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FELLOWSHIPS
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PUBLIC POLICY

Improving the Quality of Age-Related Residential Care through the Regulatory Process

Prepared by
April Ferrino

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April Ferrino
Wellington, August 2013

EXECUTIVE SUMMARY

The need for long-term care services and supports for older adults¹ is immediate and overdue in many countries. With each passing day, the timeliness of this issue increases because the proportion of the world's population age 60 years and older grows. With the increasing longevity comes the need for long-term care services and supports to assist persons to maintain their ability to perform daily activities and routines.

Long-term care is a broad term used to describe the type of assistance with daily activities that older persons and persons with disabilities receive to minimise, rehabilitate, or compensate for the loss of independent physical or mental functioning. Long-term care for older adults and persons with disabilities occurs on a continuum and may be provided in many settings ranging from institutions, also called residential care², to a person's home, also known as community- or home-based care. In this report age-related long-term care refers to services and supports specifically needed by older adults because of age-related illness or injury.

Despite the vast differences in the New Zealand and US regulatory systems for age-related residential care, one country's system is not superior to the other. Each has its own characteristics stemming from their respective country's origins and development. Each country continues to grapple with quality of care issues. Neither has been exempt from the reporting of poor quality and negligent outcomes that have affected elders in these facilities.

Society's concept of what high-quality aged residential care is continues to evolve. In the US, data collection is the cornerstone of its aged residential care quality improvement processes. The US is currently integrating its use to improve its regulatory inspection process for age-related residential care. Ensuring quality health services in New Zealand is a shared responsibility among many entities and supported by legislation and contractual agreements.

The examination of how to improve the quality of care in age-related residential facilities begins with the regulatory process. Because regulations are the minimum standard set forth by governments for service providers, regulations are a natural starting point for consumers and stakeholders to form a judgement whether the care provided is of adequate quality and how it could be improved.

Several recommendations in this report to support quality improvement make use of ideas or practices that have been implemented for many years in the US. The ideas suggested are universal and can be readily adopted in New Zealand with necessary modifications. Each also has ample evidence and research for New Zealand stakeholders to use when considering their implementation. The ten recommendations are grouped into four themes to address gaps and strengthen current efforts to support quality improvement efforts. These themes are:

- Incentivise Person-centred Care,
- Assist Providers with Quality Improvement,

¹ Older adults/person is defined as persons age 65 and older.

² Residential care is here defined as on-going live-in care provided in a congregate setting. Literature demonstrates no consensus for the definition of "residential care" because the nature and scope of services vary tremendously.

- Expand Penalty and Sanction Options for Regulators,
- Use Data and Technology to Support Quality Improvement Efforts.

Three additional issues are identified that are intrinsically linked to improving the quality of age-related residential care and worthy of close monitoring by the government and all long-term care stakeholders. They are: (1) formalise investigations and data collection on elder abuse, neglect, and exploitation, (2) publicly release the names of deficient providers, and (3) standardise healthcare assistants' training requirements. Ignoring these issues for any additional length of time may be to the detriment of the aged care sector.

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INTRODUCTION

The quality of care provided in nursing homes across the US has been under scrutiny for decades. Stronger regulations, closer scrutiny, and hefty penalties have been enacted to deter the provision of substandard care. New Zealand's regulatory system sits at the other end of the spectrum from the US model. It is based on a compliance model allowing for providers to learn from standards violations and bilateral cooperation. New Zealand's regulatory standards are outcome-based allowing providers the freedom to meet them in a myriad of ways. However, both countries continue to face serious concerns about the quality of care in residential care facilities.

Quality improvement in long-term care is a massive topic; and for this reason I focus on one aspect, how quality improvement can occur through the regulatory process. Regulations for residential care facilities, such as nursing homes, are the minimum standards that must be met to operate legally. The purpose of this report is to put forth ideas to encourage quality improvements to assist providers not only to meet the minimum requirements, but to exceed them. The ideas include both short-term, low-cost ideas and long-term ideas that would require investment budgeting (pay now to reap savings later). The goal of each recommendation is to enhance the regulatory system so that it fosters greater awareness and adoption of quality improvement practices, thereby resulting in improved quality of care for residents.

Chapter 1 provides a brief overview of the New Zealand and US long-term care systems with a focus on aged residential care. The overview includes information about the aged residential care population, access, funding, and costs. Chapter 2 discusses age-related care regulation: its models, influences, and significant regulatory reform efforts. Chapter 3 begins the discussion about quality improvement efforts in New Zealand and the US. Chapter 4 provides ten recommendations how New Zealand can support quality improvement efforts in age-related residential care. Finally, Chapter 5 highlights three issues New Zealand long-term care stakeholders, chiefly the government, should monitor closely because of their gravity and profundity to impact age-related residential care.

1 AGE-RELATED LONG-TERM CARE OVERVIEW

The need for long-term care (LTC) services and supports for older adults³ is immediate and overdue in many countries. It is an especially timely issue because the proportion of the world's population age 60 years and older is growing rapidly. With the increasing longevity comes the need for LTC services and supports to assist persons to maintain the ability to perform daily activities and routines.

