Outcomes-focussed regulation of aged care

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Summary

This is a submission on the draft Regulator Performance Guide, made on behalf of consumers. It uses aged care regulation as a case study, and suggests some principles that may apply to other regulators.

Under the *Aged Care Act 1997*, aged care has been regulated by subjective assessments of aged care providers. The recent Royal Commission into Aged Care Quality and Safety found many defects in quality of care. Many of the Commission's 148 recommendations have been accepted by the government, but there is considerable uncertainty about their implementation.

Making subjective assessments of aged care providers has been frustrating for the assessors, and has yielded uneven quality of care. Technological advances have now made it possible to automatically monitor many aspects of care quality. Research into alternative technologies, and investment in the best of them, should yield better care. More precise targetting of government subsidies, and outcomes-focussed regulation, should result.

Outcomes-focussed regulation should allow quick intervention by regulators when needed. For example, automatic monitoring of the temperatures of aged care residents, together with automatic transmission of staff logon and logoff times, might allow more effective responses to pandemics such as COVID-19.

Outcomes-focussed regulation may allow more competition and innovation. For example, minimum care hours are now proposed for aged care residents, including minimum nursing care hours. Research relating quality outcomes to staff hours should guide any proposed minimums, and avoid unnecessary impediments to innovation.

Outcome data should be provided to regulators frequently, at low cost, and with very little opportunity for fraud by the regulated. Three quality indicators became mandatory for residential aged care providers in July 2019, but the data are retained by providers, with only a manual summary provided quarterly to the regulator. Automatic measurements, provided directly to the regulator, would reduce error and fraud, and allow very quick intervention.

The concept of "continuous improvement" has been used in Australian aged care regulation since 1997. What is now needed is leadership by the Commonwealth, testing alternative transponders, and paying the capital costs for selected devices.

1. Introduction

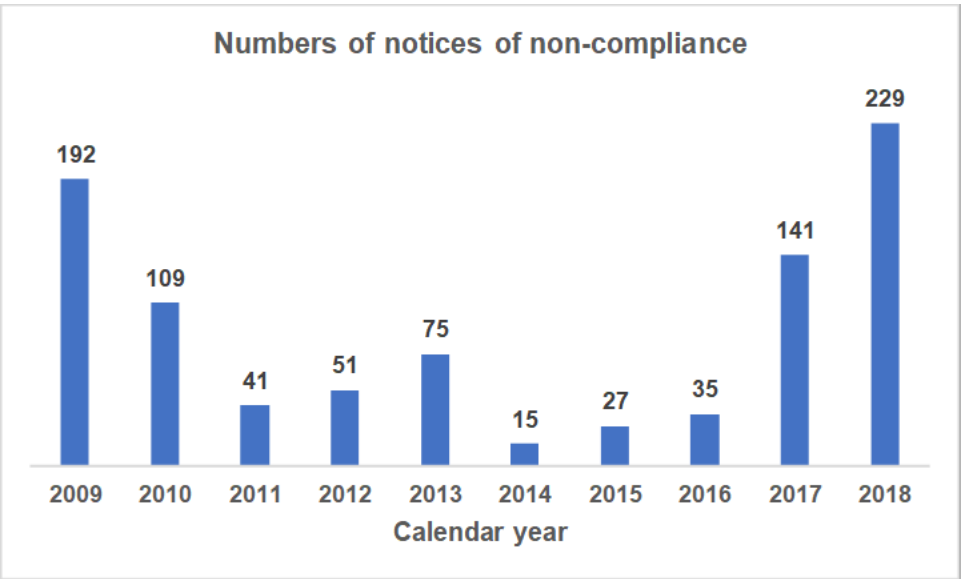
1.1 Royal Commission into Aged Care Quality and Safety

The Royal Commission received its initial terms of reference on 6 December 2018, and submitted its final report on 26 February 2021 [1, p iii]. They received 10,534 submissions and heard 641 witnesses. Total expenditure was about $91.7m. The final report had 2,779 pages, and made 148 recommendations.

1.2 Absence of quantitative data on aged care outcomes

A major limitation on the work of the Royal Commission was the lack of quantitative data on the quality of aged care. Throughout the operation of the Aged Care Act 1997, the Commonwealth has chosen to rely on subjective assessments of care providers, rather than on objective measurements of care outcomes.

1.3 Large variations in numbers of notices of non-compliance



In a submission to the Royal Commission, Cumpston & Bail said

"We do not think the large decreases in notice numbers after 2009, or the large increases after 2016, reflect real changes in the residential care being provided in Australia. Rather, we think these changes reflect major changes in the decision-making of the Commonwealth government agencies responsible for aged care." [2]

2. Glimpses from the Royal Commission's data

2.1 Compounding impacts of malnutrition

The Royal Commission noted that evidence at hearings and public submissions often highlighted the compounding impact of poor care [3, p94]. For example, poor nutrition can lead to reduced muscle mass, reduction in the body's ability to repair skin and a compromised immune system, which increases the risk of infection and pressure injuries.

The Dietitians Association of Australia estimated that between 22% and 50% of older people in residential care are malnourished [3, p115].

2.2 Detrimental effects of poor continence care

"High quality continence care is critical because 71% of people in residential care have experienced urinary or faecal incontinence or both. Incontinence has negative effects on people's lives, including increasing the risk of depression and reduced quality of life. It can undermine a person's dignity and well-being as well as increase the likelihood of pressure injuries and infections. Poor continence care can lead to urinary tract infections, incontinence associated dermatitis, constipation and faecal impaction. Incontinence is also associated with an increased risk of falls…" [3, p124]

2.3 Falls

It is disturbing that in 2018/19 25,596 permanent residents aged 65+ had a hospitalisation or emergency department presentation resulting from a fall [4, p19]. There were about 176,500 permanent residents aged 65+ on average in 2018/19, so this was a fall rate of about 15%. About 50 facilities had fall rates significantly higher than might have occurred by random chance.

