

## Aged Care Reform Series - Quality of care

*The National Aged Care Alliance (the Alliance) developed this paper to provide additional advice to Government, through The Hon Mark Butler, MP Minister for Mental Health and Ageing, as it considers the proposed aged care reforms from the Productivity Commission's Caring for Older Australians report which was released in August 2011. Quality of care is one in a series of six papers available on the Alliance website ([www.naca.asn.au](http://www.naca.asn.au)), other papers in the series include: Assessment and entitlement (including the Gateway), Financing aged care in Australia, Palliative care, Wellness and Workforce.*

The Productivity Commission has acknowledged the complexity of measuring, monitoring and improving the quality of aged care and has raised a number of issues around how to improve quality, but their responses have been directed primarily at new structures. They note that in the new system there is a need to provide easy to understand comparable information on the quality of care and support. This will enable families to make decisions about care options and would also drive continuous improvement and provide incentives for providers to improve the quality of their services.

As part of improving the quality of care, the Commission has recommended changes to the regulatory system of aged care. They have suggested the Department's responsibilities be limited to setting policy, funding and supporting advocacy. They recommend the establishment of a new independent regulatory commission, the Australian Aged Care Commission (AACC) which would include the functions of the Complaints Scheme, Aged Care Standards and Accreditation, setting prices, data collection and dissemination. The Commission also identifies the need to reduce the burden of regulation and to harmonise and simplify regulation and jurisdictional responsibilities.

There are two distinct perspectives on the current quality of care within the aged care sector.

From a consumer perspective:

- the quality of aged care services is variable and at times poor;
- the current system is confusing;
- consumers find it difficult to evaluate the quality of the care provided in a facility or to compare the services offered by providers; and
- the quality of care and access to care is variable for those with complex needs, including people with psycho-geriatric issues and in respect of end of life needs.

From the provider perspective:

- current regulation is excessive and takes up staff time that should be spent with residents;
- the demarcations of responsibilities between the Department and the Accreditation and Standards agency are confusing and result in inefficiency; and
- the focus should be on continuous improvement rather than regulation.

There are three additional debates at a high level which need to be considered and addressed as the system evolves over time.

First there is a question of how to balance risk and choice with regulation of aged care. There is a need to manage concerns about vulnerability and ensuring quality of care services while providing greater consumer direction. From the consumer perspective there is a desire for an aged care system that provides greater choice and is less risk adverse. The best way forward may be to expand the Consumer Directed Care packages and respite and to closely monitor the outcomes in respect to risk and choice.

Second, there is a debate about whether regulation in aged care is excessive and how regulation relates to quality. Further work needs to be done to clarify the roles of the AACC in monitoring minimum standards and encouraging quality improvement. The key may be in the development of the culture of the AACC and the dynamics of its relationship with service providers. Once the new quality framework and regulatory system has been established, and consumers have access to greater information, the role of regulation in ensuring minimum standards may be reduced.

Third, there needs to be greater consideration given to how consumers are involved in the quality and regulatory system of aged care. Consumer confidence cannot rest solely on the complaints mechanism through the AACC. Instead there is a need to bolster consumer advocacy, develop the community visitors programs and find ways to link consumers to other aspects of the aged care system. One example of how this has been done well is in the Veterans Review Board where a consumer is always included as a member of the three person review panel for complaints taken to the Board about entitlements.

Attached you will find two papers:

1. **Quality Indicators in Aged Care** – This paper provides an overview of the international evidence on quality indicators and makes recommendations for the development of such indicators in Australia.
2. **Australian Aged Care Commission** – This paper reviews the PC's proposal of an AACC and provides an analysis of both potential benefits and concerns about the new structure.

The Alliance has made the following recommendations:

## Quality framework

1. Any changes to the quality framework should be developed with strong consumer involvement and incorporate outcomes that are meaningful to consumers.
2. Any changes to the quality framework should include structures that promote transparency.
3. Any changes to the quality framework should include mechanisms through which consumers are provided with greater indication of the quality of care provided by **community and residential** aged care services.

## Measuring and monitoring quality care

1. A national set of quality indicators be developed for Australian aged care services.
2. Development of a set of quality indicators for the **community and residential** aged care sector should include:
  - Development of a definition of quality of care and a clear purpose of the use of quality indicators in aged care.

- Extensive review of the background and use of quality indicators in the acute health care sector and in other industries.
  - Development of reliable and valid definitions, data collection methods and infrastructure to support collection and reporting.
  - Consideration to measurement strategies and appropriate benchmarking values.
  - Extensive piloting to determine the feasibility, validity and reliability of quality indicators.
  - Consideration to potential negative consequences of quality indicators and how these may be addressed.
3. All work on development of quality indicators should include consumer and provider representatives and incorporate a consumer and provider feedback mechanism. Quality indicators must be relevant and meaningful to consumers from all cultural backgrounds.
  4. Current use of quality indicators is primarily confined to residential aged care. Consideration should be given to the incorporation of community based aged care and aged palliative services into projects focused on quality indicators.
  5. Development of a strategy for transparent, accessible and meaningful public reporting is an essential component to the development of quality indicators. Clinical indicators should only be reported where the context of the indicators can be clearly stated.
  6. Significant attention should be given to the development of consumer education resources and strategies related to quality of care.

## Public reporting

1. A public reporting system that is transparent and readily available to consumers seeking an aged care community service or residential care provider (eg. a myagedcare website).
2. Consumers should be a strong driving force in the identification of aspects of facility service provision to be reported and the most appropriate frameworks for reporting.
3. A public reporting system should incorporate aspects of facility service provision considered meaningful and relevant to consumers.
4. Quality indicators could be used in public reporting once their use has been established (e.g. clear definitions, data collection techniques, benchmark values). Consideration is required in public reporting of quality indicators in a manner that will not disadvantage facilities (e.g. an indicator of 'residents with depression' may discourage admission and/or assessment of residents with mental health diagnoses, particularly where the indicator will be publically reported).

