Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes

Department of Health and Ageing

Aged Care Standards and Accreditation Agency Ltd

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

2

Canberra ACT
16 June 2011

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency Ltd with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit and the accompanying brochure to the Parliament. The report is titled *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

3

AUDITING FOR AUSTRALIA

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ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

4

Contents

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

5

Tables

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

6

Figures

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

7

Abbreviations

ACC	Ageing Consultative Committee
Act (the)	*The Aged Care Act 1997*
Accreditation Agency (the)	Aged Care Standards and Accreditation Agency Ltd
AACD	Ageing and Aged Care Division
ANAO	Australian National Audit Office
BBP	Better Business Program
BPG	Better Practice Guide
CAC Act	*Commonwealth Authorities and Companies Act 1997*
Campbell Report (the)	*Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, 2008
CI	Continuous Improvement
CIS	Complaints Investigation Scheme
COTA	Council of the Ageing
CVS	Community Visitors Scheme
CQC	Care Quality Commission—UK
DoHA	Department of Health and Ageing
EBPRAC	Encouraging Best Practice in Residential Aged Care
EO	Expected Outcome
ERMP	Enterprise Risk Management Plan

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

8

GDP	Gross Domestic Product
HoI	Homes of Interest
JCPAA	Joint Committee of Public Accounts and Audit
NACAP	National Aged Care Advocacy Program
NALG	National Agency Liaison Group
NAPS	National Approved Provider System
NDIS	Notice of Decision to Impose a Sanction
NHS	National Health System
OACQC	Office of Aged Care Quality and Compliance
PBS	Portfolio Budget Statements
Protocol (the)	*Protocol for referrals, compliance monitoring and compliance action between the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency*, 2002
QUEST	Quality Education on the Standards
ROACA	*Report on the Operation of the Aged Care Act 1997*
SALG	State Agency Liaison Group
SO	state office
SOE	Statement of Expectations
SPoC	Service Providers of Concern
STO	state and territory office
TFI	Timetable for Improvement
TRG	Technical Reference Group

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

9

Glossary

Accreditation site audit | These occur before a residential aged care home's existing period of accreditation expires. An assessment team reviews a home's application for accreditation, which includes a self-assessment. If the application proceeds, a site audit is conducted by the assessment team against the Accreditation Standards and all 44 expected outcomes.

Approved Provider | A person or organisation approved under Part 2.1 of the Act to be a provider of care for the purpose of payment of a subsidy (a provider approved since the commencement of the Act must be a corporation).

Case Management | Encompasses the steps taken, following an initial risk assessment, to confirm whether or not there has been non-compliance with the Accreditation Standards, through to a residential aged care home's return to compliance or, failing that, some concluding regulatory action against the Approved Provider.

Continuous Improvement | The Accreditation Agency defines continuous improvement (CI) as a systemic, ongoing effort to raise a home's performance against the Accreditation Standards and recognises that, under the Act, Approved Providers have a responsibility to actively pursue CI throughout the accreditation period.

Community Visitors Scheme (CVS) | The Community Visitors Scheme provides one-on-one volunteer visitors to residents of Australian Government-subsidised aged care homes who are socially or culturally isolated, and whose quality of life would be improved by friendship and companionship.

Key Personnel | An Approved Provider's key personnel includes any person exercising one or more of the following functions: a member of a group of persons responsible for the executive decisions of the entity, including directors and board members; a person who has authority or responsibility for, or significant

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

10

influence over, planning, directing or controlling the activities of the entity; any person who is, or is likely to be, responsible for the nursing services provided by the service; and any person who is, or is likely to be, responsible for the day-to-day operations of the service.

National Aged Care Advocacy Program (NACAP)	The department funds an advocacy service in each state and territory to provide free and confidential services to assist people receiving Government-subsidised aged care services (residential and community) as well as other representatives acting on behalf of residents.
Quality of Care	The Quality of Care Principles detail the high standards of health and personal care that residents of accredited aged care homes can expect to receive from Approved Providers. These high standards are incorporated in the Accreditation Standards.
Quality of Life	Refers to broad 'psycho-social and cultural considerations' as they relate to residents of aged care homes. This expression focuses on the consumer's point of view (in contrast to 'quality of care' which emphasises more the provider's point of view and focuses on a medical model of care).
Residential aged care services	The Act uses the term 'residential aged care services' to mean 'residential aged care homes'. The Act does not use the term 'residential aged care homes'.
Review audits	Involve a complete review of a residential aged care home's care and services as measured against *all* of the Accreditation Standards. Review audits may be announced or unannounced. The legislation provides that the accreditation body can only undertake a review audit in circumstances prescribed in *Accreditation Grant Principles*, which are amended from time to time.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

11

Sanctions	The final consequence of non-compliance with an Approved Provider's responsibilities under Part 4.1, 4.2 or 4.3 of the Act. Sanctions may include: the appointment of an advisor to an Approved Provider, the appointment of an administrator to an Approved Provider, a temporary freeze on resident numbers, or the cutting of funding to a home.
Secretary	Secretary of the Department of Health and Ageing.
Support contact	The *Accreditation Grant Principles 1999* defined a support contact as a contact between the accreditation body and a residential care service for one or more of the following purposes: to supervise the residential care service's process of continuous improvement; to identify whether there is a need for a review audit; and/or to give the approved provider additional information or training. The 1999 Principles have been revoked and replaced by the *Accreditation Grant Principles 2011* which came into effect on 20 May 2011. The term 'Assessment contact' has been introduced in place of 'Support contact'.
Timetable for improvement (TFI)	If an Approved Provider is found to be non-compliant with the Accreditation Standards, they must agree to a plan for improvement with the Accreditation Agency. If, at the end of the TFI, the Accreditation Agency is not satisfied that the level of care provided by the residential care service complies with the Accreditation Standards, the Accreditation Agency must inform the Secretary and make a recommendation as to whether or not sanctions should be imposed.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

12

Summary and Recommendations

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

13

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

14

Summary

Introduction

The aged care sector

1.   Australia's aged care sector currently provides care to over one million older[1] Australians—over a third of all older people and about 4.6 per cent of the Australian population. Care is provided through either residential aged care services or through services to older Australians in their homes (community care).

2.   Public and private expenditure on aged care in 2008–09, at an estimated $12.9 billion, accounted for 1.0 per cent of GDP, with the Australian Government's $8.6 billion contribution to that expenditure accounting for some 3.1 per cent of its revenues. In 2009–10 the Australian Government provided just over $6 billion in residential aged care subsidies to Approved Providers of residential aged care homes for the purposes of providing care and services to residents.[2]

3.   The Australian Government's *Intergenerational Report* 2010 reported that over the next 40 years the number of aged care recipients is projected to increase by approximately 150 per cent. On these projections, by 2049–50 over 2.5 million older people (around 8 per cent of Australia's population) would be utilising aged care services (both residential aged care and community care). Public and private expenditure on aged care is projected to account for about 1.8 per cent of GDP, with the Commonwealth's contribution accounting for about 7.4 per cent of its revenues, on current policy settings. It is estimated that by 2049–50, about 4.9 per cent of the Australian workforce will be employed in the delivery of aged care.

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[1]   The term 'older' refers to non-Indigenous Australians aged 65 and over, and to Indigenous Australians aged 50 and over.

[2]   Department of Health and Ageing, *Annual Report 2009–10*, p. 185. The Budget Estimate is over $6.6 billion for 2010–11 and $7 billion for 2011–12.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

15

4.   An ageing population, increased longevity[3] and greater diversity in the care expectations and preferences of residents (including an increasing demand for culturally, linguistically and gender relevant care[4]) are placing pressure on the sector. Its capacity to respond is being limited by current business models, homes operating at full or near full capacity and a general shortage in the residential aged care workforce.[5] [6]

The quality, regulatory and accreditation framework under the Act

5.   The Commonwealth *Aged Care Act 1997* (the Act) establishes the legal framework for the funding, regulation and accreditation of aged care services. The framework is informed by ten objects specified in the Act, which include the promotion of high quality of care and accommodation that meets the needs of individuals, and the protection of the health and wellbeing of the recipients of aged care services.[7] The Act provides for a national quality assurance framework for residential aged care, encompassing building certification, accommodation bonds, accreditation of homes, continuous improvement in service delivery, complaints handling and the support of users' rights.

6.   The Act also establishes a link between quality and expenditure by the Australian Government on residential aged care. To be entitled to receive Australian Government subsidies for providing residential aged care services, an organisation must be approved by the Australian Government as an 'Approved Provider' and have 'places' allocated at its homes providing those

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[3]   The Australian Nursing Federation notes that: 'More and more older Australians are remaining in their own homes for longer, and are entering nursing homes only when their care needs are too complex to be managed in the community', available at: <http://www.anf.org.au/html/publications_factsheets.html>, [accessed March 2011].

[4]   The Accreditation Agency Better Practice Melbourne Conference, August 2010, Melbourne, and also referenced on the Centre for Cultural Diversity in Ageing website: <http://www.culturaldiversity.com.au/>, [accessed March 2011].

[5]   The Productivity Commission's draft report, 2011, 'Caring for Older Australians' notes that the supply of workers is problematic. The formal aged care system faces difficulties in attracting and retaining workers. These difficulties are expected to intensify due to increasing competition for workers as the overall labour market tightens in response to population ageing.

[6]   In its 2010 incoming government brief, DoHA advised the Australian Government that 'it will be a challenge for the current structures of the (aged care) system to respond to the increased demand for aged care services arising from the ageing population', and 'it will also be a challenge for the current business models to meet the changing expectations of aged care recipients, including greater levels of self determination and choice in the type of aged care they receive. '*Incoming Government Briefing: Volume 1',* Ageing and Aged Care System, p. 3, available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/min-briefs>, [accessed March 2011].

[7]   The Act, Division 2, Section 2-1(1) (b).

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

16

services. To receive subsidies for the services provided by a particular home, the home must be accredited.

7. As at June 2010, 2 773 residential aged care homes across Australia were accredited, with the capacity to provide about 178 000 residential aged care places.[8]

8. DoHA and the accreditation body appointed under the Act, have key roles in the legal framework established under the Act. Their respective roles as regulator and accreditation assessor are separate but complementary.[9]

9. DoHA's regulatory and compliance role is undertaken by the Office of Aged Care Quality and Compliance (OACQC), which is responsible for:

• responding to individual complaints regarding the quality of care provided and, where DoHA suspects that the subject of a complaint applies to more than one resident, transferring this information to the accreditation body for further investigation;

• monitoring Approved Providers' compliance with prudential responsibilities and matters that affect suitability to provide aged care; and

• taking action under the Act in response to non-compliance.[10]

10. Since 1998 the accreditation role has been performed by the Aged Care Standards and Accreditation Agency Ltd (the Accreditation Agency), a Commonwealth company limited by guarantee and subject to the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997*.[11]

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[8] In 2009–10, not-for-profit Approved Providers (religious, charitable and community-based providers) were responsible for almost 59 per cent of residential aged care places while private for-profit Approved Providers increased their share of residential aged care places by a further one per cent to 35 per cent. The remaining six per cent of places were operated by state and local governments.

[9] State, territory and local governments also have regulatory roles in particular areas of residential aged care, such as the determination of staffing and industrial awards, and monitoring compliance with building and fire safety regulations.

[10] In 2009–10, the department issued 134 Notices of Non-Compliance in relation to quality of care. DoHA issued seven Notices of Decision to Impose Sanctions to seven Approved Providers, and at the end of 2010 three of these sanctions remained in place.

[11] Under Part 5.4 of the Act, the Secretary of DoHA may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for: accreditation of residential care services in accordance with the *Accreditation Grant Principles*; and any other purposes specified in the *Accreditation Grant Principles.* The sole member of the company is the Australian Government, represented by the Minister with responsibility for the *Aged Care Act 1997.*

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

17

11. The *Accreditation Grant Principles*[12] made under the Act provide that the functions of the Accreditation Agency include:

- managing the accreditation process using the Accreditation Standards;

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

- assessing and strategically managing services working towards accreditation; and

- liaising with DoHA about services that do not comply with the standards applicable to them.

12. Accreditation is a process of assessing the performance of an organisation against generally accepted standards of performance. The *Accreditation Standards* for the residential aged care sector established by the Australian Government outline the standards for the quality of care and services to be provided to residents and the quality of life that residents can expect to experience.[13]

13. Under the *Accreditation Grant Principles*, the Accreditation Agency is required to liaise with DoHA about homes that do not comply with the Accreditation Standards. DoHA is then responsible for determining the appropriate compliance action. The sharing of information and the action each party is required to take when non-compliance is identified, is formalised through the *Department – Agency Compliance Protocol* of July 2002. The Protocol is currently being renegotiated to better reflect current practice.

14. The legal framework provides for a graduated response to identified non-compliance, by Approved Providers, with the *Accreditation Standards* and their other responsibilities under the Act. If Approved Providers breach their responsibilities, such as by failing to implement improvements required by the Accreditation Agency or the department, DoHA is responsible for taking

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12   The *Accreditation Grant Principles 1999* have been revoked and replaced with the *Accreditation Grant Principles 2011* which commenced on 20 May 2011. The functions of the Accreditation Agency remain the same.

13   While accreditation as a process contributes to quality, it cannot guarantee that all residential aged care homes will, at all times, provide the quality of care and services to residents envisaged under the Act. In addition a range of other variables, such as workforce issues and revenue streams, may influence care outcomes for residents.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

18

compliance action commensurate with the degree of non-compliance, which may include imposing sanctions.

Audit objective, scope and criteria

15. The audit objective was to assess the effectiveness of monitoring arrangements (by the Accreditation Agency) and compliance activities (by DoHA) put in place to achieve residential aged care homes' compliance with the Accreditation Standards and their other, related, responsibilities under the Act and its associated instruments.

16. The ANAO's assessment considered whether:

• a sector-wide compliance strategy was in place and aligned with effective monitoring and compliance activities at the operational level;

• there was a clear articulation of the separate but complementary roles and responsibilities of DoHA and the Accreditation Agency; and

• performance information gathered by both agencies to support public reporting and business improvements was useful and enabled comparison of performance over time.

Previous audit coverage

17. ANAO Audit Report No. 42 2002–2003, *Managing Residential Aged Care Accreditation*, recommended that an evaluation of the impact of accreditation on the quality of care in the residential aged care sector be undertaken. A subsequent Parliamentary Joint Committee of Public Accounts and Audit (JCPAA) hearing into the ANAO report recommended that this be extended to incorporate quality of life considerations. In response, DoHA commissioned research in 2004 to evaluate the impact of accreditation on quality (broadly) in subsidised residential aged care homes. The research report, commonly known as the Campbell Report, was released in October 2007. A key finding of the Campbell Report was that accreditation has had a positive impact on the quality of care and quality of life for residents in Australian Government-subsidised aged care homes and is part of a robust regulatory framework.[14]

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14   Commonwealth of Australia, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, 2007, p. ix.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

19

Overall conclusion

18. The accredited residential aged care sector currently attracts over $6 billion in Australian Government subsidies for 2 773 homes nationally, which between them have the capacity to provide 178 000 places. Spending on aged care is projected to grow from 0.8 per cent of GDP in 2009–10 to 1.8 per cent of GDP in 2049–50, with growth in spending on residential aged care projected to be the main contributor to the increase.[15] Australia's ageing population is the primary driver of aged care spending over the next 40 years, and will continue to place pressures on the system while also creating opportunities for new service providers.[16]

19. Australians expect high standards of care in aged care services. An effective monitoring and compliance framework, focused on improving the quality of aged care services through compliance with minimum standards, is an important means for maintaining confidence in the capacity of the sector to provide quality care and services to residents, many of whom are among the most frail and elderly in the community.

20. Within this context, DoHA and the Accreditation Agency have key roles. DOHA administers the Act, advises the Australian Government on aged care policy and manages a suite of aged care programs. It also has a regulatory role, monitoring compliance by Approved Providers with all their responsibilities under the Act and taking compliance action (including sanctions) if Approved Providers breach their responsibilities. The Accreditation Agency has a more defined role, with responsibility for promoting high quality care through its management of the accreditation process, the provision of information and education to industry, and monitoring homes' compliance with the Accreditation Standards. The sharing of information and the action each organisation is required to take when non-compliance is identified, is formalised through a Protocol.

21. The framework places a strong emphasis on Approved Providers accepting responsibility for providing, maintaining and improving service, and the framework's regulatory processes are designed to give Approved

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[15] Commonwealth of Australia, *The 2010 Intergenerational Report*, Chapter 4.3.

[16] While the majority of Approved Providers continue to be not-for-profit, there is a large and growing proportion of for-profit providers.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

20

Providers every opportunity to address non-compliance.[17] Consistent with this approach, the Accreditation Agency and DoHA have adopted a range of strategies to educate Approved Providers about their obligations, monitor compliance with the framework at the level of individual homes, enable them to work with Approved Providers to address non-compliance, and share information to inform their decision-making.

22.   In 2009–10 the Accreditation Agency conducted an average of 2.2 visits to each accredited home, or a total of 6 119 visits. These visits are undertaken to assess and monitor homes against the Accreditation Standards,[18] and take the form of accreditation site audits, review audits and Support Contacts.[19] Support Contacts are conducted to give assurance to the Government, community and residents that homes are providing quality care.[20] As required by the Australian Government, all homes received at least one unannounced Support Contact during 2009–10. The Accreditation Agency adopts a case management approach, involving risk-based decision-making on the timing of Support Contacts and the details of the Accreditation Standards to be assessed during Support Contacts. However, the current operational policy[21] does not enable assessors to alter the scope of assessment for a Support Contact, even where concerns arise about the performance of the home in areas outside the assigned scope of a Support Contact. Where this occurs, assessors are required to contact their state office Assessment Manager for direction if they consider their concerns warrant further assessment, or include an outline of their concerns in the Support Contact record. While recognising the benefits in maintaining a focus on the pre-identified issues, there are also potential benefits in terms of both efficiency and effectiveness in allowing assessors

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[17]   DoHA, *Report on the Operation of the Aged Care Act 1997*, 1 July 2009 - 30 June 2010, 2010, p. 78.

[18]   The performance of a home is assessed against the 44 Expected Outcomes (EOs) of the four Accreditation Standards, relating to management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safe systems. A complete assessment is carried out during site audits and review audits, with more targeted assessment against a smaller number of EOs during Support Contacts.

[19]   The term 'Assessment Contact' was introduced in place of 'Support Contact' following the revocation of the *Accreditation Grant Principles 1999* and their replacement by the *Accreditation Grant Principles 2011* on 20 May 2011. The term 'Support Contact' is used in the audit report as it was in effect during the conduct of the audit.

[20]   Aged Care Standards and Accreditation Agency Ltd, 'Support Contact Arrangements', AS_PL_00456, version 2.2, 30 October 2009, p. 1.

[21]   ibid, p. 6.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

21

some latitude to examine other risks to service delivery that they identify during visits.

23. Information from Support Contacts, especially where serious risk to the health, safety and wellbeing of residents is identified, is provided to DoHA to inform its compliance action, as required under the framework. Accreditation Agency staff communicate regularly with DoHA, including at the regional office level, and the Agency has adopted a structured education program to inform and support industry.

24. DOHA has also established a network of regional compliance officers, with responsibility for monitoring compliance, issuing Notices of Non-Compliance to Approved Providers, and, where the non-compliance is not addressed, imposing sanctions. DoHA undertakes compliance action commensurate with the level of non-compliance identified, and its compliance response is informed by information and intelligence received from the Accreditation Agency, the Complaints Investigation Scheme (CIS)[22], Approved Providers and state and territory health departments.

25. While the specific strategies adopted by DoHA and the Accreditation Agency are generally effective and appropriate, the ultimate test of the regulatory framework is its ability to respond to issues in a timely and appropriately calibrated manner. Past incidents in the sector[23] serve as a reminder of the potential impact of non-compliance on frail and elderly residents, and the importance of adopting a proactive and flexible approach to the administration of the framework, including the timely reporting and assessment of information collected by DoHA and Agency staff.

26. The framework's design and administration are informed by the size of the residential aged care sector, its home-based structure, and the primary responsibility placed on Approved Providers for quality care. Accordingly, both the framework and the majority of strategies adopted by DoHA and the Accreditation Agency are focused on promoting quality in individual accredited homes, with a lesser focus on sector-wide risks to quality and

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[22] In the course of a CIS investigation, where a DoHA officer considers that the subject matter of an individual complaint may apply to more than one resident, there are formal channels for the referral of this information to the Accreditation Agency for further consideration.

[23] The most prominent was the disclosure in early 2000 that some residents at a private nursing home had been bathed in a kerosene solution as a cure for scabies.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

22

compliance. Notwithstanding this, non-compliance can arise from the actions or inactions of management and staff within a single home, through to non-compliance relating to an individual home's capacity to deal adequately with risks arising from sector-wide developments or pressures. A variety of sector-wide risks has been identified by stakeholders and DoHA in recent times, which may influence the ability of homes to comply with the framework. In this context, further developing the existing home-focused monitoring and compliance strategy to take account of sector-wide risks would be beneficial.

27.   In the course of performing their respective functions, DoHA and the Accreditation Agency collect information which could be leveraged to provide additional assurance on the full range of compliance risks. DoHA has recently developed a Service Providers of Concern (SPoC) list, which contains up-to-date information on a range of risk indicators, typically for about 30 Approved Providers.[24] The Accreditation Agency has developed a separate Homes of Interest (HoI) list, which also uses risk indicator information, typically for about the same number of homes found to be non-compliant with the Accreditation Standards.[25] At present, only a small proportion (about five per cent) of homes is covered by the two lists, meaning that risk indicators are not compiled for the great majority of homes. The development of a common risk profile, to be completed for each accredited home, and the analysis of information from such risk profiles at an aggregate level would contribute to an improved understanding of trends in both compliance and non-compliance across the sector. The consolidation and expansion of the existing SPoC and HoI lists would provide a starting point for such an approach.

28.   The compliance framework places a strong emphasis on the responsibilities of Approved Providers and could be further strengthened by improving Approved Providers' understanding of DoHA's role and expectations under the framework. The Accreditation Agency has a *Charter of Commitment to Service Quality* which outlines its commitment to providing

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[24]   The initial focus of the list was on identifying prudential risks, but there is now an increasing focus on incorporating *quality of care* risks, whether or not these were initially caused by a home's financial status. For example, the list now includes homes which have a history of non-compliance with the Accreditation Standards, a questionable track record of addressing non-compliance, current or recent complaints activity and key changes in governance arrangements.

[25]   The number of homes on the HoI list is not constant and varies over the accreditation cycle. For example, the Accreditation Agency advised that in 2009–10 its National Case Management Committee reviewed approximately 180 homes.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

23

quality monitoring and education services, and there would be value in DoHA also developing a Service Charter. Reporting against these charters would also assist stakeholders to better understand the separate but complementary roles of DoHA and the Accreditation Agency.

29.   The accountability and performance framework could also be strengthened further by developing a more complete reporting framework to assist stakeholders to assess the respective contributions of the Accreditation Agency's compliance monitoring role and DoHA's regulatory role to quality improvement in residential aged care. Currently, the Accreditation Agency and DoHA largely report performance on an activity basis, such as the number of homes visited as part of the accreditation process and the numbers of Approved Providers on whom sanctions were imposed. By its nature, and in isolation, activity-based reporting limits the extent to which stakeholders can develop an appreciation of regulatory performance and its contribution to improvements in the quality of outcomes.

30.   The Campbell Report (2007) acknowledged the challenges, in a sector as complex as residential aged care, for developing meaningful, appropriate and measurable quality indicators. Nevertheless, the report concluded that there was a need to provide a more rigorous mechanism for the monitoring of quality, so that improvements could be measured over time and progress reported. The report set out a range of options for measuring quality improvement, and DoHA is considering the most appropriate approach. Within the context of this work, DoHA could consider how best to assess and report on the contribution made by accreditation to the overall goal of quality improvement sought by the Australian Government.

31.   The ANAO made three recommendations to support DoHA and the Accreditation Agency to further strengthen the compliance framework and to enhance the monitoring and reporting of quality and performance.

