Attachment 2 *to COTA National Comments on the Productivity Commission's Annual Review of the Regulatory Burdens on Business: Social and Economic Infrastructure Services - Chapter 2 Aged Care*

Submission to the Department of Health and Ageing

on the

Review of the Accreditation Process for Residential Aged Care Homes

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COTA National

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Contents

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1. Introduction

COTA National [(1)] is the national peak policy organisation of the state and territory Councils on the Ageing (COTAs). COTAs have been operating for over 50 years. Though their more than 1500 member organisations of seniors, and their own direct membership of seniors, COTAs represent the interests of over 500,000 older Australians.

COTAs have always had a strong interest and involvement in aged care, and have been and are represented on a range of departmental and ministerial advisory bodies dealing with aged care matters. As peak consumer bodies COTAs have a particular interest in resident and consumer rights and engagement.

COTA National plays a leading role (sponsor organisation) in the National Aged Care Alliance (NACA) and is co-leading a NACA initiative to develop a new vision for aged care based on the centrality of community care and support and client-directed care.

COTAs have bi-lateral links with aged care provider peaks and major provider organisations at both state/territory and national levels. COTA is in particular in a collaborative relationship with ACSA.

COTA National has not consulted either within NACA or with provider peaks in the development of this submission, in part due to the short time available to us to complete the submission.

COTA National has consulted with state and territory COTAs Policy Councils and received input from a number of them; and has also consulted with aged care consumer and advocacy bodies.

We are concerned that there does not appear to have been any departmental strategy to obtain input on the issues and questions of the Review's Discussion Paper directly from residents and families. This needs to be addressed in the next phase of the process and we deal with this in section 6 of this submission.

The views advanced in this submission have taken into account input from COTA Policy Councils and are fully consistent with and informed by COTA National policy principles and current policy. However the submission has not been through the formal COTA policy approval processes and some of its views are therefore provisional.

This submission has been prepared specifically from a consumer viewpoint. By "consumer" we mean a resident plus that resident's (chosen) family members, close friends and / or advocates.

We do mention in the submission matters relating to provider experience and perspectives. However our submission is without apology substantially written from the biased viewpoint of consumer interest and particular consumer experiences.

Some of our observations and recommendations may seem "unfair" to the majority of providers, or even to the Department. Some of the negative experiences and outcomes we

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(1) COTA National is the new trading name of COTA Over 50s Ltd. It is intended to formally change the name of COTA Over 50s Ltd in the near future. This may be to COTA National or to another appropriate related name.

cite may apply to only a small minority of residents. However we make no apology for our goal being that such experiences and outcomes should not ever occur.

Our ultimate goal is that the aged care system should improve the quality of life of residents, rather than merely maintain life. That goal will require significant reform of the aged care framework and service models.

2. General comments on the current accreditation system

The Review Discussion Paper asks whether the current accreditation and monitoring regime for residential aged care homes is effective in identifying deficiencies in care, safety and quality, and if not, why not?

COTA strongly supports the need for an approved accreditation regime in aged care. However whether our current regime is optimal is open to debate – including in some key ways not canvassed in the Discussion Paper. We discuss this later.

We recognise that the vast majority of facilities would be accredited under any form of accreditation regime, as evidenced, for example, by the fact that around 90% have received three year accreditation.

However we do have significant concerns about some aspects of the current system. We have publicly expressed concern that some facilities have received three year accreditation and then within months been found to have major breaches of standards, with no change having occurred in key personnel or ownership which might explain this quandary. While the Accreditation Agency rejected our pubic criticism it could offer no credible explanation for the occurrence. No-one can. The system is not fail-safe. However there has been no independent forensic examination of why these events occur.

We can also cite instances of facilities which have been required to effect improvements in key areas of resident well-being (e.g. nutrition) and to accept external input to improve, then regaining full accreditation, but advocacy groups shortly thereafter being informed by residents that practice is a long distance from the paperwork (specifically in the nutrition case the new menus and the meals being delivered bearing little relation to each other).

In the next section of this submission we deal extensively with the issue of consumer engagement with the accreditation process so we shall only say here that this is the most sub-optimal aspect of the current system. Frankly it is unacceptable. The proposals in the Discussion Paper likewise go nowhere close to dealing with the issue. Public servants, providers and assessors are all in general out of touch with this aspect of the system.

In a way our concerns relate to the Discussion Paper's advice that the question of introducing Quality Indicators will be addressed separately, as will a review of the Standards. COTAs believe that these are inter-related matters. Indications are that so do consumers. We are increasingly concerned not principally with facilities' capacity to demonstrate a paper-based adherence to standards but with the capacity of facilities to improve rather than reduce residents' quality of life, something to which the system's overall structure, resourcing and incentives are as crucial as behaviours in individual facilities.

