

School of Public Health

**Accreditation of Residential Aged Care Facilities: Experiences of
Service Providers**

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

Signature:

Date:

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Abstract

The need to address the issue of quality in aged care service provision in Australia has received increasing emphasis in recent decades. Particularly since the 1980s, the federal government has played a key role in ensuring that this is the case through the implementation of various reforms and regulatory strategies. In 1998, the national standards monitoring system which had been in place since the mid 1980s was replaced with a new system based on an accreditation model. In contrast to the former system which was wholly controlled by government and involved one-off inspections by government standards monitors, responsibility for managing the new system has been devolved to an independent body, the Aged Care Standards and Accreditation Agency. One of the Agency's primary functions is to assess compliance with the accreditation standards.

A key component of the new system is its emphasis on continuous improvement which has been incorporated into the accreditation standards. As a consequence, the new system requires a much greater level of involvement and commitment by providers than previously. In order to continue receiving government funding all facilities had to be accredited by January 1st 2001.

This study represents an evaluation of the accreditation system based on the views and experiences of service providers in Western Australia. It explored a number of issues relating to the basic philosophy and principles underlying the new system, the implementation process, the accreditation standards that are used as a basis for assessing service quality and the overall impact of the system on providers. It also sought providers' views about the strengths and limitations of the system and any areas in need of change or improvement.

A descriptive design, using in-depth interviews as the method of data collection, was adopted for the study. Participants from three levels of service provision, namely, facilities, organisations and peak bodies were selected on a stratified purposive basis. A total of 45 informants were interviewed.

The findings indicated that, overall, as a regulatory approach the accreditation system was generally supported by providers and was regarded as having a number of positive features, particularly in comparison to the previous system. At the same time a number of concerns were identified. These related in particular to the assessment process, specifically the lack of consistency amongst assessors and the self assessment tool, and to the extent of information and guidance provided by the Agency. Concerns regarding the latter's role in relation to, and extent of independence from, the federal government were also identified.

The study also found that the introduction of the system had impacted on providers in a variety of ways, both positive and negative, but particularly in terms of the demands on staff and financial resources. A number of 'broader' level factors, such as funding, nursing shortages and other often competing demands (e.g. assessing residents according to the Resident Classification Scale) were also felt to be impacting on providers' capacity to meet the requirements of the system. These concerns, along with concerns about the way in which the system would develop in the future, appear to have created a degree of uncertainty and in some cases apprehension amongst many providers.

Although this study has focused on the experiences of Western Australian service providers, evidence from other reviews of the accreditation system where providers' views have been sought has indicated a widespread similarity in perceptions. This suggests, therefore, that there is a need for further review and refinement of certain aspects of the system as it moves into the second round.

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List of Abbreviations

ACS	Aged and Community Services
AIHW	Australian Institute of Health and Welfare
ANHECA	Australian Nursing Home and Extended Care Association
CEO	Chief Executive Officer
CI	Continuous Improvement
CQI	Continuous Quality Improvement
CMS	Centers for Medicare and Medicaid Services
DON	Director of Nursing
EQUIP	Electronic Quality Information for Patients
EN	Enrolled Nurse
ISO	International Organisation for Standardisation
JCAHO	Joint Commission for the Accreditation of Healthcare Organisations
MQAS	Management and Quality Assurance System
NCSC	National Care Standards Commission
OBRA	Omnibus Budget Reconciliation Act
OSH	Occupation Health and Safety
PCAI	Personal Care Assessment Inventory
QA	Quality Assurance
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
RN	Registered Nurse
TQM	Total Quality Management
U.K.	United Kingdom.
U.S.	United States
W.A.	Western Australia

Chapter 1: Introduction

1.1 Background to the Study

Since the implementation of the Aged Care Reform Strategy in Australia (1986-96) there has been increasing emphasis placed on the issue of quality in aged care service provision. A key development in this regard was the introduction of outcome standards for nursing homes (1987) and hostels (1990). These standards formed the basis of a government regulated quality assurance system that involved the external monitoring and assessment of residential aged care homes by federal government standards monitoring teams (Commonwealth Department of Health Housing and Community Services 1991; Gibson 1998).

With the passing of the Aged Care Act in 1997 and the implementation of a residential aged care structural reform package, the standards were revised and incorporated into a new system for regulating quality which requires that services are accredited in order to receive ongoing Commonwealth funding. This involves meeting a number of requirements relating to resident care as encompassed in the accreditation standards, the built environment as identified in the building certification standards, resident rights, equity and access, and prudential arrangements. Accreditation, or the formal recognition that a service meets an authorised standard or service criteria, is regarded as particularly appropriate to the residential aged care sector given that there is such a wide range of facilities available and the fact that, unlike hotel or other service industries, the industry has no recognised ratings system (Denham 1997).

The introduction of the new approach has involved the establishment of the Aged Care Standards and Accreditation Agency (the Agency), a body which operates independently of the federal government and is responsible for managing the overall process. The establishment of the Agency represents a major philosophical shift in terms of how the provision and maintenance of high quality residential aged care can be achieved. Rather than involving an externally imposed, government regulated approach in which government inspectors assess facilities on the basis of 'one-off'

visits, the new system emphasises industry involvement, cooperation and flexibility (Commonwealth Department of Health and Aged Care 1999b; Commonwealth Department of Health and Family Services 1998; 'Accreditation by 2001: the journey begins' 1998).

A further significant feature of the approach is the incorporation of continuous improvement into the standards. This is intended to help address some of the limitations of the previous system such as its tendency to focus on the achievement of minimum standards rather than on care or innovation and its often rigid and adversarial nature (Commonwealth Department of Health and Aged Care 1999b).

Since its inception in 1998 the accreditation system has attracted considerable attention from a variety of circles, both within and outside the industry. Although it has been acknowledged that certain aspects of it require improvement, many critics are of the view that it has already achieved a number of positive outcomes. In his review of the Aged Care Reforms Gray (2001) identified these as including the fact that all residential aged care facilities have been reviewed within a relatively short time frame, that it has been able to identify homes where the standard of care is inadequate (and that this information has been made publicly available) and that the imposition of sanctions has provided the basis for an improvement in care. Importantly, he also noted that it has provided some '*market signals for choice*' through mechanisms such as the ratings system and the accreditation periods granted (op cit. p.93).

Other analysts, however, have not been so positive. While approving of features such as the incorporation of continuous improvement, Braithwaite (2001, p.445) suggested that there was a lack of enforcement during the first round (completed in January 2001), a lack of spot checks and a tendency towards an '*audit mentality*' that has done little to foster quality improvement. Others, including academics from outside Australia, have been even more critical. For example, Kerrison and Pollock (2001, p.2) have argued that in succumbing to industry pressure the government has replaced a system based on '*legally enforceable sanctions*' with a less effective accreditation-based regulatory approach that has had '*disastrous consequences*', although they do not provide specific details of the latter.

The new system has also attracted widespread media attention, including in Western Australia (W.A). Much of this publicity has focused on reports of inadequate standards of care in different facilities visited by the Agency, for example:

Nursing homes censured: Agency finds staff are not managing residents' medication properly. (Mallabone & Butler 2001, p.7)

Strangulation perils at aged care home: watchdog. (Watts 2002, p.6)

Who cared? Health alert marks down Perth nursing home on eight vital points. (Mallabone 2000, p.1)

Aged shame: Perth nursing homes a disgrace: watchdog. (Heinzman 2002, p.1)

Nursing home in spotlight after report of maggots. (Claremont-Nedlands Post, 9 September 2002, p.5).

Quinn (2000, p.15) suggested that the negative media exposure resulting from the introduction of the accreditation system, in particular the publicity surrounding the closure of one facility (Riverside Nursing Home) during the first round, has come at 'significant cost ...to the reputation of the industry' and has 'severely damaged' its morale and credibility.

1.2 Rationale for the Study

As stated, the accreditation system represents a major shift in approach to the regulation of quality in residential care in a number of important ways. The way in which it has been implemented and managed since its introduction is, therefore, not only critical to its acceptance by the aged care industry but also to its ultimate effectiveness.

Although ensuring the welfare of residents is the primary focus of the system, service providers are the stakeholder group most immediately and directly affected by it.

This is particularly because the new system requires a greater level of service provider commitment and involvement than its predecessor. More specifically it requires that service providers understand and embrace the principles that underpin it and that they have in place the infrastructure and systems needed to support quality service provision and care. The system's effective implementation and operation is also dependent, to a large degree, on service providers' perceptions of the system as one that is managed appropriately and efficiently, where quality is assessed in a fair, thorough and professional manner, and which ultimately results in improved quality of care and quality of life for residents.

Quite clearly, a detailed review of the system that focuses on the views and experiences of service providers would provide a means of determining whether or not this is the case. It would also allow for a fuller understanding of the system in terms of the way in which it functions, including those aspects of it that appear to be working well and those that may require further review and/or refinement.

1.3 Study Objectives

The overall aim of this study was to explore, in-depth, the views and experiences of service providers in W.A. of the national accreditation system for residential aged care facilities. The findings provide a basis for evaluating the appropriateness of the system as a new approach to regulating quality, the nature of its impact on providers and whether any changes or improvements are required.

Specific objectives were to:

- assess the extent of support for the new system in terms of its basic philosophy and principles.
- describe the way/s in which the system has been implemented and any associated issues or concerns.
- assess the extent to which the accreditation standards and related requirements, as set out in the Standards and Guidelines for Residential Aged Care Services, are perceived as appropriate to the achievement and maintenance of quality.

- assess the impact of accreditation on service providers and other key stakeholders.
- identify the strengths and weaknesses of the new accreditation system and, in particular, any areas for change or improvement.

The study focused primarily on providers' experiences of the first three year cycle (round) of the system which was completed in January 2001.

1.4 Significance of the Study

At the time this study was conceived no formal evaluations of the system had been conducted although Gray's (2001) Two Year Review of the Aged Care Reforms did devote some attention to it. A national evaluation coordinated by the Department of Health and Ageing (Commonwealth Department of Health and Ageing 2002b), commonly referred to as the Lessons Learned review, commenced some time after. Although both of these reviews sought input from service providers, this was not their sole focus. A number of State-based industry peak bodies are reported to have conducted their own 'in-house' surveys of members, however, with one exception (Aged Services Association of NSW and ACT 2001) the results have not been formally published.

As indicated, therefore, this study provides a means of obtaining some valuable insights into the way in which the accreditation system has been implemented from the perspective of service providers, and about its overall impact on the industry. This information will not only enhance knowledge and understanding of the new system but will also help to inform decision making about various aspects of the programme that may require attention. It should be of particular interest and relevance to the Agency (particularly the local Agency), the Commonwealth Department of Health and Ageing and to service providers, at all levels. In addition, given that the ultimate aim of all evaluations of human services or programmes is to contribute to *'the provision of quality services to people in need'* (Posavac & Carey 1997, p.13), the study has relevance to residents and their families as well as to potential residents.

This research was also regarded as particularly timely in the light of the widespread, and mainly adverse, media attention that the system was attracting at the time.

1.5 Definition of Terms

A number of different terms are used in this thesis. They have been defined as follows:

Accommodation bond: an amount of money paid by a resident on entry to a low care facility as a contribution towards the cost of their accommodation. The amount is dependent on the prospective residents' assets and can be paid as a lump sum, via periodic payments or a combination of both. When paid it must leave the resident with assets of at least 2.5 times the annual single pension rate. An agreed proportion of this bond can be retained by the service provider each year, up to a certain amount, for a maximum of five years. The residual is refunded to the residents' estate or resident on discharge. The bond (and any interest gained from it) is mainly used by providers for capital replacements.

Assessor: see *Quality Assessor*

Auditor: see *Quality Assessor*

Best practice: 'any practice, knowledge, know-how or experience that has proved to be valuable or effective within one organisation and that may have applicability to other organisations' (O'Dell & Grayson 1997, p.86).

Board of Management: a group of people with governance responsibility for an aged care provider.

Care Manager: see *Supervisor*

Carer: A personal carer – i.e. a staff member who provides personal care (e.g. help with dressing, showering, eating, etc) to a resident of an aged care facility under the supervision of a nursing member of staff. Personal carers are generally preferred to

have undergone formal training (to certificate level) as carers, however, in practice this is often not the case.

Certification: the process of evaluating residential aged care facilities to determine whether they meet specified building standards using a building inspection instrument. Inspections are conducted by qualified building surveyors. Facilities meeting the standards are then certified.

Concessional and assisted residents: residents who, for various reasons, can only afford to pay a small accommodation bond or charge. Providers receive an additional funding supplement for such residents.

Direct care staff: staff working within a residential aged care facility who are responsible for providing hands on care. Includes registered nurses, enrolled nurses and carers. Facility managers (e.g. DONs) are also often involved in providing direct care.

Director of Nursing: the head nurse of a high care facility who also has a general management function within the facility. Must be a registered nurse

Enrolled nurse: a nurse who is registered by the State (or Territory) Nurses' Board or Council to practise in that State/Territory. Must have at least a one year diploma in nursing from a tertiary education institution or equivalent from a recognised hospital based programme. Generally holds less responsibility than a Registered Nurse (RN).

Facility: see *Residential Aged Care Facility*

Facility manager: a person responsible for managing a residential aged care facility. Includes Directors of Nursing (high care) and care managers/supervisors (low care).

High care facility: a residential aged care home that provides services and care, including nursing care, for highly dependent residents. Registered nursing care is available on a 24 hour basis. Formerly known as 'nursing homes'.

Hostel: see Low Care Facility

Long Term Care: see Residential Aged Care

Low care facility: a residential aged care home that provides services and care for residents with low dependency needs. In practice this involves the provision of basic personal care services, however, staff are also available on an on-call basis at night. Supervision is provided by nursing staff. With the emergence of ageing in place, low care facilities are now expected to provide the full continuum of care if possible and/or appropriate. Low care facilities were formerly known as 'hostels'.

Priority Action Workplan: a worksheet provided in the accreditation application kit that enables facilities to record, in order of priority, identified continuous improvement tasks.

Quality assessor: a person registered to perform accreditation audits of residential aged care facilities. They may be employed or contracted by the Aged Care Standards and Accreditation Agency.

Quality Auditor: see Quality Assessor

Registered nurse: a nurse who is registered in Division One with the Nurses' Board of Australia. Usually has a degree, and may have post-graduate qualifications. Has highly developed assessment skills and knowledge about multiple disease processes, is able to work independently and has an overall coordinating responsibility for a resident's care. Coordinates input from other staff and also has a supervisory role in relation to junior staff.

Residential aged care: care provided within a residential establishment for older people who, for reasons such as physical frailty, health problems or cognitive impairment, are unable to remain living in the community. Includes the provision of 'hotel' services (meals, laundry, cleaning) as well as personal (e.g. dressing, getting around) and medical (nursing, therapy) care depending on whether low or high level

care is provided. Entry to care is conditional on approval by an Aged Care Assessment Team.

Residential aged care facility: an establishment that provides residential aged care. Often classified as 'high' or 'low' care (see above) although with the emergence of the ageing in place philosophy this distinction has become somewhat blurred.

Resident Classification Scale: a casemix tool that is used to assess funding for a residential aged care facility and which is based on resident acuity rather than type of facility (high or low care). It is based on eight different levels of resident dependency, with Level 1 being the highest level through to Level 8 which is the lowest. It comprises 22 questions each of which involves an assessment by the facility of the required nursing/personal care support (according to four levels) related to a particular dimension (e.g. personal hygiene). Weightings allocated to each level for each dimension are summed and a resident's RCS category (1-8) is determined based on the total score. The appropriate level of funding for each resident is then identified based on the RCS category. Samples of claims are audited by the Department of Health and Ageing.

Senior care manager: a person working at the organisational (rather than facility) level who is responsible for managing the provision of resident care in all facilities associated with that organisation, regardless of the level of care.

Senior manager: a Chief Executive Officer, General Manager, Administrator or similar who is responsible for the overall management of an organisation including its residential aged care facilities and other services and programmes.

Supervisor: manager of a low care facility.

1.6 Organisation of Thesis

This thesis comprises seven chapters. The first chapter provides an introduction to the study including relevant background details and a rationale for its implementation.

Chapters Two and Three provide a review of relevant literature. Chapter Two focuses on issues relating to the management and assessment of quality. It includes an overview of three key approaches to quality with a particular focus on inspection-based and continuous improvement-based approaches. External mechanisms for assessing quality, including accreditation and government regulatory mechanisms, are also discussed. A brief description of long term care regulatory systems in the United Kingdom and United States is included.

Chapter Three provides an overview of quality regulation within residential aged care in Australia and includes a description of the standards monitoring system that was in place prior to 1998. The accreditation system is then described in detail along with a summary of its key features and ways in which it differs from the previous system. In addition, a rationale for the development of the study objectives based on information presented in the literature review is provided.

Chapter Four describes the overall method used for this study. It outlines the evaluation framework adopted and study design, including the target group for the research and sampling and recruitment approach. The methods of data collection and analysis are described in detail. In addition, the chapter discusses issues pertaining to the overall rigour of the study and key ethical considerations.

Chapter Five presents the results. The first section describes the final study sample in terms of numbers and characteristics. This is followed by the key findings which are structured in accordance with the study objectives. A further section presents the main themes that emerged from these findings.

Chapter Six discusses the results in terms of issues raised in the literature, also taking into account the findings of other reviews of and/or commentaries on the system. The discussion focuses on four main issues, namely: evaluation-related issues; continuous improvement; regulatory models; and the relevance of a broader, systemic perspective.

Chapter 2: The Management and Evaluation of Quality

The need to address the issue of quality in human services delivery and care, including aged care, has been increasingly recognised in recent decades. In part, this trend can be attributed to the increasing complexity of care provision, concerns on the part of both service providers and governments about the need to contain spiralling costs, and the increasing expectations of consumers (Bartlett 1993; Fletcher 2000; Harvey 1996). As a consequence, a variety of approaches for managing quality have been developed. These include approaches developed by organisations themselves as a vehicle for self-development and/or for external accountability purposes, and those developed by external bodies, including governments, for example as part of a regulatory system.

The aim of this literature review is to provide a context for the present study in regard to the management of quality and some of the specific issues involved. The first part, presented in this chapter, discusses quality from a theoretical perspective and includes consideration of some of the issues surrounding its interpretation and assessment along with an overview of major approaches to its management. Specific external mechanisms by which quality can be evaluated, including accreditation approaches and the role of government in these processes, are also discussed. The following chapter focuses on the management and regulation of quality within residential aged care in Australia and includes a detailed description and analysis of the accreditation system. It concludes with a brief summary of key features of the system based on issues identified in the literature along with a rationale for the development of the study objectives.

2.1 The Meaning of Quality

Most writers acknowledge the complexities involved in defining what is actually meant by the term 'quality' and it appears that its definition is largely dependent on the purposes for, and context within which, it is to be used. Øvretveit (1998, p.235) noted that although simple definitions such as *'the ability of a service to satisfy customers'* may be useful for communicating an idea to employees as part of the development of an organisation's quality programme, they are of limited use in

regard to the assessment of service quality for purposes such as accountability. It is beyond the scope of this review to discuss the complexities surrounding the meaning and definition of quality in detail. However, a number of interrelated issues are relevant in terms of their implications for the nature of quality programmes and, in particular, for the ways in which service quality is evaluated.

2.1.1 Context

Some writers are of the view that quality can only really be understood, and hence defined, in relation to the context to which it applies (e.g. Brenner 1985; Kinney, Freedman & Loveland Cook 1994). Thus the meaning of quality in an acute care hospital setting is likely to differ from that in a long-term care context. Moreover, Kinney, Freedman and Loveland Cook (1994) argued that even within long-term care settings, definitions and measures can differ depending on whether care is provided in an institutional or community based setting. They suggested, for example, that in a community setting issues such as caregiver burden should be taken into account whereas this would not be relevant in residential care.

In addition, in contexts such as health care quality is generally understood and defined in terms of services and care. In long-term care settings, however, it has been argued that it is important to differentiate between 'quality of care' and 'quality of life' and, furthermore, that both need to be taken into account, particularly for evaluation purposes (Ammentorp, Gossett & Euchner Poe 1991; Bartlett 1993; Boldy & Grenade 2000).

Defining quality of life, however, appears to be equally as problematical as defining 'quality of care'. Ammentorp, Gosset and Euchner Poe (1991 p.145) have suggested that quality of life is '*a "warm fuzzy" that makes us feel good when we talk about it*' but that '*it is also a "fuzzy" that makes us nervous when we are held accountable for delivering it to our clients*'. They suggest that this is largely due to the fact that it cannot be measured directly and, moreover, that many clients cannot articulate whether or not their lives are 'quality' lives. Bartlett (1993) observed that quality of life has been defined in terms of environmental characteristics as well as in terms of an individual's subjective response to those characteristics whereas definitions of

quality of care tend to focus on the comparative effects of different institutions or settings on residents' objective status.

2.1.2 Quality from whose perspective?

A second issue highlighting some of the difficulties involved in understanding what is meant by the term 'quality', particularly when it comes to developing approaches for evaluating service quality, is that a number of different stakeholders are generally involved. These include policy makers, funders, service providers, clinicians and consumers, each of whom will have a different interest or perspective (Bartlett 1993; Fletcher 2000; Øvretveit 1998; Zabada, Rivers & Munchus 1998). Although some writers (e.g. Senge 1990; Zabada, Rivers & Munchus 1998) have suggested that ultimately quality is best defined from a consumer perspective, others (e.g. Kaluzny, McLaughlin & Kibbe 1995; Øvretveit 1998) are of the view that, particularly for external evaluation purposes, a broader view that encompasses other stakeholder perspectives needs to be adopted. Øvretveit (1998) suggested that 'quality' is a political term whose definition will vary depending on the interests of the different professional groups concerned.

2.1.3 Multiple dimensions

To some extent implied in the above is the fact that quality is a multidimensional concept, with its various dimensions and components varying according to the particular context and perspectives involved (Bartlett 1993; Fletcher 2000; Kinney, Freedman & Loveland Cook 1994). These dimensions can assist in developing definitions of quality as well as deriving specific criteria for its measurement and evaluation (Øvretveit 1998).

Health service quality is often described in terms of dimensions such as effectiveness, appropriateness, efficiency, access and equity (e.g. Fletcher 2000; Maxwell 1984; New South Wales Health 1999). Other dimensions that have been identified include safety and consumer participation (New South Wales Health 1999), performance and outcomes (Fletcher 2000) and social acceptability (Maxwell 1984).

Increasingly in conceptualisations of service quality there is an attempt to incorporate dimensions that are defined by the consumer. As a consequence, there have been a number of studies conducted in order to identify the meaning of quality from the consumer perspective, several of which have focused on residential aged care (e.g. Bartlett 1993; Boldy & Denton 1995; Bowers, Fibich & Jacobson 2001; Spalding & Frank 1985). However, as Bowers, Fibich and Jacobson (2001) noted, how these dimensions can best be incorporated and assessed remains a subject of considerable debate.

2.1.4 'Static' and 'dynamic' conceptualisations

Zabada, Rivers and Munchus (1998) have pointed out that quality is often conceptualised in terms of certain 'requirements' that must be met or conformed with. These requirements thus represent or incorporate what are regarded as the essential components or dimensions of quality. Such conceptualisations reflect a fairly 'static' view of quality and contrast with those which regard quality as an ongoing process and are hence more 'dynamic' in nature. As will become evident, these different views have had a major influence on the types of approaches for evaluating quality that have been developed.

2.1.5 Quality as structure–process–outcome

One of the most well known and utilised conceptualisations of quality was formulated by Donabedian (1966; 1980). In this model, which was originally developed in relation to health care, he proposed that quality can be understood and evaluated in terms of three basic interrelated components or dimensions, namely, structure, process and outcome.

Structure refers to the organisational setting in which the service or care takes place. It includes things like physical structure, staffing levels and qualifications, financing and administration. The structural dimension thus focuses on the underlying capacity of a service or organisation to deliver quality care in terms of the inputs available to it. The assumption here is that good quality is more likely to follow if the setting is

satisfactory (Bartlett 1993; Braithwaite et al. 1993; Donabedian 1980; Kinney, Freedman & Loveland Cook 1994).

The *process* dimension refers to the actual delivery of care, both in terms of the technical competence of those directly providing the care and aspects of the patient-provider relationship, and the broader level practices within an organisation that impact on the way care is provided (Bartlett 1993; Braithwaite et al. 1993). Within a long-term care setting process may include things like resident repositioning practices, accounting procedures in place for the management of resident finances and continuity of care (Braithwaite et al. 1993). The importance of the process dimension is based on the assumption that competent professional and organisational performance and practices are more likely to produce care that is beneficial to the patient or resident (Bartlett 1993; Donabedian 1980).

The third component or dimension Donabedian called the *outcome* dimension. As the term implies, this dimension focuses on the end results of care. It was defined by Donabedian (1980, pp.82-3) in terms of the changes in a '*patient's current and future health status that can be attributed to antecedent health care*'. Le Sage and Young Barhyte (1989) suggested that outcomes should also focus on consumers' satisfaction with the care they receive. This idea is also implied in Hegyvary's (1991) categorisation of outcomes which, apart from clinical, functional and financial outcomes, also includes a 'perceptual' outcome.

A number of variations and/or expanded versions of the Donabedian model have been proposed. De Geyndt (1970) proposed a five part model comprising process, structure, outcome as well as 'content' and 'impact'. 'Content' refers to practice related issues such as the appropriate and/or adequate use of procedures or drugs. 'Impact' focuses on the effects of care on the general community, thus providing an indication of issues such as access and outreach.

Similarly, Øvretveit (1998) has developed a model that incorporates Donabedian's three dimensions (although he prefers to use the term 'inputs' rather than 'structure') as well as the major stakeholder groups involved, namely, patients, professionals and managers. He claims that this model provides a better basis not only for developing a

more comprehensive definition of quality, but also for identifying the specific measures or criteria that can be used for evaluation purposes. According to this model, patient quality relates to whether a service gives patients what they want. Professional quality relates to professionals' views of whether a service meets patient's needs and whether staff correctly select and carry out procedures believed to be necessary to meet patients' needs. Management quality focuses on the most efficient and productive use of resources to meet client needs within limits and directives set by higher authorities.

2.2 Evaluating Quality

Quality evaluations can be conducted on a variety of different bases and take a variety of forms. They can also differ in terms of focus. Thus, in some cases, an evaluation may focus on specific aspects of a service or services provided by a particular professional group within an organisation; in others it may be the capacity of the organisation as a whole to provide a quality service. Nevertheless, as Øvretveit (1998 p.9) observed, the evaluation process itself is similar to that of any type of evaluation in that it involves making some kind of *'comparative assessment of the value of the evaluated...using systematically collected and analysed data, in order to decide how to act'*.

Øvretveit (1998) has suggested that there are four factors that are particularly critical in determining the nature of, and approach to, a quality evaluation. These are:

- the 'users' of the evaluation: that is, those for whom the evaluation is to be conducted (e.g. practitioners themselves, service managers, funders, government, or a combination of these);
- whether or not clearly defined evaluation criteria exist, and the nature of these criteria;
- whether or not the evaluation is to be conducted on a 'one-off' or routine basis; and
- whether the evaluation is conducted internally, for example by the same people who provide or manage a service, by a quasi- external evaluator (e.g. a special unit within an organisation) or externally, for example by an independent organisation such as an auditing or accrediting body.

2.2.1 Evaluation criteria

One of the most central issues in evaluating service quality relates to the choice of the criteria to be used for making a judgment about it (Le Sage & Young Barhyte 1989; Øvretveit 1998; Pawsey 1990). In some cases, these criteria may be the quality objectives developed by a service or organisation itself, in others they may be existing performance or outcome standards developed by a professional body or government department. as Øvretveit (1998) suggested that, ultimately, this choice will largely depend on the perspective of quality adopted and the type of evaluation to be conducted. In all cases, however, it must be possible to measure these criteria in some way and to identify relevant data sources. These criteria also need to be relevant, important, reliable (including over time), stringent and efficient in identifying both 'poor' and 'good' quality (Bartlett 1993; Le Sage & Young Barhyte 1989; Pawsey 1990).

The use of standards as evaluation criteria

Many quality evaluations, particularly those conducted by an external agency or body, use standards as the criteria by which the quality of a service can be assessed. A standard has been described as '*an agreed upon or desired level of performance*' that is relevant to a particular target group or population (*Health Services Quality Development Guide* 1998; Le Sage & Young Barhyte 1989).

However, as with any quality evaluation criteria, standards can vary widely in terms of their source and nature. For example, they may have been developed by an external body (e.g. government department, professional association) and be based on established clinical guidelines, research findings or 'expert' opinion. Alternately, they may have been developed internally by managers or practitioners to reflect more specific goals for service provision and care (Bartlett 1993; Denham 1997; Le Sage & Young Barhyte 1989). Often they are developed using the Donabedian structure-process-outcome paradigm as a basis (Kroeber 1991; Pawsey 1990).

For measurement purposes, more specific criteria (or 'indicators') relating to the different standards also need to be developed. In some cases there may be several criteria associated with a particular standard; in others there may be only one. Achievement of the standard is assessed by the degree of compliance with its

associated criteria when compared with an aspect of actual service or care (Pawsey 1990).

Given that they form the basis for making a judgment about the quality of a service, there are a number of considerations that need to be taken into account in the development of standards. One is that they provide a valid and reliable basis for assessment. Another is that they are attainable and acceptable to those who are using them (Bushy & Roloff 1988; Wilson 1987). In regard to the latter, it has been suggested that performance standards that are too high can result in those whose performance or service is being assessed blaming sub-standard performance on others or other entities (e.g. services). This can be a particular problem in situations where practitioners or service providers have had little or no involvement in developing the standards in the first place (*Health Services Quality Development Guide* 1998). However, it has also been observed that even in cases where standards have been developed in consultation with, for example, relevant professional organisations, their achievement may still be limited by factors beyond the control of management and staff (ibid).

Other important considerations relating to the development of standards include ensuring that they are related and that they are clearly specified in a way that is descriptive, unambiguous and objective (Le Sage & Young Barhyte 1989; Øvretveit 1998). In regard to their application, additional concerns include deciding whether different weights or values should be given to individual criteria or whether all criteria should have equal value. A further issue is deciding on an acceptable degree of compliance with the standard, although a common practice is to adopt a simple approach based on whether a standard is met or not met. Le Sage and Young Barhyte (1989) suggested that a simple four category system based on four possible responses or ratings: 'yes' (i.e. met), 'no' (i.e. not met) as well as 'not applicable' and 'information not available', is suitable for most purposes.

Structure-process-outcome focus

As indicated earlier many evaluations of service quality, including in residential aged care, have used criteria, often in the form of standards, that are based on the Donabedian structure, process and outcome paradigm. In countries such as the

United States (U.S.) and Australia most quality evaluations conducted within residential aged care prior to the early to mid 1980s focused on the structural and/or process aspects of care, but particularly the former (Ammentorp, Gossett & Euchner Poe 1991; Bartlett 1993; Braithwaite et al. 1993; Kane & Kane 1987). Bartlett (1993) stated, however, that although the majority of structural measures of quality are intended to assess a facility's capacity to provide quality care, they give little or no indication as to whether that capacity is actually used nor do they give any indication of outcomes for the consumer. In addition, and as will be discussed later, the assumption on which such approaches are based, specifically that if such criteria are satisfied, quality will follow, has proven a spurious one in the wake of scandals about nursing home care quality in both the U.S. and Australia during the 1970s and 1980s.

Process focused approaches are also associated with a number of potential problems. These include the reliability of the assessment process, the reliance on records, whose standards may vary widely, as indicators of performance, problems arising from applying lists of criteria from different sources (e.g. stakeholder organisations) and statistical problems in the translation and reporting of results (Bartlett 1993). Because they tend to focus on the technical rather than interpersonal aspects of care they also, like structure focused approaches, often exclude consumers (ibid).

Limitations of evaluation approaches based on structure and/or process criteria, along with problems relating to the often abstract and subjective nature of the dimensions involved has, since the 1980s, led to a move towards more outcomes focused evaluations (Bartlett 1993; Binstock & Spencer 1997). Many writers, including Donabedian (1980), are of the view that outcomes are the ultimate validators of the effectiveness and quality of care, although views as to the extent to which they should represent the main focus of quality evaluations vary. Although this difference of opinion may, at least in part, relate to 'philosophical' differences regarding the meaning and measurement of quality for evaluation purposes, it also appears to relate to the difficulties of identifying appropriate outcomes and associated measures. This has proved to be particularly difficult within the residential aged care context where the use of criteria such as death or disability and measures such as discharge rates, recovery or length of stay, as typically used in health service quality evaluations, are not appropriate. As discussed earlier, there is also a need to take into account

outcomes that relate to quality of life issues such as psychological and social functioning, enjoyment of the living environment, dignity and autonomy (Bartlett 1993; Binstock & Spencer 1997; Gibson et al. 1992). However, the development of appropriate measures for these is equally, if not more, difficult.

Binstock and Spector (1997) have suggested that outcomes focused approaches to evaluating quality also pose particular problems within the aged care context. This is because of the difficulty of obtaining a perspective on the part of care recipients themselves, for example if they are cognitively impaired, and the often blurring of the consumer/provider distinction given that family members are often involved in managing, monitoring and providing care.

A further problem associated with outcomes focused approaches relates to the possibility of intervening variables influencing the outcomes which thus makes interpretation difficult. This can be a particular problem in situations where longer periods of observation are involved (Bartlett 1993, Le Sage & Young Barhyte 1989). Le Sage and Young Barhyte (1989) suggested that this has been one of the main reasons why, for many years, approaches to evaluating quality in the United States tended to use structure and process criteria. Longer-term observations can also be expensive and run the risk of subject attrition (Bartlett 1993). According to the latter author, inconsistency in interpretation is a further problem often associated with solely outcomes focused approaches.

Because of such problems, deciding what constitutes the most appropriate basis for assessing service quality remains a subject of much debate. As will be seen later, scholars such as Braithwaite et al. (1993) have argued that, within the residential care context at least, a solely outcomes focused approach should be adopted. The view of Kane and Kane (1988), however, is that if a totally outcomes focused approach is adopted there is no basis for identifying how quality can be improved.

Obviously, therefore, a critical issue in determining the type of evaluation focus that should be adopted revolves at least in part around assumptions regarding the nature of the relationship between the three elements of the Donabedian framework and their relative importance. Understanding these relationships has proven difficult,

however, with evidence being generally inconclusive (Bartlett, 1993; Braithwaite et al., 1993; Øvretveit, 1998). Thus although each component may be important, it cannot be assumed that high quality in one component (e.g. structure) will guarantee high quality in another (e.g. outcomes). Perhaps because of this, many writers (e.g. Fletcher 2000; Renwick & Harvey 1990; Wyszewianski 1988) are of the view that all three must be taken into consideration. Fletcher (2000) argued that incorporating all three also implies a more systemic focus.

2.2.2 Evaluation approaches

In his discussion of quality evaluations, Øvretveit (1998) suggested that a number of different approaches (or evaluation ‘designs’) can be used depending on the nature and purpose of the evaluation. These approaches can range from simple descriptions of a programme and its background to rigorously controlled experimental designs that examine the links between different components.

One of the most popular evaluation approaches, and one that is used by organisations for their own internal quality evaluation purposes as well by external agencies (e.g. government departments or regulatory bodies), is based on an audit model. Quality audits can be carried out in relation to specific activities within a service or profession, as in a clinical or medical audit, as a means of evaluating the quality of a service or programme as a whole, or as a means of assessing the capacity of an organisation to consistently provide a quality service (Øvretveit 1998; Pawsey 1990). Øvretveit (1998) pointed out that the latter type of audit, referred to as an ‘organisational audit’, can also be used for accreditation purposes. Regardless of the type of audit, however, the evaluation process itself involves comparing an activity, service or programme with certain specified criteria which may be in the form of standards, procedures or objectives.

The effectiveness of a quality audit is dependent on a number of factors, many of which are common to most types of evaluation. These include the validity and reliability of the criteria that are used as a basis for assessing quality (Øvretveit 1998) and the ease with which the activity or aspect of service of interest can be examined and relevant data collected (Pawsey 1990). In the view of Øvretveit (1998), the audit

approach can serve as a useful basis for identifying and understanding the particular strengths and/or problem areas within a service. From a quality evaluation perspective, however, their main weakness is that there has been very little research into the link between high scores on input and process standards and high quality outcomes (ibid).

2.2.3 Internal and external quality evaluations

Quality evaluations can be conducted on an 'internal' or 'external' basis, although the way in which these two categories are differentiated in the literature sometimes varies.

For the purposes of this discussion internal evaluations are those that are conducted 'in-house', by a service or organisation itself, using criteria (e.g. procedures or standards) that it has developed or that have been determined by an outside body or agency. The evaluation can be conducted on a peer review basis, in which case practitioners within the same organisation review each other's practice, or by a special section or unit within the organisation that has been specifically established for such purposes. Internal quality evaluations tend to have a strong self improvement focus and hence are often equated with the concept of 'self-assessment'. However, the latter term is sometimes used in a broader sense to include assessment by an external peer review group (e.g. *Health Services Quality Development Guide* 1998).

'External' quality evaluations, on the other hand, involve assessment by an 'outside' agency or body and include evaluations by an independent accrediting or auditing agency, a university research centre or government department. Øvretveit (1998) suggested that perceptions of the main purpose of external quality evaluations vary widely but often tend to centre around two main viewpoints. The first is that they should act in the interests of the service consumer and/or taxpayer, performing an 'inspection' or 'watchdog' function. According to this view, therefore, the aim of the evaluation is to ensure that aspects of quality that consumers cannot readily assess can be identified and assessed. The assumption here is that this will create extra pressure on the provider to improve. The second view is that quality evaluations

should perform a developmental function, serving as a means of giving service providers data and ideas about how to improve quality, and that this information should be kept confidential. Øvretveit added that because it tends to be easier to discover and measure poor quality than measure adequate or high quality, external quality evaluations often tend to be regarded as a negative, often punitive exercise rather than one which also focuses on the strengths of a service.

2.2.4 The evaluation process

Regardless of the type or purpose of a quality evaluation it is essential that the actual assessment process is conducted in a reliable and systematic way (Øvretveit 1998; Shaw 2000). It also needs to be a fair and balanced process. Braithwaite (1998; 2001) and Posavac and Carey (1997) emphasised the importance of evaluators recognising the good work of members of staff and providing positive feedback through the assessment process rather than focusing solely on shortcomings. Evaluations also need to be conducted in a manner that is professional and ethical (ibid).

2.2.5 Quality evaluators

In regard to the specific skills and backgrounds of quality evaluators, Posavac and Carey (1997) suggested that apart from the obvious need to possess appropriate technical expertise, they also need to have credibility in the eyes of those whose performance is being evaluated. These authors also stressed the importance of an evaluator possessing certain qualities such as objectivity, fairness, trustworthiness and a commitment to encouraging programme improvements.

2.3 Specific Approaches to Addressing Quality

Approaches for monitoring and ensuring quality of service provision that are adopted within organisations vary widely. Based on a review of quality in industry, Harvey (1996) has identified three main approaches, each of which differ in terms of their focus and the specific evaluation strategies employed. Although Harvey's discussion focused on the relevance of these three models to health care organisations, they also have applicability to other types of human services, including residential aged care.

2.3.1 The 'Traditional' approach

The first approach, which Harvey called the 'traditional' approach, is based on the belief that quality can be assumed by virtue of the highly skilled and trained professionals working within an organisation. As such, the best means of achieving quality is by investing in the appropriate selection and training of individuals entering their respective professions. Although this approach is regarded as having a number of advantages, such as its potential for fostering excellence in practice, it is very labour intensive and tends not to promote widespread sharing of knowledge and experience amongst practitioners (ibid). Such limitations, along with broader level developments relating to changes in the nature of work processes and the increasing emphasis on organisations to be accountable, have led to the development of more 'explicit' approaches. The most notable of these are those based on inspections and, more recently, continuous improvement.

2.3.2 Inspection-based approaches

'Inspection' approaches are based on the assumption that there is always one 'right' way to perform a task and that 'experts' or specialists are needed to define that 'right' way. Thus while practitioners are responsible for the work itself, other 'experts' are responsible for planning, evaluating quality and taking corrective action. Within this model, quality is generally understood as meaning '*an absence of mistakes or defects*' (Harvey, 1996, p.343) and evaluated in terms of the extent to which an activity or service meets certain specified criteria (usually in the form of standards) via some kind of 'inspection' process.

The inspection model is often closely aligned with Quality Assurance approaches (Gaucher & Coffey 1993) although, as many writers observe, interpretations and definitions of the latter, and the techniques associated with it, vary widely (Kroeber 1991; Pawsey 1990; Philp & Rockwood 1993). From an evaluation perspective the model is quite clearly based on the audit approach described earlier.

Apart from addressing some of the limitations of traditional approaches to quality, inspection-based approaches, with their emphasis on assessing whether or not an activity or service meets certain specified standards, are generally regarded as useful

for certain types or aspects of service delivery. These include those where 100% compliance is the only acceptable measure of quality, as would be the case with some aspects of clinical care, and/or where assessment by an expert is required. It has also been argued that, if well constructed, they may help to minimise sources of role conflict and role ambiguity by helping to reduce uncertainty about how certain tasks should be carried out (*Health Services Quality Development Guide* 1998). Furthermore, as with all audit-based approaches, they can serve as a valuable source of feedback to individual employees, departments or organisations about the things that are being done well as well as those that require change or improvement (Øvretveit 1998).

Nevertheless, evidence indicates that attempts to change practice and improve care through the use of inspection-based approaches have shown only limited success (Dimant 1991; Harvey 1996). This may be for a number of reasons. One, often identified as being one of the major limitations of inspection-based approaches, is that they provide little or no impetus for practitioners or organisations to actually change or improve their standards. This is unless they need to do so in order to meet the standards and/or for funding purposes. Another is the lack of practitioner involvement and sense of control and ownership of quality generally associated with these approaches which, in some cases, can promote a sense of resistance amongst employees (Harvey 1996; *Health Services Quality Development Guide* 1998). It has also been suggested that in cases where performance criteria (e.g. standards) are deficient and/or 'contaminated', inspection-based approaches may actually reinforce or help perpetuate performance or behaviours that are inappropriate (*Health Services Quality Development Guide* 1998).