Key findings by chapter

Communicating roles and responsibilities

32.   DoHA is a regulator and the Accreditation Agency assesses compliance against the Accreditation Standards. While their roles are separate but complementary, confusion can arise in the minds of stakeholders in some circumstances, such as when the two organisations are working within the same home simultaneously.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

24

33. Government policy[26] requires Australian Government agencies to develop a Service Charter in consultation with the community they serve. DoHA has not developed a Service Charter with its regulated community— Approved Providers. The Accreditation Agency has a *Charter of Commitment to Service Quality*, but does not report its performance against the commitments in the Charter. The industry's understanding of DoHA's and the Accreditation Agency's separate but complementary roles would be improved by the introduction of a DoHA Service Charter which outlined the roles, commitments and obligations of the parties concerned. In particular, a Service Charter would enable DoHA to communicate, in an accessible format, its goal of assisting Approved Providers to achieve and maintain compliance and could outline to them the graduated actions DoHA will take where non-compliance is not remedied, and the rationale for sanctions and timeframes for decision-making. The accountability and performance framework would also be strengthened if both organisations reported annually against their Charters.[27]

34. DoHA consults formally with stakeholders through a national Ageing Consultative Committee. However, communication with stakeholder groups at the state level is less structured, and this may have affected stakeholders' level of understanding about the respective roles of DoHA and the Accreditation Agency. More structured communication may contribute to improved stakeholder understanding.

35. The Accreditation Agency has implemented a communication strategy comprising a number of practical elements: industry training, formal liaison meetings and the appointment of Relationship Managers. A number of stakeholders interviewed by the ANAO, particularly advocacy groups and specialised professional groups such as a nursing organisation, saw opportunities for improved communication with the Agency. In the light of this feedback, the Accreditation Agency may wish to consider how best to structure a deeper engagement with advocacy and professional groups.

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[26] Commonwealth of Australia, Guide to the Government's small business statement—*More Time for Business*, March 1997, Canberra, p. 11.

[27] The Accreditation Agency has undertaken to report performance against the Charter in the 2010–11 Annual Report.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

25

36.   DoHA and the Accreditation Agency have in place a Communication and Referral Protocol which could be revised to improve consistency in the exchange of information. Communication at the operational level, including at the regional level, is regular.

Compliance strategies

37.   The legislative framework places a strong emphasis on Approved Providers accepting responsibility for providing, maintaining and improving service, and the framework's regulatory processes are designed to give Approved Providers every opportunity to address non-compliance. DoHA and the Accreditation Agency have formal arrangements in place to monitor and address non-compliance at the level of individual homes.

38.   The Accreditation Agency uses a range of risk-based indicators, aligned with the Accreditation Standards, to inform its operational level planning and monitoring strategies. DoHA uses a broader range of indicators, drawing on additional information available to it as a regulator, to inform its planning and compliance strategies. There are also established procedures in place to facilitate the ongoing exchange of information between DoHA and the Agency, including information obtained from their monitoring and compliance activities, residents or their representatives and other stakeholders.

39.   The framework is focused on promoting compliance and quality in the 2 773 individual accredited homes, with a lesser focus on sector-wide risks to quality and compliance. While the risk of non-compliance by a particular Provider requires attention at the level of the individual home, DoHA and stakeholders have identified a range of sector-wide risks which may affect an individual Provider's capacity to comply with the Accreditation Standards and other related responsibilities under the Act.

40.   The development of a common risk profile, to be completed for each accredited home, and the analysis of information from such risk profiles at an aggregate level, would contribute to an improved understanding of trends in non-compliance across the sector. The consolidation and expansion of DoHA's SPoC list and the Accreditation Agency's separate HoI list would provide a starting point for such an approach.

Monitoring and managing compliance

41.   The *Department – Agency Compliance Protocol*, July 2002, (the Protocol) sets out the referral process between DoHA and the Accreditation Agency and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

26

details how compliance monitoring and action will be undertaken consistent with the legislation. There are four types of referral, reflecting a graduated response.[28] Referral categories provide additional guidance to the Accreditation Agency to focus its visits, with approximately 1 550 referrals to the Agency in 2009–10.

42.   The ANAO identified variability in the referral process. Staff training would support the consistent application of the Protocol.

43.   Case management is undertaken separately by DoHA's state and territory offices and the Accreditation Agency's state offices; jointly by DoHA and the Agency at the state level; and by each state-based office with its corresponding national office. These arrangements enable case-by-case risk information to flow in multiple directions to inform the compliance and monitoring activities of DoHA and the Accreditation Agency respectively.

44.   The Accreditation Agency uses case management to determine whether a problem already exists, or is likely to emerge, and accordingly tailors its schedule of visits and the Accreditation Standards/expected outcomes to be considered. Where there is significant change in a home's level of compliance, the Accreditation Agency conducts a review to ascertain why such a change occurred.

45.   Support Contacts are conducted to give assurance to the Government, community and residents that homes are providing quality care. Under the Accreditation Agency's current operational policy, additional matters identified by assessors can be logged for future visits and are used to inform the case management of the home and the development of the scope of subsequent visits. However, the policy does not enable assessors to alter the scope of assessment for a Support Contact without reference to a decision-maker in the relevant state office, even where concerns arise about the performance of the home in areas outside the assigned scope of a Support Contact. There are potential benefits in allowing assessors in the field some latitude to examine other risks to service delivery that they identify during

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[28]   Type 1, referred for the information of the Accreditation Agency. Type 2, referred for the Accreditation Agency to consider during its next scheduled contact. Type 3 suggests the Accreditation Agency conducts a Support Contact within 4 weeks. Type 4 requires the Accreditation Agency to arrange for a Review Audit immediately.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

27

visits. The extent of this latitude could be specified to avoid significant scope variation.

46. One of the risk factors guiding the actions of the Accreditation Agency is a change to a home's key personnel, including senior nursing staff or change in an Approved Provider. The timely transfer and accuracy of data on DoHA's National Approved Providers System (NAPS) directly affects the Accreditation Agency's ability to monitor this risk indicator.

47. NAPS does not have a direct interface to the Accreditation Agency's Better Business Program (BBP) system. Key personnel changes are entered manually into NAPS from DoHA records, and are updated as data is received from Approved Providers, increasing the risk of out-of-date information remaining on the system. The management of NAPS data could be enhanced to ensure that the Accreditation Agency receives the information in a timely manner.

48. At the operational level, DoHA and the Accreditation Agency have arrangements in place to monitor and address possible non-compliance. If the Accreditation Agency identifies serious risk to the health, safety and wellbeing of residents of an aged care home, this information is transferred to the relevant DoHA state office. Appropriate compliance responses, which may include sanctions, are determined by DoHA, informed by information from accreditation activities, CIS activities, and other sources.

49. Sanctions, as the ultimate deterrent, are the final response to non-compliance. The regulatory process gives Approved Providers every opportunity to address identified non-compliance before sanctions are contemplated. Sanctions have been imposed by DoHA for significant non-compliance issues including: non-compliance with clinical care standards; staff failing to monitor or respond to distressed residents; health risks arising from the presence of rodents in a home; risks to the safety and security of residents arising from delays in maintaining equipment, fencing and the grounds surrounding a home; and for long term or ongoing non-compliance. Sanctions have taken the form of: a suspension of Australian Government funding for new care recipients, the appointment of specialist advisers, and a requirement for an Approved Provider to provide, at its expense, training for its officers, employees and agents.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

28

Monitoring and reporting performance

50. DoHA and the Accreditation Agency largely report performance on an activity basis, such as the number of homes visited as part of the accreditation process and the numbers of Approved Providers on whom sanctions were imposed. A more complete reporting framework would assist stakeholders to assess the contribution of the separate but complementary roles performed by DoHA and the Accreditation Agency to quality improvement in residential aged care. Improvements in the reporting framework could be considered in the context of DoHA's response to the 2007 Campbell Report.

Agency responses

51. A copy of the proposed report was provided to DoHA. DoHA provided the following response:

> The monitoring and compliance arrangements undertaken by the Aged Care Standards and Accreditation Agency (accreditation and monitoring) and the Department of Health and Ageing (regulation and monitoring) are an important component of the regulatory framework for residential aged care homes to ensure quality care is provided to residents.
>
> The recommendations in the report will support the work of the Department to further enhance the residential aged care monitoring and compliance framework, and the performance reporting and assessment of quality care in residential aged care homes. The outcomes of the ANAO report will also be relevant in the context of the significant reform agenda currently underway in aged care.

52. A copy of the proposed report was provided to the Accreditation Agency. The Accreditation Agency provided the following response:

> The Accreditation Agency agrees with the Report. The Report is a useful and informative analysis of the company's approach to our responsibility to promote high quality care in the aged care sector. We note that the Report reflects the extensive changes we have made in our approach since the tabling of ANAO Report No. 42, 2002–03 in May 2003, particularly the introduction of risk based case management in accreditation and the growing industry education program.
>
> The audit also provides a good outline of the regulatory environment within which aged care providers, the Department of Health and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

29

Ageing and the Aged Care Standards and Accreditation Agency Ltd operate. It clearly articulates the role of the Department as the regulator and the Accreditation Agency as the company responsible for the promotion of quality through accreditation, education and the provision of information to the sector.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

30

Recommendations

The ANAO has made the following recommendations aimed at supporting DoHA and the Accreditation Agency to further strengthen the compliance framework and to enhance the monitoring and reporting of quality and performance.

Recommendation 1 **Para 2.44**	To improve transparency on the rights and responsibilities of Approved Providers and the service standards expected of the Department of Health and Ageing (DoHA) and the Accreditation Agency, the ANAO recommends that: • DoHA develops, in consultation with Approved Providers, a Service Charter and reports annually on its performance against the Charter; and • the Accreditation Agency reports annually against its existing *Charter of Commitment to Service Quality*. **Department of Health and Ageing response**: *Agreed*. **Aged Care Standards and Accreditation Agency response**: *Agreed*.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

31

Recommendation 2
Para 3.52

As a means of contributing to a broader understanding of sector-wide trends in compliance and non-compliance with the Accreditation Standards and other related responsibilities under the Act, the ANAO recommends that the Department of Health and Ageing (DoHA) consider, as part of an enhanced compliance and assurance strategy:

- developing a common risk profile for each accredited home; and

- analysing, at an aggregate level, the information contained in these risk profiles.

Department of Health and Ageing response: *Agreed*.

Recommendation 3
Para 5.32

In the context of the Department of Health and Ageing's (DoHA) broader work on quality indicators in response to the Campbell Report, the ANAO recommends that DoHA identify Key Performance Indicators (KPIs) that assist stakeholders to assess the contribution to quality improvement made by the Accreditation Agency's compliance monitoring role and DoHA's regulatory role.

Department of Health and Ageing response: *Agreed*.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

32

Audit findings

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

33

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

34

1.   Introduction

This chapter provides background to the audit, the regulatory framework associated with Australia's aged care system, and the roles of the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency Ltd within that framework. The audit approach is also outlined.

Background

1.1   Australia's aged care sector currently provides care to over one million older[29] Australians—over a third of all older people and about 4.6 per cent of the Australian population. Care is provided through either residential aged care services or through services to older Australians in their homes (community care).

1.2   Public and private expenditure on aged care in 2008–09, at an estimated $12.9 billion, accounted for 1.0 per cent of GDP, with the Australian Government's $8.6 billion contribution to that expenditure accounting for some 3.1 per cent of its revenues. In 2009–10 the Australian Government provided just over $6 billion in residential aged care subsidies to Approved Providers of residential aged care homes for the purposes of providing care and services to residents.[30]

1.3   The Australian Government's *Intergenerational Report* 2010 reported that over the next 40 years the number of aged care recipients is projected to increase by approximately 150 per cent. On these projections, by 2049–50 over 2.5 million older people (around 8% of Australia's population) would be utilising aged care services (both community and residential aged care). Public and private expenditure on aged care is projected to account for about 1.8 per cent of GDP, with the Commonwealth's contribution accounting for about 7.4 per cent of its revenues, on current policy settings. It is estimated that by 2049–50, about 4.9 per cent of the Australian workforce will be employed in the delivery of aged care.

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[29]   The term 'older' refers to non-Indigenous Australians aged 65 and over, and to Indigenous Australians aged 50 and over.

[30]   Department of Health and Ageing, *Annual Report 2009–10*, p. 185. The Budget Estimate is over $6.6 billion for 2010–2011 and $7 billion for 2011-12.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

35

The Aged Care Act 1997

1.4   The *Aged Care Act 1997* (the Act) is the umbrella legislation for aged care in Australia. It provides for a national quality assurance framework for residential aged care, encompassing building certification, accommodation bonds, accreditation of homes, continuous improvement in service delivery, complaints handling and the support of users' rights. The legislative framework also provides for the imposition of sanctions by the Department of Health and Ageing (DoHA) for non-compliance by Approved Providers with their various responsibilities under the Act.

1.5   The ten objects[31] of the Act include to:

promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals (s 2-1 (1) (b); and

protect the health and wellbeing of care recipients of aged care services (s 2-1 (1) (c).[32]

1.6   The Act, together with a range of subordinate legislation including Principles made by the Minister under s 96-1 (1) of the Act, comprise the aged care regulatory framework. This framework supports the scheme by which the Australian Government currently provides financial support for aged care (including residential aged care) and the conditions under which that financial support is provided.

The aged care system

1.7   Figure 1.1 provides an overview of the aged care system for which the Australian Government has the overall policy, funding and other regulatory responsibilities, including the roles played by the Accreditation Agency. Figure 1.1 indicates, in dark blue, the key points in the system where the ANAO has previously undertaken performance audits. The white components are the focus of the present audit.

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[31]   The full set of legislative objects is at Appendix 1.

[32]   DoHA provides its compliance officers with Legal Awareness Training courses and suggests that the focus of their compliance work is these two objects, whereas other departmental officers performing different functions might focus on different legislative objectives.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

36

Figure 1.1

The Aged Care System

Legend

- ANAO Audit Activity
- Activity
- Phase
- ANAO focus
- Audit

ACATs assess care types (residential, community, flexible); C'wealth funded but State/Territory administered.

Administration of the Community Aged Care Packages Program (2006-07)

AASG

Medicare

Subsidies paid by Commonwealth

Building Certification

Building Certification of Residential Aged Care Homes (2007-08)

Accommodation Bonds

Paid by residents as part of entry

Protection of residential Aged Care Accommodation Bonds (2009-10)

The Planning of Aged Care (1998 - 99)

Planning

Provider Approval

Planning and Allocating Aged Care Places and Capital Grants, (2008-09)

DoHA assesses whether undertakings of the allocation have been met

Provisional Allocations

Allocation : Aged Care Approval Round

Accreditation

Managing Residential Aged Care Accreditation (2003 -2004)

Administered by independent body: Aged Care Standards and Accreditation Agency

Aged Care Funding Instrument determines care payments for residents (from March 2008)

Assessment

Operational Places

Office of Aged Care Quality and Compliance *Complaints Investigation Scheme (CIS)*

Monitoring compliance with Standards: *ongoing activities within each 3 yr accreditation cycle*

The Accreditation Agency Role

DoHA Role

Aged Care Commissioner

Examines complaints about Accreditation Agency processes. Examines CIS processes

Source: ANAO

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

37

Residential aged care services

1.8   The Act establishes a link between quality and expenditure by the Australian Government on residential aged care. To be entitled to receive Australian Government subsidies for providing residential aged care services, the Act specifies that an organisation has first to be approved by the Australian Government as an 'Approved Provider' and has to have been allocated 'places' at its homes providing those services.

1.9   In addition, for an Approved Provider to then receive subsidies for the services provided by a particular home, the home has to be accredited by the accreditation body appointed under the Act. Since 1998 this has been the Aged Care Standards and Accreditation Agency Ltd (the Accreditation Agency).

1.10   As at June 2010, Approved Providers operated 2 773 accredited aged care homes across Australia, offering about 178 000 residential aged care places and providing related services on either a permanent or short-term respite basis. Some 147 000 of these places were occupied by people aged 70 years and over.[33]

1.11   The framework[34] places a strong emphasis on Approved Providers accepting responsibility for providing, maintaining and improving service, and the framework's regulatory processes are designed to give Approved Providers every opportunity to address non-compliance.[35]

1.12   In 2009–10, not-for-profit Approved Providers (comprising religious, charitable and community-based providers) were responsible for almost 59 per cent of residential care places while private-for-profit Approved Providers increased their share of residential care places by a further one per cent to 35 per cent. The remaining six per cent of places were operated by state[36] and local governments.[37]

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[33]   DoHA, *Report on the Operation of the Aged Care Act 1997*, 1 July 2009 – 30 June 2010.

[34]   See Appendix 2 for relevant sections of the Act concerned with the legislative framework.

[35]   DoHA, op cit, p. 78.

[36]   The Victorian State Government is the largest government Approved Provider with over 200 homes.

[37]   DoHA, op cit, p. 37.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

38

Accreditation

1.13 The International Society for Quality in Health Care (ISQua) describes accreditation as 'a public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards'.

1.14 In the residential aged care sector in Australia, the Accreditation Standards are established by the Australian Government.

1.15 These Accreditation Standards, detailed in the *Quality of Care Principles 1997*[38], outline the standards for the quality of care and services to be provided to residents and the quality of life that residents can expect to experience. The Principles specify 44 expected outcomes across four Standards:

- Standard 1—management systems, staffing and organisational development;

- Standard 2—health and personal care;

- Standard 3—resident lifestyle; and

- Standard 4—physical environment and safety systems.[39]

Monitoring and managing compliance

1.16 The Australian Government is responsible for determining most of the legislative framework used to regulate Australian Government-subsidised residential aged care services.[40] This framework sets out the separate but complementary roles that DoHA and the Accreditation Agency have in monitoring and assisting accredited aged care homes to comply with the Act.

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[38] Quality of Care Principles 1997. Attorney-General's Department website: <http://frli.law.gov.au/s97.vts?action=View&VdkVgwKey=1998B00264&Collection=FRLI&ViewTemplate=frliview.hts>, [accessed16 October 2010].

[39] The Aged Care Standards and 44 Expected Outcomes are listed at Appendix 3.

[40] State, territory and local governments also have regulatory roles in particular areas such as the determination of staffing and industrial awards, and monitoring compliance with building and fire safety regulations. The regulatory roles of different levels of government are summarised in the Productivity Commission's 2010 *Report on Government Services*, at paragraph 13.9.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

39

DoHA's and the Accreditation Agency's roles

1.17 DoHA, has summarised the key features of its role and that of the Accreditation Agency as follows:

> Both the Accreditation Agency and the department have a role in monitoring residential care services. In broad terms, the Accreditation Agency manages the accreditation process and monitors compliance with the Accreditation Standards. DoHA is responsible for managing the community care quality reporting program and monitors compliance with the Community Care Standards. DoHA monitors compliance by Approved Providers with all their responsibilities under the Act. DoHA is responsible for taking sanctions[41] action when Approved Providers breach their responsibility, including failing to implement improvements required by the Accreditation Agency or DoHA.[42]

DoHA's compliance role

1.18 DoHA is responsible for administering the Act and the Australian Government's aged care programs under its Outcome 4: Aged Care and Population Ageing. For 2010–11 and 2011–12, Outcome 4: 'aims to ensure that older people receive a choice of high quality, accessible and affordable care, and that carers get the support they need to look after frail older people living at home. The Government also aims to encourage older people to live active and independent lives'.[43] The department's Ageing and Aged Care Division (AACD) and Office of Aged Care Quality and Compliance (OACQC) share the responsibility for Outcome 4, including 'promoting quality residential care services'.

1.19 DoHA's role of *promoting quality residential care services* was detailed in its 2010–11 Portfolio Budget Statements (PBS) as follows:

> The Australian Government is committed to the provision of quality aged care services and the protection of residents' accommodation bonds. To promote the delivery of high quality care, the department administers programs that encourage sound financial governance and ensures that funding provided matches residents' care needs. The department ensures that providers understand their responsibilities as Approved Providers under the *Aged Care*

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41   Under the legislation, the Secretary of DoHA has the authority to impose sanctions, by notice, in writing when an Approved Provider breaches their responsibilities under the Act.

42   DoHA, *Report on the Operation of the Aged Care Act 1997*, 1 July 2009 – 30 June 2010, p. 78.

43   Commonwealth of Australia, *Portfolio Budget Statements 2010–11*: Heath and Ageing Portfolio, p. 163.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

40

Act 1997 and undertakes targeted compliance assessments of providers meeting their care and financial obligations. If providers breach their responsibilities, appropriate remedial action, including formal sanctions, can be applied.[44]

1.20   A similar statement appears in DoHA's 2011–12 PBS:

The Australian Government aims to:

- ensure the availability of high quality, resident-centred care, by promoting equitable access to residential aged care; and

- work towards financial security for residents to support their choice of an aged care home, improve the quality of aged care services through compliance with minimum standards, and encourage continuous improvement.[45]

1.21   Within Outcome 4, DoHA's 2011–12 budget for Program 4.6: Residential Care is approximately $7.23 billion.[46] The majority (97 % or around $7 billion) of this funding is a special appropriation for residential aged care subsidies.

The Accreditation Agency's monitoring role

1.22   Part 5.4 of the Act states that the Secretary (of DoHA) may, on behalf of the Commonwealth, enter into a written agreement with a body corporate under which the Commonwealth makes one or more grants of money to the body for the following purposes:

- accreditation of residential care services in accordance with the *Accreditation Grant Principles*; and

- any other purposes specified in the *Accreditation Grant Principles*.

1.23   Appendices 1 and 2 provide an overview of those parts of the Act and its subordinate legislation that give effect to the funding and roles played by the accreditation body.

1.24   Since 1998, the Accreditation Agency has been the appointed accreditation body. It has recently been reappointed through to 2014. The Accreditation Agency is owned and partially funded by the Australian

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[44]   Commonwealth of Australia. *Portfolio Budget Statements 2010-11:* Health and Ageing Portfolio, p.199.

[45]   Commonwealth of Australia. *Portfolio Budget Statements 2011-12:* Health and Ageing Portfolio, p.195.

[46]   ibid, p. 197.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

41

Government. It is a company limited by guarantee[47] and subject to the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997* (the CAC Act). The sole member of the company is the Australian Government, represented by the Minister with responsibility for the *Aged Care Act 1997*. Its Commonwealth funding, which is paid as the accreditation grant under the Act, is $24 965 000 for 2010–11 and $20 322 000 for 2011–12.[48] The annual grant is variable and reflects the peaks and troughs in accreditation activity over the three year cycle.

1.25   The Accreditation Agency's central office is located in Sydney, with regional offices located in all the states.[49] Each regional office has a senior executive responsible for its activities. As at 30 June 2010, the Accreditation Agency had 210.6 full-time equivalent staff. It had 457 aged care assessors on its register[50] as at 30 June, with 133 being permanent employees of the company. The balance is engaged on a contractual or casual basis to meet workload demands.[51]

1.26   The *Accreditation Grant Principles* specify that the Accreditation Agency (as the body with whom the Secretary has an agreement) must carry out regular supervision of an accredited residential care service, through Support Contacts[52], during which the accreditation body will:

   (a) monitor compliance with the Accreditation Standards, and

   (b) assist the service to undertake continuous improvement.

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[47]   A company limited by guarantee is a company whose members have limited liability.

[48]   Commonwealth of Australia, *Portfolio Budget Statements 2011-12,* Health and Aging Portfolio, p. 415. The Accreditation Agency advised that this grant funding represents, over the three-year accreditation cycle, 64 per cent of its income, with the remainder derived from accreditation fees paid by approved providers (30 per cent), education activities (4 per cent) and interest income (2 per cent).

[49]   The Accreditation Agency does not have offices in any of the territories. The ACT is managed by the NSW state office and the NT is managed by the SA state office.

[50]   The legislation provides that the accreditation body will appoint a registrar of aged care quality assessors. The function of the registrar and the requirements to become a registered aged care quality assessor and maintain registration are set out in the *Accreditation Grant Principles*.

[51]   Aged Care Standards and Accreditation Agency Ltd. Annual Report 2009/10. <http://www.accreditation.org.au/site/uploads/annual%20report%202009_2010.pdf>, [accessed April, 2011].

[52]   See the Glossary for a definition of a Support Contact, known since 20 May 2011 as an Assessment Contact.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

42

1.27   Under its separately reported 2010–11 budget for Program 1.1[53], the Agency aims to:

- assess and strategically manage residential aged care services working towards accreditation;

- monitor residential aged care services for compliance with the Accreditation Standards; [54]

- further develop education activities to promote high quality aged care; and

- provide information to industry to help improve the quality of care for residents.

1.28   The Accreditation Agency and DoHA have a Protocol, known as the *Department-Agency Compliance Protocol* July 2002, regarding the actions each party is expected to undertake where non-compliance by an Approved Provider is identified or suspected. The Protocol is currently being renegotiated to better reflect current practice.

