Victorian Healthcare Association

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WHITE PAPER

Residential Aged Care: Finding the balance between red tape, quality and risk

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About the VHA

The Victorian Healthcare Association (VHA) is the peak body supporting Victoria's publicly funded health services to deliver high-quality care. Established in 1938, the VHA represents Victoria's diverse public healthcare sector, including public hospitals, community health services, public sector residential aged care services and bush nursing services. As well as providing a unified voice for the sector, the VHA advocates sector-critical issues on behalf of its members by engaging and influencing key decision-makers involved in policy development and system reform.

Executive Summary

Over the past five years, State and Commonwealth entities have introduced numerous compliance measures across residential aged care services in order to uplift sector quality and safeguard older Australians. While the VHA recognises the vital need for robust quality systems, these measures are cumulative and have a substantial impact on the sector. Public sector residential aged care services (PSRACS) are disproportionately impacted compared to private and not-for-profit providers due to their position within parallel care systems, including health services, aged care, NDIS, and mental health. This paper seeks to summarise the sector challenges in managing compliance across parallel care systems and briefly outline the opportunities for alignment and consolidation of processes.

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About publicly funded aged care services

Across the VHA's membership, residential aged care services are delivered across 171 public sector residential aged care services sites (most in regional and rural communities), which are either:

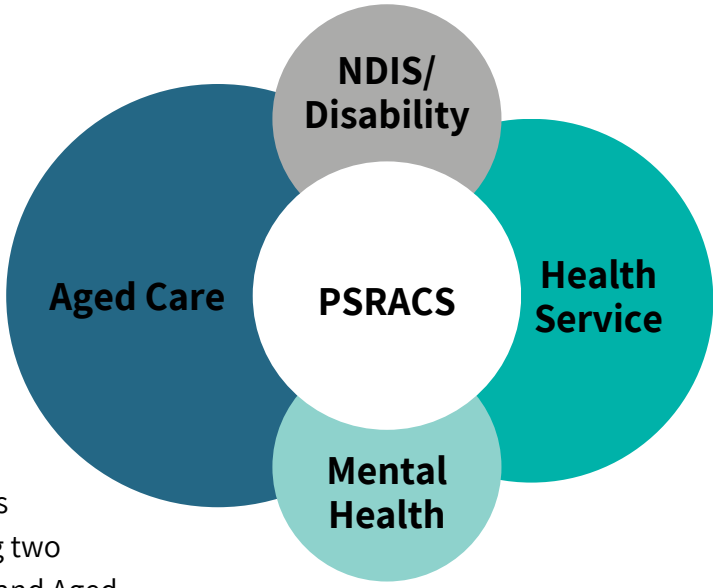
- Delivered as part of a broader health service offering. These health services are governed by a Board of Directors appointed by the Victorian Minister for Health, or
- Standalone (i.e., not connected to a health service).

Unlike most other states and territories, PSRACS are a unique service option in Victoria. The 171 sites include more than 5,000 residential aged care beds. This equates to approximately nine percent of all operational residential aged care beds in the state, compared to zero to four percent across other states and territories. In an environment of growing complexity for health services seeking to discharge older Australians from acute care, PSRACS offer an important service option for rural and regional Victorians who are unable to remain at home.

What we have heard from services

Caught in the middle of parallel regulation

Victorian's unique system design means that PSRACS occupy a challenging yet essential space between parallel care systems. While PSRACS primarily offer residential aged care services, they also intersect with health services and, on a smaller scale, mental health and the National Disability Insurance Scheme (NDIS) - all with different quality standards, reporting, auditing, accreditation, and compliance requirements.



Over the last five years, the compliance burden on services from parallel systems has significantly increased following two Royal Commissions (into Victoria's Mental Health System and Aged Care Quality and Safety) and the introduction of the NDIS practice standards.
The independent aged care news publication, Insider Ageing[1] stated that on average, providers reported a 32% increase in compliance since the Aged Care Royal Commission, and three out of four providers report it as a major issue.

1 https://insideageing.com.au/a-perfect-storm-in-aged-care/

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Services report that competing systems often lead to additional layers of compliance burden, such as duplicate incident reporting, complaints, quality, financial, and performance reporting to both state and Commonwealth entities. Several services note that the complexity of funding streams and reporting and compliance requirements across State and Commonwealth impacts their decision-making when accepting new residents.

An example of duplicative arrangements is that as a health service, PSRACS boards are appointed by the Victorian Minister for Health. However, as a residential aged care service, services must notify the Commonwealth within 14 days of a board member's appointment. As these appointments are made through an independent process, services often do not have access to the 'key personnel' information and are required to retrospectively follow up with board members post-appointment. It is a requirement that is difficult for services to meet within the notification timeline and is also duplicative and unnecessary. There is an opportunity to exclude PSRACS from this process, either by Commonwealth acknowledgement of the state's responsibility to ensure that board appointments meet the necessary skills and safety requirements or by the state assuming the reporting responsibility for all PSRACS as an embedded part of the health service board appointment process.

This example highlights one simple duplicative process between Commonwealth and state and between aged care and health. For PSRACS there are many of these examples for each of the parallel care systems they intersect with, including mental health and NDIS, resulting in a volume of duplication and waste.

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Case study - Large metropolitan service

This service is based in metropolitan areas with multiple sites and more than 190 residents. This service has a notable number of psychogeriatric beds and residents receiving NDIS funding.

This service highlights the following:

- There are incongruent policies between health services and aged care, although sometimes co-located, resulting in conflicting operational directions. For example, the PSRAC threshold for wearing marks differs from private providers due to their connection with health services.
- Frustration that the NDIS does not recognise their trained health service teams that support restrictive intervention and behaviour support processes for psychogeriatric residents, often resulting in duplicative processes.
- This service employs 0.8 FTE specifically to manage the compliance reporting requirements, not including the daily clinical and non-clinical personnel reporting contributions over the course of their shifts.

This service submits 125 external reports over a 12-month period through the Agency Information Management System (AIMS), Government Provider Management System (GMPS) and the National Aged Care Mandatory Quality Indicator Program (QI); this equates to approximately ten different points of external reporting every month.

Recognition of expertise and safeguards

As PSRACS are part of a health service they have robust governance and governance mechanisms in place and access to a highly skilled workforce. There is an opportunity to recognise the level of oversight and safeguards to consolidate or align parallel reporting requirements. All services contributing to the set of case studies spoke of the challenge of duplicative compliance within PSRACS and questioned why there are no additional exceptions for services that are successfully operating in these already highly regulated environments.

Fragmented and manual systems don’t speak the same language

Reporting within services is fragmented by topic, funder, and accountable agency. Reporting requirements often use system-specific definitions for terms that do not align with sector systems. For example, the definition of ‘employed’ for workforce reporting under the aged care National Quality Indicator Program is based on a threshold number of hours within a set period, which means that despite working a shift, an employee may still not meet the workforce data definition of employed.

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Sector-specific definitions often mean services rely on manual reviews and processes, with several services describing the workforce data submission as 'taking hours' to manually adapt prior to submission.

In addition, information is often duplicated in reporting across multiple platforms such as AIMS, GPMS, Services Australia and My Aged Care; systems often have varying language and exclusion criteria, contributing to the rates of manual adaptation required at the service level.

Case study - Large metropolitan service

This service is a large provider based in metropolitan areas with multiple sites and more than 110 residents.

This service highlights the following:

- The time taken to submit workforce data via manual collection and adaption processes due to the definition of 'employee' and 'hours'. This service raises challenges with reporting thresholds and the need for supplementary explainer information outside a specific figure. This adds additional and often unseen workload to the process.
- The information statement received from Services Australia is reformatted and submitted to the State. Raising additional opportunities to streamline data submissions.

Case study - Small regional service

This service is a small provider based in rural and regional areas. It has a single site, less than 60 residents, and several residents receiving NDIS funding.

This service highlights the following:

- Concern about the ability of systems to cope with the reporting requirements and often resorts to manual workarounds to compensate. For example, GMPS cannot upload more than three documents at a time, and key personnel data submissions don't always accommodate culturally sensitive naming conventions, e.g. the submissions require a first name and last name.
- This service raises the risk of compliance burden contributing to a single point of failure, particularly on smaller, more rural services, where the skills and experience often fall to one person within the service.

This service submits 129 individual data points each quarter through the QI program, equating to approximately 516 data points over a 12-month period.

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The value of reporting can be unclear

Several services report that the value of external reporting is often unclear at the frontline level and perceived to be sparked by requirements rather than quality practice provision. With one service submitting 125 external reports within a 12-month period, members question the reporting volume versus its impact on quality service delivery. There are also questions about the active use of data, as members query whether reports are effectively used if they are evaluated by artificial intelligence (AI).

Each reporting element contributes to the time frontline staff spend in direct care minutes supporting older Australians. While the VHA recognises the value of an accountable sector, sector capacity should be directed at innovative and quality delivery rather than keeping up with compliance, of which the value is sometimes unclear.

Case study - Medium regional service

This medium service is based in rural and regional areas, with multiple sites and more than 70 residents.

This service highlights the following:

- Frustration with the volume of reporting under the National Quality Indicator Program and the proposal of an expanded program, including the inclusion of community settings.
- This service raises the opportunity to streamline auditing requirements through communication and consolidation of the assessment process, assessing the service overall rather than by separate sites.

This service has submitted 69 external reports within a 12-month period. This service has had 15 external audits in the last 12 months, and on one occasion, two auditing teams from different agencies attended the service on the same day.

The sector is bracing for more compliance

While PSRACS falls under the umbrella of a health service, the health service standards are not always appropriate for the residential aged care environment and are not comparable to the standards applicable to private and non-profit aged care providers. While the Victorian government recognises this incongruence and burden through the provision of top-up funding, services still report fatigue from the combination of Commonwealth and State-based requirements.

PSRACS are already bracing for more compliance, with the Commonwealth planning to expand the National Quality Indicator Program by introducing three new staffing indicators. Services raise that they already report on 129 different data points as part of the existing program.

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Services are frustrated that growing compliance requirements are taking staff away from caring for residents. Additionally, changes under the Aged Care Act and NDIS reform will likely result in additional compliance measures.

While the change from accreditation to a registration model under the Aged Care reforms is predicted to streamline processes, there is an additional opportunity to further streamline sector compliance through the introduction of the Local Health Service Networks in 2025.

Recommendations:

- The VHA recommends investigating opportunities for further harmonisation of Commonwealth and State base compliance.
- The VHA recommends identifying opportunities to streamline Commonwealth and State reporting processes through platform, timeframe and process consolidation to increase efficiency and reduce the impact on services.
- The VHA recommends further recognition of the expertise and safeguards within PSRACS and a review of the balance across parallel systems such as health service, NDIS, mental health and aged care compliance.

Conclusion

The VHA recognises that a high-quality aged care system must safeguard and respect the rights of older Australians and be innovative, efficient, and well-governed. However, as outlined in this paper, VHA members are concerned that the strengthened regulation has not yet struck the right balance between incentivising quality practice and over-burdensome and duplicitous compliance.

The VHA recognises that the upcoming implementation of the Local Health Service Networks poses an opportunity for sector review, including but not limited to compliance systems.

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Appendix 1 - Examples of compliance reporting mechanisms across Aged Care and parallel systems

External reporting requirements

Quarterly national quality indicators

- Pressure Injuries
- Physical Restraint
- Unplanned Weight Loss
- Falls and Major Injury
- Medication Management
- Activities of daily living
- Incontinence care
- Hospitalization
- Workforce
- Consumer experience
- Quality of life
- State-based indicators

Quarterly financial reporting

- Viability and Prudential Compliance Questions
- Year-to-Date Financial Statements
- Residential Care Labor Cost and Hours Reporting
- Quarterly Food and Nutrition Report
- Home Care Labor Cost and Hours Reporting

Other

- Care minutes
- AN-ACC scores, number of residents
- Respite places and new admissions
- Demographic classifications
- Statutory duty of candour
- Medication, including PPIs
- Workforce reporting – 24/7 RN
- Vaccination data
- Use of agency staff

Annual service operations reporting

- Executive position details
- Governing body membership
- Statement signed by the governing body they did or did not comply with its duty
- diversity information
- Kind of feedback and complaints

Annual financial reporting

- Statement of Financial Performance
- Statement of Financial Position
- Statement of Changes in Equity
- Notes to the Financial Statements
- Prudential Compliance Questions

External auditing requirements

- Aged Care Quality and Safety Commission
- Local council – food and kitchen audit
- Food and dining experience
- Fire inspection
- Hand hygiene
- NDIS Quality and Safeguards Commission
- Community Visitors
- Infection control monitoring
- Covid – emergency preparedness
- Financial audits – resident agreements
- NSQHS Standards
- Prudential audit
- Care minute audit
- Workforce audit
- Medication compliance audits
- VAGO auditing

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