## Australian Aged Care Commission

There is broad agreement of the members of the Alliance that there is a strong case for the proposed AACC and that it has the potential to create greater independence, better communication and transparency by separating the funding body from regulatory activities but there are still some concerns. There is a risk that the lines between quality improvement, complaints and compliance and regulation will be blurred and continue to lack transparency. The view of the CEO of the Accreditation and Standards Agency is that accreditation is not compatible with a regulatory

function. The Commission itself recognises this in the proposal to have three Commissioners as part of the AACC. The Alliance recommends that in taking forward the implementation of the AACC the following recommendations should be considered:

1. The AIHW should be given automatic access to all the available aged care data held by the AACC, including data for assessment, community services and packages and residential aged care and be adequately resourced to conduct independent analysis in order to encourage transparency and independence in aged care policy research and evaluation.
2. The Complaints Scheme should be moved out of DoHA and made independent. How this is done is less clear. Some members support an independent complaints system as part of the AACC. Others have concerns about whether this will lead to real independence and believe establishing complaints separately from AACC would increase consumer confidence. Complaints about the Gateway including levels of entitlement should first be referred to an internal complaints mechanism within the Gateway but if the complaint cannot be resolved it should be referred to the AACC Complaints Scheme for further review. Consumers should also have access to the Administrative Appeals Tribunal for an independent review of decisions.
3. The AACC should network with existing organisations with relevant expertise and experience such as the Independent Hospital Pricing Authority, the Australian Commission on Safety and Quality and the Australian Prudential Regulation Authority to reduce duplication and build on existing expertise. The recent work that has been done on reforming the complaints system and updating Accreditation Standards should be used to inform the new system. The restructure of the regulatory systems should be efficient and not lead to additional costs.
4. The AACC should develop a model for meaningful consumer engagement that goes beyond involvement on advisory committees. The AACC should draw on the work the Accreditation Agency has done on international models of consumer engagement including input through consumer surveys and interviews, focus groups or involvement in the Accreditation Assessment Teams. There may also be value in examining consumer engagement in the Veterans Aged Care System, ASIC and ACCC.
5. The restructure of the regulation system should occur in the first phase of the implementation of reforms. The AACC as well as the quality framework, outcome measurement and enforcement will be key to improving the quality of aged care services and providing information to consumers.

## Quality indicators in aged care: a brief snapshot of Australian and international experience

Despite a high level of regulation in the Australian aged care sector, comprehensive assessment, monitoring and national benchmarking of quality of care remains a concern. The current Residential Aged Care Accreditation Standards offer a process of monitoring care; however, they do not have a strong focus on clinical outcomes, and the standards represent a minimal rather than optimal quality of care.<sup>1</sup> As such, numerous efforts have been undertaken to develop frameworks through which quality assessment can be consistently conducted, reported and compared within a service over time and between service providers. These frameworks focus on the identification and measurement of appropriate indicators of the quality and safety of health care practice.

Quality indicators are quantitative markers calculated from assessment data and used to indicate the presence or absence of potentially poor quality of care. They do not provide a direct measure of quality, but rather, they describe clinical and/or social outcomes that represent the results of care input, providing an indication of areas of care that require greater attention.<sup>2</sup> Quality indicators identify aspects of quality care that may be variable, improvements in which lead to a reduction in risk or harm. Quality indicators can be used both within a facility to inform the focus of quality improvement activities and on a national level as a means through which the quality of care provided by aged care services could be both monitored and directly compared.

To be a meaningful tool, a quality indicator needs to be:<sup>3</sup>

- clearly defined;
- supported by a rationale and purpose;
- measure events for which improvement is achievable;
- measure events that can be attributable to care actions;
- reliable and valid;
- supported by a feasible and reliable data collection strategy; and
- be free from unintended negative outcomes.

The clinical and/or social outcomes defined in quality indicators provide only one view of quality of care. Such data requires cautious interpretation as it is difficult to attribute causality (i.e. an achieved outcome may not be a direct result of the care provided) and changes in process rarely lead to an immediate observable change in a clinical outcome. Indicators that define outcomes for which there is a stronger causal relationship between structures and processes and the outcome can provide a greater level of confidence that the care provided has led to the outcome.<sup>4</sup> Thus, identifying the most appropriate quality indicators is important if the findings are to be relevant and provide a meaningful indication of care quality.

Development of quality indicators has received significant attention in the acute health care sector, with a focus on preventing harm through the minimisation of preventable adverse events. Extensive work has also been done both within Australia and internationally to develop quality indicators for aged care. The purpose of this paper is to provide a brief overview of some of the more comprehensive quality indicator suites in that have already been developed and may underpin future work in this area.

<sup>1</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2007. Development of a systematic approach to assessing quality within Australian residential aged care facilities: the Clinical Care Indicators Tool. *Australian Health Review*; 31(4) 582-591

<sup>2</sup> Evans D, Tan-Torres Edejer T, Lauer J, Frenk J, Murray C. Measuring quality: from the system to the provider. *Int J Qual Health Care* 2001; 13:439-46

<sup>3</sup> Australian Commission on Safety and Quality in Health Care. 2011. Practice-level indicators of safety and quality in primary health care: Consultation paper. [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/FA18B96288243577CA25790A0006A72D/\\$File/consultation-paper-practice-level-indicators.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/FA18B96288243577CA25790A0006A72D/$File/consultation-paper-practice-level-indicators.pdf)

<sup>4</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2009. The relationship between clinical outcomes and quality of life for residents of aged care facilities. *Australian Journal of Advanced Nursing*; 26(4):51-7.

## Relationship between quality indicators and quality of life

One Australian group of researchers<sup>5</sup> has investigated the relationship between quality indicators and quality of life. Through literature searches, consultation with industry representatives and a pilot study, the group developed a tool that identified 23 clinical care areas considered to be relevant indicators of care quality. These included indicators related to resident health (e.g. pressure injuries, polypharmacy), personal care (e.g. hydration, dental care), lifestyle (e.g. sleep, activities) and the care environment (e.g. restraint use, depression, communication, access to medical services). Data were analysed for significant associations between these clinical care outcomes and resident self-rated quality of life on a previously validated tool. The researchers established significant associations between quality of life and the indicators of care quality. The strongest associations were found for clinical indicators for hydration, falls and depression, suggesting these areas are particularly important to monitor when seeking to assess care quality. Activity and use of sedation were also associated with quality of life ratings. Significantly, an overall poor rating on the clinical care outcomes was associated with a lower quality of life, suggesting that assessment of quality of care does provide an indication of quality of life.<sup>6</sup>

## Residential aged care quality indicators in Australia

### *Steering Committee for the Review of Government Service Provision*

The Productivity Commission report makes reference to the performance indicators published by the Steering Committee for the Review of Government Service Provision. This suite of indicators<sup>7</sup> consists primarily of efficiency, equity and effectiveness performance indicators and would not be considered an appropriate resource for development of indicators for quality of care. Only a handful of the indicators presented are relevant as indicators of the quality of care provided within Australian aged care facilities.