1.29   The Accreditation Agency is certified to the international quality management standard ISO 9001. The Accreditation Agency has been externally assessed by auditors SAI-Global Limited as having met this standard. This includes a commitment to consistency and quality in the delivery of its services, and managing the residential aged care accreditation process in Australian Government-funded aged care homes.[55] Both the Accreditation Agency's management systems and its assessor training and assessor management program are accredited through the International Society for Quality in Health Care (ISQua).

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[53]   The Accreditation Agency advised the ANAO it has a separately reported budget statement because it is a Commonwealth owned company. If a non-Commonwealth owned company had been appointed as the accreditation body, only its Commonwealth funding would have been reported in DoHA's budget statement.

[54]   Appendix 3 contains the Aged Care Standards and Expected Outcomes against which the Accreditation Agency monitors compliance.

[55]   Commonwealth of Australia, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, 2008, p. ix.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

43

Parliamentary interest and other reviews

Parliamentary/committee interest

1.30 In 2003, the JCPAA held a public hearing to review progress made against the recommendations outlined in the ANAO's 2002–03 audit report *Managing Residential Aged Care Accreditation*.[56] The JCPAA enquiry found that the focus of the quality assessment data currently being used for accreditation should be broadened to include information on the quality of life experienced by residents of aged care across the industry.[57] The committee noted that: 'despite all the effort and cost to date in implementing accreditation, the Accreditation Agency's current system of accreditation tells little about whether the quality of life of people in aged care facilities *has actually improved*'.

1.31 The JCPAA recommended the extension of the ANAO recommendation to *evaluate the impact of accreditation on the quality of care in the residential care industry* to include the quality of life experienced by residents of government-funded aged care homes. DoHA responded to the ANAO and JCPAA recommendations by commissioning research in this area: *The Project to Evaluate the Impact of Accreditation on the Quality of Care and Quality of Life of Residents in Residential Aged Care Services*.

1.32 The project report, commonly referred to as the Campbell Report, was released in 2008. It commented favourably on the aged care accreditation process in Australia and canvassed options for the future measurement of quality in residential aged care. The report remains under consideration by the Australian Government and DoHA. Further details of this report are available in Appendix 4.

Prior and current reviews

1.33 There are also a number of prior and current reviews of aged care arrangements that are of interest for this audit. Prior reviews include:

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[56] ANAO Audit Report No 42. 2002–03, *Managing Residential Aged Care Accreditation*.

[57] Generally, the focus of quality improvement initiatives in the health sector (including residential aged care) has been on *quality of care*. However, there is increasing recognition of the importance of *quality of life* as an outcome of residential aged care and there is a need to develop appropriate methods for measuring both quality of care and quality of life, to monitor performance and stimulate quality improvement.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

44

- *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, 2008;

- the Productivity Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, 2009; and

- Review of the Aged Care Investigation Scheme 2009 (the *Walton Review*).

1.34 Current reviews include:

- the departmental review of the accreditation process and the Accreditation Standards; and

- the Productivity Commission's draft report: *Caring for Older Australians*.

1.35 Further details and key findings of these reviews can be found at Appendix 4.

The audit

Audit objective, scope and criteria

1.36 The audit objective was to assess the effectiveness of the monitoring arrangements (by the Accreditation Agency) and compliance activities (by DoHA) put in place to achieve residential aged care homes' compliance with the Accreditation Standards and their other, related, responsibilities under the Act and its associated instruments.

1.37 The ANAO's assessment considered whether:

- a sector-wide compliance strategy was in place and aligned with effective monitoring and compliance activities at the operational level;

- there was a clear articulation of the separate but complementary roles and responsibilities of DoHA and the Accreditation Agency; and

- performance information gathered by both agencies to support public reporting and business improvements was useful and enabled comparison of performance over time.

Audit methodology

1.38 To form an audit opinion against the objective, the audit methodology consisted of:

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

45

- an examination of policy documents, guidelines, procedures, operational planning documents and reports in relevant areas of DoHA and the Accreditation Agency;

- interviews with relevant DoHA and Accreditation Agency staff at the national level as well as at state levels, including accompanying Accreditation Agency assessors on announced Support Contacts to two residential aged care homes;

- reviews of the effectiveness of DoHA's and the Accreditation Agency's Quality Systems to ensure conformance with established regulatory policy and procedural guidelines and documentation, supported by examining a sample of the Accreditation Agency's files;[58]

- a survey of DoHA state and territory office compliance functions;

- structured interviews with key stakeholders; and

- reviews of relevant literature.

1.39 The audit was conducted in accordance with ANAO auditing standards at a cost of $575 800.

Previous ANAO audits

1.40 The ANAO has conducted a number of performance audits of aged care arrangements and programs. These include:

- *Protection of Residential Aged Care Accommodation Bonds*, Audit Report No. 5, 2009–10;

- *Planning and Allocating Aged Care Places and Capital Grants*, Audit Report No. 40, 2008–09;

- *Building Certification of Residential Aged Care Homes*, Audit Report No. 35, 2007–08;

- *Administration of the Community Aged Care Packages Program*, Audit Report No. 38, 2006–07;

- *Managing Residential Aged Care Accreditation*, Audit Report No. 42, 2002–03;

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[58] The outcomes of these file reviews are presented at select points within this report.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

46

- *Home and Community Care Follow-up Audit,* Audit Report No. 32, 2001–02;

- *Home and Community Care,* Audit Report No. 36, 1999–2000; and

- *The Planning of Aged Care,* Audit Report No. 19, 1998–99.

Structure of the report

1.41   The remaining chapters of the report are:

- Chapter 2 – Communicating roles and responsibilities;

- Chapter 3 – Compliance strategies;

- Chapter 4 – Monitoring and managing compliance; and

- Chapter 5 – Monitoring and reporting performance.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

47

2. Communicating Roles and Responsibilities

This chapter outlines the roles and responsibilities of the Department of Health and Ageing and the Accreditation Agency as defined in the legislation and other relevant documentation. It examines the communication of these roles, obligations and commitments to stakeholders and the communication between DoHA and the Accreditation Agency.

Introduction

2.1 The *Aged Care Act 1997* (the Act) established the framework for aged care in Australia. DoHA is responsible for administering the Act. This includes monitoring Approved Providers to ensure they are meeting their obligations under the Act and for taking compliance action where Approved Providers have breached, among other things, their responsibility to provide quality aged care, as set out in the Accreditation Standards.

2.2 The Accreditation Standards, detailed in the *Quality of Care Principles 1997*, outline the expected standard of quality of care for residents of aged care homes. The Secretary of DoHA has appointed the Accreditation Agency to undertake the role of the accreditation body, which is partially funded by a grant made under the Act. Its role is to promote high quality care and continuous improvement through the assessment and ongoing monitoring of homes' compliance with the Accreditation Standards and through its education and information activities.

2.3 In this context, DoHA is the regulator and the Accreditation Agency assesses compliance with the Accreditation Standards. While the roles of the two organisations focus on different aspects of the legal framework, they are complementary.

2.4 In this chapter, the ANAO:

- outlines the roles of DoHA, the Accreditation Agency and the related role of the Aged Care Commissioner;

- examines the communication of roles, obligations and commitments; and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

48

- assesses the communication between DoHA and the Accreditation Agency.

Roles of DoHA and the Accreditation Agency and the related role of the Aged Care Commissioner

2.5 The Act requires an annual report of its operations to be published. The *Report on the Operation of the Aged Care Act 1997* (ROACA) contains information to aid understanding of aged care programs and policies.

2.6 The 2009–10 ROACA stated that:

- both DoHA and the Accreditation Agency have a role in monitoring residential aged care services:

    – DoHA monitors compliance by Approved Providers with all their responsibilities under the Act;

    – in broad terms, the Accreditation Agency manages the accreditation process and monitors compliance with the Accreditation Standards.

- DoHA is responsible for taking sanctions action when Approved Providers breach their responsibility, including failing to implement improvements required by the Accreditation Agency or the department.

The role of DoHA

2.7 As the regulator for 2 773 accredited aged care homes delivering residential care[59], DoHA's role is determined by the Act. DoHA's Office of Aged Care Quality and Compliance (OACQC) has both a regulatory and a quality improvement focus, including:

- responding to individual complaints regarding the quality of care or services provided to care recipients by Approved Providers;

- monitoring Approved Provider compliance with prudential responsibilities and matters that affect suitability to provide aged care; and

- taking action under Part 4.4 of the Act in response to non-compliance.

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[59]   As at 30 June, 2010.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

49

2.8   In undertaking its regulatory function, DoHA utilises its state and territory office (STO) network to respond to information provided by the Accreditation Agency where the Agency may have found non-compliance as the result of a visit to an aged care home. The DoHA state and territory offices make decisions on the appropriate course of action in response to non-compliance.

2.9   Table 2.1 outlines the roles of DoHA as articulated in legislation and its corporate documents. State-based operational arrangements are examined in more detail in Chapter 4.

Table 2.1

Articulation of the role of DoHA

Role	DoHA Activities
Legislation— the *Aged Care Act 1997* (the Act)	DoHA monitors compliance by Approved Providers with all their responsibilities under the Act. When an Approved Provider is not complying with their responsibilities under Part 4.1, 4.2 and 4.3 of the Act, the department is required to take appropriate compliance action under Part 4.4 of the Act. This Part sets out the consequences of non-compliance and the types of compliance action (including sanctions) that can be taken against Approved Providers. The department does this through a monitored sanction period. This period can involve placing a Nurse Advisor within the home to oversee improvements in the clinical care of residents. DoHA can also request improvement plans from the home in the form of a Notice to Remedy, which precedes the formal sanction period.
Corporate operations	The Office of Aged Care Quality and Compliance (OACQC) and the Ageing and Aged Care Division (AACD) are responsible for planning and delivering DoHA's Program 4.6 (Residential care). Program 4.6 involves: • quality assurance, including legal review of all notices of non-compliance or sanction notices received from state and territory offices; • providing training and advice to state and territory offices in relation to compliance issues; and • oversight of the Accreditation Agency's performance in meeting its wider obligations under the contract/Deed of Funding.

Source: ANAO

DoHA's compliance actions

2.10   Where Approved Providers are suspected or found to be non-compliant with their responsibilities under the Act, DoHA can apply appropriate sanctions.

2.11   When the non-compliance is considered a major concern, but does not pose an immediate and severe risk to the safety, health and wellbeing of

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

50

residents, the consequences of the non-compliance, under Part 4.4 of the Act, begin with issuing an Approved Provider with a Notice of Non-Compliance. This Notice sets in train a series of actions designed to give the Approved Provider every opportunity to comply with its responsibilities. The Notice of Non-Compliance asks the Approved Provider to implement required actions to rectify the non-compliance, including rectifying non-compliance with any of the 44 outcomes of the Accreditation Standards.

2.12 Depending on whether or not the Approved Provider remedies the non-compliance, further notices can follow, including: a Notice of Intention to impose Sanctions; and a Notice of a Decision on whether to impose Sanctions.

2.13 There are two possible pathways to imposing a sanction:

- if an Approved Provider fails to comply with an undertaking to remedy the non-compliance identified in a Notice of Non-Compliance, the Secretary may impose a sanction based on this failure. The sanction imposed will be commensurate with the type of non-compliance. For example, if the non-compliance is primarily a failure to provide adequate quality of care as required under Part 4.1,[60] the sanction may require the Approved Provider to put in place a nurse adviser for the period of the sanction; and

- when an Approved Provider is found to not be meeting its responsibilities under the Act and the non-compliance is of a serious nature and poses an immediate and severe risk to the safety, health and wellbeing of residents, the regulatory action under Part 4.4 may include a decision to go straight to a sanction and the sanctions imposed will be commensurate with the type of non-compliance.

2.14 The types of sanctions that DoHA can impose are listed in Table 2.2.

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[60] Part 4.1 sets out Approved Provider responsibilities regarding the quality of care provided.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

51

Table 2.2

Sanctions available under the Act

Sanctions available under the Act
Under the legislation, the Secretary of DoHA has the authority to impose one or more of the following sanctions, by notice in writing: • revoking or suspending approval as a provider of aged care services • restricting approval to existing services or places • restricting funding to existing residents • revoking or suspending the existing allocation of places • varying the conditions of approval for allocated places • prohibiting the further allocation of places • revoking or suspending extra service status • prohibiting the granting of approval for extra service status • revoking or suspending certification • prohibiting the charging of accommodation charges or accommodation bonds • requiring the repayment of grants • other sanctions as specified in the Sanctions Principles

Source: Productivity Commission, *Caring for Older Australians—Draft Report*, January 2011, p. 415.

The role of the Accreditation Agency

2.15 The Accreditation Agency is a part of the regulatory framework established under the Act. An outline of the Accreditation Agency's role can be found in the *Accreditation Grant Principles 1999*.[61] The Chairman of the Board observed in the Accreditation Agency's 2009–10 Annual Report that: 'as the accreditation body, we play a pivotal role in promoting safety and quality in Australian Government-subsidised residential aged care homes'.

2.16 Table 2.3 provides a summary of the Agency's role. Operations at the state level are examined in Chapter 4.

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[61] The Agency's role remained unchanged with the introduction of the *Accreditation Grant Principles 2011*, which commenced on 20 May 2011.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

52

Table 2.3

Articulation of the role of the Accreditation Agency

Role	Accreditation Agency
Legislation—the *Aged Care Act 1997* (the Act)	Under Part 5.4 of the Act, the Accreditation Agency is the body corporate appointed by the Secretary of DoHA as the accreditation body for the purpose of accrediting residential care services in accordance with the *Accreditation Grant Principles*. Functions include: • managing the accreditation process using the Accreditation Standards; • promoting high quality care, and helping industry to improve service quality by identifying best practices and providing information, education and training to industry; • assessing, and strategically managing, services working towards accreditation; and • liaising with DoHA about services that do not comply with the standards applicable to them (the Residential Care Standards or the Accreditation Standards, as appropriate).

Source: ANAO

2.17   Since 1998 the accreditation role has been performed by the independent Aged Care Standards and Accreditation Agency Ltd. Being 'independent' is referred to briefly but not explained in the Second Reading Speech to the Act. Similarly, the Explanatory Memorandum refers to the introduction of an 'external accreditation process'. While the Act itself and the subordinate legislation do not directly specify the intended nature of the accreditation body's independence, the legislation does make it clear that the accreditation body is expected to operate at arm's length from government and the department regarding its decision-making under the *Accreditation Grant Principles*. In addition, as the Accreditation Agency is a body corporate wholly owned by the Commonwealth, it has considerable operational independence in how it conducts and reports on its affairs, subject to the requirements of the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997*.

2.18   Under the *Accreditation Grant Principles*, the Accreditation Agency (as the body with whom the Secretary has an agreement) must carry out regular supervision of an accredited residential care service, through Support Contacts[62], during which the accreditation body will:

(a) monitor compliance with the Accreditation Standards, and

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[62]   See the Glossary for a definition of a Support Contact.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

53

(b) assist the service to undertake continuous improvement.

2.19 While the Accreditation Agency has the authority to vary or revoke a home's period of accreditation, it has no other enforcement powers.[63]

The related role of the Aged Care Commissioner

2.20 The Aged Care Commissioner (the Commissioner) is a statutory office holder under the Act whose functions are performed independently of DoHA and the Accreditation Agency. The Commissioner reviews appeals or complaints made by stakeholders about the decisions and processes of the Complaints Investigation Scheme (managed by the Office of Aged Care Quality and Compliance within DoHA) and the actions of the Accreditation Agency.[64]

2.21 The Commissioner can make recommendations, but not determinations, to DoHA and the Accreditation Agency in relation to individual appeals and complaints. In 2009–10, the department accepted 96 per cent of the Commissioner's recommendations concerning 114 appeals against CIS decisions. During the same period, the Commissioner completed reports on one complaint about the conduct of the Accreditation Agency and three complaints about assessors. The Commissioner found that none of these complaints were substantiated.[65]

The communication of roles, obligations and commitments

Effective communication in the regulatory environment

2.22 It is usual for a regulator to have a range of stakeholder groups with which it interacts. The regulator's relationship with each group will have specific characteristics which, by their nature, shape the regulator's approach to communicating with them. The broad categories of stakeholder groups within the sphere of residential aged care that DoHA and the Accreditation Agency communicate with include:

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[63] Productivity Commission, *Caring for Older Australians* – draft report, January 2011, Canberra, p. 388.

[64] Part 6 of the Act sets out the Commissioner's functions; see Appendix 2 for a summary.

[65] Aged Care Commissioner, *Annual Report*, 1 July 2009 - 30 June 2010, p. 27.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

54

- Approved Providers (the regulated community) and on-site personnel**;**

- general representative groups—advocacy groups and groups representing older Australians, such as National Seniors, and the Council of the Ageing (COTA);

- specialised professional organisations—Alzheimers Australia, the Australian Nursing Federation; Palliative Care Australia and, importantly,

- aged care residents, relatives and their representatives.

2.23 The relationship a regulator has with stakeholders (including the regulated community, in this instance—Approved Providers) can make an important contribution to the effective administration of regulation and the promotion of continuous improvement. Open and cooperative relationships are beneficial to all parties. Increasing the transparency of, and the regulated community's confidence in, the regulatory regime can also be expected to increase the level of voluntary compliance.[66]

2.24 Under the regulatory framework for the residential aged care sector, the Accreditation Agency is the organisation that regularly works with Approved Providers to achieve compliance with the Accreditation Standards and promote continuous improvement.

2.25 By contrast, DoHA takes on a regulatory role when events occur that are outside the 'normal run of business', for example, when a large number of expected outcomes are not met by a particular aged care home.

2.26 When addressing non-compliance with the Accreditation Standards and other Approved Provider responsibilities under the Act, it is important that DoHA and the Accreditation Agency minimise any perceived overlap or duplication of their roles as this can result in confusion within the industry. Recent departmental reports (the Campbell Report 2008 and the Walton Review 2009) both indicated that, for a number of stakeholder groups, the roles of the department and the Accreditation Agency in the regulatory framework were blurred.

2.27 Confusion can arise when DoHA and the Accreditation Agency are working with the same home simultaneously. It can happen, for example, that

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[66] ANAO, *Better Practice Guide—Administering Regulation*, March 2007, Canberra, p. 25.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

55

after an instance of non-compliance with the Accreditation Standards has been revealed in a particular home, the Accreditation Agency agrees a Timetable for Improvement (TFI) with the home management and, at the same time, DoHA issues a Notice of Non-Compliance, either for the same reason or a different one. DoHA and the Accreditation Agency can also both attend a home when the severity of non-compliance is high, leading to the imposition of sanctions for 'immediate and severe risk to residents'.

2.28 Maintaining good relationships with all categories of stakeholders is also important, as each has a different function in supporting the provision of high quality care and continuous improvement in aged care homes. Communicating with all categories of stakeholders in a manner that emphasises clarity of role, technical competence, timeliness, courtesy and respect has benefits for:

- Approved Providers—by improving their understanding of both DoHA's and the Accreditation Agency's operations and performance expectations against the requirements of the Act;

- DoHA and the Accreditation Agency—by improving their understanding of the motivation and abilities of Approved Providers to meet their obligations; and

- all stakeholders—through improved information flows including clarity around the respective roles of DoHA and the Accreditation Agency.

2.29 Figure 2.1 illustrates the roles played by DoHA and the Accreditation Agency in ensuring that accredited aged care homes comply with the Act. It also identifies the involvement of other stakeholders, especially residents and their families. As the regulatory role of DoHA and the monitoring role of the Accreditation Agency are complementary, it is important that the differences between these roles are clearly communicated to and understood by stakeholders, including the regulated community—Approved Providers.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

56

Figure 2.1

Relationship between DoHA, the Accreditation Agency, stakeholders and residents
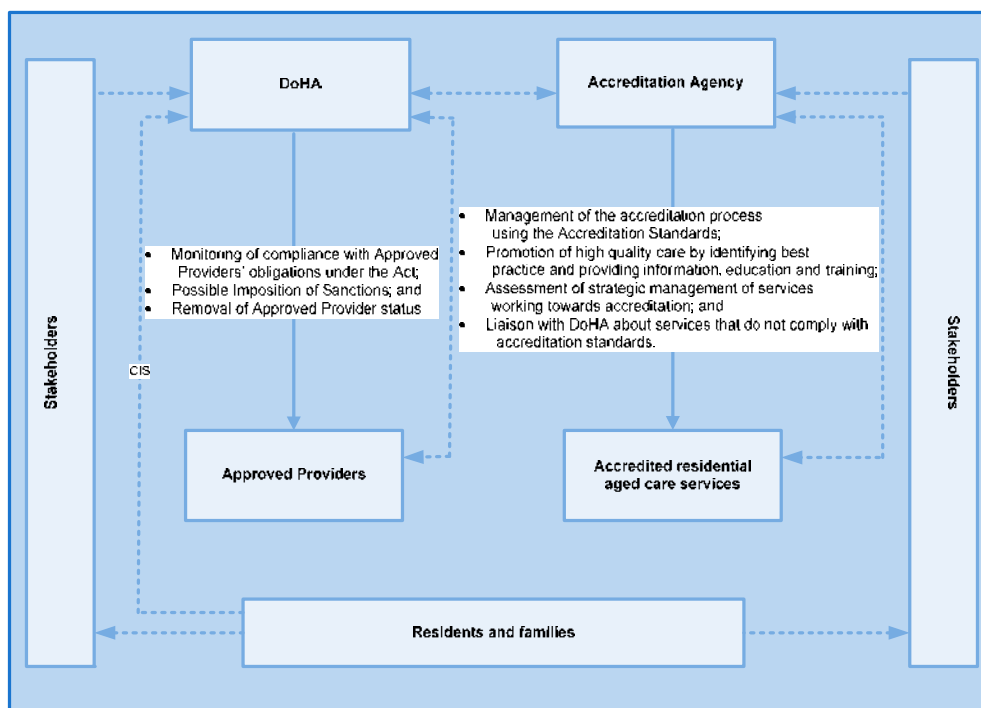
Source: ANAO

DoHA's communication with the regulated community—Approved Providers

2.30   The Act outlines the conduct Approved Providers can expect from DoHA when administering the regulatory framework and undertaking compliance activity. For example, time-frames for making decisions are clearly specified, natural justice requirements (such as providing opportunities to make submissions) are built into the decision-making pathways, and review rights are specified clearly.

2.31   Government policy also requires all government departments and agencies, including those with regulatory functions, to publish a Service Charter and report annually on performance against the charter. The relevant government policy, *More Time for Business*, states that:

> Government departments and agencies which deal with the public will be
> required to develop service charters in consultation with small business and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

57

the community they serve. Service charters will make the public service focus on the needs of its clients first.[67]

Benefits of a Service Charter

2.32   A Service Charter is a tool which enables the regulator to define the parameters of its relationship with the regulated entity. A Service Charter sets out the standards of service that regulated entities can expect and also establishes a strong performance measurement and accountability regime as it focuses on service outcomes.[68]

2.33   Currently DoHA does not have a Service Charter with Approved Providers against which it can report publicly its performance against indicators such as natural justice and review rights available to Approved Providers under the Act.

2.34   The compliance framework places a strong emphasis on the responsibilities of Approved Providers, and could be further strengthened by improving Approved Providers' understanding of DoHA's role and expectations under the framework. In particular, a Service Charter would provide a mechanism for DoHA to:

•   set out its service standards as well as the rights and responsibilities of Approved Providers; and

•   publicly report on its service performance.

The Accreditation Agency's communication with approved providers

2.35   Accreditation exists primarily for the benefit of residents. To make accreditation work, the Accreditation Agency needs to foster an appropriate relationship with the organisations that are accredited. The nature of the work is such that the relationship the accreditation body has with an Approved Provider will necessarily be different to that of the regulator (DoHA).

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[67]   Commonwealth of Australia, Guide to the Government's small business statement—*More Time for Business*, March 1997, Canberra, p. 11.

[68]   ANAO Audit Report No. 5 2009–10, *Protection of Residential Aged Care Accommodation Bonds*, p. 68.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

58

2.36 The Accreditation Agency has a *Charter of Commitment to Service Quality*[69] which outlines its commitment to providing quality services and products. These commitments include:

- giving highest priority to the health, safety and wellbeing of residents in aged care homes;

- working with aged care providers to promote continuous improvement and better practice in aged care homes;

- providing accurate information in plain language; and

- being ethical, honest, courteous, professional and respecting confidentiality.

2.37 The Agency does not report its performance against the commitments set out in the Charter.

Communication initiatives

2.38 Both DoHA and the Accreditation Agency undertake activities to minimise the potential for industry confusion concerning their respective roles. The department has developed the *Residential Care Manual* with an objective to:

> help Approved Providers comply with their responsibilities under the Act and to assist staff of aged care services understand the regulation of residential aged care.[70]

2.39 DoHA state offices meet on an as-needs basis with Approved Providers in circumstances where they may be experiencing financial difficulty or undergoing organisational change.