LTC is a broad term used to describe the type of assistance with daily activities that older persons and persons with disabilities receive to minimise, rehabilitate, or compensate for the loss of independent physical or mental functioning. LTC for older adults and persons with disabilities occurs on a continuum and may be provided in many settings ranging from institutions, also called residential care⁴, to a person's home, also known as community- or home-based care. In this report age-related LTC refers to services and supports specifically needed by older adults because of age-related illness or injury.

Long-Term Care Continuum

The age-related LTC continuum consists of formal and informal providers. Formal providers are trained and paid caregivers and can include congregate settings such as rest homes and geriatric hospitals in New Zealand and assisted living facilities and nursing homes in the US. Informal providers bring care to the individual's place of residence and are unpaid caregivers such as family members, neighbours, friends, volunteers from religious and community organisations.⁵ Both types of providers vary in the level of care they provide.

Age-related residential care providers in New Zealand and the US offer similar types of services; however, each country uses different nomenclature for the settings and definitions for levels of care. Moreover, a setting in one country, such as a rest home in New Zealand may not correspond exactly to a similar setting, such as assisted living, in the US. The US residential care service continuum includes adult foster care homes, board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities. Figure 1 provides brief descriptions for each type of setting.

³ Older adults/person is defined as persons age 65 and older.

⁴ Residential care is here defined for this report as ongoing live-in care provided in a congregate setting. Literature demonstrates no consensus for the definition of "residential care" because the nature and scope of services vary tremendously.

⁵ Institute of Medicine (IOM, 2001), p. 41 and 59

Figure 1: US Residential Care Descriptions, 2011

Type of Care	Description
Board and Care Homes	Group homes, privately owned, usually with 20 or fewer residents. Residents receive personal care and meals, but nursing and medical care are not provided.
Assisted Living	Privately owned, usually with 20 or more persons. Residents live in own rooms and share common areas. Services provided are personal care, meals, social activities, housekeeping, laundry, and medication assistance.
Nursing Homes	Highest level of care offered. Nursing care supervised by registered nurse, 24-hour supervision with licensed nurses. Other services: three meals/day, assistance with activities of daily living, social activities, and rehabilitation services.
Continuing Care Retirement Communities	Provide different levels of care (independent, assisted living, nursing home) in one location. Meals, healthcare services, and activities are offered, but vary by care level.

Source: US National Institutes of Health.

New Zealand age-related residential care continuum contains two types of facilities, rest home and geriatric hospital, that differ by the level of care provided. Each type has a subtype that provides care for those with dementia-related illnesses. New Zealand rest homes may be considered similar to the US assisted-living facilities because they typically are home to residents that have stable medical conditions and do not require the presence of a registered nurse 24-hours-a-day. Geriatric hospitals are a close equivalent to US nursing homes.⁶ People who are highly dependent and/or have complex care or medical needs that require the presence of a registered nurse 24-hours-a-day receive care in this setting.⁷ Unlike in the US, some New Zealand facilities provide both rest home care and geriatric hospital care in the same facility. Figure 2 shows the types of facilities and their level of care that most closely resemble each other in New Zealand and the US.

⁶ Whitehead, N. pers. comm. 4 Jan 2013

⁷ Whitehead, N. pers. comm. 4 Jan 2013

Figure 2: New Zealand and US Formal Care Settings for Older Adults, 2013

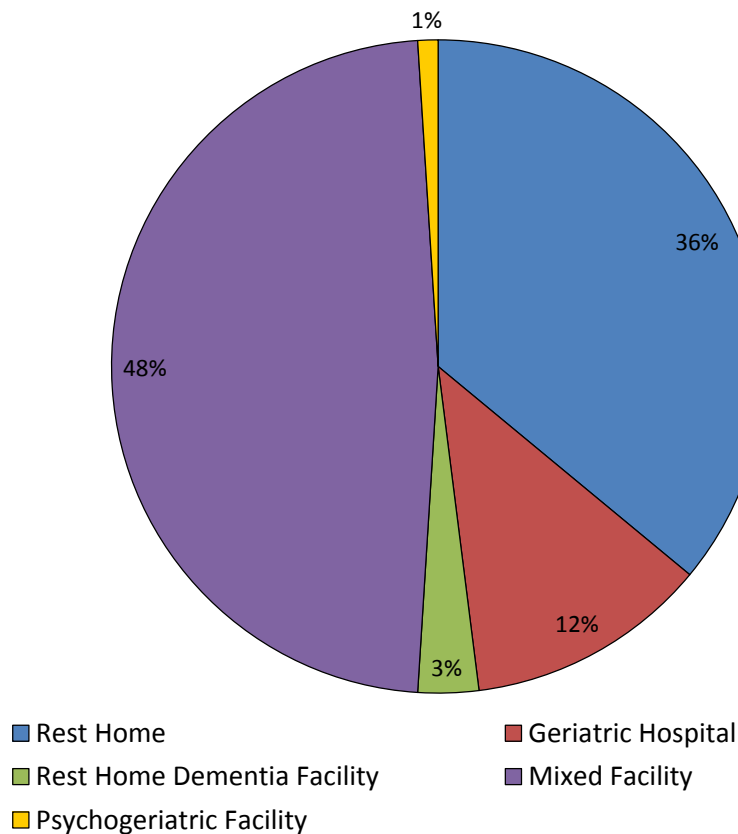
New Zealand				
Rest Home	Rest Home Dementia Care	Geriatric Hospital	Psycho-geriatric Hospital	Surgical/Acute Care Hospital
Less Care			More Care	
Assisted Living	Nursing Home and Dementia Care			Surgical/Acute Care Hospital

USA

Source: Institute of Medicine and New Zealand Ministry of Health.