### *Australian Institute of Health and Welfare*

The Australian Institute of Health and Welfare (AIHW) have also developed a set of performance indicators for the health and aged care sectors.<sup>8</sup> This work consists of forty quality indicators, developed through review of currently reported data, other performance indicator sets and stakeholder consultation. The indicators are designed for use in all types of Australian health care settings, and many are able to be benchmarked internationally. The set of indicators has emerged primarily from data that is currently reported to the AIHW in various other formats, and is proposed as a universal quality framework under which industry or facility-specific quality indicators may also sit. Of the 40 indicators, ten are reported by AIHW as being specifically relevant to the aged care sector (Table One). A clear definition, rationale, method of calculation and data collection sources are provided for each quality indicator, alongside a cost estimate for data development and collection. Favourably, data from which many of the quality indicators are calculated is already accessible to AIHW through various existing reporting structures.<sup>9</sup> However, these indicators cover a variety of domains including access and industry sustainability, and not all could be considered as indicators of care quality. On the whole, the AIHW indicators are not considered as being indicators that would provide an adequate assessment of the quality of care provided to aged care consumers.

<sup>5</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2009.

<sup>6</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2009.

<sup>7</sup> SCRGSP (Steering Committee for the Review of Government Service Provision) 2010, Report on Government Services 2010, Productivity Commission, Canberra.

<sup>8</sup> Australian Institute of health and Welfare (AIHW). 2008. A set of performance indicators across the health and aged care system, Prepared by the Australian Institute of Health and Welfare for Health Ministers, AIHW: Canberra.

<sup>9</sup> Australian Institute of health and Welfare (AIHW). 2008.

**Table One: AIHW performance indicators relevant to the aged care sector<sup>110</sup>**

<b>Prevention</b>
Indicator 9 Immunisation rates for vaccines in the national schedule
<b>Access</b>
Indicator 11 Health service use differentials
Indicator 12 Selected potentially preventable hospitalisations
Indicator 15 Residential and community aged care services per 1,000 pop aged 70+ yrs
Indicator 16 Hospital patient days by those ACAT assessed, waiting for residential aged care
<b>High quality - appropriate</b>
Indicator 25 Prop. of health/aged care services accredited
<b>High quality - safe</b>
Indicator 26 Selected adverse events in acute and other care settings
<b>Integration and continuity of care</b>
Indicator 29 Prop. discharge summaries transmitted electronically w/in 1 day of discharge
Indicator 30 Discharge plans for complex care needs within 5 days of discharge
<b>Patient-centred</b>
Indicator 33 Patient experience (based on domains of concern to patients)

### *The Campbell Report*

As part of a larger project evaluating the impact of the Australian aged care accreditation system,<sup>11</sup> a set of quality indicators were developed.<sup>12</sup> The aim of these indicators was to provide a framework for quantitative assessment of quality of care and quality of life for aged care residents for facilities to use in monitoring their own performance.

The suite of quality indicators (see Table Two) were developed from consultation with consumers, providers and experts in aged care, and supplemented with a literature review. Data from the literature was found to primarily address quality of care indicators, with minimal focus on quality of life. Proposed indicators were scored on criteria considered important for effective quality indicators including clarity of intent, relevance to stakeholders, reliability, validity and data collection feasibility. At the time of publication, the quality indicators had not been pilot tested; however, provider and expert consultation was sought via an online process and there was broad support for inclusion of all the indicators in the draft suite.<sup>13</sup>

Each of the quality indicators is supported by information that defines the indicator rationale, domain and the method for calculating the indicator value, all of which are expressed as percentage. Data sources are defined for many of the indicators, including proposed standardised Resident Experience Survey and Staff Survey suggested for development in piloting phases. A proposed reporting frequency is included with the report, with data collection ranging from monthly (e.g. weight loss) to annually (e.g. pressure ulcer prevalence).<sup>14</sup>

<sup>10</sup> Australian Institute of health and Welfare (AIHW). 2008.

<sup>11</sup> Campbell Research & Consulting (CR&C). 2007. 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. Final Report. Publications Number: P3-2094.

<sup>12</sup> Campbell Research & Consulting (CR&C). 2006. Developing resident-centred quality indicators in residential aged care to support the project for 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. Publications Number: P3-2093.

<sup>13</sup> Campbell Research & Consulting (CR&C). 2006.

<sup>14</sup> Campbell Research & Consulting (CR&C). 2006.

The report identifies specific issues that require additional research and development including:<sup>15</sup>

Identification of valid, reliable and consistent tools to collect clinical data:

- Pain assessment
  - Pressure injury staging
  - Depression assessment
- A clear definition of weight loss
- Meaningful and objective definitions for choice in meals and activities and implementation of resident preferences
- Identification of effective components of a resident orientation
- Clear definition of physical restraint
- Resident Experience Survey and Staff Survey that clearly define issues such as comfort, homeliness, safety and security.

**Table Two: The Campbell Report quality indicators<sup>16</sup>**

Indicator 1.1 Medication (prevalence)
Indicator 1.2 Falls resulting in fractures (incidence)
Indicator 1.3a Pressure ulcer (incidence)
Indicator 1.3b Pressure ulcer (prevalence)
Indicator 1.4 Weight loss (incidence)
Indicator 1.5 Depression assessment (incidence)
Indicator 1.6 Pain assessment (incidence)
Indicator 1.7. Health satisfaction
Indicator 2.1 Choosing social activities
Indicator 2.2 Reviewing social interactions
Indicator 2.3 Family and carer role
Indicator 2.4 Staff satisfaction
Indicator 2.5 Resident perspective on interactions
Indicator 3.1 Choosing meals
Indicator 3.2 Choosing recreational activities
Indicator 3.3 Reviewing meals and recreational activities
Indicator 3.4 Implementation of resident preferences
Indicator 3.5 Resident perspective on services
Indicator 4.1 Orientation
Indicator 4.2 Staff training in managing autonomy and independence
Indicator 4.3 Use of restraint
Indicator 4.4 Resident perspective on dignity and respect
Indicator 5.1 Resident injuries due to environment
Indicator 5.2 Resident perspective on the environment

*Queensland University of Technology (QUT) /Uniting Care*

In 2003 a research team from QUT and Uniting Care developed the Clinical Care Indicators Tool (sometimes referred to as *ResCareQA*) that defines 23 quality indicators, proposed as a tool that would enhance the current accreditation system (Table Three). The project built on previous work in the Australian setting<sup>17</sup> that identified potential quality indicators specific to high level aged

<sup>15</sup> Campbell Research & Consulting (CR&C). 2006.

<sup>16</sup> Campbell Research & Consulting (CR&C). 2006.

<sup>17</sup> Spencer L. 2000. Quality of care for nursing home residents: development evaluation and review of clinical indicators of care [PhD thesis]. Armidale: The University of New England.

care, and was also informed by the US Minimum Data Set (MDS). Using these sources as a base, a group of experts considered and rated the areas they considered most significant to address in a set of quality indicators. The first version of the tool was trialled in 27 facilities and confirmed as being a useful tool to provide holistic clinical data that was comparable between resident groups and facilities.<sup>18</sup> After minor modifications, a final version of the tool was completed and its use was piloted in four facilities,<sup>19</sup> tested for reliability and validated against the Resident Classification Scale.