2.40 The Accreditation Agency has developed a three-day training course for Approved Providers to ensure that they have a comprehensive understanding of the role of the Accreditation Agency and its accreditation arrangements.

2.41 These efforts to educate industry would be further supported by DoHA developing a Service Charter with Approved Providers that clearly articulates

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[69]   The Accreditation Agency has also developed documents addressing corporate values and a code of conduct for the Aged Care Assessors.

[70]   DoHA, *The Residential Care Manual*, 2009.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

59

DoHA's role, the level of service Approved Providers can expect from the department and their obligations under the Act.

2.42 In particular, a Service Charter would enable DoHA to communicate in an accessible format a number of the key aspects of its role and the regulatory framework, such as:

- its goal of assisting Approved Providers to achieve and maintain compliance with their obligations under the Act;

- the types of notices that will be issued to Approved Providers if non-compliance is found and the subsequent opportunities providers have to improve their performance in response;

- the time-frames for its decision-making and Approved Providers' time-frames for responding; and

- the rationale for sanctions as a mechanism of last resort to address the impacts of non-compliance on the health and safety of residents of aged care homes.

2.43 The accountability and performance framework would also be strengthened if DoHA and the Accreditation Agency reported annually on performance against such Service Charters.

Recommendation No.1

2.44 To improve transparency on the rights and responsibilities of Approved Providers and the service standards expected of the Department of Health and Ageing (DoHA) and the Accreditation Agency, the ANAO recommends that:

- DoHA develops, in consultation with Approved Providers, a Service Charter and reports annually on its performance against the Charter; and

- the Accreditation Agency reports annually against its existing *Charter of Commitment to Service Quality*.

2.45 The Department of Health and Ageing has agreed to implement the recommendation in full and the Aged Care Standards and Accreditation Agency has undertaken to report its performance against commitments set out in the *Charter of Commitment to Service Quality* in its 2011-12 Annual Report.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

60

DoHA's communication with other stakeholders

2.46 As well as its formal relationship with the regulated community of Approved Providers, DoHA has an interest in communicating more broadly with stakeholders in the aged care sector (see Figure 2.1). In this regard, structured communications can contribute to: a consistent and equitable approach to engagement with key stakeholders; the consistent communication of key messages; and the establishment of feedback mechanisms to support the exchange of views and continuous improvement.

2.47 Table 2.4 summarises DoHA's approach to communicating with stakeholder groups in the residential aged care sector.

Table 2.4

DoHA's communication strategies

Stakeholder Group (and its role)	DoHA's Communication	ANAO comment
The Ageing Consultative Committee (ACC) (Advisory —provision of advice to the Minister for Ageing)	Formal	The ACC was established in 2008. The committee includes Approved Providers (commercial and not-for-profit), consumer groups and professional and union bodies.
Accreditation Standards Technical Reference Group (Advisory)	Formal	The Aged Care Accreditation Standards Technical Reference Group (TRG) was convened to assist the Department of Health and Ageing to undertake the review of the Aged Care Accreditation Standards. The TRG is comprised of individuals with expertise in one or more of the following areas: health and aged care standards; residential aged care accreditation; or development and implementation of quality indicators for residential aged care. While membership is based on individual expertise, total membership of the TRG reflects key aged care sectors including policy, clinical care delivery, industry, accreditation and consumer/carer sectors.
Community Visitors Scheme (CVS)[71] State Coordinators	Formal	Annual meeting bringing together the State Coordinators of the CVS for discussion on the program.

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[71] See the Glossary for a definition of the Community Visitors Scheme.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

61

Stakeholder Group (and its role)	DoHA's Communication	ANAO comment
Council of the Ageing (COTA) (lobby group)	Ad hoc	The various state-based COTA groups visited by ANAO indicated that they have very little formal interaction with DoHA. DoHA previously held quarterly meetings with the various stakeholders in this field, including COTA. However, since 2007 a move to 'recentralise' DoHA's approach to communicating with stakeholders has resulted in less frequent contact at the state level.

A number of state-based COTA groups indicated to the ANAO that there is some blurring of the roles of DoHA and the Accreditation Agency. |
| Aged Care Advocacy Groups (residents' representative) | Formal | The National Aged Care Advocacy Program (NACAP) was established in 2002 to encompass all recipients of aged care. The NACAP is part of the Australian Government's Aged Care Quality Assurance framework. Each advocacy group is independent and contracts individually with DoHA's Central Office. All groups, however, abide by a set of guidelines and protocols which were developed cooperatively with DoHA. Advocacy groups who were interviewed during the course of the audit commented that while they used to have quarterly meetings with DoHA's state offices, these ceased in 2007. The advocacy groups were informed in 2007 that DoHA's central office would communicate with them directly. Since that time, one meeting has taken place.

On 30 November 2010, DoHA met with the NACAP organisational representatives and agreed to recommence formal annual face-to-face meetings and to hold teleconferences in each of the other three quarters. |

Source: ANAO

Note: DoHA, at both the Central Office level and the state and territory office level meets with, and has regular correspondence with, a range of stakeholders in addition to the formal arrangements presented above.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

62

2.48 The formal communications strategy that DoHA has adopted with the national Ageing Consultative Committee, in its role of providing advice to the Minister, is appropriate[72] and other formal means of communication are appropriate to the circumstances. However, communication with stakeholder groups at the state level is less structured. A more structured approach towards communication with state–based stakeholder groups may also assist in clarifying the different roles of DoHA and the Accreditation Agency in the regulatory framework.

The Accreditation Agency's approach to communication

2.49 Effective communication with stakeholder groups beyond Approved Providers is useful in a quality of care context.

2.50 The Statement of Expectations (SOE) with the Accreditation Agency formally outlines the Government's expectations concerning the operations of the Agency and how it will meet these expectations. The SOE includes the expectation that the Accreditation Agency will ensure Approved Providers have a comprehensive understanding of the accreditation arrangements and the role of the Accreditation Agency.[73]

2.51 In its Corporate Plan, the Accreditation Agency recognises the need to 'build relationships with a range of other organisations such as those who provide services to our clients, those who provide services to the Company, consumer groups and media'. The Accreditation Agency's *Charter of Commitment to Service Quality*, commits the Agency to 'consult, on a regular basis, with representatives of the aged care sector and consumers'.

2.52 Table 2.5 summarises how the Accreditation Agency communicates with its key stakeholders. As well as the methods listed below, the Accreditation Agency seeks out speaking opportunities at relevant conferences and publishes a monthly industry magazine–'The Standard'.

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[72] As a formal structure, intended to be a mechanism to provide the Minister with across-industry advice.

[73] *Statement of Expectations, Statement of Intent*, Aged Care Standards and Accreditation Agency Ltd, 8 April 2010, pp. 6-7.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

63

Table 2.5

The Accreditation Agency's communication strategies

Stakeholder Group (and its role)	Agency Communication	ANAO comment
National Agency Liaison Group (NALG) (consultative)	Formal	The NALG is the principal mechanism for formal Agency liaison with national organisations representing the providers of aged care, consumers and employees in aged care. The NALG meets at least quarterly.
Industry representatives generally (consultative)	Informal	There are several means through which the Accreditation Agency maintains informal contact with industry representatives outside the committee structure. The agendas for these meetings are 'loose' and designed to build and maintain relationships: - the Agency's Board rotates its meetings across states so that it can meet informally with industry representatives; - the Agency executive frequently meet with stakeholders, sometimes on a one-on-one basis; - the Agency sometimes also meets with the Executive or Board of an Approved Provider; - Agency staff routinely attend industry conferences as speakers or delegates and take part in industry working groups and committees; - the Agency also aims to recruit a number of staff and executives with aged care, consumer, government and business backgrounds in the for-profit and not-for-profit sectors.[74]

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[74] For example, the current Queensland State Manager is a former CEO of Carers Queensland. The current South Australia State Manager is a registered nurse with a background in aged care. Many Assessors have backgrounds in healthcare.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

64

Stakeholder Group (and its role)	Agency Communication	ANAO comment
Approved Providers (service provision)	Formal	The Agency has two processes in place to facilitate and coordinate its relationship with Approved Providers: • the Agency General Manager Operations appoints 'Relationship Managers' for Approved Providers that operate across state boundaries so that Agency understanding of these providers is maintained at a high level. Additionally, State Managers are the relationship managers for large groups that operate exclusively within a state; • all Approved Providers are able to assess the performance of the Agency through feedback forms provided at Agency visits to homes and returned to an independent company for analysis. Results are then reported in the Agency's Annual Report. They are also published in 'The Standard'. A quarterly minimum data set is provided to industry, including consumers, through the formal agency liaison group. Industry performance is included in these data.
State Agency Liaison Group (SALG) (consultative)	Formal	The SALGs occur quarterly and information discussed is conveyed to the NALG. At each SALG, the Agency presents a report detailing its activities, education programs and feedback received.
Council of the Ageing (COTA) (lobby group)	Informal	The branches of COTA visited by ANAO indicated a greater level of contact with the Accreditation Agency than with DoHA. COTA staff undertake the assessor training provided by the Agency and attend the organisation's information days which COTA believes does, to an extent, assist in clarifying the respective roles of the Accreditation Agency and DoHA.
Aged Care Advocacy Groups (residents' representative)	Informal	The Advocacy groups have little contact with Accreditation Agency assessors. They are usually not involved in visits which address systemic issues and so are not available to help residents during these times. The Advocacy groups are also not involved in providing residents with feedback following Agency visits. Some Advocacy groups have expressed the view that they should be invited by the Agency to play a formal role during site audits: providing assistance to residents and educating them on how best to participate.

Source: ANAO

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

65

2.53 The Accreditation Agency has developed effective and practical components of a communication strategy comprising industry training, formal liaison meetings and the appointment of Relationship Managers. However, as indicated in Table 2.5 some stakeholder groups, particularly advocacy groups and specialised professional groups such as a nursing organisation interviewed over the course of the audit, were less positive about communication with the Agency. Consumer representatives and some professional groups, such as nurses, are already part of the Accreditation Agency's formal liaison arrangements, and the Agency may wish to consider whether there are further opportunities for improved communication with these groups.

Other forms of communication

2.54 DoHA and the Accreditation Agency use a range of other avenues to communicate with stakeholder groups, including through websites, programs, seminars and conferences to support the quality of care in aged care homes.

Communication between DoHA and the Accreditation Agency

2.55 DoHA and the Accreditation Agency have separate but complementary roles which require a sound understanding of each other's roles and responsibilities.

2.56 There is a Communication and Referral Protocol to guide the relationship between DoHA and the Accreditation Agency, including information transfer. The purpose of the Protocol is to ensure that DoHA and Accreditation Agency personnel have a shared understanding of their respective roles and responsibilities in the administration of the framework.

The Protocol

2.57 The Protocol:

- sets out the referral process between DoHA and the Accreditation Agency and how compliance monitoring and compliance action will be undertaken consistent with aged care legislation;

- aims to ensure that DoHA and the Accreditation Agency maximise the efficient use of their resources to provide the highest possible level of supervision of the sector, in a manner which does not place undue burden on the sector through duplication of effort; and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

66

- provides for regular, formal information exchange between DoHA and the Accreditation Agency.[75]

2.58   At the time of the audit, a new Protocol was being drafted to better reflect the strategies implemented by the department and the Accreditation Agency to improve their communication and information exchange.

2.59   Over the course of the audit, a number of stakeholders commented that access to the Protocol would assist them to understand the actions each organisation takes when non-compliance is identified or suspected. In a 2009 report, the Productivity Commission recommended that the Protocol be communicated more broadly to assist in clarifying the roles of the two organisations. The Government accepted this recommendation. In its draft report on *Caring for Older Australians*, the Productivity Commission noted DoHA has indicated that the issue of communicating the Protocol more widely will be considered in the context of implementing outcomes from the 2010 review of the Complaints Investigation Scheme (CIS), and the review of accreditation processes and standards (currently underway).[76] The operation of the Protocol is considered further in Chapter 4.

Communication at the operational level

2.60   Communication occurs between the two organisations at multiple levels. The state and territory offices of DoHA and the Agency communicate regularly and there is also communication between DoHA's Central Office and the Agency's Operations Division. These communications take the form of: regular meetings; teleconferences and ad hoc contacts; formal referrals; and routine data exchange facilitated by the Central Offices of the two organisations.

2.61   Table 2.6 provides examples of communication between DoHA's state and territory office (STO) network and the Accreditation Agency's state offices (SOs).

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[75]   DoHA, *The Protocol for referrals, compliance monitoring and compliance action between the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency,* July 2002, Canberra, p.1.

[76]   The Productivity Commission, *Caring for Older Australians* – Draft report, January 2011, Canberra, p. 391.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

67

Table 2.6

Communication at the state office level

state office level communication
Between most state-based offices, there is a fortnightly teleconference with a set agenda on key topics, hot issues, Agency activity and Homes of Interest between DoHA and the Accreditation Agency (smaller offices with less compliance activity do not necessarily do this but use more of a case based approach to guide communications).
This is in addition to the 'as needed' communication between DoHA and the Accreditation Agency portfolio manager (Compliance Manager) and the Agency assessment coordinator.
There is also a quarterly face-to-face meeting between DoHA and the Accreditation State Manager which involves the Compliance Manager and the Assessment Manager.
Formal weekly communication between the Accreditation Agency and DoHA assists to ensure that all relevant information is passed on. Other communication occurs on an 'as-needed' basis. Where information is not relevant to Accreditation Standards, the information may not necessarily be passed on to the Accreditation Agency.
DoHA meets with the Accreditation Agency once a month and exchanges information. The Delegate and members of the compliance team talk to Accreditation Agency staff on a weekly basis.

Source: ANAO

2.62   This level of contact is designed to facilitate coordination between DoHA at the state level and the Accreditation Agency. DoHA considers that, as a result of this contact, its announced visits to residential homes are sufficiently coordinated with those of the Accreditation Agency state offices.

2.63   There are, however, some state-to-state variations. For example, in Victoria a formal teleconference occurs fortnightly, whereas in Queensland there is a less formal weekly phone call between the Agency Assessment Manager and the DoHA Queensland Assistant Director. The ANAO acknowledges that a certain level of variation in communication can be expected, because this reflects the different levels of compliance activity in different states.

2.64   The Protocol does not specifically guide the level of interaction between DoHA and the Accreditation Agency. While the current broad outline for communication facilitates flexibility and allows for individual approaches and initiative, it also needs to ensure consistency in the exchange of information. Specific communication requirements can also assist organisations during times of staff turnover.

2.65   The Accreditation Agency and DoHA staff communicate regularly, including at the regional office level. To further improve communication at the operational level, there may be scope to consider more structured

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

68

communications arrangements between DoHA and the Accreditation Agency as part of the process of renegotiating the Protocol.

2.66 Publication of the operational level Protocol between DoHA and the Accreditation Agency would improve stakeholders' understanding of their respective roles under the framework. The publication of such information, and a revised approach to communications which combines the best of the current efforts, supplemented by the effective use of Service Charters and a deeper engagement with stakeholder groups, would contribute to the quality of communication with the sector. The Protocol is currently being renegotiated and the Accreditation Agency has advised that it will consider placing it on its website once negotiations have been finalised.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

69

3.   Compliance Strategies

This chapter examines DoHA's and the Accreditation Agency's compliance strategies and their supporting risk management practices.

Introduction

3.1   The compliance framework's design and administration are informed by the size of the residential aged care sector, its home-based structure, and the primary responsibility placed on Approved Providers for quality care. The framework is accordingly focused on promoting quality in individual accredited homes, with a lesser focus on sector-wide risks to quality and compliance. Notwithstanding this, non-compliance can arise from the actions or inactions of management and staff within a single home, through to non-compliance relating to an individual home's capacity to deal adequately with risks arising from sector-wide developments or pressures. A variety of sector-wide risks has been identified by stakeholders and DoHA in recent times, which may influence the ability of homes to comply with the framework.

3.2   These developments suggest that DoHA and the Accreditation Agency can derive benefit from strategies which enable them to identify and treat compliance risks at two different levels:

- the operational (case-by-case) level—at certain times, certain approved providers will be more likely than others to fail to meet Accreditation Standards;[77] and

- the systemic level—various forms of non-compliance can emerge over time across the residential aged care sector.[78]

3.3   The effective use of these two levels of compliance strategies can contribute to DoHA's and the Accreditation Agency's understanding of the full range of risks and help them determine how the risks of non-compliance by aged care service providers are best treated, and the priority to be given to

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[77]   The ANAO's 2007 Better Practice Guide (BPG) *Administering Regulation* observes, at p. 56, that compliance treatments at this level need to be sufficiently flexible to enable operations managers to react promptly to sudden or unpredictable changes in regulatory risks.

[78]   The ANAO's BPG also describes, at p. 56, this type of strategy as one where the systematic monitoring of the regulatory environment enables a regulator to adjust a compliance strategy to ensure it remains effective and targeted at the highest regulatory risks.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

70

those treatments. Depending on the nature of the risk, treatments may focus on the individual home, a group of homes, or the sector as a whole.

3.4 In addition, both levels of compliance strategies should initially incorporate a range of compliance treatments that are proportionate to the severity and type of non-compliance detected. In particular, the compliance strategies may incorporate treatments which promote ongoing compliance through an appropriate mix of education, assistance, incentives and sanctions.[79]

3.5 Figure 3.1 identifies the main components of an integrated compliance treatment framework incorporating both case-by-case and sector-wide compliance strategies, and supporting risk management practices.

Figure 3.1

Integrated compliance treatment framework
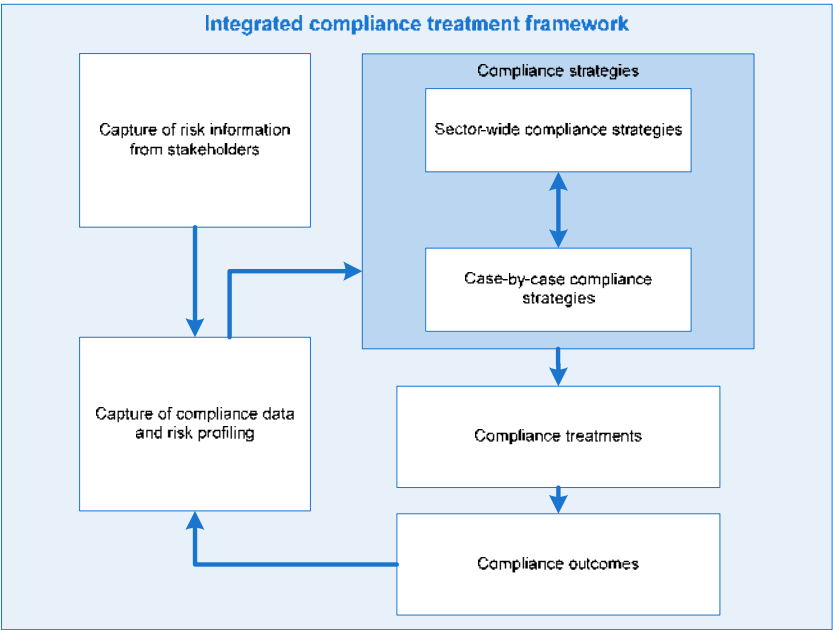
Source: ANAO

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[79]   ibid., p. 8. See also the Productivity Commission, *Caring For Older Australians*, Draft Report, January 2010, Appendix E.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

71

3.6 The ANAO has used this framework as a reference point when:

- considering compliance risks, especially those which concern the health, safety and wellbeing of residents in aged care homes;
- examining the basis of DoHA's and the Accreditation Agency's planning for their compliance strategies, at both the operational and sector-wide levels;
- assessing the Accreditation Agency's case management policy; and
- examining how DoHA and the Accreditation Agency share risk information.

Compliance risks in the residential aged care sector

3.7 When assessing DoHA's and the Accreditation Agency's compliance strategies and supporting risk management practices, the ANAO took into account a range of current and emerging risks to the health, safety and wellbeing of residents of aged care homes, which have been identified by the Accreditation Agency, DoHA and stakeholder organisations.

3.8 At the level of an individual home, the level and nature of risks to the health, safety and wellbeing of residents can change significantly over relatively short periods of time. Consequently, it is important that a previously planned program of visits to aged care homes is flexible enough to enable prompt responses to new information, including information provided by residents, their families, their representatives or other concerned stakeholders. Concerns about a lack of appropriate medication and medical treatment, food and nutrition, activities and independence are examples of compliance risks warranting a flexible, case-by-case level response.

3.9 A range of other events will also warrant a case-by-case level response. DoHA and the Accreditation Agency have formally identified a number of these *risk indicators*,[80] which include: change of ownership of a residence (a change of the Approved Provider); loss of key personnel including senior nursing staff;[81] changes in management systems; rapid growth in resident numbers; rapid change in the mix of residents' needs; building programs and/or relocation of premises; changes in process and procedures not

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[80] The Accreditation Agency, *The Standard*, September 2007 and DoHA, *Prudential Risk Factors 2010.*

[81] Approved Providers have to report to DoHA changes in Approved Provider status and changes in key personnel at homes they operate.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

72

supported by appropriate staff training; change in business strategy/restructuring; and industrial disputation.

3.10 In addition to identifying risks which warrant a case-by-case treatment at the level of the individual home, recent developments in the sector suggest that strategies need to be put in place to help identify those risks that may have deeper, systemic drivers. These risk drivers might require treatment on a sector-wide basis.

3.11 Regulatory and stakeholder publications, including submissions to recent official inquiries[82], have identified a range of systemic level risk drivers which have the potential to reduce the capacity of Approved Providers to fully meet their various obligations under the Act.[83] They include:

- a general shortage in the residential aged care workforce;[84]

- homes operating at full or near full capacity, with insufficient skilled staff and management systems;[85]

- challenges associated with an ageing population and increasing longevity (such as more residents with high care needs including dementia);[86] and

- increasing diversity in the care expectations and preferences of residents, including an increasing demand for 'culturally, linguistically and gender relevant' care.[87]

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[82] Appendix 4 provides a list of these inquiries.

[83] Several of these drivers were identified in the ANAO's Performance Audit Report No. 5 of 2009-10 *Protection of Residential Aged Care Accommodation Bonds,* at p. 55. The remainder were identified in Chapter 3 (Drivers of future demand) of the Productivity Commission's draft report (2011) *Caring For Older Australians* and in DoHA *Prudential Regulation Risk Factors 2010.*

[84] The Productivity Commission's draft report, 2011, *Caring for Older Australians* notes that the supply of workers is problematic. The formal aged care system faces difficulties in attracting and retaining workers. These difficulties are expected to intensify due to increasing competition for workers as the overall labour market tightens in response to population ageing.

[85] ibid.

[86] The Australian Nursing Federation notes that: More and more older Australians are remaining in their own homes for longer, and are entering nursing homes only when their care needs are too complex to be managed in the community, available at: <http://www.anf.org.au/html/publications_factsheets.html>, [accessed March 2011].

[87] Accreditation Agency Better Practices in Aged Care Conference, August 2010, Melbourne, and also referenced on the Centre for Cultural Diversity in Ageing website: <http://www.culturaldiversity.com.au/>, [accessed March 2011].

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

73

3.12 These risks have been recognised by the Department of Health and Ageing (DoHA), which advised the Australian Government in 2010 that:

- it will be a challenge for the current structures of the (aged care) system to respond to the increased demand for aged care services arising from the ageing population; and

- it will also be a challenge for the current business models to meet the changing expectations of aged care recipients, including greater levels of self determination and choice in the type of aged care they receive.[88]

Planning for compliance strategies

3.13 Continuing success in managing compliance risks is largely dependent upon risks being identified and integrated into an organisation's wider planning processes. Integrating compliance risks in this way directly links them to the organisation's core business and helps ensure that risk treatments are aligned with program delivery and reporting responsibilities.[89]

DoHA's planning framework

3.14 Table 3.1 summarises how DoHA incorporates the risks of non-compliance with Accreditation Standards by Approved Providers of residential aged care services into each level of planning in the department.

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[88] *Incoming Government Briefing: Volume 1*, Ageing and Aged Care System, 2010, p. 3.

