national
AGED CARE alliance

APRIL 2017

NATIONAL AGED CARE ALLIANCE RESPONSE

Department of Health Consultations on Single Aged Care Quality Framework (Draft Aged Care Quality Standards & Options for Assessing Performance against Aged Care Quality Standards)

About the National Aged Care Alliance

The National Aged Care Alliance (the Alliance) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. Further information about the Alliance is available at naca.asn.au

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Introduction

The Alliance welcomes the opportunity to respond to the Department of Health (the Department) Consultation Paper on the Draft Aged Care Quality Standards and the Options Paper for Assessing Performance against Aged Care Quality Standards. This response follows the format of the online survey questions published on the Department's consultation hub at

- consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft-standards

  and

- consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-assessing-performance

The Alliance looks forward to making further contributions to the next stages of the development of the Aged Care Quality Standards, supporting materials, assessment processes and related amendments to the Aged Care Act 1997 and legislative instruments.

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Single Quality Framework Draft Aged Care Quality Standards Consultation Paper 2017

- consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft-standards

Questions from the Standards Consultation Online Survey

General questions about the draft standards

Please give us your views on the draft standards by answering the questions below. You will also have an opportunity to provide feedback on each standard in the next section.

10. Do the consumer outcomes in the draft standards reflect the matters that are most important to consumers?

○ Yes, always ● Yes, mostly ○ Yes, sometimes ○ No ○ Don't know

Why? Do you have any suggestions about how they could be improved?

The Alliance considers that having relevant and meaningful consumer outcomes for each standard is important, as it will shape consumer expectations, help them formulate goals and preferences and provide a basis for negotiating with service providers and exploring how their goals and preferences might be achieved.

The consumer outcomes are written in plain English and easy to understand for the most part. They address important issues such as choice, dignity of risk, partnership, quality of life, and meeting the needs, goals, and preferences of consumers. The evidence guide for consumer outcomes should provide examples encompassing cultural and spiritual needs as well as physical needs.

The Alliance makes the following comment about particular draft consumer outcome statements:

- *Consumer outcome 1: "I am treated with dignity and respect and can maintain my identity. I can make choices about my care and services and how they support me to live the life I choose."*

  This statement recognises being treated with dignity and respect, maintaining identity and exercising choice are central to quality of life in aged care. Being treated with dignity and respect should also encompass upholding the consumer's rights and supporting consumers to understand their rights and to make this clear, the evidence guide for this standard should refer to the Charters of Care Recipients' Rights and Responsibilities for Residential and Home Care (or the single Charter of Care Recipients' Rights and Responsibilities when available) and providers' responsibility to support consumers to understand their rights and responsibilities. As culture is integral to the maintenance of identity, the evidence guide also needs to discuss how culture and diversity can be supported in the context of identity.

- *Consumer outcome 2: "I am a partner in ongoing assessment and planning of my care and services"*

  Consumers expect the assessment and planning process to be both collaborative and effective, in that it accurately captures their needs and preferences and informs the delivery of quality care and services. We note that the organisational expectation for Standard 2 covers both aspects.

The Alliance recommends that consumer outcome statement 2 be re-written to be consistent with the organisation statement, along the lines of: "I am a partner in the ongoing assessment and planning of care and services that help me get what I need" to reflect that assessment and planning should be effective as well as collaborative.

These issues are discussed more fully under each standard.

11. Are the organisation statements and requirements in the draft standards achievable for providers?

○ Yes, always ● Yes, mostly ○ Yes, sometimes ○ No ○ Don't know

Why? Do you have any suggestions about how they could be improved?

- *Organisation Statements*

  The Alliance considers that these statements are clear and achievable, but it is not always clear that a provider's successful achievement against the requirements will demonstrate achievement of the organisation statement. The organisation statement needs to be highly consistent with organisational requirements. For example, the organisation statement for Draft Standard 3 refers to personal care and clinical services being delivered in accordance with the consumer's needs and preferences whereas the requirement to demonstrate this refers only to aligning services with consumer preferences.

- *Organisation Requirements*

  Generally, the requirements appear well developed to ensure that compliance will result in meeting the standards. As stated above, there is a need for organisation requirements to be expressed in language that is consistent with consumer outcome and organisation statements. The need for requirements to be measured consistently across organisations is discussed in Q.12 and Q.14 below and in the standard specific feedback.

  The Alliance is also concerned about how organisational requirements will be considered in the assessment process to cover a wide range of providers operating across a wide range of settings with varying levels of risk and without over burdening smaller providers with red tape. There is uncertainty as to whether very small 'providers', for example, a sole health professional will be subject to these standards where their services are purchased through a subcontracted arrangement from a Home Care package provider and if so, whether they would be able to meet all the organisation requirements. Any future policy direction on 'cashed out' or 'debit card' arrangements would also need to consider how these standards might apply. The Alliance notes that this issue is an emerging concern within the NDIS and it would be prudent for future proofing that the standards give regard to this possible future in aged care following further policy decisions in line with the roadmap destinations.

