

# **How is quality being monitored in Australian residential aged care facilities?**

## **A narrative review**

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## **Abstract**

### **Background Issues**

“Quality of Care” is a difficult concept to measure, particularly within the context of residential aged care, which involves lifestyle issues as much as health issues. Recent years have seen an increased focus on quality within residential aged care, yet Australia does not have a structured and comprehensive quality monitoring system within this sector.

### **Problem**

While the Australian Accreditation Standards have been credited with contributing to improving care since their introduction in 1998, they are only considered to represent minimum (rather than optimal) standards of quality, and they do not sufficiently focus on clinical outcomes. Further, individual facilities might only be assessed against these standards every three years, within which time there is much scope for quality variations to go unnoticed.

### **Implications**

This paper contends that collecting and analysing comprehensive clinical data from aged care facility residents constitutes an essential step in the process of monitoring quality in this environment. Such data can be used to formulate indicators of quality, that is, to create markers to highlight areas of clinical care which might be of questionable (or exceptional) quality, enabling more detailed investigations of care practices within a facility.

## Conclusions

The above processes could thus fill the current gap in quality monitoring that exists within the Australian residential aged care system, thus ensuring the provision of best practice care to this vulnerable population.

### Word Counts

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Abstract: 225 words

## Background

Since the mid-1980's, numerous changes to the Australian aged care system have been implemented in an effort to improve management and care practices within residential facilities. Concerns about quality within residential aged care facilities are regularly raised in the media as questionable care practices or carer behaviour are exposed, but *monitoring* quality in this context remains problematic and poorly addressed. The United States has introduced, and continued to refine, a compulsory system of assessment within its nursing homes, aimed at monitoring quality of care and clinical outcomes. Known as the Minimum Data Set/ Resident Assessment Instrument, it is a comprehensive system of forms, which must be completed at prescribed intervals to meet a number of purposes, such as care planning, casemix funding, and quality monitoring. The process incorporates the use of Quality Indicators as a means of implementing quality assurance and improvement within residential aged care; these are markers that make use of assessment data to indicate either the presence or absence of potentially poor care practices or outcomes. The Minimum Data Set data is consequently used not only to monitor residential aged care quality on a national level, it is also used to provide individual facilities with reports indicating their progress in terms of clinical care benchmarks, thus enabling them to determine areas for attention in their quality improvement cycles. To date, a comparable system of quality assessment does not exist within Australian residential aged care facilities, neither do established benchmarks of quality for this setting.

## Purpose of Paper

The purpose of this paper is to investigate and comment on the current state of quality monitoring within the Australian residential aged care system. This includes

an examination of the concept of quality of care and its measurement, as well as an exploration of international examples of quality assessment in residential aged care.

### **Literature Search Strategy**

In examining the above issues, literature was initially located through searching the CINAHL, Medline, Web of Science and PsychINFO databases, using the keywords “Nursing Homes”, “Long Term Care”, “Quality of Care”, “Quality Indicators”, and “Minimum Data Set” – either alone or in combination. “Australia” was also added to searches to specifically locate activity within Australia, although internet searches proved more successful for the latter. Other search strategies included searches for specific authors, cross referencing citations from articles, and searching government websites from Australia, United States, Britain, Canada, and New Zealand.

### **Aged Care in Australia**

The evolution of the aged care system within Australia is not dissimilar to that of other developed nations. Prior to the mid 1980’s, “aged care” really meant “residential care”. That is, services provided to older people requiring support largely occurred within the context of residential facilities, and admission to these settings often occurred because nothing else was available [1-4]. Residential facilities had been subsidised by the Commonwealth Government since 1962, but the funding was not highly regulated [5]. As a result, there were some very poor quality facilities with unscrupulous practices. Lack of eligibility criteria and the paucity of community care also led to a number of “social” admissions, related more to social isolation and lack of social support than to the need for care and assistance [3, 5, 6].

