrangements for aged care, especially in relation to those covering the quality of care.

F.1 Why regulate?

Chapter 4 has outlined in some detail the major reasons for government involvement in aged care and the main forms of such involvement (for example, information provision, standards setting, funding, direct service delivery, pricing and third party purchasing). Regulation is a key form of involvement and is applied to quantity, price and quality of aged care.

Rationales for regulating aged care and accommodation

Both international and Australian evidence show that concern about the quality of aged care has typically resulted — often over a period of time — in an array of regulations governing provider behaviour. In addition, concerns about fiscal risks associated with government expenditure have resulted in regulations which restrict access to subsidised aged care by older Australians. In the presence of quantity restrictions, price regulations limit the potential for abuse of local market power by providers and help to manage the government's fiscal risk.

The key rationales for government regulation (chapter 4) are: the presence of information asymmetries; protection of the vulnerable; support for government objectives relating to access and equity; high transactions costs associated with change care services (especially between different types of residential care); and support for carers in their caring roles. These rationales lead to governments providing:

- assurances of acceptable approved standards in community and residential aged care services
- appropriate protections for vulnerable older Australians, including prudential regulations and social safety net supports together with some 'accountability

rules' around this support (for example, eligibility conditions attaching to subsidies) to allay concerns associated with taxpayer financed expenditures and fiscal risk

- ease of access to information in a digestible format (for example, explaining complex financing options and public reporting of performance measures, and best practice).

Regulation and risk

Government action associated with the management of various risks underlies a number of these rationales. Indeed, a distinctive feature of regulation across social and economic infrastructure services revolves around governments responding to risk and trying to manage risk (PC 2009a). These risks include: prudential risk; the risk of fraud and inappropriate use of taxpayer monies; fiscal risks for all levels of government; and health and safety risks to consumers and the workforce.

However, it is important to note that governments are not best placed to manage all risks. For example, consumers can manage some of the risks they face by acquiring relevant information to help them make decisions which are right for them and their circumstances. Further, providers can also manage some of the risks they face through implementing appropriate internal risk management processes and strategies. Even so, many risks cannot be eliminated, even at great cost.

Risks (for example, of poor quality care) to any one individual can pose a political risk to government as well as a risk to the reputation of service providers. In managing one-off events arising from poor quality care, governments need to assess whether the event reflects a systemic risk or simply a one-off idiosyncratic occurrence. Regulation is ideally aimed at addressing systemic risk; it cannot address idiosyncratic risk without creating undue burden and limiting choice and flexibility.

Governments should allocate risk to where it is best managed — most efficiently and cost effectively. As a guide, providers are best placed to manage operational risks and their own financial risks that, in turn, can pose risks to the quality and continuity of services to clients. But they need appropriate incentives to do so and also active consumers who assess quality before entry and monitor quality in delivery. Government may have a role in providing the infrastructure to support consumers in this role, and remove constraints on consumers to play their role and for providers to respond. Beyond this, because of the vulnerable nature of consumers and the high level of government funding, government has a responsibility for oversight of the system. Governments are best placed to manage

the fiscal risks posed by their own expenditure programs. However, managing the prudential financial risks might best be achieved through a joint effort, as this risk is associated with holding a client's assets in trust rather than being a 'taxpayer funded' risk.

Reducing risk can be costly and the incentives for providers and consumers to actively manage risk depends on the magnitude of the costs the risks may impose. The challenge for government is to get the regulatory balance right.

Regulation to reduce risk can add unnecessarily to costs, have unintended consequences and may not be effective.

Examples of regulation which can add to costs include overly prescriptive regulations, 'black letter law' interpretation of regulations by regulators and excessive (and often multiple) reporting requirements.

The sector-wide consequences of applying additional regulation as a visible and public 'solution' to deal with a small — and often isolated — number of businesses is also an issue of concern. This led the Commission recently:

> The intrinsically heavy burden of regulation on the social and economic infrastructure services sector places an additional responsibility on policy makers designing the regulation and those administering the regulation to be cognisant of the additional burdens they may be placing on businesses. Unfortunately, as submissions to this review reveal, this is not always the case. (PC 2009a, p. XXV)

The Commission also noted that ill-considered interventions can often have significant unintended consequences:

> … excessive risk management can impede innovations in service delivery, increase costs, undermine staff morale and commandeer resources for compliance purposes away from the core aspects of service delivery. In some cases, it can lead to major ethical concerns regarding the rights of service recipients … Also, the risk being managed appears to be not always that of the service recipient or to public funding, but that of the regulators and government agencies. (PC 2009a, p. XXIV)

Moreover, excessive regulation can also inhibit innovation and efficient production (Ergas 1999). This side-effect of excessive regulation was raised by a number of participants including Blake Dawson:

> Regulating in detail every aspect of the care services provision stifles the ability of providers to deliver innovative yet high quality services. (sub. 465, p. 38)

Many participants representing the industry argued that the current regulatory environment is overly burdensome and, at the margin, is actually reducing rather than improving the quality of care (chapter 5). A key issue for this inquiry is the

scope to improve the efficiency and effectiveness of regulation while continuing to achieve its objectives, such as maintaining an acceptable standard of quality for aged care (including the protection of consumer rights).

F.2 What are the features of best practice regulation?

As alluded to in chapter 5, the historical development of aged care regulation has appeared to show little recognition of and adherence to the Principles of Best Practice Regulation, which have been recently reaffirmed and revised in the Australian Government's *Best Practice Regulation Handbook* (2010e).

Using the *Best Practice Regulation Handbook* as a foundation, this inquiry has adopted a wider perspective and identified a broad set of features that make up best practice regulation. These include:

- establishing good governance arrangements
- choosing appropriate standards
- implementing a 'responsive' regulatory model which encourages and enforces compliance
- developing streamlined reporting arrangements.

These features are discussed in further detail below.

Good governance

Establishing good governance arrangements involves:

- *clarity in jurisdictional responsibilities* — making clear 'which level of government regulates what' is required for good governance. This helps minimise the costs of regulatory overlap and the possibility that responsibility for regulation 'falls through the cracks'. As Australia's Constitution does not explicitly assign responsibility for aged care to the Australian Government, agreement about which level of government is responsible for regulating various aspects of aged care is made by the Council of Australian Governments (COAG).
- *separation of policy advice from regulation and interactions with individual recipients* — the broad lesson from the history of regulation suggests that best practice governance arrangements ideally should separate the policy advice agency from the independent regulator or the body which administers the law. Moreover, where government also provides substantial funding or subsidies to

individuals and families, emerging best practice also points to governance arrangements that separate the policy agency from the 'consumer interface' agency. This already occurs in a number of Government arrangements (for example, Australian Tax Office, Centrelink, Medicare and the Families Assistance Office).

- *well structured complaints handling with the right of independent appeal* — well structured complaints handling and appeals processes are also features of good governance arrangements. They can encourage openness and transparency, act as a lever for quality improvement for both the providers of services and the regulator (Office of the Aged Care Commissioner, sub. 364) and build confidence and credibility in the system as a whole.
  - Typically, consumer complaints are handled by a regulator (ACCC 2006, ASIC 2008 and NCAC 2009) and indeed feed into a regulator's armoury of information on businesses within the 'responsive regulation' model (outlined below). In the first instance, the regulator will often encourage the consumer to raise any concerns about a service in the first instance with the business in question. However, where the consumer's concern remains unresolved then the regulator will have a clear and transparent process for the consumer to lodge a formal complaint. Consumers' complaints will then be escalated, with the urgency of the complaints handling depending on the regulator's initial evaluation using a risk-based assessment tool.
  - To ensure that businesses do not feel that enforcement decisions are arbitrary and without recourse, as well as to provide clarity around the way regulations are enforced and how effective this is, regulatory arrangements in any industry must be transparent and the regulators need to be held appropriately accountable for their actions (OECD 2002). Appeals in relation to the regulator's or the decision-maker's determinations are best done transparently and at arm's length from both the policy and regulation agencies. Set up in this way, appeal mechanisms can increase the likelihood that businesses (and individuals) avoid costs that should not be imposed on them. The Government has provided these appeal mechanisms through organisations such as the Administrative Appeals Tribunal (AAT) and the Social Security Appeals Tribunal (SSAT).
- *freedom for advocacy* — this freedom covers both personal and policy advocacy.
  - Personal advocacy involves standing alongside a person who is disadvantaged and speaking on their behalf in a way that represents the best interests of that person. Advocacy agencies provide an independent, free and confidential service to consumers through the delivery of information, referral, support, advice and/or representation to both individuals and groups.