We return to a matter not addressed in the Department's Discussion Paper. We are aware e of long stated suggestions that accreditation should occur through recognition of a number

of independent competitive accreditation bodies (as occurs in the hospital sector) rather than being undertaken by a body such as the Aged Care Standards and Accreditation Agency – government owned and public sector in culture.

There is a strong professional argument that the processes of accreditation and indeed industry education should be separate from monitoring, complaints investigation and compliance processes, which might be characterised as “policing”. If accreditation was independent and competitive as in the rest of the health sector, then a new agency, independent of but funded largely by federal government, could undertake monitoring, complaints handing and other quality compliance activities. COTA has long argued that these functions should be separate from the Department.

COTA is not, at present, saying we should definitely move in this direction. However it is a discussion worth having openly because it directly addresses the complexities and contradictions of trying to combine quality improvement with policing.

3. Engaging residents and their significant persons

The Discussion Paper asks whether the current accreditation process allows for appropriate levels of consumer input. If not, why not and how might this be improved?

The highest priority message that COTAs want to advance in response to this Review is in two parts. It is first that the current accreditation process falls down badly in terns of consumer engagement and input. In fact it is unacceptable and has significant deleterious effects on the adequacy of the accreditation process.

In its second part, our message is that meaningful consumer engagement in the accreditation process can really only occur if that engagement becomes part of the infrastructure of the aged care system itself. We cannot have consumer engagement in assessment if we do not have consumer engagement in the very processes of residential aged care and in the shape, resourcing and operation of the whole aged care system.

Let us look at the first part of our message. The current accreditation process fails to deliver appropriate levels of consumer involvement in the following ways:

- We know that often residents, families and other significant persons are unaware that a re-accreditation process is underway and a site visit about to occur. Some efforts may be made to inform them but these are either inadequate of the information does not get through.

- An even greater issue is that people do not understand what this process means, how they can be involved in it, how they could do so confidentially, exactly what is being looked at, and so forth. Much greater effort is requited in many cases to inform consumers about the process and how they can be engaged in it.

- Despite that fact that it is expressly stated that this should not happen we are aware that in some instances the providers decide which residents and families will meet assessors and discourage other who wish to do so, or tell them that the arrangements have all been finalised.

- Interactions between assessors and residents are reported to often be confusing and unsatisfactory. There is often a lack of structure to meetings with residents and

families, with participants unclear what matters they could raise and no guidance from assessors.

- The above is exacerbated by the fact that assessors are seen as part of the system with considerable power over the facility and therefore over the lives of residents. Residents and families may want to talk about things that are not “up to scratch” or could be significantly improved, but not at the risk of losing their home.

- A different angle on the same dynamic is that as we know many residents do not complain to provider managements because of the substantial power imbalance between consumer and provider which carries the fear of retribution or withdrawal of service. Residents do not always have confidence that matters they might raise will be treated confidentially, so they do not raise them. However a couple of weeks later they might raise those issues with an advocate, when they would not with an assessor.

- Assessment visits and meetings with residents and families are rarely held in evenings or on weekends, thus further disenfranchising many family members.

Consumers should have a range of channels and times through which they can communicate with assessors in advance of a site visit, during a visit, and after the visit. One specific need is for an “exit interview” between consumers and assessors.

We receive reports that many assessors have limited experience and skills at engagement of residents and families in the accreditation process, especially given the imbalance of power referred to above. Assessors need to have specific training in this regard, and the accreditation process needs expert advice and assistance from consumer organisations and advocates in the consumer engagement.

In addition the assessors should either include a consumer representative or should have access to an expert advisor with demonstrable experience in consumer engagement.

This brings us to the second part of our message - that meaningful consumer engagement in the accreditation process can really only occur if that engagement becomes part of the infrastructure of the aged care system itself.

Time constraints do not allow us to develop this message in depth in this submission, but we will be doing so over coming months in articulating a new vision for aged care reform.

However making consumer engagement integral to the aged care system has many dimensions. These range from the goals and assumptions on which aged care is based, to the balance and proportions of community and residential care, to the service models in both forms of care, to the way in which individual services and facilities operate.

At the simplest level all residential facilities and provider organisations should be required to develop consumer engagement policies and strategies which should have the same priority as care policies and planning. Such policies and strategies should be developed with expert advice from consumer organisations with proven expertise in consumer engagement.

4. Announced or unannounced? and related issues

The Discussion Paper spends some time on the question of announced or unannounced accreditation site visits and related questions of whether facilities should have to reapply for accreditation and if so how this should occur.

COTAs are sympathetic to the point that the accreditation process should not require substantially more paperwork than is required for normal business, clinical and care management needs. We have some sympathy with the view that quality accreditation processes in the health and aged care sectors have placed too much emphasis on excessive paper trails rather than on actual outcomes being achieved.