The changes instigated over the last two decades are regarded to have had a largely positive impact on the direction of aged care within Australia, although a number of problems still remain [4, 5, 7]. Initiatives of these reforms relevant to residential care have included a standardised system of assessment (Resident Classification Scales) to determine resident care needs (and associated funding), and a formal system of Accreditation to ensure quality service delivery (also required to maintain funding). Further, requiring assessment by an Aged Care Assessment Team prior to admission to residential care has eliminated the so-called “social admission”. Consequently, the residential care population has become frailer and more functionally impaired, with a considerably shorter length of stay [3, 4]. The increasing frailty of the population creates a further imperative to ensure quality service delivery. However, concerns remain regarding the adequacy of quality monitoring within residential aged care facilities.

## **The Dilemma of Quality**

“Quality of care” is not easy to define, given that it is something that involves interactions between humans, such that at least part of it is an abstract [8-11]. There is no one single measurement that definitively assesses quality of care [9, 11-13]; it is also somewhat subjective, in that everyone has different conceptions about the nature of quality [12]. Despite its ambiguities, quality of care is an important concept to operationalise, so that the standards of health care facilities can be objectively judged and compared.

Donabedian [8, 9, 14] suggested that three areas of care could be scrutinised to draw conclusions about the quality of care in a facility: *structure*, *process*, and *outcome*. He emphasised that these were not attributes of quality per se, but that they represented areas of focus for assessment [9]. *Structure* refers to the setting in which

the care occurs – including physical layout and resources, human resources, and organisational framework. *Process*, as the name suggests, refers to what is actually done in providing the care, and *outcome* refers to the results of care. The three are interlinked, in that sound structures facilitate good processes, which in turn facilitate positive outcomes – the endpoint of care [8-10, 14]. Donabedian [9] postulated that quality improvement is enabled by receiving feedback about the above three aspects of care and acting on that feedback. He described this feedback as being in the form of indicators of quality.

### **Indicators of Quality**

Indicators of quality are not direct or definitive measures of quality; rather, as their name suggests, they *indicate* areas of care requiring greater scrutiny [15-19]. Donabedian [9] suggested that the stronger the causal relationship between structure, process, and outcome, the more valid the item as an indicator of quality and the more confidence that could be placed in the quality assessment [9, 10]. This is particularly so when using outcomes as indicators of quality, given that outcomes represent the result of all inputs into care, including the patient's own, hence knowledge of a strong causal relationship between existing structures and processes and the final outcome enables confidence in assuming that the care provided was largely responsible for the outcome achieved [8, 9, 14, 20]. In an international review of quality monitoring within health care systems, Mainz contended that quantifiable clinical indicators of quality were a necessity [19]. However, while recent years had seen an increased focus on quality within health care, he suggested that very few systems effectively utilised such indicators.

## Elements of Successful Quality Assessment

Because quality of care is a multi-dimensional concept, no one area of assessment can provide an accurate indication of quality [12-14, 19]. Thus an effective assessment should contain as many items as needed to cover all areas considered relevant to quality care in the context being assessed [14]. To this end, it is necessary to develop assessments with quality measurement in mind, as reliance on standard medical records as a source of information often results in inadequate data [14]. However, if a quality assessment is too long and too complex, then whole sections might be poorly completed by assessors [21]. Moreover, the instrument needs to be constructed so as not to be perceived as a burden [22, 23]. When a trial quality assessment in Britain resulted in a low participation rate due to the extra time needed to complete it, Hughes and colleagues [22] suggested that quality measures should be integrated into routine clinical practice, without substantially adding to the workload; although they acknowledged that this was difficult to achieve.

## The Current State of Assessment in Australian Residential Care Facilities

### Resident Classification Scales

The Australian Society for Geriatric Medicine [7] described the Resident Classification Scales as the “*antithesis of a funding system that generates incentives for quality health outcomes*” (p.46). This criticism refers to short falls of the Resident Classification Scales that have not been corrected, despite multiple revisions – that the system focuses only on what care is *provided*, rather than best-practice requirements, and that deterioration in function is rewarded by attracting more money. Essentially, the funding system provides no incentives for improvements in quality care practices [6, 24]. Thus, because the Resident Classification Scales is a funding tool it only

provides an indication of care *needs*, with no potential for assessing *outcomes* of care [7]. The Australian Government recently commissioned a review of the Resident Classification Scales [25], and as a result of this review, a new assessment tool – the Aged Care Funding Instrument – has been developed and trialled [26], and is to be introduced Australia-wide in 2007. However, while the assessment system has been changed to reduce the paperwork burden, it remains a funding-only tool and, as such, continues to have no bearing on quality.