Due to the presence of vulnerable elderly (such as frailty and dementia), advocacy services are an important element of best practice consumer protection. Appropriate government involvement includes funding their services as well as establishing appropriate governance arrangements to ensure that they are independent of government, including any regulator.

  - There is also a broader role for peak industry and consumer organisations to advocate for their constituencies to influence policy development.

- *effective and regular review mechanisms* — a final element of good governance involves establishing mechanisms which allow regular reviews of existing regulations as well as appropriate assessments of any new regulatory proposals.

Appropriate choice of standards

The Commission's recent regulation benchmarking report on occupational health and safety (OHS) noted that there are generally four main types of standards aimed at influencing behaviour (box F.1).

These different standards are not mutually exclusive and the choice of standard depends on the nature of the rationale behind the regulation and the nature of the industry. Whether an outcome is able to be assessed in practice also matters. The challenge is to adopt the most appropriate mix of approaches to the circumstances so as to achieve the desired policy outcome while avoiding the creation of a counterproductive regulatory overload. In this context, Bluff and Gunningham note the following:

> Coglianese and Lazar (2002) have argued that the optimal choice will depend upon a number of circumstances. When objectives can be clearly defined and are easily measured (or assessed), they suggest that performance-based regulations are desirable, on the basis that duty holders can be assumed to have superior knowledge to regulators about how best to achieve a given result. Such an outcome-based approach will, accordingly, be the most cost-effective. However, when objectives are not easily defined and measured, but the target group is relatively homogenous (that is, most enterprises have similar operations and technology tends to be stable over time), then a prescriptive approach may be both effective and efficient. In contrast, where it is difficult for government to measure performance and the target group is made up of heterogeneous firms facing heterogeneous conditions, then they argue that systems-based (or what they call management-based) regulation will probably be preferable to its alternatives. (2004, p. 40)

In developing detailed regulation, including national standards, the foundations should be based on the principles of good regulatory process agreed by COAG in 2007 (box F.2).

Box F.1 **Four types of regulatory standards**

Prescriptive standards

These are regulations which specify precisely what measures to take. Such a standard identifies 'inputs', that is, the specific preventive action required in a particular situation.

These standards often provide greater certainty and information to businesses and are especially valued by small and medium sized enterprises. However, they can also: limit flexibility; lead to regulatory overload; increase apathy and encourage a minimum compliance mentality by both management and workers (Bardach and Kagan 1982); impose costs on companies without commensurate improvements in safety (PC 2010c); and inhibit innovation and potentially slow productivity growth.

General duties

These are regulations which set out principles which duty holders must follow, leaving it to the discretion of the 'duty holder' as to how they satisfy those principles or goals. For example, in OHS, employers are empowered to determine, in consultation with their employees, how they will comply with general duties to ensure OHS in the workplace.

These standards create a flexible system which provides incentives for organisations to move beyond prescription and either meet or exceed the basic standards laid out in regulations. This provides opportunities for enterprises (usually medium or large) to develop their own cost effective and efficient practices which best suit their individual circumstances. Greater levels of prescription may provide more certainty to small businesses as to their obligations under legislation but it can reduce flexibility and stifle opportunities for more cost effective practices for other organisations. Broad general duties that impose responsibilities can also create significant burdens irrespective of any specific requirements.

Performance-based standards

These are regulations which specify the outcome of the improvement or desired level of performance but leave the concrete measures to achieve them open for the 'duty holder' to adapt to varying local circumstances. Performance-based standards can be either targets or outcomes, both of which need to be measurable.

Performance standards are attractive because they focus on the outcomes to be achieved rather than the means of achieving them. They can accommodate changes in technology and organisation of work (unlike process standards) and allow firms to determine the most cost effective means of achieving compliance and permit innovation. Although they do not provide an incentive for continuous improvement or best practice, they do not preclude it.

(Continued next page)

Box F.1 **(continued)**

Systematic process-based standards

These are regulations which identify a process, or series of steps, to be followed in pursuit of achieving a desired outcome. For example, in OHS, these type of standards include the requirement to identify hazards and assess and control risks (found in many national standards). This 'identify, assess, control' approach is one example but other examples can include more detailed and onerous risk based requirements (such as obligations to establish major hazard management plans including specified critical controls) and a more holistic and systemic approach to managing safety through the creation of safety and health management systems.

The desirability of the 'identify, assess, control' approach is broadly recognised. However, in OHS, there remains debate about whether the introduction of management systems should be left to the discretion of employers or mandated by regulation. Many policy-makers in the general field of safety, health and environmental regulation remain unconvinced that the latter approach is necessary.

Sources: Bluff and Gunningham (2004); Gunningham (2006); PC (2010c).

Box F.2 **Principles of Best Practice Regulation**

COAG has agreed that all governments will ensure that regulatory processes in their jurisdiction are consistent with the following principles:

1. establishing a case for action before addressing a problem
2. a range of feasible policy options must be considered, including self-regulatory, co-regulatory and non-regulatory approaches, and their benefits and costs assessed
3. adopting the option that generates the greatest net benefit for the community
4. in accordance with the Competition Principles Agreement, legislation should not restrict competition unless it can be demonstrated that:
   a. the benefits of the restrictions to the community as a whole outweigh the costs and
   b. the objectives of the regulation can only be achieved by restricting competition
5. providing effective guidance to relevant regulators and regulated parties in order to ensure that the policy intent and expected compliance requirements of the regulation are clear
6. ensuring that regulation remains relevant and effective over time
7. consulting effectively with affected key stakeholders at all stages of the regulatory cycle
8. government action should be effective and proportional to the issue being addressed.

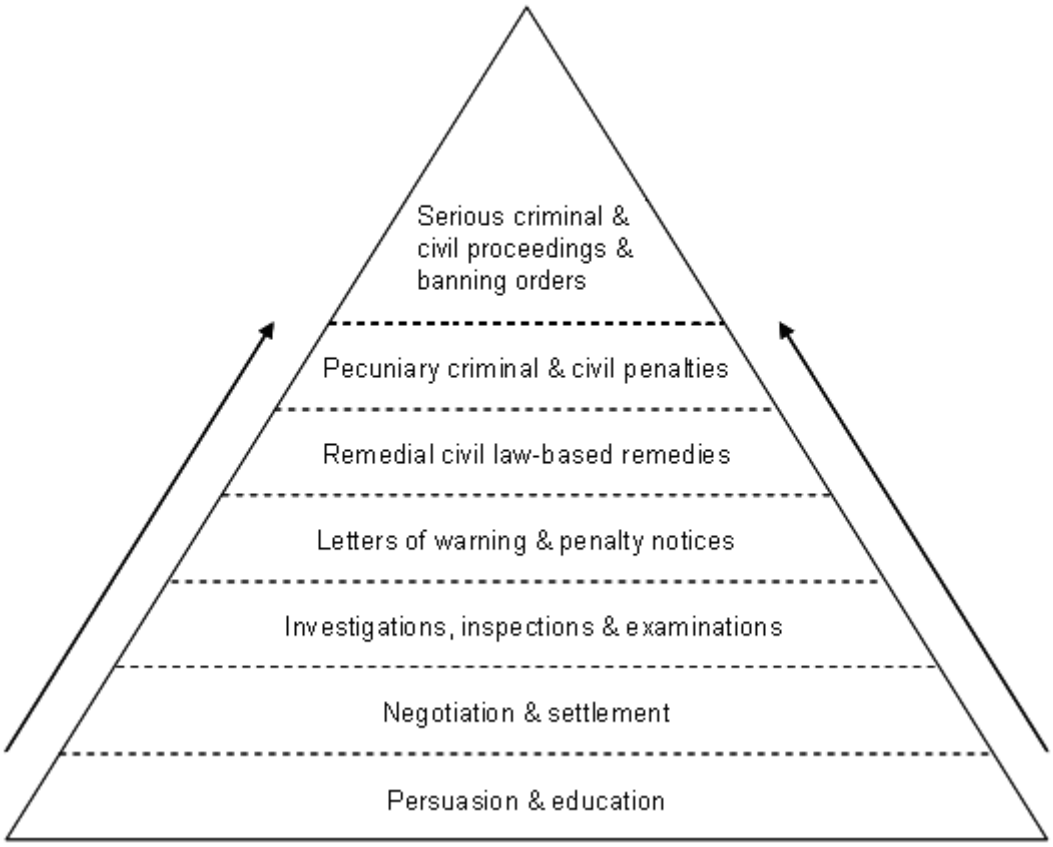
Source: COAG (2007).