Figure 3 shows the percentage of each type of age-related long-term residential care providers in New Zealand.

Figure 3: New Zealand Age-related Residential Care Facilities by Provider Type, 2010



Source: Grant Thornton.

Long-Term Care Population Growth

Researchers predict the worldwide older adult population to increase from 10 per cent in 2005 to 22 per cent by 2050.⁸ In New Zealand, as of 2007, 13 per cent of the New

⁸ Wieland (2012)

Zealand population was 65 years or older and projected to increase to 22 per cent by 2030 and then expand further to 25 per cent by 2050.⁹

In the US similar projections are forecast, but the proportion of older adults to the overall population is not expected to rise to the levels forecast for New Zealand. According to the US Administration on Aging, in 2005 36.7 million or 12.4 per cent of Americans were age 65 and older and by 2030, the population is predicted to increase to 71.4 million or nearly 20 per cent.¹⁰ By 2050, the number of older Americans is projected to be 88.5 million, but proportionally will remain around 20 per cent.¹¹ In both New Zealand and the US, the “baby boomers” or persons born between 1946 and 1964 are largely responsible for this increase in the older population because they began reaching age 65 in 2011.¹²

Despite the vast difference in each country’s total population, currently the fastest growing age group in both New Zealand and the US is people age 85 and older. In New Zealand, this age group is expected to grow to 250,000 by the middle of the century,¹³ while in the US by 2030 this group is predicted to be 2.6 per cent of the total the US population or 9.6 million.¹⁴

Accessing Age-Related Residential Care

US Access

Currently, there is no national US system of long-term care insurance. Persons are required to rely on their own resources until they are almost depleted, and then apply for benefits from the joint federal-state Medicaid programme.¹⁵ All states are federally required to cover nursing home benefits as part of the Medicaid programme. To qualify for Medicaid benefits, persons need to be age 65 and older or disabled and have very low incomes and limited assets (e.g. savings accounts).

The US government defines nursing home care as health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition. The need for nursing home services is defined by each state that establishes criteria to determine eligibility for receiving this level of care.

When an individual requires long-term care, eligibility is determined based on a functional needs test and an income/resources test to determine if a person qualifies for Medicaid benefits. Medicaid should not be confused with Medicare, a federal social insurance programme that provides health coverage for individuals ages 65 and older and for younger people with permanent disabilities.¹⁶ The Medicaid programme finances 40 per cent of all long-term care spending, and more than 6 of every 10 nursing home residents’ care is paid by Medicaid.¹⁷

⁹ Booth, Miller, and Mor (2007)

¹⁰ US Administration on Aging. “Projected Future Growth of the Older Population,” (2013)

¹¹ US Administration on Aging “The Next Four Decades” (2013)

¹² US Administration on Aging “The Next Four Decades” (2013)

¹³ Statistics New Zealand. (2013)

¹⁴ Project Growth of Older Population by State (2013)

¹⁵ Kaiser Edu. (2013)

¹⁶ Kaiser Family Foundation “Medicare Primer,” (2010)

¹⁷ Kaiser Family Foundation. “Medicaid Primer,” (2013)

Federal law specifies a set of benefits that state Medicaid programmes must provide and a set of optional benefits that states may choose to provide. The Medicaid programme is the main source of coverage and financing for long-term care because nursing home care is a federally mandated benefit. Approximately 10 million Americans require long-term care.¹⁸ Half of them are older adults and half are children and working-age adults with disabilities.¹⁹

Medicaid eligibility varies by state. In some states eligibility for other government benefits can automatically qualify an individual for the Medicaid programme. For example, in Texas all people eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. SSI is the federal cash assistance programme for low-income people age 65 and older and those with disabilities. The 2012 monthly income limit to qualify for SSI is US\$698 per month with an asset limit of US\$2,000. Persons who do not qualify for Medicaid are required to “spend down” their assets by paying for needed long-term care services “out-of-pocket” until their assets (excluding their primary residence) and income are below a level that will qualify them for Medicaid.

In 2010 the US Health and Human Services Department reported that there were approximately 1.7 million nursing home beds in 16,000 Medicare and/or Medicaid certified nursing homes. Between 2000 and 2010, the nursing home bed occupancy for the US was stable at 82 per cent. According to the U.S. Census Bureau in 2010, 1.3 million or 3.1 per cent of Americans age 65 years and older resided in a nursing home.