The CCI Tool presents quality indicators in four domains: resident health, personal care, resident lifestyle and care environment. Piloting suggested the tool was quick to complete, taking approximately 30 minutes. Each quality indicator includes a definition and method of calculation.<sup>20</sup> For some indicators residents are also classified as being at high or low risk for problems related to the indicator;<sup>21</sup> however, use of the adjusted risk information is unclear in descriptions of the tool and its development.

**Table Three: QUT/Uniting Care Clinical Care Indicators<sup>22</sup>**

<p><b>Resident Health</b></p> <ul style="list-style-type: none"> <li>Pressure ulcer rates</li> <li>Skin integrity (presence of ulcers lesions)</li> <li>Presence of infections</li> <li>Medication (polypharmacy and no pharmacy review)</li> <li>Pain (pain frequency: daily pain and pain severity: severe pain)</li> <li>Decline in cognitive function</li> </ul>
<p><b>Personal care</b></p> <ul style="list-style-type: none"> <li>Continence (bladder and bowel)</li> <li>Poor hydration</li> <li>Activities of daily living decline</li> <li>Dental health</li> <li>Care of the senses (sensory decline and sensory aids)</li> </ul>
<p><b>Resident life style</b></p> <ul style="list-style-type: none"> <li>Nutrition</li> <li>Meaningful activity</li> <li>Sleeping patterns (sleep disturbance and use of sedatives)</li> <li>Communicating (communication difficulties, communicating without aids and access to translators)</li> <li>Adaptation and behaviour patterns (disruptive behaviour)</li> </ul>
<p><b>Care environment</b></p> <ul style="list-style-type: none"> <li>Restraints (physical and chemical)</li> <li>Depression (symptoms and symptoms without treatment)</li> <li>Falls in the last month</li> <li>Family involvement</li> <li>Allied health contact</li> <li>Doctor visits</li> <li>Multi-disciplinary case conferences</li> </ul>

### *Victorian Government quality indicators*

In 2006 Victorian public sector residential aged care services (PSRACS) introduced five quality indicators, intended as a tool for identification of good practice and areas for further improvement, and benchmarking against other facilities. In 2004, 23 potential quality indicators were identified

<sup>18</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2007.

<sup>19</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2009.

<sup>20</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2009.

<sup>21</sup> O'Reilly, M. 2010. Clinical indicators of quality for Australian residential aged care facilities: Establishing reliability, validity and quality thresholds. PhD thesis, Queensland University of Technology.

<sup>22</sup> Courtney M, O'Reilly M, Edwards H, Hassall S. 2007.

and following wide consultation and a pilot study the five quality indicators in Table Four were introduced across all PSRACS. The quality indicators were validated and reference ranges developed in 2009.<sup>23</sup>

Each of the quality indicators are supported by an objective, appropriate definitions, data collection techniques and frequencies and a data reporting form that includes instructions for recording relevant context (e.g. where falls occurred in the facility). The instructions for quality indicator reporting also include an information sheet for residents.<sup>24</sup> The quality indicators are supported by a strong drive government towards clinical governance and effective quality management. This includes a resource aimed at reducing clinical risk through the use of clinical audit and standardised evidence based care practices, *Strengthening Care Outcomes for Residence with Evidence (SCORE)*.<sup>25</sup>

**Table Four: Quality indicators used in Victoria<sup>26</sup>**

Prevalence of stage 1 to 4 pressure ulcers
Prevalence of falls and related fractures
Incidence of use of physical restraint
Incidence of residents using nine or more medications
Prevalence of unplanned weight loss

## Residential aged care quality indicators in the United Kingdom

### *National Health Service England*

In England, NHS services are guided by the *Essence of Care* document for benchmarking and assessing quality care. The criteria and principles outlined in the document are appropriate for use in a variety of health care settings and indicators are organised according to the process and/or body system.<sup>27</sup> Although the principles presented for use in assessing care quality in NHS services in England are relevant, they are not quantifiably measureable and many are broad statements of care aims rather than specific, identifiable outcomes achieved through care. These quality indicators would not be appropriate to use for comparison within or between facilities.

### *National Health Service Scotland*

In Scotland, a large pilot study was conducted in 2005 to develop quality indicators of nursing care provided in NHS facilities (including all services where skilled nursing care is provided, excluding midwifery).<sup>28</sup> The project was designed from a consumer-centric position, underpinned by the principle that issues considered important by consumers should be the focus of a set of nursing care indicators. Consumer focus groups, literature reviews and an expert practitioner group informed the development of 22 potential quality indicators. A scoring system was used to prioritise the five indicators considered to:

- be relevant to the largest number of patients;

<sup>23</sup> Cameron M, Ibrahim J, Ow P, Balding C. 2010. Clinical Governance and Risk Management in Residential Aged Care: Caring is not a substitute for good risk management. Victorian Government Department of Health.

<sup>24</sup> Victorian Government Department of Human Services. 2007. Resource manual for Quality Indicators in Public Sector Residential Aged Care Services 2007-2008. Rural and Regional Health and Aged Services Division Victorian Government Department of Human Services: Melbourne.

<sup>25</sup> Victorian Government Department of Human Services. 2007. Resource manual for Quality Indicators in Public Sector Residential Aged Care Services 2007-2008. Rural and Regional Health and Aged Services Division Victorian Government Department of Human Services: Melbourne.

<sup>26</sup> Victorian Government Department of Human Services. 2007.

<sup>27</sup> Department of Health, 2010. *Essence of Care* 2010. Benchmarks for the Fundamental Aspects of Care. TSO: Norwich.

<sup>28</sup> NHS Quality Improvement Scotland. 2005. The Impact of Nursing on Patient Clinical Outcomes. Developing Quality Indicators to Improve Care. NHS Scotland.

- have a strong cause and effect relationship between nursing care and patient outcomes;
- have greatest potential for improvement; and
- be sufficiently evidence based.

The five resulting quality indicators were pilot tested throughout Scottish health facilities in 2005 and the pilot indicated that the indicators were appropriate and acceptable to staff members collecting data. The NHS Quality Improvement Scotland recommended that the quality indicators in Table Five be implemented as a broad assessment of quality of care, and the set be expanded to incorporate other indicators developed via similar methods.<sup>29</sup>

**Table Five: NHS Quality Improvement Scotland Indicators<sup>30</sup>**

Indicator 1 Incidence of healthcare associated pressure ulcers – the number of patients who develop pressure sores following inpatient admission

Indicator 2 Provision of nutritional screening and care planning – the process of nutritional assessment on inpatient admission and adherence to care planning.