‘Responsive regulation’ to encourage and enforce compliance

A regulator plays an important role in regulatory regimes by encouraging compliance through education and advice, as well as enforcing laws and regulations through disciplinary means.

The approach to regulation that encapsulates both deterrence and persuasive strategies is known as ‘*responsive regulation*’. It recommends that a regulator’s compliance and enforcement policy is based on a pyramid-shaped escalation of sanctions (Ayres and Braithwaite 1992; Gilligan et al. 1999; Gunningham and Sinclair 2007). The less severe (more often used) advice and persuasion options are reflected in the lower half of the pyramid while the more severe (but less often used) punitive strategies are represented at the peak of the enforcement pyramid (figure F.1).

Figure F.1 **Example of a compliance and enforcement pyramid**[a]



a Adapted from Gilligan, Bird and Ramsay (1999).

Source: PC (2010c).

'Responsive regulation' involves a graduated strategy ranging from tools which encourage and reward compliance, to reminding and nudging businesses to comply to credible punitive enforcement sanctions.

- *Encouraging and rewarding compliance* — the first step by a regulator is to support business compliance through the dissemination of information and education, the provision of incentives and other forms of support.
  - Depending on the circumstances of the market and industry sector, regulators are able to adopt a number of different strategies to encourage business compliance. These include: using various *modes* of communication; providing *measures* to encourage a culture of compliance; conducting *education campaigns* and workshops; and providing *targeted assistance* to small business with limited resources, those who are remote from information sources and employers from non-English speaking backgrounds.
- *Reminding and nudging compliance* — this stage is at the lower to middle level of the pyramid where compliance has not been achieved voluntarily but where a presumption of 'compliant virtue' may still be justified. This restorative justice approach gives the offending business the chance to put things right.
  - The types of strategies which can be adopted at this stage can include bringing problems to the employers attention (especially where a problem may not have yet become sufficiently visible or urgent to gain corporate attention), improvement and prohibition notices, a slight slap on the wrist in the form of 'on-the-spot fines', enforceable undertakings and restorative orders.
- *Punitive sanctions to enforce compliance* — this stage is at the top end of the pyramid for the minority of cases of (recalcitrant and uncooperative) businesses who are only likely to respond where the (mostly financial) costs of not complying outweigh the benefits.
  - The main tools here are a few credible 'big sticks' (as opposed to 'carrots and small sticks' used in other stages of the pyramid), including criminal sanctions, penalties against individuals and/or threat of closure.

The Commission explains how this mix of strategies can be used to ensure compliance and achieve the potential benefits of regulation:

> This sliding scale of enforcement options allows for a 'tit-for-tat' strategy where a regulator is initially cooperative and adopts a soft approach to encourage business compliance. But, if a business remains uncompliant, the regulator can adopt more severe enforcement options. When a business chooses to comply, the regulator can revert to its cooperative position (Ayers and Braithwaite 1992). Thus a regulator can be both confrontational and forgiving and, with a mix of options, can apply a variety of

> enforcement tools and approaches to promote compliance and deter non-compliance. (PC 2010c, p. 111)

Needless to say, for the 'responsive regulation' model to work well, a range of tools is necessary and assessors/inspectors need clear guidance on how, and in what circumstances, to use the various enforcement tools. This is difficult to achieve when one aspect of the regulatory responsibility is structurally separate from the regulator (for example, compliance checking and enforcement decisions in the regulation of quality in residential aged care). The emphasis in this model is on a risk-based approach to compliance and enforcement, where those doing the compliance checking are also able to carry out compliance and enforcement actions.

Other best practice actions in a 'responsive regulation' model include the three principles of '*consistency*', '*proportionality*' and '*transparency*' (PC 2010c). The principle of consistency ensures that similar workplace circumstances lead to similar enforcement outcomes. The proportionality principle focuses on the need for responses to be proportional to the seriousness of non-compliance. Finally, the principle of transparency is about the regulator demonstrating impartiality and balance in the decisions it makes.

While a greater range of enforcement instruments is consistent with the approach of 'responsive regulation' and the compliance and enforcement pyramid, this is not necessarily a straightforward process for regulators. The size of the financial penalty can have unintended consequences for some businesses. Accordingly, additional measures, such as criminal liability, may be used.

In addition, where regulators determine that the operations of a business are considered to have high risks to either employees or clients, a number of different options may be available. These can range from shutdown and evacuation to the take-over of the management of a business by an external team appointed by the regulator (see PC 2010c; APRA 2009).

'Responsive regulation' also suggests that regulators need to be responsive to different industry structures as well as opportunities for the effective self-regulation of businesses. An unnecessary compliance burden can be created when the regulator fails to take these private self regulatory systems into account (PC 2010c).

Finally, in achieving a consistent approach to compliance and enforcement, regulators (including across different jurisdictions) need to undertake a variety of activities to enable uniformity in the interpretation of regulation(s). These can take the form of supervisory oversight and structured training activities within the regulator as well as regular liaison (to discuss regulatory overlap and gaps etc) by the regulator with other regulatory agencies that deal with the same industry.

Streamlined reporting

The Banks Review found that regulatory compliance cost Australian businesses tens of millions of dollars each year and divert time and resources from core business activities (Banks 2006). Accordingly, streamlined and efficient reporting arrangements from business to the government are an important consideration in the implementation of best practice regulation.

For example, in response to the Banks Review, the Government approved the development of Standard Business Reporting (SBR) for business to report financial information to government. SBR (which follows the lead taken by the Netherlands) involves collaborating across agencies to agree to develop a single set of definitions and language for the information reported by business to government (box F.3). SBR has been endorsed by COAG and commenced operation in May 2010.

Box F.3 Standard Business Reporting (SBR): an overview

SBR relies on a collaborative methodology which will deliver capabilities that, when incorporated in businesses software, will reduce the reporting burden. SBR is simplifying business-to-government reporting by:

- removing unnecessary or duplicated information from government forms
- using business software to automatically pre-fill forms
- adopting a common reporting language, based on international standards and best practice
- making financial reporting a by-product of natural business processes
- providing an electronic interface to agencies directly from accounting software, which will also provide validation and confirm receipt of reports
- providing a single secure sign-on for users to all agencies involved.

The future scope of SBR

While the current scope of SBR is to reduce the burden of business-to-government financial reporting, there is broad potential for SBR methodologies to ease regulatory burdens in other areas.

A number of reviews and reports have indicated that SBR could potentially be applied to other business reporting. Similarly, the SBR Program Board is working with other government agencies to understand the potential application for SBR in their business reporting requirements. However, at this stage, no decision has been made as to whether SBR will be expanded and if so how. The SBR Program Board will evaluate a range of options over the coming months and provide, for consideration by government, advice about future directions.

Source: Australian Government (2010l).

F.3 What are the regulations?

As the Australian Government is the primary regulator of aged care (currently covering residential aged care and, in future, community aged care for most jurisdictions) much of the material contained in this section focuses on Australian Government regulations. Nonetheless, where relevant, state and territory regulations are also discussed, especially in relation to the quality of community aged care.