New Zealand Access

New Zealand has a higher proportion of its citizens in residential care²⁰ than other member countries of the Organisation for Economic Co-operation and Development (OECD).²¹ According to the New Zealand Aged Care Association (NZACA), the use of institutional care is on the rise and they estimate that more than 31,000 people currently receive care in nearly 700 age-related residential care facilities across the country.²²

To access government subsidised residential care in New Zealand, a person must meet certain age requirements and have a needs assessment and a financial means assessment. Persons must be age 65 or older to enter residential care. The needs assessment performed by the District Health Board²³ (DHB) determines the person’s level of need. Based on the assessment, a person’s needs will be determined to be very low, low, medium, high, or very high. Once a person qualifies for residential care, a financial means test will determine if a person is also eligible for the government’s residential-care subsidy. The financial means test comprises an asset and an income test.

The residential care subsidy is provided by the Ministry of Health (MOH) to the DHBs. It assists with the cost of contracted care for clients in long-term residential

¹⁸ Kaiser Family Foundation. “Medicaid Primer,” (2013)

¹⁹ Kaiser Family Foundation. “Medicaid Primer,” (2013)

²⁰ New Zealand age-related residential care includes rest homes, dementia-specific rest homes, geriatric hospitals, and psycho-geriatric hospitals.

²¹ New Zealand Green Political Party (2010)

²² Ministry of Health “Premium-only Aged Residential Care” (2012)

²³ DHBs are regional entities, created in 2001, to provide or fund health services in their district.

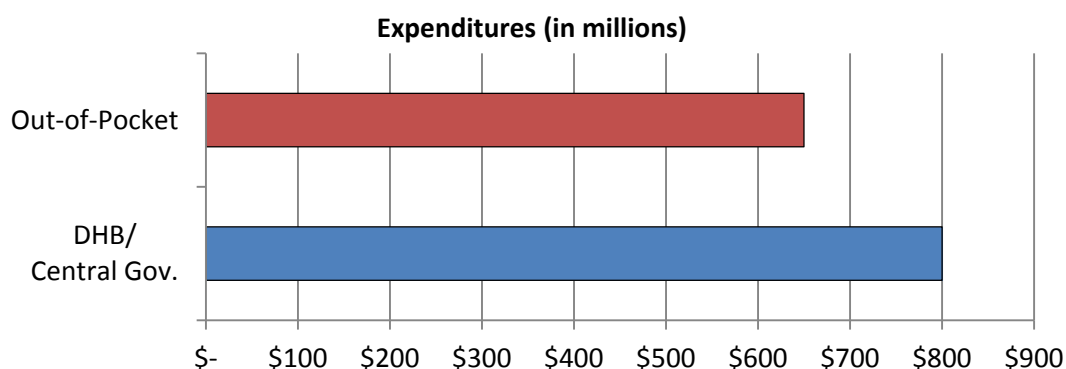
care. The amount of subsidy is the difference between the cost of contracted care and the amount a client is required to contribute for that care. If the financial means test shows that a person's assets are equal to or below the established threshold, the person would qualify for the subsidy. Persons receiving the subsidy pay all of their income, including their New Zealand Superannuation, towards the cost of their care, apart from a personal allowance of \$42.58 a week (plus a \$266 annual clothing allowance and \$945 a year of income from investments).²⁴ DHBs make up the difference between the amount the resident pays and the cost of their care.²⁵ The amount qualified persons would be required to pay would be an assessed amount up to the maximum contribution (as determined by the government for their area) towards the cost of care. As of July 2013, the asset threshold is \$215,132 for single people or a couple when both are in care. An alternative asset threshold is \$117,811 where the family home, car, and a pre-paid funeral of up to \$10,000 are exempt as assets. The thresholds are adjusted each year in July according to the Consumer Price Index.

Age-Related Residential Care Funding and Costs

The 2010 Aged Residential Care Services Review (hereafter referred to as the Review) was commissioned by age-related residential care industry providers and DHBs to assess the cost, capacity, and service delivery of the age-related residential care services. The Review identifies the average occupancy rate for New Zealand rest homes to be 91 per cent, and geriatric hospitals and dementia facilities to be 93 and 96 per cent, respectively.²⁶ Sixty-nine per cent of New Zealand providers consist of facilities with 26 to 75 beds, according to the Review.

More payers contribute to long-term care spending in the US than in New Zealand. Figure 4 shows New Zealand pay sources for all age-related residential care in 2009/10. Figure 5 shows the projected 2012 expenditures by source for one type of long-term care, nursing home care, in the US. Figure 6 illustrates the percentage each source is projected to pay.