Indicator 3 Incidence of healthcare associated catheter-associated urinary tract infection - the number of individuals with a urinary catheter in place who develop a urinary tract infection

Indicator 4 Patients' experience of pain management

Indicator 5 Patients' experience of the provision of educational information

## Residential aged care quality indicators in Europe

With increasing focus on quality management and improvement within European Union member states, a recent project<sup>31</sup>, *Quality Management by Result-oriented Indicators – Towards Benchmarking in Residential Care for Older People* was conducted by European partners to develop and validate result-oriented quality indicators. Monitoring systems and frameworks identified in Austria, Germany, the Netherlands and the UK underpinned the initial development stages of this project. Indicators were selected with a view to their feasibility (ease of collection), validity (appropriateness and usefulness as a measure of quality), quantifiability, comparability (between services and over time) and ability to steer improvement. The project appears to have a strong focus on the relevance and importance of quality of life, and its relationship with quality of care.

After piloting in 25 care facilities, the European consortium finalised 94 quality indicators, clustered in five domains – quality of care, quality of life, leadership, economic performance and context. Each indicator is supported with a description, instructions for value calculation, explanation of the use and purpose of the indicator and detail of the perspective (e.g. patient, relatives, staff). The quality indicators are considered to be an important element in improving transparency and trust between care facilities and inspectors of facilities, providing a results-oriented approach to quality assessment and improvement.<sup>32</sup>

## Residential aged care quality indicators in New Zealand

New Zealand does not currently have a national set of quality indicators for the residential aged care sector. A recent report by the New Zealand opposition parties together with Grey Power New Zealand<sup>33</sup> recommended the introduction of quality indicators alongside a star rating system for the

<sup>29</sup> NHS Quality Improvement Scotland. 2005.

<sup>30</sup> NHS Quality Improvement Scotland. 2005.

<sup>31</sup> European Centre for Social Welfare Policy and Research. 2010. *Measuring Progress: Indicators for Care Homes*. <http://www.euro.centre.org>

<sup>32</sup> European Centre for Social Welfare Policy and Research. 2010.

<sup>33</sup> New Zealand Labour, Green Party of Aotearoa New Zealand and Grey Power New Zealand. 2010. *A Report into Aged Care: What does the future hold for older New Zealanders?* <http://labour.org.nz/sites/labour.org.nz/files/Aged%20Care%20Report.pdf>

New Zealand aged care sector. There are current trials underway investigating the effectiveness of monitoring clinical indicators in reducing adverse events and increasing quality care in New Zealand residential aged care.<sup>34</sup>

## Residential aged care quality indicators in the USA

### *Minimum Data Set*

The MDS is a data collection tool used in US residential aged care facilities to compile assessment data on residents. The form covers a variety of clinical and process outcomes, generally focused on resident clinical problems. Aspects of the data collection focus on the resident’s history and routines in order that the MDS data can inform care planning. The MDS is used in various ways in the US, including informing the Nursing Home Quality Initiative (NHQI) that reports on aged care quality. Importantly, annual completion of the MDS for every resident has been mandatory since its introduction in 1996, and is now considered to be part of regular care and quality improvement.<sup>35</sup>

### *National Nursing Home Quality Measures*

The Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, commenced development of the NHQI in 2002. The NHQI provides a framework for public reporting on quality measures indicating the care quality provided in aged care homes. The measures, which form part of the MDS, are derived from data routinely collected from resident assessments at specified intervals and assess the physical and clinical conditions and abilities, as well as preferences and life care wishes.

There are two sets of quality measures – those for short-stay residents (e.g. respite care) and those for long stay residents – allowing for context of care delivery to be considered.<sup>36</sup> These quality indicators are reported on the CMS website and are data for all US aged care services is publically accessible, providing consumers with a source of information on how well residential aged care services meet their residents’ physical and clinical needs.

**Table Six: Quality measures reported for US long term stay aged care**

Percent of residents experiencing one or more falls with major injury
Percent of residents who self-reported moderate to severe pain
Percent of high risk residents with pressure ulcers
Percent of long stay residents assessed and given, appropriately, the seasonal influenza vaccine
Percent of long stay residents assessed and given, appropriately, the pneumococcal vaccine
Percent of long stay residents with a urinary tract infection
Percent of long stay residents who lose control of their bowels or bladder
Residents who have/had a catheter inserted and left in their bladder
Percent of residents who were physically restrained
Percent of residents whose needs for help with daily activities has increased
Percent of long stay residents who lose too much weight
Percent of residents who have depressive symptoms

<sup>34</sup> Australian and New Zealand Clinical Trials Registry The PASS study: A performance assessment system for success in residential aged care. ACTR Number ACTRN12611000486921. [http://www.anzctr.org.au/trial\\_view.aspx?id=336554](http://www.anzctr.org.au/trial_view.aspx?id=336554)

<sup>35</sup> O’Reilly, M. 2010. Clinical indicators of quality for Australian residential aged care facilities: Establishing reliability, validity and quality thresholds. PhD thesis, Queensland University of Technology.

<sup>36</sup> Abt Associates Inc. 2004. National Nursing Home Quality Measures User’s Manual. U.S. Dept. of Health & Human Services and Centers for Medicare & Medicaid Services.

## Quality indicators in community based aged care services

This brief review did not identify any current quality indicators for community based aged care services. One project in this field being undertaken by a team at the Dementia Collaborative Research Centre (Assessment and Better Care) was identified. The project aims to identify quality indicators for packaged community care from the perspective of consumers, service providers and policy makers; however the project is ongoing and data is not currently available.<sup>37</sup>

## Quality indicators in palliative care services

A recent systematic review reported on published quality indicators for palliative care. Although eight sets of quality indicators were identified, only two of these sets were specific to aged care palliation. One set include 23 quality indicators that addressed structures and processes of care (e.g. informed decision making, facility organisation), physical aspects of care (e.g. managing symptoms), psychological care and ethical/legal aspects of care. The reviewers categorised all the quality indicators as being related to processes rather than clinical outcomes. The indicators included clear statements of appropriate processes and rationales for the statements' however did not appear to be quantitative or have benchmarkable qualities.<sup>38</sup>

The second set of quality indicators related to care of terminally ill patients in residential nursing home. This set included eight indicators, seven of which were defined by the reviewers as relating to process. The indicators covered the domains of physical care, psychological care, care during period of imminent death and ethical/legal issues. The indicators were clear statements of quality care that included performance standards and contexts when the indicator may not be relevant. Once again, these indicators were not qualitative in nature.<sup>39</sup>

## Discussion

This review highlights the international use of quality indicators in residential aged care and supports the Productivity Commission report recommendation to develop quality indicators for Australian facilities. Quality indicators are seen as supporting the current aged care accreditation system through the provision of benchmarking resources to assist in quality assessment and improvement. Introduction of quality indicators could also support reporting of publically accessible quality data, assisting consumers in making informed choices associated with aged care services.