## **Accreditation**

Outcome Standards for residential care in Australia were introduced in 1987 [2, 21]; prior to this, assessment of residential care quality had been poorly addressed. Implementing the Outcome Standards included the use of Standards Monitoring Teams, which were Government-appointed bodies responsible for assessing residential care facilities' compliance with the Standards. The Standards Monitoring process resulted in improved quality of care within residential care facilities [6]. This system was further strengthened by the introduction of the Aged Care Standards and Accreditation Agency in 1998, which compels residential aged care facilities to seek Accreditation in order to maintain Government funding [3, 6].

While there is support for the Accreditation Standards, there is also an acknowledgment that, as minimum standards, they merely represent the level below which no service provider should fall [7]. Further, clinical care forms only a part of the Standards, and the Australian Society for Geriatric Medicine [7] noted there are numerous gaps in the clinical care section; with some outcomes vaguely defined, and a number of significant health issues for this population missing from consideration (e.g. management of depression, prevention of hip fractures). Accreditation assessment is based on documentation review [6] but the Standards do not currently

require the collection of basic measurable outcomes, such as the number of in-house acquired pressure ulcers, the percentage of residents with urinary tract infections, or the rate of falls. In his analysis of the Australian system, Rosewarne [6] noted that, while Accreditation singled out those facilities at the upper and lower extremes of quality, there was very little discrimination between the majority of facilities, which fell in the middle.

Thus, the two major forms of assessment and monitoring within Australian residential aged care are separate from each other, and based on administrative outcomes over clinical outcomes, thereby limiting detailed assessment of quality of care. In their review of the residential care funding system, the Australian Productivity Commission [27] recommended that funding should be tied to the achievement of national benchmarks of quality; this suggests an alternative to the current funding structure, which allocates funding on the basis of care provided, whether it is best practice or not, and facilities are directed towards preventing a fall in quality below a minimum standard, rather than striving to achieve an optimum standard [7].

## **Quality Indicators for Residential Aged Care**

Residential aged care is unique in the health care context, in that as well as providing clinical services, residential aged care facilities also provide a place to live, so it is not surprising that perceptions of what constitutes quality of care would encompass a broader range of issues than in more traditional health care organisations, such as acute hospitals. Within residential aged care facilities, concepts of quality of life and quality of care tend to overlap [28-32]. Further, Marquis [11] advocated that the focus of quality assessment in aged care should be on resident outcomes, rather than service outcomes, as tends to be the case in Australia at present.

Quality of life is itself difficult to define and measure, thus adding to the challenges inherent in assessing quality of care in this context. However, Clark and Bowling [33] suggested that quality of life in residential care could be ascertained by looking to measurable indicators such as general health, functional status, mental health, comfort, emotional wellbeing, privacy, choice, and autonomy.

In focus group discussions with residents and staff of Australian residential aged care facilities, Doyle and Carter [28] found that the areas considered most important in meeting the Residential Care Standards for health were “*doctor of choice, food, mobility and dental care*” (p.4). When talking to residents of British nursing homes, Raynes [30] found that their views of quality care were less about the “nursing” and more about the “home”. Of the 12 characteristics of quality in nursing homes identified by Raynes, most were psychosocial or environmental in nature, with two referring to staff attributes and staffing patterns.

Glaser [31] suggested that, at an individual level, comprehensive clinical assessment was a necessary component of good quality care in nursing homes, and that it should be used to provide measures against which individual, as well as facility-level care is evaluated. After interviewing clinical nurses and aged care facility managers in Australia, Courtney and Spencer [15] identified a list of six measurable indicators of quality clinical care in residential aged care facilities: *pressure ulcer rates, incontinence rates, hydration management, rates of infection, skin integrity, and polypharmacy*. Spencer [23] also interviewed residents and families, and further to the six clinical areas already mentioned, other areas identified for quality assessment included a number related to quality of life.

Thus, when considering quality assessment for residential aged care facilities, indicators of quality should encompass areas of clinical care directly related to

residents' physical health, as well as quality of life and lifestyle-related issues, such as activities and family involvement.