12. Are the draft standards measurable?

○ Yes, always ● Yes, mostly ○ Yes, sometimes ○ No ○ Don't know

Why? Do you have any suggestions about how they could be improved?

The Alliance understands from the Department that it is intended that the consumer outcomes will be assessed through individual consumer feedback.

The Alliance notes the definition of 'consumer' at page 12 of the consultation guide is: "Consumer refers to the person receiving care and services. Where applicable, it may also include the person's representative, carer, family member or substitute decision maker." It will be important that this definition is understood by assessors and incorporated in the evidence guide for the standards so that measurement of consumer outcomes can include feedback from nominated representatives where the person receiving care and services is unable to provide feedback. The assessment methodology should enable representatives' and care recipients' feedback to be distinguished in any reporting.

The Alliance expects that consumer experience will be measured from consumer feedback and through direct engagement with consumers in the assessment process, through surveys and interviews, and that the sampling for these will be valid, robust and representative. The details and nature of how this information will be assessed for measurement will be developed by the Australian Aged Care Quality Agency and the Alliance does not intend to provide further commentary on the Quality Agency process as part of this submission.

The Alliance also understands if the organisation requirements are met, the organisation would meet the organisation statement, but that the number of requirements to be met will depend on the type of care and services offered by the provider. Additionally, it is understood the way a particular requirement is to be met will vary by care types and services offered.

The language of the organisation requirements needs to be very clear and defined, so that each requirement can be audited consistently across organisations.

When the word 'quality' is used in an organisational requirement it will need to be defined in the evidence guide, so as to enable measurement.

The piloting of the standards should include an assessment of their auditability, through utilising a range of auditors for each organisation and checking consistency between auditors.

Some measures depend on accurate and timely reporting and recording within the organisation – for example, when determining if plans are reviewed when circumstances change or after an incident, it will be difficult to assess if reporting and recording was timely or if changes and incidents have been logged at all.

13. Are there any gaps in the draft standards?

● Yes ○ No

If so, what are they?

Volunteers are a significant component of the workforce delivering front line services and ancillary support in aged care services. The volunteer workforce and best practice volunteer management need to be referenced in the organisation statement, organisation requirements and the evidence guide for Standard 7 (Human resources), which should include demonstration of adequate training and ongoing support of volunteers to ensure the provision of quality services and protection for consumers.

Cultural identity through the meeting of cultural obligations, connection to family, and connection to country is a key concept underpinning the physical and psychosocial health and wellbeing of Aboriginal and Torres Strait Islander peoples. Provision of adequate aged care supports to Aboriginal people requires cultural safety to be embedded in all aspects of service

provision. The evidence guide for each standard should require providers to demonstrate that the cultural needs of consumers have been addressed.

14. Is the wording and the intent of the draft standards clear?

○ Yes, always ● Yes, mostly ○ Yes, sometimes ○ No ○ Don't know

Why? Do you have any suggestions about how they could be improved?

The Alliance considers that the wording should always clearly reflect the intent, and would recommend that before the standards are finalised a thorough check is undertaken to match wording to intent, to check consistency of wording, and to confirm that when similar but different words are used in relation to connected outcome statements and organisational requirements, this is intentional. The piloting/field testing of the standards should include determining if there is common understanding of terms and words used in the standards. For example, words such as autonomy, identity, and independence.

The terms 'well-being' and 'quality of life', used throughout the standards, mean different things to different people, and as such, the Alliance recommends that the evidence guide clarify that 'well-being' and 'quality of life' are determined through reference to consumers' own perceptions of what contributes to their well-being and quality of life.

The language of the draft standards (including the consumer outcome, organisation statement and requirements for each standard), while 'plain English' and clear for English speakers, may pose a challenge for understanding/interpretation in services where the majority of staff are from a non-English speaking background (including Aboriginal and Torres Strait Islander staff working in remote regions of Australia). It would be highly desirable to produce culturally specific supporting materials for the standards that have been reviewed and amended (as needed) by Aboriginal and Torres Strait Islander experts to interpret 'service jargon', and incorporate culturally appropriate concepts, and language for use in NATSIFACP contexts.

This applies both to Aboriginal service personnel and clients who speak English at home/as a preferred language and as well as to those who speak English as a second (third or fourth) language.

Other difficulties with wording are discussed under each standard.

15. Are any draft standards or requirements NOT relevant to the following services?

If so, please provide details below.

