Accreditation and the quality journey in aged care

SPECIAL ARTICLE

D Briggs[1] FCHSE, FHKCHSE

[1] Faculty of Education, Health and Professional Studies, University of New England, Australia

ABSTRACT

Background. This paper reflects on the early and successful implementation of an accreditation system for residential care for elderly people in Hong Kong in terms of the Australian aged care accreditation experience.

Methods. Reflection and critical analysis focusing on content analysis of Hong Kong and Australian reports relevant to aged care accreditation and the author's experience of the Australian aged and health care accreditation systems.

Results. The Australian experience suggests that an accreditation system leads to improved quality of care but does not maintain or improve quality on its own, nor does it prevent the occurrence of adverse events. It is most effective at developing a culture of staff and resident empowerment, continuous improvement, best practice, ongoing learning and innovative research. The relationship between accreditation and regulation of the industry sector, how standards are developed, assessors selected and trained are important considerations in its successful operation.

Conclusions. Governments need to ensure efficient use of available resources while assuring the quality of services while industry needs to participate to ensure its relevance and competitiveness. Health care professionals, government, and industry stakeholders sometimes have competing interests but their first priority should be those to whom they provide care. Engaging elderly people, carers, and staff in values-based advocacy of independence, autonomy and quality care is needed to balance these competing interests. Valuing the contribution of elderly people together with a greater emphasis on researching the effectiveness of care should be the measure of success of the journey to quality that commences with the accreditation process.

Key words: Accreditation; Quality assurance, health care

Correspondence to: David Briggs, 7 Lawrence Avenue, Tamworth NSW, Australia 2340. E-mail: dsbriggs@northnet.com.au

INTRODUCTION

The Hong Kong Association of Gerontology published its'Report on Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong'[1] as a precursor to the voluntary introduction of accreditation for residential aged care facilities. This paper compares the findings and recommendations of that report to those in similar reports on the Australian residential aged care accreditation experience and the author's own experience of the Australian health and aged care accreditation systems generally.

METHODS

Reflection and critical analysis are focused on content analysis of the'Report on Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong' of 2004,[1] the Australian and international

Table 1
Findings and recommendations of the Hong Kong report on accreditation

Findings	Recommendations
Quality management is a standard and essential practice in health care	Establish an accreditation system for Residential Care Homes for the Elderly
Licensing and regulation are government processes setting minimum standards for operation	The proposed accreditation body be operated by a non-statutory independent body, at least initially
Accreditation is usually a separate process, delivered by a non-government organisation to assess and recognise the attainment of pre-determined and established standards	Governance of the accrediting body should consist of a wide range of health professionals familiar with services for older people. Advisors should also be drawn from the industry and government
Licensing and accreditation co-exist but are best delivered as distinct entities	The accreditation body should have three essential functions: operating accreditation; research and development; disseminating information
Accreditation focuses on achievement of standards and continuous improvement	The accreditation body should also seek accreditation
The involvement of professional bodies in accreditation is deemed essential	Assessors should be experienced health professionals
Accreditation is peer review and includes education and consultation. Quality of assessor training is important	Accreditation should be voluntary, standard-based with, peer review
Accreditation is process and outcome focused and uses performance indicators and emphasises research and development	The accreditation status and ratings should be simple and easily understood
It is not unusual for accreditation to be a voluntary process	A three-year accreditation cycle with annual review is recommended
Assessors/surveyors achieve invaluable professional development and networking opportunities through participation	Assessors should undergo training and monitoring

Source: Report on Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong, 30 September 2004

literature and the author's experience of the Australian health and aged care accreditation systems.

RESULTS

The Report[1] provides a comprehensive review of the literature on aged care accreditation and continuous quality improvement. The contents traverse international trends in both quality assurance and accreditation of residential homes together with a review of quality systems in Hong Kong and the development of local standards and conclude with recommendations supportive of the introduction of an accreditation system for Residential Care Homes for the Elderly (RCHEs).

The findings and recommendations (**Table 1**) of that Report are drawn from the international literature and the issues and challenges of establishing an accreditation system. The author suggests that, as the implementation of the accreditation system progresses and matures, new challenges and issues will arise. This is demonstrated by the findings of a recent review of aged care accreditation in the more mature Australian experience, summarised in **Table 2** and recent industry stakeholders' views, described in **Table 3**.

Given that the accreditation process continues to be contested and challenged, accreditation providers are advised to ensure that their system is values based, inclusive of carers and consumers and has a defined role within a performance framework, to meet major future challenges.