Australian Government

An overview of the two main Australian Government acts — the *Aged Care Act 1997* (the Act) and the *Home and Community Care (HACC) Act 1985* (the HACC Act) — which govern aged care are provided below.

Three other related Australian Government Acts are the *Aged or Disabled Persons Care Act 1954*, the *Aged Care (Bond Security) Act 2006*, and the *Aged Care (Bond Security) Levy Act 2006* (DoHA 2009e). However, these are not discussed in this section.

The following summary draws heavily on reports and guides prepared the Department of Health and Ageing (DoHA) (2009e, 2009f and 2010n).

The Aged Care Act 1997

The Act (comprising 476 pages), its associated 22 Aged Care Principles (box F.4) (totalling around 500 pages) and Determinations provide the regulatory framework for Australian Government funded aged care providers and provides protection for aged care recipients. These arrangements determine:

- who can provide care, and their roles and responsibilities
- who can receive care, and their rights and responsibilities
- what types of aged care services are available
- how aged care is funded.

The Act and its 22 Principles are administered by DoHA.

Box F.4 **The 22 Aged Care Principles**

- Accountability Principles 1998
- Accreditation Grant Principles 2011
- Advocacy Grant Principles 1997
- Allocation Principles 1997
- Approval of Care Recipients Principles 1997
- Approved Provider Principles 1997
- Certification Principles 1997
- Classification Principles 1997
- Community Care Grant Principles 1997
- Community Care Subsidy Principles 1997
- Community Visitors Grant Principles 1997
- Extra Service Principles 1997
- Flexible Care Grant Principles 2008
- Flexible Care Subsidy Principles 1997
- Information Principles 1997
- Investigation Principles 2007
- Quality of Care Principles 1997
- Records Principles 1997
- Residential Care Grant Principles 1997
- Residential Care Subsidy Principles 1997
- Sanctions Principles 1997
- User Rights Principles 1997

Sources: DoHA (2009e,); Australian Government (2011b).

Residential, community and flexible care

The Act primarily regulates residential aged care. However, other types of care — namely Community Aged Care Package (CACP), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D), Transition Care, Multi-Purpose Service (MPS) places, and Innovative Care — are also provided for under the Act. Arrangements for the various types of flexible care (excluding CACP) are set out in the Flexible Care Subsidy Principles 1997.

Determinations

Chapter 3 of the Act empowers the Minister to determine, in writing (by legislative instruments or 'Determinations'), the daily amounts of residential care, community care and flexible care subsidies that are payable to approved aged care providers. Accommodation subsidies are indexed in March and September each year and all other subsidies are indexed annually in July.

While the majority of Determinations relate to the amount of Government subsidies, the Act also empowers the Minister and/or the Secretary of DoHA to determine other matters, such as conditions on the allocation of aged care places. Determinations made in each are published in an annual *Report on the Operation of the Aged Care Act 1997*. Unless they have been rescinded, Determinations made in previous years are also in effect during current years.

The 27 Determinations made during 2008-09 are listed in Appendix A of DoHA (2009e). 27 Determinations were also made during 2009-10 (DoHA 2010n).

Approved providers

To receive Australian Government subsidies for providing aged care, an aged care service must be operated by an organisation that has been approved under the provisions of the Act, and hold an allocation of places in respect of care recipients occupying those places in a service.

The amount of aged care that an aged care provider can deliver depends on the number of aged care places allocated to it under Part 2.2 of the Act. Under these arrangements, an Approved Provider can only receive payment for care (subsidies) for the specified number and type of aged care places allocated through the Government's allocation process.

Approved Providers are required to comply with a wide range of on-going responsibilities under the Act. These include meeting their responsibilities in relation to: quality of care; user rights; accountability requirements; and allocation of places. Appendix C in DoHA (2010n) sets out these requirements in detail.

DoHA monitors compliance by Approved Providers with their responsibilities and should the Approved Provider cease to be suitable, DoHA is required to revoke its Approved Provider status under the provisions set out in the Act.

Further details on the Act's requirements for the quality of residential aged care (accreditation) are provided below. In addition, Approved Providers are subject to Certification requirements. Certification focuses on the building quality of aged care homes. A home must be certified to be able to receive accommodation payments and levy Extra Service charges. DoHA (2009e) also notes that the requirements of the 1999 Certification Assessment Instrument do not override the building and fire safety regulations within each state and territory. The state and territory building regulations, through the Building Code of Australia, set the minimum community standard for safety, health and amenity of buildings.)

All Approved Providers are accountable for the subsidies they receive. In the case of residential aged care, subsidies are based on the Aged Care Funding Instrument (ACFI) appraisals they complete to show the assessed care needs of the residents in their care. As it is the care staff in the home that complete the appraisals on which a funding classification is determined, DoHA checks the accuracy of the appraisals to protect taxpayer funding and ensure that the funding for a sample of residents reflects their assessed care needs.

Prudential requirements

All Approved Providers of residential care and Multi-Purpose Service flexible care services that hold accommodation bonds and entry contributions are required to comply with the prudential requirements set out in the Act and the User Rights Principles 1997.

The prudential requirements are supplemented by the Accommodation Bond Guarantee Scheme established under the *Aged Care (Bond Security) Act 2006*.

Approved Providers holding accommodation bonds or entry contributions must comply with three Prudential Standards: the Liquidity Standard, the Records Standard and the Disclosure Standard.

On 26 May 2011, the Australian Government introduced amendments to the Act designed to enhance the prudential framework around accommodation bonds. Many of these were previously announced as part of a 2010-11 Budget measure ($21.8 million over four years) to strengthen protections for accommodation bonds held by aged care providers (Australian Government 2010c and 2011c).

Care recipients and assessments of need

People entering into Australian Government subsidised residential care must first be approved as a care recipient under Part 2.3 of the Act. Under these arrangements, comprehensive assessments are conducted to take account of the restorative, physical, medical, psychological, cultural and social dimensions of the person's care needs. This assessment is undertaken by an Aged Care Assessment Team (ACAT or Aged Care Assessment Service in Victoria). In emergency situations, a person in need of care may be placed in an aged care home before an ACAT assessment is conducted.

These assessments, however, can be over-ridden by an Approved Provider with the approval of DoHA.

Complaints

The Aged Care Complaints Investigation Scheme (CIS) commenced operation on 1 May 2007 and was established through changes to the Act and the introduction of regulations under the Act (that is, the Investigation Principles 2007). The CIS covers both residential and community aged care services subsidised under the Act.

In addition to receiving and dealing with complaints, the CIS has the power to conduct investigations on its own initiative and issue Notices of Required Action (NRA), where an Approved Provider is found to be in breach of their responsibilities under the Act.

CIS officers may visit either the Approved Provider's premises or the aged care service during the course of investigating a case. Visits may be announced or unannounced.

An NRA is issued when an Approved Provider is found to be in breach of their responsibilities under the Act or Principles and has not already taken action to address the breach. Each NRA sets out the details of the breach, what the provider must do to address the breach and the timeframe in which this action must be taken. The intention of a NRA is to give the provider an opportunity to address the breach before compliance action is considered. An NRA may cover more than one breach.

External review

The Aged Care Commissioner is a statutory office created under the Act. The functions of the Commissioner are outlined in the Act and include:

- examining, in response to a complaint or on their own initiative, the Secretary's processes for handling matters under the Investigation Principles 2007
- examining decisions made by the Secretary under the Investigation Principles 2007 which are identified, by those Principles, as being examinable by the Commissioner
- making recommendations arising from the Commissioner's examinations, to either confirm DoHA's original decision, or set aside the original decision (and replace it) or vary the original decision (and replace part of it)
- examining complaints about the Aged Care Standards and Accreditation Agency (ACSAA) with regard to the accreditation of Australian Government subsidised aged care services. This includes the power to examine complaints about the conduct of a person carrying out an accreditation audit or support contact, but does not include the power to examine complaints about accreditation decisions.

The Aged Care Commissioner can also conduct an 'own motion' examination, that is, to undertake a review of CIS's processes or the conduct of the CIS even when a request for a review has not been received.

