The role of sanctions in Australia’s residential aged care quality assurance system

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Abstract

Objective. To assess the role of sanctions as the highest level of enforcement in Australia’s residential aged care quality assurance (QA) system.


Setting. A total of 138 sanctioned homes among all aged care homes in Australia (n = 2830 in 2007–08).

Main outcome measures. Chi-square test of differences between sanctioned and non-sanctioned homes, and z scores to identify variables underlying differences.

Results. Sanctions are a rare event as more frequent enforcement actions at lower levels of regulatory action mean that a diminishing number of homes are subject to higher levels of action. Relationships between the risk of sanctions and characteristics of homes (state, size, sector and level of care) were evident. Sanctions provide only limited signals on quality to potential users and do not reflect the full scope of the QA process and the range of quality of care found.

Conclusions. The effectiveness of sanctions in contributing to quality improvement has to be seen within the wider regulatory framework, which in turn has to be set in the context of other factors driving quality of care. Quality improvement in Australia and elsewhere will depend on further development of QA systems but will also require attention to wider contextual factors that contribute to quality outcomes, including quality of the aged care workforce.

Keywords: sanctions, quality assurance, residential aged care, quality ratings, Australia

Background

The framework for quality assurance (QA) in aged care homes in Australia is based on a regulatory pyramid in which enforcement progresses from dialogue and persuasion, through deterrence, to incapacitation [1]. The sanctions that are the subject of this article can result in incapacitation through suspension of funding for new residents and other measures that impose costs on providers, and ultimately, revocation of the operator’s Approved Provider status can lead to home closure and withdrawal of bed licences that incurs a substantial financial loss. The severity of these outcomes means that the risk of having sanctions imposed is taken very seriously in the aged care sector.

The sanctions that were part of the dual standards monitoring processes that applied separately to nursing homes and hostels (akin to assisted living facilities, providing personal care but not 24-h nursing care) in Australia until 1997 have continued in the single system of accreditation of all aged care homes introduced under the Aged Care Act 1997 [2]. Under the Act, former nursing homes were approved to provide ‘high care’ and hostels ‘low care’, and some homes were approved to provide both levels of care to enable residents to age-in-place as their care needs increased. The statutory functions of the ‘accreditation body’ set out in the Act are carried out by an independent statutory body, the Aged Care Standards and Accreditation Agency (the Agency), in conjunction with the federal Department of Health and Ageing (the Department).

The most recent evaluation of the impact of the Australian accreditation system on the quality of care commissioned by the federal government in 2006–07 [3] noted
that sanctions were appropriately structured to promote compliance and improvement, and punish non-compliance, and that they contributed to the capacity of the accreditation system to meet its objectives. No details were, however, reported on the frequency with which sanctions were imposed, the nature of sanctions applied or the outcomes that followed.

The analysis presented here aims to address this gap by reporting on these aspects of sanctions and assessing their effectiveness in the overall QA system. Beyond informing policy development in Australia, this examination is relevant to attempts to enhance quality of care elsewhere as QA systems in the USA, the UK and many other countries fit the regulatory pyramid model of progressive enforcement and penalties.

Pathways to sanctions
All aspects of the QA process, including the quality standards and procedures for imposing sanctions, are legislated under the Aged Care Act 1997 and full details are available through the websites of both the federal Department (www.health.gov.au) and the Agency (www.accreditation.org.au).

Each home undergoes a Site Audit in each 3-year accreditation cycle, and a number of the pathways can lead to sanctions over the cycle. Homes found to comply with the standards are accredited for 3 years, or a lesser period, usually 1 year, where minor shortcomings are identified; also, new homes can be accredited for 1 year only. Prior to the Site Audit, each home must submit a self-assessment report to the Agency, and when on site, the Agency assessors review documentation of residents’ care, observe the environment and care practices and speak to staff, residents, relatives and visiting professionals such as doctors and pharmacists. Identification of non-compliance at the Site Audit, usually taken as failure to meet four of the 44 outcomes, is the beginning of one pathway that can lead to sanctions.