Before quality indicators can be used effectively in the Australian aged care sector, significant work is required to better our understanding of quality of care and relevant appropriate quality care markers. Development of quality indicators needs to be evidence-based and driven by research supporting the effectiveness of specific health care practice and its relationship to quality of care. This work needs to provide clear output and direction including:

- definitions of quality;
- definitions of, and rationales for quality indicators;
- appropriate infrastructure and tools to collect data reliably;
- appropriate measurement strategies and acceptable ranges for quality indicators;

<sup>37</sup> Low L-F, Brodaty H, Jeon Y-H, Gresham M. 2010–2011. Identifying desirable outcomes and associated quality indicators in community care: consumer, service provider and policy perspectives. Dementia Collaborative Research Centre – Assessment and Better Care (DCRC-ABC).

<sup>38</sup> Pasman H, Brandt H, Deliëns L, et al. 2009. Quality indicators for palliative care: a systematic review. *J Pain Symptom Manage*; 38: 145-156.

<sup>39</sup> Pasman H, Brandt H, Deliëns L, et al. 2009.

- identification of resources to complement the use of quality indicators (e.g. evidence based management strategies to reduce a specific risk being measured); and
- education for all stakeholders on the use of quality indicators.

Potentially negative implications should also be considered in pursuing the development of aged care quality indicators. Implications of measuring and reporting clinical events (e.g. pressure injury rate) include reluctance on the part of facilities to accept residents for whom there is a high risk of pressure injury (e.g. spinal cord injury patients). Services meeting the needs of patients at high risk may be disadvantaged by public reporting of quality indicators without careful introduction of such a system.

This brief review highlights a potential gap in the use of quality indicators in community based aged care and minimal work on quality indicators for aged care palliative services. Importantly, most quality indicators used in Australia relate to clinical areas leaving a major gap in relation to quality of life. A more comprehensive review is required to identify resources in this field.

## Recommendations

1. A national set of quality indicators be developed for Australian community and residential aged care services.
2. Development of a set of quality indicators for the aged care sector should include:
  - Development of a definition of quality of care and a clear purpose of the use of quality indicators in aged care.
  - Extensive review of the background and use of quality indicators in the acute health care sector and in other industries.
  - Development of reliable and valid definitions, data collection methods and infrastructure to support collection and reporting.
  - Consideration to measurement strategies and appropriate benchmarking values.
  - Extensive piloting to determine the feasibility, validity and reliability of quality indicators.
  - Consideration to potential negative consequences of quality indicators and how these may be addressed.
3. All work on development of quality indicators should include consumer and provider representatives and incorporate a consumer and provider feedback mechanism. Quality indicators must be relevant and meaningful to consumers from all cultural backgrounds.
4. Current use of quality indicators is primarily confined to residential aged care. Consideration should be given to the incorporation of community based aged care and aged palliative services into projects focused on quality indicators.
5. Development of a strategy for transparent, accessible and meaningful public reporting is an essential component to the development of quality indicators.

## Examples of quality indicators from different development sources

### AIHW quality indicator<sup>40</sup>

Indicator details	
<b>Description</b>	The dimensions of care that patients value include: <ul style="list-style-type: none"> <li>• Access to care</li> <li>• Coordination and integration of care</li> <li>• Transitions and continuity of care</li> <li>• Respect for patient's values, preferences and expressed needs</li> <li>• Information and education</li> <li>• Physical comfort</li> <li>• Emotional support</li> <li>• Family and friends</li> <li>• Continuity of care and transition after discharge (Picker Institute 2008)</li> </ul>
<b>Rationale</b>	The way health services are delivered is a key component of their quality. A patient experience survey first identifies priority areas for improvements across the system and then when weaknesses are addressed one can expect to see improvement in the third or fourth year of survey.
<b>Numerator</b>	Survey respondents rating services as good/very good/excellent or answering yes to a particular question
<b>Denominator</b>	Respondents to patient survey
<b>Presentation</b>	Percentage of survey respondents rating services as good/very good/excellent or answering yes to a particular question.
<b>Equity and other breakdowns</b>	Indigenous status, Remoteness, SEIFA, Sex, Age group
<b>Level of government/ health sector breakdown</b>	States/Territories, health area/region
<b>Health sector(s) covered</b>	Hospital (admitted patient, outpatient, non-admitted emergency), primary care and community health, dental
<b>Is this a current indicator?</b>	NSW has an extensive patient experience survey in which 80 or so questions are asked of patients from different areas of the health system. Other States also have patient experience surveys, but there is no consistency in the questions asked.
<b>Endorsement</b>	No
<b>Is this indicator suitable for benchmarking?</b>	No.
<b>Related to</b>	NHHRC PIs 5.4, 7.1, 11.1
<b>International comparisons available?</b>	Possibly, depending on survey questions used
Data collection details	
<b>Data source</b>	Data not currently available nationally
Action required/issues	
<b>Is any data development required?</b>	Yes. A national survey is needed, so state and regional comparisons can be made. The national survey could draw on the best of the State surveys.
<b>Estimated additional costs for data development/ collection</b>	Very high. A national patient experience survey—covering hospital and nonhospital patients is estimated as costing between \$5-10 million. This would build on and/or harmonise the experiences of States already conducting such surveys.

<sup>40</sup> Australian Institute of health and Welfare (AIHW). 2008. A set of performance indicators across the health and aged care system, Prepared by the Australian Institute of Health and Welfare for Health Ministers, AIHW: Canberra. Page 119.

## Campbell Report quality indicator<sup>41</sup>

Indicator 1.3a Pressure ulcer (incidence)	
Indicator topic	Resident physical and psychological health is monitored and appropriately managed.
Rationale	Pressure ulcers can occur in any person of limited mobility, regardless of acuity, and are preventable.
Indicator definition	'Pressure ulcers' are defined as per the Australian Wound Management Association definitions, Stages 1 to 4 inclusive. All pressure ulcers should be counted and a notation made of those present on admission, and how many of each stage are identified.
Numerator	The number of residents developing one or more pressure ulcers over the past X months.
Denominator	Number of occupied bed days over the past X months. <i>Expressed as a percentage.</i>
Data source	Resident care plan; resident medication record; clinical record; incident reporting system; and Resident Experience Survey.