The HACC Act 1985

The largest part of the Australian Government's support for community care is provided outside of the Act, through the joint Australian Government, state and territory government funded HACC program. The HACC program is administered under the HACC Act. At the time of writing, the Australian Government provided 60 per cent of funding and maintains a broad strategic policy role with day-to-day management provided by state and territory governments.

Following the COAG's federal financial framework reforms, Australian Government funding for the HACC program is paid to states and territories by the Australian Government's Department of the Treasury under a National Partnership Agreement.

The HACC Review Agreement is a bilateral funding agreement between the Australian Government and state and territory governments, and took effect on 1 July 2007 (replacing the 1999 HACC Amending Agreement). It is the legal basis on which funds are provided by the Australian Government and state and territory governments for the operation of the HACC program.

Determining who provides care services through the HACC program is the responsibility of individual state and territory governments. All HACC service providers must provide services in accordance with the HACC National Service Standards and the National HACC Program Guidelines 2007.

Following the agreement of all state and territory ministers responsible for the HACC Program, the National Service Standards were gazetted on 17 May 1995.

State and territory governments are now required to include the Standards in all service contracts. Monitoring and compliance with the Standards is now a major part of service reviews.

Quality of residential aged care

An overview of residential aged care quality regulations is outlined below (largely sourced from Weiner et al. 2007, ACSAA's website, DoHA 2009e and the Act).

Accreditation standards

Schedule 2 of the Quality of Care Principles 1997 under the Act also specifies Accreditation Standards for residential aged care, covering four areas:

- management systems, staffing, and organisational development

- health and personal care
- residential lifestyle
- physical environment and safe systems.

Each standard consists of a statement of a principle, a set of indicators, and expected outcomes. The first standard also has an 'intention' which indicates it acts as the umbrella for the other three standards. In total, there are 44 indicators and associated expected outcomes (table F.1). The standards and associated indicators and expected outcomes are general statements; they do not constitute a checklist, and they do not tell providers how to meet expected outcomes. Furthermore, the standards are not measurement tools, but rather a framework around which ACSAA builds evidence to determine whether a home complies with each standard.

According to Weiner et al. (2007), flexibility is used to apply the standards in recognition of the fact that not all providers respond to standards in the same way. An accreditation guide for providers and a handbook for assessors provide advice on the expected performance and the opportunities that providers can use to demonstrate that they have achieved each outcome.

The standards call for attention to the special needs of different population groups, including people with dementia, people from CALD backgrounds, Indigenous Australians and people living in remote areas.

The accreditation standards do not set ratios for nursing or other staff to residents. Instead, the standard for human resource management requires that skilled and qualified staff be sufficient to ensure that services are delivered in accordance with the standards and the residential care facility's philosophy and objectives. The standard for regulatory compliance requires staffing to be in accordance with separate legislation and regulation of nursing practice, particularly in relation to the management of medication and technical nursing procedures.

Weiner et al. (2007) also note four broad steps are used in the accreditation of quality of care. First, homes complete a self-assessment to demonstrate how the facility is meeting the standards and submit it to ACSAA. Second, quality assessors perform a desk audit of the self-assessment information, to check compliance with reporting standards and to gather more information if necessary. Third, assessors visit each facility to conduct an on-site assessment. Fourth, assessors prepare a detailed report following a standard format, and a staff member from ACSAA outside the audit team decides whether the facility should be accredited and for how long. Meeting 40 of the 44 indicators and associated expected outcomes is an informal benchmark for accreditation.

Residential care standards

Schedule 3 of the Quality of Care Principles 1997 under the Act also specifies Residential Care Standards, covering three areas:

- health and personal care
- residential lifestyle
- physical environment and safe systems.

Similar to the Accreditation Standards, each standard consists of a statement of a principle, a set of indicators, and expected outcomes. In total, there are 35 indicators and associated expected outcomes (table F.2)

Other specified services

Schedule 1 of the Quality of Care Principles 1997 under the Act also set out Specified Care and Services for Residential Care Services. Sub-section 18.6 (1A) of the Act provides that the care and services listed in Schedule 1 are to be provided in a way that meets the standards set out in Schedule 2 (Accreditation Standards) or Schedule 3 (Residential Care Standards), as the case requires. In addition, the services in Part 3 of Schedule 1 only apply to residents receiving high level care (sub-section 18.6 (3)).

Schedule 1 is set out differently to Schedules 2 and 3, for each element of care or service provided outlined in column 2, column 3 specifies in the content of the care or service to be provided (table F.3).

Quality of packaged community aged care

Schedule 4 of the Quality of Care Principles 1997 under the Act also specifies quality standards for packaged community care (including aged care) (table F.4).

Packaged community aged care providers are required to report against program standards and complete a 'Quality Review' at least once during a three year cycle (DoHA 2010q). The Quality Review is a four step process involving the initial self-assessment report, a desk review, site visit and appropriate follow-up including compliance action where necessary. The results of these reviews do not appear to be publicly available.

Quality of basic community care (HACC)

States and territories have day-to-day regulatory responsibility for basic community care funded through the HACC program. Basic community care (HACC) is also regulated by the Australian Government under both the Act and the HACC Act.

Prior to Community Care Common Standards, quality standards for HACC were set out in the *HACC Standards Instrument* (HACC 1998a). The instrument, which is sent to all providers, is designed to measure quality of services against outcomes for consumers in seven areas encompassing 27 national standards — each of which is stated as an expected consumer outcome (table F.5).

According to Weiner et al. (2007, Appendix B), states and territories implement the instrument using one of two methods. The joint assessment method allows service providers to supply answers against the performance information. The ratings and provider appraisal summary form are then completed in conjunction with the visiting assessor, who is appointed by the state or territory department administering the program. The self-assessment and verification method enables the service provider to complete the standards instrument, including their ratings, transfer this information to the appraisal summary form, and complete an action plan. The appraisal is then discussed and verified by a visiting assessor (box F.6).

There was also a *HACC Consumer Survey Instrument* (HACC 1998b), which ran in parallel with the HACC Standards Instrument. Different methods (mail-out, telephone, face-to-face surveys and focus groups) sought information in three areas:

- consumers' experiences of service provision
- respect for clients' rights and receipt of information
- satisfaction with services.

Although there is a HACC minimum data set (DoHA 2010k) there appears to be no comprehensive data publicly available on the extent to which HACC services meet these (previous and new) national standards.

New quality standards for all community care: Community Care Common Standards

The Community Care Common Standards (DoHA 2010n) have been developed jointly by the Australian Government and State and Territory Governments as part of broader community care reforms to develop common arrangements that help to simplify and streamline the way community care is delivered.

From 1 March 2011, Community Care Common Standards applied to basic and packaged community care as well as the National Respite for Carers Program (NRCP). All Ministers endorsed the standards and all, with the exception of Queensland, agreed on the implementation date of 1 March 2011 (DoHA, pers. comm. 11 November 2011).

- However, if care is provided through a community care service before 1 March 2011, the Community Care Common Standards (set out in Schedule 4 of the Quality of Care Principles 1997) apply.

Under the new quality standards for community care (Community Care Common Standards), there are three standards with 18 expected outcomes (table F.6). The three standards are:

- effective management
- appropriate access and service delivery
- service user rights and responsibilities.

It is anticipated that the quality review process will be conducted at least once in a three year cycle. Quality reviews for packaged care and NRCP will be undertaken at the service outlet level, however arrangements for HACC program services vary between jurisdictions. The components of the quality review process are outlined in table F.7

It is unclear whether the results of the quality review process will be made publicly available.

Table F.1 **Accreditation Standards for residential aged care**

Part 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.

Intention of standard: This 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.

Item	*Matter Indicator*	*Expected Outcome*
1.1	Continuous improvement	The organisation actively pursues continuous improvement.
1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
1.4	Comments and complaints	Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.
1.5	Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.
1.6	Human resource management	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.
1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available.
1.8	Information systems	Effective information management systems are in place.
1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.

Part 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.