Each home receives at least one Support Contact Visit each year, either announced or unannounced. If non-compliance is identified at a visit, the second pathway to sanctions begins. The Agency must order a Review Audit, initiated by issuing a Notice of Non-compliance and setting a Timetable for Improvement, usually 3–6 months. Only when the Timetable is not met can the Secretary of the Department proceed to impose one or a number of sanctions. Sanctions may be lifted ahead of the Timetable on application by the home or when a further Support Contact Visit establishes that compliance has been achieved, or they may run their course and expire.

Action taken also depends on the degree of non-compliance. Less serious non-compliance may mean a shorter Timetable for Improvement and a greater likelihood of sanctions being lifted early. Conversely, in exceptional circumstances where extensive non-compliance poses a severe risk to residents’ health and well-being, the Agency can recommend immediate imposition of sanctions.

The accreditation reports for each home are made publicly available through posting on the Department’s website, and aggregate outcomes are reported by the Agency and in the Report on the Operation of the Aged Care Act 1997 prepared annually by the Department and submitted to the Australian Parliament [4]. This information is widely disseminated in the aged care sector and among consumer bodies.

Research themes
Five themes have commonly been addressed in QA research in Australia and internationally. The broadest theme is the effectiveness of QA systems in improving quality in aged care services as a whole, with consistency of application and outcomes as a sub-theme. A second theme is the relationship between quality, care processes and structural attributes of aged care homes.

Third, research into the content of quality assessment has raised concerns about the development of quality indicators (QIs), particularly the adequacy of clinical indicators, and the need to develop measures of quality of life and resident satisfaction. A fourth theme has been how quality information can be best made accessible and meaningful to potential residents and others involved in choosing a home, and how a more informed consumer choice can in turn drive quality improvement. Finally, comparative studies have not only examined the content and operation of QA systems but have considered practices in long-term care within wider regulatory cultures of different countries.

Data sources and analysis
While the Aged Care Act 1997 was passed in October 1997, the Agency only began to conduct substantial numbers of Site Audits and Support Contact Visits from mid-1999 and the deadline for the first round of accreditation was set at 1 January 2001. June 1999 thus provides an appropriate starting date for this analysis, with three full accreditation cycles covered by June 2008. The three publicly available sources detailed in Table 1 were drawn on to compile the data on accreditation activity presented in Table 2. Chi-square tests (for categorical data) for differences between sanctioned and non-sanctioned homes in terms of state, size of home, sector and level of care are reported in Table 3 and standardized residual scores (z scores) are also given for significant associations between these characteristics and the risk of sanctions being imposed.

Results
Frequency of imposition of sanctions
Over the 9-year period, sanctions were imposed on 138 homes. Just under 5% of homes were ever subject to sanctions, and the incidence of sanctions in each 3-year accreditation cycle was 1.6%. This rate remained steady over time and the number of homes sanctioned in each cycle was very similar, with annual fluctuations within each cycle in line with the level of Site Audits and Support Contact Visits.
This low incidence has to be seen as the outcome of the series of enforcement measures that precede the imposition of sanctions. Most homes have only one Site Audit in each accreditation cycle, but the average of 1.1 per home indicates that some 10% had more than one, mainly because they were accredited for 3 years. Each home also received an average of 3.3 Support Contact Visits over a 3-year cycle, but some homes receive more visits than others as the Agency works on a risk management basis that takes account of factors such as changes of ownership and complaints.

The average of 394 Notices of Non-compliance issued in each cycle means that just 14% of homes failed to meet the quality outcomes. The majority of Notices, close to six out of 10, were issued in conjunction with the 231 Review Audits, and just over 8% of homes were subject to a Review Audit in each cycle.