## QUT/Uniting Care CCI Tool quality indicators<sup>42</sup>

Indicator	Numerator	Denominator	Risk adjustment	Collection
Prevalence of stage 1 to 4 pressure ulcers*	Residents with pressure ulcers stages 1 to 4 on most recent assessment	All residents on most recent assessment	HIGH: Impaired transfer or mobility OR comatose OR malnourished OR end-stage disease on most recent assessment LOW: All others on most recent assessment	Inspection

\* (source: from the Australian Quality Matrix)

## European Indicators<sup>43</sup>

Indicator No. 1	
Definition	Percentage of residents who suffer from decubitus ulcers stage 2 to 4 that began in the care home.
Operationalisation	To measure this indicator an initial assessment of the decubitus status is needed at the point of admission. Pressure ulcers stage 1 are excluded due to measuring difficulties causing unreliability. This indicator is measured on a defined day once a year as a prevalence measure. Alternatively, it can be based on continuous care documentation.
Measurement/ Calculation formula	Numerator: Number of residents with decubitus ulcers stage 2 to 4 Denominator: Number of residents who have been assessed
Use/Purpose	The purpose of this indicator is to improve strategies to prevent decubitus ulcers, mainly by regularly changing residents' positions in their beds to relieve pressure on the same skin areas. Decubitus ulcers are not only painful and debilitating, but can have a devastating longterm impact on the health and quality of life of residents.
Perspective	Residents
Theme	Quality and safety of care
Source	Inspired by: KVZ-VVT, 2007; KVZ-VVT, 2010; E-Qalin, 2009; MDS, 2009; US DHHS, 2008; CSCI, 2008

<sup>41</sup> Campbell Research & Consulting (CR&C). 2006. Developing resident-centred quality indicators in residential aged care to support the project for 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. Publications Number: P3-2093 Page 17-28.

<sup>42</sup> O'Reilly, M. 2010. Clinical indicators of quality for Australian residential aged care facilities: Establishing reliability, validity and quality thresholds. PhD thesis, Queensland University of Technology.

<sup>43</sup> European Centre for Social Welfare Policy and Research. 2010. Measuring Progress: Indicators for Care Homes. <http://www.euro.centre.org>. page 31

# Australian Aged Care Commission

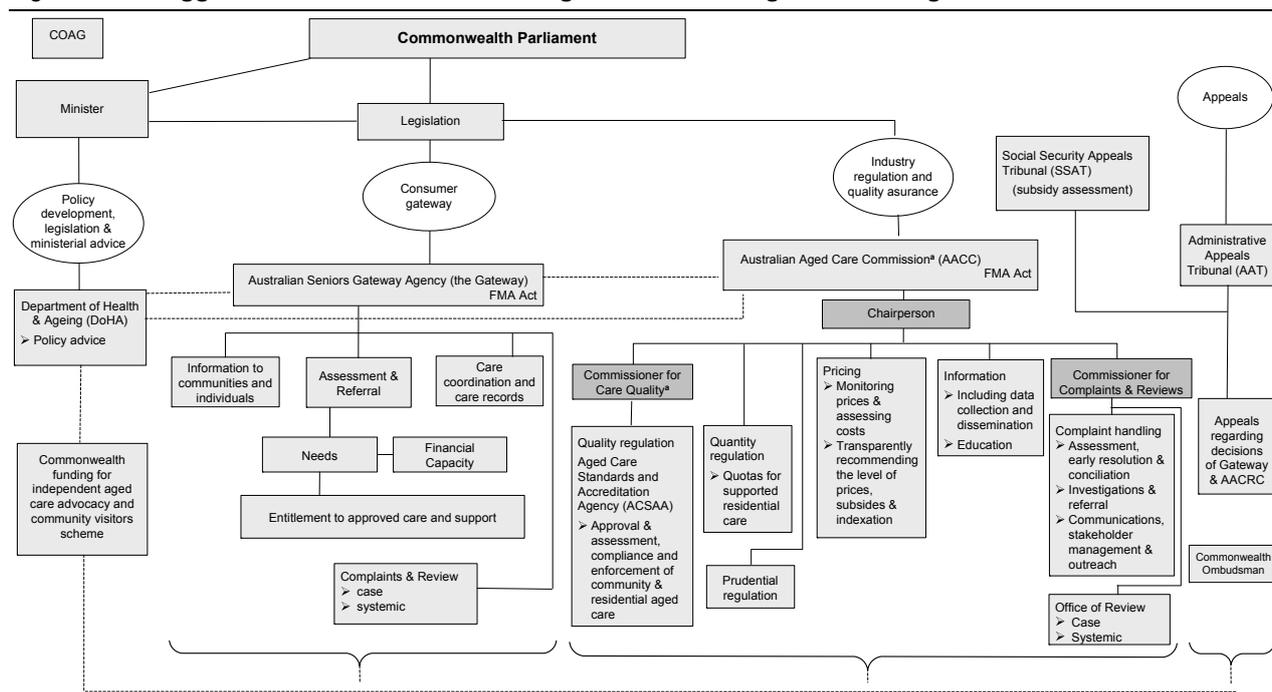
## Overview

The Productivity Commission has recommended the creation of a new independent regulatory agency - The Australian Aged Care Commission. This Commission would take over all regulatory activities of the Department except policy advice on regulatory matters. The responsibilities of the Commission would include accreditation, complaints, monitoring and compliance, prudential regulations, setting prices, data collection and dissemination.

The Commission suggests that this new structure will create greater transparency and independence by separating the funder and policy development of the system (DoHA) from the regulatory responsibilities. The Commission also suggests that by bringing together all of the regulatory functions into one organisation there is potential for greater efficiency and integration of information across the different aspects of regulation. With regards to the inclusion of the Accreditation Agency in the new structure, the Commission indicates that best practice responsive regulation is hard to achieve when one aspect of regulatory responsibility is structurally separate from compliance or enforcement (as is currently the case with the Accreditation Agency).

A copy of the proposed structure from the report is below.

Figure 15.2 Suggested Australian Government governance arrangements for aged care



<sup>a</sup> Advisory committees (with broad ranging membership) would also be established to support the AACC and the Commissioner for Care Quality.

## Potential Benefits of New Structure

### Independence

- A number of organisations have provided feedback to the Commission that there is a conflict of interest in having the Department as both the funder and regulator of the aged care system.
- Independence in pricing seen as a major benefit in transparency by consumers and providers. The Alliance discussed whether the AACC should be responsible for setting prices for aged care or if this

responsibility should be given to the Independent Pricing Authority. The consensus of the Alliance members was that pricing should remain within the AACC as specialised expertise in the aged care system is required.

- The enhanced independence of AACC could provide greater power to the Commissioner responsible for aged care complaints and reviews. The current office of the Aged Care Commissioner can make recommendations but has no authority.