## **Implications for the Australian System**

*"... it is essential to develop clinical indicators directly related to the care standards covered in the accreditation process if quality of care is to improve further." [6, p.134-5]*

Despite the Australian residential aged care system being highly regulated and subject to multiple assessments, there is a gap in terms of determining the quality of care practices being utilised. There is no real emphasis on clinical outcomes in either the Resident Classification Scales or Accreditation assessment. Moreover, as the key quality assessment, for the majority of facilities Accreditation is only conducted once in three years. Clearly, more timely assessment and feedback would be preferable for monitoring quality of care. While the Accreditation Agency requests that each individual aged care facility develop their own individual approach to collecting quality indicator data and implement benchmarking activities, the ideal of optimal quality clinical care for all residents is not enforced. Further, there is no requirement for specific quality data to be gathered across all facilities nationally so that comparisons could be made. Collecting objective assessment data in terms of outcomes, particularly in relation to clinical care indicators, would help aged care agencies and service providers to demonstrate how they have improved over time, as well as contributing to the continued improvement of standards within the aged care system as a whole [7]. Indeed, Bruen [4] suggested that in a system such as Australia's, where demand exceeds supply (thus minimising competition), the mandatory use of such quality assessment is essential for ensuring ongoing quality improvement.

## Developing an Australian Quality Assessment

*"It is widely agreed that the key to evaluation of quality, effectiveness and outcome of care of older people is the use of comprehensive assessment ..."* [29, p.263]

While it might be tempting to suggest that the Minimum Data Set/ Resident Assessment Instrument be introduced into Australia, given it is a lengthy assessment developed for a different aged care system (i.e. The United States), it is reasonable to consider developing a similar type of assessment, focused more specifically on the needs of the Australian system. Certainly, the Australian Federal Government has not indicated its intent to adopt the Minimum Data Set/ Resident Assessment Instrument. Doyle and Carter [28] recommended the development of an Australian quality assessment containing objective indicators of quality, to be used in conjunction with subjective assessments. However, despite indicating their desire to develop such an instrument, it does not appear to have eventuated. The Victorian State Government has recently introduced a small suite of quality indicators to be used within its state-run residential aged care facilities [34, 35], but their use remains limited to the state of Victoria. A joint project between the Queensland University of Technology and an Australian national aged care service provider has been developing an assessment of quality based on holistic clinical outcomes [36]. It is hoped that, following psychometric analysis (currently underway), this assessment could be utilised within the service provider's network in the first instance, and then more widely throughout Australia.

## Conclusion and Recommendations

The development of Australian aged care over the last two decades has resulted in progressively frailer residents in residential aged care facilities, presenting further challenges to the system to provide good quality of care [3]. The key to

quality care is the collection of clinical outcome and process data in order to properly judge the quality of care being provided [4, 7, 19]. It is imperative to be able to standardise, benchmark, trend and compare this data for it to be meaningful. When facilities use facility-specific non-standardised assessment forms, comparisons of resident and facility characteristics are difficult if not impossible; changes cannot be tracked readily over time and outcomes are difficult to measure. To evaluate and improve care delivery, it is also important to compare resident and facility characteristics and outcomes. When these characteristics and outcomes are compared across facilities, it is possible to identify other facilities that achieve better outcomes with similar residents. These types of comparisons encourage clinicians to question previously accepted practices and stimulate them to design better ways of caring for residents and to subsequently improve outcomes [37].

Thus, there is a need for an Australian assessment tool for routine use that encompasses the mental, physical and social characteristics of older people, and allows the measurements to be compared across all facilities. The current Australian residential aged care system consists of two streams of assessment, documentation and reporting that do not effectively “speak to each other”, and which do not assess quality of care in any systematic manner [7]. In the absence of an assessment system that combines quality with funding, quality should not be abandoned as too difficult to tackle. Rather, what is needed is a quality-monitoring tool that is comprehensive and resident focused, while requiring the minimum of time and effort to complete. The quality of care aspect of the Minimum Data Set/ Resident Assessment Instrument provides an excellent example of standardised quality assessment, and while it might not be appropriate to transplant it to the Australian system, an assessment utilising a

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similar approach and tailored to Australian needs would be a useful addition to residential aged care in this country.

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