2.3.3 Continuous improvement approaches

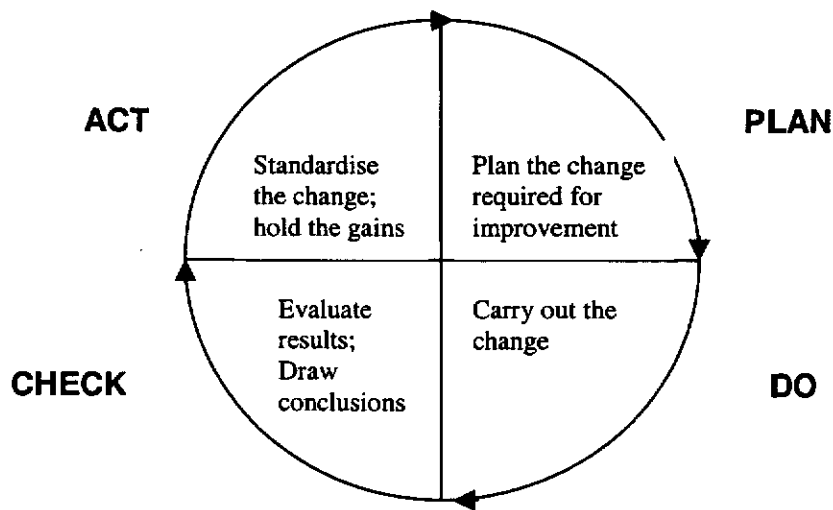
Concerns about the limitations of the inspection-based approaches, in particular their effectiveness in improving quality, along with concerns about the rising costs of inspections, prompted the emergence during the mid 1980s of another general approach to quality that is variably called Quality Management (QM), Total Quality Management (TQM), Continuous Quality Improvement (CQI) and Quality Improvement (Dimant 1991; Fletcher 2000; Gaucher & Coffey 1993; Kinney,

Freedman & Loveland Cook 1994; Zabada, Rivers & Munchus 1998). Based on the thinking of theorists such as Deming, Juran and Ishikawa, this new approach, described by Hackman and Wageman (1995) as almost akin to a 'social movement', involved building quality into organisational processes rather than inspecting for quality 'after the event'. It thus has a more systemic, preventive focus than the latter approach (Leebov & Ersoz 1991). Within this model quality is conceptualised in more 'dynamic' terms and is regarded as improvement and opportunity rather than the identification of mistakes or 'defects' (Harvey 1996; McLaughlin & Kaluzny 1990). Now widely adopted in a variety of service settings, it has also been recommended for use within residential aged care (e.g. Dimant 1991; Kinney, Freedman & Loveland Cook 1994).

Literature pertaining to continuous improvement (CI) based approaches tends to be complex and often confusing, however, with the various concepts often defined and/or linked in different ways. In some cases, TQM and CQI are assumed equivalent (e.g. Kinney, Freedman & Loveland Cook 1994; Zabada, Rivers & Munchus 1998) whereas in others they are differentiated and the integration of the two approaches referred to as 'Quality Management' (Clarke & MacDonald 2000). As for QA approaches, definitions of the same concept vary, as do the techniques associated with them.

Despite the complexities surrounding their definition and the terminology used, CI approaches tend to reflect a number of common elements or principles, many of which clearly illustrate the ways in which they differ from inspection-based approaches. One of the most central of these is the idea that the achievement of quality involves a continual process of monitoring and change. In other words, rather than quality efforts being subjected to periodic audits as in many QA approaches, organisations can never relax but should be constantly aiming to improve (Gaucher & Coffey 1993; McLaughlin & Kaluzny 1990; Weech-Maldonado, Zinn & Brannon 1999). The Plan-Do-Check-Act (PDCA) Cycle, sometimes also referred to as the Deming Cycle, is often used to illustrate this idea. A modified version of the cycle is shown in Figure 1.

Figure 1: The Plan-Do-Check-Act (PDCA) Cycle



(Source: Health Services Quality Development Guide 1998, p.36)

Also central to such approaches is their focus on the total process of care rather than on specific services, sections or individuals within an organisation. In other words, the achievement of quality is a collective rather than individual responsibility which encompasses the whole organisation and requires the commitment and participation of personnel at all levels (Leebov & Ersoz 1991; McLaughlin & Kaluzny 1990; Weech-Maldonado, Zinn & Brannon 1999). Teamwork is thus an essential part of this process (Weech-Maldonado, Zinn & Brannon 1999). It also implies the need for commitment from senior levels of management, this being in accordance with the views of the founders of the approach that quality is a management responsibility and necessitates a 'top down' implementation approach (Hackman & Wageman 1995).

A further feature of CI approaches is that rather than focusing on adhering to objectives or (external) standards as in QA approaches, they are concerned with improving internal processes. The assumption is that improving processes will generate higher quality outputs (products, services) or outcomes (Beyea & Nicoll 1998; Flarey 1993; Leebov & Ersoz 1991; McLaughlin & Kaluzny 1990; Weech-

Maldonado, Zinn & Brannon 1999). In this respect, therefore, improvement is based on both outcome and process (McLaughlin & Kaluzny 1990)

Continuous improvement approaches are also characterised by a 'customer' focus. Customer is generally defined in the broadest sense to include people working within an organisation as well as the consumers of the service. Any changes that are implemented are thus based on the needs of the 'customer' rather than on the values of providers or 'experts' (Flarey 1993; Leebov & Ersoz 1991; McLaughlin & Kaluzny 1990; Weech-Maldonado, Zinn & Brannon 1999). As Gaucher and Coffey (1993) observed, the ultimate goal of such approaches is to meet or exceed customer expectations.

The use of statistical methods by which variations in processes and specific causes of dysfunction in the system or its processes can be identified is a further feature (Flarey 1993). Although the particular tools and techniques employed vary according to the purposes for which they are to be used, for example, to display, analyse and/or rearrange data, they often include flow charts, histograms, Pareto diagrams, trend charts, scatter diagrams, control charts and cost-of-quality analysis (Flarey 1993; Hackman & Wageman 1995; McLaughlin & Kaluzny 1990). These tools are generally used in combination with each other rather than alone (Flarey 1993).

Although not specifically advocated by its founders, competitive benchmarking is often strongly associated with the continuous improvement model, at least in the U.S. (Hackman & Wageman 1995). Essentially benchmarking involves an organisation or service comparing its current activities and performance with the 'best' of other services or organisations with the aim of developing an improved product or service (Hackman & Wageman 1995; McLaughlin & Kaluzny 1990). However, it has also been suggested that the aim of benchmarking is not necessarily to establish the 'best' level of performance or to emulate the performance of another organisation but to understand the means by which this superior level of performance is achieved (*Health Services Quality Development Guide* 1998).

The concept of 'best practice' is central to the benchmarking process although, as with many other quality-related concepts, it tends to be defined in a variety of ways.

Writers such as Kibbe et al. (1997) have focused on the actual process of comparison. Others, however, have defined it in terms of the 'standard' by which the comparison is made (e.g. Australian Health Ministers' Advisory Council 1996; O'Dell & Grayson 1997). According to the latter authors, best practice can take a variety of forms ranging from clinical pathways and protocols to guidelines and standards of care. These, in turn, may be based on processes designed by a single organisation or data gathered by a professional organisation, government agency or private organisation (Kibbe et al. 1997).

As McLaughlin and Kaluzny (1990, p.11) have observed, benchmarking has obvious relevance to the continuous improvement philosophy in that *'it explicitly acknowledges that there is a competition to be studied and surpassed'* rather than simply meeting the established standard or norm. As such, it not only helps to improve outcomes for consumers, but can also help consumers determine what they can expect from other similar services. It is also a means by which providers can learn alternative work processes, reduce their costs and, in some cases, establish their quality improvement goals (Hackman & Wageman, 1995; Kibbe et al., 1997). Hackman and Wageman (1995) noted, however, that discovering a new idea or way of working does not mean that it will necessarily be adopted as this may often be difficult within a particular service setting or because limited resources are available.

As is evident, therefore, CI approaches differ from inspection-based and more traditional approaches to quality in a number of important ways. As Harvey (1996) has observed, their emergence has involved a major shift in organisational approaches to organising and managing their work. Fletcher (2000) suggested that the emergence of CI approaches is also significant in that it not only reflects the recognition of the complexity and dynamic nature of most organisations but also of the need to develop a more 'systemic' organisational focus.

From an evaluation point of view CI approaches obviously differ from inspection-based approaches in that a key focus is on assessing whether there has been an improvement over time in relation to certain specified outcomes or indicators rather than whether certain standards have been met or adhered to. Thus, if it is of interest to assess the impact of a different way of working or of a new staff training

programme, some form of experimental design (e.g. a simple before-after design) rather than one based on an audit model, as is typically the case within traditional QA approaches, would be more appropriate (Øvretveit 1998).

As many authors have pointed out, however, CI and QA are not necessarily mutually exclusive but can be regarded as complementary (Gaucher & Coffey 1993; Leebov & Ersoz 1991). In the view of Gaucher and Coffey (1993), a certain amount of inspection will always be part of the CI process but CI based approaches reduce the reliance on inspection as the primary means of achieving quality. They also provide a more dynamic, positive approach to quality that focuses on *'improving the processes for everyone rather than identifying only the problems and unacceptable few'* (ibid, p.57).

Implementation issues

Implementing a CI based approach in an organisation can be a difficult and complex process and generally demands a major change in thinking and approach. This revolves in part around the fact that organisations involve a variety of different work and professional groups who may respond to and be affected by the changes in different ways and at different rates (Harvey 1996).

A variety of factors have been identified as critical to the success with which such an approach is implemented. One of these is the extent to which organisations have appropriate infrastructures in place to support this form of quality management. This includes practical considerations such as the availability of resources, both financial and human, and systems for maintaining relevant records (Dimant 1991).

As indicated earlier, they also necessitate a total commitment by management, requiring the latter not only to understand the concepts involved and to learn the meaning of statistical thinking, but also to be willing to act on the results (Denham 1997; Dimant 1991; Gaucher & Coffey 1993; Leebov & Ersoz 1991; McLaughlin & Kaluzny 1990). Dimant (1991, p.207) observed that a demonstrated management commitment is particularly crucial given that there may be some resistance amongst employees to changing their normal approach to addressing quality. In this regard, therefore, it is vital that managers foster a 'culture of quality' within the organisation.

The latter has been described as comprising '*some basic beliefs about quality of care and quality of life that are shared by all employees, supervisors and managers*' (Ammentorp 1991, p.2). However, as several writers have pointed out, this will require a much more participative and flexible management style than usually exists and one that involves both residents and employees in quality problem solving (Ammentorp, Gossett & Euchner Poe 1991; McLaughlin & Kaluzny 1990).

Related to the above is the importance of education and training for all organisational members. Gaucher and Coffey (1993) recommended that these programmes address issues such as the reasons for change, underlying philosophy, the quality improvement process, analytical tools, techniques and skills, people skills and links with previous programmes.

Hackman and Wageman (1995) suggested that the successful implementation of CI approaches (referred to in their article as TQM) is also based on the assumption that employees care about the quality of their work and will undertake quality improvement initiatives if they are provided with the tools and training needed, and management pays attention to their ideas. There are several other features of CI approaches that may create problems for implementation. One is the fact that they do not 'respect' existing professional standards but are continually demanding new ones. Another is that they challenge prevailing models of the 'customer' as only including the 'patient' (or 'resident'). This means that a much broader view of customer needs must be adopted when implementing changes within the organisation (McLaughlin & Kaluzny 1990).

Gaucher and Coffey (1993, p.53) stressed the importance of avoiding a '*cookie-cutter*' approach to the implementation of a CI approach, suggesting that the specific approach and speed of implementation should be tailored to the organisation. In regard to the latter, McLaughlin and Kaluzny (1990) have suggested that a realistic time frame for full implementation would be from three to five years.

Finally, it has been suggested that the complexity of CI approaches and the costs often associated with their implementation, for example, staff training and ongoing education, development of specific systems and databases, often act as disincentives

for many organisations, particularly smaller ones (Dimant 1991; Fletcher 2000; Gaucher & Coffey 1993; Rantz et al. 2001). This is, of course, unless their adoption is mandatory, as in the case of the accreditation system introduced within Australian residential aged care.

Effectiveness

Quite clearly, and despite some of the challenges involved in their implementation, CI based approaches, by virtue of their more holistic, dynamic, customer focused nature and generally more 'positive' and forward looking focus, have many advantages over inspection-based approaches. However, despite their widespread adoption in various types of organisations around the world, empirical evidence as to their effectiveness and impact remains both scarce and inconclusive (Hackman & Wageman 1995; Weech-Maldonado, Zinn & Brannon 1999). The dangers of simply transferring concepts such as TQM and CQI from broader industry to human services organisations have also been noted (Fletcher 2000; Ghobadian & Spellar 1994). The latter authors observed that many managers and organisations have jumped onto the 'quality' bandwagon, adopting the various concepts and practices of TQM as panaceas for success, with little regard for the different contexts and circumstances involved in their development and implementation. It has also been suggested that knowledge regarding the most effective application of the different tools involved remains limited (Fletcher 2000).

Nevertheless, there have been some encouraging results from research into continuous improvement-based approaches in long-term care settings. For example, in reviewing the impact of the implementation of a continuous improvement programme in a large private nursing home in the U.S., Dimant (1991) found that the initial results indicated an improvement in the quality of care. In this study quality was assessed in terms of indicators such as adverse outcomes, use of physical restraints, mobility and independence, and resident and family satisfaction. There is also some research evidence suggesting that CI-based approaches to quality in nursing care promote greater staff involvement and acceptance, thus reducing negative feelings associated with quality assessment and enabling staff to implement changes and actions for improvement (Harvey 1996). However, it has been emphasised that the achievement of such results requires that attention be paid to the

process of implementation in order to ensure that the underlying principles of the approach are upheld (ibid).

Findings from other studies, however, including some that have focused on more specific components of CI approaches, have been less conclusive. For example, in assessing the impact of providing best practice information on improving practice and resident outcomes in several long-term care facilities in the U.S., Rantz et al (2001) found little evidence to support the usefulness of the former and that more active clinical consultation and support provided by experts was needed. The researchers added that this result was not surprising given the amount of time that continuous improvement activities generally involve. Problems within the long-term care industry in the U.S. relating to staff shortages and high staff turnover were also cited as influential factors.

2.4 External Mechanisms for Evaluating Quality

As discussed earlier, evaluations of service or organisational quality, whatever the approach adopted, can be conducted 'in-house' or by an external body of some kind. In some cases the latter type of evaluation may also be conducted as part of a government regulatory system. In this section two often related external approaches, peer review and accreditation, are discussed. Approaches employed by governments are considered in the following section.

2.4.1 External peer review

Shaw (2000, p.169) defined an external peer review system as:

'a regional or national process entered voluntarily by service provider organisations for the improvement of the organisation and delivery of [...] services assessed against explicit, published standards by peer group teams moderated by a non-partisan authority involving (but impartial to) users, providers, purchasers and government'.

Central to such systems is the idea that assessment is carried out by appropriate 'peers', these being people who are of similar standing in terms of professional background or service type. In some cases the focus may be on assessing the work

practices of an individual practitioner or professional group within an organisation; in others it may be on assessing a service as a whole (Australian Health Ministers' Advisory Council 1996; New South Wales Health 1999; Shaw 2000).

The basic rationale underlying the use of peer review approaches is that the most competent people to evaluate the performance of a particular profession or service are those who come from the same profession or service (Norman 1997). As the latter author observed that the value of peer review in evaluating quality is that it assesses the quality of care provision and helps to identify the strengths and weaknesses of care provided by a practitioner, or service, thus enabling the introduction of strategies for improvement.

As implied in Shaw's (2000) definition, peer review approaches are typically entered into on a voluntary basis rather than being 'imposed', for example by government. Shaw observed, however, that a key question is the extent to which they can be used to meet '*increased governmental demands for transparency, consistency and accountability*' (p.167).

There are a number of external systems for evaluating quality that involve peer review. In a study of approaches used within health care in Europe, Shaw (2000) identified four as having widespread use. Two of these, the 'Excellence' model, which originates from the business sphere and assesses specific areas of practice against different performance standards, and the International Organisation for Standardisation' (ISO), which focuses on specific aspects of service but primarily those relating to administrative procedures rather than clinical results, are based on models developed within industry. The other two, 'visitatae', an approach developed and executed by professionals themselves and which focuses on professional specialties, and accreditation (discussed in more detail below), were developed specifically for use within the health sphere. All, however, share a number of similar characteristics, particularly in relation to the assessment process which generally involves a number of discrete steps.

Based on Shaw's description, these steps are as follows:

- provision of preliminary information and self evaluation, the latter often involves completion of a self assessment 'questionnaire' in which basic data (e.g. relating to staff activity) must be provided and/or where more detailed information about the extent to which the participant complies with various standards is required.
- desk appraisal: this involves an external examination of certain specified internal documents such as policy or procedures manuals as well as information pertaining to prescribed performance indicators.
- site visit: this visit is generally in the form of a formal external 'survey' that may last anything from one to five days depending on the size and complexity of the organisation and the number of assessors involved. It can involve scrutiny of management, personnel and patient/client records, systematic observation of clinical and support services, and interviews with staff and, in some cases, also clients. Shaw observed that for cost efficiency purposes, observations of topics, staff and/or sites in larger organisations may be done on a sampling basis.
- report and evaluation: at the end of the site visit a preliminary verbal report is usually given. This is not only in order to test the 'validity' of the observations made but also to ensure that there are no surprises when the detailed, formal report is made available. Such reports usually aim to highlight both the positive features of the service/organisation as well as areas of non-compliance or concern. They generally also include recommendations for action or improvement.

Shaw (2000) added that in many external quality evaluation systems the process often ends at this point, however, that in others further steps may be involved. These may include carrying out internal consistency checks on the report, providing a numerical score, and independent scrutiny to verify the award or, in the case of accreditation systems, the accreditation period granted.

2.4.2 Accreditation

'Accreditation' tends to be defined in a variety of ways depending on the purposes for, and context in which, it is to be used (Scrivens 1998; Shaw 2000). Although often involving evaluation on a peer review basis, as identified above, this is not always the case.

New South Wales Health (1999, p.30) defines accreditation as '*a mechanism whereby an organisation is assessed by an external body to determine its compliance with agreed standards and its performance as demonstrated by the impact of its services on its consumers*'. Similarly, Øvretveit's (1998, p.234) definition of quality accreditation is '*a certification through an external evaluation of where a practitioner, equipment or service meets standards which are thought to contribute to quality processes and outcomes*'. Essentially, therefore, accreditation can be described as an evaluation conducted by an external agency which usually results in some kind of formal recognition, for example a certificate or award, that a service meets an authorised standard or service criteria (Denham 1997; Øvretveit 1998; Scrivens 1998).

Accreditation is usually entered into voluntarily with the assessment conducted by teams that are often multidisciplinary and usually peer review based (Australian Health Ministers' Advisory Council 1996; Scrivens 1998; Shaw 2000). According to Shaw (2000) most accreditation systems tend to be managed at regional or State level rather than nationally.

Accreditation outcomes are often expressed in terms of number of years' accreditation. Organisations with high levels of compliance with the standards are usually granted a greater time between assessments (Scrivens 1998). However, the latter author has pointed out that decisions about an appropriate time period between assessments are complicated in that, if it is too long, standards may have changed and/or an organisation may have changed its practices and no longer complies. On the other hand, however, too short a period may result in an organisation becoming stressed as a result of too many reviews. Too frequent assessments can also place an additional burden on organisations if they have to pay to be assessed (ibid).

In many external quality evaluation systems information about individual institutions is not made public, however, accreditation approaches usually involve the issuing of a certificate that can be publicly displayed. In some cases lists of recognised or accredited organisations may also be published (Shaw 2000). In the view of some (e.g. Australian Health Ministers' Advisory Council 1996), information of this nature should always be made publicly available. Moreover, as Shaw (2000) has pointed out, in cases where accreditation programmes are run by governments the reports automatically fall within the public domain.

Strengths and weaknesses

Accreditation is often regarded as an important mechanism for ensuring quality care and a number of potential strengths have been identified. These include its capacity for identifying areas for improvement in a service, providing accountability to governments and funders, and providing consumers with an indication that a service meets certain established standards of performance in areas of service regarded as 'critical' (Fletcher 2000).

Klazinga (2000) suggested that compared with many other external quality evaluation systems, accreditation approaches can also provide a very detailed reflection of the specific services provided in an organisation and often closely approximate the way in which care is delivered. In Klazinga's view, their generally heavy emphasis on standards and performance indicators also means that they tend to have high face validity for specific application, thus providing a good basis for benchmarking. A further strength is the detailed feedback, generally via a written report, that is provided to organisations as part of the accreditation process (*Health Services Quality Development Guide* 1998). Although the approach does not itself guarantee quality, it is also regarded as providing a useful infrastructure for organisations to develop a quality culture (New South Wales Health 1999).

The usefulness of the accreditation model is, however, dependent on a number of factors, several of which are common to all quality evaluation approaches involving assessment of the extent of compliance with standards. One is the importance of having in place an agreed quality reference framework that incorporates valid standards and a reliable process of assessment (*Health Services Quality Development*

Guide 1998; Shaw 2000). Accreditation approaches, particularly those involving evaluation by a peer review body, have often been criticised as lacking in the latter and, as a result, producing information that is of 'dubious' quality and limited usefulness (Australian Health Ministers' Advisory Council 1996; New South Wales Health 1999). Bias resulting from assessors having personal relationships with organisational members has also been identified as a potential problem (*Health Services Quality Development Guide* 1998). In Shaw's (2000) view, however, there are various ways in which such problems can be addressed. These include via internal audits, developing assessment protocols, providing adequate surveyor training, and seeking consumer feedback and assessment by independent panels. He also recommended that assessors have a balance of clinical and managerial expertise.

Other potential problems often associated with, although not necessarily exclusive to, accreditation systems include: possible difficulties accessing valid data; the limited scope of the assessment due to the limited time frame involved; lack of ownership of the process or outcomes of the assessment on the part of the organisation being accredited; and the generally mechanistic approach often involved that is not felt to contribute to an understanding of organisational behaviour or performance (*Health Services Quality Development Guide* 1998).

Health service accreditation programmes in Australia have been specifically criticised for their undue focus on structure and process and for the absence of spot checks. In relation to the latter, the fact that hospitals can prepare for accreditation means that what is observed during the assessment process may not be typical everyday practice. Other criticisms include the inadequate systems in place for ensuring that hospitals respond to identified concerns and the lack of public reporting on information arising from the accreditation process (Australian Health Ministers' Advisory Council 1996).

Accreditation approaches can also be costly (Fletcher 2000; Klazinga 2000). Fletcher (2000, p.25) commented that the inability of many health care organisations to meet these costs '*has driven many services to seek more affordable equivalents to accreditation – including the establishment of benchmarking networks*'. He has also suggested that this search for alternative approaches tends to undermine recent

acceptance by the industry of continuous improvement because providers consider the cost advantages of doing only the minimum to comply with government and funder requirements.

The need for accreditation systems to move away from static, 'point in time' compliance testing to an approach that has a more ongoing, dynamic and developmental focus is becoming increasingly recognised. The new standards developed by the Joint Commission for Accreditation of Healthcare Organisations (JCAHO) in the United States reflect a move away from the inspection-based, 'go versus no go' approach to one that incorporates a process for continuous improvement (McLaughlin & Kaluzny 1990; Øvretveit 1998). Similarly, the Australian Health Ministers' Advisory Council (1996, pp.18-19) has argued that accreditation should be an ongoing process that involves regular reviews of organisations, supplemented by a smaller number of spot checks that focus on specific components of organisations or service delivery, in order to prevent it becoming an 'all or nothing' process.

The need to place more emphasis on outcomes within accreditation programmes has also been emphasised as a way of enhancing their credibility (Australian Health Ministers' Advisory Council 1996; New South Wales Health 1999; Scrivens 1998). At the same time it has been argued that a focus on certain processes and systems, such as complaints mechanisms, should be retained as these are just as important as outcomes (Australian Health Ministers' Advisory Council 1996).

Accreditation systems in long-term care

Although the concept of accreditation was initially developed for use within the health care sphere in the United States during the early part of the 20th century, it has since been exported to various other parts of the world, including Australia. Its use has also been extended to other service spheres, including long-term care (Denham 1997; Shaw 2000). Denham (1997) suggested that accreditation systems are particularly suited to the latter due to the fact that there is such a wide range of facilities providing services and because, traditionally, the industry has not had any recognised ratings systems like in the hotel or some other service industries. This same author also noted the advantages of such a system for prospective residents

and/or their relatives who may find it extremely difficult to assess the quality of facilities on the basis of only one or two brief visits.

Over the years a number of quality schemes based on an accreditation model have been developed for use within the long-term care sector in both the United Kingdom and United States. In the United States, for example, JCAHO has developed a voluntary accreditation system for nursing homes based on standards that are said to surpass the minimum standards set by the federal government as part of the latter's regulatory system (Greenwood 2001; Le Sage & Young Barhyte 1989). The Commission also provides staff development programmes relating to the standards and publishes information to assist facilities to meet them (Le Sage & Young Barhyte 1989).

Accreditation as a regulatory tool

Although accreditation systems are generally conducted on a voluntary basis, they are sometimes also used for regulatory purposes through, for example, being tied to government funding (Fletcher, 2000; Scrivens, 1998). It has been suggested, however, that mandatory accreditation runs the risk of becoming an 'inspectorial' approach to quality that could work against incorporating quality improvement. In the view of the Australian Health Ministers' Advisory Council (1996, p.19) one way of preventing this from occurring, and the development of a '*large resource intensive industry which is divorced from the everyday reality of care delivery*', is by incorporating into the process many of the activities that are carried out by professional associations and bodies.

According to Klazinga (2000) the use of accreditation systems as a regulatory mechanism is primarily motivated by a need on the part of governments to have an alternative to direct government control in the realm of external quality assurance and overall accountability rather than to the introduction of competition between service providers, as is sometimes suggested.

2.5 Government Intervention in Quality

As outlined by Fletcher (2000), the ways in which governments intervene in quality vary according to their beliefs about the nature and relative importance of different factors that play a role in driving quality improvement. These factors include competition, accountability, regulation, professional ethos and consumer involvement.

Bartlett (1993) observed that in the United States, for example, there is a strong belief in the importance of competition to improve quality and that the role of government is to strengthen the capacity of stakeholders within the market. In other countries, such as the United Kingdom, however, there is a belief that the government needs to be more prescriptive and involved and there is greater emphasis on the need for accountability. Such attitudes have had a significant impact on the way in which systems and approaches for addressing quality in various service spheres, including residential aged care, have developed.

As indicated earlier, quality is also often directly linked with the provision of government funding to service providers in order that various quality objectives can be achieved. This strategy, which is often used in conjunction with others as part of a regulatory approach, involves the reduction or withholding of government funding to services or providers that are not considered to be providing a quality service. However, as Fletcher (2000) pointed out, the use of financing and purchasing levers as a means of ensuring quality poses a number of challenges. Some of these relate to the general difficulties, already discussed, of finding appropriate measures of, and mechanisms for, assessing quality. Others relate to the possibility that linking data about quality to accountability requirements as part of overall funding arrangements can create various '*perverse and unintended incentives*' which may result in service providers developing various strategies for dealing with being assessed (ibid, p.2).

It has also been emphasised that although each of the different factors involved in determining quality are important 'levers' to the achievement of policy objectives, none represents a complete response (Institute of Medicine 1999).

2.5.1 Regulation

Regulation is one of the key strategies used by governments to ensure high quality service provision. Essentially a method of control (Phillips 1984), regulation involves the use of rules, generally in the form of standards, that are backed by sanctions of some kind to prescribe behaviour (Bartlett 1993). As such, it necessitates some kind of evaluation of the extent to which services or organisations are complying with the rules or standards that have been specified. This evaluation can be carried out by the regulating body itself (e.g. a government 'inspectorate') or an organisation specifically contracted for such purposes (e.g. an independent auditing agency).

As Bartlett (1993) has outlined, the basic purpose of regulatory systems is to protect the interests of individuals or special groups, industries or the State itself. This is regarded as necessary because of the perception that, in certain types of industry, competition is not fully effective and that, if left to its own accord, the market will fail to operate efficiently (Fletcher 2000; Phillips 1984). In addition, in some industries, consumers' general inability to assess professional (i.e. technical) quality means that the government has a duty to protect them from harm (Øvretveit 1998).

Regulatory approaches

Although the ways in which regulatory systems are structured and managed vary widely, two main approaches to regulation are generally identified in the literature. These are deterrence approaches and compliance approaches (Bartlett 1993; Walshe 2001). Deterrence approaches are generally regarded as the 'hard' option and are based on the belief that organisations are opportunists who are prepared to break the rules if necessary to achieve their aims (Walshe 2001). As a consequence, such approaches tend to be formal, punitive and sanction oriented, often involving legal prosecution (Bartlett 1993; Parker 2000; Walshe 2001). In some cases they may also incorporate strategies that make it physically difficult or inconvenient for a service or provider to break the rules (Bartlett 1993). Walshe (2001) commented that the United States has been one of the strongest proponents of this approach compared with other countries.

Compliance approaches, by contrast, have a more developmental focus and are based on the assumption that organisations are basically well intentioned and will make every attempt to comply with the regulations (Walshe 2001). Often regarded as the 'soft' strategies, they focus on the provision of education and advice, persuasion and collaboration rather than deterrence, with sanctions being applied only as a 'last resort' (Bartlett 1993; Parker 2000; Walshe 2001). According to Parker (2000), in contrast to deterrence-based approaches, the focus of compliance oriented regulation is on maximising voluntary compliance and on fostering the development of in-house compliance systems through building on already existent systems, processes and cultures. The development and maintenance of an ongoing relationship between the regulator and regulatee is also regarded as central to this approach (Bartlett 1993; Parker 2001).

Both deterrence and compliance approaches have a number of associated advantages and disadvantages. Deterrence approaches, for example, are regarded as having the potential to achieve change quickly, are less likely to be undermined than compliance approaches and can be useful in cases where a large number of disparate organisations are to be regulated (Walshe 2001). Bartlett (1993) also stated that in situations where the chances of detection and punishment are minimal and the likelihood of rules being evaded therefore high, deterrence approaches may be the only viable solution. However, such approaches have not always proven effective, particularly in regard to achieving longer-term change. In addition, in some cases, they can promote defensive behaviour on the part of regulatees (Bartlett 1993; Walshe 2001). They can also be costly (Walshe 2001).

Although often considered weaker and less aggressive than deterrence approaches, compliance approaches are often felt to have greater potential for achieving change in the longer term (Walshe 2001). In Parker's (2000) view, a further advantage of compliance approaches is their capacity to improve the controls, efficiency and rationality of certain processes within organisations. However, she has added that that because they 'intrude' into the practices and processes of organisations and require an intimate relationship between the regulator and regulatee, they are not necessarily easy approaches to implement. Other limitations identified by Parker

include the costs often involved and danger that they can be used simply to manage appearances without effecting any real change.

In reality, regulators often use a combination of the two approaches or select one that is most appropriate to a situation (Bartlett 1993; Walshe 2001). Walshe (2001) identified the emergence of a 'third' approach that has been advocated by regulatory theorists in recent years. Variably called 'responsive' or 'smart' regulation, this approach attempts to incorporate the advantages of both compliance and deterrence models, producing a more flexible approach. Within this model interventions range from 'softer' options, typical of a compliance approach, to stronger measures and sanctions that may ultimately include those generally associated with deterrence approaches, such as legal prosecution or closure of a service.

Factors influencing the effectiveness of regulatory systems

A number of factors appear to be critical in influencing the overall effectiveness of regulatory systems. One of these is the way in which the system is structured. Walshe (2001, p.136), for example, pointed out that in some systems different agencies are responsible for different activities or functions and that this often leads to *'duplication, increased regulatory burden and higher regulatory costs, as well as conflict or confusion between the requirements of different regulators'*. He has identified fragmentation as a particular issue in nursing home regulation in the United States, suggesting that a simpler structure involving one regulator would be a far more efficient and effective alternative.

The need for a balance in regulatory governance arrangements between accountability and independence has also been emphasised. Walshe (2001) has observed that although agencies established for public regulatory purposes are usually accountable to an elected legislative body, either directly or indirectly, there may be instances where they need to make decisions or take action that may be unpopular politically or are of concern to key stakeholder groups. Thus it is also important that they are able to act independently and impartially. Phillips' (1984) view, however, is that even in cases where independent regulatory commissions or agencies are established, complete political independence is not only largely impossible, as they operate within a political environment, but not always

advantageous in terms of ensuring the overall effectiveness of the regulatory system, for example in relation to the need for political support and leadership. He added that the line between '*improper and proper*' political contact is often a fine one to draw (ibid, p.711).

The importance of regulatory systems, both in terms of the standards that underpin them and the procedures involved, being based on an appropriate legal structure has also been emphasised. Bartlett (1993) observed that this has been suggested as playing a crucial role in enhancing compliance on the part of regulatory officials and service providers alike. At the same time, however, the importance of these structures being flexible enough to allow the system to respond to new developments and changes has also been recognised (Bartlett 1993; Phillips 1984).

Braithwaite et al. (1993) observed that the Donabedian quality paradigm has had a major influence on the development of regulatory strategies in terms of the nature of standards that underpin them. In keeping with general trends in quality evaluation discussed earlier, there has been a noticeable shift over the past few decades in the focus of many regulatory systems, including those relating to residential aged care, from structure and processes to outcomes. However, views about the appropriate extent of this shift tend to vary. With respect to residential aged care, Braithwaite et al. (1993) have supported the development of standards that are solely outcomes focused, arguing that structure and process are important only in so far as they deliver better outcomes for residents. Parker (2000) also favoured outcomes focused approaches to regulation, suggesting that they allow organisations greater flexibility in terms of how they go about achieving those outcomes and, moreover, that they can be a useful way of encouraging innovation, particularly within larger organisations.

Braithwaite (2001, p.445) has suggested that the standards used within a regulatory system should be limited in number ('*few enough to be regulated conversationally*'), broad in scope and able to be assessed without the use of defined assessment protocols. Whilst acknowledging the importance of the assessment process being reliable, he has also argued that many countries are overly concerned with this issue in the development of their regulatory systems and that there is actually greater

likelihood of reliability being achieved when the latter is not a central concern. He refers to this notion as the '*reliability paradox*' (Braithwaite 1998, p.172).

Although views about the necessity of defined protocols for assessing standards compliance within a regulatory system may vary, most writers agree on the need for this process to be fair and appropriate (Bartlett 1993; Braithwaite et al., 1993). As outlined earlier, this is a basic requirement of any quality evaluation. Braithwaite et al. (1993) suggested that the principles of '*procedural justice*' should be adhered to in any regulatory assessment. These principles were identified as impartiality, ethicality, consistency, decision accuracy, control (in terms of the process of decision making as well as input into the decision itself) and correctability (i.e. the right to appeal). The provision of informal praise through the assessment process has also been identified as beneficial, not only helping to improve compliance but also encouraging the dissemination of best practice (Braithwaite 1998; 2001). Apart from 'standard' regulatory inspections, Braithwaite (2001) has also strongly advocated the use of spot checks.

A further factor that has been identified as critical to the success of regulatory systems is the need to have an enforcement mechanism that is appropriately and consistently applied (Bartlett 1993; Braithwaite 1998; Harrington 2001; Parker 2000). In regard to compliance-based systems, many authors point to the need to have in place a graded hierarchy of sanctions or '*enforcement pyramid*' (Ayres & Braithwaite 1992). This pyramid indicates the different levels of enforcement that can be used within a regulatory regime, beginning with more 'cooperative' options at the base of the pyramid through to the strongest measures at the top. The intention of such a mechanism is to provide an incentive to organisations to make regulation work at lower levels, however, if they do not do what is required they may progressively move up the pyramid until the ultimate sanctions are imposed. Parker (2000) likened this graded approach to enforcement to the idea of restorative justice within the criminal process in which the offender is given the chance to be restored back to full citizenship on correction of wrong doing, thus becoming a more 'law abiding' person. Provided the stronger sanctions are in place and imposed when necessary, evidence suggests that the use of this more graduated approach, which Walshe (2001) noted also underpins 'responsive' regulatory approaches, can be

equally as effective as the more 'negative' or 'punitive' ones generally associated with deterrence approaches (Makkai & Braithwaite 1994; Parker 2000).

The choice of enforcement agency is a further factor critical to the success of a regulatory system. Bartlett (1993, p.15) suggested that in systems where responsibility for enforcement rests with public bureaucrats, possible problems include a lack of practice standards and a risk of 'under-enforcement' because the gain to the enforcement agency *'is often less than the offender's potential penalty'*. Bartlett also stated that similarity in training and background between regulators and regulatees can be a potential problem in that regulators may tend to err in favour of the industry rather than the (anonymous) consumer.

The importance of incorporating various rewards and incentives into regulatory systems in a way that acknowledges innovation and helps to disseminate best practice has been emphasised by several writers (e.g. Le Sage & Young Barhyte 1989; Parker 2000; Walshe 2001). With respect to long-term care regulation in the United States, Le Sage and Young Barhyte (1989) mentioned that many States have developed systems to reward superior facilities through, for example, the use of a star system, with lists of 'six star' homes being published in newspapers. Apart from providing recognition and acting as a source of pride for staff, such schemes are also recognised as being a valuable way of encouraging and lifting overall compliance performance (Le Sage & Young Barhyte 1989; Parker 2000).

A number of other factors have been identified as important elements of regulatory systems. These include the need for transparency (Braithwaite 2001), for a 'tripartite' system that involves stakeholders other than the regulator and regulatee, such as staff and/or residents and their families (Walshe 2001) and the incorporation of continuous improvement into the standards and use of the latter as an outcome measure (Braithwaite 2001).

2.5.2 International approaches to the regulation of long-term care

As for other types of human service delivery, views about the need for, and extent of, government regulation of long-term care vary from country to country. This has

resulted in considerable variation in the specific approaches adopted. In addition, many regulatory approaches, such as those in the United States, focus only on nursing home (high level) care. This section provides a brief overview of the approaches adopted in the United States and the United Kingdom as they provide a useful basis for comparison with the Australian system to be discussed in the next chapter.

The United States

Walshe (2001) has described the approach to nursing home regulation in the United States as very prescriptive and as reflecting many of the features of a 'deterrence' model. The origins of the current approach date back to the 1970s and early 1980s when concerns about the quality of nursing home care led to a series of reforms aimed at strengthening government regulation of the industry. The reforms were based on the findings of a review conducted by the Institute of Medicine (1986). This review had been requested by Congress amidst concerns about proposals put forward by the Reagan administration to deregulate the industry. Introduced via the Omnibus Budget Reconciliation Act (OBRA) in 1987, the reforms established federal regulations for all nursing homes with publicly funded residents and now form the basis of the current regulatory system in that country (Harrington 2001; Harrington & Carillo 1999; Walshe 2001).

The system comprises three main elements, namely, the regulatory standards, monitoring (surveying) procedures, and enforcement (Harrington 2001). Walshe (2001) observed that although administratively complex, the system is conceptually fairly simple. The federal government, via the Centers for Medicare and Medicaid Services or CMS (previously the Health Care Financing Administration) is responsible for the development and maintenance of the standards, including their enforcement. The States are responsible for the licensing and certification of homes receiving federal subsidies via the CMS and for carrying out compliance inspections, investigating complaints and reporting back to the CMS (Harrington 2001; Le Sage & Young Barhyte 1989; Walshe 2001).

Facility inspections (surveys), which are conducted every nine to fifteen months by State agency inspectors, involve evaluating whether the various standards or

'requirements' have been met. There are 17 different categories of quality 'requirements' (e.g. residents' rights, resident behaviours, quality of life, quality of care, physical environment, administration) comprising a total of 185 specific items, plus various 'life safety' requirements (Harrington 2001; Harrington & Carillo 1999). The standards represent a mix of structure, process and outcome standards although, since the OBRA reforms, now place much greater emphasis on the latter (Le Sage & Young Barhyte 1989). Data is collected via resident interviews or assessments and observation (Harrington 2001).

In cases where a facility fails to meet a particular standard state surveyors issue a 'deficiency'. Since 1995, as part of a more 'graded' approach to enforcement that has been adopted, surveyors have been required to rate these deficiencies in terms of their scope and severity, based on their likely negative impact on resident health and safety. This means that rather than a home immediately being subjected to the most severe penalties, such as closure for non-compliance, 'intermediate' sanctions such as fines, withholding payment for new residents and bringing in external managers may first be applied. If these do not prove effective, ultimate sanctions such as immediate closure and/or withdrawal of funding can be enforced (Harrington 2001; Harrington & Carillo 1999). Compliance data and data on individual facilities is maintained centrally and made available to the public via the internet (Harrington 2001).

Despite the reforms that have been introduced, poor quality care and claims of fraud and financial mismanagement appear to remain a common problem throughout the nursing home industry with regulatory policy being the source of constant criticism and debate (Harrington 2001; Harrington & Carillo 1999; Parsons 1999; Walshe 2001). Hovey (2000, p.43) described the current system as *'the worst of all worlds'* in that it is both *'burdensome to the industry'* as well as *'ineffective in protecting consumers'*. In his view an alternative system based on a combination of 'co-regulation', involving the use of private accreditation agencies, and 'deregulation', whereby state certification of need laws are repealed, would be more effective. Similarly, Peck (2000) has described the system as confusing, as expecting too much of those providing care and as inflexible, thus providing little scope for innovation. He advocates an alternate approach based on what he refers to as a *'tripwire'*

approach, that is, one that allows '*room for manoeuvring toward compliance while imposing dire consequences on those who fall over the wire*' (p.4).

As mentioned earlier, in an attempt to address some of the ongoing problems surrounding the provision of nursing home care, JCAHO has developed an accreditation system, based on its own standards, for those long-term care providers who wish to participate. Together with the Commission on Accreditation of Rehabilitation Facilities (CARF) it has also implemented a peer review monitoring system for assisted living facilities, based on an accreditation model.

Other industry-driven developments include the recently launched 'Quality First' initiative, a scheme involving three of the largest long-term care organisations in the United States and representing a total of 17,000 nursing homes plus assisted living and community services providers. This scheme requires providers to commit themselves to a number of principles relating to issues such as quality improvement, public input and public disclosure of data. The aim of this initiative, according to the American Association of Homes and Services for Ageing (AAHSA), is not only to achieve high quality care but also to secure public confidence in the industry (American Health Care Association 2002).

The United Kingdom

Traditionally, approaches to the regulation of long-term care in the United Kingdom have tended to be based on a 'soft' compliance approach, often incorporating a voluntary element and, in some cases, self regulation (Bartlett 1993). Recently, however, a new regulatory framework for all aged care homes, similar in terms of its key components, that is, regulations and standards, monitoring and inspection, and enforcement, to that of the U.S., has been established (Kerrison & Pollock 2001).

Under the new legislation, as in Australia, the distinction between nursing homes and residential care homes (those providing lower levels of care, roughly equivalent to 'hostels' in Australia) will disappear. In addition, and in contrast to the previous system whereby individual health or local authorities were responsible for the licensing and inspection of homes, the latter tasks will be handled centrally by a Commission for Health Improvement and three other new central agencies based in

England, Scotland and Wales respectively (Harrington 2001; Kerrison & Pollock 2001). Standards compliance, monitoring and enforcement will be handled centrally by the National Care Standards Commission (NCSC) which is also responsible for disseminating best practice information, advising service providers regarding meeting the standards and providing information to the public (Bartlett & Boldy 2001).

Consistent with trends elsewhere, the regulatory standards reflect a move away from structural dimensions towards outcomes, with an emphasis on indicators relating to quality of care and quality of life. There are 38 standards in all, grouped according to key areas including management and administration. Increased emphasis has been placed on staff training, systems and documentation as well as continuous self monitoring. Compliance is assessed via a combination of inspection, discussion and observation (Bartlett & Boldy 2001). Although not legally enforceable, they can be used as evidence of failure to comply in the case of prosecution (Kerrison & Pollock 2001).