- *Residential care*

  Nil. The Alliance considers all the draft standards apply to residential care.

- *Home care*

  The achievement of requirements for Standard 4 (lifestyle supports) in home care settings will need to be tailored to, or reflect, the services provided by the organisation. The evidence guide and other proposed materials will need to address these variations between service providers who may offer one, two or several of the distinct services that have been grouped under lifestyle supports.

  The Alliance notes that Standard 5 and its outcome, statement and requirements relate

only to the physical environments of residential care, respite care and day therapy centres, and are therefore not relevant to care delivered in private homes, including home settings such as communal living, retirement villages, caravan and mobile home parks, or supported residential services.

- *Commonwealth Home Support Programme services*

  The Alliance notes that a provider of single services such as gardening or transport may not be required to meet all standards and all requirements under the standards. CHSP providers would not be required to meet Standard 5 (Service Environment) unless they are delivering a service within the community such as day therapy centres. Importantly for both CHSP and Home Care packages providers, it must be recognised that an organisation may not necessarily provide all of the lifestyle services and activities that are necessary to sustain quality of life for each consumer. Consideration will need to be given in the evidence guide how Standard 4 (Delivering lifestyle services and supports) will be assessed against only those services provided.

- *Transition care*

  Where transition care is provided by an organisation subject to another quality regime, this should be recognised for like service types and risk levels.

  Where there are gaps, an assessment should be made if the relevant aged care standard (s) should also apply to the organisation.

- *National Aboriginal and Torres Strait Islander Program services*

  Whilst it is agreed that Standards 3, 4, and 5 should only be applied to organisations providing personal and clinical care, lifestyle support and/or services in a service setting, we are concerned about the extent to which these standards may be applied to National Aboriginal and Torres Strait Islander Flexible Aged Care Program service settings which have previously not been held accountable to accreditation standards. Significant transitional arrangements are likely to be needed to bring NATSI providers to a similar level of understanding with other more traditional areas of aged care as part of the move to a single aged care quality framework. This may include targeted NATSI training and transitional / mapping explanations between current and future states for these providers.

- *Multi-purpose services*

  As for transition care.

- *Innovative care services*

  The Alliance has provided no comment on these services.

- *Short term restorative care services*

  As for transition care.

Specific suggestions about each draft standard

If you have any additional comments on how to improve any of the individual draft standards and requirements, please provide these in the relevant spaces below.

16. Do you have any specific suggestions in relation to draft Standard 1: *Consumer dignity, autonomy and choice?* If so, what are they?

The organisational requirements need to include providing support for consumers to understand their rights and responsibilities, as discussed at Q.10.

At 1.5, there is a requirement for information to be provided to consumers in a form that they understand; this should be expanded to tailoring content and delivery method to the needs of the consumer and their family and/or caregivers, ensuring information is culturally appropriate including where necessary by facilitating access to an independent third party (e.g. for Aboriginal people this may be a cultural broker/trusted third party who can translate 'service jargon' into culturally relevant concepts, Aboriginal language or plain English, as appropriate).

The shifts in language between consumer outcome statement, organisation statement and organisational requirements around consumer autonomy are confusing.

The organisation expectation statement that "the organisation supports consumers to exercise choice and independence" should read to "exercise choice and maintain independence" to match the intention in the 'Rationale and evidence' section, which emphasises that treating people with dignity and respect includes recognising their strengths and ability to act independently and make choices, and empowering them to maintain that independence.

The Alliance notes that throughout the standards there is no reference to consumers directing or controlling their services and support. While control can be exercised through the capacity to choose and change providers, not all consumers will have choice of providers or be able to change providers easily. Accordingly, the evidence guide should make clear that consumers' capacity to "make decisions about their own care and the way that care and services are delivered" is not simply being able to choose from an array of options determined by the provider but encompasses the ability to ask for something they have not been offered if they so wish. This ability should arise from a genuine partnership between the consumer and provider, with the provider responsible for sharing professional views on service needs and identifying risks in order to inform consumer choice and direction.

The right of consumers to have their sexuality and intimacy needs respected should also be recognised in this standard.

Accordingly, the Alliance notes that in the evidence guide that 1.3c must specifically include mention of both "social and intimate" relationships of choice. Further the results and processes guide must address the issues of "intimacy", ensuring that consumers are provided with the ability for private intimate moments of their choosing.

17. Do you have any specific suggestions in relation to draft Standard 2: *Ongoing assessment and planning with consumers*? If so, what are they?

The concept of partnering is not well understood or commonly used in aged care and the explanation in the rationale and evidence section refers to consumer-centred care when the

industry has invested significant time and effort to move to consumer-driven care and services (as per the Roadmap). The Alliance supports the inclusion of partnering but believes the supporting documentation should better reference the current context of consumer-driven care and services to ensure an equal contribution to the partnership model.