DISCUSSION

The Hong Kong Association of Gerontology has pioneered an accreditation system in RCHEs that is leading the broad health and community sector by adopting accreditation on a voluntary basis. This approach is similar to an earlier initiative of the health care industry in Australia, which established a voluntary accreditation process in the 1970s. Accreditation was established by setting up a health profession/health industry representative body now known as The Australian Council on HealthCare Standards (ACHS).[2] Although focused

Table 2
Findings and recommendations of the Australian Senate Community Affairs Committee report into Quality and equity in aged care

Findings	Recommendations
Lack of consistency in assessments by different assessors	-
The training of assessors needs to be improved	The Agency ensure that the training of quality assessors delivers consistency in Agency assessment of aged care facilities
Need to establish benchmarks against which assessors' decisions can be evaluated	The Agency publish data on the accuracy of assessors' decisions in conducting assessments against Agency benchmarks and that this data be provided in the Agency annual report and on its website
Concern that 'topping up staff and tidying up facilities prior to visits' occurs	The Agency further develops and improves information to residents and their families about the accreditation process
Need to increase involvement of residents and families in accreditation process and emphasis on consumer choice	The Agency develop a rating system that allows residents and their families to make informed comparisons between different aged care facilities
The need for a range of choice of accreditation providers	View not supported by Committee
Need for increased monitoring and spot checks	All facilities to be subject to a minimum one random spot check and one visit with notification
Need for realistic staff levels and skills mix	The Agency consultatively develop a flexible benchmark of care that ensures the level of staffing and skills mix is sufficient to deliver the care required
Difficulty of access for aged care residents to medical and allied health workers	-
Issues around medication management and use	-
Concerns about quality of food and nutrition standards	Review the Accreditation Standards to define in precise terms each of the Expected Outcomes…especially nutrition, oral and dental care and cultural aspects of care provision
Need for aged care residents to have better access to transport	-
Need to respond appropriately to the diversity of cultures of aged care residents	Greater use of interpreters and increased cultural competency training of assessors
Need to address the aged care needs of Indigenous Australians	-
Inadequacy of complaints resolution scheme	Review complaints resolution scheme
Instances of retribution against residents and their families	Consider adoption of whistleblower legislation
-	Specific investigation into allegations and need for national strategy to address the issue
Need for high quality care through education and accreditation activities	Develop evidence-based approach to best practice and provide aggregated information on best practice
Excessive administrative and paperwork burden on staff	Review information required, report by exception and increase take-up rate of IT

Source: Adapted from Chapter 3 – The aged care standards and accreditation agency, The Report of the Senate Community Affairs Committee into Quality and equity in aged care, Commonwealth of Australia 2005. Accessed from http://www.aph.gov.au/senate/committee/clac_ctte/aged_care04/index.htm. Accessed 15 June 2006

on hospitals, the ACHS accreditation was available to aged care providers wishing to participate until a specific residential aged care accreditation system was mandated in 1997 using a separate accreditation provider.

Since then, Australia, like many other countries has moved towards a national performance management framework setting out how health determinants, health status, and organisational performance are described and measured. The roles of accreditation, benchmarking, risk management, clinical governance, and performance management approaches are also addressed within those frameworks.[3] Without such an approach, any attempt at health care quality and performance measurement can be described as 'a patchwork of disparate activities'.[4] Accreditation is still emerging in Hong Kong and there is no indication of

Table 3
National Aged Care Alliance—principles for an effective accreditation system and recommendations for change

Principles	Recommendations
Have credibility in the eyes of the Australian community	Aged care accreditation should be situated in the quality/ accreditation industry
Readily applicable across the continuum of care	Accreditation systems should extend across the continuum of aged care not just one industry sector
Maintain an improvement orientation in its own right	Customer focused, flexible, responsive and dynamic
Not only maintain its independence, but be seen to do so	A competitive model with choice and no cross subsidising
Provide choice for users of accreditation services	Pooling of best practice examples by an independent body
Be economically sustainable into the future	Clear delineation of government and accreditation provider responsibility—independence and impartiality
Be transparently accountable to the Australian community	Ownership of Standards remain with government, with industry/stakeholder input to review

Source: Adapted from National Aged Care Alliance Discussion Paper on Aged Care Accreditation. Canberra; November 2004

an industry or system-wide approach to performance measurement. The proponents of accreditation should consider demonstrating further leadership in moves towards 'across the continuum' accreditation in aged care or the broader health industry and how accreditation might best be described in any future performance measurement framework.