[89] The ANAO's 2007 Better Practice Guide (BPG) *Administering Regulation,* identifies this and a number of other factors which can enhance the effectiveness of regulatory risk management.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

74

Table 3.1

DoHA's planning framework

Planning	ANAO comment
Enterprise Risk Management Plan	DoHA's current ERMP, dated October 2007, identifies case-by-case level but not systemic, sector-wide risks that could impact directly on the department's ability to meet its responsibilities relating to quality residential aged care, as set out in the Act.
OACQC Business Planning	DoHA's Office of Aged Care Quality and Compliance (OACQC) and the Ageing and Aged Care Division (AACD) have a joint responsibility for planning and delivering the department's Program 4.6 (Residential care), which includes the objective of improving the quality of aged care services through compliance with minimum accreditation standards and encouraging continuous quality improvement. OACQC's Business Plan for 2010–11 identifies its two main operational level deliverables for fiscal year 2011–12: • 100 per cent of Approved Providers issued with a Notice of Required Action or referred for further compliance action, where an investigation has been completed and a breach identified, and where the Approved Provider has not remedied the breach by the required time; and • 100 per cent imposition of sanctions on Approved Providers where immediate and severe risk to the health, safety or wellbeing of care recipients is identified.
OACQC Risk Management Planning	OACQC's 2010–11 risk management plan identifies the following two broad, related types of compliance risk: • failure to identify and adequately respond to non-compliance by Approved Providers with their regulatory and accountability obligations; and • high levels of non-compliance by Approved Providers with their regulatory and accountability obligations for quality of care and prudential issues.
OACQC Quality and Monitoring Branch Business and Risk Management Planning	The recent reorganisation within OACQC meant that the 2010–11 operational and risk management plans for the new Quality and Monitoring Branch were not finalised until February 2011.The plan recognised the following risk: • failure to identify, assess and adequately respond to environmental or sector-wide risk factors.
State office Operational Planning and Risk Management	Four of the state and territory offices (STOs), including the largest ones (NSW, Vic, QLD, SA) provided either final or draft operational plans for the residential aged care sector. None of these STOs was able to provide a sector-wide risk profile/risk assessment relating to their State. The QLD STO provided a list of different types of compliance risks.

Source: ANAO analysis of DoHA's planning and risk management documentation

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

75

DoHA's approach to managing compliance risks

Enterprise risk management plan (ERMP)

3.15 DoHA's current ERMP is dated October 2007. This is a portfolio level document and is intended to be the key reference point for planning at all levels in the department. The ERMP focuses on risks that may have an 'extreme' or 'high' adverse impact on the achievement of DoHA's Portfolio Budget Statement (PBS) Outcomes or other corporate objectives. ERMP risks are grouped under five broad risk types, namely: government priorities; external environment; operational processes; resources; and regulatory framework.

3.16 For the residential aged care sector, the ERMP identifies a 'regulatory framework' risk but not any other types of risk. The ERMP defines regulatory framework risks as those having:

> the potential for a regulated entity or industry to cause adverse health and/or ageing effects with links to the department's role in ensuring satisfactory health outcomes.

3.17 The particular regulatory framework risk identified for the residential aged care sector is: 'failure to respond appropriately to an emerging aged care incident'. This ERMP risk was given a likelihood rating of 'likely', a consequence rating of 'major' and an overall risk rating of 'high'. It provides a clear reference point for OACQC's subsequent planning for, and risk management of, the residential aged care sector on an emerging, case-by-case basis (as noted in Table 3.1 and discussed further in Chapter 4).

3.18 While the focus is on a possible incident at an individual home, the proposed treatments for this ERMP risk include the development of a more broadly conceived sector-wide approach to risk management, namely the need to:

> improve the department's capacity to identify significant emerging compliance risks and respond proactively through the gathering of industry data and intelligence, statistical analysis and risk rating of homes to assess possible non-compliance problems.[90]

3.19 As indicated in Table 3.1, OACQC recognised in its Business Plan for 2010–11 that there was a risk of high levels of non-compliance by Approved

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[90] Department of Health and Ageing, *Enterprise Risk Management Plan*, October 2007.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

76

Providers with their responsibilities under the Act. This risk was given a likelihood rating of 'possible' and an overall consequence rating of 'high'.

3.20 Correspondingly, OACQC's Business Plan for 2010–11 states that:

> over the past year, the Office has focussed on developing its capacity to gather and use regulatory compliance information more effectively through closer cooperation and information sharing with [the Accreditation Agency], greater integration of compliance risk assessments across the aged care programs and more proactive management of emerging compliance risks. The Office will continue to build on this critical work during 2010–11.[91]

3.21 This work has centred on the further development of OACQC's relatively new Service Providers of Concern (SPoC) list (see below). However, OACQC has not, as yet, established a composite list of possible types/sources of 'quality of care' compliance risks or set of risk ratings for homes in the residential aged care sector, as specified in the 2007 ERMP. Some state offices have developed their own lists of risks which they use for assessing particular homes. The ANAO's fieldwork indicated that, where available, these lists were used only informally in respect to individual homes and were not employed to make risk comparisons across different homes.

DoHA's emerging systemic level compliance strategy

3.22 Table 3.1 identifies that OACQC's newly formed Quality and Monitoring Branch's 2010–11 Operational Plan has reaffirmed the need to 'identify, assess and adequately respond to environmental or sector-wide risk factors'. The failure to do so was given a current likelihood rating of 'possible', a consequence rating of 'moderate' and an overall risk rating of 'medium'.

3.23 The Quality and Monitoring Branch has in place the following controls for mitigating environmental and sector-wide risks:

- manage workflows during peak periods to ensure resources are allocated effectively to manage Approved Providers in difficulty;

- assess environmental and sector-wide factors individually;

- communicate regularly with state and territory offices (STOs) on trends in the aged care sector.

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[91] The ERMP 'regulatory framework' risk, identified in 2007 for the residential aged care sector, recognised the need for this work, including the 'risk rating of homes to assess possible non-compliance problems'.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

77

3.24   A systemic, sector-wide approach to risk management requires a risk assessment methodology which includes the identification and monitoring of key risk indicators applicable for most, if not all, of the regulated community.[92]

3.25   The Quality and Monitoring Branch's 2010–11 Operational Plan indicates an intention to implement a strategy which would support a more systemic approach to risk assessment. This strategy entails a:

> formal six monthly environmental scan and risk analysis to identify and assess emerging risks (in consultation with other OACQC Branches, the Ageing and Aged Care Division and the Accreditation' Agency).

Service providers of concern (SPoC) list

3.26   Although not referred to in either OACQC's or the Quality and Monitoring Branch's risk management plans for 2010–11, OACQC already has in place a potentially valuable element of such a risk assessment methodology, namely the recently developed 'Service Providers of Concern' (SPoC) list. This initiative was acknowledged in the ANAO's 2009–10 performance audit of DoHA's administration of prudential arrangements for the *Protection of Residential Aged Care Accommodation Bonds.*

3.27   Typically, the SPoC list comprises approximately 30 aged care homes or Approved Providers which the department has identified as representing a high risk of significant non-compliance. Initially the focus was on identifying prudential risks. However, there is now an increasing focus on incorporating *quality of care* risks, whether or not these were initially related to a home's financial status. For example the SPoC list now includes homes which have a history of non-compliance with the Accreditation Standards, a questionable track record of addressing non-compliance, current or recent complaints activity and key changes in governance arrangements.

3.28   DoHA's guidance materials for the SPoC list state that:

> The 'Service Providers of Concern' list is intended to provide an overview of those aged care services/providers identified by the Department as being at the

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[92] The ANAO appreciates that the value of monitoring a particular risk indicator needs to be tested before it can be used with confidence. DoHA's *Prudential Regulation Risk Factors 2010* states that the department will investigate two possible indicators to determine whether they can be used to assess whether or not a provider is responding appropriately to changes in residents' service expectations: namely, occupancy levels and resident turnover.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

78

highest risk of significant non-compliance with the *Aged Care Act 1997* and the Aged Care Principles.

Identification on the list does not necessarily indicate that actual significant non-compliance has been identified. Rather, it may indicate emerging risks of significant non-compliance.

The list is not intended to automatically include services/providers that are currently under sanction or are undergoing the sanctions process. While some of these cases will be picked up, they should only be included where there continue to be significant risks of continued non-compliance (including slow progress in taking remedial action).

3.29 The SPoC list is compiled from homes nominated for inclusion by each area in OACQC and the STOs. The nomination and decision-making process has recently been enhanced through use of a 'Service Providers for Consideration' template.

3.30 The Service Providers for Consideration list consolidates compliance related data for analysis from a range of additional sources (including Financial Risk Assessment synopses; adverse media commentary; Question Time Briefs) and promotes the sharing of information between OACQC and DoHA's STOs.

3.31 The SPoC list provides a sound basis for sharing information on a regular, structured basis with the Accreditation Agency, which has its own, separate version of SPoC, namely the 'Homes of Interest' (HoI) list, discussed below. In particular, the information contained in SPoC about possible 'financial distress' has the potential to provide an early warning that a home might not be able to continue to meet its quality of care obligations to residents under the Act—potentially well before the Provider defaults on a prudential obligation.

The Accreditation Agency's planning framework

3.32 As previously indicated, the Accreditation Agency is a company governed by a board of directors which is directly accountable to the member (the Minister) for its performance in meeting the objectives of the company and addressing government priorities. Consistent with the duties of directors under the Corporations Act the Board is independent in its capacity to determine the Accreditation Agency's strategies (including for risk management) and the planning and work programs required to achieve these outcomes, in the context of the government requirements set out in:

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

79

- the *Accreditation Grant Principles 1999 (the Principles)* (now replaced by the 2011 Principles)*:*

    which specify the accreditation body's functions and the procedures for accreditation;

- the Minister's Statement of Expectations (SOE):

    which states generally that the Accreditation Agency should develop, and annually revise, a 'corporate/business' plan. Business objectives should focus on implementing risk management strategies[93] aimed at identifying and addressing non-compliance with the Accreditation Standards, while continuing to promote continuous improvement; and

- DoHA's Deed of Funding with the Accreditation Agency:

    which requires a rolling three-year 'service delivery' plan to be provided to the Minister at least once a year. In practice, the Accreditation Agency's Corporate Plan constitutes its service delivery plan. The Deed of Funding includes the Accreditation Agency's objectives and functions, operational environment and strategies, associated delivery risks, performance measures and targets, and reviews against previous targets.

The Accreditation Agency's approach to managing compliance risks

3.33 Table 3.2 summarises the level at which risks are identified and assessed in the documentation prepared by the Accreditation Agency as part of its planning processes.

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[93] See Table 3.3 for further details on the Accreditation Agency's response to this expectation.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

80

Table 3.2

Accreditation Agency's planning framework

Planning	ANAO comment
Corporate/ Business planning	The Accreditation Agency's Corporate/Business plan does not identify measurable medium term goals, expected outcomes or time-frames for its compliance related responsibilities. In addition, the Accreditation Agency's future priorities, likely compliance risks and mitigation strategies for delivering its responsibilities are only identified in broad terms.
Operations Division's planning	The Operations Division's plan for 2010–11 and 2011–12 recognises the number and type of visits required under the Minister's SOE and the Deed of Funding. It provides structured information for the planned numbers and types of visits: • mandatory visits: accreditation site visits; DoHA initiated Review Audits; required minimum number of unannounced visits each year (1 per home, of which there were 57 Review Audits). • risk based visits: other unannounced visits (mostly Support Contacts); announced Support Contacts; other announced Review Audits. • In response to the Minister's SOE, the Accreditation Agency stated that it would support changes to the accreditation arrangements that facilitate the development of an IT model based on electronic collection of information from providers. The Accreditation Agency's Operations Division reported in March 2010 that work on this model had commenced, but further work had been deferred until 2011–12 because the accreditation standards are under review.

Source: ANAO analysis of the Accreditation Agency's planning documentation

The Accreditation Agency's case management policy

3.34   The Agency's approach to managing the risks of non-compliance by service providers is largely driven by its case management policy. The policy states that:

- the purpose of case management is to protect the welfare of residents by initiating and managing timely and relevant action to address potential and identified risks of poor care and services and to support improvements. A case management approach ensures all relevant available information is applied to decision-making and communication with key stakeholders; and

- case management ensures the coordination of a range of services and actions. This includes the scheduling of site visits, the focus of assessments and monitoring on site, and targeting of education efforts. It also drives liaison with the Department of Health and Ageing (DoHA) and the Approved Provider, media management and coordination, and the publication of materials to our website.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

81

3.35   Some of the relevant case management principles outlined in the policy are as follows:

> case management occurs at state and national levels in accordance with this policy and other guidelines established; case management committees operate at both state and national levels; liaison with DoHA is essential in the mutual exchange of information and shared responsibility for actions; risk indicators are used to guide case management decisions, including those stated in the *Accreditation Grant Principles 1999* and others developed and refined by the Agency; and Agency action in response to non-compliance or indicators of non-compliance is prompt.

3.36   The day-to-day implementation by state offices of the Accreditation Agency's case management principles includes reviewing the planned schedule, frequency and type of visits to homes. In doing so, the state offices apply the set of risk factors and priority ratings identified in Table 3.3.

Table 3.3

Case management risk factors and priority risk ratings

The Accreditation Agency case management risk factors	Priority risk rating
Changes in processes and procedures not supported by training staff	3
Rapid Growth in resident numbers (<3 months)	3
Loss of key personnel	2
Change of Approved Provider	2
Changes in management systems	2
Rapid change in mix of residents' needs (<12 months)	2
Building programs or new locations	2
Change in business strategy/restructuring	2
Industrial disputation	1

Source: The Accreditation Agency

Note: A risk rating of 3 represents the highest priority.

3.37   In addition to these risk ratings, state office decision-making about the type and timing of visits is informed by individual homes' and Approved Providers' compliance histories, including the history of other homes managed by the Approved Provider and its associated companies.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

82

3.38 ANAO analysis indicates that in 2008–09 the selection, timing, focus and scope of a significant number (3 148 or some 41%) of the Accreditation Agency's 7 595 visits to aged care homes was determined by the Agency primarily on the basis of its own risk assessments, rather than by particular legislative or policy requirements, reflecting an active approach to monitoring risk.

3.39 When determining and case managing the program of these (essentially 'own motion') risk-based visits, the Accreditation Agency has to take into account its particular obligations to deliver:

- the statutory requirement that Review Audits requested by DoHA are actioned;[94]

- the Minister's SOE policy that each aged care home receives at least one unannounced visit per year;[95] and

- the Deed of Agreement's requirement of an average of 1.75 visits per home be conducted each year.

3.40 Table 3.4 summarises the Accreditation Agency's reported performance against each of these obligations, and also in undertaking accreditation site visits (discussed later in this chapter).

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[94] Part 3 (Continuous Improvement) of the *Accreditation Grant Principles 1999* at Section 3.21 (6).

[95] The Accreditation Agency advised the ANAO that this policy requirement has been accommodated as part of its operational level case management of support visits, the majority of which in practice are unannounced visits (see Table 3.4).

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

83

Table 3.4

Required and reported number of Accreditation Agency's visits to homes

Required/ reported performance	2006-07	2007-08	2008-09	2009-10
Average number of visits per home each year				
Required (a):	1.75	1.75	1.75	1.75
Reported:	2.19	1.84	2.7	2.2
Accreditation Site Visits				
Reported (b):	1 014	426	1 622	993
Required: At least one unannounced visit per home each year (c):	Reported achieved	Reported achieved	Reported achieved	Reported achieved
Reported Support Contact Visits:	5 221	4 731	5 869	5 066
% unannounced (c):	68%	65%	59%	70%
Reported Review Audits:	94	87	104	60
% requested by DoHA (d):	20%	25%	30%	20%

Source: ANAO analysis of Accreditation Agency Annual Reports

Notes:

(a)   The previous requirement of an average number of 1.25 visits was increased to 1.75 following the Minister's requirement of at least one unannounced visit per home each year, starting in 2006–07.

(b)   All Accreditation Site Visits are announced. The required number of these visits is not directly specified. Instead, all of them are to be conducted within the period specified for valid applications.

(c)   The previous requirement was that 10 per cent of Support Contact Visits had to be unannounced.

(d)   There are no quantitative requirements set for Review Audits since they are carried out only when there are specific reasons to do so, including mandatory requests from DoHA.

National Office level

3.41   A National Case Management Committee meets weekly and reviews all cases where non-compliance has been identified with four or more of the expected outcomes specified in the Accreditation Standards. The media is also scanned to identify reports concerning quality of care, management changes, mergers, acquisitions and other information to inform case management. These cases constitute the Accreditation Agency's 'Homes of Interest' (HoI) list which includes approximately 30 homes and is the equivalent of DoHA's SPoC list.

3.42   Cases where accreditation might be refused, revoked or varied are also reviewed. Any contentious issues associated with particular homes or Approved Providers are also considered. The National Committee collates and reviews information about Approved Providers operating in a number of

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

84

states, and also those operating a large number of homes in a particular state. Reports for each of these cases are presented and updated as new information becomes available. The HoI listing and other information reviewed by the National Case Management Committee is shared with DoHA, also on a weekly basis. The case management information collated by the committee for the HoI list could be leveraged further as part of an enhanced compliance assurance strategy, discussed below.

3.43   Chapter 4 examines further the Accreditation Agency's implementation of its case management policy.

The accreditation cycle

3.44   Every three years all of the homes operated by Approved Providers, currently some 2 779 homes, are reassessed against each of the 44 expected outcomes of the Accreditation Standards at least once.[96] To date, the Accreditation Agency has completed four rounds of accreditation—2000, 2003, 2006 and 2009.

3.45   The Accreditation Agency observed that:

> 2009–10 marked the commencement of 'round four' of accreditation as residential aged care homes went through the triennial audit cycle. In addition, we delivered the Australian Government's commitment that each home receives at least one unannounced visit each year…This involved an unprecedented level of activity…[which]… will continue into the first half of 2009–10;[97] and thereafter accreditation site visits will next peak in 2011–12.[98]

3.46   The Agency's analysis of the data obtained from these comprehensive (re)accreditation assessments indicates that:

- the number of homes fully complying with the Accreditation Standards is improving over time;

- the incidence of non-compliance with the expected outcome (EO) concerned with continuous improvement (CI), while high in rounds

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[96]   The accreditation and (re)accreditation of the services delivered by Approved Providers entails announced site visits being conducted at each of the facilities operated by them. The (re)accreditation entails services being assessed against all 44 expected outcomes specified in the Accreditation Standards.

[97]   The Accreditation Agency, *Annual Report 2008-09*, p. 5.

[98]   The Accreditation Agency, *Agency Budget Statement*, 2010-11, p. 419.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

85

two and three is now further down the list of categories of non-compliance compiled for round four;

- the EO concerning Nutrition and Hydration remained high on the list of non-compliant outcomes over the four rounds; and

- while there has been some improvement in compliance with the EO concerning Information Systems, it still remains high on the list of non-compliance outcomes.

3.47 The data obtained from (re)accreditation assessments can also contribute to an enhanced compliance and assessment strategy.

The development of a sector-wide compliance strategy

3.48 DoHA and the Accreditation Agency each have well-developed operational level strategies for monitoring and treating the risks of non-compliance on a case-by-case basis, that is, at the level of individual homes. These strategies include the ongoing case management, at both national and state levels, of those homes where non-compliance constitutes a serious risk to residents' health and wellbeing, and the regular sharing of information by DoHA and the Accreditation Agency. Information is shared at both a local and national level, through a variety of formal and informal means. There is an additional level of oversight at the national level, centering on DoHA's SPoC listing of about 30 homes and the Accreditation Agency's HoI list of a similar number of homes.

3.49 These mechanisms have enabled both organisations to identify certain potential instances of non-compliance at a sector-wide level. For example, the Accreditation Agency considered that there might be an elevated risk of homes not meeting the Accreditation Standards over the 2009–10 Christmas/New Year period, due to the pressures arising from staff leave, public holidays and the additional activities staff provided for residents. The Accreditation Agency therefore incorporated a focus on staffing levels into all its visits. Similarly, the Accreditation Agency provided all homes with a fact sheet on infection control in 2006–07 about the possible spread of avian influenza, which was subsequently updated to include information about swine flu.

3.50 These examples demonstrate the importance of identifying and treating compliance risks at the sector-wide level in addition to the operational (case-by-case) level. At present, there is a well-developed approach for doing so at the operational level, while the approach to monitoring and treating sector-

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

86

wide risks is less well developed and tends to focus on the treatment of discrete, episodic risks which have been identified without the benefit of a systemic monitoring strategy.

3.51 The consolidation and expansion of the existing SPoC and HoI lists provides a starting point for developing such a strategy. The development of a common risk profile for each accredited aged care home and the analysis of information from such risk profiles at an aggregate level, would contribute to an improved understanding of trends in non-compliance across the sector.

Recommendation 2

3.52 As a means of contributing to a broader understanding of sector-wide trends in compliance and non-compliance with the Accreditation Standards and other related responsibilities under the Act, the ANAO recommends that the Department of Health and Ageing (DoHA) consider, as part of an enhanced compliance and assurance strategy:

- developing a common risk profile for each accredited home; and

- analysing, at an aggregate level, the information contained in these risk profiles.

3.53 The Department of Health and Ageing has agreed to implement the recommendation.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

87

4. Monitoring and Managing Compliance

This chapter reviews the operational level arrangements DoHA and the Accreditation Agency have put in place to support their monitoring of residential aged care homes' compliance with the Accreditation Standards and other responsibilities under the Act.

Introduction

4.1 In this chapter the ANAO's examination covers:

- the compliance monitoring roles performed by DoHA's and the Accreditation Agency's state offices;

- the implementation of DoHA's information referral protocol with the Accreditation Agency; and

- DoHA's and the Accreditation Agency's state level case management of identified non-compliance.

Compliance monitoring by DoHA and the Accreditation Agency state offices

4.2 Together, DoHA and the Accreditation Agency are responsible for monitoring compliance with the Accreditation Standards by 2 773 residential aged care homes. The initial risk assessments are performed by the state offices of both organisations. Most of the subsequent visits to homes are undertaken by the Accreditation Agency's state offices, either by their own volition or on behalf of DoHA.

The roles of DoHA's state and territory offices

4.3 Table 4.1 summarises the compliance monitoring and related roles of DoHA's state and territory offices (STOs).

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

88

Table 4.1

The roles of DoHA's state and territory offices

STO Roles
Undertaking compliance action, including issuing Notices of Non-Compliance and the imposition of sanctions.
Leading interactions with other state-based agencies to assist in the coordination of resources (including the Accreditation Agency) to manage emergencies that affect whole communities including residential aged care homes such as floods, fires and cyclones. When advised by a home that there is an infectious disease outbreak such as gastroenteritis, the STO will ensure that the home is taking the appropriate remedial action including putting in place an infection control plan.
Contributing to aged care compliance reports and analysis that accurately describe the quality of care system as well as preparation of briefs and Ministerial responses to inform and support the Minister for Ageing.
Referring to the Accreditation Agency 'systemic' concerns, which may arise from an individual complaint, about the quality of care provided by Commonwealth-subsidised aged care services.
Monitoring certain Approved Provider responsibilities including the reporting of allegations of reportable assaults, missing residents and police check requirements.
Maintaining an operational interface between DoHA and the aged care sector in the state or territory.
Assisting with the provision of information to the aged care sector and the broader community, e.g. provision of information to DoHA Central Office to upload to <www.agedcareaustralia.com.au>. The nationally coordinated website publishes non-compliance and sanctions information by state.

Source: DoHA

4.4 Much of the STOs' compliance monitoring work involves acting on information received through the Complaints Investigation Scheme (CIS)[99], from the Accreditation Agency and from other stakeholders about possible instances of non-compliance by particular aged care homes with the Accreditation Standards and their other responsibilities under the Act. The STOs' roles include determining whether to formally refer individual homes to the Accreditation Agency for further examination, and whether DoHA should proceed with compliance action.

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[99] The 2009–10 *Report on the Operation of the Aged Care Act 1997* reported that of the 8 055 'in scope' cases received, 96.5 per cent (7 775 cases) related to care and services provided in residential aged care homes. The most commonly reported issues related to: health and personal care; abuse; consultation and communication; personnel; and the physical environment.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

89

4.5   In practice, almost all instances of detected non-compliance are addressed without DoHA imposing a sanction. For example, in 2009–10, in relation to quality of care, DoHA[100]:

- issued 134 Notices of Non-Compliance against residential aged care services; but only

- issued sanctions to seven Approved Providers, of which only 3 sanctions remained in place as at 30 June 2010; and

- revoked the Approved Provider status of one provider.