In addition, the definition of "consumer-centred" in the glossary is much less strong than the definition of "person-centred" in the National Disability Standards (NDS) and given both sets of standards will be national standards under Australian Government control, there should be closer alignment. The Alliance recommends the definition of consumer-centred should be aligned with the NDS as follows: "Services and supports that are centred on the individual and their strengths, needs, interests and goals. Service delivery ensures that the person leads and directs the services and supports they use."

The evidence guide for this standard needs to clearly and concisely outline who can complete assessment and planning. It is noted that initial assessment and care planning of nursing services for consumers in residential care must be carried out by a nurse practitioner or registered nurse, as per the Quality of Care Principles 2014, made under section 96 1 of the Aged Care Act 1997 (Item 3.8 of Part 3), and this should be referenced in the evidence guide for this standard.

The evidence guide's discussion of item 2.2f 'Advance care planning' should provide that best practice is such that planning occur at admission or close to admission to a service.

In item 2.2 there should be an additional point h) to cover the provision of culturally appropriate assessments and the evidence guide should cover specialist assessment of needs such as cognition levels, pain levels, depression and mobility.

As recommended at Q.13, the evidence guide for the standard also needs to explicitly reference cultural safety, as effective service delivery for Aboriginal people is not possible without culturally safe assessment and planning processes. Organisations should be able to demonstrate ongoing partnership with the consumer and/or their family and career in assessment of their care and services, and provide tailored information and other supports to facilitate active participation of the consumer and their family/carers in the assessment and planning processes.

18. Do you have any specific suggestions in relation to draft Standard 3: *Delivering personal care and/or clinical care*? If so, what are they?

During consultations, several views were raised about the appropriateness of mentioning specific clinical risk areas at 3.7 of the organisational requirements. While the Alliance understands that these areas have been chosen based on their prevalence and impact on consumers from the available literature, we propose these important areas of concern identified by the literature be discussed in greater detail in the evidence guide. Additionally, this approach will realign the standard's focus on the risks pertaining to each individual consumer. In addition to the identified areas listed currently in the draft standard, our consultations identified further areas that should be considered for inclusion in the evidence guide. These include dementia, appropriate use of restraints and nutritional risks.

It would also be beneficial to provide a definition of 'function' in the evidence guide for Standard 3.

In particular, although people living with dementia comprise more than half of all consumers receiving aged care services in residential care, there is no reference to dementia in the standards. The Alliance notes this is in line with not mentioning any group of people within

the standards, but given the strong association between a diagnosis of dementia and high impact and high prevalence risks in the delivery of personal and clinical care, recommends that significant discussion of this occur within the supporting materials around this standard.

Likewise, the supporting materials should reference clinical best practice with regard to the use of restraints, while acknowledging that organisations should have flexibility to adopt emerging practice.

The Alliance supports the differential application of this standard as described on page 11 of the consultation paper.

The supporting materials should specify that high-impact and high-prevalence risks need to be monitored through data collection and analysis to improve consumer outcomes.

At 3.8, implementation of antimicrobial stewardship should not be a requirement of organisations given it is whole of community responsibility, but organisations should be required to adopt measures within their control to minimise antimicrobial resistance. It should be noted in the supporting materials that in addition to Medical Practitioners, Nurse Practitioners can prescribe antimicrobials.

19. Do you have any specific suggestions in relation to draft Standard 4: *Delivering lifestyle services and supports*? If so, what are they?

The Alliance is unsure if food safety and food quality (nutritional benefit) are adequately covered under 'optimising the consumer's well-being and quality of life' or if additional organisational requirements are needed. Food and nutrition considerations are appropriate to be considered under lifestyle services and support but are also relevant to personal care and/or clinical care (beyond malnutrition and dehydration acknowledged in the 'rationale and evidence' section for Standard 3). Best practice for organisations providing food and nutrition related services should include the requirement to identify and manage nutritional risk, including risk of malnutrition/ undernutrition and dehydration, special dietary needs, food intolerance or allergy and dysphagia.

As well as catering to consumers' dietary needs for clinical reasons, food services should provide variety and take account of consumers' likes, dislikes, and cultural needs, as being able to exercise choice is an essential component of quality of life.

The Alliance considers that the organisational requirement should be to deliver services and supports 'in accordance with' the consumer's needs and preferences rather than 'be aligned with' the consumer's needs and preferences. This will make the requirements consistent with the organisation statement for this standard and reflect that care and services should be consumer-driven rather than provider-driven, while recognising the challenges of a finite funding environment.

Measurement of this standard will depend on consumers and providers agreeing on the 'lifestyle' support that is appropriate to each individual's circumstances and including it in care and service plans, so that performance can be measured consistently across services, given the variability in volume and type of care likely to be provided.