#### *Reducing 'doubling up' of investigation or regulation*

- In the current system in some cases both the complaints and accreditation agency can be looking at the same issue although in some cases this may be appropriate as the Complaints Scheme investigate specific issues where as the accreditation teams look at systems and processes that may have led to a specific complaint.
- Opportunity to streamline system of approval and accreditation which are both required for Government funding but done by separate agencies.

#### *Improve communication*

- Bringing complaints, accreditation and monitoring together could improve communication and information sharing.
- There may be some benefits to inclusion of Accreditation in terms of communication and efficiencies. For example, a responsive regulation model requires that they sit together to ensure a feedback process. As the Complaints Scheme moves to a culture of complaints resolutions instead of investigations there may be greater synergies between the two organisations.
- Setting prices could be taken in the broader context of the provision of quality aged care services.

## Concerns

#### *Independence*

- Although the new structure separates regulation from the Department both the AACC and the Department report to the Minister. This is identified as a problem with the current arrangements for the Agency.
- There could be an argument for an Aged Care Ombudsman who would report directly to the Parliament to ensure greater independence and strengthen the consumer focus.
- The establishment of a new agency may not reduce confusion. Moreover, separating policy from regulation could lead to inefficiencies if it resulted overtime in the replication of functions across the Department and the AACC. As the Productivity Commission has suggested there will be a need for a formal Memorandum of Understanding between DoHA, the Gateway and AACC which would establish communication protocols and potentially reduce confusion, especially if it is published.

#### *Confusion and conflicts between quality improvement, compliance and regulation and complaints may not simply be resolved by putting them all in one agency.*

- The Accreditation and Standards Agency has expressed serious concern about mixing quality improvement and 'policing' of aged care. It believes that the UK model which may have influenced the Commission is flawed and there is no research to suggest there are any significant benefits to putting quality improvement and regulation into a single organisation.
- Again there will be perceived conflicts of interest in having complaints, accreditation and regulation in one agency. One option is the establishment of an Aged Care Ombudsman to take over

Complaints. This may give greater independence in removing complaints from the funder, policy maker and regulator and may also facilitate greater consumer engagement.

#### *Duplication of existing expertise*

- The AIHW already has the capacity to undertake macro-level data analysis and dissemination. In order to encourage transparency and independence in aged care policy research and evaluation, the AIHW should be given automatic access to all the available aged care data held by the AACC, including data for assessment, community services and packages and residential aged care and be adequately resourced to conduct independent analysis. The role of an AACC should be confined to analysis of data at the level of the service level.

#### *Need for networking with related agencies*

- The AACC should network with the Independent Pricing Authority for Hospitals to avoid unnecessary duplication particularly around sub-acute care.
- The AACC should also network with the Australian Commission on Safety and Quality in Health Care, particularly in the development of quality indicators.
- The Alliance also discussed whether the AACC should have responsibility for prudential regulation. The PC acknowledges this could go to APRA and in the text of the report says it is up to government to decide but they have included it for purposes of completeness. Putting it with APRA rather than the AACC would reduce the need for the AACC to duplicate the skills already held in APRA and would make it more independent from the aged care system. Further work should be done to explore whether using APRA for this purpose would lead to unreasonable burden on aged care providers. If this is the case then the regulation of bonds in the AACC should be networked with APRA.

#### *Delays in implementing new quality frameworks*

- Structural change needs to be achieved quickly to avoid delays in developing and implementing a new quality framework.
- Consumers would be very concerned if the implementation of the new quality system was to be delayed. The proposed deregulation of supply increases the need for an enhanced quality regulation system.

#### *Consumer Engagement*

- There is a need for greater consumer involvement in accreditation and monitoring. The Aged Care Standards and Accreditation Agency has started exploring models for greater consumer engagement and this work should be built on in the development of the AACC. The PC recommends the establishment of a stakeholder advisory committee to provide advice to the AACC in relation to consumer and industry interests (Rec 15.1). This is unlikely to be sufficient for meaningful engagement. There may be merit in having two groups - one for consumers and one for the industry modelled after consumer advisory committees of ASIC and ACCC. Involvement in the AACC could also include input through consumer surveys and interviews, focus groups or involvement in the Accreditation Assessment Teams.

#### *Cost*

- There will be concern amongst consumers that the Government is investing in new bureaucratic structures instead of investing in care. If the resources are transferred from DoHA then the additional costs should not be as great.

## Recommendations

There is broad agreement of the members of the Alliance that there is a strong case for the proposed AACC and that it has the potential to create greater independence, better communication and transparency by separating the funding body from regulatory activities but there are still some concerns. There is a risk that the lines between quality improvement, complaints and compliance and regulation will be blurred and continue to lack transparency. The view of the CEO of the Accreditation and Standards Agency is that accreditation is not compatible with a regulatory function. The Commission itself recognises this in the proposal to have three Commissioners as part of the AACC. The Alliance recommends that in taking forward the implementation of the AACC the following recommendations should be considered:

1. The AIHW should be given automatic access to all the available aged care data held by the AACC, including data for assessment, community services and packages and residential aged care and be adequately resourced to conduct independent analysis in order to encourage transparency and independence in aged care policy research and evaluation.
2. The Complaints Scheme should be moved out of DoHA and made independent. How this is done is less clear. Some members support an independent complaints system as part of the AACC. Others have concerns about whether this will lead to real independence and believe establishing complaints separately from AACC would increase consumer confidence. Complaints about the Gateway including levels of entitlement should first be referred to an internal complaints mechanism within the Gateway but if the complaint cannot be resolved it should be referred to the AACC Complaints Scheme for further review. Consumers should also have access to the Administrative Appeals Tribunal for an independent review of decisions.
3. The AACC should network with existing organisations with relevant expertise and experience such as the Independent Hospital Pricing Authority, the Australian Commission on Safety and Quality and Australian Prudential Regulation Authority to reduce duplication and build on existing expertise. The recent work that has been done on reforming the complaints system and updating Accreditation Standards should be used to inform the new system. The restructure of the regulatory systems should be efficient and not lead to additional costs.
4. The AACC should develop a model for meaningful consumer engagement that goes beyond involvement on advisory committees. The AACC should draw on the work the Accreditation Agency has done on international models of consumer engagement including input through consumer surveys and interviews, focus groups or involvement in the Accreditation Assessment Teams. There may also be value in examining consumer engagement in the Veterans Aged Care System, ASIC and ACCC.
5. The restructure of the regulation system should occur in the first phase of the implementation of reforms. The AACC as well as the quality framework, outcome measurement and enforcement will be key to improving the quality of aged care services and providing information to consumers.