Therefore a simplification of paperwork is supported.

However the question of whether or not facilities should have to reapply or not, or be reassessed without reapplying, somewhat mystifies us, unless it is assumed that not having to reapply would mean not having to do a self-assessment as part of the re-accreditation process.

We would not support this, as self-assessment is a vital component of an accreditation process with continuous quality improvement as its goal. If paperwork requirements are streamlined then self-assessment is not an onerous requirement unless a facility has let its quality processes drop.

While COTA understands the different concerns behind the “should visits be announced or unannounced?” debate, we suggest that:

- Accreditation processes do require notice and preparation. They constitute a periodic major review of quality control systems and procedures for a facility and accreditation processes of which we aware involve the facility knowing well ahead when the formal visit will occur. Accreditation processes are not about catching facilities out, they are about promoting and enabling quality improvement.

- Monitoring and “policing” processes of their very nature need to be unannounced. COTAs are very keen on a rigorous program of unannounced visits for monitoring purposes within the current aged care services construct.

This distinction raises again the question of whether these two different functions should be undertaken by the same body and seen as the same process. At present the policing function is dominant in the relationship between the Commonwealth and the residential aged care sector. This appears to be detrimental to the core accreditation process.

While COTA believes this question should be further addressed in some depth among all stakeholders, COTA also believes that whatever the system there must be both random and targeted unannounced visits.

It is difficult to comment on the precise proportion of facilities that should be subject to random visits but 5% is not unreasonable. The suggestion that another 5% could be selected based on their risk profile is more problematic. COTAs suggest that the percentage should be determined by the risk profile. All facilities that meet certain risk profile parameters should be subject to unannounced visits.

However COTAs also recognises that unannounced visits can create major issues for providers that have nothing to do with compliance with standards. For example, providers having to cancel staff training and indeed resident activities, recall managers from important commitments, and similar, due to unannounced visits.

We suggest that in the case of randomly generated visits the facility is contacted at senior level on the day and should have the opportunity to request a brief deferral of the visit by up to a limited number of days (e.g. 3 days) on reasonable grounds (of which a list of likely reasons could be agreed).

5. Other Discussion Paper questions

We list here all questions in the Discussion Paper and advise which we believe we have answered elsewhere in the submission, and provide brief answers to others.

Questions for consideration p10
Should approved providers have to apply for re-accreditation or should the accreditation body conduct a rolling program of accreditation audits, which ensures that each home is reassessed prior to their current period of accreditation running out (without the need for the approved provider to put in an application)? What are the advantages/disadvantages of the two approaches?

Should the provision of detailed self-assessment data continue to be a requirement of any application process? If so, why?

Would the removal of the requirement to provide self-assessment data on application create a more stressful accreditation site audit? If so, how might this be avoided?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p10
What problems, if any, have approved providers /services experienced in respect of accreditation audits and electronic records?

What are the current barriers to assessment teams utilising electronic records and how might these be overcome?

We have no comment on these questions

Questions for consideration p 11
Should approved providers continue to be able to nominate a quality assessor as a member of the assessment team that will be conducting the site audit on their aged care home?

We do not believe that providers should be able to nominate an assessor. They should be able to object to an assessor on certain grounds.

Questions for consideration p13
Should the accreditation body have the flexibility to contract 'expert members', who are not quality assessors, to participate on an assessment team? If not, why not?

If yes, what sort of 'expert members' might be used and what safeguards, if any, would need to be put in place to maintain the integrity of the assessment process?

Should it be a legislative requirement for assessment teams conducting visits to high care facilities, or to low care facilities with a significant number of high care residents, to include a quality assessor who is a registered nurse?

Yes they should have this capacity. Our major concern is that it should be used to provide expertise in relation to consumer engagement, in which the accreditation process is currently deficient.

Questions for consideration p16
Should accreditation site audits be unannounced?

If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a homes general performance be addressed?

If yes, what strategies need to be put in place to minimise disruption to staff and residents?

What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?

Should a home be able to nominate some 'black-out' days, during which the accreditation body will try to avoid scheduling a site audit? If not, why not?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p19
Does the current accreditation process allow for appropriate levels of consumer input? If not, why not? How might this be improved?

Should there be a minimum target set for consultations with residents and/or their representatives during visits to a home by the accreditation body? If so, what would be an appropriate number or percentage?

Should assessment teams seek to attend homes out of normal business hours? Would this increase opportunities for consultation with relatives/representatives?

Are there other strategies that may increase engagement with residents and/or their representatives?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p20
Should approved providers be required to organise a meeting with residents and their representatives to discuss incidences of non-compliance?

If so, should this be a general requirement for any non-compliance, or should it only apply where there is major non-compliance, for example, non-compliance with four or more expected outcomes, or non-compliance against specified outcomes?