Figure 4: New Zealand Age-related Residential Care Payers and Expenditures, 2009/10



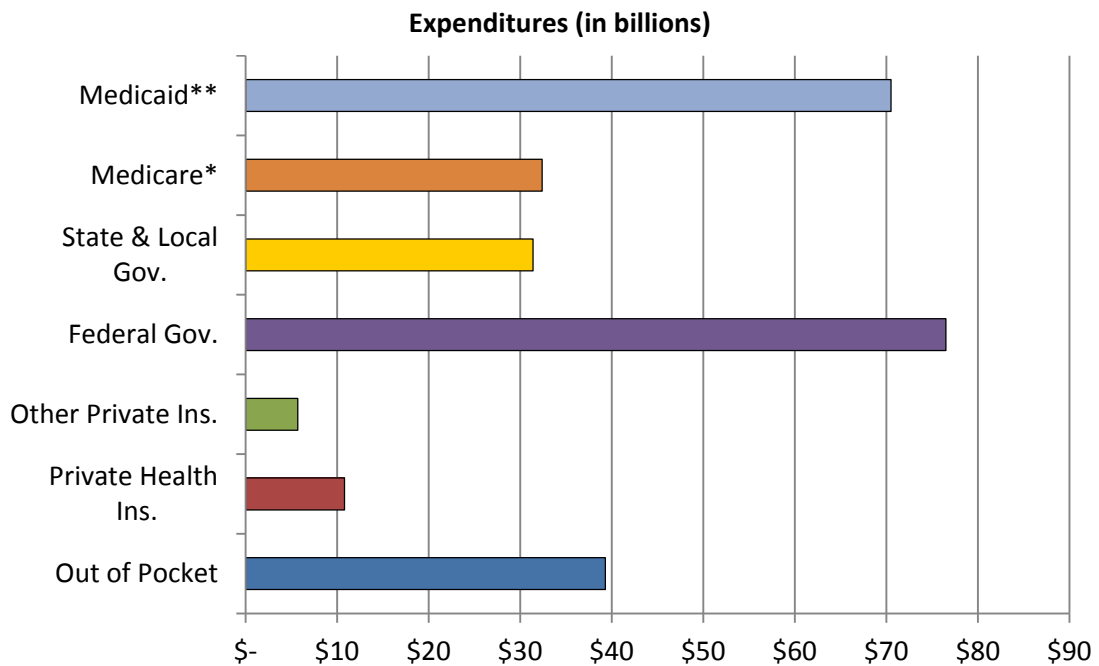
Source: New Zealand Association of Economists.

²⁴ Judge, R. pers. comm. 10 Jul 2013

²⁵ Judge, R. pers. comm. 10 Jul 2013

²⁶ Grant Thornton (2010)

Figure 5: USA Nursing Home Payers and Projected Expenditures, 2012

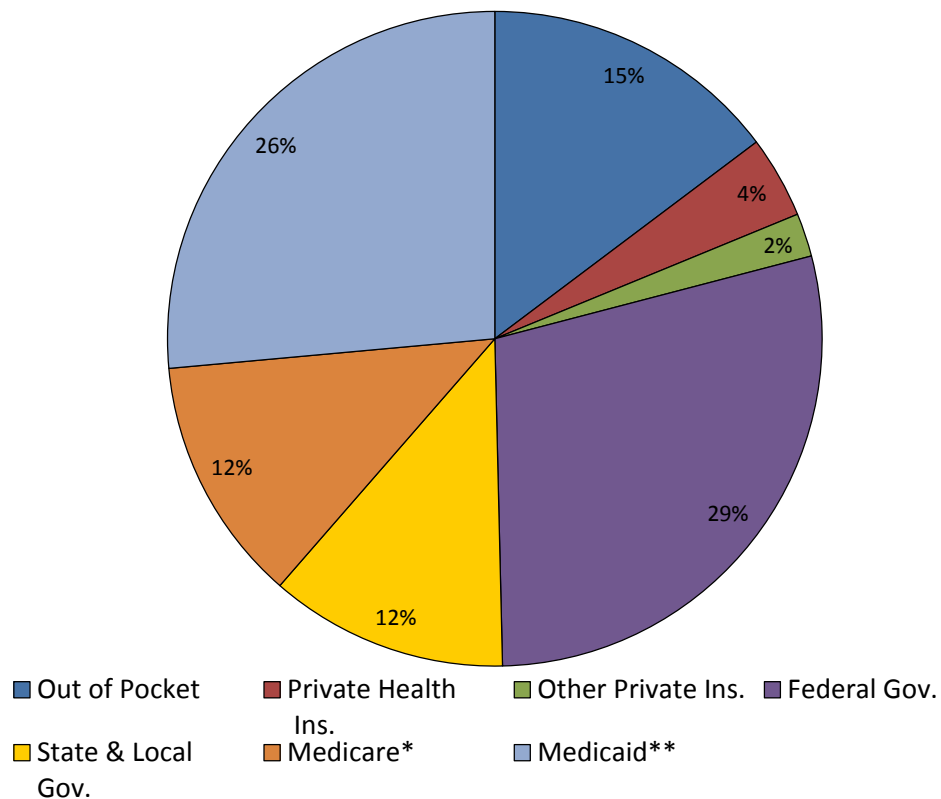


*Medicare is a subset of federal government expenditures.

**Medicaid is a subset of state, local, and federal government expenditures.

Source: Centers for Medicaid and Medicare Services.