Significant issues arising during the implementation of accreditation in RCHEs in Hong Kong were the nature of the accreditation body and the mandatory or voluntary nature of the process. Accreditation can be provided by the industry and the professions, a specialist independent accreditation provider or by government through its regulator and/or funder role.[1,4] In Australia, the broader ACHS accreditation process is located within the health industry and the professions and is voluntary, although participation in a recognised accreditation system is generally an implied condition of funding. The aged care accreditation system established in 1997, saw the setting up of a statutory accreditation body and an exclusive arrangement under the Aged Care Act of 1997 and the Accreditation Grants Principles. By linking government funding of residential aged care providers to accreditation, the funder, The Department of Health and Ageing, clearly placed the accreditation process in the mandatory category and aligned it with their licensing and regulatory role.

This contrasts with the findings and recommendations of the Hong Kong Report[1] which supports separating the regulatory body as a means of providing 'independence and flexibility…being independent, objective, highly credible and providing for the involvement of relevant professional bodies.' This view is consistent with the literature,[5] particularly in the early development of accreditation[2,6] but in the Australian context, aged care providers must be accredited and meet regulatory requirements in order to be licensed.

There is no easy answer to the question of where accreditation should be placed because there are 'a variety of audiences with different—and sometimes conflicting—interests and priorities.' It is one aspect of accountability, with multiple approaches described as 'professional, market driven or public–sector'. The question is: what is the primary purpose of accreditation? Is its role to assure quality and promote continuous improvement, to inform regulation and licensing or to be an integral component of that latter process? The answer to that question will very much depend on the audience and its particular 'interests and priorities' and 'ultimately what is the appropriate role of government.'[4]

Prior to the implementation of aged care accreditation in Australia, outcome standards were in place and these standards had a positive impact on continuous improvement and produced a 'thorough-going qualitative change in attitudes to quality of care'.[7] However, some have characterised the previous system as focusing on achieving minimum standards, and being rigid, adversarial, and intrusive.[8] Others continue to be strident in their criticism of the Australian reforms suggesting that 'industry successfully lobbied to replace legally enforceable regulations with less effective accreditation schemes.'[9]

This suggests that standards, quality approaches and regulation is a contested area where good providers 'who welcome opportunities to improve' will use accreditation reports as the 'basis for improvement' while others with different motivations will contest and challenge accreditation outcomes through litigation.[10]

Notwithstanding these disparate views, providers, industry associations, and government have tended to judge the aged care accreditation system, now in its third cycle of operation and approaching a decade of experience, a success, and an improvement on the previous system.[8,11] Despite these positives, the system was not implemented without some criticisms. These centred around demands placed on staff, emphasis on documentation and resource use, inconsistency and subjectivity in the conduct of site audits, interpretation of ratings and problems becoming familiar with the intent of continuous improvement.[8,11] Other groups such as industrial associations (unions) argue about the adequacy of accreditation standards, particularly with respect to staffing levels while 'seniors' groups, raising similar concerns, expressed opposition to the operation of the accrediting agency. They suggested that the agency favours proprietors, that it should be abolished and that the Department of Health and Ageing should be directly responsible for aged care, which is, of course, already the case.[11,12]

Adverse events and the concerns of families about their elderly relatives have led to the development of web-based advocacy groups concerned with the care of older people such as www.agedcrisis.com. Carers and professional staff have produced educational materials and articles critical of the residential aged care system, its staffing, and the accreditation system.[13] Recently, the Australian government's National Audit Office indicated that the Accreditation Agency could not demonstrate that accreditation had achieved any impact in its 7 years of existence.[11]

Staffing levels continues to be a vexed question[11] with minimum levels and categories of staff not prescribed in a system that is both regulated and funded by government. While this lack of prescription gives staffing flexibility to proprietors and managers, consideration needs to be given to the reality that care is being provided to a group that will become increasingly frail, disabled, and dependant. There are also suggestions that some proprietors 'top up' staff during accreditation processes and have inadequate staffing levels at other times.[11,13,14] However, the Aged Care Accreditation Agency said that during the 2004-2005 financial year it conducted '553 of its visits as spot checks with less than 30 minutes notice' and proposed that 'all aged care facilities will receive at least one unannounced visit each year.'[15]