20. Do you have any specific suggestions in relation to draft Standard 5: *Service environment*? If so, what are they?

The Alliance notes that a safe environment should also be a secure one, in terms of providing

privacy and risk-based protection from harm, whether it be harm from intruders or thieves, harm from falling or leaving the premises unaccompanied if it is not safe to do so.

Providing a secure environment for those consumers who need it should not have the effect of restricting the freedom of other consumers to come and go as they please.

21. Do you have any specific suggestions in relation to draft Standard 6: F*eedback and complaints*? If so, what are they?

The organisation requirements should include ensuring privacy and confidentiality when a consumer seeks this in making a complaint, and providing for consumers to make an unidentified complaint if they wish, as the notion of consumers feeling safe to make complaints is not picked up in the requirements.

Cultural safety is also relevant here as anecdotal evidence shows that Indigenous people and people from other ethnic backgrounds may not speak up at all if their cultural needs are not met. Consequently, the requirement for this standard should include "promotion and facilitation of access to a culturally appropriate advocate".

The Roadmap identifies the need for informed consumers. We note the rationale and evidence section on page 29 states that organisations are expected to support consumers to make complaints, including by giving access to resources about how to make complaints and what they can complain about. Culturally appropriate and accessible information and resources should be available to consumers as part of the intake and assessment process and regularly thereafter, to ensure that consumers do not have to seek this information as part of the process of making a complaint.

22. Do you have any specific suggestions in relation to draft Standard 7: *Human resources*? If so, what are they?

The Alliance is concerned that the term "sufficient workforce" is unclear and recommends that this be defined in the evidence guide for assessors.

In general, the accompanying notes use stronger language than the organisation requirements. For example, the term "high-quality care" is used, whereas in the Standard itself, and in other Standards the term "safe and quality care" is used. Is there a difference? The same term should apply across the Standards documentation, and be defined in the glossary.

The reference to qualifications in 7.2b should be expanded to ‘qualifications and training’, as some roles require on-the-job training rather than qualifications, for example, laundry workers.

While the guide to terminology on page 12 of the consultation paper includes volunteers in the definition of workforce, volunteers are not referred to as part of the workforce in the draft Standard 7. Volunteers comprise a significant component of the workforce in aged care settings. Whilst the broad reference to "workforce" may be inclusive of volunteers, the organisation statement, requirements and the evidence guide should specifically include volunteers as part of the workforce.

The organisation requirements need to include an additional requirement for organisations to demonstrate adequate screening, induction, training and ongoing support of volunteers engaged in the delivery of services for older people across all service settings and service types. In addition, the explanatory notes need to explicitly reference volunteers within each of the 5 key concepts outlined.

23. Do you have any specific suggestions in relation to draft Standard 8: *Organisational governance*? If so, what are they?

The Alliance notes that different organisations will use different ways of partnering with consumers in the planning, delivery and evaluation of care and services, ranging from monitoring complaints and feedback, to consumer surveys and meetings through to consumer participation in the organisation's quality governance structures. Over time, the evidence guide should identify best practice in relation to partnering with consumers in organisational governance.

The organisation statement of expectation should state to whom the organisation is accountable, that is, consumers and other stakeholders where relevant.

Other comments

Please provide details below about any other suggestions or comments you may have about the draft standards.

24. Do you have any other comments or suggestions about the draft standards?

As stated above, the Alliance is concerned about how the organisation requirements for each Standard will be adapted so that they are proportionate to the size, scope and location of a provider.

There should also be consideration of how the proposed draft standards can be streamlined for organisations operating in multiple markets or for whom professional registration requirements apply.

The Alliance also considers that further development will need to be undertaken to identify:

- How organisations and Certifying Bodies engage with the scheme
- The activities undertaken by organisations to attain as well as maintain certification with the scheme
- The requirements a Certification Body must meet and maintain to be approved to audit the standards
- How the scheme will be operated, managed and administered.

There would need to be a strong communication and transition strategy on the part of the Department across the sector that is interactive and supportive, and inclusive of providers and clients/residents.

Continuous improvement could perhaps be more strongly identified as a cornerstone to the delivery of quality services and operation of an effective organisation.

Single Quality Framework Options for assessing performance against quality standards – Options Paper 2017

- consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-assessing-performance/

Questions from the Assessing Performance Options Paper Online Survey

Questions about how service provider performance is assessed against the aged care draft standards

Please share with us below your views about the current arrangements and any other comments or suggestions you would like to make about the reforms.

The Options Paper includes sections entitled "Your thoughts" which may help prompt your feedback to questions in this section of the online survey.