Figure 6: Projected US Nursing Home Expenditures by Percentage and Source, 2012



*Medicare is a subset of federal government expenditures.

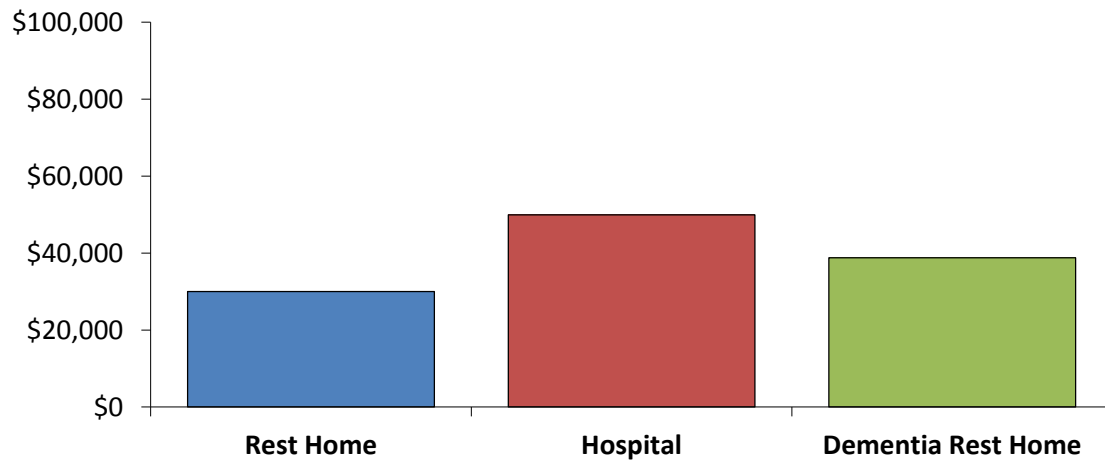
**Medicaid is a subset of state, local, and federal government expenditures.

Source: Centers for Medicaid and Medicare Services.

Residential care in New Zealand experienced significant changes in the last ten years with the ownership of facilities shifting from individual and local private providers to for-profit foreign and corporate-owned facilities. As of 2012, industry analysts report that New Zealand’s age-related residential care sector is made up of 78 per cent for-profit and 22 per cent of non-profit providers,²⁷ compared to the US’s composition in 2009 of 67 per cent for-profit, 27 per cent non-profit providers, and 6 per cent government-owned.²⁸

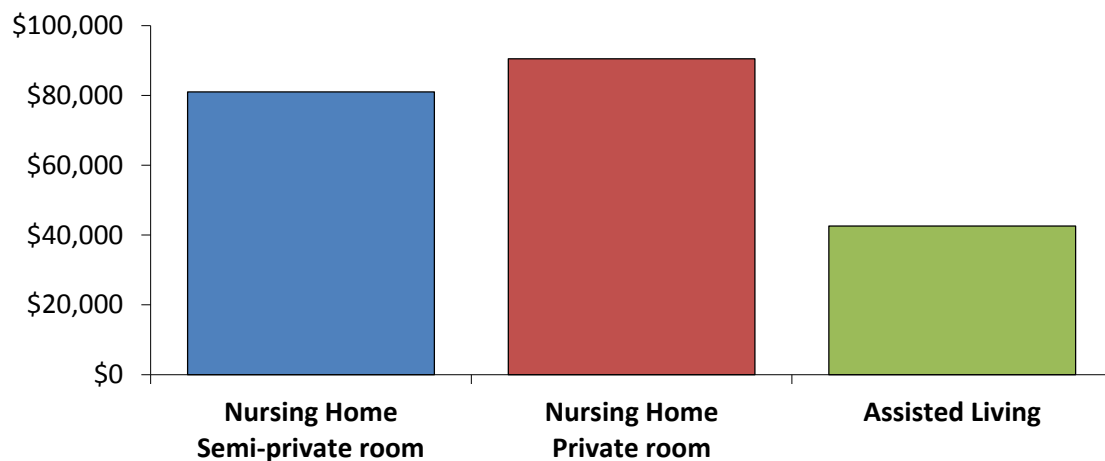
The cost of residential care in both countries varies widely. Data is not available to conduct a side-by-side comparison of costs because service requirements, staffing ratios, and administrative requirements vary greatly between the two countries. Figures 7 and 8 show the estimated operating cost by setting for New Zealand age-related residential care and the consumer costs by residential care setting for USA, respectively.

Figure 7: Estimated Annual Operating Costs per Resident for New Zealand Age-Related Residential Care, 2010



Source: Grant Thornton.

Figure 8: Estimated Annual Average US Consumer Costs per Resident for USA Residential Care, 2012



Source: MetLife Survey of Long-Term Care Costs.