4.6   The seven sanctions imposed by DoHA largely related to the identification of serious risk by the Accreditation Agency and a subsequent departmental determination that there was an immediate and severe risk to the health, safety or wellbeing of residents. In the course of one Support Contact, the Accreditation Agency assessors identified significant non-compliance (19 instances) with expected outcomes concerning the quality of clinical care, leading to medication errors, provided at an aged care home.

4.7   Other instances of non-compliance identified by Agency assessors included:

- staff not monitoring or responding to distressed residents;

- the safety and security of residents and their belongings being compromised by delays in the maintenance of equipment, grounds and fencing surrounding a home; and

- the presence of rodents representing a risk to residents' health.

4.8   These instances resulted in the identification of serious risk by the Agency and the immediate transfer of this information to the relevant DoHA state office. As a consequence DoHA imposed the following sanctions—a requirement for the Approved Provider to appoint an adviser with nursing experience for a defined period of time; no Australian Government funding for new care recipients for a defined period of time; and a requirement that the Approved Provider provide, at its expense, training for its officers, employees and agents.

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[100]   DoHA, *Report on the Operation of the Aged Care Act 1997*, 1 July 2009 – 30 June 2010.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

90

4.9   In determining whether a Notice of Non-Compliance or a sanction is necessary, STOs are supported by specialist legal and compliance staff within DoHA's Office of Aged Care Quality and Compliance (OACQC), as discussed later in this chapter. However, these decisions are the responsibility of STO staff holding the necessary delegations from the Secretary of DoHA. The Accreditation Agency is not involved in this decision-making, but is kept informed as part of the regular exchange of information.

The roles of the Accreditation Agency's state offices

4.10   Table 4.2 summarises the compliance monitoring and related roles of the Accreditation Agency's state offices (SOs).

Table 4.2

The roles of the Accreditation Agency's state offices

SO Roles
Form and frequency of Support Contacts, other support visits, desk audits, and site audits.
Monitoring certain Approved Provider responsibilities. Making accreditation decisions, including revoking or varying the period of accreditation.
Matters in respect of which improvements must be made and where improvements are necessary to recommend continuation of accreditation, dates of effects, and the need to agree with the home management on a timetable to make improvements (where required).
Publishing original decisions.
Assessing 'systemic accreditation concerns' about the quality of care provided by aged care services, referred from DoHA STOs.
Maintaining an operational interface with Approved Providers, DoHA, advocacy services, and the aged care sector.
Assisting with the provision of information to the aged care sector and the broader community, e.g. Education Seminars and Better Practice events.
Contributing to aged care compliance reports and analysis that accurately describes the aged care system for both DoHA and the Minister.

Source: The Accreditation Agency

4.11   The SOs' compliance monitoring work is coordinated through, and overseen by, the Accreditation Agency's National Office, particularly the Operations Division. Most of the SOs' compliance monitoring work involves the planning and conduct of Support Contact (now known as Assessment

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

91

Contact) visits.[101] Unlike a Review Audit, which assesses a home's compliance against all the 44 expected outcomes of the four Accreditation Standards, a Support Contact or Assessment Contact visit focuses on just a few expected outcomes, determined on the basis of risk.[102]

4.12　Analysis of published Accreditation Agency data for 2008–09 indicates that 77 per cent of the total number of its visits to homes (5 890 out of 7 579 visits) comprised Support Contact and other support visits.[103]

4.13　The planning and conduct of compliance monitoring visits takes into account the regular flow of information from DoHA and other stakeholders about possible instances of non-compliance with the Accreditation Standards. One of the SOs' main responsibilities in this respect involves satisfying the requirements of the Information Referral Protocol entered into with DoHA (discussed below).

4.14　Typically, following a Support Contact visit, a SO is responsible for determining whether or not to place a home on a Timetable for Improvement (TFI)[104] or conduct a more comprehensive own motion Review Audit.[105] These decisions are often made in consultation with the Accreditation Agency's National Office staff.

4.15　In practice, and in common with DoHA's experience in relation to sanctions, most instances of non-compliance identified by the Accreditation Agency are subsequently addressed by homes without the need to vary or revoke their period of accreditation. For example, in 2009–10 the Accreditation Agency[106]:

- issued TFIs to 186 homes identified as being non-compliant with one or more of the Accreditation Standards' 44 expected outcomes;

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[101]　Sections 1.3 and 3.20 of the *Accreditation Grant Principles 1999* respectively defined and specified the purpose of Support Contacts.

[102]　Appendix 3 describes the four Standards and the corresponding 44 Expected Outcomes.

[103]　Accreditation Site visits accounted for some 21 per cent, and Review Audits (including those requested by DoHA) accounted for most of the remaining 1 per cent of visits. See also Table 3.4 for further details. The Glossary provides the definitions of Accreditation Site visits, Support Contact visits and Review Audits.

[104]　See the Glossary for a definition.

[105]　The Accreditation body cannot revoke or vary a period of accreditation as a result of a Support Contact.

[106]　DoHA, op cit, p. 76.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

92

- varied the period of accreditation of 38 homes; and

- revoked the accreditation of one home.

4.16 DoHA is not involved in this decision-making, but is kept informed through established communication channels. DoHA also takes the Accreditation Agency's decisions and the subsequent compliance outcomes into account when determining whether or not to impose a sanction on an Approved Provider. Correspondingly, DoHA may decide to defer imposing a Notice of Non-compliance (NCC) until the end of a TFI period, based on the Accreditation Agency's assessment as to whether the home is still failing to comply with the Accreditation Standards.

The information referral protocol

4.17 As noted in Chapter 2, the 2002 *Protocol for referrals, compliance monitoring and compliance action between the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency* (the Protocol) guides the referral and exchange of information between the two organisations.

DoHA's referral of information to the Accreditation Agency

4.18 A key feature of the Protocol is the specification of four types of information which DoHA is required to use when formally referring information to the Accreditation Agency. Table 4.3 provides a description of these referral types and their relative importance in 2009–10.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

93

Table 4.3

Types of DoHA referrals of information to the Accreditation Agency

Referral type	Percentage of referrals 2009-10 %	Description of non-compliance with Accreditation Standards	Accreditation Agency's required response
Type 1	38	Non-compliance identified by DoHA/CIS addressed by service provider. No further action required.	For information only; no response required.
Type 2	43	Non-compliance identified by DoHA/CIS still being addressed by service provider.	The 'expected outcomes' may be assessed at next scheduled Support Contact visit.
Type 3	7	Risk of non-compliance identified by DoHA/CIS considered to be 'of concern' but not 'severe'.	The response may include either no further action or an assessment of the specific systems and processes involved at a Support Contact visit.
Type 4	1	Risk of non-compliance or other issues (e.g. change of key personnel) identified by DoHA/CIS considered to be 'severe'.[107]	All 44 'expected outcomes' to be subject to a Review Audit as a matter of urgency.
Other	11	Not specified. Includes issues such as notified outbreak of disease.	For information only; no response required.

Source: The Protocol and ANAO analysis of Accreditation Agency data for referrals in 2008-09

4.19   A significant proportion of the information DoHA refers to the Accreditation Agency is based on complaints about a home reported to the CIS by or on behalf of a particular resident. Only those complaints which DoHA STO compliance staff[108] consider may concern the wellbeing of more than one resident are subsequently referred to the Accreditation Agency. Often, CIS or

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[107]   The ANAO file review identified a home that had demonstrated consistent compliance with the Standards for eight years but was then found to be suddenly non-compliant against 12 expected outcomes. This followed a DoHA Type 4 referral due to a complaint from the home's staff concerning: cleaning and hygiene, living environment, clinical care, personal care, internal complaints process, infection control, resident safety and staffing. The ANAO was advised by the Accreditation Agency that this is not a 'one-off' situation. It sometimes happens that a home will be fully compliant for many years and then suddenly have instances of non-compliance across all of the four Accreditation Standards. The Accreditation Agency advised that, in some cases, it is not possible to identify the cause of the failure.

[108]   In some STOs, DoHA staff perform both CIS and compliance roles.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

94

other DoHA staff will have already visited the home in question to investigate the particular complaint.

4.20 As indicated in Table 4.3, the referral type considered necessary by DoHA determines the general nature of the response required of the Accreditation Agency. However, DoHA advised the ANAO that its use of a particular referral type is meant to be a guide as to the likely significance of the risk to the wellbeing of residents at an aged care home. This is because DoHA's risk assessment is necessarily based only on currently available information and so does not constitute a full assessment of the risk. Correspondingly, the Accreditation Agency advised the ANAO that it makes its own risk assessment of the information accompanying a referral (Table 3.3 in Chapter 3 lists the main risk categories used, and their weightings).

4.21 In this context, it is important to note that state office staff of both organisations advised that there were no instances where their monitoring and related compliance activities were materially affected by an inability or failure to promptly obtain information from the other organisation.
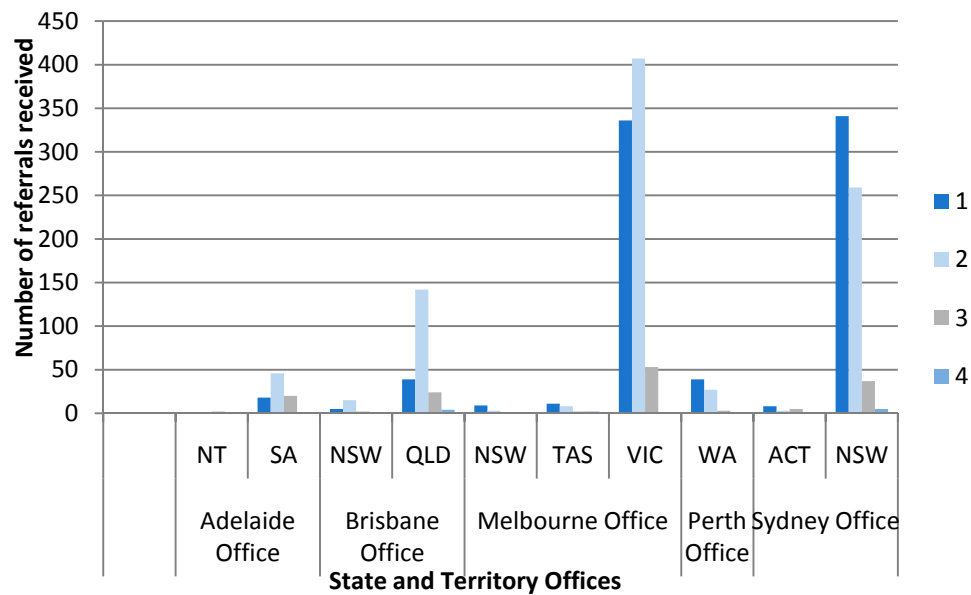
4.22 The Accreditation Agency provided a state-by-state breakdown for the different types of referrals from DoHA's STOs in 2009–10. The ANAO's two main observations here, presented in Figure 4.1 below, are that DoHA's:

- Sydney-based STO made markedly more Type 1 than Type 2 referrals, in contrast to the opposite situation for the other larger STOs; and

- Brisbane-based STO made a significantly higher proportion of referrals identified as type 'other' (not specified in the Protocol), compared with the other larger STOs.

4.23 The ANAO recognises that these two differences in referral types will, in part, reflect differences in the way DoHA's and the Accreditation Agency's state offices work together. However, there would be merit in DoHA undertaking a quality review of its referral classification processes to ensure a consistent national approach.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

95

Figure 4.1

DoHA referrals to the Accreditation Agency, by state and type of referral, 2009–10

Source: ANAO analysis of Accreditation Agency data

Note: The top row of state names refers to DoHA's STOs, while the bottom row refers to the Accreditation Agency's SOs, which can operate across state boundaries.

The Accreditation Agency's responses to DoHA's referrals of information

4.24   The ANAO reviewed a small sample of the Accreditation Agency's case files to clarify how the Accreditation Agency responds to DoHA's information referrals. Ten of the 18 randomly selected case files identified referrals from DoHA. Examples of how information is transferred from DoHA to the Accreditation Agency, drawn from these ten files and covering five different homes, are presented in Table 4.4.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

96

Table 4.4

The Accreditation Agency's responses to DoHA referrals

Referral Type	The Agency's summary of DoHA referrals	Agency response
1	This referral concerned a gastroenteritis outbreak at a home. The referral was made in late August 2009.	The relevant State Case Management Committee decided to continue with its next scheduled visit, planned for early September.
2	The referral was based on anonymous information concerning the administration of medication. The referral was made in July 2009.	The Agency decided to continue with its prior decision to conduct an unannounced Support Contact, scheduled for September.
3	This referral indicated a high possibility of significant non-compliance against three of the four Accreditation Standards Prior to this referral the home had a good compliance record.	The Agency subsequently visited the home four times within one month. Widespread non-compliance was identified and the home was placed on a Timetable for Improvement (TFI). The Agency monitored the home closely during this period and all non-compliance was resolved.
4	This referral followed a wide range of complaints made by staff concerning cleaning and hygiene, infection control, resident safety and staffing.	The Agency conducted a Review Audit and found non-compliance against 12 expected outcomes. The home was put on a TFI and its period of accreditation was reduced by nine months. The TFI was extended until all non-compliance was corrected.
'Other' (6)	There were six separate DoHA referrals over an 18 month period concerning a particular aged care home. These referrals concerned matters such as changes in bed allocation numbers and the transfer of beds.	Each referral was incorporated within the Agency's existing schedule of visits.

Source: ANAO analysis

The Accreditation Agency's reporting back to DoHA

4.25   The compliance monitoring visits, in the form of Support Contacts or Assessment Contacts undertaken by the Accreditation Agency, are a key requirement of the *Accreditation Grant Principles* and also of the Deed of Agreement entered into with DoHA. The results from these visits can provide DoHA with important information on the extent and nature of non-compliance with the Accreditation Standards by aged care homes, post accreditation.

4.26   Accordingly, under the Protocol, the Accreditation Agency is required to report back formally to DoHA on its compliance monitoring actions taken in

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

97

relation to Type 3 and 4 information referrals, which are shaded dark blue in Table 4.4 By contrast, formal reporting back is not required for Type 1 and 2 referrals, which are shaded light blue in Table 4.4.

4.27   Table 4.3 indicates that in 2009–10, Type 1 and 2 referrals accounted for 81 per cent of the information referrals from DoHA. Given the extensive use of these referrals, it is important that DoHA is informed as to how they are addressed by the Accreditation Agency. All STOs, except the small Northern Territory office which makes few referrals[109], advised the ANAO that they received this information, including the homes' responses to their identified non-compliance with the Accreditation Standards.

Accreditation Agency referrals to DoHA

4.28   In addition to their formal and informal reporting back on DoHA referrals, the Accreditation Agency's SOs refer other information to DoHA. The frequency and formality of these referrals depends on the urgency of the situation.

4.29   If, through its visits, the Accreditation Agency becomes aware of serious risk to the health, safety or wellbeing of residents, it is required to report this to the department as soon as it becomes aware of the evidence, and to recommend whether or not sanctions should be imposed.[110]

4.30   As discussed in Chapter 2, the Accreditation Agency's SOs also provide a wide range of other information to DoHA's STOs at both formal monthly face-to-face meetings and during informal weekly telephone conferences.[111] These communication channels help the two organisations' state offices discuss and coordinate their respective visit schedules (including CIS visits), so as to minimise disruption to residents and staff of aged care homes. The state offices' respective roles in addressing identified non-compliance and possible additional compliance treatments are also discussed.

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[109]   The ANAO was advised that most of the small number of referrals concerning Northern Territory aged care homes are made by DoHA's South Australia STO.

[110]   *Accreditation Grant Principles 1999*, Part 4, section 4.5 (2).

[111]   The ANAO attended a weekly telephone conference between DoHA and Accreditation Agency state offices.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

98

Summary of the Protocol's effectiveness in promoting information referrals

4.31 The Protocol provides a sound basis for both the formal and informal referral of information between DoHA's and the Accreditation Agency's state offices.

4.32 DoHA's and the Accreditation Agency's formal responsibilities in relation to Type 1, 2, 3 and 4 referrals are clearly articulated in the Protocol and in both organisations' Operating Procedures.

4.33 More generally, the Protocol promotes the prompt exchange of information (both formally and informally) between DoHA and Accreditation Agency state offices, including the latter offices' responses to Type 1 and 2 referrals.

4.34 However, as indicated previously there is scope for achieving greater consistency in the use of referral types by DoHA's STOs. The Accreditation Agency may need to consider whether its SOs are responding to and reporting back on Type 1 and 2 referrals consistently.

Case management by DoHA and the Accreditation Agency

4.35 The effective compliance treatment of identified risks to the health, safety or wellbeing of residents in aged care homes benefits from a holistic case management approach.[112] This is particularly important where two organisations have separate but complementary roles in treating identified risks, and where the performance of their respective roles requires the regular exchange of information. The ANAO examined the case management approaches adopted by DoHA and the Accreditation Agency concerning existing and emerging compliance risks in individual aged care homes.

DoHA's approach to case management

STO level

4.36 DoHA STOs' responses to an ANAO survey indicated there was a common approach to case management, including the referral and wider exchange of information with the Accreditation Agency.

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112 See the Glossary for a definition of 'case management'.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

99

4.37 Reflecting the importance of CIS information, CIS and compliance staff[113] in each STO have daily and fortnightly meetings to discuss:

- new information and emerging issues;

- all current CIS complaints and the progress in addressing them, including ensuring that all relevant material is properly documented and processed (so as to allow DoHA compliance action to be commenced promptly); and

- possible new referrals and the progress with previous referrals to the Accreditation Agency.

DoHA's Standard Operating Procedures (SOPs)

4.38 These and other STO case management procedures are supported by DoHA's detailed computerised documentation of its SOPs. This documentation includes information capture/reporting templates and the procedures to be followed when communicating formally with homes and Approved Providers.

4.39 DoHA's SOPs also require a quality review by Central Office staff of an STO's proposal to issue an Approved Provider with a Notice of Decision to Impose a Sanction (NDIS):

- the first part of the quality review ensures that any additional information held by Central Office is taken into account by the STO decision-maker; and

- the second part of the quality review involves a DoHA legal officer advising the STO decision-maker whether or not the proposed decision is consistent with the Act.

DoHA's national approved provider system (NAPS)

4.40 STOs' case management is also supported by DoHA's NAPS database. This database contains details of Approved Providers, including their key personnel, and the residential and other aged care services they provide.

4.41 Under the Act, Approved Providers are required to notify DoHA within 28 days of a change to its key personnel. DoHA updates this information in NAPS within two days.

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[113] In the smaller STOs, CIS staff also perform compliance roles.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

100

4.42 Both DoHA and the Accreditation Agency consider a change in an Approved Provider's key personnel at residential aged care homes to be a key compliance risk indicator. While the Accreditation Agency monitors job advertisements, and obtains staffing information from its visits and other contacts with homes, it is still largely dependent on NAPS for information on changes to key personnel. Reliable access to NAPS information is important to case management staff in both DoHA and the Accreditation Agency.

4.43 The ANAO examined the NAPS data for Approved Providers' key personnel information at residential aged care homes. The main findings were that, as at October 2010:

- overall, some 9 per cent (240) of the 2 860 residential aged care homes listed on NAPS had no key personnel information recorded against them. Of the larger states:

    – Victoria recorded the highest corresponding percentage: 12 per cent (95) of 800 homes;

    – New South Wales recorded the lowest corresponding percentage: 7 per cent (67) of 910 homes;

- there were substantial differences in the way state-level information on key personnel was recorded and updated on NAPS.

4.44 DoHA advised the ANAO that most of the homes without key personnel recorded against them have that information recorded in NAPS against the approved provider of the home.

4.45 Over the course of the audit, the department made two main improvements to NAPS:

- States are no longer responsible for recording or updating NAPS, improving consistency by removing differences in the recording of State level information; and

- changes to key personnel are now recorded at the service level (that is, the home) if the key personnel are responsible for nursing services or the day-to-day activities of the service and changes at the approved

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

101

provider level are recorded if the key personnel are responsible for executive decisions.[114]

4.46 To facilitate Accreditation Agency case managers' ready access to data of importance to their work, DoHA could consider providing the Accreditation Agency with direct access to the relevant parts of the NAPS data base.

The Accreditation Agency's case management approach

4.47 The Accreditation Agency's case management approach includes the following elements:

- a national policy that applies across the Accreditation Agency's state offices;

- the use of standard procedures to guide state office case management considerations;

- documentation to support quality assessors in the field; and

- a quality assurance framework for decision-making, which limits the number of decision-makers, provides for the review of decisions, and involves formal training for decision-makers.

4.48 The National Case Management policy provides the framework to support the Accreditation Agency's accreditation function. The policy states that the purpose of case management is to protect the welfare of residents by initiating and managing timely and relevant action to address potential and identified risks of poor care and services and to support improvements. The case management approach helps to ensure all relevant available information is applied to decision-making and communication with key stakeholders. Access to all relevant available information is especially important at the state office level as each state office has a dedicated case management committee which, after an assessment of all the relevant available information, makes decisions concerning the scheduling of visits to aged care homes within that State and which Accreditation Standard and expected outcomes will be assessed during that visit.

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[114] The *Aged Care Act 1997* distinguishes between key personnel responsible for the executive decisions of an entity; key personnel with the authority or responsibility for planning, directing or controlling the activities of the entity; and, if an entity conducts an aged care service (that is, a home), people responsible for the nursing services provided by the service and responsible for the day-to-day operations of the service.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

102

Accreditation Agency state office case management

4.49 In common with their DoHA counterparts, each Accreditation Agency state office holds weekly case management meetings to review the outcomes of previous visits and compliance actions, and to determine which cases should remain open, require further visits or other compliance treatments, or can be closed. The already planned future schedule of visits to homes and the new information referrals from DoHA are also reviewed and, if warranted, the schedule of visits is updated.

4.50 The ANAO observed a weekly case management meeting at one of the Accreditation Agency's state offices and assessed the meeting against the principles set out in the National Case Management Policy. The scope and conduct of the meeting was consistent with the case management principles. State office staff have considerable responsibility for implementing the Accreditation Agency's case management policy and are supported in this by a range of procedural documentation.

Support Contact Operational Policy

4.51 Support Contacts, known as Assessment Contacts since 20 May 2011, are an important part of the accreditation process, with over 5 000 conducted in 2009–10 and over 3 500 of these being unannounced. The Accreditation Agency's operational policy on Support Contacts states that they have an assurance function:

> We conduct Support Contacts to give assurance to the Government, community and residents of aged care homes that homes are providing quality resident care.[115]

4.52 The form and frequency of Support Contacts is decided on a case-by-case basis depending on the level and frequency of supervision required to ensure residents receive appropriate care and services. Non-compliant homes or those with a past history of non-compliance may be visited more frequently than homes with a record of consistent high performance.

4.53 Support Contacts are generally of lesser duration than full accreditation site audits or review audits and the scope of the visit is determined by state office decision-makers. Support Contacts may consist of: case-specific matters,

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[115] Aged Care Standards and Accreditation Agency Ltd, 'Support Contact Arrangements', AS_PL_00456, version 2.2, 30 October 2009, p. 1.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

103

an assessment module or a combination of an assessment module and case-specific matters.

4.54 The ANAO observed two Support Contact visits by agency staff in two states—one at a home of a large not-for-profit Approved Provider and one at a smaller community-based aged care facility. On both occasions, quality assessors used the required documentation and conducted the assessment against the Accreditation Standard and expected outcomes that were decided at the state office case management meeting.

4.55 The current operational policy on Support Contacts[116] does not enable assessors to alter the scope of assessment for a Support Contact, even where concerns arise about the performance of the home in areas outside the assigned scope of a Support Contact. Where this occurs, assessors are required to contact their state office Assessment Manager for direction if they consider their concerns warrant further assessment, or include an outline of their concerns in the Support Contact record.

4.56 Under the current operational policy, additional matters identified by assessors can be logged for future visits and are used to inform the case management of the home and the development of the scope of subsequent visits. However, the policy does not enable assessors to alter the scope of assessment for a Support Contact without reference to a decision-maker in the relevant state office, even where concerns arise about the performance of the home in areas outside the assigned scope of a Support Contact. While recognising the benefits in maintaining a focus on pre-identified issues, there are also potential benefits in terms of efficiency and effectiveness in allowing assessors in the field some latitude to examine other risks to service delivery that they identify during visits. The extent of this latitude could be specified to avoid significant scope variation.

4.57 State office staff with responsibility for decision-making are supported in their job by the Accreditation Agency's broadly based Quality Assurance policy.[117] According to this policy, decision-making is subject to regular peer review.

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[116] ibid, p. 6.