Item	*Matter Indicator*	*Expected Outcome*
2.1	Continuous improvement	The organisation actively pursues continuous improvement.
2.2	Regulatory compliance	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.
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.

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Table F.1 **(continued)**

Part 2: (continued)

Item	*Matter Indicator*	*Expected Outcome*
2.4	Clinical care	Residents receive appropriate clinical care.
2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.
2.7	Medication management	Residents' medication is managed safely and correctly.
2.8	Pain management	All residents are as free as possible from pain.
2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained.
2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration.
2.11	Skin care	Residents' skin integrity is consistent with their general health.
2.12	Continence management	Residents' continence is managed effectively.
2.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively.
2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents.
2.15	Oral and dental care	Residents' oral and dental health is maintained.
2.16	Sensory loss	Residents' sensory losses are identified and managed effectively.
2.17	Sleep	Residents are able to achieve natural sleep patterns.

Part 3: Residential 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.

Item	*Matter Indicator*	*Expected Outcome*
3.1	Continuous improvement	The organisation actively pursues continuous improvement.
3.2	Regulatory compliance	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.
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis.
3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected.

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Table F.1 **(continued)**

Part 3: (continued)

Item	*Matter Indicator*	*Expected Outcome*
3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.
3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnical backgrounds are valued and fostered.
3.9	Choice and decision-making	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.
3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities.

Part 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.

Item	*Matter Indicator*	*Expected Outcome*
4.1	Continuous improvement	The organisation actively pursues continuous improvement.
4.2	Regulatory compliance	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.
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
4.5	Occupational health and safety	Management is actively working to provide a safe work environment that meets regulatory requirements.
4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
4.7	Infection control	An effective infection control program.
4.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Source: Schedule 2, Quality of Care Principles 1997 made under sub-section 96-1 (1) of the *Aged Care Act 1997*.

Table F.2 **Residential Care Standards**

Part 1: 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.

Item	*Matter Indicator*	*Expected Outcome*
1.1	Continuous improvement	The organisation actively pursues continuous improvement.
1.2	Regulatory compliance	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.
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
1.4	Clinical care	Residents receive appropriate clinical care.
1.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
1.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.
1.7	Medication management	Residents' medication is managed safely and correctly.
1.8	Pain management	All residents are as free as possible from pain.
1.9	Palliative care	The comfort and dignity of terminally ill residents is maintained.
1.10	Nutrition and hydration	Residents receive adequate nourishment and hydration.
1.11	Skin care	Residents' skin integrity is consistent with their general health.
1.12	Continence management	Residents' continence is managed effectively.
1.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively.
1.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents.
1.15	Oral and dental care	Residents' oral and dental health is maintained.
1.16	Sensory loss	Residents' sensory losses are identified and managed effectively.
1.17	Sleep	Residents are able to achieve natural sleep patterns.

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Table F.2 **(continued)**

Part 2: Residential 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.

Item	*Matter Indicator*	*Expected Outcome*
2.1	Continuous improvement	The organisation actively pursues continuous improvement.
2.2	Regulatory compliance	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.
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
2.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis.
2.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
2.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected.
2.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.
2.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
2.9	Choice and decision-making	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.
2.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities.

Part 3: 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.

Item	*Matter Indicator*	*Expected Outcome*
3.1	Continuous improvement	The organisation actively pursues continuous improvement.
3.2	Regulatory compliance	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.
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.

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Table F.2 **(continued)**

Part 3: (continued)

Item	*Matter Indicator*	*Expected Outcome*
3.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
3.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements.
3.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
3.7	Infection control	An effective infection control program.
3.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Source: Schedule 3, Quality of Care Principles 1997 made under sub-section 96-1 (1) of the *Aged Care Act 1997*.

Table F.3 **Specified care and services for residential care services** [a]

Part 1: Hotel services — to be provided for all residents who need them

Item	*Matter Indicator*	*Expected Outcome*
1.1	Administration	General operation of the residential care service, including resident documentation.
1.2	Maintenance of buildings and grounds	Adequately maintained buildings and grounds.
1.3	Accommodation	Utilities such as electricity and water.
1.4	Furnishings	Bed-side lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw-screens (for shared rooms), resident wardrobe space, and towel rails. Excludes furnishings a resident chooses to provide.
1.5	Bedding	Beds and mattresses, bed linen, blankets, and absorbent or waterproof sheeting.
1.6	Cleaning services, goods and facilities	Cleanliness and tidiness of the entire residential care service. Excludes a resident's personal area if the resident chooses and is able to maintain it himself or herself.
1.7	Waste disposal	Safe disposal of organic and inorganic waste material.
1.8	General laundry	Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed. Excludes cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a resident chooses and is able to do this himself or herself.
1.9	Toiletry goods	Bath towels, face washers, soap, and toilet paper.
1.10	Meals and refreshments	(a) Meals of adequate variety, quality and quantity for each resident, served each day at times generally acceptable to both residents and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper. (b) Special dietary requirements, having regard to either medical need or religious or cultural observance. (c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice.
1.11	Resident social activities	Programs to encourage residents to take part in social activities that promote and protect their dignity, and to take part in community life outside the residential care service.
1.12	Emergency assistance	At least one responsible person is continuously on call and in reasonable proximity to render emergency assistance.

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Table F.3 **(continued)**

Part 2: Care and services — to be provided for all residents who need them

Item	*Matter Indicator*	*Expected Outcome*
2.1	Daily living activities assistance	Personal assistance, including individual attention, individual supervision, and physical assistance, with: (a) bathing, showering, personal hygiene and grooming (b) maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management (c) eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary) (d) dressing, undressing, and using dressing aids (e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids (f) communication, including to address difficulties arising from impaired hearing, sight or speech, or lack of common language (including fitting sensory communication aids), and checking hearing aid batteries and cleaning spectacles. Excludes hairdressing.
2.2	Meals and refreshments	Special diet not normally provided.
2.3	Emotional support	Emotional support to, and supervision of, residents.
2.4	Treatments and procedures	Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a resident's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of State or Territory law.
2.5	Recreational therapy	Recreational activities suited to residents, participation in the activities, and communal recreational equipment.
2.6	Rehabilitation support	Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a resident's ability to perform daily tasks for himself or herself, or assisting residents to obtain access to such programs.
2.7	Assistance in obtaining health practitioner services	Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents, or are made direct with a health practitioner.
2.8	Assistance in obtaining access to specialised therapy services	Making arrangements for speech therapy, podiatry, occupational or physiotherapy practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents.

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Table F.3 **(continued)**

Part 2: (continued)

Item	*Matter Indicator*	*Expected Outcome*
2.9	Support for residents with cognitive impairment	Individual attention and support to residents with cognitive impairment (eg dementia, and other behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such residents and ongoing support (including specific encouragement) to motivate or enable such residents to take part in general activities of the residential care service.

Part 3: Care and services — to be provided for residents receiving a high level of residential care

Item	*Matter Indicator*	*Expected Outcome*
3.1	Furnishings	Over-bed tables.
3.2	Bedding materials	Bed rails, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each resident's condition.
3.3	Toiletry goods	Sanitary pads, tissues, toothpaste, denture cleaning preparations, shampoo and conditioner, and talcum powder.
3.4	Goods to assist residents to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs. Excludes motorised wheelchairs and custom made aids.
3.5	Goods to assist staff to move residents	Mechanical devices for lifting residents, stretchers, and trolleys.
3.6	Goods to assist with toileting and incontinence management	Absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas.
3.7	Basic medical and pharmaceutical supplies and equipment	Analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, and urinary alkalising agents. Excludes goods prescribed by a health practitioner for a particular resident and used only by the resident.
3.8	Nursing services	Initial and on-going assessment, planning and management of care for residents, carried out by a registered nurse. Nursing services carried out by a registered nurse, or other professional appropriate to the service (eg medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team).