10. What are the features of the existing assessment and monitoring process that should be retained? What are the strengths of the current aged care quality assessment arrangements?

Positive features of the existing process include the generally continuous improvement focus, the approach taken during site visits and the supportive contact quality reviewers make with staff and consumers during interactions.

The current complaints process through the Aged Care Complaints Commissioner, in conjunction with the Quality Agency and Department of Health handling of non-compliance, are features that will need to be retained, or replicated in a way that ensures the effective management of issues and poor performance.

One of the strengths of the current assessment arrangement is the sliding scale of quality assessment depending on whether the program comes under the aegis of the Aged Care Act or not. That is, the current assessment process has recognised the differences between service types and has accordingly applied an appropriate level of proof on providers, rather than applying a blanket standard to all service types and providers.

One of the benefits of the previous NATSI Flexible Aged Care Program standards was that they allowed services to be extremely responsive to the lifestyle choices and needs of Aboriginal and Torres Strait Islander clients, including shifting care to different settings/locations to continue to provide care whilst enabling the older person to meet their familial obligations and to retain their connection to country, wherever possible. The new standards and their assessment must apply a cultural lens to the operation of NATSIFACP-funded facilities to ensure that they continue to meet the cultural needs of Aboriginal consumers and consequently enhance their health and wellbeing.

The current service self-assessment is useful, both in terms of providing a structure to review progress between visits and to guide preparation before a site visit.

The verbal feedback session following the site visit is also extremely helpful and provides ‘immediate’ feedback to site staff who have been involved in the visit and who might not read a formal written report. (This is particularly relevant for NATSIFACP sites where a large proportion of staff are local Aboriginal people for whom English is a second, third, or even fourth language, and

for those who find 'service jargon' difficult to interpret – even though English is spoken at home.)

11. What are the features of the existing assessment and monitoring process that need to be changed?

- **What aspects of the current quality assessment arrangements need to be improved?**
- **What other issues need to be considered in the design of any new quality assessment arrangements?**

The introduction of a single set of standards means that organisations providing a range of services across aged care can now apply a single assessment process across all services, reducing the staff burden to know multiple systems and giving a level of consistency across their service profile.

Changes are required to create a single process that is scalable from complex residential to single service home care.

Consumer engagement and involvement in the assessment processes are essential and new methods to achieve these are required. Consideration must be given for culturally safe mechanisms to engage consumers, their families and care givers. This will require whole-of-community engagement and provision of tailored information, and may also require involvement of a 'trusted third party' for particularly vulnerable clients of an Aboriginal and Torres Strait Islander background– an independent advocate who can act as a cultural broker.

Likewise, in terms of feedback and complaints, some populations (e.g. Aboriginal and Torres Strait Islander peoples) will need encouragement and authority to respond genuinely without fear of losing the support of the service, particularly in locations where there is no or very limited choice of services/providers.

The Alliance believes that new thinking on assessment of risk and quality is essential if the Aged Care Sector Roadmap aspirations for the future are to be pursued.

Changing the standards under a new framework leads to consideration of the need for new assessment and monitoring models and approaches, allowing a range of organisations – that must meet designated criteria for independent accreditation bodies – to participate in future accreditation across the whole sector. If this is to occur, then the framework and organisation requirements must explicitly state the differing levels of evidence required to demonstrate acceptable performance for each service type against each standard to ensure consistency between different accrediting bodies and between the same service types in different locations.

Assessment and re-assessment data provide valuable information for accreditation bodies. These and other data about the type of consumers being cared for in particular services may assist in moving towards a risk based process within residential care settings.

Questions about the options proposed

Please give us your views on options by answering the questions below.

The Options Paper includes sections entitled "Your thoughts" which may help prompt your feedback to questions in this section of the online survey.

12. Which option do you prefer? Please give reasons.

○ Option 1 ○ Option 1 with Option 3 ○ Option 2 ● Option 2 with Option 3 ○ Other

Reasons for preferred option.

Option 2 provides an effective alternative. The Alliance notes that Option 2:

- Allows organisations to implement one set of standards across all services with efficiencies of scale
- Can apply a risk analysis from the governance level to the service level that provides assurance of compliance
- Enables broad consumer involvement in the quality systems of organisations as well as in participation in assessments and monitoring
- Is consistent with the Roadmap vision of a single quality system for the sector
- Gets closer to mutual recognition of other quality systems

The Alliance suggests that a risk profile tool be sourced or developed for organisations, for services and service types, and for consumers and client groups to give definition to the relative and appropriate levels of risk for the sector.

The inclusion of Option 3 would be based on this risk relativity, and participating organisations would still be required to have appropriate safeguards in place. We also note the requirement for all standard legislative requirements to be met, including having a complaints resolution mechanism and engaging with the Aged Care Complaints Commissioner to resolve complaints. Consumers would be protected under Australian Consumer Law, and providers would be required to remain compliant with relevant state and territory legislation.