[117] Accreditation Agency, *Quality Assurance Activity Evaluation Policy*. This policy states that quality assurance activities, such as peer reviews, are 'to be integrated into all areas of the organisation'.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

104

4.58   In addition, the National Case Management Committee (see Chapter 3) oversights the quality of state office case management and decision-making for those cases where non-compliance in four or more expected outcomes has been identified at a home; a home's accreditation has been refused, varied or revoked; and there are contentious issues associated with a particular home or its Approved Provider.

4.59   Where appropriate, the National Case Management Committee also considers assessment reports for those Approved Providers operating a number of residential aged care homes, some of which may be located in different states. Here, the National Case Management Committee may identify the need for and lead coordinated action by the relevant state offices.

4.60   The constituent elements of the Accreditation Agency's case management at the national and state office level are designed to facilitate consistent and quality decision-making across the organisation. Similarly, DoHA also has in place a structured case management approach to support decision-making.

4.61   At the operational level, DoHA and the Accreditation Agency have arrangements in place to address possible non-compliance. Sanctions, as the ultimate deterrent, are the final response to non-compliance. Between the initial identification of non-compliance and the imposition of sanctions, the regulatory process affords Approved Providers multiple opportunities to address identified non-compliance before DoHA contemplates sanctions.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

105

5. Monitoring and Reporting Performance

This chapter examines the approaches adopted by DoHA and the Accreditation Agency to monitor and report on their performance in relation to their compliance function and the Accreditation Standards monitoring role.

Introduction

5.1   Monitoring and reporting activities have two broad purposes: identification of achievements and possible scope for improvement; and accountability and disclosure.

5.2   The legislative framework for the provision of quality services to the residents of aged care homes is complex, involving both DoHA and the Accreditation Agency at different points. In this context, both organisations face challenges to accurately identify and report on their individual contributions, and the impact of their joint efforts towards ensuring that the recipients of aged care services receive high quality of care as envisaged by the Act.

5.3   The ANAO's examination of the performance management arrangements focused on DoHA's and the Accreditation Agency's:

- reporting on outcomes to the Parliament and the public, through:

    – the articulation of performance indicators published in Portfolio Budget Statements (PBS) and corresponding public reporting of effectiveness in Annual Reports,

    – DoHA's reporting of its compliance activities and the Accreditation Agency's Standards monitoring—through the annual *Report on the Operation of the Aged Care Act 1997* (ROACA); and

- internal planning processes and monitoring arrangements for the Deed of Funding agreement between the two organisations.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

106

Reporting outcomes to Parliament and the public

5.4   PBS and Annual Reports are key accountability documents. The PBS informs Parliament of the proposed allocation of resources to government outcomes by agencies within a portfolio, while Annual Reports inform the Parliament of agency performance. The PBS is also a key internal management document, which is used by agencies to align their business plans and performance reporting with the Government's strategic priorities.

DoHA's PBS performance information

5.5   Performance information for the department's administration of residential aged care was grouped in its 2009–10 PBS under *Program 4.8: Residential Care*:[118]

> The Australian Government aims to promote the quality of care delivered to residents by Approved Providers of aged care. This is achieved by ensuring they understand their obligations for delivering quality aged care and their prudential and other responsibilities as Approved Providers under the Aged Care Act 1997. It is also reinforced by targeted compliance activity to identify Approved Providers that may not be meeting their care and financial obligations, and taking appropriate remedial action including formal sanctions, if required. *The work promoting the delivery of quality aged care and regulatory compliance is undertaken in cooperation with the Aged Care Standards and Accreditation Agency Ltd*.[119] (ANAO italics)

5.6   The ANAO assessed whether DoHA's 2009–10 PBS contained suitable performance measures and sufficient explanatory detail to allow stakeholders to identify the contribution of Program 4.8 and associated major activities to the higher-level Outcome 4: Aged Care and Population Ageing:

> access to quality and affordable aged care and care support services for older people, including through subsidies and grants, industry assistance, training and regulation of the aged care sector.[120]

Effectiveness indicators

5.7   Portfolio agency PBS should include performance information in the form of effectiveness indicators to enable the Parliament and the public to

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[118]   DoHA's 2011–12 PBS groups residential aged care under Program 4.6

[119]   Commonwealth of Australia, *Portfolio Budget Statements 2009–10*: Health and Ageing Portfolio, p. 182.

[120]   ibid, p. 147.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

107

assess the relative success or otherwise of a program in meeting its objective and, as a result, the contribution the program makes to an agency's outcomes.

5.8   DoHA's effectiveness measures for its *Program 4.8: Residential Care* and annual reporting against these measures for 2009–10 are presented in Table 5.1.

Table 5.1

Comparison of DoHA PBS effectiveness measures and Annual Report results

2009-10 Deliverables	Indicator provided	Target provided	Annual Report result
Qualitative: Regular stakeholder participation in program development, through avenues such as surveys, conferences, meetings and submissions on departmental discussion papers.	Quality: Enhancements to the accreditation process are developed in consultation with key stakeholders, including consumers of residential aged care services and the aged care industry.	This will be measured by reporting on the consultation process undertaken by the department in reviewing the accreditation process.	DoHA reported that it met this target.
Quantitative: Number of unannounced visits per aged care home per year (*conducted by the Aged Care Standards and Accreditation Agency*).	Quantity: ≥ 1	≥ 1	DoHA reported that it exceeded this target: 1.29.

Source: Health and Ageing Portfolio, *Agency Budget Statements – Outcomes and Planned Performance,* 2009-10 and *Annual Report 2009–10,* Canberra, pp. 181–182

Note: The italicised words included in the above quantitative deliverable were absent in the PBS but included in the Annual Report

Qualitative indicators

5.9   DoHA provided sufficient information in its Annual Report against the qualitative deliverable for Residential Support and Accreditation under Program 4.8 to meet the 'clear read' principle between PBS information and that reported in its Annual Report.

5.10   In its program objective, the department acknowledges that promoting the delivery of quality aged care and regulatory compliance is undertaken in cooperation with the Accreditation Agency. However, there are no effectiveness indicators in place to enable stakeholders to assess the efficiency or effectiveness of this 'cooperation'. The strength of the cooperative effort supports both the delivery of quality aged care in aged care homes and regulatory compliance. The development of, and reporting against,

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

108

appropriate performance indicators would enable external stakeholders to assess the contribution made by this relationship to program outcomes.

Quantitative indicators

5.11 DoHA's PBS included one quantitative deliverable: 'number of unannounced visits per aged care home per year' with a quantitative indicator and a target of more than one visit per year.

5.12 Neither the PBS nor the Annual Report provided sufficient explanatory text as to the assumed causal relationship between 'unannounced visits' and the Government's Program 4.8 objective to: 'promote the quality of care delivered to residents by Approved Providers of aged care'.

The Accreditation Agency's PBS performance information

5.13 The legal and regulatory framework for the Accreditation Agency, as a wholly–owned Australian Government company, provides it with independence from some detailed government planning, operational and review processes applicable to CAC authorities.

5.14 In particular, while the Accreditation Agency is required to follow Department of Finance and Deregulation guidance for the preparation of Portfolio Budget Statements—especially when determining whether new programs or changes to existing programs are necessary—there is no formal requirement that it present information in its Annual Reports that is consistent with its PBS. Reporting requirements for the Accreditation Agency are set out in the CAC Act, the Corporations Act and general orders of government.

5.15 The Deed of Funding Agreement between DoHA and the Accreditation Agency summarises the Agency's reporting requirements:

- the Agency meet its requirements under the CAC Act and the Corporations Act and provide all reports and plans required by this Agreement with the Commonwealth;

- the Agency also provides input to the department to allow the department to report against the relevant Outcome in its Annual Report, Annual Report on the Operations of the *Aged Care Act 1997*, Government Services Report and other reports to meet the Government's requirements.

5.16 The ANAO assessed whether the Accreditation Agency's 2009–10 PBS entry contained suitable performance measures and sufficient detail to allow stakeholders to identify the contribution of its program and associated activities to its stated Outcome:

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

109

high quality residential aged care for older people, including through accrediting Australian Government-funded aged care homes, identifying best practice, and providing information and education to the aged care sector.[121]

5.17   Within this Outcome, the Accreditation Agency had a single Program 1.1: 'Accrediting, monitoring and promoting high quality care through information, education and training for Australian Government-funded aged care homes', with an objective to:

> improve outcomes in the provision of care to aged care residents. To safeguard aged care residents against poor quality care, the Agency will manage the accreditation and supervision of Australian Government-funded aged care homes, and provide information and education services.[122]

5.18   The deliverables identified by the Accreditation Agency for its Program 1.1 were: *High quality residential aged care for older people, including through accrediting Australian Government-funded aged care homes, identifying best practice, and providing information and education to the aged care sector.*

5.19   Table 5.2 provides a comparison of the Accreditation Agency 2009–10 PBS effectiveness measures and its 2009–10 Annual Report results, where possible.

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[121]   ibid, p. 391.

[122]   ibid, p. 393.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

110

Table 5.2

Comparison of the Accreditation Agency PBS effectiveness measures and Annual Report results

2009-10 Deliverables	Indicator provided	Target	Annual Report results
Qualitative: Monitoring compliance with the Accreditation Standards.		The accreditation of care and services of aged care homes, measured by completing accreditation decisions according to statutory requirements for all homes submitting accreditation applications.	The 2009-10 Annual Report reported that: • 100 per cent of accreditation site audits were conducted in response to valid accreditation applications; and • accreditation decisions were made within 60 days of the accreditation expiry date for each service.
Qualitative: Education activities to promote high quality care.		Develop and deliver publications and education services that promote high quality care, measured by the number of Better Practice conferences, seminars, assessor courses, quality education activities, and the number of attendees.	The 2009-10 Annual Report reported that: • six Better Practice Conferences were held with 1 126 delegates; • 27 four-day industry courses on 'understanding accreditation' were held, attended by 347 industry participants; • 49 industry-focused seminars were held with 617 participants; and • 263 QUEST sessions provided to 3 848 participants from 290 aged care homes.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

111

2009-10 Deliverables	Indicator provided	Target	Annual Report results
Quantitative: Percentage of Agency compliance with Deed of Funding requirements.	Number of homes found with non-compliance during the year.	< 300	The 2009-10 Annual Report reported that:
	Percentage of homes to have achieved compliance by the end of the Timetable for Improvement period.	≥ 90 per cent	• 54 homes were on a Timetable for Improvement as at 30 June 2010; • 187 homes or 98.4 per cent achieved compliance by the end of their Timetable for Improvement.
	Service compliance with the Accreditation Standards at the last accreditation audit.	> 92 per cent	
Quantitative: At least one unannounced visit per aged care home per year.			The 2009-10 Annual Report reported that: • 3 750 unannounced visits were conducted and all homes received at least one unannounced visit.

Source: Health and Ageing Portfolio, *Agency Budget Statements – Outcomes and Planned Performance,* 2009–10 and the Aged Care Standards and Accreditation Agency Ltd, *Annual Report*, 2009–10

Qualitative indicators

5.20   The qualitative indicators and targets for the measurement of the Accreditation Agency's activity against the deliverables, where they are included, provide a relatively limited basis for stakeholders to assess the performance of the Accreditation Agency's program in achieving the stated Outcome. However, the Accreditation Agency does, largely in narrative form, discuss the education activities it will undertake to promote high quality care within residential aged care homes and uses analysis of feedback from attendees at these sessions as part of its quality improvement framework.

5.21   The performance information contained in the Accreditation Agency's 2009–10 Annual Report, while not directly related to that contained in the 2009–10 PBS, is far more detailed and useful in helping readers to assess Agency activities concerned with the deliverable of: *Monitoring compliance with the Accreditation Standards.* The deliverable *Education activities promote high quality care* includes performance information that measures attendance at education sessions and Better Practice conferences. Independent follow-up surveys of conference participants are also conducted. One of the key

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

112

questions asks whether the participant has introduced any changes in their aged care home following attendance at the conference. The results are reported in the Accreditation Agency's Annual Report.

5.22 In the long term, a program of periodic reviews that could measure changes in the behaviour of the target group (Approved Providers and their staff) would serve as a means to identify improvements in the quality of care and services delivered to residents of aged care homes as a result of *Education activities promote high quality care*. Reporting on the periodic reviews would also assist stakeholders to assess how effective Agency operations are in achieving the stated PBS Outcome: *high quality residential aged care for older people, including through accrediting Australian Government-funded aged care homes, identifying best practice, and providing information and education to the aged care sector.*

Quantitative indicators

5.23 In its 2009–10 PBS entry, the Accreditation Agency did not include quantitative performance indicators that could be used to make an independent assessment of the contributions made by its programs to the higher level Outcome. As an example, the Accreditation Agency provided a quantity indicator: *Percentage of homes achieving compliance by the end of the 'timetable for improvement'[123] period;* with a target of ≥90 per cent. The indicator referred to 'homes' achieving compliance but did not articulate the role played by the Accreditation Agency and its quality assessors in supporting aged care homes to achieve the target.

5.24 While the content of the Accreditation Agency's 2009–10 Annual Report complied with the requirements of the Corporations Act, more could be done to make it a more useful vehicle for communicating publicly with stakeholders on its activities and results.

Indicators to address legislative objectives

5.25 The ANAO assessed DoHA's and the Accreditation Agency's public reporting of their compliance and monitoring activities by examining public reports and the degree to which legislative objectives were addressed in the

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[123] See the Glossary for a definition of a Timetable for Improvement (TFI).

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

113

DoHA and the Accreditation Agency annual reports for 2009–10. Table 5.3 assesses reporting against those legislative objectives relevant to this audit.

Table 5.3

Reporting against relevant legislative objectives

Relevant legislative objectives	Reported	ANAO comment
Promote a high quality of care and accommodation.	Partial	The Accreditation Agency's mission is to ensure the delivery of high quality aged care by (*inter alia*): • promoting innovation and better practice; and • working with services to continually improve their performance. This is partially reported against in the Agency's Annual Report.
Protect the health and wellbeing of residents.	Partial	This is partially reported in the Accreditation Agency's Annual Report and can be inferred from DoHA's Annual Report in relation to Program 4.3—Ageing Information and Support which includes statistical details on actions taken by the Complaints Investigation Scheme (CIS) and also the compliance function, including the imposition of sanctions.

Source: ANAO

5.26   In common with their general approach to reporting, DoHA and the Accreditation Agency largely report performance against legislative objectives on an activity basis, such as the number of homes visited as part of the accreditation process[124] and the percentage of providers on whom sanctions were imposed. By its nature, and in isolation, activity-based reporting limits the extent to which stakeholders can develop an appreciation of regulatory performance and the quality of outcomes. The development of more robust outcome measures would better place DoHA and the Accreditation Agency to report to the Minister and the Parliament on their performance in realising the objects of the Act.

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[124]   The Accreditation Agency also reports to some extent on the type of visit and its outcomes, how the visit was conducted, the frequency of non-compliance, which expected outcomes were non-compliant, and the reasons for failure to meet the expected outcomes.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

114

The Campbell Report

5.27   ANAO Audit Report No.42 2002–2003, *Managing Residential Aged Care Accreditation*, recommended that an evaluation of the impact of accreditation on the quality of care in the residential aged care sector be undertaken. A subsequent JCPAA hearing into the ANAO report recommended that this be extended to incorporate quality of life considerations. In response, DoHA commissioned research in 2004 to evaluate the impact of accreditation on quality (broadly) in subsidised residential aged care homes. The research report—*Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, (more commonly referred to as the Campbell Report) was released in October, 2007.[125] A key finding of the Campbell Report was that accreditation has had a positive impact on the quality of care and quality of life for residents in Australian Government-subsidised aged care homes and is part of a robust regulatory framework.[126] A focus of the Report was on the need to develop quality of care and quality of life measures as a benchmark of quality in aged care homes against which future change/improvements could be measured.

5.28   The report observed that while there was a clear focus within the Accreditation Standards on identifying continuous improvement, the capacity for measurement to directly inform quality improvement was limited:

> the lack of timely, sensitive measures of performance as a basis of the measurement of continuous improvement means that while quality performance can be promoted, it is not measured and monitored in a way that can inform performance and provide feedback into the process of continuous improvement.[127]

5.29   As discussed previously in paragraph 5.21, the Accreditation Agency has implemented a range of initiatives to promote quality improvement (such as training, information seminars and improvement awards).[128] However, the Campbell Report noted that these initiatives can only promote an educative

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[125]   Appendix 4 provides more details on the Campbell Report.

[126]   Commonwealth of Australia, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes*, 2007, p. ix.

[127]   ibid, p.82.

[128]   Appendix 5 provides an overview of the Accreditation Agency's and DoHA's initiatives to promote quality improvement in the residential aged care sector.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

115

focus on quality improvement or acknowledge effort, as they were not designed as a measure of quality improvement across the sector.

5.30   The report acknowledged the challenges in developing meaningful, appropriate and measurable quality indicators, but concluded that there was a need to provide a more rigorous mechanism for the monitoring of quality so that improvements could be measured over time and progress reported. In response to the Campbell Report, DoHA has initiated a project to develop a set of resident-centred quality indicators. This is a long-term project requiring input from multiple stakeholders. The project has not yet commenced.

5.31   The Campbell Report acknowledged the challenges, in a sector as complex as residential aged care, for developing meaningful, appropriate and measurable quality indicators. The report concluded that there was a need to provide a more rigorous mechanism for the monitoring of quality so that improvements could be measured over time and progress reported. It set out a range of options for measuring quality improvement, and DoHA is considering the most appropriate approach. In doing so, DoHA could consider how best to assess and report on the contribution made by the Accreditation Agency's monitoring role and DoHA's regulatory role to the overall goal of quality improvement sought by the Australian Government.

Recommendation No. 3

5.32   In the context of the Department of Health and Ageing's (DoHA) broader work on quality indicators in response to the Campbell Report, the ANAO recommends that DoHA identify Key Performance Indicators (KPIs) that assist stakeholders to assess the contribution to quality improvement made by the Accreditation Agency's compliance monitoring role and DoHA's regulatory role.

5.33   The Department of Health and Ageing has agreed to implement the recommendation.

Report on the Operation of the Aged Care Act 1997 (ROACA)

5.34   Division 63–2 of the Act requires that the Minister for Ageing present to Parliament a report on the operation of the Act for each financial year. Both DoHA and the Accreditation Agency provide input to this report. Division 63–2 states that the report must provide information including matters relevant to this audit:

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

116

- the extent to which providers are complying with their responsibilities under the Act; and

- the imposition of any sanctions for non-compliance under Part 4.4, including details of the nature of the non-compliance and the sanctions imposed.

5.35 The Regulation and Compliance section of the ROACA contains information on residential care accreditation, accreditation reform and compliance/sanctions.

Residential care accreditation

5.36 In this section of the ROACA, DoHA reported that the Accreditation Agency had conducted:

- 993 accreditation site audits;

- 60 Review Audits, of which 33 were unannounced; and

- 5 066 Support Contacts, of which 3 537 were unannounced.

5.37 Concerning the 60 Review Audits, there were 58 decisions:

- 19 homes were the subject of a decision not to revoke or vary the period of accreditation;

- 38 homes were the subject of a decision to vary accreditation; and

- one home was subject to a decision to revoke accreditation.

5.38 DoHA also reported that the Accreditation Agency had, during 2009–10, identified 186 homes (of a total of 2 773 accredited homes) as being non-compliant with one or more of the 44 expected outcomes of the Accreditation Standards.

Accreditation reform

5.39 The ROACA details DoHA's and the Accreditation Agency's activities concerning the review of the accreditation process and the Accreditation Standards.

Compliance/sanctions

5.40 The 2009–10 ROACA stated that DoHA issued 134 Notices of Non-Compliance against aged care services in relation to quality of care, and an additional 16 Notices of Non-Compliance against Approved Providers in relation to prudential matters. The department also issued seven Notices of Decision to Impose Sanctions to seven Approved Providers. On 30 June 2010,

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

117

three of these sanctions remained in place. Details of the sanctions imposed are presented at Appendix D of the ROACA.

5.41 Appendix D reported that six of the seven decisions made were a direct result of the Accreditation Agency's prior determination of a serious risk. The ANAO considers that, although DoHA and the Accreditation Agency collect useful information relating to their individual activities, there could be an improvement in reporting this information to stakeholders, especially where coordinated efforts are required to achieve the Program objective of *'promoting the quality of care delivered to residents of Approved Providers of aged care.'*[129]

Internal planning and monitoring processes

5.42 A good performance management framework facilitates effective internal management while also informing stakeholders whether agency operations are achieving program objectives and contributing to higher level government Outcomes.

DoHA—divisional performance information

5.43 The Office of Aged Care Quality and Compliance (OACQC) Business Plan for 2010–11 provides a clear description of the various roles it performs. As required by DoHA's planning guidelines, the business plan was aligned with the corresponding components of Program 4.8–Residential care.

5.44 OACQC's Business Plan identifies and describes a number of particular strategic initiatives, approaches, challenges and opportunities for delivering the Program.

5.45 Strategic objective 4.8 was to:

> improve financial security for residents to support their choice of an aged care home, *improve the quality of aged care services through compliance with minimum standards*, and encourage continuous quality improvement.

5.46 The Business Plan also refers to the approaches adopted by the office to deliver against its strategic objectives, including developing its capacity to gather and use regulatory compliance information more effectively through closer cooperation and information sharing with the Aged Care Standards and Accreditation Agency.

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[129]   DoHA, *Agency Budget Statements – Outcomes and Planned Performance,* 2009-10, p. 182.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

118

5.47 The performance framework would be strengthened by OACQC developing appropriate performance indicators against its strategic objective 4.8 that are aligned with those contained in the PBS for Program 4.8–Residential care (now Program 4.6).

The Accreditation Agency—corporate plan performance information

5.48 The August 2010 version of the Accreditation Agency's Corporate Plan includes measures of how the Agency will know when it is succeeding. In relation to monitoring service provider compliance with the Accreditation Standards, three measures are provided:

- 92 per cent or more of all homes will be fully compliant against the Standards at the last site audit or Review Audit;

- 90 per cent of homes with non-compliance will achieve compliance within the period of their Timetable for Improvement (TFI); and

- we will meet the Minister's expectations as set out in the Statement of Expectations, all targets in Deed of Funding and requirements in legislation.

5.49 The first two measures of success correlate with the performance information included in the Accreditation Agency's PBS. The Deed of Funding contains a corresponding target for the second measure (see Appendix 6). The third measure refers broadly to the Accreditation Agency's obligations under the Minister's Statement of Expectations. The Accreditation Agency's Statement of Intent addresses those expectations.

5.50 For consistency purposes, it would be useful if the Accreditation Agency aligned its performance information across its accountability documents, including the contract/Deed of Funding with the department. The Accreditation Agency has advised that it agrees with this observation and will consider how to operationalise it in 2011–12.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

119

5.51   The alignment of performance information would also contribute to the development of a more complete reporting framework, combining activity-based reporting and reporting on quality indicators. A well-balanced reporting framework would assist stakeholders to assess the contribution to quality improvement made by the Accreditation Agency's compliance monitoring role and DoHA's regulatory role.

Ian McPhee   Canberra ACT

Auditor-General   16 June 2011

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

120

Appendices

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

121

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

122

Appendix 1: Extract from the *Aged Care Act 1997*

Division 2—Objects

2-1 The objects of this Act

(1)   The objects of this Act are as follows:

   (a)   to provide for funding of aged care that takes account of:

   (i)   the quality of the care; and

   (ii)   the type of care and level of care provided; and

   (iii)   the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and

   (iv)   appropriate outcomes for recipients of the care; and

   (v)   accountability of the providers of the care for the funding and for the outcomes for recipients;

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

   (c)   to protect the health and wellbeing of the recipients of aged care services;

   (d)   to ensure that aged care services are targeted towards the people with the greatest needs for those services;

   (e)   to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;

   (f)   to provide respite for families, and others, who care for older people;

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

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

   (ii)   facilitate the independence of, and choice available to,

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

123

those recipients and carers;

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

 (i) to plan effectively for the delivery of aged care services that:

  (i) promote the targeting of services to areas of the greatest need and people with the greatest need; and

  (ii) avoid duplication of those services; and

  (iii) improve the integration of the planning and delivery of aged care services with the planning and delivery of related health and community services;

 (j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.