The 138 sanctioned homes represent only 12% of the homes issued with Notices of Non-compliance, indicating that in the great majority of homes issued with Notices of Non-compliance, quality shortcomings were addressed within the Timetable for Improvement. Of the sanctioned homes, only one in five was sanctioned as the result of non-compliance identified at a Site Audit, and in four out of five homes, non-compliance was identified at a Support Contact Visit, persisted at the Review Audit and was not remedied within the set Timetable.

### Characteristics of sanctioned homes

Significant relationships were found between structural characteristics of homes and the risk of sanctions. The incidence of sanctions among the states was significantly different from each state’s shares of all homes. This association is driven by both the low proportion of homes ever sanctioned in New South Wales (z = 4.5) and the high proportion in Victoria (z = 3.3). Sanctioned homes were also more likely to be: smaller rather than larger, with this

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### Table 1  Data sources and data items selected

<table>
<thead>
<tr>
<th>Source</th>
<th>Published by</th>
<th>Individual/aggregate data</th>
<th>Data items selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report on the Aged Care Act 1997</td>
<td>Published annually by Department of Health and Ageing (see [2])</td>
<td>Individual cases of sanctions imposed from June 1999 and resolved by mid-2008, and checked on the Departmental website</td>
<td>Name, state, approved provider, nature of sanctions imposed, date on which imposed, outcomes at end of Timetable for Improvement. Number of beds, level of care approved for beds in each home, and sector</td>
</tr>
<tr>
<td>Residential Aged Care in Australia, 2007–08: A Statistical Overview</td>
<td>Published annually by the Australian Institute of Health and Welfare (see [14])</td>
<td>Aggregate data on all homes as of 30 June 30 2008 (N = 2830)</td>
<td>State, size, sector and level of care</td>
</tr>
</tbody>
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### Table 2  Site Audits, Support Contact Visits and sanctions imposed, 1999–2000 to 2007–08

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of homes</th>
<th>Accreditation Site Audits</th>
<th>Support Contact Visits</th>
<th>Notices of Non-compliance</th>
<th>Review Audits</th>
<th>Sanctions</th>
</tr>
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<tr>
<td>1999–2000</td>
<td>3005</td>
<td>1505</td>
<td>530</td>
<td>148</td>
<td>678</td>
<td>16</td>
</tr>
<tr>
<td>2000–01</td>
<td>2977</td>
<td>1490</td>
<td>1084</td>
<td>1294</td>
<td>2378</td>
<td>199</td>
</tr>
<tr>
<td>2001–02</td>
<td>2961</td>
<td>205</td>
<td>1693</td>
<td>1204</td>
<td>2897</td>
<td>158</td>
</tr>
<tr>
<td>2002–03</td>
<td>2927</td>
<td>1965</td>
<td>1310</td>
<td>819</td>
<td>2129</td>
<td>128</td>
</tr>
<tr>
<td>2003–04</td>
<td>2932</td>
<td>879</td>
<td>2262</td>
<td>553</td>
<td>2815</td>
<td>149</td>
</tr>
<tr>
<td>2004–05</td>
<td>2933</td>
<td>339</td>
<td>3453</td>
<td>563</td>
<td>4016</td>
<td>208</td>
</tr>
<tr>
<td>2005–06</td>
<td>2931</td>
<td>1743</td>
<td>2304</td>
<td>886</td>
<td>3190</td>
<td>83</td>
</tr>
<tr>
<td>2006–07</td>
<td>2872</td>
<td>1014</td>
<td>1655</td>
<td>3566</td>
<td>5221</td>
<td>165</td>
</tr>
<tr>
<td>2007–08</td>
<td>2830</td>
<td>426</td>
<td>1675</td>
<td>3056</td>
<td>4731</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9566</strong></td>
<td><strong>15 966</strong></td>
<td><strong>12 089</strong></td>
<td><strong>28 055</strong></td>
<td><strong>1181</strong></td>
<td><strong>693</strong></td>
</tr>
<tr>
<td><strong>Average per 3-year cycle, for 2830 homes operating as of 30 June 2008</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>3189</td>
<td>5322</td>
<td>4030</td>
<td>9352</td>
<td>394</td>
<td>231</td>
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<tr>
<td>Per home</td>
<td>1.1</td>
<td>1.9</td>
<td>1.4</td>
<td>3.3</td>
<td>13.9</td>
<td>8.2</td>
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<td>Homes (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.6</td>
</tr>
</tbody>
</table>
association driven by homes with 61–80 beds ($\zeta = 2.3$); in the for-profit sector ($\zeta = 6.2$) rather than the not-for-profit or government sectors, and approved to provide high care only ($\zeta = 2.5$) or low care only ($\zeta = 2.3$) rather than both levels of care. Of the 138 sanctioned homes, 29 (21%) were small, private homes approved for high care only.