Some research is said to demonstrate that low staff levels are associated with poor quality care.[9] There is a view that the aged care resource base is inadequate[8] and the implementation of accreditation and demands for adequate levels of documentation have placed additional demands on that staffing.[11] Research in the United States reported at an Australian Parliament Senate Committee Inquiry into 'Quality and equity in aged care' suggests that identified staffing threshold levels are associated with avoidance of 'critical quality care problems', but that movement above those thresholds does not translate into further improvement in the quality of care.[11]

The Australian Senate Community Affairs Committee Inquiry into 'Quality and equity in aged care' in 2005 received some 243 submissions and held nine public hearings around Australia.[11] Selected findings and recommendations arising from that report, relating to accreditation and quality are summarised in **Table 2**. These findings and recommendations represent consideration at the political level of the contested views of the full range of stakeholders in the Australian aged care industry. Many of those stakeholders have argued their views as criticisms of the accreditation process. However, it can also be argued that this demonstrates that the continuous quality improvement aspect of accreditation is working effectively as collectively, issues and areas needing improvement are being identified and progressively addressed. It is when adverse events and the need for improvement in aged care are viewed from a historical perspective that progress is more accurately described.[16]

Again, the Senate Community Affairs Committee report rejected suggestions asking for a choice of accreditation providers and the industry concerns about an agency that has a quality improvement role and a compliance role. Prior to this report, the National Aged Care Alliance issued a discussion paper on aged care accreditation that contained the

principles of an effective accreditation system and recommendations for change. These are summarised in **Table 3** to provide a useful comparison of the views of Alliance members, a 'broad church' of aged care stakeholders, to the subsequent findings of the Senate Committee described in **Table 2**.[17]

These principles and recommendations reflect nearly a decade of regulated aged care accreditation in Australia and may be useful for the emerging voluntary RCHE accreditation system in Hong Kong. While the experience may not be easily transferable or applicable, the issues raised may need strategic consideration as the Hong Kong system gains momentum and matures. For example, while the system remains voluntary, government might consider offering incentives to RCHE providers to take up accreditation. Aged care and health care are also delivered in multiple settings. Therefore, it would be wise to work towards common standards across care settings and to work towards an alliance of industry providers to both accommodate the needs of multiple care providers and to make accreditation cost effective.

Importantly, coalescence between the professions, providers, consumers, carers, and communities needs to be developed if accreditation is to remain credible and be able to lift industry and care standards. If this does not occur, it is likely that an alliance will form between government and consumers, carers and communities, possibly at the expense of the professions and industry providers.[6] For aged care and voluntary accreditation to be credible to consumers and accepted by government a values-based approach to consumers and carers needs to be demonstrated. One approach suggests that the 'transcendence of nursing homes from marginalised providers of nursing care to thriving centres of activity that are integral to the community' may 'pave the way for better sharing of the responsibility of care by members of the community.'[18] Values-based models of care require an approach that has a commitment to respect for the person, a focus on abilities and strengths, personal preferences and choice and participatory decision making between clients and staff.[19]

There are increasing calls in the literature for more compassionate approaches to aged care that encompass both the autonomy of older people and advocacy on their behalf.[20,21] This challenges government, health professionals, care providers, educational institutions, and those responsible for accreditation to make decisions based on well-researched evidence and to provide best practice care.[22] The degree of difficulty of this challenge was demonstrated recently when the Hong Kong Geriatrics Society published its response to a Hong Kong SAR Government discussion paper on health care delivery.[23,24] The Society called on government to 'take the lead to rekindle the Chinese virtue of filial piety', for longevity to be viewed positively and to dispel ageism. While these values are worthy of support, are they the province of government or of all of us? In the case of filial piety, worthy as it is, does it represent the view of older people, and if so, how do we translate that value into standards of care?

Research suggests that the psychological well being of hostel dwellers is better than that of older people living alone or with family. This suggests that living separately from children may reduce the tension of intergenerational conflicts, reflecting a change in attitude to the tradition of co-residence with children.[25] Other research suggests facility size and a strong positive association between staff and resident satisfaction where staff are 'empowered to deliver excellent person-centred care' are important.[26] Therefore, there are many countervailing influences impinging on values that need to be understood before standards are determined.