Providers should have to inform consumers in relation to any matter of non-compliance. This should occur as part of their consumer engagement strategy. Consumer representatives should in fact be automatically informed of matters of non-compliance as part of an engagement strategy.

Questions for consideration p21
Does the lack of confidentiality for staff act as a barrier to them providing frank information to the accreditation body?

Should the confidentiality protections provided in the Aged Care Principles for residents or their representatives be extended to all persons who provide information to the accreditation body?

Confidentiality protections provided in the Aged Care Principles for residents or their representatives should be extended to all persons who provide information to the accreditation body.

Questions for consideration p22
Is the current accreditation and monitoring regime for residential aged care homes effective in identifying deficiencies in care, safety and quality? If not, why not?

If the accreditation and monitoring regime was to be enhanced, what approaches should be adopted?

Should homes be required to collect and report against a minimum data set?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p23
Should decisions only be appealable to the Administrative Appeals Tribunal if they have already been subject to reconsideration by the accreditation body?

The answer to this question depends on the future role of the Accreditation Agency. In principle, however, all internal appellate processes should be exhausted before appeal to another authority.

Should the accreditation body be able to undertake 'own motion' reconsideration of decisions in certain circumstances?

Yes.

Questions for consideration p23
Is the current way in which audit reports and decisions are published adequate? If not, why not?

Should audit reports and decisions of the accreditation body that are subject to reconsideration or review be made publicly available prior to the finalisation of the review process? If not, why not?

Should approved providers be required to provide residents and carers with access to reports and decisions of the accreditation body?

We recognise the complexities of public and media exposure and highlighting of these matters. However, consumers should be informed of all reports and decisions, and if the provider is appealing them.

Question for consideration p24
Are the current distinctions between different types of visits conducted by the accreditation body appropriate? If so, why? If not, why not?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p26
Is it problematic for the accreditation body to provide education to industry?

If not, why not? What are the benefits of the current approach?

If yes, what are some alternate models for providing education to industry?

Does there need to be another source of advice for industry, besides the accreditation body, about issues in respect of accreditation and improving performance? If so, what would be an appropriate source for such advice?

It is not problematic for an accreditation body to provide education. However, that should be as part of a broader education program in which the accreditation body is one but not the only partner. Other partners need to include the industry itself and key representatives of consumers.

It becomes problematic when the accreditation body is also policeman.

Questions for consideration p26
Should there be a maximum period of accreditation specified in the legislation?

Should homes that have sustained compliance with the Accreditation Standards over a number of years be rewarded with a longer period of accreditation?

Are there other means of rewarding good performance?

COTA does not think that a maximum period should be legislated. Three years is a reasonable period but there is no gain in legislating it.

Yes, there should be an option of an extension in the circumstances outlined. This has in the past been coveted by providers. Subject to later experience the extension should be only one year. It should not exclude that provider from random audits.

6. Process for Improving the Accreditation Process

COTA notes that this Review has been generated internally to the Department and that there are no external processes to involve consumers in the process. As far as we are aware there are similarly no such processes in relation to providers, or the public. Indeed the public is unaware of this and related internal “reviews” of bits and pieces of the current aged care system.

COTA has for some years been of the view that the aged care system in Australia is in need of major reform. We have participated in several efforts of government that might have led to that, but which failed to see the light of day. This was not due not lack of clear answers – these were agreed by departmental, consumer, provider and expert representatives - but due to a failure of government leadership and commitment.

If we are looking just at improving the accreditation process then COTA suggests the next steps in the Review should be:

- The Department prepares a report on the submissions and other input obtained.
- That report should not aim at either a “consensus” or a lowest common denominator outcome, but should reflect the full variety of views and evidence presented.
- That report should be provided to all stakeholders.
- A roundtable should be convened comprising the Department, provider representatives, consumer representatives and other key players and experts.
- The roundtable should be externally and expertly facilitated.
- The roundtable should be tasked with coming up with a model of the optimal accreditation, monitoring and compliance processes in residential aged care and recommending it to the government

However, the degree to which we can improve the accreditation process is limited by the current nature of the aged care system itself. Therefore the process proposed above is in the end secondary to a major review of the overall system.

7. Conclusion

COTA hopes that the government will finally agree to initiate a major review of the Australian aged care system, of which the accreditation process is but one, albeit important, part. As we have indicated earlier the accreditation process is itself a sub-set of the basic values, assumptions, goals and infrastructure of that system.

It is past time that the Australian aged care system be the subject of fundamental review. The core elements and indeed basic outcomes of that review are understood and largely agreed by leading providers, consumer representatives and the public service already. The task before us is to design a system that is sustainable to 2050 and of which Australia can actually be proud.

It is time to act to delineate a new vision of aged care and to put into place the steps to achieve it.

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