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Table F.3 **(continued)**

Part 3: (continued)

Item	*Matter Indicator*	*Expected Outcome*
3.8 (cont)	Nursing services (cont)	Services may include, but are not limited to, the following: (a) establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side effects (b) insertion, care and maintenance of tubes, including intravenous and naso-gastric tubes (c) establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters (d) establishing and reviewing a stoma care program (e) complex wound management (f) insertion of suppositories (g) risk management procedures relating to acute or chronic infectious conditions (h) special feeding for care recipients with dysphagia (difficulty with swallowing) (i) suctioning of airways (j) tracheostomy care (k) enema administration (l) oxygen therapy requiring ongoing supervision because of a care recipient's variable need (m) dialysis treatment.
3.10	Medications	Medications subject to requirements of State or Territory law.
3.11	Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services	(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents' levels of independence in activities of daily living. (b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to reach a level of independence at which maintenance therapy will meet their needs. Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.
3.12	Oxygen and oxygen equipment	Oxygen and oxygen equipment needed on a short-term, episodic or emergency basis.

a Sub-section 18.6 (1A) provides that the care and services listed in Schedule 1 of the Quality of Care Principles 1997 are to be provided in a way that meets the standards set out in Schedule 2 or 3 (as the case requires).

Source: Schedule 1, Quality of Care Principles 1997 made under sub-section 96-1 (1) of the *Aged Care Act 1997*.

Table F.4 **Community Care Standards**

Part 1: Information and consultation

Principle: Each care recipient and prospective care recipient (or his or her representative) is to have access to information to assist in making an informed choice about available community care services.

Item	*Matter Indicator*	*Expected Outcome*
1.1	Assistance	Each prospective care recipient (or his or her representative) is assisted to make informed choices about the community care services.
1.2	Rights and responsibilities	Each care recipient and prospective care recipient (or his or her representative) is informed of the rights and responsibilities of care recipients and approved providers in relation to community care services, and given the opportunity to discuss with the provider the recipient's rights and responsibilities.
1.3	Fees	Each care recipient and prospective care recipient (or his or her representative) is assisted to understand the fees applying to services.

Part 2: Identifying care needs

Principle: Each care recipient is to receive quality services that meet his or her assessed needs.

Item	*Matter Indicator*	*Expected Outcome*
2.1	Identifying care needs	Each care recipient receives an initial assessment and on-going monitoring that takes all of his or her support needs into account and identifies any changes in the needs.

Part 3: Coordinated, planned and reliable service delivery

Principle: Each care recipient (or his or her representative) is enabled to take part in the development of a package of services that meets the care recipient's needs.

Item	*Matter Indicator*	*Expected Outcome*
3.1	Service delivery plan	Each care recipient has a documented service delivery or care plan outlining the services the care recipient can expect to receive.
3.2	Referral arrangements	Each care recipient benefits from the establishment of appropriate referral arrangements to ensure continuity in best meeting his or her needs when community care services are no longer appropriate.

Part 4: Social independence

Principle: Each care recipient should be enabled where possible, and encouraged, to exercise his or her preferred level of social independence.

Item	*Matter Indicator*	*Expected Outcome*
4.1	Social independence	Each care recipient is encouraged to exercise his or her preferred level of social independence.
4.2	Financial independence	Each care recipient is encouraged to maintain financial independence.

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Table F.4 **(continued)**

Part 5: Privacy, dignity, confidentiality and access to personal information

Principle: The dignity and privacy of each care recipient are to be respected, and each care recipient (or his or her representative) will have access to his or her personal information held by the provider.

Item	*Matter Indicator*	*Expected Outcome*
5.1	Privacy and dignity	Each care recipient's dignity and privacy is respected.
5.2	Procedures	Each care recipient is told of the service provider's privacy and confidentiality procedures and his or her rights under the procedures.
5.3	Access to information	Each care recipient (or his or her representative) has access to personal information about the care recipient held by the approved provider.

Part 6: Complaints and disputes

Principle: Each care recipient (or his or her representative) has access to fair and effective procedures for dealing with complaints and disputes.

Item	*Matter Indicator*	*Expected Outcome*
6.1	Complaint procedures	Each comment or complaint about a service, or access to a service, is dealt with fairly, promptly, confidentially and without retribution.

Part 7: Advocacy

Principle: Each care recipient will have access to an advocate of his or her choice.

Item	*Matter Indicator*	*Expected Outcome*
7.1	Choice of advocate	The care recipient's choice and involvement of an advocate to represent his or her interests at any time is accepted by the approved provider.

Source: Schedule 4, Quality of Care Principles 1997 made under sub-section 96-1 (1) of *the Aged Care Act 1997*.

Table F.5 **The HACC National Service Standards**

Objective 1: Access to services

To ensure that each consumer's access to a service is decided only on the basis of relative need.

Item	*Consumer outcome*
1.1	Formal assessment occurs for each consumer.
1.2	Consumers are allocated available resources according to prioritised need.
1.3	Access to services by consumers with special needs is decided on a non-discriminatory basis.
1.4	Consumers in receipt of other services are not discriminated in receiving additional services.
1.5	Consumers who reapply for services are assessed with needs being prioritised.

Objective 2: Information and consultation

To ensure that each consumer is informed about his or her rights and responsibilities and the services available, and consulted about any changes required.

Item	*Consumer outcome*
2.1	Consumers are aware of their rights and responsibilities.
2.2	Consumers are aware of services available.
2.3	Consumers are informed of the basis of service provision, including changes that may occur.

Objective 3: Efficient and effective management

To ensure that consumers receive the benefit of well-planned, efficient and accountable management.

Item	*Consumer outcome*
3.1	Consumers receive appropriate services provided through the processes of ongoing planning, monitoring and evaluation of services.
3.2	Consumers receive services from agencies that adhere to accountable management practises.
3.3	Consumers receive services from appropriately skilled staff.

Objective 4: Coordinated, planned and reliable service delivery

To ensure that each consumer receives coordinated services that are planned, reliable and meet his or her specific ongoing needs.

Item	*Consumer outcome*
4.1	Each consumer receives ongoing assessment (formal and informal) that takes all support needs into account.
4.2	Each consumer has a service delivery/care plan which is tailored to individual need and outlines the service he or she can expect to receive.
4.3	Consumers cultural needs are addressed.
4.4	The needs of consumers with intellectual difficulties, including dementia, memory loss and similar disorders, and intellectual disabilities are addressed.
4.5	Consumers receive services which include appropriate coordination and referral processes.

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Table F.5 **(continued)**

Objective 5: Privacy, confidentiality and access to personal information

To ensure that each consumer's rights to privacy and confidentiality are respected, and he or she has access to personal information held by the agency.

Item	*Consumer outcome*
5.1	Consumers are informed of the privacy and confidentiality procedures and understand their rights in relation to these procedures.
5.2	The release of consumer information occurs with the consent of the consumer or their advocate or legal guardian.
5.3	Consumers are able to gain access to their personal information.

Objective 6: Complaints and disputes

To ensure that each consumer has access to fair and equitable procedures for dealing with complaints and disputes.

Item	*Consumer outcome*
6.1	Consumers are aware of the complaints process.
6.2	Each consumer's complaint about a service, or access to a service is dealt with fairly, promptly, confidentially and without retribution.
6.3	Services are modified as a result of 'upheld' complaints.
6.4	Each consumer receives assistance, if requested, to help with the resolution of conflict about a service that arises between the frail elderly person or younger person with disability and his/her carer.