The recommendations, findings, and principles described in **Tables 1**, **2**, and **3** reflect the quality and accreditation journey of two aged care systems at different stages of development, as community and health care standards continue to evolve and develop. Industry and the professions need to engage residents, carers, and communities as stakeholders in the accreditation process or become subservient to government direction. To remain viable and evolve to meet changing standards, the accreditation system must be able to measure and demonstrate its achievements. Viability of accreditation will eventually require a broader approach, application to more than one industry sector or delivery into other geographic regions in partnership or alliance with like-minded organisations. Finally, a greater emphasis on values, innovation and best practice, fostered by the accreditation journey, should be seen as a positive destination.

References

1. *Hong Kong Association of Gerontology Report on Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong*. Hong Kong: Hong Kong Association of Gerontology; 2004.
2. *The Australian Council on Healthcare Standards, ACHS 30 Years*. Melbourne: ACHS; 2004.
3. Isouard G, Briggs DS, Hanson S, McAlpin S, Messum D. Improving organisational performance in health care. In: Harris MG, editor. *Managing health services—concepts and practice*. Eastgardens: Maclennan and Petty; 2002:331-59.
4. Darby M. *Health care quality: from data to accountability—background paper*. Washington DC: The George Washington University; 1998.
5. Gosfield AG. Who is holding whom accountable for quality? *Health Aff (Millwood)* 1997;16:26-40.
6. Giraud A. Accreditation and the quality movement in France. *Qual Health Care* 2001;10:111-6.
7. Howe A. Future directions for residential care. *Australas J Ageing* 1999;18.3(Suppl):S12-8.
8. Grenade L, Boldy D. The accreditation experience. Views of residential aged care providers. *Geriaction* 2002;20:5-9.
9. Kerrison SH, Pollock AM. Regulating nursing homes: Caring for older people in the private sector in England. *BMJ* 2001;323:566-9.
10. Kendig H, Duckett S. *Australian directions in aged care: the generation of policies for generations of older people*. Sydney: Australian Health Policy Institute, University of Sydney; 2006.
11. Senate Community Affairs Committee. *Quality and equity in aged care*. Canberra: Parliament of Australia; 2005.
12. *National Aged Care Alliance. Aged care accreditation. A continuous improvement orientation for the accreditation system applied to the aged care community throughout Australia*. Canberra: National Aged Care Alliance; 2004.
13. Bryant J. *The truth behind aged care. One nurse's perspective*. Aged Care Crisis Team website: www.agedcarecrisis.com/acc/pdf/thetruthbehindagedcare.pdf. Accessed 15 Jun 2006.
14. *Accreditation: from a nurse's perspective*. Aged Care Crisis Team website: www.agedcarecrisis.com/acc/pdf/thevisitorsarecoming.pdf. Accessed 15 Jun 2006.
15. Brandon M. Just a word... The Standard. 2006 June.
16. Braithwaite J. Regulating nursing homes: The challenge of regulating care for older people in Australia. *BMJ* 2001;323:443-6.
17. NACL. *National Aged Care Alliance Discussion Paper on Aged Care Accreditation*. Canberra: National Aged Care Alliance; 2004.
18. Sitoh YY. Nursing homes in Singapore: a quiet evolution. *Singapore Med J* 2003;44:57-9.
19. Evans LK, Strumpf NE. Changing embedded practice: lessons from gerontology. *J Psychosoc Nurs Ment Health Serv* 2004;42:14-7.
20. Rockwood K. Capacity, population aging and professionalism. *CMAJ* 2006;174:1689,1691.
21. Chew M, Armstrong RM, Van Der Weyden MB. Can compassion survive the 21st century? *Med J Aust* 2003;179:569-70.
22. Flicker L. Healthcare for older people in residential care—who cares? *Med J Aust* 2000;173:77-9.
23. Health and Medical Development Advisory Committee, Health, Welfare and Food Bureau, Hong Kong SAR Government. *Building a healthy tomorrow—Discussion paper on the future service delivery model for our health care system*. July 2005. http://www.hwfb.gov.hk/hmdac/english/dis_papers/dis_papers.html. Accessed 20 July 2005.
24. "Will you still cure me, will you still care for me, when I'm 75?" The Hong Kong Geriatrics Society's response to the "Building a Healthy Tomorrow—discussion paper on the future service delivery model for our health care system". *Asian J Gerontol Geriatr* 2006;1:36-48.
25. Ng KM, Lee TM, Chi I. Relationship between living arrangements and the psychological well-being of older people in Hong Kong. *Australas J Ageing* 2004;23:167-71.
26. Boldy DP, Chou SC, Lee AH. Assessing resident satisfaction and its relationship to staff satisfaction in residential aged care. *Australas J Ageing* 2004;23:195-7.