### Nature of sanctions and actions required

More than one sanction may be imposed when a home is sanctioned depending on the areas of non-compliance. A total of 229 specific sanctions were imposed, other than revocation of the Approved Provider status. More homes received two sanctions rather than only one (58% compared with 38%), but a few received three sanctions (4%).

Suspension of funding for new residents was most frequent, accounting for 44% of all sanctions ($n = 229$), and was imposed on 73% of the sanctioned homes ($n = 138$). Appointment of a nurse advisor was next most common, accounting for 36% of all sanctions ($n = 229$) and imposed on 60% of sanctioned homes ($n = 138$). These two specific sanctions were commonly imposed together; both were imposed on three out of four of the 86 homes that received multiple sanctions, and in only 13 homes was neither imposed.

The remaining sanctions were far less common: 11% required appointment of an administrator and 5% required staff training. The remaining 2% of sanctions involved withdrawal of the approval to operate high-care beds or to offer Extra Services (for which higher resident fees can be charged), although allowing the home to continue operating. All these sanctions were usually applied in conjunction with a suspension of funding and were rarely applied alone.
Outcomes

In 51% of the 138 sanctioned homes, the sanctions ran their course and expired at the due time. Another 32% of homes applied successfully to have the sanctions lifted before the end of the Timetable for Improvement, and in the remaining 17% of sanctioned homes ($n = 138$), sanctions were lifted early as care had improved, but without the home applying.

Closure of a home following revocation of Approved Provider status was unusual: only 19 of the 138 sanctioned homes closed (14%). Eleven of these homes closed without transfer of beds and these closures appear to be related to business decisions precipitated by loss of beds licences, such as realizing the capital value of sites or buildings. In the other eight homes, beds licences were transferred to another Approved Provider who either took over the home or relocated the beds to another home. The Department oversees such transfers and these licences are reallocated rather than sold on the open market, precluding any financial return to the initial provider.

The much more common outcome was for restoration of accreditation and continued operation by the same provider. Accreditation was restored to all these 119 homes following the lifting or expiry of sanctions, and in all but 20 homes, accreditation was restored for a full 3 years.

Discussion

The imposition of sanctions is a rare event in the Australian QA system in relation to the total of close to 3000 homes accredited in each 3-year cycle. This low incidence prompts questions as to how sanctions contribute to quality improvement and about their role in the QA process. The five themes identified at the beginning of this article provide a frame of reference for discussing the findings of this study in the wider context of QA systems.

Do sanctions contribute to improvements in quality?

Three findings suggest that although sanctions are imposed only at the peak of the regulatory pyramid, they contribute to improvements in quality through the rest of the QA process.

First, the proportion of homes subject to progressively stronger enforcement measures diminishes as the QA process proceeds. Enforcement through dialogue and persuasion occurred three times more frequently through Support Contact Visits than through triennial Site Audits, while enforcement through deterrence fell from 14% of homes issued with Notices of Non-compliance, to 8% then undergoing a Review Audit, to only 1.6% being sanctioned. It is evident that the threat of sanctions generates remedial action in response to lower levels of regulatory action.