From a consumer perspective, the risk of using such services is already understood in the fee for service, non-government subsidised market. When we pay for a house cleaner or a gardener, we understand the risk of the commercial transaction. If we are not happy, we stop using the service, as there are no exit penalties or transactional costs in changing providers.

Further information is needed about the application of Options 1 and 2 to National Aboriginal & Torres Strait Islander Flexible Aged Care services, particularly where those services provide residential support. As currently proposed in the Options paper for both options 1 and 2, it would appear that any NATSIFACP service that provides residential support (and which was previously reviewed against the NATSIFACP standards) will be assessed against the same standards as residential care services under the jurisdiction of the Aged Care Act (1997).

If this is the case, then it is likely that many NATSIFACP services (particularly those operated by local community organisations in regional and remote communities) will struggle to meet the more stringent residential care accreditation requirements.

In relation to the features proposed to be common to all options:

- **Do you agree that the features common to all options should be part of aged care quality assessments?**
- **What are some of the different ways in which an organisation (and its services) could demonstrate its performance against the standards?**
- **How could consumers be more effectively involved in the assessment process?**
- **What information is most valuable to consumers?**
- **What are the critical elements of any assessment process?**
- **How information gained from a quality assessment can drive competition in the market and assist consumers to make choices**

The Alliance supports the common features proposed, however raises the following matters that need further information and exploration to ensure the successful implementation of the new system:

- Current descriptors rely on the role of the AACQA in methodology, data availability and intelligence gathering, consumer engagement (residential) and feedback, capacity for recognition of compliance with other standards, complaints, and better information about outcomes.
- The proposal on reduced regulatory effort on low risk services seems lacking in available data. What evidence do we have that lower risk services need less time/effort in frequency of monitoring and /or support? Can consumers experience harm from failure of low risk services?
- The use of three yearly quality assessment reports to provide site information for consumers appears inadequate when consumers want real time information to be able to make choices
- The statement on top of page 23 that organisations demonstrating effective governance could have reduced assessments by AACQA does not explain how such 'effectiveness' is being measured or promoted or even promoted as a strategy for risk based performance. More clarity would be appreciated.
- Greater consumer involvement is welcomed but the approaches to being 'more inclusive of consumers' are critical and need further development to ensure that the selection of consumers allows both self-selection and random selection to inform the development of advice and usable material to foster consumer choice.

The Alliance also wishes to emphasise the need for culturally appropriate and safe approaches for Aboriginal and Torres Strait Islander people to ensure their involvement as consumers in quality assessment processes and specific community engagement processes to engender dialogue about the purpose of aged care quality assessment and its relevance to the care of elders.

We also agree that standards 3,4, and 5 should only be applied to organisations providing personal and clinical care, lifestyle support and/or services in a service setting, however we are concerned about the extent to which these standards may be applied across service settings which have previously not been held accountable to accreditation standards (particularly National Aboriginal and Torres Strait Islander Flexible Aged Care Program services).

If Option 1 was adopted:

- **What are the advantages and disadvantages of this option?**
- **Should any new assessment approaches be included in this option?**
- **How can this option best accommodate future changes in service delivery (for example, new models of service delivery)**?

The Alliance does not support Option1.

One of the key features of option 1 is that there would continue to be one quality assessment process based on the care setting, with different approaches for residential care (accreditation) and another for home/community care (quality reviews) based on the status quo. What is lacking in the information outlined in the options paper is clarity about which assessment processes would be applied to NATSIFACP services, particularly those delivering residential support services in regional and remote locations where there are limited culturally appropriate residential care services available to local Aboriginal and Torres Strait Islander people.

If Option 2 was adopted:

- **What are the advantages and disadvantages of this option?**
- **To differentiate between organisations (and their services) to enable more targeted quality assessments, would it be sufficient to consider the following risks or should other matters also be taken into account:**
  - **The nature of the services being delivered**
  - **The level of responsibility the service has for the consumer's health, safety and wellbeing**
  - **The performance history of the organisation and its services**
  - **The organisation's compliance with any other relevant standards or quality frameworks?**
- **How can we best create a more risk-based approach to performance assessment?**
- **What support would organisations (particularly community/home care organisations) need to transition to this approach?**
- **Should organisations that provide transition care also be subject to this single quality assessment framework (noting that the quality of most of these organisations is regulated by state and territory governments)?**

The Alliance supports the implementation of Option 2 with Option 3.

As in Q. 12, we suggest that a risk profile tool be sourced or developed for organisations, for services and service types, and for consumers and client groups to give definition to the relative and appropriate levels of risk for the sector.