In placing strong emphasis on education and persuasion, the new system still reflects many features of a compliance model. It also allows for the use of four types of sanctions that range in severity. These are: formal notice of non-compliance; fines for specific offences; withdrawal of an operating licence; and exclusion of individuals from the industry. At present no intermediate sanctions such as those used in the U.S. system are available to the NCSC (Kerrison & Pollock 2001).

Kerrison and Pollock (2001) have raised a number of concerns about the potential of the new system to protect residents, particularly those living in private, for-profit facilities. Some of these concerns relate to monitoring and enforcement. These include the generally limited resources allocated to the NCSC to undertake its activities and the lack of intermediate sanctions available. Others relate to staffing, in particular the absence of any mechanisms for ensuring adequate staffing levels, and to the need for more stringent transparency and accountability mechanisms, particularly on the part of private industry providers. They have also suggested that one of the main reasons why the U.K. regulatory system is so flawed in these areas is due to the 'compromises' that have been made by the government with the industry.

From a service provider perspective, concerns relating to the likely expenses incurred by them to effectively implement the system, such as staff training, and in order to meet specific building requirements, for example, those regarding room space, have also been identified (Bartlett & Boldy 2001). In addition, and in line with earlier discussion, it has been suggested that the one-off nature of the inspection process will provide little incentive to service providers to change or improve unless they are required to do so and/or if the standards are not met (ibid).

As in the U.S., a number of industry driven schemes and initiatives for addressing quality in long-term care have been developed over the years. Denham (1997) described eight such schemes, some of which are assessed 'in-house', while others involve assessment by external inspectors (e.g. industry or regional peer review teams). In some cases the schemes are also used as a basis for obtaining accreditation.

2.5.3 The need for regulation in long-term care

Despite the development of regulatory systems for long-term care in many countries, continued concerns about the quality of care being provided, particularly in the United States and United Kingdom, have led some critics to question their usefulness.

A number of factors have been suggested as contributing to their apparent ineffectiveness. These include 'technical problems' relating to a general lack of knowledge about measuring quality (Braithwaite et al. 1993; Kurowski & Shaughnessy 1985), a lack of will on the part of regulators to enforce decisions (Braithwaite et al. 1993; Kane & Kane 1988), the way in which the systems are structured and managed (Harrington 2001; Walshe 2001), and inadequate resources being available to the regulatory body to effectively operate the system (Bartlett, 1993; Kerrison & Pollock, 2001; Walshe, 2001). Harrington (2001) has identified issues relating to the federal reimbursement system for providers and staffing (skill mix and staffing levels) as major factors contributing to the problems in the U.S. system and has expressed similar concerns about the new system proposed for the U.K.

Despite such problems, many writers are of the view that regulation of the aged care industry is necessary and that it can be effective. According to Walshe (2001), in spite of the ongoing problems surrounding nursing home regulation in the U.S., the OBRA reforms have achieved some important quality improvements. Similarly, and as will be discussed shortly, the system introduced in Australia in the late 1980s was also regarded as having been particularly successful in achieving better quality care for nursing home residents (Braithwaite 1998). Braithwaite (2001) has argued, however, that one of the main arguments in favour of the regulation of residential aged care rather than relying on market mechanisms relates to the fact that older people are often not in a position to exercise their rights by, for example, leaving or complaining.

It has also been suggested that the need for regulation in long-term care has become increasingly necessary in view of the current political trend in many Western countries, including Australia, towards deregulation and the increasing domination of the long-term care industry by the private sector. These concerns are said to be particularly justified in view of evidence indicating that for-profit nursing homes provide a significantly lower quality of care than their not for profit counterparts (Braithwaite 2001; Harrington 2001; 'Non-profit homes receive fewer deficiencies' 1999).

Regardless of their nature and the basis on which they are established, it is obvious, however, that if regulatory systems are to be effective in ensuring quality within the residential care context, a variety of issues need to be addressed. Although many of these appear to relate to the ways in which the systems are structured and managed, others relate to factors that extend beyond the system itself and hence may be more difficult to resolve. The importance of regulatory systems becoming more dynamic in nature, thereby serving as a basis for stimulating change rather than merely focusing on compliance and/or maintaining 'order', has also been emphasised (Institute of Medicine 1986; Phillips 1984), although in the view of Phillips (1984) this will require deep seated change on the part of policy makers and regulators.

The need for more research and formative evaluation of nursing home regulation has also been identified (Harrington & Carillo 1999; Walshe 2001). Walshe (2001)

observed that little is known about the specific impact of regulation on nursing home performance and quality of care, with most attention having been directed at examining its implementation and management. In addition, he notes that there is little evidence available to determine whether the benefits of regulation justify the costs involved. The importance of regulatory bodies themselves being reviewed periodically has also been identified as has the need to regularly review the necessity of continued regulation and to explore the potential for using alternative approaches (Phillips 1984).

2.6 Summary

In summary, it is clear that quality is a complex concept whose management and evaluation can be approached in a variety of ways. Similarly, the extent to which governments intervene in the management and regulation of quality also varies widely. Although most government regulatory models tend to favour either a compliance or deterrence approach, the specific ways in which these models are developed and applied can differ substantially.

Nevertheless, a number of dominant trends have emerged in recent years in relation to the management and evaluation of quality. These include the trend towards more outcomes based approaches, although the extent of this shift varies, and the increasing emphasis on continuous improvement as a more dynamic, holistic way of addressing quality. Although these trends are particularly evident within the acute health care sphere, they are also receiving increasing attention within long-term care and in some cases have been incorporated into government regulatory systems.

Accreditation is often used as a basis for evaluating the quality of services or care, again particularly within health care. The literature suggests that most accreditation systems, including several developed for use within the long-term care industry, are conducted on a voluntary, peer review basis. However, they can be used for regulatory purposes, as in the case of the Australian system which is the focus of the next chapter.

Chapter 3: The Regulation of Quality in Australian Residential Aged Care

3.1 Background

Prior to the 1970s in Australia, and despite the large amounts of federal government funding that were being provided to nursing homes, responsibility for issues such as quality was left largely to individual service providers. This was consistent with the government's generally 'laissez faire' approach to aged care policy at that time (Howe 1990). Prompted by widespread criticisms of the lack of any coordinated policy for long-term care, the government introduced a series of regulatory measures in the early 1970s. However, these measures were primarily concerned with the growth of nursing home beds, admissions and fees rather than quality (ibid).

In response to increasing concerns about the mistreatment and neglect of nursing home patients that emerged later that decade, the government requested the Auditor General (1981) to conduct a review into their efficiency. Despite this report being highly critical nature of the government's failure to obtain 'value for money', Howe (1990) suggested that the commissioning of a review of this nature exemplified the government's continued perception of the problems within the industry as being primarily administrative. Regulatory measures that had been introduced during this period, which involved both federal and state governments but particularly the latter, revolved mainly around licensing and funding (Braithwaite et al. 1993; Gibson 1998). The federal government also conducted 'status' inspections that looked at quality-related issues such as cleanliness, fire regulations and adequacy of staffing levels, however, these were solely inputs focused. The latter feature had attracted considerable criticism from both within and outside the industry (Braithwaite et al. 1993; Courtney, Minichiello & Waite 1997).

Dissatisfaction with the government's response to the situation resulted in a further inquiry into aged care which was conducted by the House of Representatives Standing Committee on Expenditure (1982). According to Braithwaite et al. (1993), however, this report, often referred to as the McLeay report, also represented a 'reprieve' for the government and the nursing home industry as regards quality

regulation in that it focused primarily on the imbalance in spending between institutional and community care. In addition, it made no recommendations for strengthening standards in nursing homes, instead appearing to support a proposal by the Australian Nursing Homes Association for the trialling of a self regulatory approach.

Ongoing concerns about the standard of care being provided in residential aged care homes prompted two further reports that were instrumental in bringing about a substantial restructuring of the funding mechanisms for residential care and the introduction of stringent monitoring of care standards and regulations. The first, conducted by the Senate Select Committee on Private Hospitals and Nursing Homes (1985) and commonly known as the Giles report, identified wide variability in standards of care between facilities within and between States. This finding was confirmed in a later government report (Department of Community Services 1986). The report was also strongly critical of the government's focus on inputs as a means of ensuring quality. As a consequence it recommended the development of new national standards for nursing homes that focused on resident outcomes which were to be in the form of adverse events. It also recommended the establishment of a government inspectorate whose role would be to develop inspection guidelines, coordinate the inspections, prosecute offenders and investigate minor complaints. The federal government's Nursing Homes and Hostels Review (Department of Community Services 1986) that followed also recommended the revision of the nursing home standards and a move away from an inputs to resident outcomes focus (Braithwaite et al. 1993; Fiveash 1997).

These two reports led to the establishment of a Commonwealth/State Working Party on Nursing Home Standards whose brief was, in consultation with industry, consumer, professional and union groups, to develop appropriate standards in line with the recommendations (Healy 1990). The standards, along with a new system for their monitoring (described in more detail below), were introduced as part of a major reform package of long-term care policy introduced by the federal government in 1986. Known as the Aged Care Reform Strategy, it was implemented over the ten year period between 1986 and 1996 (Braithwaite et al. 1993; Fiveash 1997).

Apart from the introduction of the new regulatory system, other significant initiatives introduced as part of the reforms included: the development of outcome standards for hostels in 1990 (Department of Health Housing Local Government & Community Services 1990); the introduction of a Charter of Residents' Rights and distribution of 'Your Guide to Residents Rights in Nursing Homes' (Commonwealth Department of Health Housing and Community Services 1992) to all nursing homes, following a national study on resident rights (Ronalds, Godwin & Fiebig 1989); the establishment of advocacy services and government complaints units in each State and Territory; the conduct of national and State consumer forums; and the formation of a community visitors scheme (Bartlett 1993).

A number of other relevant developments occurred around this time. One of the most significant was the identification, via another national study, of appropriate staffing levels relative to resident dependency (Department of Community Services and Health 1986). Another was the introduction in 1988 of a new funding mechanism for nursing homes based on the Resident Classification Instrument (RCI), whereby funding was linked with residents' dependency levels (Fiveash 1997).

3.2 The Standards Monitoring System

The introduction of the new regulatory system, known as the standards monitoring system, involved the establishment of federal government inspection teams in each State and Territory. These teams were responsible for evaluating the quality of care provided by nursing homes (and later hostels) using the outcome standards as a basis. Monitoring of nursing homes commenced in late 1987 and in January 1991 for hostels (Rhys Hearn & Boldy 1986).

The standards that underpinned the system focused on issues relating to quality of life as well as quality of care and provided a legislative basis for enforcement (Courtney, Minichiello & Waite 1997; Gibson et al. 1992). There were 31 outcome standards for nursing homes, grouped under seven broad headings, and 24 for hostels, grouped under six broad headings. Both sets of standards contained many similar elements. These included an emphasis on freedom of choice and residents' rights, privacy and dignity, the need to create a 'homelike' environment and provide a

variety of experiences, and the need to maximise social independence. The nursing home standards also included outcomes relating to physical safety and health, while those for hostels included outcomes relating to meeting residents' identified care needs (Commonwealth of Australia 1987; Department of Health Housing Local Government & Community Services 1990; Gray 2001). In both cases these standards represented the minimum levels of care that could be provided.

The monitoring process itself involved teams of monitors, usually comprising two to three people, spending one to two days in a facility to assess the service using the relevant standards as a basis. Facilities were generally notified in advance that a visit was to take place (Braithwaite et al. 1993). Although it was originally intended that the monitoring teams comprised both Commonwealth and State representatives, they tended to be made up of State-based monitors, usually a departmental representative and a nursing officer. This was because of the practical difficulties such as travel that were often involved (Bartlett 1993; Braithwaite et al. 1993).

The visits usually involved interviews with staff, including the Director of Nursing (DON) or hostel supervisor, residents (both on a pre-arranged and casual basis) and any visitors (e.g. relatives) present at the time, as well as reviews of relevant documentation such as policies, care plans and financial statements. The approach adopted by standards monitors during the visits has been described as 'flexible' in the sense that it was more concerned with whether certain desired outcomes for residents had been achieved via the caring process than with how they had been achieved (Braithwaite et al. 1993; Gibson et al. 1992).

Following their inspection visit, the team left the facility to discuss their findings and observations and to assign ratings for each of the standards. One of three possible ratings could be assigned. These were that the standard had been met, that action was required, or there was a need for urgent action. The teams then revisited facilities, generally within 48 hours of the initial visit, to discuss their interim findings with the DON/supervisor and interested others. These discussions were also intended to provide facilities with the opportunity to challenge the findings, which sometimes resulted in ratings being changed, and to discuss appropriate action plans and time frames (Braithwaite et al. 1993). The latter authors noted that proprietors were

encouraged to attend these meetings and that this frequently occurred. Final reports were generally sent to facilities within ten days of initial visit and were also made available to the public (ibid).

The system involved a process whereby most facilities received at least one follow up visit in order to check that action plans had been implemented. Homes that had not complied after three visits were identified as 'homes of concern'. The enforcement system was based on a graded approach and allowed for a variety of sanctions. These ranged from 'softer' options such as a letter of intent or short suspension of benefits for new residents, to harsher sanctions such as total withdrawal of funding and 'de facto' closure (Braithwaite et al. 1993; Gibson et al. 1992).

The standards monitoring system as implemented in nursing homes was the focus of a major five year review that also involved comparison of the Australian system with equivalent regulatory systems in U.S., U.K., Japan and Canada. Described as a 'formative' evaluation, it involved people at all levels and included industry representatives, unions, professional groups and consumer groups (Braithwaite et al. 1993).

From a service provider perspective, the evaluators found that although there had been strong criticisms, particularly initially, about various aspects of the system it was generally supported by the industry and felt to be of benefit to residents (Braithwaite 1998; Braithwaite et al. 1993). Providers also regarded the standards against which they were assessed as appropriate and practical and the standards monitors as generally fair, cooperative, reasonable, thorough, professional, and courteous in their approach. Although some providers had been required to spend major sums on renovations in order to meet certain standards, the evaluators claimed that there was *'little reason to worry'* that regulatory costs would act as a major impediment to industry efficiency or reduce compliance levels (Braithwaite et al. 1993, Executive Summary, p.xii).

An examination of the appropriateness of the nursing home standards themselves as a basis for assessing quality also formed part of the evaluation, the results of which

were reported to be encouraging (Braithwaite et al. 1993). Although noting that they were not linked to specific, easily measurable, objective indicators of programme performance and hence did '*not automatically inspire confidence amongst the evaluation researchers*', the evaluators concluded that it was the process by which the standards were appraised, rather than their content, that was the key element in their successful application (Gibson et al. 1992, p.4). Moreover, the evaluators argued that the absence of defined protocols for the assessment process, and hence the degree of subjectivity inherent in it, had not adversely affected the implementation of the system but had contributed to its superiority over systems elsewhere (Braithwaite, 1998; Braithwaite et al., 1993; Gibson et al., 1992). It was concluded that, overall, the standards did give consistent and valid compliance ratings, although a number of issues relating to cross-referencing and inter-state reliability for some standards were identified.

The report concluded, therefore, that despite some 'deficiencies' compared with other systems, the Australian standards monitoring programme was a better designed process than that operating in the other countries reviewed. It was also regarded as being more likely to achieve improvements in quality of nursing home life in the longer term and as representing better value for the taxpayer's dollar (Braithwaite et al. 1993). A later analysis of national data by the Australian Institute of Health and Welfare (1995) also found that the programme had resulted in improved quality of care.

3.2.1 The need for a new regulatory system

As Braithwaite (2001) observed, the introduction of the standards monitoring system represented the culmination of a period of increasing government involvement in the regulation of residential aged care. Consistent with general trends in quality regulation during this period, it also represented a significant shift in focus from inputs to (resident-centred) outcomes and, in fact, has been described as one of the most outcome oriented of any regulatory system in the world at that time (Braithwaite 2001; Braithwaite et al. 1993; Gibson et al. 1992). Although quite clearly an inspection-based approach to evaluating service quality, Bartlett (1993,

p.21) suggested that it was a much more 'collegial' regulatory model than had been used previously.

Despite its early support by the industry and generally favourable evaluation findings, a number of limitations of the system were also identified, some of which became increasingly apparent over time. As will be seen, many of these reflect issues that have already been identified through this review in relation to quality approaches (e.g. inspection-based models), regulatory systems and/or the evaluation of quality in general. One such limitation, also identified in the evaluation of the system, related to the apparent lack of enforcement of sanctions in cases where homes failed to comply with the standards (Bartlett & Boldy 2001; Braithwaite et al. 1993). As outlined, there were also concerns about inconsistencies in ratings for some standards, particularly across States (e.g. Braithwaite et al. 1993).

In addition, the system was criticised for the one-off nature of its inspections which was felt to provide little basis for the identification of systemic problems. It was also regarded as focusing providers on paperwork and the achievement of minimum standards rather than on care or innovation (Bartlett 1993; Commonwealth Department of Health and Aged Care 1999b; Commonwealth of Australia 2001; Gray 2001). Many also felt that it had become unnecessarily intrusive and adversarial, thereby doing little to support service providers to meet acceptable levels of care (Commonwealth Department of Health and Aged Care 1999b).

Braithwaite et al. (1993) were also critical of the lack of spot checks in the system, stating that there was evidence of staff filling out care plans en masse the night before a visit, of extra staff being rostered on the day of a visit and of practices such as placing pot plants and other items around prior to the visit in order to create a more 'homelike' atmosphere. They did, however, support the practice of giving advanced notice of a visit during the first round, saying that '*the first visit was more than anything else a learning experience for those involved*' (ibid, p.109).

The apparent inability of the system, in many cases, to identify poor quality care became an ongoing concern. As a consequence, it became widely regarded as a 'weak' approach to quality assurance that did little to promote continuous

improvement within facilities or to recognise those providing exemplary care (Gray 2000). Such considerations, along with pressure from the industry for a different type of system that was independent of both government and industry, resulted in the introduction of a new system based on accreditation. This system is described in detail in the following sections.

3.3 The Accreditation System

The accreditation system was introduced as part of the federal government's Structural Reform Package which came into being with the passing of the Aged Care Act in 1997. Under the new system quality is linked with funding. This meant that in order to continue receiving Commonwealth funding, facilities must be accredited.

Developed in consultation with the industry, consumer groups and union representatives, the system is based on a framework of five elements, each of which is taken into consideration in the granting of accreditation. These are as follows:

- The accreditation standards: there are four standards associated with 44 expected outcomes. Quality care is defined as being provided when specific standards of care are met.
- User rights: user rights or 'meeting residents' needs' are regarded as a key element of the new system and are incorporated into the accreditation standards. They are also addressed via other avenues including the federal government's complaints resolution processes, advocacy services and community visitor arrangements.
- Building quality: to be accredited facilities must have also received building certification during 1997 or, alternately, must have met the relevant standard but chosen not to be certified and retained entitlement for government financial assistance to upgrade the facility. Providers are required to submit relevant documentation with their accreditation applications. All buildings must meet all certification requirements by 2008.

- Concessional and assisted resident ratios: this component relates to the extent to which a facility is considered to meet the needs of such residents in their respective areas and is determined by the federal government.
- Prudential arrangements: Facilities holding accommodation bonds must comply with Commonwealth requirements.

(Aged Care Standards Agency 1998; Barker 2002; Gray 2001).

A significant feature of the new system is that its overall management has been devolved to an independent body, the Aged Care Standards and Accreditation Agency (see below). The federal government retains responsibility for imposing sanctions, based on recommendations from the Agency, and also manages the building certification and complaints resolution schemes.

The reforms introduced via the Residential Aged Care Structural Reform Package encompassed a number of other elements that have particular relevance to this study. One was the unification of nursing homes and hostels under one system in order that all facilities could offer the full continuum of care. It also included a number of funding reforms. These included: the introduction of a single funding tool, the Resident Classification Scale (RCS) which replaced the RCI in nursing homes and the Personal Care Assessment Inventory (PCAI) in hostels; a single payment system which removed any direct regulation of funds spent on care and placed responsibility for spending decisions with providers; and changes to fee arrangements within facilities which included allowing facilities to seek a capital contribution from residents who could afford it, provided the home meets care standards and building quality (Gray 2001).

3.3.1 The Aged Care Standards and Accreditation Agency

The Aged Care Standards and Accreditation Agency was established as an independent body responsible for managing the new system. It is required to meet the legislated requirements contained within the Aged Care Act 1997 and the Accreditation Grant Principles 1999 (Burns & Carey 1999).

Its specific functions, as set out in the Accreditation Grant Principles 1999, are to:

- manage the residential aged care process using the Accreditation Standards;
- promote high quality care and assist industry to improve service quality by identifying best practice, and providing ongoing information, education and training;
- assess and strategically manage services working towards accreditation; and
- liaise with the Department of Health and Ageing about services that do not comply with the relevant standards.

(Aged Care Standards and Accreditation Agency 2001; Gray 2001).

More specifically, this role involves assessing and monitoring compliance with the accreditation standards, ongoing monitoring, and conducting review audits to ensure continued compliance. It also involves carrying out spot checks and support visits (Aged Care Standards and Accreditation Agency 2001).

The Agency's head office is in Sydney, with branches in each State, although the Australian Capital Territory and Northern Territory are covered by the New South Wales and South Australian State branches respectively. A Board of Directors comprising industry representatives and other relevant stakeholders (e.g. consumer advocates and academics) oversees the Agency's operations and provides advice regarding general policy directions ('Accreditation by 2001: the journey begins' 1998; Aged Care Standards Agency 1998).

A Chief Executive Officer (formerly known as General Manager) is responsible for the operations of the Agency and for ensuring that it fulfils its core functions. This person is assisted by a small number of staff based in the national office to develop and implement relevant policies, monitor progress, coordinate education and training, and communication and finance. The role of the State branches revolves mainly around the management of accreditation and the monitoring of ongoing compliance and continuous improvement of facilities (Aged Care Standards Agency 1999a; Aged Care Standards and Accreditation Agency 2001; Aged Care Standards and Accreditation Agency 2002).

The role of the Agency in relation to the Department of Health and Ageing is described as involving the promotion of quality aged care in accordance with the Department's 'Enhanced Quality of Life for Older Australians' portfolio outcome. In practice this includes liaising with the Department regarding facilities that do not meet requirements, providing recommendations to the Secretary regarding sanctions, conducting review audits as requested by the Secretary, and providing regular reports about the status and performance of facilities (Aged Care Standards and Accreditation Agency 2001). As stated earlier, in all other respects it is intended that the Agency operates as an independent body.

Quality assessors

The Agency employs or contracts quality assessors who are responsible for conducting desk and site audits and for preparing assessment reports. Contracted assessors must have completed a registered five day training course which is generally conducted by either the Australasian Auditing and Certification Services or Pacific ETRS Training. Assessors must also be registered by the Quality Society of Australasia (QSA) Recognition Services, the official registrar appointed by the Agency in 1998 (Aged Care Standards Agency n.d.; Aged Care Standards and Accreditation Agency 1999). To remain registered external assessors must have been involved in at least two audits per year.

Assessors are selected on the basis of a number of criteria. These include demonstrated qualifications and/or a background in aged care, management systems review audits or quality management. Various qualities and skills are also required or considered desirable. They include *'a strong commitment to quality principles'*, *'empathy with people requiring care and their families and carers'* and *'demonstrated excellent verbal and written communication skills'* (Aged Care Standards Agency n.d.). The Agency encourages industry based personnel to train as assessors stating that it views their role *'as a vital ingredient in the success of the accreditation programme'* (Burns & Carey 1999, p.16).

As at mid 2002, the W.A. Agency employed 15 staff. They included a State manager, a 'coordinator', eight quality assessors and various clerical staff (Aged Care Standards and Accreditation Agency 2002).

3.3.2 The accreditation standards

The standards that underpin the system are legislated according to Aged Care Act 1997, in particular the Quality of Care Principles 1997, and apply to all approved residential aged care facilities (Commonwealth Department of Health and Family Services 1998).

Although similar to the standards used for the previous system in terms of their outcome focus and coverage of issues relating to resident quality of care and quality of life, they have been expanded to include a standard relating to management, systems, staffing and development. There are four standards, each of which is associated with a number of expected outcomes, of which there are 44 in all. The latter are often also referred to as 'standards'. These expected outcomes are in turn linked to a set of criteria. There are 232 criteria. The latter were developed as a means of assisting the evaluation process and their use is described in detail in the guide prepared by the federal government (Commonwealth Department of Health and Family Services 1998).

A further departure from the previous standards is the inclusion of outcomes relating to continuous quality improvement, regulatory compliance, and education and staff development. These expected outcomes extend across all four standards.

The four standards are:

- Standard 1: Management systems, staffing and organisational development

This standard, which in a sense forms an umbrella over the other standards, is intended to encourage facilities to implement appropriate systems, processes and procedures that are responsive to the needs of residents and/or their representatives, staff and other stakeholders, as well as to changes within the environment. More specifically, its inclusion is intended to create *'an expectation that quality performance under all of the standards will be promoted through demonstrated continuous improvement and education and staff development'* (Commonwealth Department of Health and Family Services 1998, Forward, para.4). It is associated with nine different outcomes including comments and complaints, planning and leadership, information systems, and inventory and equipment.

- **Standard 2: Health and Personal Care**

Focuses on the promotion of a resident's physical and mental health. Wherever possible this is to be achieved on a partnership basis between the resident (and/or his or her representative) and the care providers. It is linked with 17 expected outcomes including clinical care, medication management, pain management, palliative care, behavioural management and mobility, dexterity, and rehabilitation.

- **Standard 3: Resident Lifestyle**

Is concerned with the rights of residents and their being assisted to retain control over their lives within the facility and wider community. It is linked with ten expected outcomes including emotional support, independence, cultural and spiritual life, and choice and decision making.

- **Standard 4: Physical Environment and Safe Systems**

Focuses on the provision of a safe and comfortable environment for residents as well as staff and visitors. It is associated with nine expected outcomes including occupational health and safety, infection control, catering, cleaning and laundry. (Commonwealth Department of Health and Family Services 1998).

A full list of the standards and their associated outcomes is provided in Appendix 1.

The accreditation standards are said to form part of an integrated matrix with each as important as any other in the achievement of quality. The emphasis is, therefore, very much on facilities having systems in place that allow residents' needs to be met in an appropriate and effective way. Moreover, rather than providing '*a recipe for satisfying expectations*', the aim has been to develop standards that provide for some flexibility in terms of how quality is pursued '*in ways that best suit the characteristics of each individual aged care service and the needs of its residents*' (Department of Health and Aged Care 2001b, Introduction, para.2).

The standards ratings system

Assessment of the extent to which facilities comply with the standards is a central component of the accreditation process. In the first three year cycle of the system, this assessment involved the application of a four category ratings system, namely,

'commendable', 'satisfactory', 'unacceptable' and 'critical', to each of the 44 expected outcomes as well as to the four standards overall (Aged Care Standards Agency 1998; Commonwealth Department of Health and Family Services 1998).

For individual expected outcomes, the criteria used to determine an appropriate rating were as follows:

- *Commendable*: a service's policies and practices meet the expected outcome as indicated by all the criteria associated with that standard being satisfied, there is evidence of continuous improvement and there are no identified health or safety risks or concerns about resident welfare, and there is a consistent level of achievement of that outcome. The service would also be expected to demonstrate 'innovation and creativity' for that outcome and 'innovative alternatives to local circumstances or difficulties' (Aged Care Standards Agency 1998, D4).
- *Satisfactory*: some minor deficiencies are identified but the facility is able to provide evidence that an appropriate plan is in place to address these within an appropriate time frame and it otherwise generally meets the expected outcome. In addition, there are no identified risks to the health or safety of residents.
- *Unacceptable*: the expected outcome is not met due to major deficiencies (other than major risks to residents) and, despite corrective action, it will take considerable time to rectify. Alternatively, major risks or concerns regarding residents are identified but there is evidence that an appropriate plan has been implemented to address these concerns within an acceptable time frame.
- *Critical*: there are major concerns about resident health, safety and/or well-being and no evidence of an adequate plan to address these deficiencies. Immediate corrective action is therefore required.

(Aged Care Standards Agency 1998, D4-D5).

Overall ratings for the four standards are given on the following general bases:

- *Commendable*: a service has scored at least one '*commendable*' rating for an outcome and there are no '*unacceptable*' or '*critical*' ratings in the standard.
- *Satisfactory*: a service has scored less than three '*unacceptable*' outcome ratings in a standard and all other outcomes are either '*satisfactory*' or '*commendable*' or; all outcomes are rated as '*satisfactory*'.
- *Unacceptable*: a facility has scored three or more '*unacceptable*' outcome ratings in a standard.
- *Critical*: at least one outcome has been rated as '*critical*', indicating a need for immediate corrective action.

(Aged Care Standards Agency 1998, D3-D5).

3.3.3 Quality management and continuous improvement

The requirement, built into the standards, that facilities demonstrate evidence of a commitment to continuous improvement and that this is incorporated in all areas and processes on an organisation-wide basis represents a major shift in approach from that of the standards monitoring system. As has been discussed, this is consistent with the worldwide trend in approaches to the management of quality in many service spheres. Its inclusion also serves as a means of addressing some of the limitations sometimes associated with regulation systems based solely on assessment of outcomes through the emphasis on organisations to be continually focusing on processes and their links with outcomes.

In the Agency's accreditation guide (Aged Care Standards Agency 1998, Appendix 1), continuous improvement is defined as '*continuous review by managers, staff, residents and carers of policies, practices and service outcomes to identify and implement improvements for better outcomes*'. More specifically, it is:

- progressively increasing value to residents and other stakeholders through changes designed to better address their needs and preferences;
- enhancing performance against the accreditation standards; and

- commitment to identifying needs and opportunities for improvement in a systematic and planned way.

(Aged Care Standards Agency 2001b).

The concept is further explained through reference to the '*continuous improvement cycle*' which is similar in many respects to the PDCA Cycle described earlier. The CI cycle requires a service to demonstrate its current activities in relation to meeting an expected outcome and what it will do in relation to its current practices and processes in order to continue improving on them (Aged Care Standards Agency 1998, Appendix 1). More specifically, this means that for any particular process within an organisation:

- the needs of customers of that process are understood;
- an approach to meeting those needs is devised, through consultation;
- the approach is implemented;
- an outcome is achieved; and
- improvements have been made to the approach and delivery to produce even better results, as evidenced by trend.

(Aged Care Standards Agency 1999c).

In much of the information provided by the Agency continuous improvement is identified as a critical component of 'quality management', the latter being described as a '*comprehensive system to manage and improve the quality of services provided*' (Aged Care Standards Agency 2001b). The key principles underlying this overall management approach are identified as including:

- responsiveness to residents and their needs; that is, a 'customer' focus that incorporates resident involvement and input and integration of resident information into the service's quality management system;
- organisational improvement that is leadership driven and which includes seeking input from all key stakeholders, including residents;
- a process and systems focus that incorporates critical analysis of work practices, how they inter-relate and the outcomes of those practices;
- the ongoing use of appropriate data that allows for the quality and effectiveness of a service to be evaluated and demonstrated;

- development and involvement of staff, including a commitment to their ongoing education;
- a quality culture; that is, quality improvement and self assessment are integrated into a service's everyday activities.

(Aged Care Standards Agency 2001b).

As is evident, these principles accord closely with those generally associated with continuous improvement-based approaches.

3.3.4 The accreditation process

The assessment process followed in the Australian accreditation system comprises a number of discrete steps or stages and is similar to that adopted in most accreditation programmes. The specific stages are described in detail below:

- Self assessment and application

The self-assessment phase is regarded as a key component of the process, providing service providers with a basis for deciding whether or not they are ready to apply for accreditation ('Accreditation by 2001: the journey begins' 1998). The Agency defines self assessment as '*a structured internal process of assessment against a set of standards to identify strengths and opportunities for improvement*' (Aged Care Standards Agency 2001c, p.6).

At the practical level it requires a facility to complete a self assessment document relating to the four standards and their associated expected outcomes, each of which is represented as a single A3 size worksheet. Specific information to be provided includes a service's assessment of the extent to which it thinks it meets the various criteria associated with each of the outcomes linked with the four standards, information regarding possible improvements, and a self assessed rating. With respect to continuous improvement, services are required to work through four basic steps or questions that have been designed to assist them to develop a plan for continuous improvement. These are:

- 'What do we say we do to achieve this expected outcome?'
- 'What do we do to achieve this expected outcome?'

- *'What is the result?'; and*
- *'What will we do to improve our performance against this expected outcome?'*

(Aged Care Standards Agency 1998).

The self assessment also involves completion of a Priority Action workplan.

The completed self assessment and other information relating to building quality, concessional resident and prudential arrangements are then submitted together with an application fee. This fee is generally estimated so that it is no greater than 1% of a facility's annual income, with facilities of less than 20 places being exempted. Specific amounts payable can range from \$1,500 to \$12,550 (Aged Care Standards Agency 2001a). In order to encourage early application, a substantially reduced baseline fee was payable by those facilities who applied before November 1999 (Gray 2001).

In their application facilities can nominate up to three assessors of whom the Agency will attempt to include at least one on the assessment team. The Accreditation Guide also stipulates that nominated assessors should not have any pecuniary interest in the service nor have provided assistance with a quality management system, including preparation for accreditation, within the previous three years (Aged Care Standards Agency 1998).

Once the application is submitted by a facility, and provided that it is considered by the Agency to be 'valid', an assessment team is appointed. According to the Accreditation Guide (Aged Care Standards Agency 1998), the ultimate composition of the team in terms of number and skills is based on a number of factors including the size of the facility, whether it caters for special needs groups and its number of high care residents. Generally, however, teams comprise at least two assessors who are either Agency employees or contracted by it. Facilities are advised of the team membership and have the right to object in the case of any perceived conflict of interest (ibid).

- Desk audit

The desk audit involves a thorough review by the selected assessment team of the self assessment kit submitted by a facility in order to assess whether it is ready for a site audit and, if so, to identify specific issues to be explored further during the visit. Information regarding prudential arrangements, assisted resident ratios and building quality are also reviewed in association with information provided by the Department of Health and Ageing. Any relevant complaints are also considered at this point, although according to the Agency these '*will not necessarily preclude [a facility] from receiving accreditation*' (Aged Care Standards Agency 1998, C4).

Subject to desk audit documents meeting requirements, the team contact the facility to make arrangements for the site audit visit. A copy of the site audit schedule is sent to the facility prior to the visit for feedback and input. A key concern at this stage is that any disruption to staff and residents of the service caused by the visit is kept to a minimum (Aged Care Standards Agency 1998; Burns 1999).

- Site audit

The site audit involves an assessment team visiting facility premises to verify information provided in the self assessment and to review any other relevant issues. This is done via checking relevant documentation such as management policies and procedures and care plans. It also involves observing the environment and practices of the home, and conducting interviews and informal discussions with staff, residents and their relatives and other relevant people, such as visiting doctors (Aged Care Standards Agency 1998; Aged Care Standards and Accreditation Agency 2001; Burns 1999).

Site audits usually take two days and commence with an entry meeting and tour of the facility. The aim of the entry meeting is for assessors to discuss with facility managers and staff their findings based on the desk audit, to clarify what issues will be pursued during the visit and to provide an opportunity for facility staff to ask questions. During the visit assessors' comments and their overall ratings for each outcome are recorded on the self assessment instrument (Aged Care Standards Agency 1998). The Agency has stated, however, that as far as possible the intention

during this process is to maintain an 'open' dialogue between assessors and facility staff (Burns 1999).

At the end of the visit an exit meeting is held with staff to discuss the general findings of the visit. This meeting focuses on any major areas of concern, such as major health or safety risks or major concerns regarding resident well-being, as well as key areas of achievement (Aged Care Standards Agency 1998). A preliminary report (Statement of Major Findings) is presented at this time. Facilities have 14 days to provide a written response. According to the Agency's General Manager, provided open communication has been maintained during the visit, this report is not intended to produce any '*surprises*' (Burns 1999, p.33). Assessors must also prepare and submit a final report (Site Audit Report) to the Agency within the same period (Aged Care Standards and Accreditation Agency 2001).

The Agency has outlined a number of strategies that it employs to address possible subjectivity during the site audit. They include the development of specific 'decision rules' and the incorporation of the self assessment component which is regarded as providing '*a sound basis on which to agree on progress with the assessment team*'. However, it acknowledges that a certain degree of professional judgment is inevitably involved (Aged Care Standards Agency 1998, D10). It also states that there are a variety of mechanisms in place to increase the 'integrity' of the process. These include various requirements under the Accreditation Grant Principles, for example that residents and families must be given advance notice of accreditation visits by providers and that any resident must be allowed to meet privately with accreditation team members if they so request. Other provisions include preserving the identity of people providing information to the teams and meeting with at least 10% of residents (or their representatives) during a site visit (Gray 2001).

Feedback regarding the site audit is sought via a questionnaire that is given to facilities on completion of this stage.

- Decision and site audit report

A final decision about the facility is made by the State manager, based on the findings of the assessment team in conjunction with feedback from the facility and

other relevant information from the Department of Health and Ageing relating to, for example, certification or complaints lodged. This decision, which must be made within 28 days of submission of the site audit report unless otherwise arranged, involves deciding a period of accreditation, the form and frequency of support visits and whether or not improvements are required (Aged Care Standards and Accreditation Agency 2001). The Agency notes that it is quite common for the State manager's final decision to differ from the recommendations made by the audit teams *'because he or she may be in possession of further information and may, under administrative law, give different weight to matters that must be considered'* (ibid p.15).

Homes that are regarded as performing well, as indicated by ratings of *'satisfactory'* or *'commendable'* on each of the four standards, are generally granted three years' accreditation. Those where some improvements are required, as indicated by one or more standards being rated as *'unacceptable'* but appropriate plans are in place to address these, may be accredited for one year. New homes generally receive an initial one year accreditation (Aged Care Standards Agency 1998; Gray 2001).

Once a decision is made, and if accreditation has been granted, facilities receive a letter advising them of the accreditation period, any improvements that are required, the number of, and arrangements for, support contacts to be conducted during the accreditation period, a copy of the site audit report including the rating for each of the four standards, and a certificate of accreditation. Information regarding reconsideration of the accreditation period or decision is also provided (Burns, 1999). As for the site audit, feedback about the site audit report is sought via distribution of a questionnaire.

The Agency provides an explanation for those homes not accredited. This decision is made on the basis of one or more standards being rated as *'critical'* or *'unacceptable'* and a need for extensive corrective action required that could not be achieved within an acceptable timeframe. Facilities must provide written evidence (Improvement Outline) of how they propose to address the issues identified, with the Agency taking responsibility for managing these issues. Since completion of the first accreditation round, however, this process has changed with any non-accredited

facility now having its government funding automatically withdrawn ('closure') (Aged Care Standards Agency 1998). As Gray (2001) points out, however, closure does not mean loss of allocated aged care places but rather the transfer of those places to another site, provided it meets certification requirements, and/or provider. If building quality is the reason for non-accreditation, the site itself is usually sold to another provider willing to invest in its upgrading. Gray also notes that the Department of Health and Ageing has stressed that non-accredited homes are generally '*assisted to consider all their options and, if they choose to, to close as early as possible to enable appropriate relocation and care of residents*' (p.89).

Facilities can request reconsideration of Agency decisions regarding accreditation and/or the period of accreditation but, according to the Agency, this only occurs in a minority of cases. If they are still dissatisfied with the outcome of the Agency's reconsideration, facilities can apply to the Administrative Appeals Tribunal for a further review of the decision, however, such cases are rare (Aged Care Standards and Accreditation Agency 2001). Summaries of audit reports, along with the accreditation decision, are published on the Agency website.

The monitoring process continues throughout the accreditation period granted in the form of support contacts. The purpose of these contacts is to ensure that the facilities are making improvements to their service delivery and practices in accordance with those indicated in the 'Priority Action Workplans' contained within the self assessment documents; that is, as part of the continuous improvement requirement (Aged Care Standards Agency 1998; 2000). These contacts, which may be made by phone, via a desk review or involve a visit by an assessor or team of assessors, can focus on the overall performance of the facility or on specific aspects of care or service. The number of contacts will vary according to how well the facility performed, however, at least one contact is made during the accreditation period. Services rated as '*satisfactory*' would normally expect to receive three or more support contacts during the three year period (Aged Care Standards Agency 1998; Aged Care Standards and Accreditation Agency 2001).

Spot checks, either on a random or targeted basis, can also be made as part of the overall process of supervision. These checks can occur at any time, including weekends (Aged Care Standards and Accreditation Agency 2001).

The Agency also conducts review audits. Similar in purpose and nature to the site audits, they can be arranged if the Agency believes that a facility is not complying with the standards, if it has not complied with the arrangements made for the support contacts or there have been certain changes within the facility, such as a change of ownership or key personnel, or changes made to the premises. Review audits are also conducted by the Agency at the request of the Department of Health and Ageing, for example, as a result of a review of a complaint by a Commonwealth complaints resolution officer. Review audit reports are also published. Non-compliance with the standards identified via a review audit can also result in sanctions being imposed (Aged Care Standards and Accreditation Agency 2001; Aged Care Standards and Accreditation Agency n.d.).

3.3.5 Sanctions

Sanctions can be imposed on a provider if the service does not meet its responsibilities as specified in the Aged Care Act 1997 in relation to quality care, user rights, accountability and the requirements relating to allocation of places. The process begins with the Agency advising the Secretary of the Department of Health and Ageing in writing that it has identified a facility's failure to comply with any of the above responsibilities. If the Secretary is satisfied that this is the case, a Notice of Non-Compliance outlining details, the action needed to remedy the situation and the sanctions that can be imposed, may be issued to the provider. The provider has 14 days to respond to this notice. If the Secretary is satisfied with the provider's response, which may include proposed actions to be taken to remedy the non-compliance, a Notice to Remedy Non-Compliance may be issued. In such cases the provider agrees in writing that the situation will be rectified within 14 days. This statement is generally referred to as an Undertaking to Remedy Non-Compliance (Gray 2001).

Specific sanctions that can be imposed include: revoking or suspending approval as a provider; denying approval for new premises or places; denying funding for new residents; revoking, suspending the existing allocation of approved places or varying conditions for approval of the latter; revoking or suspending extra service status or denying approval of same; revoking or suspending building certification; prohibiting the charging of accommodation bonds and; requiring the repayment of grants (Gray 2001).

Similar to the practice regarding accreditation reports for individual facilities, information regarding sanctions action that has been taken is made publicly available via the Department of Health and Ageing website. According to Gray (2001, p.102), this serves the dual purpose of providing information to the community about homes that are non-compliant as well as *'providing an incentive to providers to avoid the consequences of non-compliance'*.

3.3.6 Other elements of the quality system

Although not the primary focus of this research, two other components of the accreditation framework are worthy of mention here because of their particular relevance. These are the certification system and the Complaints Resolution Scheme, both of which are managed by the Department of Health and Ageing.

Certification

Certification focuses on the physical state of buildings and requires that certain minimum standards are met in order to ensure the safety and comfort of residents. Prior to the implementation of the reforms, there were no requirements imposed on facilities regarding building quality. The latter was the domain of individual States and Territories. With the reforms, however, a new federal government managed certification system was developed. This system involves inspections to assess whether the certifications standards, which relate to fire safety, security, resident privacy, occupational health and safety, lighting, heating and cooling, and ventilation, are met. The Aged Care Certification instrument, the current version of which came into effect in 1999, is used as a basis for this assessment (Barker 2002; Gray 2001).

As an incentive to providers to meet the standards, homes must be certified in order to charge accommodation payments and to receive a concessional resident supplement for those residents who are eligible. As for accreditation, certification is conducted in cycles or 'rounds'. All facilities are required to meet all standards by 2008. Gray (2001) notes that it is likely that the Department of Health and Ageing will require that each facility is assessed for certification purposes at least once in each accreditation round.

Complaints Resolution Scheme

The complaints resolution process forms part of the Commonwealth's User Rights strategy. Other mechanisms include Resident Agreements, a Charter of Residents' Rights and Responsibilities, advocacy services, via the funding of Advocare, and a community visitor's scheme (Barker 2002; Gray 2001). Although all of these strategies were in place prior to the introduction of the Aged Care Act, some, including the approach to complaints, have been modified and/or strengthened.

Under the previous system complaints were dealt with via a complaints unit operated by the Department of Health and Aged Care in each State and Territory. Although facilities were also encouraged to develop their own internal complaints resolution mechanisms, this was not mandatory. With the implementation of the Aged Care Act (1997), however, this became a requirement and forms part of the accreditation assessment conducted by the Agency.

The external complaints mechanism has also been revamped as part of the establishment of the Aged Care Complaints Resolution Scheme in 1997, the functioning of which is overseen by a Commissioner of Complaints. This scheme is a free service provided by the Department of Health and Ageing and provides an avenue for anyone, for example a resident, family member or relative, to lodge a complaint, anonymously if preferred, about any aspect of a residential aged care facility's service. Where appropriate issues can be referred to other bodies, including the Agency (Barker 2002; Commonwealth Department of Health and Aged Care 1999a).

Residents or their representatives who have a complaint are encouraged to seek resolution initially via a facility's own complaints mechanisms, however, if they feel uncomfortable about doing so or are not satisfied, they can contact the Complaints Resolution Scheme. Initial contact is with a complaints resolution officer who will review the complaint and, if it is considered serious or systemic in nature, refer the matter to the appropriate body such as the police, nurses' registration board or the Agency. In other cases, after discussing the matter fully with the complainant, the Officer will then contact the service provider. In some cases a professional mediator and/or advocate may be required to help resolve the dispute. If there are difficulties achieving resolution the complaint is referred to a complaints resolution committee (Commonwealth Department of Health and Aged Care 1999a; Gray 2001).

3.4 Implementation of the New System

The new accreditation system came into being in 1997 following the passing of the Aged Care Act, although the Agency itself was not formally established until 1998. For facilities to remain eligible to receive ongoing Commonwealth funding they had to meet an accreditation deadline of 1st January 2001, with applications to be lodged no later than 31st March, 2000 (Aged Care Standards Agency 1998).

The provision of information and training about the standards and other aspects of the system was a critical component of the Agency's initial work. It developed various guidelines and training packages for providers (e.g. Aged Care Standards Agency 2001b; Aged Care Standards Agency 2001c), both in written form and via the internet, as well as through various education and training workshops that were held in the different States. Information for other key stakeholders, such as residents and their families, was also made available (Aged Care Standards Agency 1999b).

Despite having commenced operations four months later than planned due to delays in the passing of the enabling principles, the Agency completed the first round of the process within the legislated three year time frame. A total of 2938 out of 2959 facilities across Australia were awarded accreditation. A further 20 facilities received 'provisional' accreditation for six months due to 'exceptional circumstances'. One home did not meet the requirements and closed when its government funding ceased.

Its residents were relocated to other accredited facilities (Department of Health and Aged Care 2001a; Quinn 2000).

By the end of the first round Agency staff had made a total of 3000 accreditation site visits plus 2000 further visits to facilities. In addition, approximately 600 spot checks, both random and targeted, were made to monitor standards (Department of Health and Aged Care 2001a). A total of 1084 'commendable' ratings, representing approximately 9% of all outcome ratings, were granted (Aged Care Standards Agency 2000; Commonwealth Department of Health and Ageing 2002).

In W.A. the first round involved 268 facilities of which 267 were accredited and one facility granted an extension. Four facilities received '*commendable*' ratings (Department of Health and Aged Care 2001a).

3.5 Summary and Development of Study Objectives

Quite clearly, the new system represents a major shift in philosophy and approach to how the provision and maintenance of high quality residential aged care should be achieved in Australian long-term care facilities.

From a regulation perspective, the new system represents a trend away from direct government involvement towards increased industry self regulation (Braithwaite 2001; Howe 2000). However, this trend is not without its critics. Braithwaite (1998), for example, argued strongly for the merits of the previous standards monitoring system and has suggested that a possible reason why the industry lobbied so hard for an alternate approach where the government was less involved was because the former system was so successful. Although acknowledging that, in several respects, the new system represents an improvement over the previous one (see below), he has also expressed concern about this reduced level of control by the federal government in the light of the increasing dominance of the private sector in the residential aged care industry in many countries by (Braithwaite 2001). He has also questioned the cost effectiveness of the system, stating that any monetary savings anticipated by abolishing the government regulatory inspectorate and replacing it with a more 'self

regulatory' approach have virtually been eliminated as the government has been forced to almost double the amount initially allocated to support it (ibid).

Although the accreditation system does reflect a trend away from direct government control, it has, as Bartlett and Boldy (2001) have suggested, become a more punitive model of regulation. In other words, in contrast to the previous system which was based on compliance, it now increasingly reflects a deterrence approach, despite its strong emphasis on education, support and cooperation. Although it could be argued that the system is perhaps more akin to the 'responsive' model described by Walshe (2001), the absence of any graduated range of measures and sanctions for fostering compliance, as has recently been introduced in the United States, does not support this interpretation.

Regulation model aside, a further significant feature of the new system which also differentiates it from the U.S. and U.K. regulatory systems, is the adoption of an accreditation approach. In this case, however, and although the use of industry based assessors is encouraged, the approach is not based on peer review in the sense described earlier. It is also 'imposed' rather than voluntary. In other respects the system reflects most of the features typically associated with accreditation systems, particularly in relation to the assessment process involved.

There also appears to have been an attempt within the new system to address several of the potential shortcomings of accreditation systems identified earlier. Specific strategies that have been implemented include:

- the involvement of the industry and other key stakeholders in the development of the system, including the assessment procedures;
- the requirement that all assessors undergo specific training;
- the emphasis on interaction and open dialogue between assessors and those whose service is being evaluated during the assessment process, and the opportunity for feedback (e.g. during exit meetings, via site audit and site audit report questionnaires) and appeal, thereby ensuring that service providers have a greater sense of 'ownership' of the process;
- the use of spot checks; and

- the practice of public reporting which provides information to potential consumers that may assist them to make decisions about their future care.

In relation to the last point, Gray (2001) observed that considerably more information is publicly available under the current system compared with the standards monitoring system, citing sanctions as one example of this. He added that the choice of an accreditation system also serves as a means by which homes that comply with the standards, as defined under the Aged Care Act 1997, are provided with formal recognition.

Importantly also, and while retaining elements of a traditional quality assurance approach to monitoring quality, the incorporation of continuous quality improvement into the standards allows for a much more dynamic approach that focuses providers on innovation and change rather than compliance with minimum standards. Nevertheless, Braithwaite (2001) has suggested that, with its system of 'desk audits' and four (*sic*) day training of assessors by organisations such as the Australasian Auditing and Certification Services, the accreditation programme still reflects many elements of an 'audit mentality'. In his view, audit approaches tend to focus on checking outputs rather than outcomes. He has also claimed that in their most traditional form they represent nothing more than '*a ritual of verification designed to give shareholders comfort*' (p.445).

From a quality management perspective the focus on continuous improvement within the new system is also significant in that it requires facilities to have appropriate management systems and processes in place, to be continually striving to improve, and encourages the involvement and cooperation of people at all levels of the facility. As previously discussed, there have been similar moves by organisations such as JCAHO in the United States to incorporate continuous improvement into the standards used for assessing the quality of health care service providers.

As indicated in the introductory chapter of this thesis, at the time this study was conceived and first implemented, no other formal studies specifically exploring the views and experiences of service providers of the new system on an in-depth basis had been conducted, although some input from providers had been sought as part of

Gray's (2001) Two Year Review of the Aged Care Reforms. The latter report indicated general support for the system on the part of service providers, although a variety of concerns were raised. It has also been possible to glean some information about service providers' views via industry-based journals, newsletters and media reports. These have mainly focused on the impact of the system on the industry, including its effect on morale and credibility within the community (Quinn 2000), on smaller operators ('Aged home closed by Federal 'nightmare' ' 2001; Ayris 2001) and on staff (e.g. Jones 2000). Broader issues such as funding and staffing levels that are perceived to be critical in determining the extent to which the industry can meet the requirements of the new system have also been identified (Ayris 2001; Jones 2000; Quinn 2000; Sellars 2000).

In view of such concerns, and taking onto account information presented in this and the previous chapter, there are a number of issues that could be explored with service providers in order to understand more fully their perceptions and experiences of the new system. One of these relates to circumstances surrounding its establishment; that is, the widespread dissatisfaction amongst service providers and other stakeholders, including government, with the standards monitoring system. Initial feedback on the accreditation system suggests that its establishment was generally welcomed by the industry ('Accreditation by 2001: the journey begins' 1998; Gray 2001). However, with all providers now having completed the first round of the process it is obviously of interest to explore the extent to which this has remained the case and, in particular, whether it is regarded as a preferable alternative to the system it has replaced. Specific aspects of the new system such as the continuous improvement philosophy, which clearly represents a significant departure from the previous system, and its emphasis on open communication, co-operation and support, also warrant exploration. These considerations form the basis of the first major objective of this study which is:

- to assess the extent of support for the new accreditation system, in terms of its basic philosophy and principles.

The way in which any new system or programme is implemented, both in terms of the information and guidance provided as well as the specific processes involved, are obviously critical to its acceptance and overall effectiveness. As outlined, the

provision of education is a mandatory part of the Agency's role and was one of its primary activities during the early stages of implementation of the new system. Given the significant shift in philosophy and approach to quality embodied in the system, assisting facilities to understand and prepare for accreditation and to meet the requirements on an ongoing basis would have been of vital importance.

In addition, the new system involves a very different approach to the evaluation of quality than previously, particularly as it requires much greater commitment and input by providers themselves. As such, their experiences of the evaluative process in terms of the ways in which it is structured and the role of the Agency in this process, are of interest. A second key objective of this study is therefore:

- to identify the ways in which the accreditation system has been implemented and any associated issues or concerns.

The accreditation standards are a core component of the new system and form the basis of the assessment process. It is obviously critical that these standards are not only appropriate in terms of the dimensions or aspects of service and care that they cover, but also provide a reliable basis for assessment. At the same time, they need to be realistic and attainable. Given that the industry was heavily involved in their development, it could reasonably be assumed that they are 'acceptable' to them, at least in general terms. Whether they are regarded as appropriate at the 'practice' level, however, in terms of providing a clear indication of what is to be achieved and whether they are actually attainable, is a further issue of interest. Thus, a third objective of this study is:

- to assess the extent to which the accreditation standards and related requirements, as set out in the Standards and Guidelines for Residential Aged Care Services, are perceived as appropriate to the achievement and maintenance of quality.

Although it is important to understand the new system in terms of its processes and implementation, it is equally important to assess its overall impact to date. Given that the system is still in its relative infancy it would not yet be appropriate to attempt an evaluation of its outcomes. In accordance with comments made by Øvretveit (1998), however, it is possible to explore the impact of the system on providers in more

general terms. Walshe's (2001) comments regarding the tendency in evaluations of long-term care regulatory systems to focus on implementation and management rather than impact suggest that this is a particularly important issue to explore. Moreover, while the focus of this study is on service providers, it would also be useful to explore the latter's perceptions of the impact of the programme on other key stakeholders, but particularly residents. Hence a further objective of the study is:

- to assess the impact of accreditation on service providers and other key stakeholders

In view of the evaluative nature of this research, a primary aim is to provide information that could be used to help inform decision making about the new system; that is, in terms of those aspects of it that appear to be working well and those that are not and which may thus require further attention. A final objective of the study is, therefore:

- to identify the strengths and weaknesses of the new accreditation system and, in particular, any areas for change or improvement.

Chapter 4: Method

The overall aim of this study was to explore, in-depth, the views and experiences of service providers concerning the new national accreditation system for residential aged care facilities. As outlined, the specific objectives were to:

- assess the extent of support for the new system, in terms of its basic philosophy and principles;
- describe the way/s in which the system has been implemented and any associated issues or concerns;
- assess the extent to which the aged care standards and related requirements, as set out in the Standards and Guidelines for Residential Aged Care Services, are perceived as appropriate to the achievement and maintenance of quality;
- assess the impact of accreditation on service providers and other key stakeholders; and
- identify the strengths and weaknesses of the new accreditation system and, in particular, any areas for change or improvement.

4.1 Overall Framework for the Study

This study has been developed within an evaluation framework using qualitative methods as the basis for data collection. An evaluation framework was adopted in view of the fact that the ultimate intention of the research was to provide information about the accreditation system that could assist in making judgments about its development and future implementation (Øvretveit 1998; Owen 1993; Posavac & Carey 1997).

The ‘paradigm’ underlying this evaluation aligns closely with the ‘illuminative’ model described by Parlett and Hamilton (1976) in that it is mainly concerned with description, interpretation and understanding how the programme operates rather than on measurement and prediction. Specific features of this model include a focus on issues relating to programme processes, the influence of various factors and/or situations on the programme, what it is like to be a programme ‘participant’ and the

advantages and disadvantages of the programme from the perspective of those directly concerned with it (ibid).

The evaluation is largely formative in nature. This is for two main reasons. Firstly, although now moving into its second 'round', the accreditation system is still a relatively new programme that is still evolving. Secondly, the ultimate purpose of the study was to help improve the system by focusing on its operation and implementation, strengths, weaknesses, and general impact rather than to judge its 'effectiveness' in terms of predetermined outcomes (Øvretveit, 1998; Patton, 1990).

The choice of qualitative methods was based on the fact that the study was essentially exploratory in nature and aimed to provide an in-depth understanding of people's experiences. The use of such methods is also consistent with the approach adopted in many formative evaluations (Øvretveit 1998; Patton 1990).

4.2 Design

Using Øvretveit's (1998) typology of evaluation designs as a basis, and consistent with the approach adopted in many formative evaluations, a descriptive design was chosen. Descriptive evaluations aim to provide a good description of an intervention, for example a programme, and of the important features of the environment surrounding the intervention in order to make an informed judgment of its 'value'. They are used as a means of understanding processes and inputs and can also provide a general description of impact or 'outcomes', however, are not suitable for evaluating effectiveness. They are frequently used to describe a service or programme that is in its early stages of evolution with this information being used to give service providers or policy makers a basis for considering improvements (Ovretveit, 1998 p.54).

Øvretveit (1998) also noted that descriptive evaluations can be conducted 'retrospectively' or 'concurrently'. Much of the information gathered in this study is based on participants' views and experiences of the first round and hence the evaluation is essentially 'retrospective'. However, because providers' involvement in

the system is ongoing, in the sense that there is never an 'exit' point as such, the evaluation could, to some extent, also be described as 'concurrent' in nature.

4.2.1 Target group

The target group of this study was aged care service providers in W.A. This choice was based on the fact that service providers represent the primary 'recipients' of the new programme in that they are the stakeholder group most intimately involved with and directly affected by it. The focus on service providers in order to explore their experiences of, and views about, a newly implemented quality assurance programme, including its strengths, limitations and general impact, is also consistent with approaches that have been adopted by other evaluators, for example Lawrence & Packwood (1996).

Although it is recognised that residents are the ultimate focus of the new system, their views were not sought as part of this evaluation. This is mainly because it was felt that the most critical questions regarding this stakeholder group relate to the impact and outcomes of the programme, that is, whether it has resulted in improved quality of care and quality of life for residents. In order to answer such questions, however, a different kind of evaluation from that adopted in this study would have been necessary. Ideally this would have been some kind of longitudinal, outcomes-focused approach involving the collection of both quantitative and qualitative data. Nevertheless, as will be seen, some attempt has been made to explore the general impact of the new system on residents in a more indirect manner via the perceptions of service providers.

The design has also involved 'data source triangulation' (Denzin 1978), specifically, the collection of data from people working at various 'levels' within the service provider target group. These levels were: facilities (e.g. Directors of Nursing [DONs], care managers, direct care staff); 'organisations' (e.g. Chief Executive Officers [CEOs]; General Managers); and peak bodies (e.g. Executive Officers). Triangulation is not only regarded as a means of strengthening a research design (Patton 1990), but also allows a more complex picture of the phenomenon being studied to be developed (Rice & Ezzy 1999).

4.2.2 Sampling and recruitment

In selecting participants for this study, the main aim was to ensure that a wide range of facilities and organisations were represented. For this reason, and because the aim was to select 'information rich' cases for in-depth study rather than statistical representativeness, a stratified purposive sampling approach was adopted (Patton 1990; Sarantakos 1993).

Facilities

The initial sampling frame included all facilities that had been through the accreditation process between June and September 2000. This decision was made primarily because it was considered preferable to involve people whose experiences of the first round were reasonably recent. The fact that most providers in W.A. applied for accreditation in the final year (S. Leavesley, Manager, Aged Care Standards and Accreditation Agency, W.A. Branch, 2000, pers. commn, 20 April), was also taken into account. Lists of all such facilities, including key contact people and information relating to the various criteria used as a basis for selection (see below), were provided by the local Agency.

Selection was based on a number of criteria considered to be important and which were developed in consultation with staff of the local Agency. These criteria were as follows:

- *size*: large (60+ places); medium (30-59 places); small (< 30 places)
- *level of care*: high; low; both
- *location*: rural; metro (for practical reasons only those rural facilities that were within a three to four hour's drive of Perth were selected)
- *type*: stand alone (sole facility); not stand alone
- *accreditation period granted*: 1 year; 3 years
- *overall rating*: commendable; satisfactory; unacceptable; critical.

As indicated, a stratified purposive sampling approach was used to select facilities. This aimed to provide a range of facilities within each of the criteria (strata) identified above. First, using the list provided by the Agency, the total number of facilities in each category for each of the criteria (e.g. *Size*: large; medium; small)

was calculated. Individual facilities were then selected. This process involved choosing a facility from the list, initially on a relatively 'random' basis, and allocating it according to the criteria and categories it 'met' (e.g. size = *small*; level of care = *high*; location = *metro*; type = *stand-alone*; period of accreditation = *3 years*; overall rating = *satisfactory*). Thus after selecting the first facility there was a 'total' of one (facility) in one category within each of the major criteria (e.g. size = *small* [1]; level of care = *high* [1]). The maximum number of facilities per category aimed for was intended to be approximately proportional to the total number of facilities in each category (i.e. as calculated previously) but with a minimum of three facilities per category.

The selection process became increasingly 'purposive' as it continued – that is, facilities were specifically chosen in order that certain categories could be filled. In several cases, however, there were insufficient numbers of facilities in the sampling list that matched some categories. This meant that the minimum of three facilities per category was not always achieved (e.g. rating = *critical*).

An initial sample of 15 facilities was regarded as sufficient to provide a reasonable coverage of the issue. However, it was decided that a final decision about sample size would be made during the fieldwork stage on the basis of whether information was felt to have reached 'redundancy' (Lincoln & Guba 1985; Patton 1990; Rice & Ezzy 1999).

Facilities selected according to the process outlined above were then sent a letter explaining the nature and purpose of the study and inviting their participation. In all cases letters were directed to the primary accreditation 'contact person' who was usually the DON or care manager, as identified in the information provided by the Agency. Letters were followed up with a personal phone call to invite participation and arrange a suitable time to conduct an interview.

Of the 15 facilities selected initially, two did not wish to participate and in another six, the DON or care manager had recently left, necessitating eight replacements. The latter were selected according to the 'type' of replacement that was necessary, that is, as identified via the key selection criteria.

Organisations

The process of selection and recruitment of organisations was similar to that used for facilities, with modifications as appropriate. First, those criteria considered to be most relevant to the purposes of the study were identified. These were size of organization, location and auspice 'type'. As there was no list of organisations readily available that could be used as a basis for establishing an initial sampling frame, one had to be compiled. This list was based on information provided by the Department of Health and Aged Care (Commonwealth Department of Health and Aged Care 2001), information contained in facility reports available via the Standards and Accreditation Agency website, and the researcher's own knowledge (e.g. in relation to location).

Specific selection criteria used were:

- *size* (based on total number of high/low care facilities): single facility; small (2-3); medium (4-9), large (10+)
- *location* (of facilities): metro only; rural only; both
- *type*: religious/charitable; private; government (State/local)

Sampling was conducted on a stratified purposive basis, as for facilities. However, on order to maximise the range of organisations included in the sample, an organisation responsible for providing services to a specific culturally and linguistically diverse (CaLD) group was also selected. In addition, organisations linked with facilities selected in the 'facility' group above were not selected.

An initial sample of eight organisations was initially regarded as sufficient, however, this was later revised to include ten organisations as new information continued to emerge. As noted previously, this is consistent with most sampling approaches of this nature (Patton 1990; Sarantakos 1993).

All prospective study participants were sent general information about the study and contacted by phone or email to seek their participation and to confirm interview dates/times. Key contacts were identified via information available on the Agency website (facility reports).

There were no refusals amongst those organisations approached, however, in one case a replacement had to be made due to the unavailability of the CEO during the period for which the fieldwork phase was scheduled.

Peak bodies

In the case of the peak service provider bodies, of which there are two in W.A., the Nursing Homes and Extended Care Association of W.A. (ANHECA - WA) and Aged and Community Services, W.A. (ACSWA), no sampling was necessary. Approaches were made to the Executive Officers of each organisation in a similar manner to that for facilities and organisations.

4.3 Data Collection

The fieldwork stage extended from October 2000 to September 2001. Facility interviews were conducted first, during the period from October to December 2000. Interviews with organisation and peak body representatives were conducted during June to September 2001.

As indicated, the primary method of data collection in this study was personal in-depth interviews. All interviews were based on a general interview guide approach (Patton 1990) with the key issues explored reflecting the objectives of the study. In the case of interviews with representatives of organisations and peak bodies, however, some issues such as people's experiences of the site audit could not be explored in the same depth as most participants had not been (as) directly involved. A 'semi-structured' approach to the interviews was considered appropriate as it allowed for some flexibility in terms of the order and, to some extent, nature of the issues discussed compared with a more standardised, open-ended approach. At the same time, it also allowed for some comparison to be made between responses to similar questions (Patton 1990). A copy of the interview guide used for facilities is provided in Appendix 2. Similar versions were used for the other two interview groups, with modifications as appropriate.

In the facility interviews the informant was usually the facility manager, either the DON or supervisor/care manager. In organisations it was usually the CEO or General

Manager. In several cases, however, other personnel such as residential care managers, quality coordinators and carers who had been heavily involved in the first accreditation cycle also participated. The decision as to who else should be involved in the discussions apart from the main contact was left to the latter's discretion.

With one exception all interviews were audio-tape recorded subject to permission having been sought from the informant/s. One person requested that the interview not be tape recorded but gave permission for the researcher to take notes. All interviews were conducted on-site (i.e. at the facility or organisation's head office) and generally lasted approximately one hour.

Other pertinent information for this study was obtained from secondary sources such as the Agency and Department of Health and Ageing documents and reports as well as relevant newspaper articles. As Patton (1990) noted, such secondary data is both a valuable means by which knowledge and understanding of a programme can be increased and can also help to generate ideas about issues to be pursued via more direct methods of data collection, such as interviews. In this study the secondary data collected were used for both purposes.

4.4 Data Management and Analysis

All audio-taped interviews were initially transcribed verbatim. These data were then manipulated and managed with the assistance of the QSR NUD*IST Vivo (NVivo) software package (Richards 1999).

Analysis was conducted on a cross-interview basis using the topics explored in the interview guide as an overall framework. This involved grouping together each person's comments relating to the different topics explored in preparation for coding. The adoption of such an approach is common in studies where a structured interview guide has been used (Patton 1990).

The analysis was conducted in two stages. The first involved reviewing data relating to each major topic explored in order to identify initial codes or categories (content analysis). The second involved reviewing these codes for evidence of any recurring

patterns and/or themes (thematic or inductive analysis). Patton (1990, p.381) described content analysis as '*the process of identifying, coding and categorizing the primary patterns in the data*' while the focus of inductive analysis is to identify the overarching patterns or themes that have emerged. Rice and Ezzy (1999), however, have suggested that content analysis is often and, in their view, best understood as referring to the identification of codes *prior* to examination of data. The specific process adopted in this study is described below.

4.4.1 Data preparation and initial coding

As indicated in the interview guide (Appendix 2) there were seven main topics explored in the interviews. Each of these topics thus represented discrete 'sections' within the interview transcripts and was named accordingly (e.g. '*Impact of accreditation*'; '*Overall strengths and weaknesses of the system*'). Each transcript was reviewed in order to ensure that all information relevant to each of these topics or 'sections' was grouped under the relevant heading. In several cases this meant moving some information to a more appropriate section. This practice is commonly adopted in studies where a structured interview guide is used (Patton 1990).

Several of the sections were also divided into sub-sections in accordance with more specific issues that were explored within that overall topic (e.g. '*Impact on residents*' within the general topic '*Impact*'). In some sections an '*Other*' category was included as an additional sub-section to account for comments that related to a specific section but which could not be readily included within any of the other sub-sections. Comments that did not obviously relate to any of the key topics explored were initially grouped under a further major heading labelled '*Other*'. This process resulted in the establishment of twenty-five initial categories or codes.

In preparation for section coding, each transcript was also checked to ensure that the order and titles of sections were consistent across the interviews. Data from each interview were then entered into the NVivo programme.

In order that all comments relating to specific issues could be grouped together ready for further coding, each interview was first section coded in accordance with the

process outlined in the *QSR NUD*IST Vivo Reference Guide* (Fraser 1999). This approach thus represented a form of content analysis as interpreted by Rice and Ezzy (1999).

4.4.2 Further coding and identification of themes

Following the initial coding process, each major section and/or sub-section was reviewed in order to identify specific patterns or issues within each. These were identified as discrete codes or 'nodes' (Richards 1999). Once all data had been coded in this way the material was reviewed a second time to check the appropriateness of the way in which codes had been delineated and conceptualised. In several instances this resulted in the renaming of codes (nodes); in others it resulted in their deletion, merging with others or further partitioning. This process can be likened to Guba's (1978) process of checking for 'internal homogeneity' and 'external heterogeneity'.

Finally, individual codes (nodes) across all sections were reviewed in order to identify any recurring and/or closely linked issues that could be grouped together. Essentially this involved looking for similar codes (issues). These codes were then grouped together as 'sets' (Richards 1999), with each set representing a general 'theme'.

4.4.3 Field notes and memos

As is the practice in many qualitative studies an 'analytic file' (Minichiello et al 1995), in the form of a loose leaf file, was maintained throughout the study. This was particularly useful during the transcription and analysis stages as a means of recording relevant ideas, thoughts and observations that might assist with the interpretation and discussion of the findings. Rice and Ezzy (1999, p.201) noted that record keeping of this nature, which may also be in the form of a journal or memos kept within a computer programme, is a useful means of facilitating '*thinking about, and beginning to write about, the analysis and interpretation of qualitative data*'.

4.5 Study Rigour

The need for researchers who rely on qualitative methods to demonstrate the quality and credibility of their studies is generally recognised as essential (e.g. Patton 1990; Posavac & Carey 1997; Rice & Ezzy 1999). Some writers (e.g. Bartlett 1993; Le Compte & Goetz 1982) discuss this issue in terms of 'validity' and 'reliability'. Others, including Rice and Ezzy (1999) prefer to use the term 'rigour', arguing that the former concepts should not be directly applied to qualitative research due to their quantitative, experimental research origins. However, the same authors also point out that many of the issues indicated by these terms still need to be addressed within qualitative research.

Rice and Ezzy (1999) identified three main categories of rigour that need to be addressed in studies involving qualitative methods, namely: *theoretical rigour*, which relates to the extent to which the study reflects sound reasoning and argument and a choice of methods appropriate to the research question; *methodological rigour*, which, as the term implies, relates to the credibility and soundness of the basis on which the study was conducted and the findings arrived at; and *interpretative rigour*, which reflects the extent to which a study 'accurately represents the understandings of events and actions within the framework and world view of the people engaged in them' (p.36). These authors also suggest that rigour can be addressed via other means including triangulation, 'rigorous reflexivity' and adherence to ethical standards of practice.

With respect to theoretical rigour, the rationale behind and justification for the choice of approach adopted in this study for addressing the research problem has already been outlined in some detail. Rice and Ezzy (1999) suggested that the choice of appropriate sampling strategies, that is, the people or units selected are appropriate to the research question, is also central to ensuring that theoretical rigour is maintained. In this study the stratified purposeful sampling adopted has allowed for a range of views to be canvassed from members of the target group. This included service providers in terms of the different 'levels' at which they operate, namely, facility, wider organisation and peak body. In the case of facilities and organisations it also

involved people working at different levels, for example quality coordinators and carers in addition to facility or senior managers.

A full description of the methods and procedures involved in the collection, management and analysis of data has been provided in order to demonstrate the methodological rigour of this study. This is a strategy recommended by several writers (e.g. Le Compte & Goetz 1982; Rice & Ezzy 1999) in research of this nature. It is also consistent with that adopted by Bartlett (1993) in her qualitative study of nursing homes although, like Le Compte and Goetz (1982), she discusses such strategies in terms of '*validity*' and '*reliability*' rather than '*rigour*'.

One means of ensuring the interpretative rigour of a study, which Rice and Ezzy (1999) noted is an aspect of methodological rigour, is to clearly demonstrate how interpretation has been achieved. A specific example of how this can be done and one that has been used in this study is through the frequent use of verbatim quotes which help to provide '*a clearer sense of evidence on which the analysis is based*' (ibid, p.37).

Sharing interpretations with relevant others such as those being studied and/or who know the programme well is a useful strategy for developing a sense of 'correctness' of the interpretations and conclusions. Such strategies are also a further means of ensuring a study's interpretive rigour (Posavac & Carey 1997; Rice & Ezzy 1999). In this research summaries of the main findings were prepared and sent to all study participants as well as to the local Standards and Accreditation Agency, inviting comments and feedback regarding the findings and their interpretation. Only the Agency provided feedback. This focused on action that had been taken to address various issues identified in the study and has been incorporated into Appendix 3. The feedback process was also carried out as a gesture of 'courtesy' (see under 'Ethical Issues').

Triangulation is generally regarded as a means of strengthening a study's overall rigour (Patton 1990; Rice & Ezzy 1999). As mentioned previously, the design of this study involved data source triangulation. However, rather than this being between

different stakeholder groups, as is usually the case, it involved different groups within the same target group.

The centrality of the researcher's role in this study and the need to constantly reflect on that role and its implications for the overall research process has been recognised throughout. As such, and in acknowledging that this researcher has, in a sense, been the 'instrument' of the research (Patton 1990; Rice & Ezzy 1999) it is inappropriate to suggest that the study has been an 'objective' process. Although it is beyond the scope of this report to discuss in detail issues relating to the objectivity-subjectivity debate, this researcher is of a similar view to that of writers such as Patton (1990, p.481) that the issue is '*not really about objectivity*' but about '*researcher credibility and trustworthiness, about fairness and balance*'. The latter view has underpinned the approach adopted throughout this research (see also below).

4.6 Ethical Issues

Approval to conduct this research was sought from and granted by the Human Research and Ethics Committee at Curtin University. There were a number of specific ethical issues to be addressed that related to the general need to protect the wellbeing of all participants. These included issues relating to informed consent and rights, respect for privacy, anonymity and confidentiality and storage of data. Each was addressed in a variety of ways.

In regard to informed consent, all prospective informants were sent information about the study outlining its nature and purpose and other issues. The latter included the fact that participation was voluntary and that further contact would be made by telephone to ascertain a person's willingness to participate and a convenient date/time for an interview. An outline of the key issues to be explored in the interviews was included with this information. Agreement to an interview was understood as implied consent. Prior to the interviews, permission was also sought to audio-tape record the discussion.

Issues of privacy were addressed by arranging interviews so that they were as non-intrusive as possible for the informant and/or their place of work. For example,

interview dates and times were chosen in a way that was most convenient for the informant/s concerned and interviews conducted at the person's place of work, if suitable, in order that they did not have to travel elsewhere.

As a means of preserving anonymity no identifying information was maintained on either the audio-tapes or transcripts. Rather, each tape/transcript was numbered with a code and identifying information maintained in a separate location in case any information needed to be verified. Similarly, no names of any participating facilities, organisations or informants (in the case of the two peak bodies involved) have been identified in this report.

In the reporting of results, all information linking comments to their specific source/s has been kept strictly confidential. In cases where it has been deemed appropriate to identify a source, this has been done in a general way only (e.g. *'the CEO of one large organisation said'*; *'the view of one peak body representative was'*). In addition, where the nature of the information provided in the report could be potentially identifying, it has been either slightly modified or deleted.

Audio-tapes and other relevant information such as codes and participant details have been maintained in a secure location (locked filing cabinet in the researcher's office) in the School of Public Health at Curtin University. Tapes and codes are maintained in separate filing cabinets. Data maintained electronically can only be accessed by the researcher via her personal password. On completion of this study all relevant data (tapes, code lists, disks) will be stored in separate sealed containers in the School of Public Health archives for five years before being destroyed in accordance with National Health and Medical Research Council requirements.

Apart from the above ethical considerations, Posavac and Carey (1997) observe that there are a number of others that evaluators need to be aware of and that have relevance to this study. Many of these relate to the extent to which the 'credibility' and theoretical, methodological and interpretive rigour of a study can be assessed. This is because evaluators have an ethical obligation to provide information that will allow this to be done. The same authors also highlight the importance of evaluators

conducting the study in a professional and competent manner. This study has attempted to address such concerns in a number of ways, as described.

4.7 Summary

As stated, the overall aim of this study was to explore, in depth, the views and experiences of service providers regarding the recently implemented accreditation system for residential aged care facilities. An evaluation framework based on a descriptive design was adopted. Study participants represented three levels of service provision, namely: facilities, sponsor organisations and peak bodies and were selected on a stratified purposive sampling basis.

Data were collected via in-depth interviews. These interviews were semi-structured in nature and explored a variety of topics related to the overall study objectives. All interviews were audio-tape recorded and later transcribed.

The data were analysed on a cross interview basis using the interview guide as an overall analytic framework. Initial analysis involved coding for content in order to identify recurring issues or patterns. Further analysis was then conducted in order to identify general themes. The latter involved grouping together related issues or categories into broader categories. The QSR NUD*IST Vivo (NVivo) software package (Richards 1999) was used to manage and manipulate data.

Issues relating to study rigour and ethical concerns were addressed in a variety of ways. These included ensuring that all participants were fully informed about the nature and purpose of the study, arranging interviews so that they were as non-intrusive as possible, and the implementation of various strategies relating to the preservation of confidentiality, anonymity and data storage. Approval to conduct the research was granted by the Human Research and Ethics Committee at Curtin University.

Chapter 5: Results

As outlined in the previous chapter, the primary aim of this study has been to evaluate the new accreditation system using the views of service providers as a basis. In order to achieve this aim, a number of issues that reflect the main objectives of the research were explored via in-depth interviews with a range of facility-based staff, senior level managers from various organisations and peak body representatives.

This chapter presents the overall findings of the study. It is divided into two main sections. The first provides details of the final sample obtained for each of the three informant groups involved. The second and major section presents the interview findings. It is structured in accordance with the study objectives and specific issues explored. Where appropriate, the main issues identified in relation to each objective are summarised diagrammatically at the beginning of the relevant section. A further section outlines the main issues and themes that emerged from the study.

5.1 Final Sample Details

The final sample comprised 15 facilities, 10 organisations and the two service provider peak bodies in W.A. (ANHECA-W.A. and ACSWA). In order to preserve anonymity, names of participating facilities and organisations have not been identified. Details of the facilities and organisations selected according to the selection criteria are provided in Tables 1 and 2 respectively.

Table 1: Facilities by Key Selection Criteria

Care level	Location	Size	Type	Period of accredn	Rating
High 6	Metro 10	Large 6	S/alone 7	3 yrs 12	Commendable 1
Low 8	Rural 5	Med 5	Not s/alone 8	1 yr 2	Satisfactory 11
High/low 1		Small 4		Fail 1	Unacceptable 2
					Critical 1

Table 2: Organisations by Key Selection Criteria

Location		Size		Type	
Metro only	4	Single facility	2	Religious / charitable	4
Rural only	2	Small	4	Private	3
Both	4	Medium	2	Government	3
		Large	2		

Facility-based interviews involved a total of 30 informants, half of whom were either DONs or care managers/supervisors (seven and eight respectively). Other participants included registered nurses (RNs) (six), quality coordinators/managers (two), carers (two), systems/service managers (two) and a Board of Management member, regional manager and enrolled nurse (EN).

Organisation based interviews involved 13 informants, most of whom were either CEOs (or equivalent) although in some cases other senior staff (e.g. residential care manager) were also present. The peak body interviews involved two informants.

5.2 Interview Results

Results for the three groups of interviews revealed a marked similarity in terms of the issues raised and hence for reporting purposes have been presented together. Where specific differences occur, these are identified.

It should be noted that in order to preserve the anonymity of participants all potentially identifying information has been omitted. In some cases this has included deletion of specific information contained in verbatim quotes, however, in such cases the intent and/or meaning of the comment has been maintained. Similarly, in several instances information that is either repetitive or not central to the issue in question has been deleted from quotes. In all cases these deletions are identified via the insertion of square brackets ([]).

5.2.1 Support for accreditation as a new approach to quality regulation

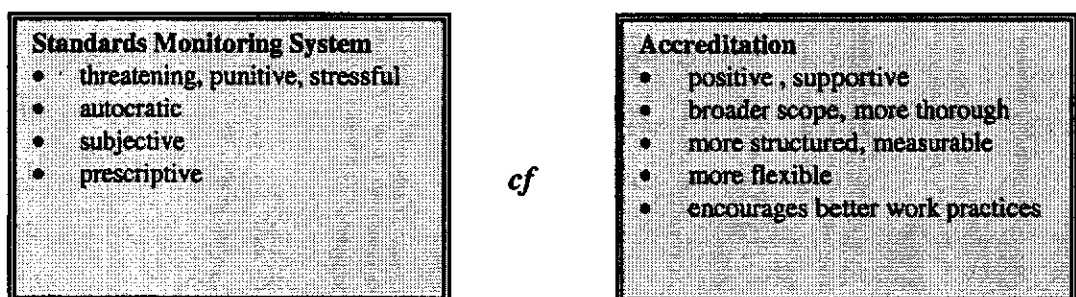
As stated, a key objective of this study was to explore views about the accreditation system as a new approach to quality regulation in terms of its basic principles and philosophy and overall appropriateness. Specific issues of interest explored included: how the accreditation system compared with the previous standards monitoring system; the emphasis on continuous improvement embodied in the new system; and the extent to which the new system was regarded as an approach based on cooperation and partnership.

Comparison with the Standards Monitoring System

In five facilities, the informants had not experienced the previous system, however, most were familiar with it and felt able to make some comment. All informants, regardless of their level of experience or position, thought that accreditation was very different from its predecessor. Most were also of the view that it was a welcome improvement on the old approach which was frequently described in terms such as '*stressful*', '*threatening*', '*autocratic*', '*prescriptive*' and '*punitive*'.

A number of specific differences were identified. The most prevalent were the generally positive and supportive nature of the accreditation system and the overall 'scope' and 'thoroughness' of the process. These and various other differences (see Figure 2) are discussed in detail below.

Figure 2: Key differences between Standards Monitoring System and Accreditation



Accreditation was regarded as a much fairer, more positive and 'supportive' approach than the standards monitoring system. Its focus on assisting facilities to

achieve what was required rather than simply being 'judged' on the basis of what was observed was frequently identified. As one DON said:

With the standards monitoring system you felt they were checking on you; this is a more positive approach - helping you to get there, to achieve your goals, to look at your priorities. You didn't feel as though you were being put through a test, you are given the opportunity to go and get information to assist you meeting the standard whereas before, if you didn't have what they were looking for, they just assumed you didn't have it.

One senior care manager commented similarly:

With the standards monitoring system it was: "If you don't do this we will shut you down - and by the way we will shut you down today". It was very threatening. With the Standards Agency, should they find a problem, it would be: "How can we help you? Have you considered these options? Would you like some assistance? There are some good places over there you might like to go and could find some solutions". So it was a totally different approach.

Several people specifically praised the helpfulness of the local Agency staff.

They were very positive to the staff on the site and they've developed and maintained very good relationships with them which is very different from the standards monitoring system.

Particularly for facility-based staff, the general scope of accreditation, in terms of the range of people it involved ('It wasn't just me...it was the Board and everyone') and the level of detail explored ('This system is more thorough, it doesn't leave any stone unturned') was also regarded as a major difference from the previous system.

Some people also felt that accreditation provided a better defined, more structured basis for ensuring quality than the standards monitoring approach.

Having the parameters in place, certainly having the outcomes defined is a much better way of delivering quality care than the alternative.

This more structured approach was also regarded by some as providing a more objective basis for assessing quality.

However, while many informants agreed with this view, some felt that in practice the assessment process did not differ significantly from the standards monitoring system in that it was still too subjective and open to personal interpretation.

It is like the old system as far as complaints about it - vague rules, subjective, open to personal interpretation. They have guidelines, but it is still interpreted in the same way. We want something more consistent as far as assessment is concerned.

Accreditation was also regarded by many as a more equitable and flexible approach compared with the previous system in which there was 'no area for giving, there were no grey areas it was black or white'. As one senior manager stated:

The Agency philosophy gives you a feeling of being able to use latitude and to actually step outside of boxes BUT to have the underpinning of the standard there.

Being able to have input into the process was regarded as particularly valuable.

Accreditation is a better system - you are actually putting forward your views on how your system works, where it's going, how you feel about it. It's not like someone arriving and telling you that you are doing all these terrible things.

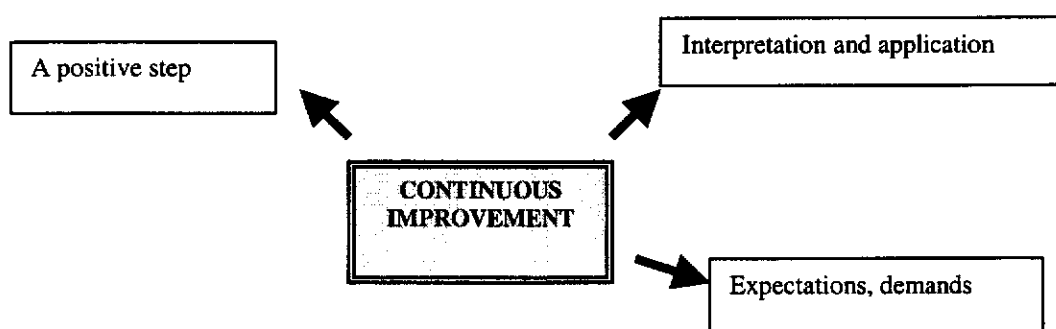
A number of people, particularly more senior level informants, also felt that accreditation encouraged better, more accountable work practices. The emphasis on continuous improvement was identified as an important influence in this regard.

People did things and said "That's great and now let's put it away now that we've done it and we've met all the requirements". That was great and people became aware of the standards, but now it's a continuous process and I think that that makes a huge difference because people know that you've reached this point but it's a continuous process and therefore we must live it every day - we must be reviewing, we must be making the effort to ensure that we are meeting outcome standards and we are improving upon those and we are asking the right questions.

Continuous improvement

As outlined previously, the accreditation system requires that service providers operate according to a philosophy of continuous improvement (CI) and can demonstrate that this is the case. Consequently, views about the incorporation of this approach into the system and issues relating to its practical application were also canvassed. The main findings are summarised in Figure 3.

Figure 3: Views regarding Continuous Improvement



As a basic philosophy underpinning the provision of services and care, the idea of CI was generally supported. As one person commented:

It's very necessary - you can't just stay the same, there's always got to be change and progress.

In one facility where staff had been unfamiliar with the approach, the DON was particularly enthusiastic saying:

I think it's brilliant. Staff don't have a problem with it and our residents are now very educated in the terminology. It's now a current day term basically. I think it has done us all really good [] and it's for the benefit of everybody, not just people in aged care or working in aged care but also for our clients in the community.

Some people identified specific benefits of the approach, one senior manager, for example, saying that *'from an organisation perspective it has its merits because you know where you are going.'*

While fully supporting the incorporation of CI into the new regulatory system, several informants mentioned that it was a concept with which they and their staff were already quite familiar and/or that it already formed part of the organisation's/ facility's approach to quality management.

We already had a culture of that through our education programmes. It's great, but nothing very different from what we've all been doing.

In one case, the incorporation of CI into the accreditation system had provided the catalyst for making major changes within the organisation.

We had the ability to manage and utilise the concept of CI as a springboard - to be able to bring about change that a lot of people have wanted to do for a long time but were perhaps psychologically unable to do because of the Draconian system in place here.

Although strongly supported as an approach to quality, many comments were made about the difficulties of ensuring that everyone concerned – from the level of management to direct care staff - had a good understanding of CI and how it should be applied at the practice level.

It's a good idea but I think it has to be owned by the people that are applying it to their particular discipline. CI is a management strategy that people need to know - it doesn't matter whether they're managerial level or they're a carer on the floor, they have to be able to see what is the improvement.

One facility staff member described her own personal struggle in trying to come to grips with the meaning of the concept and how it should be applied.

Whatever system you were to use, the goal would be not to only improve but to monitor the improvement, improve again on it and extend and extend - so it's like a tree. That's how I see it now, but when I first started I didn't see a tree, I didn't even see a full cycle, I just thought "Well that's the improvement, it's done, now what's the next one?". It becomes a huge jump,

to understand what they are asking. I know that now but I didn't understand it in the beginning.

Similarly, a DON in another facility described the difficulties that several of her nursing staff had experienced in fully understanding the meaning and implications of the concept, in this case because they were used to working in a different kind of way:

It was very difficult for some nurses to come to terms with as nurses are taught to problem solve almost immediately - for example, the patient has pain, you give medication and it relieves the pain. It poses a lot of difficulty - to know that you must go through a process, that you must collect data, evaluate it, trial and action it and then you've got to come back again. So it's a whole new mindset.

Some people were also of the view that there was still considerable confusion surrounding the meaning of CI and how it should be applied, both within the industry as well as amongst Agency staff. As one senior care manager commented:

I think they have got a bit muddled. At the education sessions we went to a lot of the auditors were still have trouble differentiating between CI and an auditing improvement.

In addition, some people commented that the Agency and the Department of Health and Ageing should embrace the CI philosophy within their own practice, the view being that, to date, there had been little evidence of this occurring.

Apart from the difficulties associated with understanding the meaning of CI and its implications for practice, another concern related to the expectations of the Agency as regards documentation. These expectations were often regarded as inappropriate and/or unrealistic, particularly in view of the demands that this made on staff time and resources. The following comment is typical of many that were made:

I think continuous improvement is important but it all comes down to proving it - all the paperwork, all the statistical analysis, the trend analysis, all this proof, all these surveys [] and we then have to assess it and see what we

can get out of it - and that's meetings, time. It's a very time consuming process.

Accreditation as a partnership

In considering the extent to which accreditation could be regarded as a system based on cooperation and collaboration, several informants, particularly those working in facilities, mentioned that the supportive nature of the assessment process and the helpfulness of Agency staff had helped to foster a certain sense of partnership. This view is reflected in the following comment:

They knew where we were at. They were very supportive and offered me anything that I needed basically. I've felt that they were there as a collaborative approach not there as a 'big brother'.

Having the achievement of quality as a common goal ('We're all working towards good quality of care') was also identified as contributing to a sense of partnership.

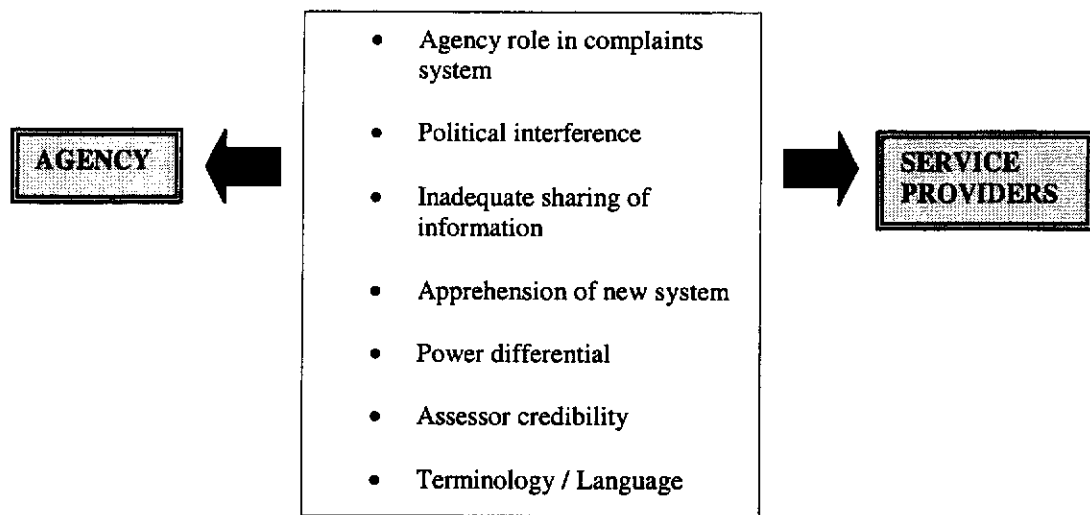
Despite such comments, few informants regarded the new system as a real 'partnership' with several people expressing their concerns and in some cases disappointment about how the system had developed.

It was working as a partnership. [] In comparison with what we were accustomed to it was a wonderful experience - quite uplifting and the staff felt positive after the assessors had left their facility. Now they feel very negative about the possibility of a visit. One of the things I've had to do with my staff is to actively talk to them about this. I say to them "you need to know that these people are not here as your friends, to enhance your ability to deliver a service, there's not an equal relationship".

Barriers to Partnership

A variety of reasons were given for this lack of a sense of partnership, with some of the more prevalent shown in Figure 4.

Figure 4: Perceived Barriers to Partnership



One barrier often mentioned, particularly by senior level managers, concerned the Agency's role in the Commonwealth complaints system which was felt to work in direct contradiction to the former's support and educative roles, thus creating a more 'punitive' image.

At the moment what happens is someone rings up the Agency (sic) and says "my Mum didn't get a meal this morning" so the worst case scenario comes out. Probably the channel needs to change to break that down, for the Agency to say "We've just been to that place and accredited it for three years, is it that bad?" I'm talking about the complaints system - the complaints are given straight from the Commonwealth Department of Health and Aged Care (sic) to the Agency and maybe the Commonwealth should be looking at the complaints, not the Agency. Here they are helping you in one breath, the next day they are telling you how bad you are!! You can't do that - that's very difficult to work under.

Another factor was the perceived 'political interference' by the (now former) Minister for Aged Care. As one person said:

The local Agency has pushed really strongly for a cooperative approach, that is the only way it can work, but Ministerial interference is pushing away from that.

There was also a perception that the Agency was not sharing information and /or consulting with the industry to an adequate extent with lack of information about best practice being a frequently cited example.

If they want to get into a partnering process maybe they need to start that now, to put a mark on the line and talk about the things they have seen that they were impressed with. If they want to be looking at a best practice model then they need to be fostering that – it's their task to foster that, to be that link, that conduit.

Some people felt that the industry's initial apprehension about the new system had also possibly worked against the development of a sense of 'partnership'. In one case it was suggested that this was because accreditation was largely an 'unknown':

Next time around may feel more like that. The first time around we weren't too sure. We were certainly told that all support was there but we felt reluctant to tap into it because we were not sure what we were tapping into.

However, another person suggested that this apprehension might have been partly a legacy of the previous system:

I think there had been a lot of scaring tactics going on - perhaps this was a left over from the standards monitoring teams - so it was very hard to actually get people to think about a partnership arrangement or that they're out to look at us to tell us how to improve. Now that we've been through it I think their perception is different, but I don't really see it as a developed partnership, it's still a 'them and us' situation.

The inherent power differential between the Agency and service providers was a further barrier identified by some.

Of course the thing that does stop it being a partnership I suppose is the fact that they have the power - they can come in and close you down. So they've got two different functions. Maybe they should not be run by the one

department. So that is an aspect of it which could detract from acceptance of the Agency. Maybe you could say we are a minor partner.

Also suggested was the questionable credibility of some Agency assessors in terms of their background and experience.

Some of the assessors haven't got as much experience in aged care as I have and they're reviewing ME. I would find it very hard to assist somebody in depth as to how to go about it. From that point of view I don't think some of those people are as credible as they might be.

One person felt that the Agency could make more use of industry-based assessors saying that, to date, this had been very limited.

A few people also identified some of the terminology used, described in terms such as 'jargonistic' and 'bureaucratic', as a further barrier. The experience in one facility was described in the following terms:

They were asking questions but the person being asked the questions didn't really know what they were asking. For example, the term 'management systems', we hadn't used that terminology before - it's too jargonistic. Had they asked the questions in a more general way - for example in terms of scenarios - she could have answered better. After the visit she realised they did have a lot of things in place.

The view of the CEO of one large organisation was that the use of 'bureaucratic' language and the general 'bureaucratic' approach of assessors (in this case in relation to a complaint) had been extremely intimidating for staff and worked directly against the possibility of any sense of partnership.

You need to put yourself in the position of a \$12.50 an hour carer who loves caring and is slogging their guts out and some bureaucrat has come in and because of some minor indiscretion starts to use this sort of language in relation to compliance and requirements - and it's all in dot point form and just draws out the negatives and uses a range of very threatening language as to what the consequences could be which is a reiteration of the terms under the Act. It is very distressing for staff.

A number of people were also of the opinion that if there was to be any real sense of 'working together', the Agency, like facilities, should be subjected to some kind of review or accreditation process.

At what point is the Agency going to be accredited too? You've got to put your money where your mouth is and they also need to be looking at what are good elements of accreditation processes and how they might be improving. If you have a partnership there has to be some equity.

Views about accreditation in the future

Despite the barriers and general concerns that were expressed, some people remained optimistic that accreditation eventually would become a partnership.

People haven't lost the objective of a having a good partnership, they are committed to the idea but they don't see it as a good partnership yet.

Others, particularly several more senior level informants, were not so convinced, with some expressing concern that the system would revert back to the style of the standards monitoring system as it moved into the second round. One CEO's comment was:

2001 was like a Hiroshima bomb going off. The Act was changed and the discretion that general managers and State managers and the Agency had was removed and a very rules oriented, bureaucratic regulatory approach to defining standards and delivering on standards was implemented. [] So what was starting to be something which was positive [] has now become one of the greatest demands and points of fragmentation in our sector, it has become a very negative force. These days when you know you're getting a visit from the Agency it engenders all the feelings of a police network - exactly as we saw the standards monitoring system.

Although others also acknowledged that problems such as political interference and the Agency's role in the Complaints Resolution Scheme were a concern, not all agreed that the accreditation system was increasingly resembling the standards monitoring system.

A lot of people are saying that the current system that's being used is too prescriptive, I don't think its prescriptive at all, that it's too similar to the

Standards Monitoring System. I don't get that - but I think it is being clouded with the complaints process.

5.2.2 Implementation: education and training

There were two key issues of interest regarding the general implementation of the accreditation system. One related to education and training, specifically views about the adequacy of the information provided by the Agency in preparation for the first round. The other was the accreditation process itself in terms of people's experiences of the different phases involved and perceptions of the way in which it was approached and managed. Given that these issues have most relevance to facility-based personnel, the majority of the information contained in this section is based on comments made by them.

Agency education and training

The Agency-provided training (organised workshops, on-site education sessions) appeared to have been the primary means by which facilities familiarised themselves with the new system and what was required, although many organisations also hired consultants and/or conducted their own 'in-house' training (see later).

In most facilities at least one staff member and, in some cases also, senior managers and Board of Management members had attended workshops or education sessions run by the local Agency. However, the number of sessions attended and the number and range of staff involved varied widely. Several informants mentioned that they would like to have attended more sessions, however were unable to for reasons such as lack of time and, in the case of some rural facilities, the time and/or distance involved in getting to them, even when they were held in rural locations (*'they were still a couple of hours away'*).

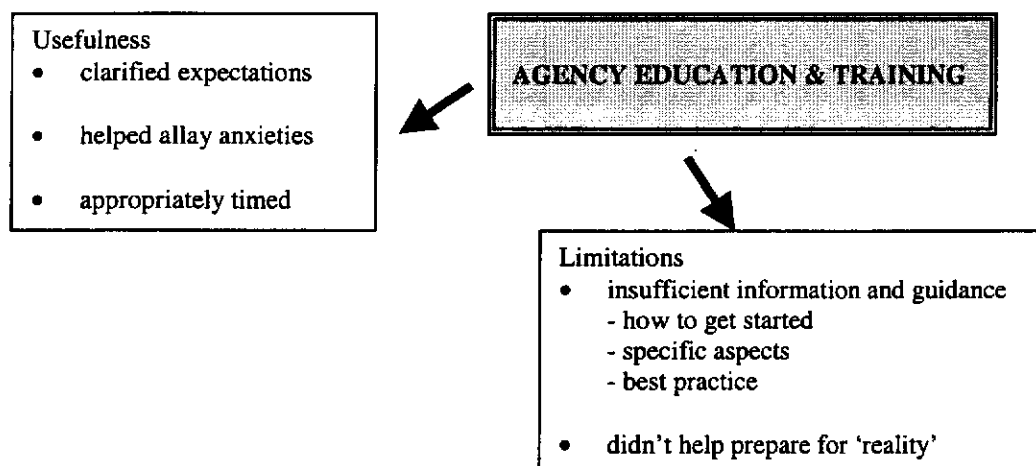
In several cases staff who attended the Agency workshops later conducted feedback sessions for other staff in their facility although this was not always perceived to have been particularly successful.

Only three staff went to the workshops. We went through them with staff when we got back here but it was not easy. Some staff are only doing domestic

duties and haven't had much schooling. It was frightening for us so it was even more frightening for them.

In some cases Agency staff had also conducted education sessions on-site with all staff. In two instances on-site sessions were also held with Board of Management members. Views about Agency education and training are summarised in Figure 5.

Figure 5: Views about Agency Education and Training



Overall usefulness

Most informants felt that the Agency workshops and education sessions had been useful particularly for clarifying what was expected and generally helping to allay people's anxieties about the process.

The Agency training was very helpful, particularly for the RNs who hold portfolios like pain management - they were able to ask what they were expecting in the audits or how they can demonstrate particular expected outcomes. So it put us all on track. It was also useful for reducing the panic syndrome of what was going to happen and so on.

One person felt that the Agency's on-site session had been particularly valuable.

The one workshop I went to I found very useful.[] But I felt the one that the Agency held here with staff was really good, it gave the staff a really good

understanding of what was going to happen and why we do it, why we are demanding documentation and forms from them and so on. I think staff went away with a different attitude, I think they went away realising what the standards were all about, that it is for the residents and their care needs. I think they had initial thoughts that they were coming down to be checked on.

Most people also felt that the timing of the Agency workshops, which for most people was several weeks before the accreditation process commenced, was 'about right'.

It was just right for the process and sequence of events. They helped us realise the depth at which we had to go. If they had been earlier they might not have had the same significance. We had already started setting up systems but at a more superficial level. After the training we realised we had to go in a lot deeper to really make sure that we met the standards.

In a couple of cases, however, it was felt that staff would have benefited from the opportunity of attending another workshop closer to the site audit.

It was a long time before accreditation. Maybe they needed two – one which was "this is how you get started, what we are expecting and so on" and one closer saying "this is perhaps where you should be at, this is the next stage".

Limitations

Although generally regarded as useful, there were also some criticisms of the Agency education and training. One of the most common, including amongst several senior managers, was that insufficient direction and guidance had been provided. This had resulted in many facilities and organisations feeling unsure as to how to proceed and whether what they had done was sufficient and/or appropriate.

At the beginning nobody was able to tell us what we were supposed to be doing – so finding the starting point was very difficult.

It was also felt that a lot of time could have been saved had more guidance been provided initially.

In hindsight, I would like to have had more help in knowing how and where to focus rather than spending hours and hours wasting our time.

One person suggested that part of the problem was that Agency staff themselves were unsure what they should be looking for and/or advising service providers:

They didn't know what they really wanted. I said to some of the assessors "It's a shame that you can't give us more guidelines" and they said "Oh we can't be prescriptive" and I said "But if you define the goals and what you're looking for we can all work to the same denominator. Everyone's out there just searching and you are frittering more money away".

Other comments related to the lack of information about specific issues such as the standards and continuous improvement and/or particular aspects of the assessment process, for example the self assessment and site audit. As regards the latter, one person said:

All the workshops we went through didn't show us how they did their desk audit or the site audit. They should have done a kind of role play to show you.

Several senior managers also expressed concern about the lack of information and guidance as providers moved into the second round, particularly in regard to continuous improvement.

There was no information or education offered by the Agency in the continuous improvement standards from towards the end of last year to leading up to the beginning of this year but that was the time that some people were due for their support visits and that's when they needed to know what they were expecting this time around, that the bar is just lifted.

Several concerns about the lack of dissemination of best practice information by the Agency were again raised.

Although a number of informants were not able to identify any specific gaps in the training itself, some commented that it didn't really prepare them for what was ahead in terms of the amount of work and time involved.

It didn't prepare us for the actuality. It wasn't easy, there were huge amounts of time involved, the staff came in on weekends - and there's no compensation or recognition for that.

Similarly, another person felt that although the Agency education and training was useful *'it was largely practical and it was actually a big cultural shift that was needed.'*

Apart from those implied in the preceding comments, a number of suggestions for additional education and training that could have been provided or should be provided in the future were made. They included more on-site education sessions, the use of training videos (i.e. so that staff could go through them in their own time) and mock site audits *'that would tell you what the situation's like.'*

Other education and training

In addition to the education and training sessions offered by the Agency, most facilities/organisations attempted to prepare themselves for accreditation in other ways. In many cases this involved facilities conducting their own internal training and/or participating in training that was provided by their parent organisation. The extent of this education and training appeared to vary widely, however, as reflected in the following two comments:

The organisation had in-service training workshops from time to time and then we went into groups to look at the various standards.

We went into a huge educational programme about a year before accreditation, all very meticulously planned. It was done by the QA manager. We also built huge quality systems from what we already had. We had a lot of data and correlated a good quality system that all staff operated, had input into and owned. It was massive, everyone was saturated by the end.

Several facilities/organisations also employed consultants to assist with various aspects of accreditation, for example in setting up appropriate management systems (the Management and Quality Assurance System or MQAS) was frequently mentioned), to help conduct an internal audit and/or for staff education purposes (e.g. continuous improvement, fire and safety, occupational health and safety). Not all had the resources to do this, however.

We had no funding to buy in training so we had to rely heavily on information provided by the Department (sic).

In addition, some facilities conducted their own 'mock audit' which, in the opinion of at least one informant, was useful as *'it helped identify gaps we hadn't thought of and gave us time to fill those before the real thing'*.

Other issues

A number of other issues were raised in relation to education and training for accreditation. One related to the difficulties of educating staff about the concepts and processes involved, as *'they had never experienced anything like this before'*. Another related to the involvement of Board of Management members and/or facility proprietors, with several facility managers of the opinion that this had been insufficient (*'they need to understand the whole aged care picture'*).

Finally, a number of people felt that the accreditation process had been as much an educative one for Agency staff as it was for service providers.

It was new for the Agency too. We had people out from the Agency arguing with one another! There was one instance when auditors came out to give a presentation and nearly came to blows! Next time round we should all be going down the same path.

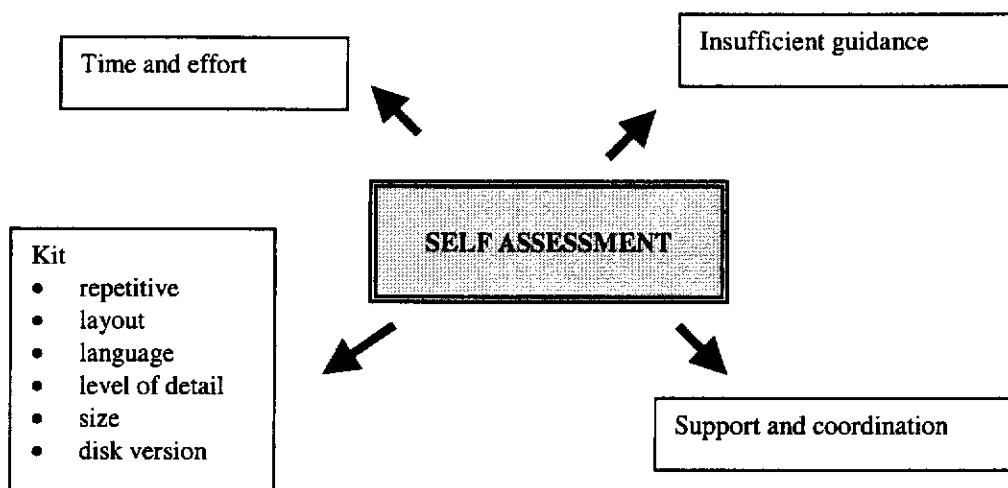
5.2.3 Implementation: accreditation process

As noted earlier, not all informants, particularly those working at more senior levels, had been directly or heavily involved in the accreditation process itself. However, many offered comments based on their observations and/or feedback from staff. Results in this section are structured around the specific stages of the process as outlined in the literature review.

Self assessment

With respect to the self assessment stage the majority of comments made concerned the large amounts of staff time and effort involved and the kit which was regarded as difficult and cumbersome. Other prevalent issues related to the perceived lack of guidance provided during this stage and support and coordination (see Figure 6).

Figure 6: Issues Relating to Self Assessment Stage



The time and effort involved in the self assessment stage was identified by virtually all informants. This related not only to the time spent completing the self assessment worksheets but also, in many instances, to the time needed for meetings and discussions prior to completing the 'final' version. Many people described this stage in terms such as 'ludicrous' and 'a nightmare', several adding that it was an experience they hoped they would never have to repeat.

I couldn't take my annual leave. I took two months in the end because I was falling over. I would never do that again.

In most cases it appears that many staff had spent numerous additional (and generally unpaid) hours outside of their normal working time in order to complete the necessary documentation. The following comments were made by two facility managers:

The task was enormous, you couldn't add up the hours that were spent. There was a lot of out of hours work. I'd take things home on the weekend so I could be in peace and quiet. There was an extraordinary amount of time required.

I had to have a week away from here to do it all and that was from daylight to dark everyday, just me, although I did have some support from the nursing consultant. But at the end of the day it was me who had to do it. It took hours and hours to do, I couldn't imagine how many hours it took.

Similarly, one CEO commented:

Feedback from the DON was that it was exhausting. And I did see the DON was just basically zapped by the time she had finished. It was like hours and hours of work.

Another administrator commented on some of the other practical difficulties involved:

The difficult thing was because we've got a lot of part time staff you're not quite sure what they're doing so you have to wait until they come in. So it's not like you can pull in all your people and say "OK let's do it". So the DON has to race around individually. You waste a lot of time ringing people, chasing people, waiting until the next week.

Although most informants were unable to put an actual figure on the amount of additional time they had put in during this phase, some estimated between 250 and 300 hours. Several respondents felt that the Agency did not have a real appreciation of the demands that preparing for accreditation had made on facility staff and, in some cases, senior management and/or Board of Management members:

I don't think from conversations I've had with the auditors that they have any idea whatsoever of how much work people have had to put in. They keep saying "We know how hard this has been, we know what effort you've put in and so on" but I don't think they have any idea of how many extra hours and blood sweat and tears has gone into this first round.

The self-assessment kit itself attracted many comments, several of which related to the large amounts of time and often frustration involved in its completion. It also appears not to have been regarded as a particularly 'user friendly' tool and as requiring a number of improvements.

Many people thought that the kit was unnecessarily repetitive and, as a consequence, fairly tedious and time consuming to complete. Comments included:

I found a lot of it very repetitious. You repeated yourself a lot and you tried to think of something different to put there - a lot of that was quite unnecessary.

It would be good if they could refine some of the tool; there's so much overlap. There IS overlap, but some is just repeating itself.

Layout was another concern, several people pointing out that there was often insufficient space provided for information to be entered, although as reflected in the following, most found their own 'solutions' to the problem.

Fitting all the information in the little columns - I didn't like it at all. We developed our own format and just attached it to each page of the manual.

There was only a small space to write everything in. Sorting out what was really necessary to put in was a real challenge. We tried to condense the information as much as possible - just to give the basics, thinking that they will ask for additional information if they want it.

Others found the kit format generally confusing and difficult to understand.

It took us some time to get our head around what was required. We couldn't understand why they had all these things on the pages.

Several comments were also made about the language used in the manual which was described in terms such as 'unrealistic', 'confusing' and 'airy fairy'. This appeared to be a particular concern people working on smaller and/or rural low care facilities, including some Board of Management members. For example, the comment of the manager of one rural low care facility was:

The way they word things is a bit confusing for someone like myself, a hostel supervisor - the interpretation, I didn't find it easy.

Similarly, a Board of Management member in the same facility said:

I had to spend time before we [the management committee] met, breaking it down and putting it into simpler language and taking things along to show them what it all means.

Such difficulties, however, were not always restricted to this type of facility. For example as the administrator of one larger metropolitan based organisation said:

The language of it I found extremely difficult and I think I'm a reasonably intelligent person but I had a real difficulty coming to grips with what they actually wanted. I went to their education sessions and I wasn't any the wiser. [] I know they had people from the industry to design it but I'd like to know where they were coming from. I think it was an academic tool, not a practical tool. We have a lot of knowledgeable people here with a lot of expertise and they were all stuffed. So I think that implies that the tool wasn't a very user friendly tool.

The level of detail required was also an issue for some.

I felt that it didn't have to be quite as extensive as it was. Like the idea of "This is what we say what we do, how we do it and so on". It could perhaps have reduced from six boxes down to three.

Also a concern was the physical size of the kit, which many found daunting.

The manual was not a user friendly document – the size - you needed a whole desk to put it on!!

Several comments were made about the disk version of the kit that was provided which proved problematical for most who attempted to use it. Some people could not open it and said that in the end they simply 'gave up'. Others said they couldn't understand how to use it:

I tried to use the disk but I couldn't work it out. I thought "this is too hard" and I couldn't find any manual to work it out.

For some who did manage to get past this point, difficulties were experienced with some of the software functions or tools, for example 'cut and paste'. This also proved to be very time consuming.

Specific sections of the manual were identified as particularly problematical by some people, for example:

The 'Impact' section – it's airy fairy stuff, too difficult. If you put the ideal it becomes impossible.

The 'Outcomes' section is fine but wipe the 'Criteria' section - it's absolute rubbish as it's only the outcome that was legislated. We got really stuck on the criteria. It said "If you don't meet the criteria explain why in the box at the top". But if they're not legislated, why are we explaining why we need it? We either meet the outcome or we don't meet the outcome. They should have just been prompts or something like that, not to throw you off track like it did.

For many informants, one of the most difficult aspects of the self assessment stage was not knowing how to proceed and/or not having any basis for comparison or a baseline from which to work. As a result, a common perception was that more guidance about this aspect of the process should have been provided.

A lot of the time there wasn't proper explanation. If a group of people in our organisation hadn't worked out some of how we were going to do it and some of what we were going to do we would have been all over the shop. It took hours of work just to get the right direction to get started because there wasn't any proper guidance.

They should have clarified what they wanted in terms of length, level of detail and so on.

Despite such problems and concerns, several people did comment that the Agency training related to the self assessment component had been useful. Others mentioned that their contact with other facilities had been helpful.

A further issue that many people raised concerned the extent of support available within their organisations/facility during this stage. Several facility managers mentioned how fortunate they had been in having had access to someone who could coordinate this part of the process for them and/or who could provide support in preparing what was required. As one DON said:

As we moved on to the desk audit it was formally put into the desk top format by the systems manager. That was a relief personally, I'd given my all just putting it down on paper. It all had to be put on disk by the systems manager. You do really need a designated person to coordinate.

In some cases, Board of Management members assisted.

It would have been difficult for me to work through but we were lucky in that we had a Board member who helped. We wrote it all in in pencil – we had it for ages before we submitted. Pinpointing times and when things would be done by and so on was difficult. So it was a big help that the Board member helped.

In others where this support was not available or forthcoming the task was felt to be particularly burdensome. As one senior care manager commented:

It was a long and tedious process. We invaded a resident library and did it there - that's all we were given. There was no secretarial help, no help given at all. If you had the support, the process would have been relatively simple – but for us it was like Silas Marner.

Despite the time and effort involved and specific problems encountered, several participants, particularly those who were reasonably new to a facility, commented that having to conduct the self assessment had been helpful and informative.

I found it was a fantastic way to orientate myself to the facility – it was a real eye opener, really useful.

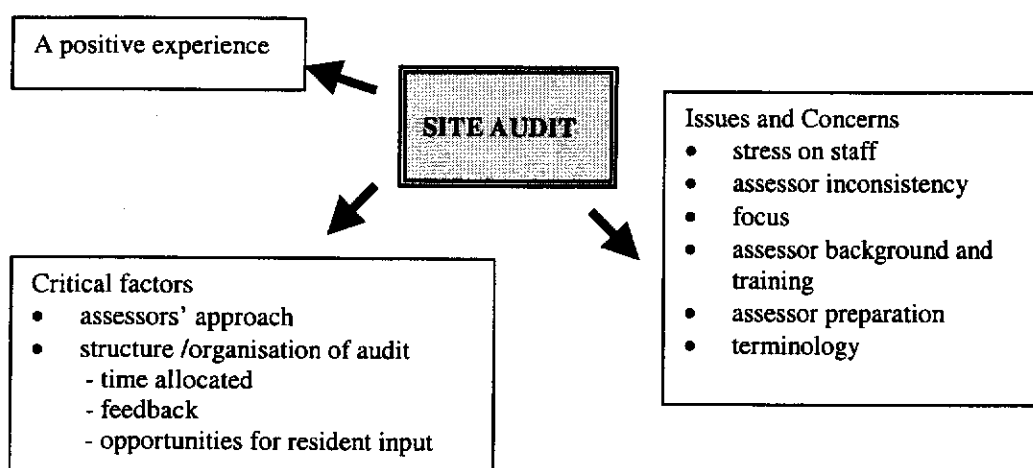
Desk audit

In most cases it appears that after submission of the application kit, there was no further contact with or from the Agency during the desk audit stage other than to confirm receipt of the manual and/or the dates of the site audit. As several people said, including informants in facilities who received either an unacceptable or critical rating, the assumption was that '*no news was good news*'.

Site audit

For the majority of informants the site audit appears to have been a generally positive and, in some cases, an enjoyable experience. A key factor contributing to this finding appears to be the general approach of the assessors who were generally highly praised. However, a number of concerns about this aspect of the process were also raised (see Figure 7).

Figure 7: Views about Site Audit



Despite the apprehension of staff (see later), most participants described the site audit experience overall in positive terms.

We enjoyed the two days, as did the assessors. There was so much stress leading up to it that we almost didn't care by the time of the visits - I felt we had done all we could. It was very relaxed; there was a lot of laughter. Overall it was a very positive exercise; we didn't feel threatened at all.

Overall I was pleased with the site visit; I felt it was very positive. Even with the standards that we had problems with it was very positive in its approach.

One person specifically commented how different the accreditation site audit was from the standards monitoring team site visit, particularly in that 'we had a chance to prepare, to respond, to defend ourselves - and we were given a schedule.'

As would be expected, comments made by those facilities that did less well than expected (e.g. 'unacceptable' ratings) were not so positive.

It was absolutely horrific. The auditors weren't rude or anything but we knew after a couple of hours that we were in trouble. It was a horrific two days. The process was O.K. but the fact that we knew we were in trouble was horrific.

Critical factors

Final decision aside, a number of factors appear to have played a key role in influencing people's perceptions of the site audit as a generally negative or positive experience. One of these was the approach and attitude of the Agency quality assessors who were generally praised for their helpfulness, openness, relaxed attitude and professionalism. The following comments are typical:

The assessors were very friendly, you felt comfortable talking to them. They explained things if you weren't too sure - they didn't just leave it if you didn't answer it. They were very helpful.

The girls were very positive. We were very pleased, they couldn't have made us feel more at ease. They were really there to meet our needs and I think they did.

I thought they did an excellent job. They actually said they were not good at things if they didn't feel confident. They had a really open attitude.

Even in facilities which failed some standards, the assessors were praised.

I was upset because I knew we had failed one standard but the assessors were very encouraging and supportive. I was trying to explain how things work and they suggested a really simple way – they helped a lot.

This was not always the case, however. One owner/proprietor, for example, recalled the experience of one of her staff members as follows:

So much depends on the auditors. The second visit was a nightmare. One of the auditors queried the clinical care coordinator about things to do with her policies and procedures so much so that she wouldn't come back in again so

I had to continue the rest of the visit. The two of them were totally opposed and that made it very difficult. The rest of the staff knew too so it wasn't a good experience. The person who was the auditor was quite unaware of the effect he'd had.

In another facility, the DON did speak with the assessors who subsequently modified their approach.

We had one situation where one staff was quite upset and in tears about the way she was spoken to. So we told the people "Could you please tame it down, come and check with us because the staff are very apprehensive and you need to develop that rapport with them until they can see where you're coming and they'll open up". So after that episode they seemed to mellow down and they were very good.

Another informant stated that certain assessors had a reputation for being 'hard':

We were told via the grapevine that each one had their pet area so we'd know when we chose the assessors. You pick it up from meetings as well from places that have been assessed, they say "don't get her, she's really hard".

One senior manager expressed concern about the unprofessional approach of an assessor who visited one of his facilities.

We weren't impressed with one of the auditors who really wasn't that professional in her manner. They made a point of saying that we'll make appointments with residents and their advocates at the beginning - so they are all scheduled and they'll know when their time is - and this one kept a resident waiting for two hours and she spent a lot of time outside smoking and extending her chatting session with different people.

Several people commented on the way the visits were organised, generally in positive terms, for example:

We were given a schedule and they kept to it. It was a very good idea, it means you can get staff in at appropriate times. And they gave feedback to all staff at the end of the two days and complimented them.

There were some criticisms, however. One CEO felt that the requirement that he attend each facility's site visits to discuss what he regarded as essentially the same management issues was time consuming and an inefficient use of resources.

We tried to have the same auditor for the management standards so I didn't have to go out to each site for each site audit but as it turned out they still wanted to sit down and talk about it at each of the nursing homes [] - so I still had to go out to every facility and sit down and say the same thing!!

In two cases concerns related more to the need for feedback during the course of the visit, particularly at the end of the first day.

I was involved in one actual audit where we had no idea at the end of the day how we were going. It was our first audit and we were quite nervous and that's not the intention. The Agency says that you should have a little bit of an idea of how you are going, even after day one of a two day audit. We made a comment to the auditors the next morning so they gave that feedback and that was sort of corrected.

A further criticism made by one informant related to receiving the schedule very late. In another case the facility had not been informed beforehand of the amount of time assessors wished to spend with certain staff members and this had created some staffing difficulties.

Informants were specifically asked about the two day time frame for the site audits, in terms of its adequacy. Again, opinions varied. Some people thought it was sufficient in terms of what assessors had to achieve, although some commented that it might depend on the site itself (e.g. size, nature).

Two days is probably enough to get a feel for whether people are getting looked after and so on. The paperwork was the big thing they were addressing - to see that you had things online, that you had plans to improve on things.

Other informants, however, felt that two days was probably not adequate, with a variety of reasons being given. For example, some people thought that it did not really allow the assessors sufficient time to fully understand and assess what went on

in a facility. Some also thought that it placed a lot of pressure on assessors themselves. As one person said:

I think it's really hard for them because it's really only a day and a half. The first day has introductions and getting to know the place and so on so they don't really get started until mid morning. So you've lost one session. And they have to get a computer printout by 3pm the following day so it's really not long at all.

However, one of the main reasons why a two day time frame was not felt to be adequate was that it did not provide staff (or residents in several cases) with enough, or any, time with the assessors during the two days. This was often said to be a major source of disappointment.

The staff would have liked the assessors to have spent more time with them. They felt they missed out after all the work they put in, all the stress.

They did talk to some residents but that was one of the problems, all the residents wanted to talk to them and they only had half an hour. Because the residents wanted to have their say as well.

Participants were specifically asked about the extent to which residents and/or their families had been actively involved in the site audit. Responses varied widely and seemed to depend, to a large degree, on the former's awareness of and/or interest in what was going on. For example, in one facility it appeared to have been relatively high:

Residents were aware of what was going on and a lot of them wanted to talk to the accreditors - and they did. Eight families came in plus a couple of people who were here decided they did too. So there was a lot of input from residents.

However, in one rural high care facility where the generally low cognitive levels of most residents combined with the practical difficulties of relatives being able to get to the facility during the audit period meant that the level of involvement had been much less.

Residents were told they were coming though there aren't many that would be aware. Relatives were invited. A couple came in and some wrote supportive letters - but it's not always easy in rural areas for relatives to be here, they live too far away. There were only about five people who really took part.

Some people also commented on the way in which the assessors actively sought input from and tried to involve residents. In one case they were highly praised for their efforts:

The two assessors were both very good, very people oriented and that goes down very well with the residents. They had morning tea with them, they really made an effort with them. The residents thought they were wonderful.

In another, however, it was felt that they should have been more 'systematic' and 'selective' in their approach.

The team members go and talk to people at random - and often to people who have dementia or who aren't really capable and who can give inaccurate information - but it all goes in the report.

Issues and concerns

Although the site audit was generally regarded in a positive light, a number of concerns about it were raised. One of the most common was the stress that it had created amongst staff.

We had staff who were petrified. It was fear of the unknown, all the paperwork, what they wanted to know. [] Some staff, like those from non-English speaking backgrounds, were very scared, they didn't know how they would be able to answer the questions.

The staff knew how the standards monitoring system operated and they thought this system was the same so there was a lot of tension and apprehension.

One administrator suggested that the Agency could have done more to allay people's anxieties prior to the site audit:

They should perhaps come out earlier and speak to staff and say "We're human beings like you, we're learning, it's a partnership and these are the sorts of things we are going to ask you about your job, about safety and so on and you just need to be honest with us" - just give them that sort of feedback and then they'll be more relaxed. Because for managers, we've been trained, we've been through it, we've been to a lot of industry training, so we know how to tackle them. But it's very hard for us to pass it on to our staff - they don't quite get that feeling.

However, another administrator was of the view that little could be done to reduce the levels of apprehension:

The carers, no matter how much you supported them, they were totally intimidated and it wouldn't matter who came in. [] All our site audits went very well and all the assessors worked really well to try and allay those fears but you can't get away from human nature when you know somebody's there auditing you, there's a lot of intimidation.

Another common concern was that the assessment process was too subjective and as a result, lacking in consistency.

From what I could see a lot of how accreditors did things was from their own personal preference or perception - it wasn't any system or standard that they could show me that they were meeting, it was how they did it when they were nursing or how they did it in the organisation they came from.

A particular criticism was that there didn't seem to be any standard assessment process involved and that auditors seemed to focus on different aspects of the facility or service:

I don't think they are rating each one the same, they are looking at different issues. I've been on different exit interviews, not just mine, and they ask different questions and they've targeted different areas. So how can they be consistent? They haven't rated the same standard all the way through, they've picked on samples of it.

There was also a perception that assessors' expectations of different facilities varied.

I have a perception that they come out, they do us at one standard, then there's another group of people who are 'fine line' and their staffing levels are much lower than the levels that we provide and they seem to lower the score.

Although acknowledging that some inconsistency did exist, some people felt that it was to a large degree to be expected, particularly in a system that was still in its relatively early stages. As one CEO said:

I think we're bound to have a little bit of inconsistency in a new process which is basically a huge shift for the industry. I would hope that in the next two to three years, whether or not the system changes slightly, that the whole thing will mature. It's probably lucky that we don't have a really strict level of consistency because I think a lot more facilities would have found it really difficult. We probably need to be a little bit patient.

Closely related to the above issue was a concern about the tendency of some assessors to be overly preoccupied with specific standards or issues, which many people felt was both unnecessary and unrealistic.

I found they would get on a roll for a particular topic and worry it to death if they had a particular 'bugbear'. I felt they did it unnecessarily, with unrealistic expectations.

Some assessors have a 'name' out there – they expect standards that demand knowledge that someone working in a facility couldn't possibly have - quality issues are one thing- little things are another.

There was also a view that focusing on one or two key areas was too limiting and did not allow a more 'holistic' view of a facility to be obtained.

What I found hardest about it was that the view of everything we do was very minimal and they just targeted a couple of areas. I felt that there was a lot that they didn't seem to notice.

For one facility-based informant, however, the concern was not that the audit was too specific but rather that it was difficult to understanding what its focus was. This had created some uncertainty and apprehension about future site audits.

Was everything audited or just random things? They don't give best practice information on some things so we had to ask someone who passed for an answer. But was it passed or was it overlooked?

A few people, mainly senior managers, questioned the level of expertise of some assessors. It was also felt that a background in aged care was preferable. One CEO said that their organisation had specifically requested an industry based assessor because it was assumed that that they would have more 'realistic' expectations.

We didn't personally know any of the audit teams but we particularly chose someone who was a currently practising DON. If it's the Department (sic) you get this purist attitude towards things but if you are out there currently working you know what the purist view is but you know what the practical view is as well - so you are able to 'bend' the view a little bit.

A few comments were made about the extent to which the quality assessors had prepared for the site audit, although perceptions varied. For example, in one case, the impression was that the self assessment documents had not been read. This was a source of considerable frustration.

I was convinced the auditor hadn't read mine. I was really frustrated about that. The amount of blood, sweat and tears that went into that. I kept asking the auditor "Why aren't you using the desk audit (sic)?" He just said it was too big - and he wasn't referring to the number of pages - he just felt that it was too big. He just went purely off the standards book that just had the outcomes and the elements set down, the whole first day. Even the second day, when he was going to see the cook, I asked "Aren't you going to take the desk audit?" and he said "No, no, this is fine, it's the same thing". I was livid.

The impression of another informant, however, was that the assessors had been through their documents very thoroughly.

The impression I had leading up to my visit was that the auditors went through the desk audit with a highlighting pen. Maybe it is a function of who the auditor was, agency or consultant but I was quite reassured by that.

As noted in an earlier section, another criticism of the site audit process related to the terminology used which was felt to be too 'jargonistic'.

Site audit report

For most participants in this study the site audit report, in terms of its content, was as expected and in line with feedback provided by assessors over the two days of the site visit and at the exit interview. Thus, as one DON stated:

There were no surprises. At the end of the first day they came and told us what they'd looked at, the outcomes and so on and reassured us and told us about one issue they had identified so we felt quite happy about it. At the end of the second day they told me what they'd put in the report and basically we'd identified most of the things. So there were no surprises whatsoever.

Similarly, the comment of the CEO of a large organisation with a number of facilities was:

There's not one issue that they've come up in all our site audits where I would say "I don't agree with that"- in fact, they've put it quite well". I've thought "I knew they'd pick up on that, we're not quite right there".

Additional comments about the site audit report related to its format and wording ('very well set out, easy to follow'; 'excellent, anything not quite right was just couched in terms of 'room for improvement'') and the fact that it also included specific suggestions which were felt to be helpful.

Some people also mentioned that as far as the actual preparation and writing up of the report was concerned, the assessors were very helpful and accommodating.

One thing I really enjoyed was one auditor asked if I'd like something mentioned in the report and helped put it in a positive way so we would get the desired improvements.

I challenged one thing at the exit interview, the auditors agreed and modified it accordingly.

Not everyone found them so 'accommodating', however:

There was one issue that we argued about all day with them. I reckoned they were wrong and we were right. We talked about it as a group after and we argued the point again the next day but they still said that they were right and they wrote that on our outcome report. I later consulted [names omitted] and they said we were right. I felt that in that particular incident the auditor had his mind made up and wasn't going to take 'no' for an answer.

Support Contacts

Views about the support contacts varied. Some felt that they were very useful:

The support visits are good and they give us the opportunity to discuss issues with the auditors. In the site audit you don't really have that time, they are constantly throwing questions at you, they are wanting the proof. But when they come out in relaxed mode and you can challenge things, I prefer those.

For others, however, they were still regarded with some apprehension.

The rumours that are going around are horrific. Maybe the Agency needs to put those fears to rest – that is, to explain exactly what they are doing when they come back out. For example, are they coming to do a support visit but actually to look at everything? Are they interested in where you are at, whether you are addressing your action plans or rather are coming to look at something else, at another standard or outcome? There is huge apprehension around about the support visits, everyone's experience seems to be different.

Other issues

A number of other issues were raised in relation to the accreditation process. One issue, identified earlier, related to the helpfulness and supportiveness of the local Agency throughout the assessment process. However, not all facilities /organisations specifically sought out that support, either because it was not felt necessary or because they perceived that it might somehow place them at a disadvantage.

Support was offered from the Agency but I was reluctant. There was a perception that if you rang, your name would be taken down and that it would be held against you. Were you going to be reprimanded for it? Would they check those areas?

Some people said that they regretted not having sought (more) support and advice from the Agency.

Next time I intend on getting all the help and support I can get. This one it was a bit 'fear of the unknown'.

Another issue related to the need for staff to be assertive, particularly during the site audit. For example, the experience of one facility was described by the organisation's CEO as follows:

The area manager felt that some of the things one of the auditors was saying were quite negative and she took it up with the lead auditor on that day and it was all sorted out. We were saying as a provider: "We're not getting any feedback that we think is useful". That's the sort of thing that you hope - that the providers are talking, that they're not waiting till something like this happens, that they're putting their points of view forward.

Similarly, in another organisation the comment was:

The staff need to be confident. You need to tell people "Don't be wilting flowers, tell them what you do". Because I think you do need to be quite assertive with them, their suggestions are not always appropriate to the context or the situation.

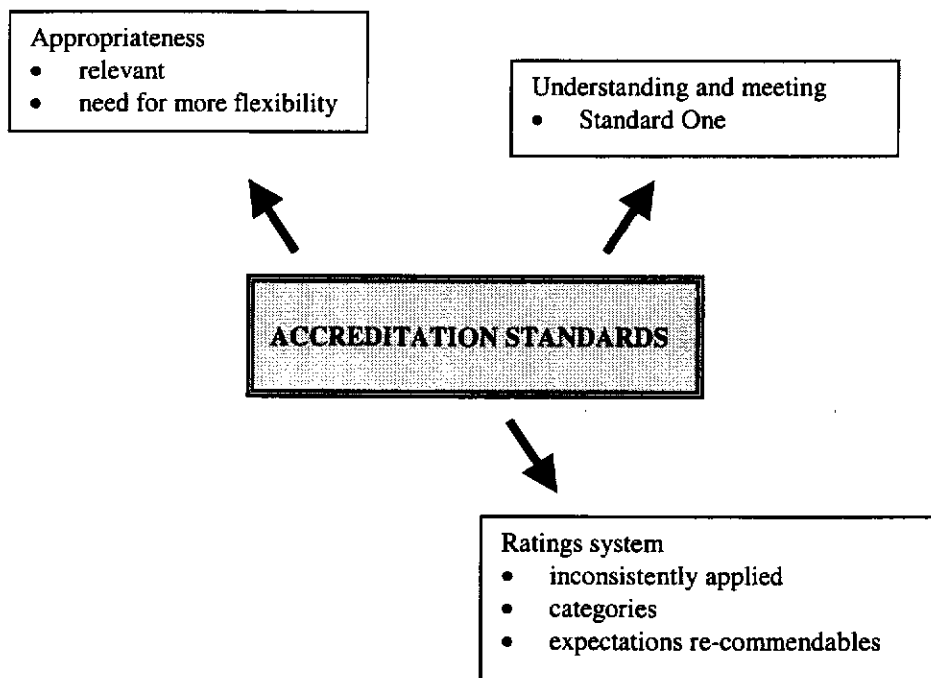
One CEO expressed concern that auditors had different expectations for site audits and review audits.

Within weeks of a visit at one time and another visit following a complaint a few weeks later, what they required from us was quite different - and it was quite clearly documented that this was OK five weeks ago but today it's totally unacceptable.

5.2.4 The accreditation standards

As outlined, the four accreditation standards represent one of the key components of the accreditation framework and form the basis of the quality assessment process. As such, people's views about these standards were sought, specifically as regards their perceived appropriateness and whether any had posed problems. The main issues identified are summarised in Figure 8.

Figure 8: Issues relating to Accreditation Standards



Appropriateness and relevance

As might be expected given the industry's involvement in their development, most informants regarded the standards as generally appropriate in terms of what service providers should be aiming to achieve. However, some people, primarily those working in facilities, questioned the appropriateness of some (aspects of the) standards in different contexts and thought that more flexibility was required. Most often such comments related to the requirement that certain aspects of service and practice (e.g. medication, contracts, resident agreements) should be formalised. For example, the comment of a RN working in a low care facility country town was:

I think some of the standards need to be looked at as they are not always applicable for country towns. For example contracts and medication – it's difficult to give a choice of doctor, as the choice is not always available. The standards are set up for the city, not small country places.

Although agreeing that a more informal approach to service provision was fairly typical of country towns because of the lack of competition, the view of other informants was that the level of formality required was not inappropriate, one care manager in a low care facility, for example, saying:

I didn't think we would need to have such things as we are a small place but we get Commonwealth funding, we do the same kinds of things. It was a lot to accept, but now it's in place, I think it is appropriate, it ensures some consistency and gives a sense of pride, that we're up there with the big guns.

Understanding and meeting the standards

A number of informants, again mostly those working at the facility level, said that they had experienced difficulty interpreting the meaning of some standards, most notably Standard One (see later). Others, however, said that they encountered no major problems and in some cases had used other resources or systems as a reference.

We had no real problems. We read them all and understood them. We referred to ISO 9002 and sorted out what we needed to do - because the standards are based on these. We also use the MQAS system.

Similarly, with regard to meeting the different standards and their associated expected outcomes, experiences varied. Some informants said that they had not had any difficulties although as one person added 'If you were aiming for commendable you might have got a bit lost but we just tried to keep to them as stated'. Others, however, had experienced problems, with specific standards and/or outcomes often identified.

Standards One and Four were horrible. The clinical side was easiest, although it was the biggest. Education was difficult, trying to meet everything we'd said we'd do.

Regulatory compliance – the staff found this very difficult to get to grips with. We did surveys to look at the staff's understanding of it. It took a lot of work.

Comments and complaints was a challenge - trying to get people to voice their concerns and views in a way they felt comfortable.

The most difficult outcome for this organisation was continuous improvement. The usual response from staff was "but we're good", but they're not looking to the future.

The costs and time involved in meeting the requirements for the various standards, with Standard One again often quoted as an example, were also identified by several people.

We had never done audits and suddenly had to tag everything. It was a huge costing that we didn't know about – an added cost and extra time. For example, we have had to put paper towels in each resident's room and tag all the transistor radios. I can see the sense but it's such a huge place.

Standard One

Standard One was by far the most frequently commented upon and as indicated proved the most difficult in terms of understanding and preparation, for a variety of reasons. Thus in the case of a small rural based facility:

It was a combination of not understanding what was required to get ready and not having the procedures in place. The standards relating to strategic planning and business plans are two examples - with the former we contracted a nursing consultant who helped. Once a base was there it was easier to identify responsibilities and so on.

Particularly in organisations where a number of different facilities were involved, other kinds of problems were experienced.

The management standard was a difficult one as we needed to develop the standard throughout a number of different nursing homes and there were so many different thoughts, so many things we had to look at, agreements, and so on - it was very, very difficult.

Often, however, many of the difficulties associated with this standard related to a lack of involvement of Boards of Management and/or their lack of familiarity with many of the more-formalised systems and procedures that needed to be in place. A lack of appreciation of the amount of work that needed to be done to meet the requirements was an additional, related reason sometimes given. This appeared to be particularly the case in smaller and/or stand alone facilities with voluntary Boards.

We had no direction from the Board as they didn't really understand what they had to do, they didn't understand the kit, they didn't want to know about it. It was too hard, out of their field. None of them were involved in aged care – it was a volunteer Board, they didn't know the problem to address the problem.

In some facilities, the lack of support from management throughout the accreditation process was identified as a major concern. As one low care facility manager said:

I spent most time on Standard One. It was difficult, the minimal amount of committee input was not seen. In fact one assessor said that if it were up to her she wouldn't have given us accreditation. That was devastating to me as I had put in a lot of time and effort but it wasn't really my job to do it - but no one else was doing it. The committee was called in and spoken to, that they had to play an active role in management, but they still don't really seem to grasp the idea.

In a couple of instances, however, this lack of support was perceived to have had positive repercussions.

We kept saying to the Board they should be involved but they didn't seem interested. But when the Agency State Manager came up, she insisted that they were booked in. So they got involved in the MQAS workshops and now it's good. It has changed a lot - they have a lot of responsibility now.

In others, despite the Board's lack of familiarity with what was required, their support and input was still much appreciated.

The Board did a lot. The assessors commented how lucky we were also.

Ratings System

The standards ratings system, in particular the inconsistency with which it was perceived to have been applied, was the focus of many comments. By far the majority of these related to the disparity in the number of 'commendable' ratings given between W.A. and other States.

If you are getting 1400 in one State and only four in WA, something's got to be wrong somewhere, we're not that backward.

Some informants suggested that this discrepancy was due to the local Agency having adopted a stricter approach to assessments than its Eastern States counterparts. In some cases there was also a suggestion that it may have been for 'political' reasons.

There is a perception that they can't give 'commendables' - and that has come out through my involvement with organisations interstate. I can't believe how many 'commendables' they got and what was required for it.

However, not everyone felt that W.A.'s 'stricter' approach, if that was the case, was inappropriate:

I actually think W.A.'s got it right. The way I read it is unless you've got a mature system of CI with all the feedback loops and all those sorts of things, you can't get a 'commendable'. Unless you've done ISO or EQUIP or something similar I'm not sure you can really have that in place and be mature enough to deserve a 'commendable' and not many places in W.A. have, so I'm quite comfortable with the way W.A.'s been done - and it also gives us some room to move.

Another person queried the logic of the Agency giving out any 'commendable' ratings at all in the first round:

I don't think any 'commendables' should have been given the first time round because it's a new system. How can you be a 'commendable'? You've got no benchmark.

The ratings categories also attracted many comments, specifically the gap between 'satisfactory' and 'commendable' which was felt to be too extreme.

'Satisfactory' is too wide a band - you can be 'satisfactory' and almost a failure and 'satisfactory' and just under the 'commendable'.

'Commendable' should be for something absolutely fantastic but there should be something in between - a couple of ratings like: 'This is good, above average, you're doing well', then 'This is really very good' and then 'Through the moon'.

It was also suggested that what was required to achieve a 'commendable' rating was often unrealistic, as reflected in the following comment by one administrator whose staff were told that they hadn't received one because their statistical information was inadequate:

The argument we put forward was "Who's got the damn time to do statistical analysis?" [] We said "We bring these things up at Occ. Health and Safety meetings, it's minuted and the corrections are put in place". But what they were saying was "We can see that it's brought up in the minutes, we can see that the decision's been made - but there's nothing to show what changed and no analysis of that change". [] I think the expectations for commendables - you can't manage it economically for what they want, their expectations are too high for the funding that we have to do it in.

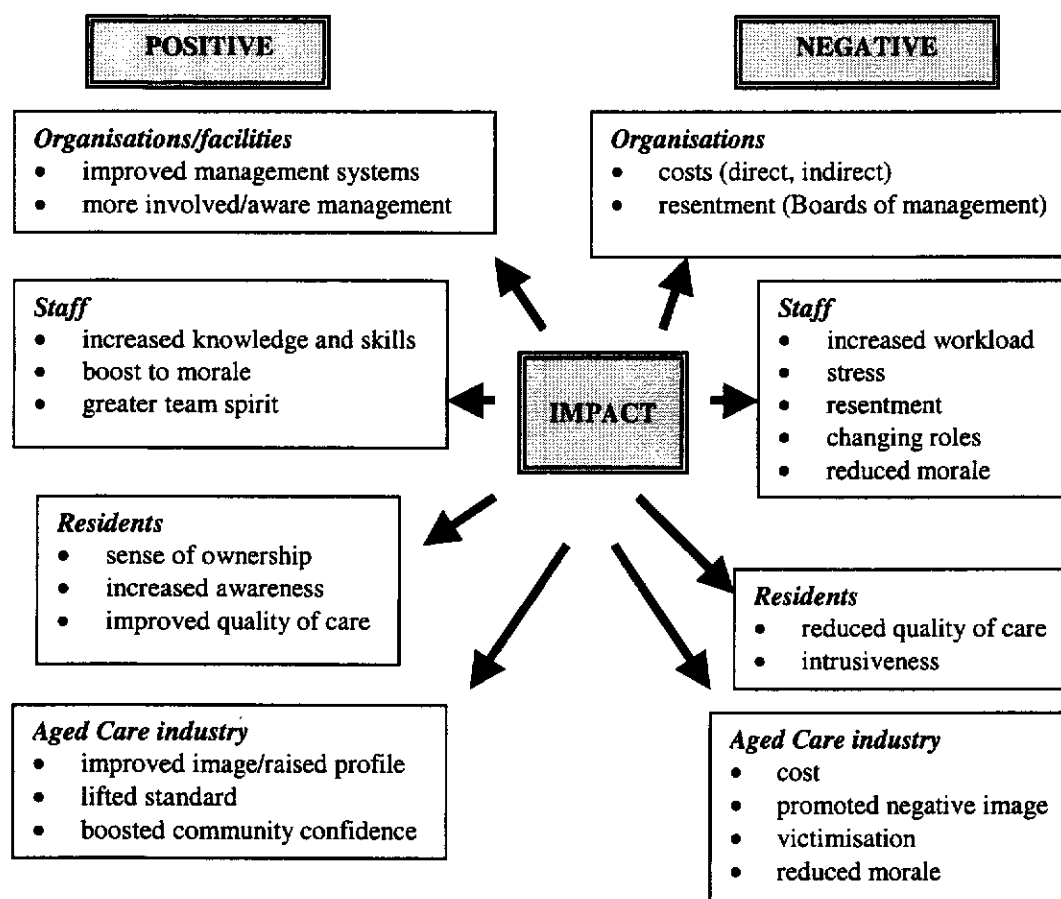
One person's view was that the current ratings system should be dispensed with altogether:

The ratings are useless. It would be better if it was 'Yes' or 'No' or 'Pass' or 'Fail' - it's wrong.

5.2.5 Impact

Accreditation was generally felt to have had a major impact, in many respects a negative one, particularly in regard to the costs to organisations and the demands on staff. However, a number of benefits were also identified (see Figure 9).

Figure 9: Impact of Accreditation



Impact on organisations / facilities

Virtually without exception accreditation was felt to have imposed major financial demands on facilities. There appeared to be fairly widespread resentment of this and several comments were made about both the federal government and the Accreditation Agency not realising the extent of this impact. As one care manager commented:

The government need to understand that there is a cost and that organisations don't have a pot of gold to constantly dip into - there's always something you have to change. Organisations are getting leaner and leaner but bureaucratic standards and demands are getting higher and higher – it will all eventually disappear somewhere. The worst case scenario is we may end up with a brilliant clerical system but no-one is getting any care.

Several people felt very strongly that the government should have devoted more resources to the industry to ease the financial burden on them.

It's totally inadequately funded - there's no funding for accreditation. Their expectations are way up here and someone has to bridge that gap...and it has cost us an absolute fortune to do that.

There was also a view that the money spent on accreditation could have been better used for other purposes, including resident care.

A lot of places have spent a lot of money on systems, people, resources just to get through this first round that could have gone on residents. It is very frustrating as we only have one pool of money.

Although a number of people acknowledged that many of the initial 'establishment' costs would not have to be met again, they also anticipated that there would be other ongoing expenses. As one facility manager said:

It will be an ongoing cost. We've got to look at the possibility of putting on another member of staff to keep the quality management going because it's impossible for the three of us to be able to do it on top of our jobs. I've just got to find some dollars as it's the most important part of our operations and you can't afford to let it go.

Most informants were unable to provide an estimate of the overall cost of accreditation to their facility or organisation, particularly because of the hidden costs involved such as staff time. As one DON said:

It would be frightening if anyone sat down and worked out how much it cost in person hours. I was here three weeks before accreditation. I was working twelve hour days and one and a half days at weekends as well, as it had to be done.

Of those who were able to provide an estimate, however, taking into account both direct and indirect costs, figures ranged from \$50,000 to over \$1million.

One of the main areas of additional expenditure identified related to the acquisition and/or establishment of appropriate management systems to meet the requirements of Standard One. This often included the costs of hiring consultants to assist with the

establishment of these systems. One senior care manager expressed her frustration about having had to do this as it was felt that the organisation already had appropriate and efficient quality systems in place:

It was for Standard One a very large amount of money. It was annoying as we have always met the standards, we have always managed well and we have a continuous improvement system in place. We thought we could perhaps have been measured on our merits without having to go through the system to start with and that would have given us a few years to put more money in the pot.

Staff related costs, for example for staff education and the employment of additional staff (e.g. RNs, quality coordinators) were also frequently identified.

We had to employ two RNs that we hadn't budgeted for, one for staff development and OSH, and the other for clinical care and medication and helping staff with the documentation.

Other expenses incurred related to tangibles (e.g. stationery, additional computers), photocopying and the costs of applying for accreditation itself. In some cases the necessity of some of these expenses was questioned:

There were huge expenses – for example all the photocopying and we needed to have locked drawers in all rooms and a new fridge for medication - but most medication doesn't need to be in a fridge, it could have gone in the residents' fridges. You have to wonder whether a lot of these things are really essential.

Several people mentioned that the requirements of certification had added to the financial burden on providers.

Despite the costs involved, a number of benefits to organisations/facilities were identified. One of the most often mentioned was that it had made them more efficient. The following two comments are typical of many that were made:

It has helped us streamline the organisation, definitely, because we've got the different departments, everyone would do it differently whereas now everyone does it the same - so we have standardised. It's made lots of areas more

efficient. So the administration or management side of things - that's definitely been streamlined and it's helped us capture all the information [] - things don't get missed like they used to be.

It has forced us to plug the holes, it has highlighted things that could become really big problems if they're not attended to and it's enabled us to get a handle on them before they've become a problem at all. So you now have a process that I'd stick with and work to - you know that you're doing, what you need to do.

In the opinion of several people, primarily those working at facility level, accreditation had also created greater awareness amongst and involvement of Boards of Management. As one organisation care manager said:

It has switched the Board on. Accreditation brought about a monumental organisational review which had implications for the Board. So the whole organisation has been touched.

The manager of a small rural facility also felt that accreditation had made the Board more supportive:

We've got things in place here that we've never had before. It has made the Board more aware and involved in the sense that I can now get the resources that I couldn't get before – and the support. So, ultimately, it has been a positive thing.

Impact on Staff

Quite clearly, accreditation is perceived to have impacted on staff in a number of ways, both 'positive' and 'negative'. Most comments related to the demands on staff time and the stress that it had created which, in a few instances, was said to have resulted in a number of resignations.

In accordance with comments made in earlier sections, one of the major perceived impacts of accreditation on staff was the additional workload it had created. This related in particular to the period prior to the site audit when, as already noted, many staff worked extra hours, often in their own time and generally on an unpaid basis, to

complete the necessary paperwork. Although the impact appears to have been greatest at facility level, many senior staff, including some CEOs, were also heavily involved. The following comments are typical:

I was working twelve hours a day, seven days a week. We were all taking work home - to do the graphs, statistics and so on. [DON]

It involved a lot of time. The managers just about killed themselves through the process. After accreditation we were like a bunch of zombies. [Quality Coordinator]

It's been a lot of hard work and it was a collective thing. All the facility managers and myself and a couple of the other managers got together and we worked day and night for a long time. [CEO]

In some smaller, stand-alone facilities there was a perception that the demands on staff were possibly greater than in larger facilities and/or those that were part of a large organisation. The assumption appeared to be that the latter had more resources on which to draw. Thus as one DON of a small rural facility commented:

In the bigger facilities they have staff development officers and the like, resources you don't have in small facilities like this. And if you don't have resources in the local community you have to get them from outside. That puts extra pressure on existing staff and also on me - I'm on call five nights a week.

However, several informants based in larger organisations described similar difficulties:

It has created more work. In a situation like this where you don't have good IT and management systems and these systems have to be put in place it is horrendous, a continual paper trail. I still seem to spend a lot of my time educating people about accreditation. If we had the systems there I don't think I'd feel so tired - and it's not over!

Several people acknowledged that accreditation was not solely responsible for the increased pressure on staff.

It would have happened anyway. Regardless of accreditation the workload in all our areas has increased so much. For the resources that we get, we can't do it in the time we've got.

Accreditation was generally regarded as having created a great deal of stress amongst service providers, but particularly amongst facility-based staff. This was related partly to the additional workload demands discussed above. However, it also related to staff apprehensions about, for example, the final outcome (i.e. decision) and the pace of the changes to be implemented.

The emotional strain and the effect on the morale of the staff - all that's been absolutely horrendous.

It has been traumatic, a fast change, very fast and it wasn't intended to be so fast. We tried very hard but we didn't know what we were supposed to be doing.

In some instances, the stress was felt to have been to some extent self-imposed.

For the DONs I think it was the stress that we really wanted to do well - I kept thinking if we didn't do well I'm going to commit suicide!!

In another case, as described by one CEO, the stress related to the unexpected outcome of a site visit.

In one of our facilities the visit went very, very well. There was just one area of concern and the assessor left everybody feeling quite comfortable. The exit visit was all soft language – and then the letters of correspondence came back with the possibility of pending sanctions if the appropriate responses haven't been delivered. So the staff were quite devastated.

Several people were also of the view that it was the combination of the demands of accreditation, as well as other demands, for example the RCS and the complaints system, that had created the stress. As one owner/proprietor commented:

You can't divorce the outcome. We've just gone through accreditation and we've just been through an RCS audit. My clinical care coordinator, after she'd spent a week with these people, I had to send her on leave. The stress

related to these particular instances is huge - the site visits are stressful, we've just had a complaint, we've had the Aged Care Department (sic) in, the Agency and then a week later we get an RCS audit.

During the course of the discussions, several people mentioned that a number of their staff had left due to 'burnout'.

We lost the administrator and now the care managers – we have lost two care managers through it and a lot of carers. We've lost a lot of staff through it and to gain what?? - I don't know. Accreditation played a very big part in all those losses, certainly in the last 18 months.

Several other informants said that they were intending to leave the industry themselves or were giving it serious thought. This included one Board of Management member who said:

Accreditation took 18 months of my life, that's how I found it. When the second visit takes place, I'm out. I can't put that sort of intensity into the place, I need a break. Maybe two years on I might feel I can give it a go. It was a huge mammoth task for this place.

Not surprisingly in the light of the previous comments several people said that accreditation had created considerable resentment amongst staff. This was primarily because of the additional demands made on their time and workloads. As one DON commented:

Staff know they do a good job, this is a just an intrusion. If someone goes out there and mentions accreditation once more this calendar year they'll just all scream because they knew they were doing a good job, they didn't see why anyone should come in and check to see that they were. There is a resentment towards accreditation.

These feelings of resentment also extended to some Boards of Management.

The Board felt that it was an intrusion on their private business, their business ethics, that it was like telling the Board how to do things, when to do them, how much to spend. Through the stress of accreditation many Board

members left - a lot of time was put in, they were all volunteers, a lot ran their own businesses and things - I think they burnt out.

Some people felt that accreditation had also had a major impact on the roles of some staff, for example RNs and/or care managers of smaller facilities. This was generally regarded as negative, particularly given the rapid rate at which these changes had occurred. As one care manager said:

I feel like our job roles have changed overnight...it's almost like we have a whole new position, regardless of whether we work at one site or wherever because everything has changed - the paperwork involved, the trends analysis now, the certification - looking at all those things. It is almost a full time job and that's sad. I think that our roles, particularly in stand alone hostels where we're very much hands on, that's gone, we've lost that ability to do that, certainly within the hours that we're paid for.

Although accreditation was perceived to have had many 'unwelcome' consequences for staff, several positive impacts were also identified. One that was frequently mentioned related to the way in which accreditation had fostered greater awareness amongst staff of their roles and provided them with a valuable opportunity to develop and enhance their skills. As one DON commented;

It has helped focus the RNs on quality improvements that they are actually doing. It has raised awareness of the things they do or try. They are trying different things, thinking more laterally.

In many cases the impact was felt throughout the facility or organisation.

We are probably more aware of the little things we took for granted, we know the process better, I think we're getting more flowing.

The staff grumble but I think we've strengthened their level of intellect. We've all grown a lot with this and a lot of skill has improved.

Accreditation was also felt by many to have generally helped boost staff morale and fostered a greater sense of pride and confidence in what they were doing.

I think getting three years accreditation, they actually gave themselves a pat on the back, it was great.

People have developed pride and a sense of achievement. I can see a real growth in their development.

One person suggested that it was also very empowering for staff.

It has empowered a lot of them - made them aware that their comments are valuable, through involving them in CI and self audits in their area. They are taking more ownership.

Understandably, however, where facilities had not done as well as expected or hoped, the effect was the reverse.

It has affected the morale of staff. When we were told we wouldn't pass we were all down in the doldrums for a while there.

In some cases accreditation had promoted a greater sense of unity and cooperation amongst staff, with several facility managers praising their staff's work and commitment throughout the process.

It has made us more of a team, the involvement of everyone in the process.

Impact on Residents

Views about the impact of accreditation on residents and their families were mixed. Some people felt that it had had very little impact whereas others felt that it had and that this impact was often negative. For example, the comment of one informant working in a facility that initially failed accreditation was:

The impact on residents has been immeasurable. They were all very happy here so they didn't understand what this was all about. The disillusionment and the impact on their families has also been immeasurable. Accreditation is seen as a hindrance rather than a help. It wasn't done properly, it could have been done in a better way that residents would have got positive feedback and felt involved. The implications of not being accredited is one thing the Agency or the management committee don't really think of.

Quality of care

In regard to the impact of accreditation on residents' quality of care, opinions also varied widely. In many cases it was stated that high quality care had always been provided in the facility and that this had not changed as a result of accreditation. As one CEO said:

I don't think it has had any impact on the quality of care. It depends on who you've got working and a lot of the culture things and who your bosses and deputies are and whether they care for the people. I think if you care for the staff they will care for the other people. I don't think it's changed. I'd like to think it's got better but I think that's more to do with us looking after the staff more than because of accreditation.

In other cases, although it was felt that high quality care was already being provided, accreditation was still regarded as having positively impacted on care for a number of reasons. One of these related to the way in which it had helped to formalise service provision.

I do think it has had an impact on the quality of care although we have always had a high quality of care. But this is establishing it and proving it, especially with the care plans, with the RNs showing us - as we are all personal care people here.

Another reason was because of the emphasis placed on residents being actively involved in, and having opportunities for, input into the services and care provided.

Services to residents have improved. For example, hospitality – we now give regular catering questionnaires to residents and families. It has stopped a lot of complaints as there is a formal system in place to address issues. It gives everyone an avenue and provides a means for feedback. People know what is going on.

One DON suggested the increased awareness amongst staff of what they were doing as a result of accreditation had also benefited residents:

It probably has improved care as we take more interest in what we are doing, we are more aware.

Not everyone agreed with this view, however. Several people stated that accreditation had actually disadvantaged residents to some degree, mainly due to the increased documentation demands.

My assessment of the situation is that our residents are receiving less personal attention, less personal care now than they were when accreditation was started. The cost of accreditation is documentation - there's more time spent documenting the care and treatment of the residents than there is actually caring for them.

As suggested earlier, some people also felt that the money invested in accreditation could have been better spent on residents.

I look at in terms of the impact on residents ultimately and the amount of money that has been spent and have come to the conclusion that that money could have been more wisely spent elsewhere. We were a facility that had the standards in place. We had CI and because no-one was there to give us a badge to say we were doing a good job, we spent a lot of money on things I would like to have spent on residents. [] We could have employed four more staff to give residents a more holistic care lifestyle.

Despite such reservations, several informants felt that there had been some direct benefits to residents. One of these was a greater sense of involvement and 'ownership' of the process:

Residents feel that they have ownership of it as they had input. And the relatives keep telling everyone how wonderful we are!

Another was an increased sense of awareness amongst residents, as well as their families, about the facility, their rights and responsibilities and the aged care system in general.

I think residents are more aware of what's going on, what we are trying to do.

They are asking more questions than they ever did – for example, things like staff ratios.

A couple of people felt that accreditation was an intrusion on residents' lives, primarily due to the amount of documentation that was required.

There's too much paperwork going around. There are forms for everything. Things have become too prescriptive. It's a huge invasion on people's privacy. It has all gone overboard.

Aged Care Industry

Concerns about the impact of accreditation on the aged care industry as a whole were also raised by some informants. Apart from the costs involved (*'it has cost the industry millions of dollars'*), accreditation was regarded by many as having promoted a negative image of the industry within the community. The adverse publicity the system had attracted was often mentioned.

The media hype over accreditation has done the industry a great disservice. Places like ours are needed but families have become reluctant to put their relatives in here.

This was also felt to have reduced morale within the industry.

We've lost confidence - or the industry's lost confidence- and the public are confused. You've got these places with 'commendables' and these places that have been closed. Hopefully it's one of those things that time will heal but I think it's done a lot of damage.

Others informants, however, felt that accreditation had improved, or had the potential to improve, the image of the industry within the community through lifting the standard of care.

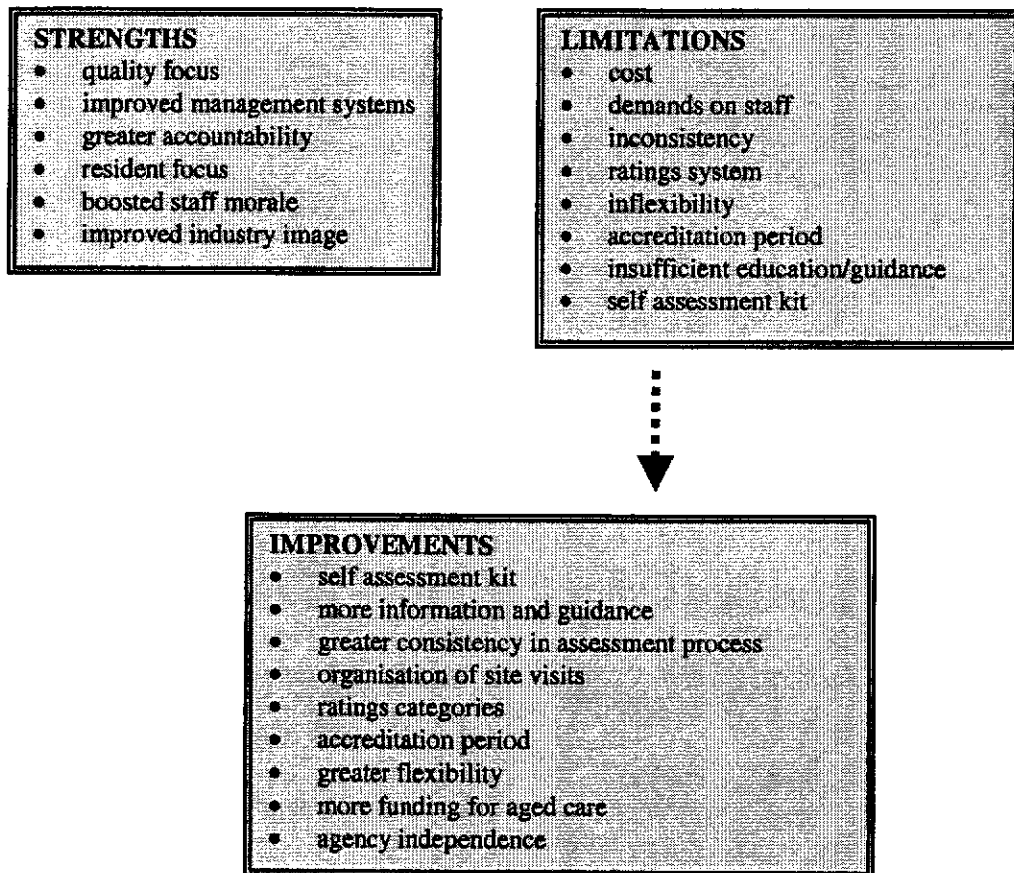
We are finally getting out of the C class hospital area – the public are realising how specialised aged care has become.

If it works right it will hopefully get rid of those who shouldn't be doing it and the overall standards will improve – "when the tide rises all boats are lifted" sort of thing so it will help bring up everyone's standards. The important thing is to make sure the community has confidence in the aged care industry.

5.2.6 Strengths, limitations, changes and improvements

Participants were asked to identify what they regarded as the main strengths and limitations of the new system along with any areas in need of improvement. As would be expected, many of these reflect issues raised in previous sections (see Figure 10).

Figure 10: Strengths, Limitations and Areas for Improvement



Strengths

Although a variety of strengths of the new system were identified, two were particularly prevalent. These were its quality focus and the improvements in management systems and processes that it had brought about. The benefits to both residents and staff were also frequently identified.

The focus on quality and quality improvement was regarded by many as a major strength of the new system.

It's a quality system - that's a first step and I wouldn't advocate taking it away because if you take it away how do you ensure best practice?

Although the benefits to residents of focusing on quality were generally acknowledged or implied, several people also commented on its importance to staff.

It gave us an opportunity to look at ourselves, how we were doing things and helped us do things better.

The impetus that accreditation had provided to many organisations and facilities to improve their existing management systems and processes was also widely recognised as a major strength.

The good that came out of accreditation was that we've had the systems but what we did was to go over them and tidy them up a bit and that's a process that's still continuing now. So they are better and it has provided us with a structure. I think what it did was to formalise that.

Several people also felt that accreditation had increased awareness amongst all stakeholders within the organisation/facility - staff, Boards of Management and residents and their families - of their management structures and practices.

It's made you aware of your organisation and your structure and its strengths and weaknesses. And it teaches you all about planning and the actual documentation system. Up until now people were doing things very well but it wasn't documented as good evidence for people to find out what you do. Now we're able to justify to our families and our groups who support us what we do and how we go about it.

As reflected in the above statement, a further strength was the way in which accreditation had improved accountability. This applied not only to staff, but also to proprietors, for example *'environment issues, it puts more pressure on them to provide quality homes.'*

The system's focus on residents, not only in regard to ensuring that they received high quality care but also as far as providing opportunities for them to have input into their care, was also identified:

The process of accreditation enables people to think through what is important, to understand the different outcomes that are being achieved and to strive towards those. What I found really exciting about that is they focused on the resident, the family members and the importance of getting those family members and residents involved and to be mindful that this is about them, not about having a spick and span home.

It encourages maximum input from residents and families. It teaches us that it's really important that everybody has a voice, that that's not just the way it is. Probably the biggest upside is people's opinions are now valued and we have to ensure there are mechanisms in place for people to have input.

Some people felt that a particular strength of the new system was the way in which it had boosted morale and sense of purpose amongst staff:

It provides encouragement to staff that what they are doing is worthwhile, that they are valued and that they are doing a good job.

Other strengths identified included: the sense of unity that accreditation had created within facilities and organisations; its fairness; the open nature of the relationship between service providers and quality assessors and the potential to provide the industry with a much needed boost. One DON also suggested that the new system had helped to promote a much broader customer focus:

It makes you have a more customer focus. It includes much more than residents – it's families, staff, suppliers and so on. You have to be much more aware that you are in a service industry.

Limitations

There were three particularly prevalent limitations identified. These were the costs involved, the demands on staff and the perceived inconsistency of the assessment process.

Many people regarded the costs associated with accreditation as one of its major limitations. Several informants were of the view that additional funding should have

been made available to help organisations cope with the additional demands that it had created. Thus as one DON said:

The government should have allocated extra funding depending on the number of residents so we could have budgeted to spend, for example, six hours a week on accreditation. We all have many different hats – it meant taking time away from residents.

Many people were also of the view that without adequate funding for the industry service providers would not be able to achieve what was required in future rounds. The comment of one owner/proprietor was:

You can't go to all this expense. Accreditation as a system I don't have any problems with. What is the problem is the industry, it hasn't got the money - it's like trying to make a Holden into a Rolls Royce.

Increased funding to employ more staff was regarded as a priority issue by many.

We can't go the whole hog. You can only ever go so far to make it practical and this is part of the problem. I don't think there's anyone in the industry that doesn't support the concept of accreditation but they would support it a damn sight more I believe if the funding was increased to allow someone to do the paperwork. Their expectations are too high for the funding that we have to do it in.

The demands on facility staff, discussed earlier, particularly in regard to the paperwork, were also regarded as major limitation. As one DON commented:

We seem to be spending more time justifying what we are doing rather than doing what we are supposed to be doing.

One care manager of a small, low care rural facility described the way her own role had changed as a result of accreditation:

I have a managerial as well as clinical role here. The paperwork-care workload was 30:70. It's now probably 15% care and 85% paperwork and the care component is rarely hands on, it's primarily ensuring that the care plans are being kept up to date, and that care is being carried out

appropriately. I would like to do more hands on care, it's important to have the contact with the residents, it helps to establish trust.

As indicated earlier, the perceived inconsistency amongst assessors in terms of how they approached the site audits (e.g. depth and breadth of coverage) and what they expected in relation to different standards was also generally regarded as a major flaw within the system.

You have all these teams, they go by the same guidelines but they all have their own way of doing things and it's so frustrating. Even when you go to their workshops they show you how to do it but then you get another lot of people who show you a different way. The guidelines are there but they all have different ways of looking at the same question or word. It makes you feel frustrated and apprehensive for the next visit. It's a stress.

The inconsistency between assessors in different States in relation to the 'commendable' ratings was also frequently identified.

Other often mentioned limitations included the following:

- The ratings system: particularly as regards the gap between the 'satisfactory' and 'commendable' ratings, but also in relation to other issues associated with their meaning and application:

For the 'satisfactory' rating it says "only minor deficiencies that will be remedied within an acceptable time frame". That seems strange to me. How can you be satisfactory if you have to remedy things? And the difference between that and major deficiencies – "will take a considerable time to rectify" - there's a big difference between the two. And the 'commendable' and 'satisfactory' ratings – commendable is that all the criteria and outcomes are consistently satisfied. That's like a 'satisfactory' outcome to me, not a 'commendable'. To me 'commendable' means you excel in everything.

- Inflexibility in application of the standards:

The main problem is they don't look at individuality, they do their desk audit, they've got their little regime, they have their set things and they don't waver

from it. X may be a very special place but that doesn't come into account - they just tick their boxes, they don't have any give or take for us.

The standards don't always apply in a hostel situation, the standards are for nursing homes. Hostels need to be given a bit of leeway as well.

- The accreditation period, specifically as regards its time frames and cycles:
It is silly, this three year, one year thing and multiple audits. It creates unrealistic expectations, it means everyone works to deadlines so it won't be a continuous system, it will be deadline driven.
- Insufficient education and guidance
It's like the RCS and standards monitoring system. The government says "This is what we want you to do but we're not going to tell you how to do it".
- The self assessment kit: in particular its repetitiveness, format, language and the disk version.

Changes and improvements

The majority of suggested changes and improvements reflected issues identified above and in previous sections. Most suggestions focused on specific aspects of the system such as the self assessment kit and assessor inconsistency. However, others related to broader level issues felt to be impacting on the system and/or the industry's capacity to meet accreditation requirements.

In regard to the accreditation system itself, several specific improvements to the self assessment kit were suggested. These generally related to ways of simplifying and streamlining the manual to '*make it more readable*' and to avoiding unnecessary repetition of information so that the time to complete it could be reduced, for example:

I think they need to look at all those questions they ask you and how you demonstrate your improvements because a lot of those questions I find a bit strange – 'How do you do it?'; 'Why do you do it?' and so on. They could do it in three questions or something rather than in that sort of way.

If they could develop a system into the package with a cross reference - like a table - for cross reference referral, it would have halved the time it took.

Several people thought that the Agency needed to provide more education and possibly training to service providers in relation to what was expected. In some cases this included information about the minimum overall standard that facilities needed to be achieved.

I don't think they need to change the system as such but they need to provide more information about the marking methodology and actually let the providers know what they need to do to achieve it. Because people may say "we don't want to be a Rolls Royce, we just want to get our funding" and there's nothing wrong with that.

Several facility-based informants felt that more information (e.g. via on-site education sessions) should also be provided to Board of Management members. This was not only regarded as a means of raising their awareness of the requirements of the system but also of encouraging them to be more involved and supportive. As identified earlier, there was also a call for the Agency to do more in relation to the sharing of best practice information.

A number of suggestions for addressing the perceived lack of consistency amongst quality assessors, both within and between States were also made. These included ongoing education and training for assessors and the establishment of a benchmarking system for the Agency whereby the local Agency could compare its performance with that of Agencies in other States. One person suggested that although assessors needed to adopt a consistent approach, it was probably still useful that some had '*areas of specialisation.*'

A few suggestions relating to various aspects of the site visits were also made. One related to the time allocated for the visits which, as noted earlier, some informants felt could be longer. Others related to the accuracy and/or timing of information, for example visit dates ('*they were often wrong, they didn't coincide with what we were told*') and the requirement that corporate representatives be present at each site audit even though the management systems were the same.

Another identified area for improvement was the ratings system, in particular the gap between the 'satisfactory' and 'commendable' categories. One CEO's suggestion was to have *'a star or percentile type thing. 'Satisfactory' could be three stars, 'commendable' five, four is 'better than average but not quite commendable' so it gives a bit more of an indication.'*

The need to review the accreditation period was also identified. Some people suggested that a five year time frame might be more appropriate.

It would be better not to have accreditation that runs for three years - maybe it's a five year period and it's a progression rather than you have this big crescendo where they'll come out seven months before the end of the period and they go mad. I believe if they had a system where they came more frequently and just do a chip at a time – say one standard at a time. Organisations will plan better rather than saying "Well we've done magnificently and we've got three years until the next one" and you could end up in a bit of a dip or trough. So five year cycles with more support visits.

Another CEO proposed a different model:

I would like to explore a six months accreditation, so it rolls on, is just part of life. It would eliminate the 'false timelines' – as there still are support visits which, in reality, could have many different consequences. The aim is quality, but the process in this respect doesn't support quality.

One person questioned the need for yearly support visits, suggesting that they *'could be conducted on a 'sampling' basis - I don't think they need to visit every place every year.'*

In line with earlier comments, a number of people also suggested that a more 'flexible' approach in regard to expectations and application of the standards in different contexts should be adopted. This was particularly the case in smaller rural facilities. As one senior level manager said:

The accreditation process doesn't always recognise what is being done in smaller rural communities and that there is a process for positively supporting people to make the changes within your own areas. That's

probably reflected in the Agency's inability to differentiate between a big bureaucratic structure - which I think does need to be scrutinised very closely - as against a small rural community where they are wanting to keep their community intact. Yes, there's probably a need for some improvements but there's a different way of tackling it because those people are not sophisticated in the jargon, they are wanting to do the best thing by their communities.

Of the 'broader' level changes identified, one of the most frequently mentioned was the need for additional funding which could be used for things like staff education and training. As one person said:

A training or staff development budget would be good. A lot of places have got a lot of staff so it can be very expensive. They could have considered TAFE courses. We have had to buy training but we've run out of money to do so now.

To support the argument for some funding assistance from the federal government, one informant also pointed out that staff training often had to be repeated due to high staff turnover.

A second 'broader' level change often mentioned, primarily by senior level managers, was the need for the Agency to be totally independent of the government, at all levels.

There needs to be a separation from the bureaucracy and the Minister's office. There should not be any capacity of the Minister's office or the bureaucracy to direct the Agency to do anything in particular. It should have a mandate in its own right, it should have industry representation on its Board, it should not be chosen by the Minister or the bureaucrats.

In discussing this issue, several people also suggested that the Agency should not play any role in the Commonwealth Complaints Resolution Scheme.

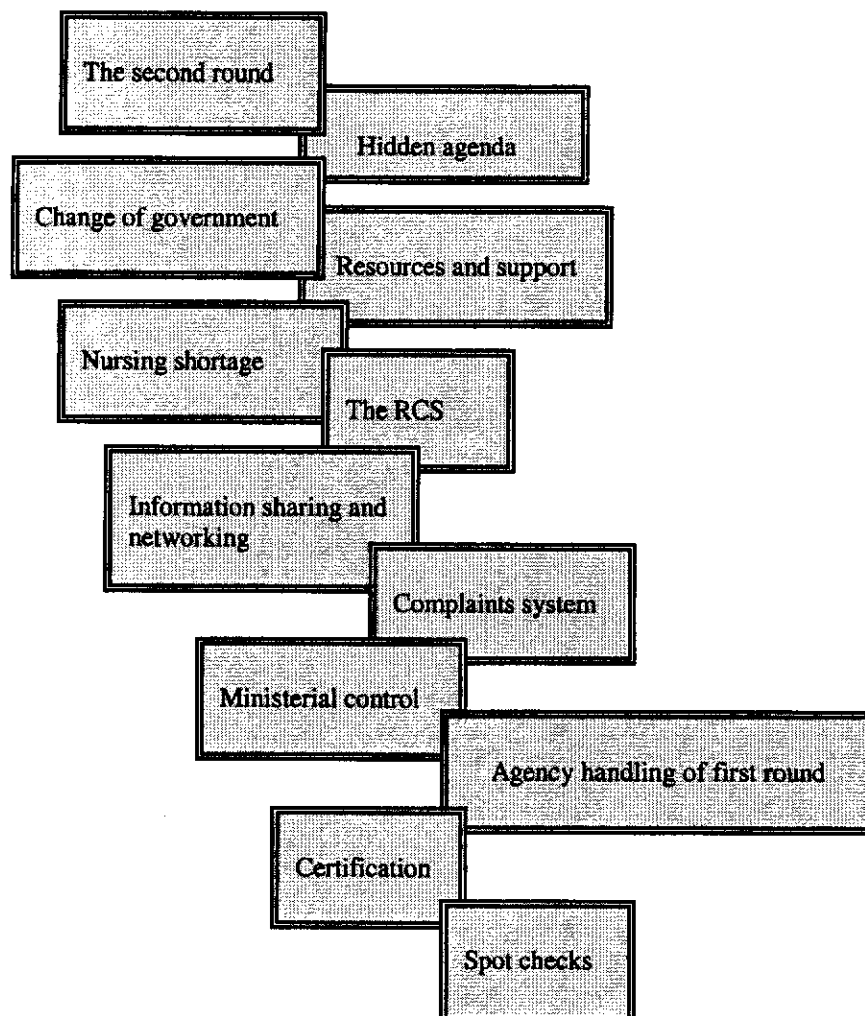
A variety of other improvements were suggested. These included: broadening the range of backgrounds represented amongst Agency assessors (currently regarded as too dominated by nurses); rationalising the links between accreditation and other components of aged care, for example the RCS and certification; more positive

exposure for facilities, such as through the organisation of national open days which might attract (positive) media attention; and reducing the amount of paperwork required.

5.2.7 Other issues

During the course of discussions with informants, a variety of other issues were raised. The most prevalent of these are discussed below (see Figure 11).

Figure 11: Other Issues Identified



The second round

A number of participants commented on the next accreditation round. Most people expressed the view that the process would be more stringent and that Agency would have much higher expectations.

The next one they won't show the mercy they did the first time – they will be right on top of you.

Many people, particularly those working in facilities, appeared to be quite apprehensive about this possibility, several expressing their concerns about 'ever changing goal posts'.

The Commonwealth have done what they said, they have lifted the game of aged care, but are they now going to come down on us with a hammer? We've done what they wanted us to do - spent time, effort, and so on - but what's coming next? What expectations are coming next? What goal posts are you going to change now?

Others, however, were not concerned. Several people commented that this was a normal part of the CI process anyway.

You'd expect that in any quality improvement programme, that the goal would shift.

However, some people did express concern that these higher expectations were not being made known to the industry. As one CEO said:

There's no doubt about the fact that the bar will be lifted. But providers just don't know what the next level of expectation is. I think it's O.K. to have a good quality system in place but I think, if it's really being treated as a partnership, that people know what those next levels are either in percentage terms or there's some sort of milestone set or they say to you: "If you now want to look for a commendable this is the extra audit that you've got to achieve".

There was also some concern that the system could become overly punitive as it moved into the second round. As one peak body representative said:

There is a lot of fear, particularly if the current Minister stays, that it will become an increasingly compliance/punitive tool. Its responsibility is to identify systemic problems, not the little one-offs or mishaps and the current Minister seems to be pushing that.

Hidden agenda

Several people suggested that the government had a hidden agenda in introducing the new system. For example, some thought that it was being used as a means of eliminating the smaller operators.

I believe that the government only wants to deal with the big players. It's a shame because the 30s, 40s and 50s type nursing homes give a good homelike interaction between families.

In most cases funding was regarded as being the main underlying motive for this.

There probably is a hidden agenda to close smaller facilities. It relates to under-funding, mainly in the capital replacement area. Any facility under 60 beds is not really viable, they are being bought out by larger organisations. It's a funding issue.

Other informants thought that the agenda was focused more on eliminating low care facilities.

I think there's a hidden agenda by the government or the bureaucrats or both to turn all the hostels into nursing homes and I think the current Minister has this idea that all low care residents should be cared for in the home.

However, many people disputed the idea of a 'hidden agenda' although some did acknowledge that the accreditation system could have some unforeseen consequences, including the gradual disappearance of smaller and/or rural facilities. As one CEO said:

I don't think it is a specific part of their agenda but I think they probably presumed that there would be that collateral damage, particularly in the small country areas. I think it's on their minds and they're not sure what to do about it.

Change of government

An additional concern related to the impact of a change of government on accreditation. As one person said:

You're dealing with bureaucrats and you don't know what they are going to do. I'm worried - say if the present government is ousted, are they going to mess it up, are they going to streamline it?

Others thought that little would change:

I don't think there will be any major changes with a change of government because we've moved so far forward that they can't afford to take it away. There'll be change because there has to be change - and that's politics and we'll just have to work with it. I think it will be a refining thing, more of a continuous improvement.

Support and resources

The need for providers to have access to appropriate support and resources from within their organisations in order to cope with the demands of accreditation, not only during the preparation stage (as discussed earlier) but also on an ongoing basis, was frequently identified. As one administrator said:

We were fortunate enough that our Board agreed for us to employ someone who was able to do a lot of the leg work for us. It was a 12 month contract but towards the end of the 12 months we realised that accreditation was going to be an ongoing demand so she became our quality assurance coordinator and she is still with us.

Several people also pointed out, however, that this had certain cost implications. One administrator said:

One of the things that organisations should be cognizant of, even the smaller ones, is you have to have a systems manager and this is a position that never existed previously. So you've got a \$30,000 plus position.

Several people expressed concern about how smaller stand-alone facilities would cope in the future.

Big facilities and organisations have built in support services, they have more resources at their disposal, common resources. Stand alones don't have those resources to draw on. So the big groups will probably manage very well, they have the systems across the organisation [] but the little ones, I am still very concerned about.

The importance of Boards of Management as well as owner/proprietors being involved was raised by several people. One CEO's comment was:

They haven't appreciated their own governance responsibilities. Traditionally they have left running of facilities to DONs or care managers who haven't been supported with the resources needed or the moral support. They have learnt that there are repercussions. My impression is that proprietors are now very informed and involved.

In addition to the above, the benefits of having already had good quality systems in place prior to the introduction of the accreditation system were mentioned.

Accreditation for us wasn't a huge impost as we were a fair way down the track with our normal quality service that we have always provided [] but I know that for some people it was huge leap, they had nothing.

Nursing shortage

Another issue frequently raised during discussions related to the difficulty of attracting and/or retaining registered nurses. This was regarded as having a major bearing on the ability of organisations/facilities to meet the ongoing demands and requirements of accreditation. The wages disparity between nurses working in aged care and those in acute care was felt to be a major factor contributing to the shortage:

The sector has been unattractive to RNs for many years. It's not just the wages issue but the wages issue is a key reason. So we end up working with a high ratio of agency staff quite often so the real duty of care obligations fall on a very small number of permanent full time staff.

The documentation demands on nurses were also identified, although accreditation was not solely blamed for this.

The documentation requirements of aged care have always been off-putting to professional nurses and that has increased ten fold. For most of them it is something that they don't want to spend their time on.

The Resident Classification Scale (RCS)

The combined demands of accreditation and the RCS, particularly in relation to the documentation, was a major concern for many informants. As one owner/proprietor said:

Accreditation is an imposition in that it's another set of paperwork that these people have to deal with just to get funding along with the RCS and you've got to do it. I have people who are still doing it three or four hours after the shift simply because they don't have the time to do it and they don't want to go until they get it done because if they work their eight hours on the floor and leave their paperwork they don't get funded.

In the view of several participants there was an urgent need to rationalise the relationship between the two systems in order to reduce these demands on staff.

Information sharing and networking

A further issue raised, particularly during discussions about best practice, was the extent to which accreditation had encouraged sharing and networking between service providers. The view was that it had not encouraged this but that it had often created an environment of 'possessiveness' and competition.

I would suggest that in the first instance accreditation may possibly have made people more competitive because they are checking to see what you were doing and you didn't want to give too much away.

One person thought that many larger organisations had become particularly 'possessive'.

I see a difference between the large and small organisations. The large organisations don't seem to be too keen on sharing information. Prior to accreditation everyone worked in a lot closer and people seemed to be a lot happier to share information.

In the case of the ethno-specific facility who participated in the study, the issue seemed to be related more to finding an appropriate facility/organisation with whom to share information.

We haven't done a lot of it ourselves because when we sat down and thought about it we thought "who could we compare ourselves with?" We're just so individual, so different - it's very hard. We did try to do a bit with one place over in Sydney but they're such a huge organisation and they have a different clientele. It's quite different and it really didn't work.

Similarly, in the view of rural-based informants, the opportunities to network and share information were often felt to be fairly limited.

Country nursing homes are few and far between – you can't really network like in the city.

One facility, which had devoted a significant amount of time to networking, questioned its usefulness anyway.

It was difficult to get help from others as everyone was doing it their own way, there was no one set manual or anything.

Others disagreed with this view. One person, for example, stated that networking had actually been a more useful means of gaining knowledge than the formal training provided by the Agency.

Complaints system

As reflected in several earlier comments a major concern amongst service providers, particularly those working at a more senior level, was the Agency's involvement in the complaints system. Many people thought that this more 'punitive' role was incompatible with other aspects of the Agency's role and compromised its independence. As one CEO explained:

Anyone can raise a complaint and the first point of contact is somebody in the Department who determines if this is likely to have an impact on more than the resident they are talking about or not. So then they may say: "Well this is reasonably easy, we can do this by letter or whatever and get a resolution hopefully" OR in fact it can generate a visit by the Commonwealth to the

organisation. If it's the latter, under the Act the Commonwealth can actually - and they do - walk in, they can look at anything and they can find and report on anything in the facility that they think's a concern - and that's dangerous because if the complaint is substantiated, the Commonwealth can instruct the Agency to do a full review visit.

So [] a facility can actually go from a complaint to a visit from the Commonwealth, to a review visit by the Agency and a bad outcome leading to sanctions. That's not necessarily wrong but it really impacts on the issues that are still there between the Commonwealth and the Agency. They probably need to be there but I'm just not clear about this punitive sort of role - so some of the old practices in terms of the policing unfortunately are still there and I think that's unfortunate for the Agency.

Ministerial control

There was also a view, primarily amongst senior managers and peak body representatives, that the Agency was being controlled in terms of what it could say publicly and that this also raised questions about its independence and the general 'transparency' of the system. As one peak body representative said:

There's a perception of secrecy. We see it as total Ministerial control of the Agency and we strongly question its independence. The only way it will work is if there is a clear separation of the Agency and the Ministerial (roles). The Agency should be the specialist in quality systems, the Department the generalist. The Department should say "This is the Act" and the Agency should be left to interpret it within reasonable standards.

Agency handling of first round

Despite the numerous concerns about accreditation that were raised, many people felt that the Agency was still learning and feeling its way as much as the industry was through the first round. For example, the comment of one person whose facility had only been granted one year's accreditation was:

After our initial disappointment what we came to realize is of course that this isn't just new for us, it's new for them. The Standards Agency haven't done

this before, this was Round One - it's new to them, it's new to us. We're going to learn from it and hopefully they will learn from it.

Some people also felt that, overall, the Agency had handled the first round extremely well.

The Agency did a great job for the first time around. They had a huge brief and they had their deadlines and pressures - and the way they did it is to be commended.

Certification

Several people made specific comments about the building certification system, mainly as regards the way in which it linked with and /or impacted upon accreditation. In several cases, the additional financial demands that certification imposed on providers and the possible implications of this were identified:

There's a lot of good places out there whose care could be wonderful but they are going to be forced out because of the hundreds and thousands of dollars needed to upgrade facilities for certification.

Spot checks

One peak body representative raised the issue of spot checks, saying:

Our members are uncomfortable about spot checks. The Agency always asks and has a high degree of focus on being courteous but spot checks do upset people, they are stressful and there are legal and human relations consequences if you say 'no'.

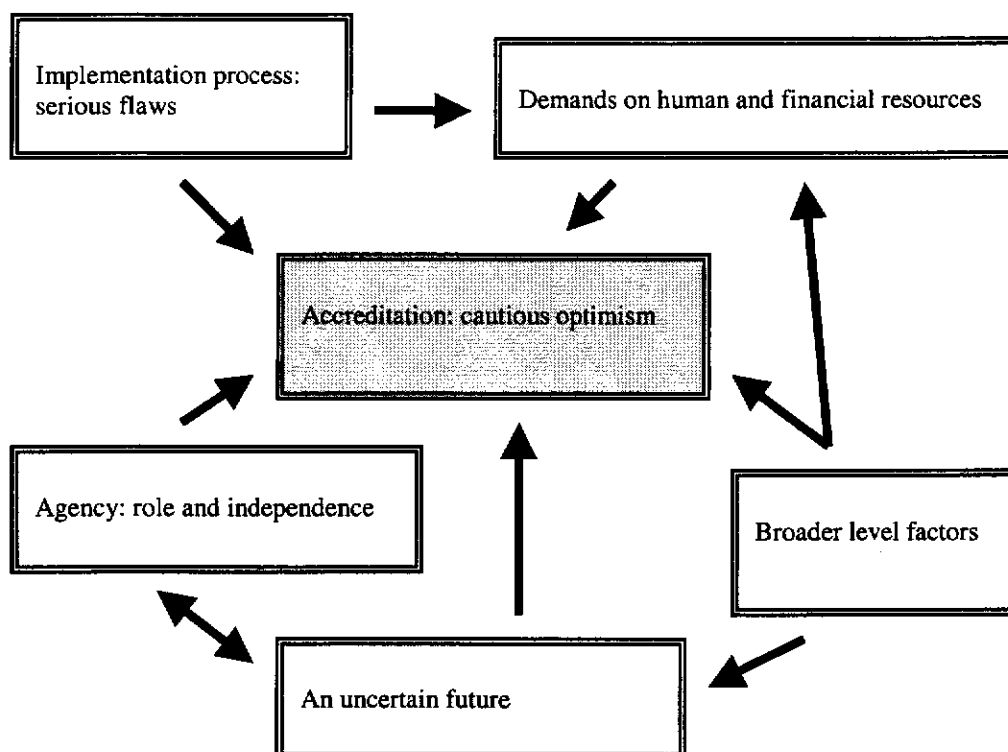
5.2.8 Key themes

Based on the information presented, a number of recurring issues or 'themes', several of which are interrelated, were identified. A central theme that extended across each of the other themes identified was that although accreditation was generally supported by providers and regarded as a positive step, this support was tempered by various concerns that many had about it. This overarching theme has been identified as '*Accreditation: cautious optimism*'.

Five other themes were also identified. The first of these, entitled '*Accreditation: serious flaws*', related to the general finding that accreditation had made considerable demands on providers both in relation to staff as well as financially. A second theme has been called '*Implementation process: serious flaws*' and reflects the various concerns that providers expressed about the way in which the system had been implemented. A third theme related to the role and independence of the Agency itself viz-a-viz the Department of Health and Aged Care and the Minister for Aged Care. Many providers regarded this role as requiring serious review. This theme has thus been labelled as '*The Agency: role and independence*'.

Concerns about a variety of extra-organisational factors in terms of their perceived impact on the implementation of the accreditation system were consistently raised throughout this study and emerged as a further theme. This theme has been called '*Broader level factors*'. The fifth and final theme has been labelled '*An uncertain future*' and relates to the widespread concerns amongst service providers about how the accreditation system would develop in the future and the impact of this on them and on residents. A diagrammatical summary of these themes and their respective interrelationships is provided in Figure 12.

Figure 12: Key Themes



Accreditation: cautious optimism

A central theme emerging from this study which, in a sense, reflects the five other themes identified, was that accreditation was generally accepted as an appropriate and potentially valuable approach to the management and regulation of quality. At the same time, however, the many limitations that it was perceived to have appeared to be working against its wholehearted acceptance. As one person commented:

I think accreditation should stay as long as it doesn't get too bureaucratic and too red taped and that it is cost effective. It would be very destructive for it to become a very cumbersome highly documented process, which is a possibility. The initial component of it is fantastic because it gets people alerted to what they need to be thinking about but it can bring an organisation to its knees because it has become so heavily laden with all this information. It needs to be a process where the information is relevant and user friendly and where you don't need to document everything to the nth degree which sometimes means you've got to employ people and it becomes

an industry in itself. What you want is an outcome that is better residential care.

It was suggested that the industry's reservations about accreditation were also due to the fact that it was 'tired' of change.

I don't think there is a real resistance to accreditation but we are suffering from 'reform fatigue'. We need a period of consolidation, of bedding down.

Nevertheless, the findings suggested that most providers were fairly optimistic that the concerns they had about the system would be addressed.

I think there's a lot of potential there. We're a bit disillusioned with the way it's gone but we're always optimistic, we have to be. And so, hopefully, it will get back on track again because, really, the issues we are dealing with we should be way beyond.

I'm still optimistic enough to think that it will work well – the principle is great, we just have to get the practicalities right.

It is also clear that accreditation was regarded as a far preferable alternative to its predecessor, the standards monitoring system, with many people of the view that the benefits of the new system were already obvious.

The concept is excellent. I think there's more consistency throughout the industry. One of the biggest problems before was each organisation was going in its own direction. Now we're getting closer and closer together about doing similar sorts of things and residents can transfer to another facility and be pretty confident that they would get a similar standard of care.

Accreditation has been a positive outcome for this place. I think the whole place shows that we've moved into the 21st century.

Demands on staff and financial resources

A second theme to emerge related to the huge demands that accreditation had made on service providers in terms of staff and managers as well as financially.

In relation to the costs involved, a common perception was that the federal government may have grossly under-estimated the financial impact of the new system on providers, with several informants having expressed concern about their ability to meet the costs involved in the future.

It has been a strain the last year. Our loss last year was \$300,000 cash flow wise - the previous year it was less than ¼ million - so it has gone up. It's something that we can't afford to do but we can't afford not to do and our reserves will get depleted over time.

Similar views were expressed about the ongoing demands on staff.

It's the longitudinal studies that will tell the story - because people can sustain things for 12 months, 24 months, 36 months - but then they're just exhausted.

As a consequence, there appeared to be fairly widespread agreement that unless such issues were addressed the ability of many service providers, particularly smaller ones, to maintain services at the required level could be seriously in doubt.

A lot of entrepreneurs who own a facility have to make a living and that's very, very tough for them - all these things have got tougher and tougher. So, particularly the small hostels and nursing homes, I believe a lot of them will disappear in the next two or three years. They'll be closed or purchased because they cannot sustain themselves.

Rationalisation of documentation requirements and greater funding support from the Commonwealth were regarded as priorities.

Implementation process: major flaws

A second theme concerned the implementation process itself which was quite clearly regarded as having a number of major limitations. The most notable of these were the perceived inconsistency of the assessment process, the self assessment kit and the general lack of information and guidance provided by the Agency.

It is evident that the perceived inconsistency amongst quality assessors in terms of the way they approached site audits and their expectations in regard to different

standards and/or facilities was a major concern. Consistency in the way the ratings system had been interpreted and/or applied, particularly between W.A. and other States with respect to the granting of 'commendable' ratings, also emerged as a prevalent issue.

Similarly, there appeared to be fairly widespread agreement that the self assessment tool was in need of urgent review. The comment of one CEO reflects this general sentiment:

It's still too hard. We've just done one again and I still can't understand most of it. It's a really difficult document to work with and I'm not sure it needs to be as complex. There are ways that you can get facilities to document more about what they are doing and tell you how they are going, what they want to improve. There must be an easier way than what we've currently got. I did some of the nitty gritty - how you fill in the boxes and so on - half the people sat there and it was no wonder the Agency were a little bit critical of the standard of self assessment that had been done.

The amount and type of guidance and information provided by the Agency both prior to and during the first round and as the system moves into its second cycle, emerged as a further major perceived limitation of the implementation process, most notably in relation to continuous improvement and best practice information. The following comment by a senior residential care manager sums up the view of most in relation to the latter:

There is a certain amount of onus on industry itself to do some of that sharing and I think some of that happens now but the Agency needs to set the agenda - that's their task, they need to be facilitating that. The Agency has put the bar in place and so they have the responsibility to talk to the industry. It's a joint thing.

The Agency: role and independence

Concerns about certain aspects of the Agency's role viz a viz the government, specifically the Department of Health and Aged Care (as it was named at the time) and the Minister for Aged Care, also emerged as a theme, particularly amongst senior managers and peak body representatives. These concerns appeared to revolve

primarily around the Agency's involvement in the Complaints Resolution Scheme and perceptions of 'political interference', both of which were felt to compromise its independence and limit its capacity to foster a real sense of partnership and trust within the industry.

For many informants, the Agency's involvement in the complaints system was regarded as incompatible with other aspects of its role, including its education and support roles.

They need to work out the Agency's role. We hope it will be as a resource - and they ARE looking at systems and all those sorts of things. But if there is an issue that comes through, then you should have a different arm of government that comes in to assess what the issue is and then once the issue is identified the Agency should be going in there and helping that facility work through it. If that organisation doesn't make a concerted effort to address those then the government comes in again and says "hey, we're not playing games here". So as long as the Agency doesn't try and play two roles because if they're not very clear about what they are going in to achieve, then they are being pulled apart.

Similarly there was a strong perception that the Agency was ultimately controlled by the Minister and/or Department of Health and Aged Care to meet the latter's own political agendas, thus contributing to a certain sense of 'powerlessness'.

They're obviously controlled by Canberra. It's a case of "that's what they've been told and they can't deviate". We can argue but we won't get anywhere.

Broader level factors

Many of the difficulties involved in the implementation of the new system appeared to be inextricably linked with other problems within the broader context of aged care. As one owner/proprietor said:

My problem is I can't divorce accreditation from the whole picture. The baseline is if you don't get accredited, you don't get funding. If you don't get your RCSs right you're not funded to the level you should be, and if you don't satisfy the auditors for the RCSs, you don't satisfy the auditors from accreditation, so forget it. But if you don't satisfy either of them it doesn't

mean that the quality of care you deliver isn't top class. I would argue that this institution actually delivers first class care as the emphasis is on the care but with the demands that are there I cannot deliver extra care to these residents because I can't pay for it. And I cannot get someone into work as a DON of the calibre I would like because I cannot pay her what she can get out there in the health care industry.

Concerns about the adequacy of current funding for aged care emerged as a major factor. The perception was that inadequate funding levels were having a major impact on service providers' ability to meet and maintain the requirements of accreditation. The adequacy of the RCS as a funding tool was a key issue in this regard:

The Department's telling you you've got to meet all these things, do all these things but if you haven't got the resources to do it, that's when you do get stressed. It's not so much the accreditation process but knowing that you want to achieve all these things but you haven't got the resources to do it properly. We never know when the Department is going to come knocking on our door wanting to go through the RCS and take \$25000 off us. They'll find a way of doing it - they just change the goal posts, and just change the rules.

Similarly, it seems that the (often competing) demands of other systems such as the RCS and building certification have created further difficulties. The view was that there was an urgent need to rationalise and/or clarify the relationship between the different systems in order to reduce the demands on providers, both financially and in terms of staff workloads.

Staffing issues, specifically the difficulties of attracting and retaining nursing staff, also emerged as a widespread concern, particularly amongst senior managers.

An uncertain future

A further theme concerned the future, specifically that there was considerable uncertainty, and in many cases apprehension, about how the accreditation system would develop and how this would impact on providers and residents. In part, this

related to fears that expectations would be raised too fast and/or to the point of being unattainable.

I guess we're scared because the Department has a history of "as soon as we're getting things right" then they change it because they're getting it right. We all think that about accreditation. Whilst we accept that the idea is continuous improvement, that's what we want to see, not that the expectation is that they leap too high too quickly. We have people to look after, that's our main thing - we can't do everything. So if they raise their expectations too quickly, then something's got to give.

As indicated, there was also widespread apprehension that the system would revert to a more 'punitive' style reminiscent of the standards monitoring system.

It is in danger of swinging back. If positively focused, rather than punitively, it would be really positive in the long term. The original concept was that it was a positive approach and a partnership - they have an opportunity if only they could see it.

The above concerns suggested that there was a general lack of 'trust' in the Government fuelled, at least in part, by the political interference that was perceived to have occurred. As a consequence, many providers were doubtful about the government's preparedness to listen to what the industry was saying, despite the steps taken to seek feedback from them. In the words of one provider, therefore:

If they take on board what people ARE saying and work out how we can make that process better, it would be great if we could do that, but I am concerned that they don't do anything. They write all these reports so everyone knows what the problem is then the Minister gets a friend to write another report and say the industry is fine. It's absolute nonsense, it's a political game.

5.3 Summary

A total of 45 informants representing 15 facilities, 10 organisations and two peak bodies were interviewed for this study. The results revealed a wide range of experiences and views regarding the accreditation system.

In relation to the first objective which sought to explore people's views about and overall support for the system as a new approach to the regulation of quality, the results suggested that it was generally supported. It was also regarded as having a number of very positive features, particularly when compared with the standards monitoring system that it had replaced. These included its generally supportive nature, thoroughness, flexibility and, in the view of some, the more 'objective' and structured basis it provided for assessing quality. The incorporation of continuous improvement into the system was regarded as a positive step although some facilities had experienced difficulties in fully understanding its meaning and practice implications. There was also a view that the documentation demands associated with continuous improvement were often unrealistic.

Although accreditation was regarded as a much more supportive approach than the standards monitoring system, few thought that it yet resembled a true or equal 'partnership'. Reasons given for this included the Agency's role in the complaints system, perceived interference by the Minister for Aged Care, inadequate sharing of information by the Agency, particularly in relation to best practice, and the industry's general apprehension about a new system being implemented. As a result, views about how accreditation would develop in the future were fairly mixed.

The second key issue explored in the study related to the way in which the accreditation system had been implemented, both in regard to education and training and to the assessment process itself. In relation to the former, most people appeared to have found the Agency education and training sessions useful in that they helped to clarify expectations and allay anxieties about the process. However, a number of limitations were identified. These included the lack of information and guidance relating to how to get started and/or specific aspects of the process such as self assessment and continuous improvement.

A variety of concerns about the accreditation process itself were also raised. Most of these related to the self assessment and site audit stages. With respect to the former these included the time and effort involved, and the self assessment tool, particularly its repetitiveness, format, the language used and level of detail required. Many people also thought that the Agency had not provided sufficient guidance to service

providers during this stage. The extent of support available to facilities from within their own organisations also appeared to have been an important factor.

With respect to the site audit most informants stated that, overall, it had been a fairly to very positive experience. A variety of factors appeared to have played a critical role in influencing people's views about this stage of the process as either positive or negative. These included the approach of the assessors, although this was in most cases highly praised, and the structure of the visit itself, particularly in terms the time frame (often thought to be insufficient), the feedback process and opportunities for resident input.

There were a number of concerns raised about the site audit. These included the stress that it had imposed on staff, the perceived subjectivity and inconsistency of the assessment process, the tendency of some assessors to place undue emphasis on particular standards or issues, and the level of expertise of some assessors.

A third area of interest in this study was the accreditation standards. Overall the standards were generally perceived to be relevant and appropriate reflections of service quality although some people, particularly those based in small, rural facilities, thought that there was a need for more flexibility in their application. Many providers also said that they had found it difficult meeting the requirements of some standards, especially Standard One (*Management Systems, Staffing and Organisational Development*). Reasons included lack of understanding and/or familiarity with the concepts involved and because of the demands on staff time and organisational resources. Lack of input and/or support from management was a further factor often cited.

The standards ratings system was also the focus of many comments. Specific concerns related to the inconsistency with which the 'commendable' rating was perceived to have been applied both within and between States, the gap between 'satisfactory' and 'commendable', and the expectations regarding the 'commendable' rating (e.g. level of documentation) which were in many cases thought to be unrealistic.

People's views about the impact of accreditation were also explored. Overall the system appeared to have had a major negative impact on service providers and had made considerable demands on facility/organisation finances and personnel. Many people also felt that the system had adversely affected residents, albeit indirectly in some cases. At the same time, a number of benefits to facilities/organisations and staff and also, in some cases, to residents were identified. These included more streamlined management systems, greater involvement and/or awareness amongst management, increased staff knowledge and skills, improved staff morale and an increased sense of ownership and awareness amongst residents of the care process. Accreditation was also felt to have had a significant impact on the aged care industry in general in terms of its overall image and morale, however, views as to the nature of this impact (i.e. positive or negative) varied.

Major strengths of the system identified included the focus on quality embodied in the new system, the positive effects on facility/organisational management systems, the greater accountability it had engendered, the resident focus, and the positive impact that it had had on staff and the industry. The main limitations were the costs involved, the demands on staff (primarily as regards documentation), the inconsistency of the assessment process and the unrealistic expectations of the industry in the face of current funding levels and staff shortages.

A number of changes and improvements to the system, most of which reflect the issues identified above, were suggested. These included streamlining the self assessment kit, providing more information and guidance, and greater consistency in the assessment process. Many people also felt that there was an urgent need to address broader level concerns such as allocating additional funding to the industry, and a rationalisation of the links between the Agency and the government and between other components of the aged care system, such as the RCS and the Building Certification Scheme.

Based on these findings, six themes, including one central or overarching theme, were identified as follows:

- *Accreditation: cautious optimism.* As a regulatory approach, the accreditation system was generally supported by providers and regarded as a welcome

improvement over the previous system. However, this support was tempered by the concerns that many had about aspects of it and how it would develop in the future. This theme represented the central or overarching theme of the study.

- *Demands on human and financial resources.* Accreditation has made considerable demands on providers, both as regards staff as well as in financial terms.
- *Implementation process: serious flaws.* The process of implementation of accreditation was regarded as having a number of major flaws. Particular concerns related to the consistency of the assessment process and standards ratings decisions, the self assessment kit and the amount of information and guidance provided by the Agency.
- *Agency: role and independence.* Many providers had major concerns about the Agency in terms of its role and independence. This appeared to be working against the development of a sense of partnership and trust within the industry.
- *Broader level factors.* A number of factors beyond the accreditation system *per se* appeared to be impacting upon providers and their perceived capacity to meet its requirements. These factors include the adequacy of the current funding system, the competing demands of different systems (such as the RCS and building certification) and nursing shortages.
- *An uncertain future.* There was considerable uncertainty and in some cases apprehension about how the accreditation system would develop in the future. Specific concerns include the possibility of more stringent and/or different requirements being imposed and that the system would become more 'punitive'.

Chapter 6: Discussion

The findings of this study reflect a wide variety of experiences and views amongst service providers of the accreditation system and the way in which it has been implemented. Despite these variations, a number of common themes and issues have emerged. These suggest that although there is in principle support for accreditation, and although its introduction is regarded as having already benefited the industry and its consumers in a number of ways, providers have some major concerns about it. Moreover, many of these concerns are regarded as urgently requiring attention.

6.1 Key Observations

In reviewing the six themes and associated issues that have been identified in this study, a number of comments can be made. Many of these reflect issues identified in the literature and can be grouped under four main headings, namely: evaluation issues; issues relating to the implementation of a continuous improvement based approach to quality; accreditation as a new regulatory approach; and the relevance of a broader perspective. These headings, in a sense, represent broader level themes beyond those already identified. The following discussion is, therefore, structured in accordance with these more 'global' themes, however, the links between them and the themes identified in the *Results* chapter are identified as appropriate.

As will also become evident, many of the issues to be discussed accord with those identified in other reviews of the accreditation system. The most notable of these are the national Lessons Learned review (Commonwealth Department of Health and Ageing 2002b) which involved consultations with a range of stakeholder groups, including service providers, and a smaller study conducted by the New South Wales/ACT branch of Aged Services Australia, involving focus group discussions with 36 senior aged care managers (Aged Services Association of NSW and ACT 2001).

6.1.1 Evaluation issues

The evaluation process is a key component of the accreditation system, providing a means by which the quality of service provision can be monitored. The findings of this study suggest that there are certain aspects of this process, or factors associated with it, for example the accreditation standards, that are of concern. Many of the evaluation issues discussed in this section clearly relate to the theme 'Implementation process: serious flaws'. Others have links, albeit less direct, to the themes 'Demands on human and financial resources' and 'Broader level factors' that were identified in the preceding chapter.

As in many quality evaluations that involve assessment by an external body, the accreditation system uses standards as the valuation criteria. The need to ensure that these standards are appropriate, meaningful and attainable, that they are measurable and provide a reliable basis for assessment, is consistently emphasised in the literature. This study suggests that most providers regard the standards as appropriate overall, however, some question their relevance in specific contexts, for example in small country towns.

In regard to their general 'attainability', Gray (2001) suggests that the fact that all but one facility Australia-wide was accredited in the first round implies that they are achievable. Nevertheless, this study suggests that many providers do have concerns about the attainability of the standards in future rounds. This is partly because of fears that the Agency's expectations of what is 'acceptable' will increase but also because of 'external' factors such as funding and the nursing shortage.

The need to develop an appropriate system for determining compliance with the standards is also frequently identified in the literature (e.g. Le Sage & Young Barhyte 1989) although opinions as to the form that this system should take tend to vary. In contrast to the 'pass/fail' (or 'met/not met') approach often used and as used in the standards monitoring system, the accreditation system has moved towards a more 'graded' approach, albeit a fairly crude one. However, evidence from this study suggests that the current ratings system is not regarded as a particularly useful means of differentiating between facilities, a view that is reinforced by the fact that the vast majority (around 90% Australia-wide) received a '*satisfactory*' rating. In this respect,

it can also be assumed that the current ratings system is of little value to (potential) consumers. Moreover, there appears to be a need for further clarification of the ways in which the '*satisfactory*' and '*commendable*' ratings categories are differentiated.

These concerns about the ratings categories appear to be common across the nation judging by evidence from other reviews (Aged Services Association of NSW and ACT 2001; Commonwealth Department of Health and Ageing 2002b), with various suggested improvements having been proposed. In the latter report, for example, it was suggested that a preferable alternative might be to have a two category rating system of 'accredited/non-accredited' or similar (e.g. pass/fail), with the strength of the 'pass' indicated by the accreditation period granted and 'excellence' acknowledged via a separate process. This same report also recommended that the ratings be explained in a more simplified way in order to facilitate their interpretation. The need to develop more 'user friendly' ratings systems has also been identified in relation to the U.S. regulatory system (Klitch 1999).

Concerns about the accreditation standards or issues relating to them have been raised by other stakeholders. The Australian Society for Geriatric Medicine (2002), for example, has questioned the lack of specificity of several (e.g. Standard 2.6: Other Health and Related Services). Particular concerns related to the lack of relevant criteria (e.g. 'complementary therapies') and of outcomes and indicators that can be directly measured. Gray (2001) identified the latter issue as a particular concern, pointing out that as a result there is no objective basis for assessing improvements over time. In order to address this issue he has recommended that an Industry Advisory Committee be formed whose role would be to assist the Agency to develop appropriate measures.

With respect to the assessment process itself, a number of comments can also be made. One is that, at least as far as the experiences of W.A. providers are concerned, the process does seem to reflect many of the features generally regarded as essential to effective (quality) evaluations. These include its scope and overall thoroughness, the professionalism of the assessors, the opportunities for providers to have input during the process, including in the preparation of the site audit report, and the use of

informal praise and positive feedback (Australian Society for Geriatric Medicine 2002; Braithwaite 1998, 2001; Posavac & Carey 1997).

At the same time, and despite measures that have been taken to ensure that the assessment process is conducted in an appropriate and systematic manner, several aspects of it have emerged as major concerns. Again, many of these reflect issues identified in the literature. For example, although the Agency has claimed otherwise (e.g. see Gray 2001, p.92), the widespread concerns about the subjectivity and inconsistency of the process raise a number of questions about the appropriateness of the assessment protocols and decision rules that have been developed. They also raise a number of other questions relating to the standards, in particular their reliability, and the adequacy or otherwise of assessor training and expertise. These questions are particularly pertinent given that similar concerns have been identified in other studies of and commentaries on the Australian accreditation system (Aged Services Association of NSW and ACT 2001; Australian Society for Geriatric Medicine 2002; Commonwealth Department of Health and Ageing 2002b; Greenwood 2001) as well as in literature pertaining to the U.S. system (Klitch 2001).

As discussed earlier, Braithwaite (1998) has argued in defence of a certain degree of subjectivity in the assessment process. More specifically, he has argued that the flexibility in approach of the former standards monitoring system was actually one of its greatest strengths. In his view, having detailed assessment protocols for each standard would have been a mistake, causing monitors '*to lose sight of the wood as they focus on the trees*' (Braithwaite et al. 1993, p.77). Nevertheless, the extent of concern expressed about assessor inconsistency does suggest that further review of this issue may be warranted.

Providers' concerns about assessor inconsistency related not only to differences in approach and expectations between local Agency assessors, but also to differences in the way the ratings, primarily the '*commendable*' rating, have been applied in different States. These concerns have been raised by providers in other States (Commonwealth Department of Health and Ageing 2002b; Gray 2001).

The general problem of between-States variation in assessment decisions appears not to be unique to the accreditation system but has also been raised in relation to the standards monitoring system (Braithwaite et al. 1993) and the current U.S. system (Harrington & Carillo 1999). It has been suggested, however, that rather than attributing these differences to assessor inconsistency, they may reflect genuine differences in service quality (Commonwealth Department of Health and Ageing 2002b; Harrington & Carillo 1999). In regard to the accreditation system, the Lessons Learned report (Commonwealth Department of Health and Ageing 2002b) suggested that the differences in '*commendable*' ratings between States could be related to factors such as the amount of education and training on accreditation that has been conducted by providers and/or their representatives. As in the Gray (2001) report, however, the difficulties of unravelling the reasons behind these differences, particularly in view of the limited data available, were also acknowledged.

Many of the concerns raised about inconsistency within the accreditation system have prompted recommendations for a number of 'assessor-focused' strategies. These include further assessor education and training with a specific focus on quality assessment in aged care, annual audits of assessor decisions, a more rigorous recruitment process, and the conduct of regular performance appraisals (Commonwealth Department of Health and Ageing 2002b). In Gray's (2001) view, however, the problem of inconsistency is mainly linked to the fact that the standards are evaluated indirectly, that is, on the basis of different types of evidence rather than via direct, objective measures. The implication here is that strategies aimed at improving the 'measurability' of the standards may also be necessary.

For most providers in this study the site audit component of the assessment process was a positive experience overall that did not unduly disrupt the facility's normal activities. Braithwaite (2001, p.445) noted that similar comments have been made by facility staff in other States. In his view, however, such positive perceptions of the site audit, combined with the fact that all but one facility was accredited during the first round, may actually reflect a lack of rigour in the assessment process. More specifically he commented that the effectiveness of a regulatory system can be severely compromised by assessors who believe in being '*nice*' to facilities.

The incorporation of a self assessment component into the evaluation process is worthy of mention at this point. Self assessment is a common feature of most accreditation approaches (Shaw 2000). In the Australian system it is central to the continuous improvement process, helping providers to identify what needs to be done in relation to specific aspects of service delivery. In order to be of value, however, the self assessment tools employed must be relevant, meaningful and generally as 'user friendly' as possible. Quite clearly, for the majority of providers in this study, this was not the case. Again, similar concerns have been identified in other reviews (Aged Services Association of NSW and ACT 2001; Commonwealth Department of Health and Ageing 2002b) with specific issues raised reflecting those identified in this study. These include the size of the document, its format, language, repetitiveness, and problems with the electronic version.

Concerns raised by several informants about the Agency assessors in relation to their level of expertise and understanding of the industry and the need for representation from a wider range of professional backgrounds, also reflect issues raised in the quality evaluation literature, including in relation to accreditation systems, about the importance of evaluator 'credibility' (e.g. Shaw 2000). Such concerns have emerged despite the various 'preventive' strategies already implemented by the Agency such as its requirements regarding assessor training, skills, experience and understanding of the industry. Braithwaite (2001 p. 445) has specifically questioned the adequacy of assessor training, noting that external assessors can become registered to audit providers *'by attending a four (sic) day course given by organisations such as the Australasian Auditing and Certification Services'*.

Many providers in this study expressed their reservations about the adequacy of the two day time frame for the site audit. This issue was also raised in the Aged Services Association of NSW/ACT (2001) study. In both cases one of the main reasons given was that two days did not allow assessors to obtain a full understanding of how a facility functions. Although this view may have some justification, particularly given that many informants also thought that the assessors appeared 'rushed', it may also reflect a certain lack of understanding of the process. In other words, although the site visit is a critical component of the evaluation process, it is not the sole basis on which decisions are made but aims to verify information contained in the self

assessment document and/or explore specific areas in more depth (Aged Care Standards Agency 1998). Thus, unlike the standards monitoring system, the accreditation site visit does not represent the evaluation *per se*.

6.1.2 The implementation of a continuous improvement approach

A second general observation about the findings of this study is that many of the issues identified appear to reflect those often associated with the implementation of a continuous improvement approach within organisations. These include the difficulties experienced as well as several of the more positive 'outcomes' of the new system. This general issue relates most closely to the themes 'Implementation process: serious flaws' and 'Demands on human and financial resources' identified in the *Results* chapter.

As the literature suggests, one of the most critical factors influencing the ease with which an organisation can adopt a continuous improvement-based approach relates to the extent to which people working within it – from senior managers to hands-on staff - understand and embrace the concepts and principles involved. Although some facilities were already quite familiar with and/or working in accordance with this approach, in many others a major cultural shift appears to have been required. The results indicated that for many service providers the difficulty of familiarising management personnel or Board members with the concepts of continuous improvement and, in some cases, of gaining their support for the approach, was a critical factor in determining their experience of accreditation. It was also clear that many facilities were still struggling to come to terms with the concept and what it involves.

Such issues highlight the vital importance of providing adequate information and training. While the Agency did embark on a large scale education and information campaign both prior to and during the first round, the extent of confusion surrounding the interpretation and application of continuous improvement that has been identified suggests that it may have underestimated the extent of the cultural shift required. This idea is largely supported by comments made in both the Gray (2001) and Lessons Learned (Commonwealth Department of Health and Ageing

2002b) reports. The latter report, for example, stated that there appeared to be significant differences in levels of understanding amongst staff and managers between facilities as well as *'enormous variation in the way homes approached the process, ranging from a management only approach to an all-inclusive, whole of-service approach involving all levels of staff, residents and representatives at various points'* (p.7). Also relevant is the fact that comprehensive written information on continuous improvement was not made available by the Agency until almost the end of the first three year cycle (Aged Care Standards Agency 2001b).

Although a general lack of familiarity with the concept of continuous improvement may be one reason for the problems experienced by many service providers, it is possible that the confusion surrounding the terminology often associated with such approaches, as reflected in literature on the subject, may have exacerbated these problems. Thus, although the Agency tends to favour the term *'continuous improvement'* in its official publications, use of the term by Agency staff is not always consistent. At a conference presentation in Perth in 2000, for example, local Agency staff discussed quality in terms of 'Quality Management', 'Total Quality Management' and 'Continuous Quality Improvement', with only passing reference to 'Continuous Improvement' (Clarke & MacDonald 2000).

The literature emphasises the pivotal role played by senior managers in the implementation of continuous improvement approaches. Evidence from this study suggests that despite the heavy involvement of many senior managers, including Board of Management members, management remains an issue in many facilities. Evidence from other sources supports this idea. For example, Chris Gardiner, the General Manager of Catholic Health Care Services, is reported to have recommended the formation of professional body for residential aged care managers which would aim to address concerns relating to their general levels of expertise and accountability ('Aged care industry needs professional managers' 2000). Similarly, the establishment in 2001 by the Department of Health and Ageing of a Reference Group on Management Development in Residential Aged Care whose aim is *'to provide advice on the improvement of management practice within the aged care sector, with a particular focus on residential care'* also indicates that there is a

recognised need for residential care managers to further develop their skills and knowledge (Commonwealth Department of Health and Ageing 2002a, p.130).

Benchmarking and best practice are often regarded as important components of continuous improvement-based approaches (Hackman & Wageman, 1995; McClaughlin & Kaluzny, 1990). In this study one of the major concerns identified was the lack of dissemination of best practice information by the Agency, both locally and nationally. Similar concerns were identified in the national evaluation (Commonwealth Department of Health and Ageing 2002b), with a number of recommendations for addressing the issue outlined in the final report. These included conducting workshops and making relevant information and examples available through the Agency's website and newsletters. The report also recommended that research on best practice be conducted and that the findings should be published as a means of assisting industry education and training.

The view of the Australian Society for Geriatric Medicine (2002), however, is that a broader approach to fostering best practice, and one which is industry driven, is needed. More specifically they have suggested that all key stakeholders - providers, professional and academic nursing bodies, medical and allied health associations and faculties and consumers - should form 'strategic alliances' as a means of determining what is currently accepted best practice within residential care and where investment should be made in targeted research. This idea supports the suggestion of several providers in this study that the industry itself should play a central role in driving best practice, although it was also felt that some providers were reluctant to share such information. The Lessons Learned review also identified the latter as an issue, suggesting that a possible reason for this reluctance could be the perception that it might jeopardise providers' chances of being awarded a '*commendable*' rating (Commonwealth Department of Health and Ageing 2002b). However, this same report also noted that a number of providers have moved towards a more commercial environment, with best practice information only being provided on a fee paying basis.

Literature on continuous improvement also highlights the importance of organisations having appropriate infrastructures and resources available to support

such an approach and that in cases where these are not in place, the demands in both financial and human terms can be considerable (Dimant 1991; Fletcher 2000; Rantz et al. 2001). In this study concerns about the costs involved in preparing for accreditation and the demands that it had made on staff emerged as a major theme. They have also been widely documented in the literature (e.g. Aged Services Association of NSW and ACT 2001; Australian Society for Geriatric Medicine 2002; Commonwealth Department of Health and Ageing 2002b; Gray 2001; Jones 2000). In many cases these demands can be clearly linked to the implementation of continuous improvement.

With respect to the financial demands on providers, numerous concerns were raised about the costs of establishing the infrastructures, management and documentation systems and/or staff education and training programmes necessary to meet the requirements of the system. Similarly, the difficulties associated with familiarising staff, managers and relevant others with the concept of continuous improvement and issues associated with its application at the practice level, such as the documentation requirements, have placed immense demands on facility personnel, both practically (e.g. additional workload) and emotionally. The demands associated with the implementation of continuous improvement may also explain why some smaller, stand-alone facilities, particularly those based in outlying rural areas, experienced such difficulties, that is, because they had neither the support infrastructures and resources available nor the necessary expertise at management level.

As indicated in the literature, however, moving to a continuous improvement approach can also have a number of benefits to organisations. This idea is illustrated by several of the findings of this study such as the increased awareness and involvement of facility staff, and often also of senior managers and/or Board of Management members, the improvements to facility management systems and the greater sense of team spirit and unity that was felt to have developed. Similar benefits were identified in the Aged Services Association of NSW and ACT (2001) study.

6.1.3 Accreditation as a new regulatory approach

From a regulation theory perspective, a number of other comments can be made about the findings. These relate in particular to the regulatory model on which accreditation is based, the way in which the system is structured and the relationships between its various components. Several of the issues discussed in this section relate directly to the themes 'Agency: Role and Independence' and 'Demands on human and financial resources'. It can also be linked, although perhaps less directly, to the theme 'An uncertain future'.

Regulatory model

As outlined earlier, accreditation differs from its predecessor, the standards monitoring system, in a number of significant ways. Although the motives behind the replacement of the former system have been questioned by some (e.g. Braithwaite 1998), the benefits of moving away from a 'point in time' solely inspection-based system to one that incorporates continuous improvement and which, in so doing, allows for more industry 'ownership' of and involvement in the process, are clearly recognised by providers. In this respect, the overall support for the accreditation system amongst service providers, also confirmed in other reviews (Aged Services Association of NSW and ACT 2001; Commonwealth Department of Health and Ageing 2002b; Gray 2001), is largely to be expected.

Despite the trend away towards greater industry self regulation (Braithwaite 2001; Howe 2000), the new system, by virtue of its increasingly deterrence-oriented nature, also represents a (potentially) harsher and more 'punitive' approach compared with the compliance-based standards monitoring system. Considered from this perspective it could be argued, therefore, that the extent of support the system has received from providers is rather surprising, although it appears that many do recognise its more 'punitive' features and/or potential.

The concerns raised about the Agency's inherently conflicting roles - that is, its educative, supportive role, normally associated with a compliance model, on the one hand, and its more 'punitive' roles, generally associated with a deterrence model, on the other - do, however, raise some fundamental questions about the 'workability' of the current model. This is particularly given that, as Braithwaite (2001, p.445) has

pointed out, there is no 'credible' hierarchy of enforcement sanctions in between the two 'extremes'. The Agency's more 'punitive' functions may also explain not only why providers are having difficulty accepting the system as one based on collaboration and 'partnership' but why many people felt unsure, even apprehensive about the way in which the system and their relationships with the Agency would develop in the future. One way of resolving such issues might be to establish a wider range of sanctions as has been done in the U.S. (although the latter are still fairly limited in nature) that would allow elements of both approaches to be incorporated, thus reflecting a more 'responsive' approach (Walshe 2001).

Structure and independence

The literature suggests that the way in which a regulatory system is structured and the roles and responsibilities of relevant departments and/or other bodies within it can play an important part in determining its overall effectiveness (e.g. Walshe, 2001). In contrast to some countries (e.g. the United States), the structure of the Australian system is relatively straightforward. In other words, it is managed by an independent body (the Agency) with the government responsible for enforcement. In practice, however, it seems that the boundaries between the Agency and government are not sufficiently clearly defined, or at least not as far as service providers in this study are concerned. Although this appears to be related largely to the Agency's role in relation to the Complaints Resolution Scheme which is administered by the Department of Health and Ageing, the perceived interference by the (former) Minister for Aged Care has reinforced the view that the Agency is not an independent body but a kind of 'adjunct' to the Department and/or Minister's office.

As Phillips (1984) has suggested, however, 'independence' in a regulatory context may be more a matter of degree than an 'either-or' situation. Thus although the Agency has been established as an independent body with its own Board of Management, it is inevitably linked to the government by virtue of the fact that it manages a government imposed regulatory system and is required to perform certain functions as laid down in government legislation. Importantly also, while the Agency can recommend that certain action is taken in relation to a facility, the federal government is ultimately responsible for its enforcement.

Nevertheless, the extent of concern regarding the nature of the links between the Agency and the Department of Health and Ageing and its general independence of government does appear to have been an important factor in determining the level of acceptance of the system amongst providers. It also seems that W.A. providers are not alone in their concerns, similar issues having been raised in the national evaluation (Commonwealth Department of Health and Ageing 2002b). The latter report recommended that specific measures be taken to address these concerns, for example via the conduct of a national information or education campaign.

Costs

One of the major impacts on providers of the accreditation system has been the costs involved. Although many of these costs appear to be associated with the implementation of a continuous improvement approach, others can be attributed to other aspects of the system. This includes the introduction of a new set of standards that, in addition to the requirements of continuous improvement, have imposed other kinds of demands on facilities, and building certification. As outlined, all facilities are also required to pay a substantial fee when they apply for accreditation. Although, most facilities have obviously managed to find the financial resources needed to meet these various requirements, that is, as demonstrated by their 'success rate' in the first round, many were doubtful about their ability and/or about the ability of others, particularly smaller operators, to do so in the future.

Braithwaite et al's (1993) earlier evaluation of the standards monitoring system also noted industry concerns that the introduction of the new system would make it difficult for many providers, particularly smaller and older homes, to survive because of the cost implications. More specifically, it was felt that smaller homes would not have the financial resources to provide the type of care required by new standards and that older homes would not be able to meet the costs of undertaking major renovations in order to satisfy the building requirements. Interestingly, the evaluators found that these perceptions did to an extent prove correct, however, that overall there was *'little reason to worry'* that such regulatory costs would act as a major impediment to industry efficiency or reduce compliance levels (Braithwaite et al 1993, Executive Summary, p.xii).

Impact on residents

As in any long-term care regulatory system the ultimate aim of the accreditation system is to ensure that all residents are guaranteed high quality care and that they can, as far as possible, enjoy an optimum quality of life. As has been reported, providers' views about the extent to which it has achieved this aim varied widely. Thus some were of the view that it had benefited residents and their families, albeit indirectly in some instances, for example as a result of improved management systems. Others were more sceptical, however, suggesting that it had resulted in less staff time and resources being available for resident care because of the additional documentation demands.

Again it appears that WA providers are not alone in their concerns. Similar views have been raised by providers elsewhere in Australia (e.g. Aged Services Association of NSW and ACT 2001; Ayris 2001a) as well as by other stakeholder groups, including staff, consumers and state and local governments (Gray 2001). As Gray observed, however, the validity or otherwise of such concerns is difficult to ascertain in the absence of more 'objective' data.

The Need for Regulation

Despite the criticisms of various aspects of the accreditation system that have been made, it is obvious that the vast majority of service providers in this study acknowledge the need for some form of industry regulation. Whether the extent of regulation encompassed in the current system is sufficient, however, is a matter of debate. Quinn (2000, p.15), for example, has suggested that one way in which '*fiascos*' such as the closure of the Riverside Nursing Home during the first round could be prevented in the future would be to increase regulation. However, he also pointed out that in order that the industry can meet the increased requirements additional funding would be necessary, either from the government or by increasing resident fees. In his view, neither of these options is likely.

On the other hand, many service providers, including several in this study, are of the view that the industry is 'over regulated'. Concerns about the documentation burden on providers have often been raised in this regard, the Aged Services Association of NSW and ACT report (2001, p.26) suggesting, for example, that '*excessive*

regulation has deflected the focus of care from the client to administration'. The extent of regulation is also said to be a source of constant debate in the United States. There, as in Australia, some people are of the view that a tougher regulatory stance is needed, whereas others argue that it should be reduced and a more 'cooperative' model developed (Hovey 2000; Walshe 2001).

A further issue relevant to the debate regarding the need for and extent of regulation relates to the frequency of inspections and the extent to which 'good' performers are 'rewarded'. As has been reported, several providers have suggested that the accreditation period and the frequency of inspections, including support visits, should be reviewed. Similar suggestions have been made in relation to the U.S. system. Stoil (2001, p.6), for example, describes the U.S. system of annual (*sic*) inspections as '*disruptive and wasteful*'. He has advocated the implementation of a recent CMS recommendation for a variable inspection schedule whereby homes with good records would be inspected once every three years and those with deficiencies several times per year. The Lessons Learned review (Commonwealth Department of Health and Ageing 2002b, p.18) has also suggested that extending the maximum accreditation period to five years would provide facilities with a '*greater incentive...to strive for excellence*'. As Scrivens (1998) has observed, however, agreement as to what constitutes an appropriate accreditation period continues to be one of the key dilemmas within accreditation systems.

Need for review

A further issue that has been identified in the literature relates to the need for the regulatory body itself to be subjected to some kind of review process (e.g. Phillips 1984). This point was raised by several informants in this study in relation to the Agency, as the 'de facto' regulatory body. Similarly, the national review has suggested that the Agency's performance be reviewed by an external auditing body and that it should '*consider achieving quality accreditation status with the appropriate quality registration body*' (Commonwealth Department of Health and Ageing 2002b, p.6).

6.1.4 The need for a broader perspective

A number of factors have been identified as playing an important role in determining providers' experiences of accreditation. Some of these, already covered in the preceding sections, relate directly to facilities themselves. They include the support and resources available from within the organisation, the management structures and systems in place, and management expertise and involvement. Others relate to the different components of the accreditation system and the interrelationships between them. They include building certification and user rights, specifically the Complaints Resolution Scheme. Still others relate to the wider system of aged care. They include the current funding system, particularly the RCS, and staffing. This section considers the latter two groups of factors, that is, factors that are largely 'external' to facilities. It has direct links to the themes 'Broader level factors' and 'Agency: role and independence'.

The Complaints Resolution Scheme

One of the main concerns identified by providers in this study relates to the Agency's role in relation to the Department of Health and Ageing administered Complaints Resolution Scheme which was perceived as 'incompatible' with its educative, supportive role and as raising questions about the extent of its independence from the government.

As outlined earlier, the Complaints Resolution Scheme forms part of the User Rights Strategy and, as such, is an integral component of the accreditation framework. At present, however, based on the views expressed in this study, it seems that the way in which it fits into this framework has not been sufficiently clearly defined. Gray (2001) notes that a review of the scheme by the Commonwealth Ombudsman in 1999 also revealed a lack of understanding within the industry of the respective roles of the Complaints Resolution Committees, the Department and the Agency in the resolution of complaints and of the complaints resolution process generally. Although some changes have been made in response to such concerns (Gray 2001), many stakeholders remain critical of it. The National Aged Care Alliance, for example, an industry group comprising consumer, employer, professional groups and unions, has claimed that it is unfair and lacks independence from the political process (Mallabone 2002).

Certification

Like the Complaints Resolution Scheme, certification forms part of the broader accreditation framework. Again, perhaps because it is managed by the Department of Health and Ageing and assessed via a separate process, it seems to be regarded as a 'separate' system whose links with 'accreditation' (i.e. the standards assessment process) are not always well understood. This confusion is possibly compounded by the fact that several of the accreditation 'standards' (expected outcomes) relate to the physical environment, for example, fire safety and privacy.

The need to clarify the links between the two systems was also identified in the national evaluation (Commonwealth Department of Health and Ageing 2002b) which expressed particular concern about the apparent degree of overlap between them. In addition, the report recommended that the role of accreditation quality assessors in relation to both systems required clarification, stating that there were often instances of assessors overruling certification reports, for example in relation to privacy and bathrooms.

Certification is also clearly regarded as having imposed an additional financial burden on providers. This is anticipated to have major consequences for some facilities, particularly smaller ones, which may not be able to meet the costs of upgrading and hence may be forced to close. Concerns about the likely closure of homes because of the financial demands of certification have also been widely reported in the media (e.g. Casellas 2001; Newton & Capp 2001).

Funding and the RCS

In regard to factors within the broader system of aged care, one of the most significant for providers in this study was the current funding system or, more specifically, its perceived inadequacy. As for many other issues that have been identified, it appears that these concerns are widespread throughout the industry (Capp 2001; Mallabone 2001a; Quinn 2000). Similarly, the perception of providers that accreditation, particularly when considered together with certification, has added to these financial pressures also seems fairly common (Ayris 2001b; Mallabone 2001b; Wakeham 2001).

The (former) Minister for Aged Care has refuted such claims. This view is supported by Gray's (2001) review of the adequacy of industry funding as part of the Two Year Review of the Aged Care Reforms. This review suggested that most providers should be able to make at least a 12% return on their investments '*even if substantial rebuilding is necessary to meet building certification standards required to be met by 2008*' (p.170). On the other hand, however, an industry commissioned study conducted by the Australian Institute of Primary Care at La Trobe University has provided evidence that supports providers' assertions of inadequate funding levels (Australian Institute of Primary Care 2001).

As the major source of provider funding, the Resident Classification Scale (RCS) has attracted particular criticism from providers in this study as well as from other sources (Australian Productivity Commission 1999; Australian Society for Geriatric Medicine 2002). The Australian Society for Geriatric Medicine (2002, pp.46-47) described the RCS as '*the antithesis of a funding system that generates incentives for quality health outcomes*' stating that rather than asking '*what is required to give quality care?*' it asks '*what is being provided?*'

In addition to its perceived inadequacy as a funding tool, the RCS appears to be impacting on providers in other ways, for example through its (competing) documentation demands. Again, similar concerns have been raised by others. At a recent national conference of the Australian Nursing Homes and Extended Care Association (ANHECA), the current president, Francis Cook, singled out the documentation burden on staff, largely due to the RCS, as one of the most critical concerns within the sector (Australian Nursing Homes and Extended Care Association 2002). Similarly, the Australian Society for Geriatric Medicine (2002) has suggested that in view of the degree of overlap between the accreditation and RCS systems in terms of their structures, demands and requirements, there is scope for the development of a more unified system. In their view the current arrangements are not only inappropriate, wasteful and have resulted in a major loss of potential productivity throughout sector, but also mean that residents are '*obliged to undergo two highly complex independent processes of assessment and consideration of care provision, neither of which...is likely to result in a beneficial health care outcome for these residents*' (p.49).

Staffing /nursing shortage

Staffing, but primarily the difficulties of attracting and retaining nursing staff, is a further 'broader level' factor identified in this study. As for funding, these concerns are widespread throughout the industry (e.g. Barker 2002; Cuniffe 2001; Gray 2001; Horner 2002; Macri 2000; Sellars 2000; Watts & Mallabone 2001; Yallop 2001). They also appear to have some justification. A review by the AIHW (Australian Institute of Health and Welfare 2001) of national nursing workforce and employment trends in Australia reported a decline of 28.5% in the numbers of nurses (both ENs and RNs) employed in publicly funded nursing homes between 1993 and 1996. A similar trend within the private nursing home sector was also noted.

A variety of factors have been identified as contributing to the problems of attracting and retaining aged care nursing staff. One of the most significant is the general shortage of nurses across all sectors (Barker 2002; Gray 2001). Others include: the relative unattractiveness of the sector; poor levels of remuneration; disparities within the industrial award system in different States; the more demanding working conditions (e.g. 'heavy' nature of the work; stress imposed by client ratios) compared with other sectors; the generally poor image and status of nurses; and rosters and shift work (Barker 2002; Gray 2001). In addition, the lack of career pathways, despite moves in the 1980s by the W.A. government, for example, to introduce a nursing career structure, lack of staff development and education opportunities, staffing mix (e.g. high proportions of agency staff and/or carers), and the creation of new roles have been identified (Barker 2002). The RCS and accreditation, in particular the documentation demands involved, have also been suggested as acting as disincentives to nurses to enter the industry (Australian Nursing Homes and Extended Care Association 2002; Barker 2002).

The literature also indicates that providers' concerns about the impact of a shortage of aged care nursing staff and increasing workloads on the quality of resident care are not restricted to the Australian aged care industry, with similar concerns having been raised in the U.S. and U.K. (Barker 2002; Harrington 2001; Harrington & Carillo 1999; Schwartz 2000). It has also been suggested that this shortage is having repercussions for other professions, for example doctors, many of whom are said to be no longer working in nursing homes because of the lack of follow up on care for

which they are ultimately responsible and the potential liability problems that this raises (Barker 2002).

Although the concerns of providers about staffing shortages and the impact of this on their capacity to meet the requirements of accreditation are understandable and seem justified, Gray (2001) has suggested that *if* accreditation can be regarded as an appropriate measure of general staffing adequacy, then it could be argued that most homes are, nevertheless, managing to maintain suitable staffing levels. In other words, the majority of facilities received accreditation in the first round, with most for three years.

Accreditation from a systemic perspective

Quite clearly there are a number of different factors impinging upon facilities that have influenced the experiences of service providers of accreditation and their (perceived) capacity to meet its requirements. These factors emanate both from within facilities and/or the organisations of which they are a part as well as from 'external' sources. It also appears that the interrelationships between these factors are varied and often complex.

It seems, therefore, that in terms of the way in which it has impacted on providers, accreditation cannot be considered in 'isolation' but rather as part of a complicated network of interrelated factors operating at a variety of levels. This idea accords with many of the basic principles encompassed within a systems perspective which, as Patton (1990, p.78) observes, provides a useful means of understanding '*real world complexities, viewing things as whole entities embedded in context and still larger wholes*'. Although it is beyond the scope of this study to discuss these ideas in detail, a systems view has obvious potential in helping to explain some of the apparent complexities within the accreditation system as it is experienced by providers, as well as the variations in their experiences. It also suggests that, in many cases, identifying and implementing strategies to address some of the concerns that have been raised may be a complex process.

6.2 Implications for Action

From an evaluation perspective, the limited scope of this study restricts the extent to which generalisations about the accreditation system can be drawn. However, comparison with a number of other reviews where service providers' views have been sought, as well as other commentaries on the system, indicates a strong similarity between many of the issues and concerns identified. These relate in particular to concerns about the evaluation process, most notably assessor inconsistency within and between States, the standards ratings categories, and the self assessment component of the process (i.e. the kit). This suggests that there may be scope for further review of these issues by the Agency.

Similarly, in regard to continuous improvement, the concerns identified in this study relating to the meaning and application of the concept and associated issues such as best practice have been raised in other reviews. Such findings again lend support to the idea that further education and information dissemination by the Agency is needed.

Aspects of the regulatory system as a whole, in particular the links between the Agency and the Department of Health and Ageing and between different components of the system, such as the Building Certification and Complaints Resolution Schemes, also appear to warrant further consideration in view of supporting evidence from other studies. In addition, the widespread concerns throughout the industry regarding broader level factors such as funding, in particular the RCS, and the nursing shortage and the (potential) impact of this on providers' capacity to consistently provide high quality care, suggest a need for further review. In this case, however, responsibility for addressing such issues would seem to rest primarily with the federal government rather than the Agency.

6.3 Study Limitations

This study has used service providers' views and experiences as a basis for evaluating the accreditation system for residential aged care. The selection of a wide range of informants from different 'types' of facilities and organisations as well as

from different 'levels' within the target group has enabled a comprehensive range of views to be canvassed.

A number of 'limitations' of the study are noted, however. One is that, for practical reasons, coverage of rural facilities was limited and thus it was not possible to include facilities in more remote areas. Although it cannot be assumed that the experiences of such facilities would have been any different, there are a number of reasons as to why this may have been the case. Such reasons include their isolation, their generally small size, and the fact that many of these facilities, particularly those in the northern part of the State, have high proportions of indigenous clients.

Similarly, it was not possible within the small sample size to cover the full range of 'specialised' facilities, for example those offering dementia specific services, although one ethno-specific facility and one providing services for 'retired' religious sisters were represented.

6.4 Implications for Further Research

This study has focused on service providers' experiences of the first round of accreditation, completed at the end of 2000. At this time the system was very much in its infancy. It would, therefore, be useful to conduct a similar study at a later point, for example following completion of the second round when the system is more established, in order to ascertain whether there has been any change in perceptions. While generalisation might again be limited, such a study would, nevertheless, allow further insights into providers' experiences of the system at a more mature stage of its development. Such information would not only help to further inform the work of the local Agency but could also be used in combination with any data being collected at the national level.

There are a number of other issues arising from this study that could be explored further. One relates to more isolated rural facilities, particularly those catering from primarily indigenous populations, as it seems that little is known about their particular experiences or about the impact that accreditation has had on them and/or their residents. Similarly, little is known about the experiences of facilities that cater

for special needs groups, such as people with dementia. In addition, there may be scope for a more detailed study of the impact on consumers of the system, from their perspective.

Chapter 7: Conclusion

This study represents an evaluation of the recently implemented accreditation system for residential aged care facilities, based on the views and experiences of service providers. Specific objectives were to:

1. assess the extent of support for the new system, in terms of its basic philosophy and principles
2. describe the way/s in which the system has been implemented and any associated issues or concerns
3. assess the extent to which the aged care standards and related requirements, as set out in the Standards and Guidelines for Residential Aged Care Services, are perceived as appropriate to the achievement and maintenance of quality
4. assess the impact of accreditation on service providers and other key stakeholders
5. identify the strengths and weaknesses of the new accreditation system and, in particular, any areas for change or improvement.

Based on the views expressed in this study, it appears that the accreditation system and the principles that it encompasses, in particular the continuous quality improvement philosophy, was generally supported by the industry. It was also regarded as having a number of very positive features, particularly in comparison to the standards monitoring system that it has replaced. These include its generally supportive nature, thoroughness, flexibility and, in the view of some, the more 'objective' and structured basis it provides for assessing quality (*Objective 1*).

However, it was also apparent that as far as the implementation of the system was concerned there were a variety of concerns relating to the assessment process, particularly its subjectivity and inconsistency, and to the self assessment tool, for example, its repetitiveness and format. In addition, there was a widespread perception that there had been insufficient information and guidance provided by the Agency prior to and during the first round in relation to issues such as to how to proceed, continuous improvement and best practice (*Objective 2*).

Although the standards were generally perceived to be relevant and appropriate reflections of service quality, many providers found it difficult to meet the requirements of some. This related in particular to Standard One (*Management Systems, Staffing and Organisational Development*) for reasons such as a lack of understanding and/or familiarity with the concepts involved and because of the demands on time and resources. Lack of input and/or support from management was a further factor often cited. The ability of some facilities/organisations to maintain the standards in the future was also identified as a concern (*Objective 3*).

Accreditation appears to have had a major negative impact on service providers, with the costs involved and demands on staff and relevant others (e.g. Board of Management members) having been considerable. Many people also thought that the system had adversely affected residents, albeit indirectly in some cases. At the same time, a number of benefits to facilities/organisations and staff, and in some cases to residents, were identified. Accreditation was also regarded as having had a significant impact on the aged care industry in general in terms of its overall image and morale. However, views as to the nature of this impact (i.e. positive or negative) varied (*Objective 4*).

Major strengths of the system identified include the focus on quality embodied in the new system, the positive effects on facility/organisational management systems, the greater accountability it had engendered, the resident focus, and the positive impact it had had on staff and the industry. The main limitations were the costs involved, the demands on staff (primarily as regards documentation), the inconsistency of the assessment process, and what were regarded as unrealistic expectations of the industry in the face of current funding levels and staff shortages.

A number of changes and improvements to the system, most of which reflect the issues identified above, were suggested. These include streamlining the self assessment kit, providing more information and guidance, and greater consistency in the assessment process. Many people also thought that there was an urgent need to address broader level concerns such as allocating additional funding to the industry, and a rationalisation of the links between the Agency and the government, and

between other components of the aged care system such as the RCS and the Building Certification Scheme (*Objective 5*).

Based on these findings six interrelated themes, one of which represented an overarching theme, were identified. These were as follows:

- Accreditation: cautious optimism. As a regulatory approach, the accreditation system was generally supported by providers and regarded as a welcome improvement over the previous system. However, this support was tempered by the concerns that many had about aspects of it and how it would develop in the future. This theme represented the central or overarching theme of the study.
- Demands on human and financial resources. Accreditation has made considerable demands on providers, both in regard to staff as well as in financial terms.
- Implementation process: serious flaws. The process of implementation of accreditation appears to have a number of major flaws, in particular in relation to the consistency of the assessment process and standards ratings decisions, the self assessment kit, and the amount of information and guidance that has been provided by the Agency.
- Agency: role and independence. Many providers had major concerns about the Agency in terms of its role and independence and this appeared to be working against the development of a sense of partnership and trust within the industry.
- Broader level factors. A number of factors beyond the accreditation system *per se* appeared to be impacting upon providers and their perceived capacity to meet its requirements. These factors included the adequacy of the current funding system, the competing demands of different systems (such as the RCS and building certification) and nursing shortages.
- An uncertain future. There appeared to be considerable uncertainty, and in some cases apprehension, about the accreditation system in the future. Specific concerns included the possibility of more stringent and/or different requirements being imposed and that the system would become more 'punitive'.

Although this study has focused on the experiences of W.A. service providers, evidence from other reviews of the accreditation system where providers' views have been sought has indicated a widespread similarity in perceptions. These include, in particular, concerns about various implementation issues such as the assessment process and the extent of information and education provided (e.g. continuous improvement, best practice). The costs and demands of accreditation on staff, concerns about the links between accreditation and other components of the system, and broader level issues such as funding and staffing have also been frequently identified. The in principle support for accreditation as a regulatory approach identified in this study is also consistent with the findings of other evaluations that have been conducted.

From an evaluation viewpoint, therefore, the accreditation system does appear to have been generally accepted by providers and to have already provided a number of benefits to the industry that may also, hopefully, ultimately benefit residents. At the same time, however, it is also evident that there are a number of issues pertaining to the assessment (evaluation) process itself that are in need of review by the Agency, as the managing body. In regard to the impact, both positive and negative, that the implementation of a continuous improvement approach has had on providers, the literature indicates that many of these are to be expected. However, the findings also suggest that the extent of the 'cultural shift' required in some organisations was possibly underestimated by the federal government and/or Agency. The implication of this, therefore, is that more work could have been done initially to help prepare providers for the changes required. The apparent lack of dissemination of best practice information by the Agency is an ongoing concern although, as some providers have suggested, the industry itself also has an important role to play.

In his review of the Aged Care Reforms, Gray (2001, p.9) observed that despite the generally acknowledged necessity of and support for them, the implementation of such a '*complex suite*' of reforms was inevitably going to be an '*ambitious and difficult task [which] could not be expected to occur without some degree of industry reaction, some transitional or 'teething' problems, and some refinement of processes and policies along the way*'. Although such comments seem particularly relevant to the findings of this study, it is also evident that the overall effectiveness of the

accreditation system and the extent to which providers (feel they) are able to cope with its requirements is determined by a wide variety of factors. Many of these factors extend beyond the facility environment as well as beyond the accreditation system itself. It is also clear that the interrelationships between these factors are often complex and varied. As such, it is not simply a matter of addressing some of the more immediate 'process' concerns but of also taking into consideration a number of broader level issues.

One of the most critical questions regarding the accreditation system, however, is whether as a regulatory approach it does have the capacity to identify poor quality care and whether it does result in improved outcomes for residents. At present, at least as far as providers in WA are concerned, opinions are varied. Whilst not the focus of this study it is, nevertheless, an issue that needs to be explored in the future, for example via a larger, longitudinal, outcomes focused evaluation.

In conclusion, therefore, it appears that the accreditation system has considerable potential as an approach to regulating quality in terms of its benefits to the industry and consumers, however, that much work remains to be done. This is largely to be expected given its relatively early stages of development at the time this research was undertaken. It is noted, however, that since then a number of developments have occurred, many of which are based on feedback from key stakeholders, including service providers. These have direct implications for the findings and are outlined in Appendix 3. These developments are encouraging and indicate a willingness on the part of both the Agency and the government to address some of the identified shortcomings of the system in order that it can serve as an effective means of ensuring high quality resident care.

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Appendix 1: The Accreditation Standards and Expected Outcomes

Standard 1: Management Systems, Staffing and Organisational Development	Standard 2: Health and Personal Care	Standard 3: Resident Lifestyle	Standard 4: Physical Environment and Safe Systems
1.1 Continuous Improvement	2.1 Continuous Improvement	3.1 Continuous Improvement	4.1 Continuous Improvement
1.2 Regulatory Compliance	2.2 Regulatory Compliance	3.2 Regulatory Compliance	4.2 Regulatory Compliance
1.3 Education and Staff Development	2.3 Education and Staff Development	3.3 Education and Staff Development	4.3 Education and Staff Development
1.4 Comments and Complaints	2.4 Clinical Care	3.4 Emotional Support	4.4 Living Environment
1.5 Planning and Leadership	2.5 Specialised Nursing Care Needs	3.5 Independence	4.5 Occupational Health and Safety
1.6 Human Resource Management	2.6 Other Health and Related Services	3.6 Privacy and Dignity	4.6 Fire, Security and Other Emergencies
1.7 Inventory and Equipment	2.7 Medication Management	3.7 Leisure Interests and Activities	4.7 Infection Control
1.8 Information Systems	2.8 Pain Management	3.8 Cultural and Spiritual Life	4.8 Catering, Cleaning and Laundry Services
1.9 External Services	2.9 Palliative Care	3.9 Choice and Decision-Making	
	2.10 Nutrition and Hydration	3.10 Resident Security of Tenure and Responsibilities	
	2.11 Skin Care		
	2.12 Continence Management		
	2.13 Behaviour Management		
	2.14 Mobility, Dexterity and Rehabilitation		
	2.15 Oral and Dental Care		
	2.16 Sensory Loss		
	2.17 Sleep		

Source: Department of Health and Family Services, 1998

Appendix 2: Interview Guide (Facilities)

1. Perceptions of the extent to which new approach differs from standards monitoring system

- is it any different? If so, in what way/s? Is it a positive change?
- views about the emphasis on continuous quality improvement
- extent to which reflects 'partnership'.

2. Education / training about the new accreditation system/process

- by whom, adequacy, comprehensiveness, clarity, timing, etc

3. Accreditation Process – ways in which implemented, issues, etc

- overall
- specific stages of process
 - self assessment
 - desk audit
 - site visit
 - audit report / feedback
- relationship with/ attitudes/ approach etc of Agency assessors
- support provided during process

4. Standards – any standards that posed problems in terms of :

- understanding of (i.e. what needed to be done to meet accreditation requirements)
- practical implementation (for accreditation purposes)

Standards

- management systems
- health and personal care
- resident lifestyle
- physical environment and safe systems

- Specific **outcomes** relating to standards that proved problematical??

5. General impact

- on facility (e.g. cost, time, quality of care/service, staff morale, etc)
- on residents / relatives (e.g. quality of care)

6. Overall strengths and weaknesses of system

- any areas for change/improvement

7. Other comments

Appendix 3: Recent Developments

As indicated, the data that forms the basis of this study was collected during the period between October 2000 and September 2001 – that is, at the end of the first accreditation round and into the beginning of the second cycle. Since that time a number of developments have occurred that have particular relevance to the findings.

Some of these developments concern specific aspects of the system itself and have been addressed in response to industry feedback via, for example, the Lessons Learned Review. These include:

- the self assessment kit: now produced in a more simplified A4 format; a modified electronic version is now also available in disk form and via the Agency website (Aged Care Standards and Accreditation Agency 2001).
- assessor inconsistency: the Agency reports that it is working on developing a consistent audit methodology and will be providing additional training for internal and external assessors (Aged Care Standards and Accreditation Agency 2001). A national workshop for all Agency quality assessors was held in June 2002 (Aged Care Standards and Accreditation Agency 2002). A national panel for processing submissions of higher ratings has also been established and a quality assessor handbook developed and distributed to all quality assessors nationally (S. Leavesley, Aged Care Standards Agency 2002, email, 3 September).
- ratings system: ratings now only apply to expected outcomes and are categorised as 'compliant', 'non compliant' or 'non compliant with serious risk'. No rating is applied to any of the four accreditation standards. Two higher award ratings, 'accreditation with merit' and can be applied to a service as a whole rather than to individual expected outcomes. The 'commendable' rating can be awarded for up to four years. To be considered for a higher rating providers must lodge a separate submission at the time of applying for accreditation, the validity of which will be assessed by the Agency (Aged Care Standards and Accreditation Agency 2001).

- site audit reports: only most recent reports on individual homes are available on the Agency website (Commonwealth Department of Health and Ageing 2002a). The format for published decisions and reports has also been revised in line with feedback (particularly from consumers) to enhance accessibility and transparency (Aged Care Standards Agency n.d.).
- information and education: a new Education and Support Division has been created within the Agency whose initial role will be to assess the educational needs of the industry regarding quality improvement, identify organisations already providing educational services and how the Agency might work with such organisations to expand their programmes (Aged Care Standards and Accreditation Agency 2002; Australian Nursing Homes and Extended Care Association of W.A. 2002). The Agency has also implemented a second round of education sessions (Mark II), produced a revised accreditation guide and developed a series of self-directed learning packages (including one relating to continuous improvement) (Aged Care Standards and Accreditation Agency 2002). In addition, the Agency newsletter, *The Standard*, has been resurrected and will be used as a forum for the promotion of best practice information (S. Leavesley, Aged Care Standards Agency 2002, email, 3 September).

At the local level, in response to the findings of this research, the Agency has also indicated that it will continue to promote feedback to the industry about the accreditation process as well as positive feedback from consumers (S. Leavesley, Aged Care Standards Agency 2002, email, 3 September).

A number of other developments that have occurred address some of the broader level concerns that have been identified. They include:

- Minister for Aged Care: appointment of a new Minister, The Hon Kevin Andrews, following the re-election of the Coalition government at the end of 2001.
- nursing shortage: the allocation of additional funding by the federal government for initiatives to address problems associated with the aged care

nursing workforce, including attraction of new staff and retention of existing staff, image and professionalism (Department of Health and Ageing 2002; Gray 2001).

- aged care funding: implementation of a review of the adequacy of pricing of residential aged care subsidies. The Minister for Ageing has stated that this review will assess '*long-term financing options for the aged care sector and will take into account the improved care outcomes required from providers and the underlying cost pressures faced by the sector*' (Commonwealth Department of Health and Ageing 2002b). However, this review has already attracted some criticism on the grounds that other concerns, such as the documentation requirements on staff, are more pressing (Australian Nursing Homes and Extended Care Association 2002).
- documentation: promises by the Minister for Ageing to review ways in which the paperwork burden on aged care nurses can be eased (Mallabone 2002).
- respective roles of the Agency, Department of Health and Ageing and the Commissioner of Complaints: national roadshow conducted in early 2002 (Aged Care Standards and Accreditation Agency 2002).

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