Second, the number of homes sanctioned in each 3-year cycle remained constant against a very small decline in the number of homes. This outcome is consistent with the quality bar being raised and indicates the continuing need for sanctions as the highest enforcement measure in the QA process.

Third, the small share of sanctions stemming from non-compliance identified at Site Audits compared with Review Audits reflects the complementary functions of these measures. The extensive self-assessment that precedes the Site Audit means that non-compliance is low at these Audits. In contrast, the role of Support Contact Visits is to ensure that quality is maintained over the rest of the cycle, and the risk management strategy in particular triggers visits when various risks appear to be present.

These findings suggest that sanctions have played a part in achieving the improvements in quality reported in earlier Australian studies. An evaluation of the initial standards monitoring introduced in nursing homes some 20 years ago found strong evidence of improvement in quality, and that improvement was greatest in homes which initially performed worst [5]. Following the introduction of separate outcome standards for hostels in 1992, continuing increases in compliance were reported in 1997 [6, 7].

Independent research and formal reviews have credited the changes made under the 1997 Act with addressing a number of the problems with the QA process as well as achieving continued quality improvements [8–10]. The most recent evaluation [3] recorded an increase in total compliance from 76% in 1999 to 90% in 2006 for homes assessed in two accreditation cycles. Inconsistency has nonetheless been a point of continuing complaint. Stakeholders’ concerns about inconsistent interpretation of standards and ratings by assessors were recorded in a recent audit of the accreditation process, which also flagged the state-based operation of the Agency as a possible source of inconsistency [9].

Consistency has been an issue in other QA systems. In the USA quality improvements following implementation of the nursing home standards by the Centers for Medicare and Medicaid Services (CMS) have been reported by Harrington and Carillo [11], but marked variations in quality outcomes were noted between states and over time. Identification of similar variations prompted Kelly et al. [12] to raise questions about inconsistencies in regulatory processes stemming from decentralization of quality surveying and related tasks that CMS contracts to state agencies.

In contrast, QA systems in England were centralized in 2009 when separate Commissions responsible for social care homes, health-care services and mental health services were brought together in the Care Quality Commission. The activities of the previous Commission for Social Care Inspection (CSCI) have been recognized as improving quality, in part by providing Local Authorities with quality ratings that can guide purchasing and by directing remedial action to poor quality homes [13], but there were concerns about consistency [14].

Is the risk of sanctions related to characteristics of homes?

The associations found between the risk of sanctions and characteristics of homes indicate that efforts to improve
quality need to take account of factors such as size, ownership and location of homes. Further, when changes in the provision of care homes over time are considered, the number of closures and transfers of beds resulting from sanctions is very small compared with the scale of the trend to increasing size of homes over the period [15]. This trend has rather been driven by capital funding needed for homes to meet building standards set out under the Aged Care Act 1997, and marginal operating viability of some small homes. Growth of provision by 31,310 beds from mid-1999 to mid-2008, an increase of 24%, was associated with a decline of 634 small homes (40 or fewer beds) as some exited the industry and others acquired more beds, and an increase of 497 in larger homes. These trends mean that the risk of sanctions associated with small homes should diminish over time.

Structural factors are also relevant to interstate differences in sanctions and the question of consistency in the QA process. The lower incidence of sanctions in New South Wales (NSW) may be in part because historically and currently, NSW has fewer small homes: from 2000 to 2008, the proportion of small homes fell from 41% to 27%, compared with 51% and 31% nationally. The two states with above-average incidence of sanctions, Victoria and South Australia, initially had above-average shares of small homes but converged to the national average over time. While the balance between sectors changed little over the period, Victoria had a persistently higher share in the for-profit sector, and the greater number of small, private, high-care homes may have contributed to the higher rate of sanctions in that state. Further, the possibility of inconsistencies in the operation of the Agency’s five state-based offices cannot be fully discounted as a factor contributing to interstate variation.

In line with the findings of the present study, the level of care provided was found to be related to quality in a Queensland study [16]. Homes offering both low and high care achieved significant improvements in medication management and infection control between the first and second accreditation cycles compared with homes providing only low care or high care. The former homes also had the highest ratings on human resource management and clinical care outcomes, although these relationships were not statistically significant.

A recent study of trends in the quality measures reported on the US Nursing Home Compare website found significant baseline differences related to facility characteristics (sector, size, etc.). It was concluded that while the CMS QA process had improved quality of care, the impact varied for different quality measures for different homes, for different residents and over time [17].

Do sanctions point to a need for more clinical indicators?

The findings that homes providing high care only were more likely to be sanctioned confirms the higher risk associated with caring for more dependent residents, and the frequency of sanctions requiring appointment of a nursing advisor lends support to calls for a standardized set of clinical QIs. The potential for clinical indicators to link QA to assessment of resident dependency for funding purposes has been flagged by Rosewarne [18]. Taking up this call, O’Reilly et al. [8] have developed and trialled a Clinical Care Indicators Tool [19] to establish 23 clinical indicators covering resident health, personal care, resident lifestyle and the care environment.

These developments parallel ongoing research into QIs in the USA in which many aspects of clinical indicators have been investigated. For example, clinical data from the MDS has been used to analyse relationships between changes in health status and quality of life [20] and ADL decline [21], and the issue of how risk should be adjusted to take account of differences in resident dependency has also been raised [22].

The need to expand QIs to include resident views of quality of life, and the difficulties of achieving this goal through the revised MDS have been canvassed in the USA [23, 24], and the usefulness of resident satisfaction as an indicator of quality of life has been demonstrated in a comparative study of homes in Western Australia and experience in the UK [25]. The recent evaluation of the Australian accreditation system [3] concluded that a resident-focused approach was central to driving further quality improvement and proposed the development of quality of life indicators and use of periodic staff and resident surveys to measure quality of care and quality of life.

Do sanctions provide useful information on quality to consumers?

As sanctions are rare, they not only provide limited signals of quality of care across all homes, but these signals can easily be distorted. Much more attention is given to the small minority of homes that are sanctioned than to the majority that meet the standards, and adverse media coverage of each new case of sanctions generates the view that poor quality care is typical and widespread, with damaging effects for residents, staff, providers and authorities.

The length and technical nature of the accreditation reports on each home means they are not user friendly. A major review of residential aged care in 2004 identified better dissemination of accreditation outcomes as a means of assisting consumers to compare homes on quality and promoting competition among providers [10]. In particular, proposals made for star ratings were supported by providers and others as a way of differentiating quality among the majority of homes that lie between the extremes of very low performing homes which are subject to sanctions and the handful of very high performing homes which receive commendations. Since late 2008, more quality information has been released by way of details of homes that are subject to a Notice of Non-compliance or Review Audit, but no move has been made on star ratings of the kind used in the USA and England.

Star ratings for overall quality, health inspections, staffing and quality measures are given on the US Nursing Home
Compare website (www.medicare.gov/NHCompare) to enable users to search and compare CMS quality data. The value of this more detailed information is supported in an investigation of quality report cards in 19 states [26], which found that information only on deficiency citations was insufficient to fully inform consumers, and that reports that included a wide array of data were most useful in assisting consumers to make informed choices.

In England, the CSCI increased access to quality information on each home by posting user friendly reports, written in plain English, on its website (www.cqc.org.uk), and including a star rating that summarized quality for each home to facilitate comparison between homes. A large-scale market research report [27] found virtually all Local Authority staff were aware of the reports and used them widely, but only around half of the relatives surveyed had used the ratings, and far fewer residents. Further, staff and relatives reported that other sources of information were equally or more important than CSCI ratings in the way they assessed quality.

Where do sanctions fit in the wider quality culture?