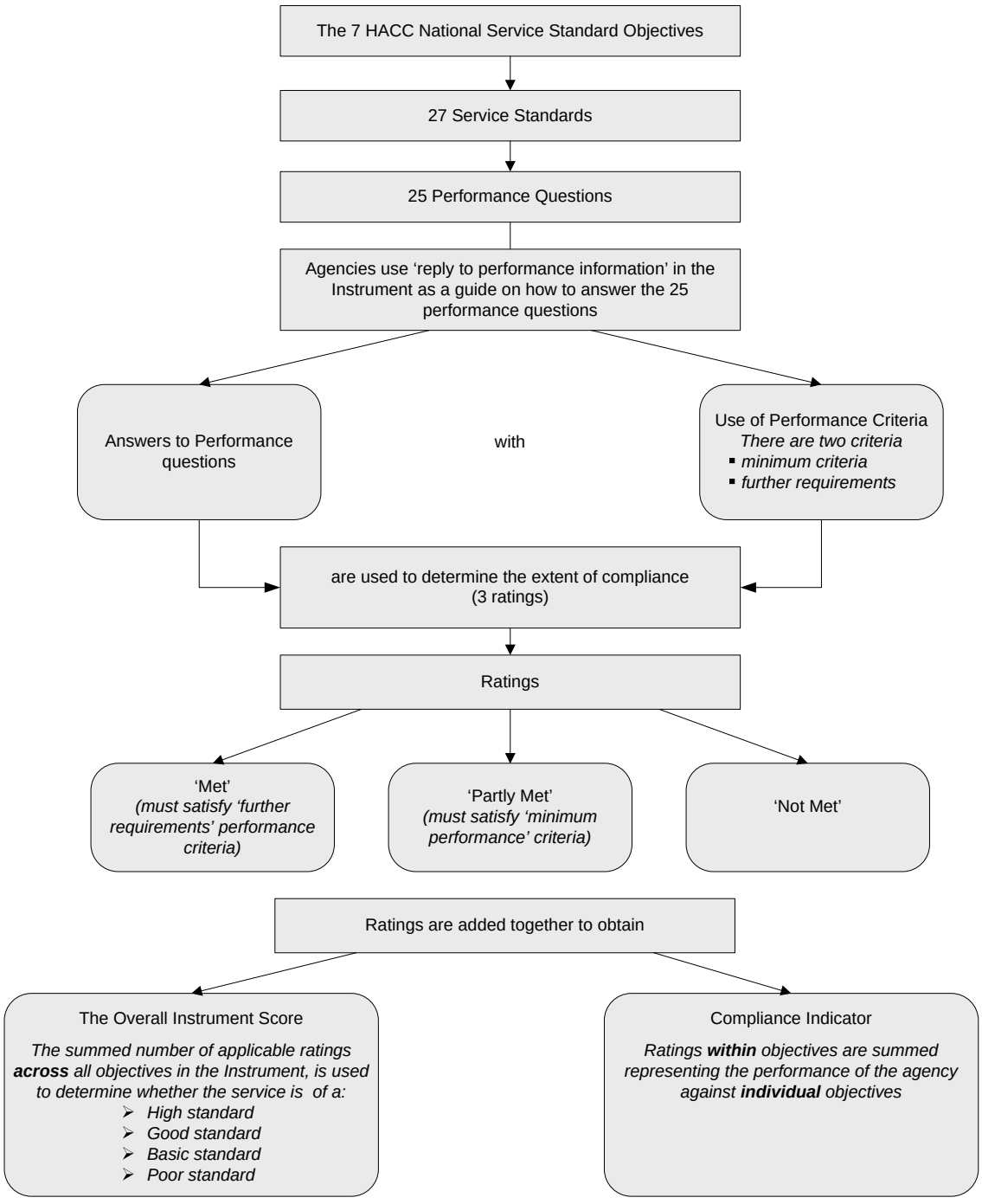
Objective 7: Advocacy

To ensure that each consumer has access to an advocate of his or her choice

Item	*Consumer outcome*
7.1	Each consumer has access to an advocate of his/her choice.
7.2	Consumers know of their right to use an advocate.
7.3	Consumers know about advocacy services — where they are and how to use them.
7.4	The agency involves advocates in respect to representing the interests of the consumers.

Source: Extracted from HACC (1998a).

Box F.5 **Process for quality review of HACC quality standards**



Source: HACC (1998a).

Table F.6 **Community Care Common Standards**

Standard 1: Effective Management

The service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery.

Item	*Matter Indicator*	*Expected Outcome*
1.1	Corporate governance	The service provider has implemented corporate governance processes that are accountable to stakeholders.
1.2	Regulatory Compliance	The service provider has systems in place to identify and ensure compliance with funded program guidelines, relevant legislation, regulatory requirements and professional standards.
1.3	Information Management Systems	The service provider has effective information management systems in place.
1.4	Community Understanding and Engagement	The service provider understands and engages with the community in which it operates and reflects this in service planning and development.
1.5	Continuous Improvement	The service provider actively pursues and demonstrates continuous improvement in all aspects of service management and delivery.
1.6	Risk Management	The service provider is actively working to identify and address potential risk, to ensure the safety of service users, staff and the organisation.
1.7	Human Resource Management	The service provider manages human resources to ensure that adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to service users.
1.8	Physical Resources	The service provider manages physical resources to ensure the safe delivery of care and services to service users and organisation personnel.

Standard 2: Appropriate Access and Service Delivery

Each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative.

Item	*Matter Indicator*	*Expected Outcome*
2.1	Service Access	Each service user's access to services is based on consultation with the service user (and/or their representative), equity, consideration of available resources and program eligibility.
2.2	Assessment	Each service user participates in an assessment appropriate to the complexity of their needs and with consideration of their cultural and linguistic diversity.
2.3	Care Plan Development and Delivery	Each service user and/or their representative, participates in the development of a care/service plan that is based on assessed needs and is provided with the care and/or services described in their plan.

(continued on next page)

Table F.6 **(continued)**

Standard 2: (continued)

Item	*Matter Indicator*	*Expected Outcome*
2.4	Service User Reassessment	Each service user's needs are monitored and regularly reassessed taking into account any relevant program guidelines and in accordance with the complexity of the service user's needs. Each service users' care/service plans are reviewed in consultation with them.
2.5	Service User Referral	The service provider refers service users (and/or their representative) to other providers as appropriate.

Standard 3: Service User Rights and Responsibilities

Each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.

Item	*Matter Indicator*	*Expected Outcome*
3.1	information Provision	Each service user, or prospective service user, is provided with information (initially and on an ongoing basis) in a format appropriate to their needs to assist them to make service choices and gain an understanding of the services available to them and their rights and responsibilities.
3.2	Privacy and Confidentiality	Each service user's right to privacy, dignity and confidentiality is respected including in the collection, use and disclosure of personal information.
3.3	Complaints and Service User Feedback	Complaints and service user feedback are dealt with fairly, promptly, confidentially and without retribution.
3.4	Advocacy	Each service user's (and/or their representative's) choice of advocate is respected by the service provider and the service provider will, if required, assist the service user (and/or their representative) to access an advocate.
3.5	Independence	The independence of service users is supported, fostered and encouraged.

Source: DoHA 2010n.

Table F.7 **The quality review process for service providers**

Review Commences	
Week 1	*Notification of Quality Review* • Quality review team sends notification letter to service provider advising of quality review • Service provider advises quality review team of contact person for onsite visit within 10 working days
Week 3-9	*Self-assessment* • Quality review team sends copy of self-assessment tool to contact person two weeks after notification of quality review • Service provider completes self-assessment and returns it to quality review team within six weeks; it may be submitted on-line, electronically or on paper, depending on jurisdiction • Quality review team reviews self-assessment prior to conducting onsite visit
Approx. weeks 12-16	*On-site Visit* • Quality review team confirms arrangements for on-site visit and, where required, ensures service provider has arranged consent to access information • On-site visit occurs, generally about four to eight weeks after review of self-assessment; it takes around six to eight hours with two reviewers, depending on size and complexity of service outlet
Weeks 16-18	*Quality Review Report* • Quality review report with improvement plan template sent to service provider within 10 days after on-site visit • Service provider may, if desired, provide additional information to quality review team within approximately 10 days of receipt of quality review report • Service provider may request reconsideration of quality review report, which may extend timeframe for completion of improvement plan
Review completed week 20	*Improvement Plan* • Service provider must submit improvement plan within 10 working days of receiving quality review report • Quality review team reviews improvement plan and may negotiate changes and time frames for improvement with service provider, especially if immediate improvements required • Improvement plan agreed to by quality review team and monitored by relevant area within Department
	Annual Improvement Plan • Following agreement of improvement plan, quality review team advises service provider when updated improvement plan will be required the following year • Service provider sent reminder four weeks before updated improvement plan due

Source: DoHA 2010n.