2.4 Pressure injuries

There were 8,198 residents with hospital admissions or emergency presentations in 2018/19, as a result of pressure injuries [4]. The number of residents reported with pressure injuries averaged 12,272 per quarter over the 6 quarters to 1 December 2020 [5].

2.5 Weight loss/malnutrition

There were 3,940 residents with hospital admissions or emergency presentations in 2018/19, as a result of weight loss or malnutrition [4]. The number of residents reported with significant unplanned weight loss averaged 14,785 per quarter over the 6 quarters to 1 December 2020 [5].

2.6 Assaults

In 2019-20, 5,718 allegations of assault were made under the mandatory reporting requirements of the Aged Care Act, including 851 involving sexual assault [6, p63]. A study by KPMG estimated that a further 27,000 to 39,000 assaults occurred that were exempt from statutory reporting, as they involved assaults on residents by other residents [3, p94]. It is possible that some of the cases reported as falls to hospitals were in fact the result of assaults.

3. Defects of the National Aged Care Mandatory Quality Indicator Program

3.1 Mandatory quality indicators

- Pressure injuries (stages 1 to 4, unstageable and suspected deep tissue injury)
- Physical restraint (all care recipients restrained, and those restrained only through the use of a secure area)
- Unplanned weight loss (significant loss in a quarter, and consecutive losses between months
- Falls (all, and with major injury)
- Polypharmacy (9 or more medications)
- Antipsychotics (all recipients, and those with a diagnosed condition of psychosis) [7].

Indicators in the first three bullet-points became mandatory on 1 July 2019. The remainder were introduced on 1 July 2021.

3.2 Need for consent by care recipient

Care recipients are required to consent before they can be examined for pressure injuries, or have their weight measured. Providers have been required to report on the numbers of residents not consenting, and variations in the percentages consenting may indicate different attitudes by providers towards obtaining consent.

3.3 Suppression of individual information

Under section 26 of the *Accountability Principles*, residential care providers are required to make measurements, compile a summary for the quarter, and give the summary to the Secretary of the Department of Health. This means the providers have to bear the expense of establishing and maintaining the data records, but the Secretary only receives the depersonalised summary. It is not clear if the Secretary will have access to the source data for audit purposes.

3.4 Longitudinal evaluation at user level not possible from summary data

In a submission to the Royal Commission, Peter Gray QC proposed that

"*The Australian Government should implement a standardised data collection program designed on the 'collect once, use many times' principle".*

The program must be designed to inform longitudinal evaluation at the user, provider, and system levels." [8 p70-74]

The quality indicator summary data will not allow longitudinal evaluation at the user level, and will thus not allow crucial research about disease progressions and compounding impacts

4. New technologies and data analysis techniques

4.1 Suggestions by Cumpston & Bail

"Modern technology should make a wide range of quality measures feasible at low cost. For example, the HbA1c pathology test can be used to monitor diabetics. Regular weight measurements should be recorded to monitor undue weight changes. Specialists in different

health fields should be invited to suggest quality measures which can be quickly implemented, at reasonable cost." [2]

4.2 Prompt help to persons by providers

Cumpston, Sarjeant & Service, in a submission to the Royal Commission, suggested

"*Help to persons could take many forms. A fall might require immediate attention. Changes to temperature and pulse rate might indicate an infection. Rises in odour levels would signal incontinence. An unexpectedly vacant room might prompt a search for a wandering resident. A lack of movement in bed might suggest over-medication or a cardiovascular event. Weight loss soon after admission might reflect an unsatisfactory mealtime environment, or unsuitable food."* [9]

4.3 Alternative technologies

Many aged care homes use call buttons to allow residents to request help, and record how long it takes to respond to calls. The movement detectors used in smart phones could detect falls and assaults, and perhaps also a lack of motion resulting from drugs or disease. Weight transponders in beds could report lack of motion as well as weight. Bedside monitors could report motion and pulse. Wall-mounted monitors could report individual temperatures and identities. Research is needed to find the least-cost set of technologies providing sufficient data, with the least possible discomfort for residents.

5. Leadership needed

5.1 Lack of continuous improvement in the aged care system.

The draft Regulator Performance Guide suggests as Principle 1:

"Regulators adopt a whole-of-system perspective, continuously improving their performance, capability and culture, to build trust and confidence in Australia's regulatory settings."

Braithwaite, Makkai and Braithwaite said in 2007, referring to Australian nursing home regulation, that

"The big accomplishment of the contemporary Australian regime is that it has given more salience to institutionalizing systems that pursue continuous improvement." [10, p176]

The authors may have been referring to continuous improvement by providers, rather than their regulator. But the evidence since 1997 suggest that the aged care regulator has not obtained appropriate data to measure quality, let alone improve it.

5.2 Leadership needed in aged care

Some providers have installed various quality monitoring systems, and shared data with other providers using the same systems. But this has been at their own expense, and the regulator has until recently not sought to make similar monitoring mandatory.

The Commonwealth funds at least 70% of the aged care system, and should meet the costs of testing alternative data monitors, and installing selected devices.. By buying in bulk, the

Commonwealth should be able to reduce capital costs, and ensure that each provider is using identical, fraud-proof transponders.

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