Formal QA processes that include sanctions operate in a wider quality culture that includes other measures that serve to improve quality or to increase identification of non-compliance. In Australia, the Aged Care Complaints Resolution Scheme operated under the Aged Care Act 1997 from 2000 until 2007 when it was replaced by the Complaints Investigation Scheme. Rates of complaints per 1000 places in aged care homes calculated from data in the Annual Report on the Aged Care Act 1997 show persisting interstate differences over the 7 years of its operation. In 2007, the range from a low of two complaints per 1000 places in NSW to 10/1000 in Victoria and 13/1000 in South Australia was broadly aligned with interstate variations in sanctions.

The Complaints Resolution Scheme was able to refer complaints to external bodies and 49% of the total of 1229 complaints received in the last year of its operation (2006–07) were referred to the Agency [28]. These referrals are one of the factors that can trigger a Support Contact Visit and the level of referrals thus feeds into variations in activities of the Agency in each state. Being informed that a complaint has been referred may, however, prompt a home to address the issues of concern, and reduce the likelihood of non-compliance being identified if a Support Contact Visit is triggered. Other advocacy bodies also contribute to distinct quality cultures in each state.

Even more widely, comparative research has shown the need to see QA systems for aged care in the context of national quality cultures. In the five-nation study carried out for AARP [29], Australia’s QA system was characterized as more consultative and collaborative compared with more emphasis on enforcement of contracts and consultation in Germany, regulation in the UK and USA, and group processes and workforce training as well as regulation in Japan. The use of strong enforcement was reported to be infrequent in all five countries.

Conclusions

Three sets of conclusions can be drawn from this analysis. Focusing first on the role of sanctions within the Australian QA system, the effectiveness of sanctions has to be interpreted within the framework of the regulatory pyramid. Analysis of intermediate levels of action in this framework shows that quality of care is subject to more intense scrutiny than is indicated by the rare imposition of sanctions; information on these actions is now publicly available and provides a fuller view of the QA process and quality in individual homes. Further, the finding that the risk of poor quality care was higher in homes caring for residents with higher levels of dependency endorses the call for further development of clinical indicators of quality of care.

Second, and turning to the wider context in which aged care systems function, the QA process works in conjunction with other factors that drive quality of care. Closures due to sanctions are a minor element in the substantial restructuring of the sector that has occurred over the last decade that has resulted in the increasing size of homes. The formal complaints resolution scheme and consumer advocacy also play complementary roles in governing quality of care.

While the former conclusions point to some areas where improvements could be made within Australia’s QA system, the latter conclusions show that the formal QA system is not the only means of monitoring and improving quality of care. It follows that continued quality improvement in Australia and elsewhere will not only depend on further elaboration and measurement of quality standards and more intense scrutiny of aged care homes but will also require recognition of and attention to wider contextual factors that contribute to quality outcomes.

Recognition of the wider quality cultures of different countries can assist in identifying other QA approaches that might be applied to support approaches that are narrowly focused on measurement and enforcement of standards. The range of approaches that has been discussed in the USA includes incentives such as quality-based payment systems [30], mediation through ombudsman programmes [31] and complementary roles in governing quality of care.

In this broader view, a suitably skilled workforce is the factor most widely recognized as affecting quality of care. Redfoot and Hauser’s comparative study of the USA, Japan and several European countries identified training and credentialing of migrant workers as critical to ensuring quality [34]. While immigrant care workers are not conspicuous in aged care in Australia [35], a national aged care workforce strategy was developed [36] and nation wide training programmes implemented to enhance quality of care by addressing staff shortages that have arisen in the strong labour market experienced in Australia over the last decade and currently.

The lessons that other countries might learn from this account of the role of sanctions in Australia’s aged care QA
system are three-fold. First, the contribution of sanctions stems more from their deterrent effect than from penalties they impose. Second, this deterrent effect depends on other levels of action taken in the overall QA system that is applied to aged care. Third, the regulation and enforcement of standards in aged care is supported by a number of other measures that uphold quality, such as complaints systems, training and workforce development. These complementary measures are not unique to QA in aged care but are consistent with wider quality cultures and address broader contextual factors that affect quality of care.

References