(2) In construing the objects, due regard must be had to:

 (a) the limited resources available to support services and programs under this Act; and

 (b) the need to consider equity and merit in accessing those resources.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

124

Appendix 2: Legislative Framework

The Act and its accompanying delegated legislation (Aged Care Principles[130] and Determinations)[131] comprise the Australian Government's framework for regulating the funding of aged care providers and protecting aged care residents.[132]

A number of the Act's 96 Divisions address aspects of the administration of the monitoring, compliance and wider regulatory framework:

- Division 54 – Quality of care;

- Divisions 55 & 56 – User rights;

- Division 63 – Accountability, which covers the responsibilities of Approved Providers;

- Divisions 64 to 68 – Procedures and consequences of non-compliance by providers;

- Division 80 – Accreditation Grants, which covers DoHA's (the Secretary's) power to enter into a written agreement with a body corporate (currently the Accreditation Agency) to provide accreditation of residential care services and undertake any other activities specified in the Accreditation Grant Principles;

- Division 86 – Protection of information relating to residents and providers;

- Divisions 87 to 89 – Record-keeping responsibilities of providers;

- Divisions 90 to 94 – Powers of authorised persons/officers, exercised with and without occupier's consent;

- Division 94A – Investigation principles;

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[130] The Aged Care Principles have the status of 'Regulations'.

[131] In 2008-09 the Act was amended by the *Aged Care Amendment (2008 Measures No. 2 Act 2008)*. The amendments included clarifying and strengthening the existing provisions to increase protections for aged care recipients. There were consequential changes to some of the Aged Care Principles, the most significant of which were in relation to missing residents, police checks and DoHA's Complaints Investigation Scheme (Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, *1 July 2008 - 30 June 2009*, p. 94; and Guide to changes to the regulatory framework for aged care, December 2008).

[132] Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, *1 July 2008 – 30 June 2009*, p. 86.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

125

- Division 95A – Aged Care Commissioner. In summary, the functions of this statutory office holder include making recommendations, where applicable:

  - to the Secretary, concerning the Secretary's decisions and processes for handling matters under the Investigations Principles;

  - to the accreditation body, concerning its (or its assessors) conduct (but not the merits of decisions) relating to its responsibilities under the Accreditation Grant Principles.

As at May 2010, 22 sets of Principles give effect to the Act. Six of these Principles directly concern the administration of monitoring, complaint handling and other compliance related issues, namely:

- *Quality of Care Principles 1997*, which set out a number of standards relating to accreditation and the subsequent responsibilities of Approved Providers. Part 4 and Schedule 3 cover 'Residential Care Standards' for 'health and personal care' (17 indicators), 'resident lifestyle' (10 indicators), and 'physical environment and safe systems' (8 indicators).

  - These standards are intended to provide 'clear statements of expected performance'…[but]…'do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents. It is not expected that all residential care services should respond to a standard in the same way.[133]

- *Information Principles 1997*, which specify the kinds of persons to whom DoHA may disclose protected information, and for what purposes;

- *Accountability Principles 1998*, which cover access to premises and the procedures for handling reportable assaults on residents;

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[133] Section 18.12: Application of Residential Care Standards.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

126

- *Accreditation Grant Principles 1999[134]*, which cover the responsibilities of the accreditation body, the Aged Care Standards and Accreditation Agency Ltd (the Accreditation Agency), for monitoring and facilitating improvements in the delivery of services that have previously received accreditation (Part 3 covers the requirements for 'Continuous Improvement'; Part 4 covers 'Dealing with non-compliance');

- *Investigation Principles 2007*

  o Part 3 'Investigations by Secretary', which covers the procedures (including site visits) to be followed by DoHA when investigating complaints and other information relating to an Approved Provider's responsibilities under the Act (or Aged Care Principles);

  o Part 4 'Outcomes of investigation by Secretary';

  o Part 5 'Feedback' to complainants and providers, including the roles played by the Aged Care Commissioner in dealing with complaints made about (i) DoHA's handling of matters and decisions covered by the Investigation Principles, (ii) the conduct of the accreditation body (currently the Accreditation Agency; see below) relating to its responsibilities under the Accreditation Grant Principles, and (iii) the conduct of persons carrying out audits or Support Contacts under those two principles.

- *Sanctions Principles 1997*, which deal with the processes concerning the consequence of non-compliance with an Approved Provider's responsibilities under the Act.

The Act also empowers the Minister to determine various matters, either by means of legislative instruments or written Determinations. Most of the determinable matters concern the subsidies paid by the Australian Government to approved aged care providers, and do not relate to particular

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[134] The *Accreditation Grant Principles 1999* have been revoked and replaced with the *Accreditation Grant Principles 2011* which commenced on 20 May 2011. The Explanatory Memorandum for the 2011 Principles states that they provide for the enhancement and streamlining of the accreditation process for both Approved Providers and the accreditation body; enhanced consumer participation in the accreditation process; the removal and amendment of outdated provisions; and greater clarity and consistency of administrative processes.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

127

monitoring and other compliance related matters. However, Subsection 96-1 (1) of the Act specifies that the Minister has to approve each of the more broadly-constructed 22 Aged Care Principles, including those covering monitoring and compliance matters.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

128

Appendix 3:   Aged Care Standards and Expected Outcomes

Table A 1

Aged Care Standards, Principles and Expected Outcomes

Aged Care Standards	Principle	Expected Outcomes
Standard 1: Management systems, staffing and organisational development	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.	1.1 Continuous improvement 1.2 Regulatory compliance 1.3 Education and staff development 1.4 Comments and complaints 1.5 Planning and leadership 1.6 Human resource management 1.7 Inventory and equipment 1.8 Information systems 1.9 External services
Standard 2: Health and personal care	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.	2.1 Continuous improvement 2.2 Regulatory compliance 2.3 Education and staff development 2.4 Clinical care 2.5 Specialised nursing care needs 2.6 Other health and related services 2.7 Medication management 2.8 Pain management 2.9 Palliative care 2.10 Nutrition and hydration 2.11 Skin care 2.12 Continence management 2.13 Behavioural management 2.14 Mobility, dexterity and rehabilitation 2.15 Oral and dental care 2.16 Sensory loss 2.17 Sleep

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

129

Aged Care Standards	Principle	Expected Outcomes
Standard 3: Resident lifestyle	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.	3.1 Continuous improvement 3.2 Regulatory compliance 3.3 Education and staff development 3.4 Emotional support 3.5 Independence 3.6 Privacy and dignity 3.7 Leisure interests and activities 3.8 Cultural and spiritual life 3.9 Choice and decision-making 3.10 Resident security of tenure and responsibilities
Standard 4: Physical environment and safe systems	Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.	4.1 Continuous improvement 4.2 Regulatory compliance 4.3 Education and staff development 4.4 Living environment 4.5 Occupational health and safety 4.6 Fire, security and other emergencies 4.7 Infection control 4.8 Catering, cleaning and laundry services

Source: *Quality of Care Principles*, Schedule 2.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

130

Appendix 4: Reviews of aged care arrangements

There are several reviews, past and current, concerning aged care arrangements.

Past reviews

Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes, 2008

This was the final report of the project commissioned by DoHA in November, 2004 in response to recommendations of both the ANAO and the JCPAA. There were two important features of the research project:

• first, an extensive review of the national and international literature on concepts of quality of care and quality of life in residential aged care and the clinical and socio-cultural factors impacting upon them, the role and evolution of accreditation and performance measures and benchmarks in promoting quality and quality improvement; and

• second, the research group carrying out the research project conducted Aged Care Surveys which examined the views of managers, care staff and family carers. The aim of the surveys was to obtain a measure of the extent to which accreditation has had an impact on the quality of life of residents and to provide a benchmark measure of quality in aged care homes against which future change could be measured.

The findings of the review are as follows:

• the current process of accreditation, whereby homes are surveyed to assess compliance with the Accreditation Standards, is appropriate and should be maintained;

• it is appropriate to link the availability of public subsidy to the achievement of accreditation;

• the government should commit to a process for regular review of the Accreditation Standards, involving all stakeholder groups including residents, their carers and representatives; and

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

131

- the administrative requirements for gaining and maintaining accreditation is seen by aged care homes as burdensome and could be reviewed.[135]

The report highlighted three possible options for improvement:

- first, a 'resident-focused quality indicator suite' could be developed as the basis of the measurement of quality improvement into the future;

- second, staff and carer surveys could be conducted and repeated biennially to provide a foundation of quality of care and quality of life measures; and

- third, a resident survey could be developed to provide a national measurement of quality of life in residential aged care homes. This survey would report on quality of life outcomes and would be administered by an organisation which is clearly independent of aged care providers.[136]

The Productivity Commission's Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services

The 2009 review examined a number of monitoring and compliance matters. The Commission concluded that:

> changes should be made to reduce the regulatory burden on residential aged care providers. In particular, the visits program should be redesigned using a risk management approach which has a greater focus on under-performing residential aged care homes.[137]

The report identified that:

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[135] Department of Health and Ageing, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government-subsidised residential aged care homes,* 2008, Canberra.

[136] ibid.

[137] Commonwealth of Australia, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, 2009, available from<http://www.finance.gov.au/publications/response-to-the-pc-annual-review-of-regulatory-burdens-on-business/docs/govt_response_pc_review_sei_services.pdf> [accessed 15 June 2010] p.19. DoHA 'signalled' to the Commission it will consider possible changes to the program 'as part of the broader current review of the accreditation process', p. 55. The Government accepted the Commission's recommendation (2.6) on this matter, although the wording is somewhat equivocal: 'The outcomes of the review of the residential aged care accreditation process will inform options for improving the accreditation process into the future'.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

132

- the regulatory framework is fragmented due to the existence of several programs regulated by numerous government departments across three tiers of government;

- there needs to be a clearer delineation of responsibilities between DoHA and the Accreditation Agency regarding monitoring of provider compliance with accreditation standards[138]; and that

- the Accreditation Agency and DoHA have not employed a well-designed and common risk management approach.[139]

Review of the Aged Care Investigation Scheme 2009 (The Walton Review)

The former Minister for Ageing, the Hon Justine Elliot MP, requested a review of the Complaints Investigation Scheme (CIS) to identify areas of improvement to ensure the scheme achieves best practice aged care complaints management. This review was undertaken by Associate Professor Merrilyn Walton and the final report was released in October 2009.

While primarily a review of the CIS, the findings of the report are relevant to the audit topic in the following areas:

- within the department's state and territory offices (STOs), the division between CIS and compliance responsibilities may vary depending on local arrangements, with some states opting to maintain separate CIS and compliance programs, and others maintaining a single CIS and compliance team;

- some states and territories manage complaints and compliance together in the same section and switch 'hats' depending on the type of matter they are dealing with;

- the CIS not only incorporates intake and investigation, but also compliance action, such as Notices of Non-Compliance and Sanctions. The process for taking compliance action is an area where CIS Managers and staff have identified a skills gap and have requested training and support;

- the department is a large complex bureaucracy with many functions - funding, approval of aged care providers, accreditation policy, compliance and complaints management. Under these circumstances role definition becomes extremely important. Misunderstanding can create a whole host of different

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[138] ibid. p. 65.

[139] ibid. pp. 22, 52, 53.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

133

and misdirected expectations. The lack of clarity between the intersections of complaints, compliance, and accreditation is a major factor in the lack of certainty surrounding the CIS role and functions; and

- the referral relationship between the CIS and the Accreditation Agency caused concern to many providers because of the perception of double-handling. A referral to the Accreditation Agency is a judgement call by the CIS officer as to whether a matter is confined to a particular incident or indicative of wider systemic failure.[140]

Current Reviews

The accreditation process and the Aged Care Accreditation Standards

Initially the reviews of the accreditation process and the Standards were being conducted separately. However, DoHA proposed to the Ageing Consultative Committee[141] that both reviews had progressed to a point where their implications could be considered together.

The departmental discussion paper concerning the Standards review highlights:

- the relative merits of announced and unannounced site visits;

- the appropriate mix of targeted and random site audits;

- the possible implications of conflicts of interest which may arise where homes choose their own accreditation assessors; and

- the value of better alignment between Support Contacts and Review Audits.

A Technical Reference Group (TRG) was convened to assist DoHA undertake the review of the Standards and the further development of residential aged care quality indicators. Membership of the TRG reflects key aged care sectors including policy, clinical care delivery, industry, accreditation and consumer/carer sectors.

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[140] Commonwealth of Australia, *Review of the Aged Care Complaints Investigation Scheme*, 2009, Canberra, pp. 26, 30, 46, 66, 67.

[141] The industry advisory committee was set up by the former Minister for Ageing, the Hon Justine Elliot, to improve dialogue with the sector, workforce and representatives of older Australians. The Ageing Consultative Committee includes commercial and not-for-profit aged care providers, consumer groups, professional and union bodies.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

134

TRG proposals concerning the review of the accreditation process and Standards are currently with the Ageing Consultative Committee.

The Productivity Commission's Issues Paper: Caring for Older Australians

Specifically, the Commission has been asked by Government to:

- systematically examine the social, clinical and institutional aspects of aged care in Australia;

- develop options for reforming the funding and regulatory arrangements across residential and community aged care (including the Home and Community Care program);

- address the interests of special needs groups, including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and veterans; and

- develop options to ensure that the sector has access to a sufficient and appropriately trained workforce.

The draft report, released in January 2011, provides an overview of the Australian aged care system, including the arrangements for the financing and regulation of the system. The report outlines various pressures on aged care, including the ageing Australian population and the increasing demand on residential aged care. It also examines concerns around caring for special needs groups and aged care workforce issues. A new regulatory framework for assessing the aged care system is proposed, as well as an outline of the role of government in this new structure.

The Productivity Commission's draft recommendations which relate directly to the issues addressed in the ANAO's audit are as follows:

- the Government should establish a new regulatory agency – the Australian Aged Care Regulation Commission (AACRC) – under the Financial Management and Accountability Act 1997;

- the functions of the AACRC would include: responsibility for compliance checking and the enforcement of regulations covering the quality of community and residential aged care, approving community and residential aged care providers for the provision of government-subsidised aged care services, assisting and educating providers with compliance and continuous improvement, and providing information to stakeholders, including disseminating and collecting data and information;

- the Department of Health and Ageing should cease its regulatory activities, except for regulation policy development and advice;

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

135

- the Aged Care Standards and Accreditation Agency should be established as a statutory office within the AACRC; and

- the Australian Government should abolish the Office of the Aged Care Commissioner and replace it with a statutory office and Commissioner for Complaints and Reviews forming part of the AACRC. Consideration should also be given to establishing an Aged Care Division within the Administrative Appeals Tribunal.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

136

Appendix 5: Other initiatives to promote quality improvement in the residential aged care sector

DoHA

DoHA programs to support quality in aged care

To support the delivery of quality care, the department has implemented a number of initiatives, including:

- assistance to develop and maintain a sufficient and skilled aged care workforce;

- strategies to improve clinical care; and

- support for consumers of aged care services.

Workforce programs

An adequate and well-qualified workforce is fundamental to the delivery of quality aged care. The Australian Government supports initiatives designed to provide additional training opportunities for existing staff and to create better career paths for all care workers. These initiatives assist Approved Providers to meet their responsibilities under the Act and to develop a well trained aged care workforce.

Encouraging Best Practice in Residential Aged Care program

The Encouraging Best Practice in Residential Aged Care (EBPRAC) program aims to improve the quality of clinical care for residents in aged care homes. The program supports the uptake of existing evidence-based guidelines by funding organisations to translate the best available evidence into effective approaches for staff to use in their everyday practice. While there are a number of existing evidence-based guidelines to assist aged care staff in providing appropriate care for residents, it is recognised that there is a need to establish strategies to translate the evidence into everyday practice. This could include training programs, improved communication procedures, assessment tools or management policies and protocols.

The selection of clinical areas for funding under the EBPRAC program, is based on two elements:

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

137

- information from Accreditation Agency reports and also from Complaints Investigation Scheme reports which identify areas of higher levels of non-compliance; and

- knowledge of existing evidence-based guidelines in the sector that could be used.

The department advised that the EBPRAC program is also one of the ways that it responds to sector-wide risks. For example, as a result of community concerns about the quality of dental care being delivered within residential aged care, a project was funded under the EBPRAC program to translate evidence based guidelines in oral and dental hygiene (an expected outcome under Accreditation Standard 2—Health and Personal Care) into appropriate strategies to support on the ground practice. The department then provided the training package and tools, developed through this EBPRAC project, to all aged care homes across Australia.

National Aged Care Advocacy Program

The department funds aged care advocacy services in each state and territory to provide independent advocacy and information to recipients or potential recipients (or their representatives) of aged care. The services also perform an educative role for aged care recipients and Approved Providers on the rights and responsibilities of care recipients.

Community Visitors Scheme

The Community Visitors Scheme provides one-on-one volunteer visitors to residents of Australian Government-subsidised aged care homes who are socially or culturally isolated, and whose quality of life would be improved by friendship and companionship.

The Accreditation Agency

Industry education programs

The following information is summarised from Annual Reports of the Accreditation Agency.

The Accreditation Agency offers a range of seminars: Continuous Improvement, Making Support Contacts work for you, Achieving compliance with expected outcome 1.8 Information systems, Managing risk to avoid non-compliance and Evidence-based practice. During the past five years, over 350 seminars have been conducted with over 7 000 participants. In 2010, 97 per

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

138

cent of participants agreed that the content was relevant to their needs and 97 per cent indicated that the seminars improved or reinforced their knowledge and skills.

The Accreditation Agency offers each home a one-and-a-half hour free training session called QUEST (Quality Education on the Standards). Homes are invited to select any of the following QUEST topics: accreditation overview; assessing the Standards, Accreditation for consumers—your role in aged care, continuous improvement for residential aged care, privacy and dignity; and using resident feedback.

QUEST is designed to improve stakeholders' understanding of the Standards and accreditation and is delivered by an Accreditation Agency quality assessor.[142]

In 2006, approximately 96 per cent of QUEST participants indicated on feedback forms that they were satisfied with the quality of the sessions, rating the style of delivery as being the main reason for their satisfaction.[143] A total of 586 people attended the Aged Care Quality Assessment course five-day program, as part of the Accreditation Agency's assessor training and management program[144] and 2 080 people have attended the Understanding Accreditation 3 day course. Throughout the 2008–2009 reporting period, 45 seminars were conducted in the major capital cities as well as regional centres, with 595 people attending the various seminars.[145]

Better Practice conferences

Commencing in 2004, these two-day conferences are held in all state capital cities by the Accreditation Agency annually. The aim is to provide an industry forum in which to share practical information and ideas for better practice in residential aged care. The conferences involve industry speakers, discussion sessions and workshops, covering a wide range of topics.[146]

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[142] Accreditation Agency, Annual Report 2008–09 – updated to reflect YTD activities.

[143] 'Your assessment of our performance', *The Standard*, September 2007, p. 7.

[144] Accreditation Agency, Annual Report 2008–09.

[145] ibid.

[146] Presentations on the projects and findings funded by the department under the first round of the Encouraging Best Practice in Residential Aged Care were included in these Better Practice conferences across the country.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

139

Of the 2 100 participants who attended the national seminar series on strategic continuous improvement in 2006, 92 per cent said they were satisfied with the overall quality of the program and 93 per cent indicated that they would be able to develop a continuous improvement program with a more strategic approach following the seminar.[147] An independent telephone survey of more than 1 700 delegates who attended Better Practice conferences in 2006, found that 97 per cent said that the Better Practice events were a 'valuable or very valuable' learning experience and 94 per cent reported that they would recommend the event to others in the industry.[148] During the 2008–2009 period, 1 221 delegates attended Better Practice events and feedback was reported as 'positive'.[149]

The Accreditation Agency provides an extensive industry education program. Because of this, there would be value in developing performance metrics for this program in order to capture and report on the outcome of activities to 'assist residential aged care services to undertake continuous improvement processes'. Drawing a causal link between education programs and the types of outcomes the Accreditation Agency is seeking to achieve is difficult. Some independent follow-up surveys of conference participants are conducted for the Accreditation Agency. One of the key questions asks whether the participant has introduced any changes in their aged care home following attendance at the conference, and the results are reported in the Accreditation Agency's Annual Report. This is a potentially valuable initiative which could be developed further through more in-depth post-event evaluations. This would provide an opportunity to gain an insight into the effectiveness of these programs, by identifying the degree to which participants are able to put 'learnings' into practice and ultimately whether or not improvements in quality of care and services to residents can be demonstrated. At present, it is unclear whether or not these training programs and Better Practice conferences are having this type of impact.

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[147] *The Standard*, p. 7.

[148] ibid, p. 7.

[149] ibid.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

140

Appendix 6: The Deed of Funding between DoHA and the Accreditation Agency

The Secretary of the Department of Health and Ageing (DoHA) appointed the Aged Care Standards and Accreditation Agency Ltd (the Accreditation Agency) as the accreditation body to undertake the functions set out in the *Accreditation Grant Principles 1999*. The delivery of these functions is subject to a written agreement between DoHA and the designated body. The Accreditation Agency has advised that it considers the Deed of Funding to be akin to a contract, for operational purposes only, with DoHA.

The Deed of Funding sets out in substantial detail the services to be provided by the Accreditation Agency, including liaising with the department about (residential aged care) homes that do not comply with the Accreditation Standards. It also includes performance indicators, targets and reporting requirements.[150] The Accreditation Agency reports to OACQC within DoHA on a twice yearly basis.

DoHA is responsible for monitoring the performance of the Accreditation Agency through the contract/Deed of Funding Agreement and ensuring that the deliverables contained in the document are sufficiently aligned with measures contributing to the achievement of Outcome 4.

Table A 2 sets out the performance measures relevant to the Accreditation Agency's Accreditation Standards monitoring role and its relationship with the department which are contained in the Deed of Funding Agreement.

The Accreditation Agency includes in its PBS a quantitative deliverable: *Percentage of Agency compliance with Deed of Funding requirements*. While this deliverable has output targets to support the measurement of the frequency of visits and the percentage of homes that have achieved compliance, there are no indicators that capture the results of the Agency coverage in relation to the quality of care delivered.

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[150] Commonwealth of Australia, *Deed of Funding Agreement Variation (No. 8)*, 2010, Schedule A and Attachment 1.

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

141

Table A 2

Performance indicators and targets in the Deed of Funding Agreement, (variation no. 8)

Performance indicator	Performance target
Optimum level of compliance with the Accreditation Standards	To work towards an optimum level of compliance with the Accreditation Standards, the Agency will: • conduct 100 per cent of site audits in response to valid accreditation applications; • maintain an average visiting schedule of at least 1.25 visits per home per year; • conduct at least one unannounced visit to each home per year; • conduct Review Audits as required, including 100 per cent as directed by the department.
Appropriate management of non-compliance	• At least 90 per cent of homes to have achieved full compliance by the end of their timetable for improvement period. • Targeted support contacts conducted as necessary in cases where non-compliance is suspected, including responding to referrals of information by the department. • Quality assessors to conduct daily visits where serious risk is identified, until the serious risk is mitigated. • Homes on a timetable for improvement, or granted 'exceptional circumstances' or homes with accreditation revoked or reduced to be regularly monitored.
Liaison with the department	Timeliness of response to referrals, consistent with the protocols with the department specifically: • notify the department of significant non-compliance in accordance with the agreed protocols; • provide a report on serious risk within 24 hours of serious risk being identified; • ensure the timeliness and quality of reports to the Commonwealth in accordance with Item E, Schedule A of this Agreement; • maintain an appropriate level of contact at state and central office levels as specified in the Protocols.

Source: Contract/Deed of Funding Agreement Variation (No. 8)

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

142

Index

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

143

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

144

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Department of Education, Employment and Workplace Relations

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

145

ANAO Audit Report No.9 2010–11

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Department of the Environment, Water, Heritage and the Arts
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Centrelink
Department of Education, Employment and Workplace Relations
Department of Families, Housing, Community Services and Indigenous Affairs

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2009–10 Major Projects Report
Defence Materiel Organisation

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

146

ANAO Audit Report No.18 2010–11
Government Business Managers in Aboriginal Communities under the Northern Territory Emergency Response
Department of Families, Housing, Community Services and Indigenous Affairs

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Department of Families, Housing, Community Services and Indigenous Affairs

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Department of Human Services

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Department of Sustainability, Environment, Water, Population and Communities

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

147

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Australian Federal Police

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Australian Taxation Office

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Attorney-General's Department

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Department of Human Services

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Department of Defence

ANAO Audit Report No.38 2010–11

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ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

148

ANAO Audit Report No.39 2010–11

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Department of Infrastructure and Transport

ANAO Audit Report No.40 2010–11

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ANAO Audit Report No.41 2010–11

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Department of Defence

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ANAO Audit Report No.47 2010–11

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Commonwealth Scientific and Industrial Research Organisation

ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

149

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ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

150

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ANAO Audit Report No.48 2010–11
Monitoring and Compliance Arrangements Supporting
Quality of Care in Residential Aged Care Homes

151