Where transition care is provided by an organisation subject to another quality regime, this should be recognised, as applicable.

Where there are gaps, an assessment should be made if the relevant aged care standard (s) should also apply to the organisation.

Additional points:

- The first stated advantage is that risk can change over time and assessment methods can be adjusted accordingly. The Alliance has queried how quickly these changes can be noticed, reported and adjusted for as risks to consumers require real time responses.

- The proposed risk-based assessment process would impose a significant additional administrative and cost burden on NATSIFACP providers who deliver 24-hour care including residential support services. Under Option 2, these services would be assessed against the same standards as residential aged care facilities, but without the same expertise, resources or experience of previously being held accountable to residential aged care accreditation standards.

If Option 3 was adopted:

- **What are the advantages and disadvantages of this option?**
- **What criteria should be used to determine whether an organisation should be subject to safety and quality declaration rather than assessment?**
- **What types of organisations should be eligible to use this arrangement?**
- **Is there an alternative approach that provides appropriate safeguards for consumers while minimising red tape for organisations that only deliver low-risk services?**

The Alliance supports the implementation of Option 3 in conjunction with Option 2.

The most notable thing about Option 3 that has not been covered above is the last dot point under advantages and disadvantages in relation to subcontractors and subcontracting and the relevant burden (or otherwise?) of requiring organisations to comply with the standards but not be subject to quality assessments.

Does the burden apply to the 'approved provider' organisation or the subcontracted organisation or both? Are there implications here for red-tape?

Also, note earlier statement about the lack of presented evidence about lower risk being equivalent to lower effort and risk of non-compliance.

In general, the Alliance supports the adoption of Option 3 in conjunction with Option 2.

Option 3 works well for low risk CHSP services such as telephone-based social support programs as well as for programs that are required to meet other quality standards (eg standards applicable to food services). However, 'low risk' services need to be clearly defined and take into account the consumer profile as well as the service type.

While the addition of Option 3 can provide a good option for smaller services, there is some concern that providers offering a broader range of services have increased accountability and may become uncompetitive in an increasingly open market. It is unclear how proportionality will be applied to an organisation that provides both low and high risk services.

13. Please provide details of any other options that we should consider.

(No response to this question).

14. Will your preferred option/s maintain appropriate safeguards for consumers? Please explain your answer.

Yes – through existing legal and statutory consumer protections as well as the increased emphasis on consumers as part of the new standards.

15. Will your preferred option/s decrease the regulatory burden on aged care organisations? Please explain your answer.

The application of Option 2 within a single framework risks introducing an increased burden for providers currently assessed through the Common Community Care Standards. The burden of evidence for those elements of the single quality standards applying to services within the home care and home support environments should have regard for the current level of documentation and not lead to undue increase in red tape. Additionally, like has been discussed within the residential care sector, through such initiatives as the SA Hub, high performing home care providers should also be considered for alternative assessment approaches when demonstrating consistently high performance.

Other comments

16. Do you have any other comments or specific suggestions about the matters discussed in the Options Paper?

The assessment of performance should align with how performance is assessed across other government standards (NDIS).

The Alliance understands that consideration of a marketplace for performance assessment will occur after the standards and assessment options are finalised and will provide further comment on this at that point.

Both options 1 and 2 as outlined will impose an additional administrative and cost burden on NATSIFACP providers, some of whom operate outside the aged care sector and who may have very limited understanding of the proposed changes to the standards.

Note that under the previous NATSIFACP standards, providers were required to demonstrate that they met 2 standards and 9 outcomes whereas under the new single Aged Care Quality Standards, NATSIFACP will be required to demonstrate that they meet up to 8 standards and many more 'requirements'. This is a significant additional workload for staff who may be working in small, stand-alone organisations, without access to the quality expertise and resources of aged care providers.

If NATSIFACP providers are required to demonstrate performance to the same level of accountability as for residential aged care (particularly NATSIFACP residential support services) then it would be reasonable to expect that some NATSIFACP providers may decide that their services are no longer viable, or that the organisational risk is too high to continue to deliver NATSIFACP services, which could impact particularly adversely in regional and remote areas where few other aged care services operate.

NATSIFACP providers (particularly those delivering stand-alone NATSIFACP or NATSIFACP plus CHSP services) will require additional funding and access to training/support to meet the new standards. The implementation of the new standards potentially imposes a much greater change on NATSIFACP services than it does on other services that have previously undergone HACC, home care package or residential aged care quality reviews. It is critical that NATSIFACP organisations are supported to prepare for the implementation of the new standards and that future quality assessment processes are conducted in a manner that takes into account the cultural safety and specific cultural needs of Aboriginal and Torres Strait Islander clients and staff.

NACA

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals.