

# QUALITY IN PUBLIC SECTOR RESIDENTIAL AGED CARE: *WHERE TO FROM HERE?*

Integrated Quality Projects Report, 2009

Department of Health, Victoria.

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## CONTENTS

	Page
Executive Summary	3
Introduction and Context	4
Project Summaries	7
Quality Systems Review	7
SCORE	9
Quality Indicator Validation Project	11
Options for Action arising from the projects	14
The Way Forward	18

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## QUALITY IN RESIDENTIAL AGED CARE: WHERE TO FROM HERE?

### Executive Summary

The 'Quality in Residential Aged Care: Where to from here?' report presents the results of three major quality projects undertaken over 2008/2009, as part of the Department of Health Residential Aged Care 'Beyond Compliance' Strategy. The purpose of this integrated report is to synthesise the findings of three separate yet inter-related projects, to identify the current status of key aspects of residential aged care quality systems, and to identify directions and actions to drive safe and quality care for residents into the future. Although the three projects were conducted in Victorian Public Sector Residential Aged Care Services (PSRACS), it is likely that the findings are applicable across all residential aged care sectors, and to some extent, to acute care safety and quality systems.

The audit driven nature of Aged Care Accreditation effectively guides aged care facilities to meet minimum quality of care and quality of life standards. To achieve optimum safety and quality goals, however, aged care quality systems must be further developed and services motivated to move 'beyond compliance'. This is not an easy undertaking within a climate of competing demands and stretched resources. Despite these difficulties, much good work has been done to strive for continuous improvement in aged care services.

The demographics, health and personal care needs of persons living in Residential Aged Care Services are changing, and we are now seeing a population that is increasingly vulnerable to clinical harm. The trends of residents becoming older, with increasing complexity and with multiple chronic conditions are expected to continue. Identifying, quantifying and managing clinical risk is a rapidly growing requirement, and an increasingly critical issue for government, health and aged care services and the community.

In the past two decades, substantial research in healthcare has led to a better understanding of clinical risk and successful reforms. The PSRACS sector is now realising the need for similar approaches and initiatives, particularly in light of the potential impact of residents' health and clinical care on their quality of life.

Despite the common governance of public sector acute and aged care services, PSRACS are often operated as discrete program areas within the broader Health Service, which can result in implementation of separate quality systems related to differing acute and aged care accreditation processes, rather than streamlining the quality systems across the continuum of care.

Many PSRACS have been unable to access and gain from advances made in acute care quality systems over the past decade, such as the development of quality and clinical governance frameworks and tools, public reporting, clearer priorities, research into improvement science and high risk areas, and learning from other high risk industries. The changing residential aged care population now provides opportunities for these issues and advances to be addressed in aged care.

Local leaders need support to break through these barriers to more innovative approaches that exceed the perceived 'paper ceiling' of accreditation compliance requirements. A clear strategy is required to support and further develop the work underway in PSRACS to drive the pursuit of optimum safety and quality of care, and to manage the growing risk and complexity of the PSRACS resident population. Developing the 'quality partnership' between acute and aged quality systems will be critical to success.

The three projects described in this report identified many examples of effective approaches to safe and quality care in PSRACS. They also found a number of opportunities for improvement in components of quality systems, such as: strategic planning, leadership to achieve optimum quality of care goals, consistent management of resident risk, standardised care processes and effective use of quality data. There is also variation in the ways in which Health Services' Board accountability for the quality of aged care provided is enacted.

The development of a PSRACS quality framework and minimum dataset to consolidate the current foundations of PSRACS quality and risk systems, would strengthen governance in the sector and support systems essential for governance, planning and data management to facilitate effective monitoring and improvement. This will pave the way for initiatives to further enhance the management of quality and risk in health services operating PSRACS. All of this builds on existing initiatives and approaches currently in place.

To drive this, a shared understanding between Government, Health Service and PSRACS, that aged care safety and quality, however good it may be, can always be better.

### **Introduction and Context**

The Victorian Department of Health (DH) Beyond Compliance strategy provides the framework for focusing on quality and safety in PSRACS. Importantly, the focus in the strategy is to encourage PSRACS to look beyond minimum accreditation requirements. The approach draws together current and future initiatives in a manner that is sustainable and ensures residents and their carers' choices are respected and quality of life is maintained. Victoria's investment in developing and implementing evidence-based, systematic improvements in quality and safety supports a leadership role for PSRACS in the provision of quality care outcomes for residents.

The strategic approach of Beyond Compliance is to improve risk management and performance by:

- providing education and training,
- developing tools and resources,
- providing specialist advice and support for staff and management
- developing and implementing strategic plans for resident safety and quality of care initiatives.

The specific outcomes of this strategy include the establishment of benchmarks for care linked to robust systems of governance within health services.

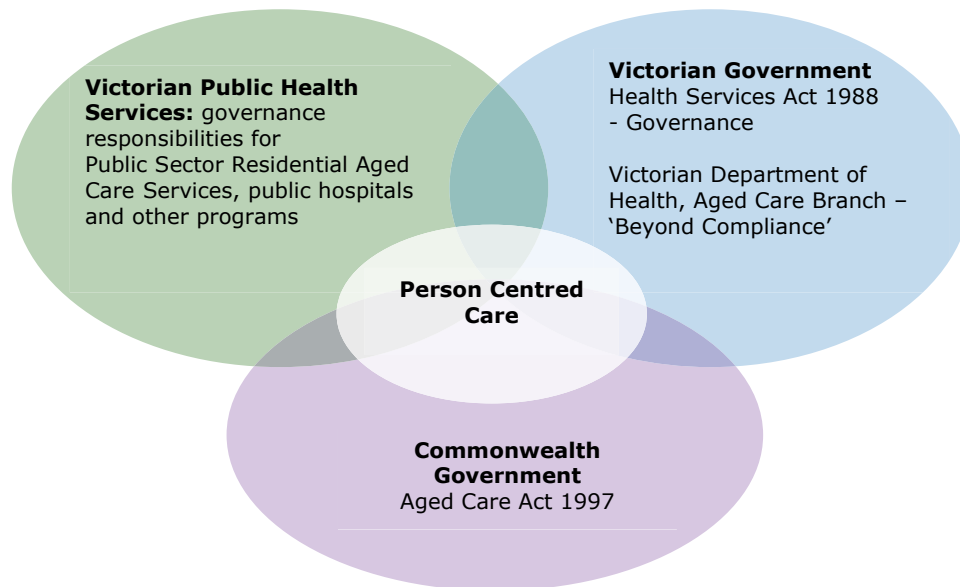
The DH Aged Care Branch commissioned three key inter-related projects over 2008-2009 to improve resident safety and quality of care in (PSRACS).

- *A review of systems for managing quality in Victorian public sector residential aged care services (Quality Systems Review)*
- *Strengthening Care Outcomes for Residents with Evidence (SCORE)*
- *Public Sector Residential Aged Care Services (PSRACS) Quality Indicator (QI) Data Validation Project.*

The projects are unique, and provide an opportunity for Victoria to lead the way nationally and internationally in the measurement and improvement of the quality and safety of residential aged care. The Quality Systems Review identifies the key components of quality systems to support quality clinical care and quality of life, and SCORE and the Quality Indicator Project explore the monitoring, prioritising and improvement of resident risk and care as key aspects of quality systems. Although the projects explore various aspects of public sector residential aged care, it is likely that the project findings are applicable beyond Victoria to aged care delivered across Australia in all settings.

## Context

The governance environment in which PSRACS operate is integral to the way in which their quality systems operate, and is depicted in Diagram 1.



**Diagram 1** Key governance influences on Victorian public sector residential aged care.

Residential aged care service provision in Australia is primarily funded and regulated by the Commonwealth Government under the *Aged Care Act 1997* (the Act). The *Quality of Care Principles 1997* under the Act identify the responsibilities of providers for the quality of care and the services they provide. As a condition of recurrent Commonwealth funding, all residential aged care services must achieve Commonwealth aged care accreditation based on minimum standards of care and services for residents. Aged care accreditation emanates from a regulatory model, legislated through The Act, and has been mandated in all residential aged care services since 2000.

The findings of the 2008 'Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes' report<sup>1</sup> support the view that aged care accreditation has been the main factor contributing to care improvement across the sector since 2000. The report also observed that both the aged care and broader healthcare contexts are changing, however, with increasing demands on services to move beyond compliance with minimum standards, to pursue progress towards optimum care goals. These demands are driven by many factors, including the ageing population, increasing consumer and community awareness of care requirements for the aged, stronger requirements for transparency around quality of care and associated media scrutiny.

The report reinforced the need for residential aged care quality systems to encompass person centred care that includes both healthcare and quality of life dimensions, including:

- **Health care** – physical and psychological health - the safety and quality of care
- **Personal issues** – belonging, well being, autonomy, dignity and respect
- **Interactions inside and outside the organisation** – family role, staff and social communication

<sup>1</sup> Department of Health and Ageing 2008, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes - Final Report*. Commonwealth of Australia.

- **Services** – meals, recreational activities
- **Environment** – safe, home-like, personal space

Residential aged care accreditation requires facilities to cover both quality of care and quality of life components, and all residential aged care quality programs currently encompass each of these important areas. The changing demographics, health and personal care needs of persons living in Residential Aged Care Services, however, is creating a population that is increasingly vulnerable to clinical harm. The trends of residents becoming older, with increasing complexity and with multiple chronic conditions are expected to continue. Identifying, quantifying and managing clinical risk is a rapidly growing requirement, and an increasingly critical issue for government, health and aged care services and the community.

In the past two decades, substantial research and investment is achieving a better understanding of healthcare clinical risk, leading to many successful reforms. A range of drivers supported this focus in the acute sector, including a major study on adverse events in hospital care; the regular collection and publication of data describing the safety and quality of care; transparent reporting and analysis of key risks and public inquiries into organisational failures resulting in poor clinical care and patient harm. Most of the corresponding improvement efforts have focused primarily on the hospital and ambulatory care settings, with limited research or initiatives undertaken to understand and manage the clinical risks and safety issues inherent in PSRACS.

In Victorian PSRACS, the accountability for increasing risk and care complexity issues sits with the Health Service Boards. The State Government plays a significant role with 23 per cent of all services, or 195 services, operated by public sector providers, accounting for 14 per cent of places state wide. The majority of PSRACS are governed by Health Services which also operate acute and other services and other programs. Over 80 per cent of health services operating PSRACS are located in rural areas and the residential aged care service is often co-located with the hospital. Within this operating context the Board and executive of health services are accountable for residential aged care services as part of their overall governance responsibilities as required under the Victorian *Health Services Act 1988*.<sup>2</sup>

Despite the common governance of public sector acute and aged care services, PSRACS are often operated as discrete program areas within the broader Health Service, which can result in implementation of separate quality systems related to differing acute and aged care accreditation processes, rather than streamlining the quality systems across the continuum of care. Many PSRACS have therefore been unable to access and gain from advances made in acute care quality systems over the past decade, such as the development of quality and clinical governance frameworks and tools, public reporting, clearer priorities, research into improvement science and high risk areas, and learning from other high risk industries.

The changing residential aged care population now provides opportunities for these issues and advances to be addressed in aged care. The impact of increasing risk and complexity in the healthcare of residents on their quality of life should not be underestimated. The findings of the three Beyond Compliance projects described in this report have the potential to significantly and similarly contribute to important and pioneering advances in aged care risk and quality management.

<sup>2</sup> DH 2009, Victorian Government residential aged care policy. Department of Health, Victoria.

## Project Summaries

### ***Project One: A review of systems for managing quality in Victorian public sector residential aged care services (Quality Systems Review)***

#### **Context and Aims**

The purpose of the Quality Systems Review was to gather information on the current status of public residential aged care quality systems to inform the ongoing development of integrated and sustainable systems for managing quality and risk in PSRACS, that will meet the challenges of providing quality aged care into the future. The project aims were to:

1. Provide an account of the current systems for managing quality in PSRACS.
2. Identify the enablers and barriers to implementing an integrated system for continuous quality improvement (CQI) in health services operating PSRACS.
3. Suggest options and directions to support the development of efficient, integrated and sustainable systems for managing quality in PSRACS which align with DH initiatives and policy and strategic frameworks.

#### **Method**

The Quality Systems Review project was conducted by Qualityworks P/L between July 2008 and February 2009. A generic definition of quality systems in aged care was developed for the purposes of the project: 'a systematic, organisational, system of governance, leadership, planning, tools, measurement, evaluation and action for the purpose of ensuring consistently safe and high quality care and services for residents.' Four components of effective quality systems were derived from the literature and formed the basis of the Review:

**Component 1:** A strategic aged care improvement plan that identifies goals, objectives, priorities and targets for improving quality of care and quality of life.

**Component 2:** Leadership and Governance of safe and high quality care

**Component 3:** Sound measurement and response systems

**Component 4:** A system to evaluate the effectiveness of the quality system.

Information on current quality systems for each of these four components was gathered from aged care industry stakeholders and peak bodies, public sector residential aged care and health service executives, managers, quality managers, and staff, including visits to 15 PSRACS operated by 14 health services.

#### **Key Findings**

The findings are discussed under the four key quality component headings.

##### ***Planning for improvement***

The 'quality system' in aged care usually refers to a rolling schedule of tasks, data collection and reporting, primarily to demonstrate compliance with accreditation standards, and to a lesser, but growing, extent, to pursue innovation and improvement. These activities, whilst demonstrating improvements in a range of areas, often lack an organising framework goals and priorities for quality care, resulting in quality programs that achieve multiple tasks but lack strategic purpose, rigour, and evaluation. The link between the activities to achieve the 44 expected outcomes for accreditation, and improvements for residents at point of care, is often assumed rather than evaluated. These findings are also reflected in the SCORE and QI Validation project discussions.

##### ***Governance and Leadership***

A number of PSRACS are working across their health services to develop a more integrated acute and aged quality systems approach. Over half the health services visited maintain separate aged and acute quality systems, however, usually occurring in the larger aged care services. The majority of sites that directly linked aged with acute quality plans were found to

be in the small to medium rural sector, sharing a campus with an acute or subacute service. An acceptance that accreditation is a measure of the quality of aged care appears to be the major force discouraging health service leaders from pursuing integrated acute and aged quality systems. Most aged care services report on quality and risk data to their Boards, but many services noted that it is difficult to compete for meeting time with acute care data, the validity of reported data is rarely tested and that little feedback is provided to staff. These issues are further discussed in the Quality Indicator Validation project.

The consultations revealed a strongly held belief across aged care personnel that accountabilities for the quality of care provided are clearly led and allocated in all organisations. There were many examples of effective leadership observed at the site visits, such as modelling positive behaviour, setting expectations around the standard of care expected and reinforcing this through orientation, delegation, meetings and education. Leadership of aged care quality systems appeared to be highly person-dependent, however, with few examples of formal, planned leadership systems. The effectiveness of the various leadership roles in improving the quality of care tended to be assumed, and were rarely supported by specific training or formal evaluation.

### ***Measurement, response and evaluation***

The dearth of valid, comparative residential aged care data that clearly identifies risks and problems with care may be the key factor precluding health services from developing more rigorous aged care quality systems, and both the SCORE and QI Validation projects address this issue. The quality of care provided to residents is difficult to assess without useful data, and in their absence a positive accreditation result may be viewed by Boards and Executives as a proxy indicator of high quality care, despite the fact that minimum standards of care are being assessed. The majority of sites believe their incident, indicator and audit data accurately reflect the care provided, and that their responses to these data are effective in improving care for residents, but the absence of systematic evaluation of quality systems renders it difficult to judge the accuracy of these beliefs. This is further discussed in the QI Validation project.

There are also gaps in external drivers for the collection of valid aged care quality data. Residential aged care is not subject to the same state and national requirements as acute care to meet targets on key priority areas and to publicly report on the quality of care provided. A number of sites commented that the application of the acute healthcare safety and quality reporting requirements to DH would help raise the profile of resident risk, engender increased support from Executives and Boards, and drive data validity and reliability.

### ***Key barriers and drivers***

The key barriers and drivers to improving the effectiveness of the quality system identified through the consultations support those articulated in the literature:

#### ***Drivers:***

- Senior support and leadership
- Accreditation
- Improving things for residents
- Implementation of evidence

#### ***Barriers:***

- Lack of time and resources
- Lack of skills and knowledge
- Lack of useful data
- Lack of senior support
- Lack of direction
- Accreditation system not supporting improvement beyond compliance.



## ***Project Two: Strengthening Care Outcomes for Residents with Evidence***

### **Context and Aims**

The modernisation of residential aged care services from traditional custodial, medical models of care to person centered care using evidence-based practice is underway. Research evidence about clinical care applicable to this setting is increasingly available. However, the translation of research into everyday practice is a work in progress. Significant challenges include: a limited ability to attract and retain an appropriately skilled workforce; a culture that is a task oriented and focused on documentation, as found in the Quality System Review, and a lack of objective information about the nature of harm and how to improve resident safety. In 2008, the DH Aged Care Services Branch commissioned the Australian Centre for Evidence Based Aged Care (ACEBAC) to complete a 3 year project aimed at addressing some of these issues, and specifically to:

1. Improve resident outcomes through the development and implementation of evidence-based standardised care process in a number of areas of clinical risk
2. Support the provision of 'best possible care' to people who live in PSRACS
3. Enable staff and administrators working in PSRACS to support each other and benchmark their performance.

### **Method**

A strategic and structured program of identifying, implementing and evaluating the implementation of standardized approaches to critical clinical care processes was developed, as follows:

**Stage 1:** Identify clinical risks and develop care processes for prioritised risks.

A multi-methods approach was applied: (i) consultation with experts in aged care; clinical practice; evidence-based practice; quality and safety; translation of evidence into practice; (ii) public consultation with stakeholders and key informants and (iii) review of published literature and existing data.

**Stage 2:** Implementation of standardized care processes. This consists of several elements:

- (1) Standardised care processes (evidence-based) for ten clinical risk areas along with the necessary tools and documentation required to implement these into practice;
- (2) Education and training of the PSRACS staff and an on-site Clinical Fellow to facilitate education and lead change management;
- (3) Expert support from ACEBAC to assist with problem solving any new issues and to engage executive support. This includes site visits and regular contact to monitor progress and
- (4) Audit of practice by measuring and reporting of adherence to the individual standardized care processes.

**Stage 3:** Evaluation of the implementation of standardised care processes into practice, with consideration of the broader state-wide implementation of SCORE.

A mixed methods evaluation program will be used to assess the effectiveness of the implementation of the standardized care processes. This includes (i) adherence to standardized care process; (ii) stakeholder perceptions of the benefits and limitations using the standardised care process; (iii) expert panel to identify factors relevant to the sustainability and transferability of this intervention.

### **Key Findings**

#### ***Supporting health services to better identify and manage clinical risk***

The extensive consultation demonstrated overwhelming consistency in clinical risks identified by the different groups. However, setting priorities was problematic with significant divergence due to difference in perception of risk. Typically debates occurred around whether the prevalence, probability of the risk occurring and consequences such as impact on residents, financial costs and damage to reputation should be the determinants for setting priorities.

The consultation also identified barriers to managing risk through implementation of standardised care processes, highlighting the fact that clinical pathways used in the health care organizations did not fit well into residential care. Other identified barriers confirmed the view that managing risks is impacted by perceived lack of time, lack of ownership and perceived lack of relevance to the aged care setting. Suggestions for engaging the staff in residential aged care service in managing risk included ensuring relevance, focusing on the resident and simple approaches.

### ***The need for a definition of clinical risk***

A specific definition of clinical risk in the literature was not found. Rather, the meaning of “clinical risk” was often implied in the context of broader discussions about risk management and risk assessment in the healthcare system. The following definition was proposed and adopted:

*‘Clinical risk is where action or inaction on the part of the organisation results in a potential or actual adverse health impact on consumers of health care.’*

### ***Selected areas for improving the management of clinical risk***

The combination of the literature review, extensive consultation with industry and input from the expert consultant group identified eighteen major or core clinical risks. From these risks, ten were selected for standardised care process development, using the following criteria: (1) an evidence-based guideline existed; (2) the application of a standard care process could significantly reduce the clinical risk and improve residents’ care and outcomes; (3) the standard care process would not duplicate other current research or project work; (4) ease of implementation; (5) low numbers of groups or stakeholders involved in implementation thereby potentially improving manageability; (6) low cost of implementation and (7) that the SCP is consistent with current processes and data collection (e.g. Quality Indicators).

The ten key risks are:-

- Choking
- Constipation
- Dehydration
- Delirium
- Depression
- Hypoglycaemia
- Oral and dental hygiene
- Physical restraint
- Polypharmacy
- Unplanned weight loss

The development and implementation of standardised care processes in these areas are expected to reduce clinical risk by improving one or more aspects of the care continuum (i.e., screening; assessment; planning; management and evaluation of care).

### ***Lack of robust, quantifiable and comparable clinical risk data across PSRACS***

The current data being routinely reported at local, state and national level about clinical risk and safety in PSRACS has significant limitations and could not be used to identify nor prioritize the significant clinical risk areas. The reasons for these limitations include: the data are not reflective of the aged care sector; the data are disparate, with inconsistent definitions, so not easily compared; data are collected for different levels of governance (e.g., facility, regional or national jurisdictions); lack of data specificity (e.g., location of the incident was not necessarily recorded). These issues were also identified in the QI Validation Project.

## **Project Three: Public sector residential aged care services quality indicator data validation project**

### **Context and Aims**

The importance of monitoring and measuring service performance and quality of care is well established. The challenge is to develop systems for effective data gathering, analysis, reporting and responding to the information. At present there is a significant lack of accepted indicators and benchmarks for service quality in residential aged care. In 2003-04 the Department of Human Services commissioned the development of a set of quality of care performance indicators designed to assist in monitoring and improving care provided to residents in Public Sector Residential Aged Care Services, and in 2006, five quality indicators were implemented across Victoria. These continue to be collected at a facility level and reported to DH. The indicators are:

- Indicator 1: Prevalence of stage 1-4 pressure ulcers
- Indicator 2: Prevalence of falls and falls related fractures
- Indicator 3: Incidence of use of physical restraint
- Indicator 4: Incidence of residents using nine or more different medicines
- Indicator 5: Prevalence of unplanned weight loss

Since their implementation in 2006, the PSRACS quality indicators have been widely accepted across the public sector. However, residential aged care services are in the early and formative stages of using quality indicators. The process is underpinned by a set of business rules refined over time and contained in the *Resource Manual for Quality Indicators in Public Sector Residential Aged Care Services*<sup>3</sup> (hereafter referred to as the *Resource Manual*). If quality indicators are to become an essential tool in efforts to continuously improve the quality of residential aged care, the data gathered needs to be reliable and “fit for purpose”. A consistent request from PRACS is a desire to understand their performance and to be able to ‘benchmark’ with similar services.

The QI Validation project explores how PSRACS in Victoria collect, interpret, report and respond to their quality indicator data, to determine the next steps for optimizing data collection, and use to improve the quality of care provided and individual resident outcomes. The project aims to:

1. Examine methods used to collect and record QI data and whether or not they are uniform.
2. Determine the current operational management of the QI data, including use in continuous quality improvement, reporting structures, and impact across the health service.
3. Evaluate the quality, validity and reliability of current QI data collected.
4. Identify opportunities for improving the consistency and comparability of QI data collected.

### **Method**

A two-tiered approach was used to obtain the data. Firstly, information across all Victorian PSRACS was gathered through an electronic survey to ascertain how quality indicator data are collected, reported and utilised for quality improvement programs. Secondly, research fellows conducted on-site visits to a representative sample of twenty (20) health services operating PSRACS including metropolitan, regional and rural areas, to gather in-depth information using an audit approach. A clinical audit tool was developed that utilised structure, process and outcome indicators in order to ascertain how QI data are collected,

<sup>3</sup> DHS 2007, *Resource Manual for Quality Indicators in Public Sector Residential Aged Care Services*. Department of Human Services, Victoria.

reported and utilised in quality improvement programs, and how these factors relate to the methods outlined by the Department in the Resource Manual.

## Findings

### **Survey**

The response rate for the survey was 57.9% (n=112) with the majority of respondents in managerial positions. Respondents claimed their facility had a high level of adherence to measuring and reporting the quality indicators. Services reported staff that collected the data is generally provided with education, training and support, and their familiarity with the quality indicator definitions was usually assessed.

### **Indicator definitions, data sources and accuracy**

Respondents claimed their facility to be consistent in their use of definitions and people assigned to collect the data, as well as checking the integrity of data prior to, and after collation. However, on the detailed and specific questions there was some discordance between perceptions and behaviour. There was variation in how the quality indicator definition was interpreted and applied. About two-thirds of facilities (68.1%) claimed that their data collectors always had education, training, or support available. About half of facilities (52.2%) claimed that staff was always assessed for familiarity with QI definitions.

There was substantial variation reported in the tools, methods and data sources used to determine the presence or absence of an indicator event. For example, respondents reported a wide range of tools for the staging of pressure ulcers, including the National Pressure Ulcer Advisory Panel (31.0%); the Australian Wound Management Association (29.2%); the Victorian Quality Council Guidelines (23.9%) and internal facility policy (13.3%). A wide range of data tools were used for each indicator, including electronic incident reporting systems, proprietary software products, paper-based incident reporting systems or specific audit tools. The most commonly used tools to collect data were in-house systems. Variation in the nature and extent of data management and checking from rudimentary through to sophisticated approaches using audit of data was also identified.

### **Reporting**

Respondents claimed their facility nearly always reported the quality indicator data to DH, to the facility manager, and to the safety or quality improvement manager. About three-quarters (72.6%) always sent reports to the Nurse Unit Manager. One-half to two-thirds always reported to their executive, board, and/or risk management committee. However, quality indicator data reports were rarely provided to facility staff, residents or general practitioners who worked in the facility. Management usually received quarterly reports, and risk management committees and other staff received quarterly reports in a high proportion of facilities. However, in over half of facilities (53.1%) residents would only receive a report "on request". The majority of respondents described that the "Quality Indicator Data Reports" rarely prompted a response except from the facility managers. However this did not reflect the broad acceptance and perceived value of the quality indicators.

### **Action in response to data and value of quality indicator reporting**

Survey respondents reported reviews of resident care were more often triggered in response to the QI data than any other review. Interestingly, changes in facility systems were least often triggered. Unplanned weight loss was the most likely to trigger action of any kind, while falls and physical restraint were least likely to trigger any action. Ten facilities (8.8%) claimed that the quality indicators always triggered resident reviews, reviews of staff practice, and reviews of systems, and that these reviews always resulted in beneficial changes for residents. At the other end of the scale, 5 facilities claimed that the quality indicators rarely or never triggered anything.

To a direct question about the perceived "usefulness of each quality indicator to the facility", 55% to 83% of respondents agreed the individual indicators were useful "always or most of the time". Only 6 respondents considered the indicators to be "rarely or never" useful. Not surprisingly, the respondents with more comprehensive approaches to data collection and

collation were also more likely to use the data post-collation to trigger actions to improve client care and systems within the residential care facility.

### **Audit**

The audit examined the respondents' expectations of quality indicators. It was pleasing to find that several staff reported that their experience was better than originally expected as the quality indicator data had been used internally for reviewing practices and was found to be useful. Overall the quality indicator data are used to monitor individual residents and practice in the PSRACS. The indicators prompted: increased awareness of clinical risk; a proactive approach to identification of risks; a more holistic approach to care and review of resident care plans.

There was wide variation in the extent to which the data were used to review resident care. Some facilities had embraced the use of quality indicators whilst others expressed that these had little relevance to their practice. Respondents also reported that the quality indicators had prompted education and skill development; increased staff knowledge of management and better practice; increased awareness of the importance of risk assessments; improved quality of care; provided evidence of change; and empowered staff. A key staff concern with the use of the data was that the quality indicators reports are often not reviewed by the organisations governing board.

In summary, the impact of the indicators on staff showed opportunities for improvement in further developing staff's understanding of how to use indicators as well as providing comparative data. Notwithstanding this, the impact of the indicators on residents showed positive results with most respondents reporting improvements in care, safety and outcomes for residents. The impact of the indicators on the service was also positive, initiating a proactive and systematic approach within the facility.

## Options for Action

There are a number of options for action to be considered to further develop and integrate PSRACS quality and risk systems. Collaborative efforts between government, research and academic groups, aged care and health care institutions have already led to substantial policy initiatives and practice changes designed to improve resident care and safety. Further improvements are achievable, and will require the same collaborative efforts. Opportunities for change may well be accelerated through the reviews currently being undertaken by the Commonwealth, and with Accreditation support.

The way forward involves strengthening and building on work already completed and in progress as well as new approaches. Aspects of the work can be adapted from initiatives emanating from the broader health system quality-related organisations such as the Victorian Quality Council and the Australian Commission for Safety and Quality in Health Care. Some suggestions are aged care specific, and will require new developments and innovation at Department and facility levels.

Importantly, all work undertaken as a result of the three projects needs to be mapped to key components of clinical governance, including the DH Clinical Governance Policy Framework<sup>4</sup> elements, as follows:

*Component One: A strategic approach to the governance, planning and leadership of safe and quality care for residents*

*Component Two: Consumer Participation*

*Component Three: Effective Workforce*

*Component Four: Care Effectiveness and Risk Management*

*Component Five: Robust measurement and response systems to support safety and quality of care*

*Component Six: Evaluating quality system effectiveness.*

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<sup>4</sup> DHS 2009, 'The Victorian Clinical Governance Policy Framework', Department of Human Services Victoria.

## The Way Forward

The findings of all three projects are consistent with the literature on quality systems drivers, barriers, strengths and weaknesses in both acute and aged care. They also echo the findings of the 2008 Evaluation of Aged Care Accreditation Report<sup>5</sup> that discusses the constraints on innovation, improvement and measurement implicit in the aged care legislative and governance context. These constraints, combined with a lack of strategic focus and availability of valid data in aged care has driven a largely audit-driven approach to meeting minimum standards. Local leaders need support to implement more innovative approaches that exceed the perceived 'paper ceiling' of accreditation. A clear strategy is required to support and further develop the work underway in PSRACS to drive the pursuit of optimum safety and quality of care and to manage the increased complexity of the resident population.

The themes emanating from the three projects are clear, and are likely to apply equally to aged care quality systems in the not-for-profit and private sectors - and to some acute care quality systems. Supporting organisations to implement rigorous, strategic and knowledge based approaches to improving the quality of resident care requires effective planning, valid data, clear priorities, strong risk management and an engaged and supported workforce. It will include the development of aged care specific internal and external drivers and supports, similar to those developed in acute care over the past decade. Existing drivers, such as DH Beyond Compliance initiatives should be strengthened and built on to further enhance effective clinical governance for aged care.

The Quality Systems Review Project outlines the need for further development of leadership and improvement commitment and skills in aged care and health services to drive quality care. A strategic residential aged care quality framework would guide services to channel their efforts into key priorities, aligned with accreditation, but focused on achieving optimum safety and quality goals, in partnership with residents and carers. Aged care and acute quality systems are both likely to benefit from further interdependence that supports a two way sharing of clinical and quality knowledge and initiatives.

Ensuring the safety of care is paramount, and the changing profile of resident risks and consequences must be central to any system. The SCORE project found that clinical risk can be managed through implementation of standardised care processes, but requires a different approach from the clinical pathways used in acute health care organisations. Managing risks is impacted by perceived lack of time, lack of ownership and lack of relevance to the aged care setting. The SCORE project provides guidance on a number of these key priorities and how to address them to better manage resident risk and care.

Better aged care data reporting is also vital to raise the profile of resident safety and quality issues and to meet the needs of a changing population. This would help establish aged care services as a critical contributor to the effectiveness and governance of the health services operating PSRACS. Boards should have access to valid aged care data and apply it in the same way as acute care quality and risk data are used to support effective governance. The further development of valid, comparative data, including a minimum dataset, would meet the growing requirement to accurately identify and respond to the risks and care quality experienced by residents.

The SCORE project summed it up best: at a local level, improving the safety and quality of resident care requires managers and staff to see the relevance of improvement strategies, a focus on the resident and simple approaches. This needs to be supported at Executive, Board and department levels by strategic approaches, improvement of the knowledge of risk and valid and meaningful data. This 'bottom up meets top down' approach will drive and support PSRACS and Health Services to meet increasing resident health and care needs and community demands, and, most critically, to support the transformation of the quality of aged care beyond compliance.

<sup>5</sup> Department of Health and Ageing 2008, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes - Final Report*. Commonwealth of Australia.