²⁷ New Zealand Aged Care Association “2012 Conference Documents,” (2012)

²⁸ Centers for Medicaid and Medicare Services. (CMS, 2010)

2 AGE- RELATED RESIDENTIAL CARE REGULATION

Theoretical Regulatory Models

Research identifies the two ends of the regulatory continuum as deterrence and compliance.²⁹ A system of deterrence is characterised as adversarial and punitive, with the intent to deter any wrongdoing. Walshe (2001) identifies that deterrence regulation achieves change quickly, but may be more expensive and result in defensive behaviour from the regulated organisations. The other regulatory style is compliance. According to Day and Klein (1987), the compliance model emphasises prevention and encourages the use of time and money to improve situations. The relationship between the regulator and the regulated entities is supportive and cooperative to achieve compliance.³⁰ The compliance model is less expensive, but may be easily undermined.³¹

A blend of the two models discussed in recent literature is responsive regulation. It is characterised by the ability of the regulating body to adapt its regulatory response to the behaviour of the regulated entities by using both deterrent and compliance methods to achieve the desired response.³² Responsive regulators are able to adapt because they have at their disposal a wide range of credible sanctions that ensure providers' compliance.³³

The type of model notwithstanding, any regulatory structure is subject to the sway of various influences. Regulators are not immune from influence whether they are external or internal forces that can affect how they operate. A growing body of literature identifies multiple influences affecting healthcare regulation. Two influences: regulator discretion and political are discussed below. The use of objective data to mitigate these influences will be discussed later in the report.

Regulator Discretion

Day and Klein (1987) point out that using discretion in the regulatory process of aged residential care is an inevitable result of translating regulatory laws and guidelines into day-to-day interactions between regulators and regulated entities.³⁴ Inspecting facilities is rarely a straightforward process, and actions and situations “do not speak for themselves,” but require the interpretation of trained professionals to make a judgement whether a violation of the standards has occurred.³⁵ For example, it would need to be determined if a bruise on a resident was the result of fall, medication side-effect, abuse, or another cause. If the bruising resulted from a fall or medication, was it related to neglect or an error by facility staff or was it an innocent consequence of a resident's daily actions? Depending on the answers, the regulator would take different, if any, actions.

²⁹ Day and Klein (1987)

³⁰ Walshe (2001)

³¹ Walshe (2001)

³² Walshe (2001)

³³ Baldwin and Black (2007)

³⁴ Day and Klein (1987)

³⁵ Day and Klein (1987)

Bureaucratic Influence

Regulators are accountable to elected officials and the public for their actions. Tensions arise when regulators must take politically unpopular actions in order to protect public safety or to remain consistent in their judgement. To maintain their credibility, Walshe (2001) identifies that regulators must be perceived as independent from influence and act as a “nonpartisan honest broker” for stakeholders.³⁶ In particular, nursing home regulators oversee an industry responsible for caring for a frail and vulnerable population where inconsistent or lax performance may result in significant impact to their quality of care.

The effect of internal influences on a regulatory entity should not be overlooked. Day and Klein (1987) refer to “street-level bureaucracy” as the difficulty any organisation has in getting its field staff to implement agency policy.³⁷ Inevitable tension exists between the objectives of the regulating entity and the desire of the regulatory staff to use their own discretion and apply their professional judgement skills to their job.³⁸ For example, some staff may view their job to act as a resource that offers advice to providers about how to comply with the standards. These actions can blur regulators’ role as being neutral and independent. Moreover, their actions may create conflicts of interest, generate inconsistent enforcement, and if guidelines are not in place, may conflict with the regulatory philosophy of the governing body, especially if it adheres to a deterrent philosophy.

Differences in US and New Zealand Regulatory Approaches

The US regulation of nursing homes is an example of deterrence regulation. It has a highly prescriptive federal process for nursing home inspections and provides a range of penalties to levy on offenders. The relationship between regulators and nursing homes is adversarial and formal. Its historical underpinnings stems from long-standing concerns about nursing homes’ poor care and quality problems. Prior to 1987, US nursing home regulation varied by state and according to Walshe (2001), many states used a compliance model that allowed facilities to consistently ignore regulations, and regulators did not have sufficient options to manage noncompliant institutions.

The US federal and state governments share responsibility for the regulation of nursing homes; however, the cost for nursing home inspections is shouldered primarily by the federal government. The federal agency, Centers for Medicaid and Medicare Services (CMS), is responsible for setting nursing home standards; interpreting federal regulations, guidelines, and policies; as well as establishing and monitoring inspection procedures.³⁹ The federal government contracts with state governments for state workers to conduct unannounced annual inspections of nursing homes that determine whether they meet the minimum CMS quality and performance standards.⁴⁰

New Zealand’s rest home regulation has many characteristics of compliance regulation. The regulatory inspection is called an audit and does not have the

³⁶ Walshe (2001), p. 138

³⁷ Day and Klein (1987), p. 330

³⁸ Day and Klein (1987)

³⁹ CMS “About Inspections” (2013)

⁴⁰ CMS “About Inspections” (2013)

prescriptive structure or as many regulatory standards as the US model. Regulatory resources are allocated by need as demonstrated by audit findings. Facilities that have poor regulatory audit results are audited more often. This is indicative of responsive regulation by matching the regulatory resources to providers' behaviour; however, New Zealand's system lacks an array of penalty options. Furthermore, New Zealand's rest home industry is characterised by a collaborative and interactive relationship between the New Zealand Aged Care Association and the MOH staff who ensure the regulatory standards are met.

Unlike the US, New Zealand age-related residential care providers are not certified annually, but may have certifications ranging from 6 months to 5 years. Certification inspections are not conducted by government employees, but by third-party accredited entities known as designated audit agencies. Additionally, age-related residential care providers select and pay for designated audit agencies to conduct certification inspections. The MOH reviews the audit reports and determines certification length. In 2009, the Office of the Auditor-General (OAG) noted in its report that the design of the system for certification has some inherent risks because it allows rest homes to choose their audit agency and pre-arrange the date and time of the certification inspection. Moreover, competition between audit agencies for business has the potential to create a "moral hazard," according to the OAG.⁴¹ In September 2009, the MOH developed a risk register to manage this and other risks.⁴²

New Zealand Regulation of Age-Related Residential Care

Significant Reform – Auditor-General Reports

In 2009 the OAG reviewed the MOH age-related residential care certification audit process to determine if it was effective in ensuring safe and quality residential care services to consumers. The OAG also reviewed whether the certification process adequately encouraged rest home providers to continuously improve their services. Their report identified the following key shortcomings:⁴³

- Inconsistent and unreliable auditing and monitoring of rest homes.
- Duplication of effort by the MOH and local health officials.
- Persistent under-performance by some rest homes in meeting required standards.

As a result of the report, several recommendations put forward by the MOH and the OAG were implemented. They include:

- Requiring providers nationwide to implement an international standardised resident assessment instrument (interRAI).
- Developing the Provider Regulation and Monitoring System (PRMS).
- Requiring audit agencies to be accredited by an approved third-party entity.
- Creating a standard audit template for auditors.
- Revising the audit agencies' handbook.
- Conducting unannounced surveillance audits.

⁴¹ Office of the Auditor-General. (OAG, 2009)

⁴² OAG (2009)

⁴³ OAG (2009)

- Combining MOH and local requirements into the audit process.
- Using new audit methods to focus on care quality.
- Ensuring local officials provide more clinical support to rest homes, and
- Publicising audit results on the MOH web site.

Implementing PRMS and interRAI are significant technological advances that can modernise how the MOH oversees the regulation of rest homes. Once operational the interRAI will allow rest home providers to use a standardised assessment to identify resident care problems that can be addressed in an individualised care plan. The interRAI will help rest home staff gather definitive information on a resident's strengths and needs as well as identify specific care areas to be addressed with current evidence-based clinical practices.

While use of the interRAI is meant to improve resident outcomes, the PRMS is meant to allow the MOH staff to be more efficient and effective in regulating rest homes. The PRMS system will be a database for maintaining and retrieving providers' certification and other audit information. It will allow MOH staff to track how well an aged residential care provider has met regulatory standards in the past and provide users with background information on past performance. The PRMS system will allow MOH staff to identify trends and issues across the aged care sector that warrant additional attention. The PRMS system is in development and is expected to be operational by the end of 2013.

In 2012 the OAG conducted a follow-up report to their 2009 review. In addition to the improvements noted above, they identified that the MOH began to use the auditing and certification information to identify common themes and trends. However, the OAG believes that the MOH has more work to do to ensure that this information is used to improve the quality of care, auditing, and certification of rest homes. For example, the MOH staff analysed issues from rest home audits from March 2009 to July 2011.⁴⁴ They found that the highest levels of non-compliance involved five criteria within the continuum of service delivery standard.⁴⁵ The MOH communicated the findings to rest home providers, but it is not clear how, or if, the rest homes acted on the information. For this reason, the OAG is unsure of what impact, if any, the certification audit improvements have had on the quality of care delivered to residents.⁴⁶

Current New Zealand Regulatory Structure

The law requires all age-related residential care providers to deliver care that meets the Health and Disability Service Standards (the Standards). To do this, providers must be certified by the Director-General of the MOH under the Health and Disability Services (Safety) Act 2001 (hereafter referred to as the Act). Section 13 of the Act allows the Minister of Health to approve the Standards that will set the minimum level requirements expected of health and disability providers including age-related residential care providers.⁴⁷ The term "certification" is used to describe the MOH's permission for a provider to operate.⁴⁸ When the MOH has certified a rest home, the

⁴⁴ OAG (2012)

⁴⁵ OAG (2012)

⁴⁶ OAG (2012)

⁴⁷ OAG (2009)

⁴⁸ OAG (2009)

provider may enter into a contract with their local DHB to provide care to residents who receive a government subsidy.⁴⁹ Through the contract, the age-related residential care provider receives funding from the DHB to provide necessary services for older people. All age-related residential care providers must be certified regardless if they provide services for persons receiving a government subsidy for their care.

Certification periods may not be more than five years.⁵⁰ To remain certified, providers must be audited to verify they meet the many criteria set out in the Standards. The Standards, last revised in 2008, include general/core standards, a restraint minimisation standard, and infection prevention and control standards. The general/core standards include consumer rights, organisational management, continuum of service delivery, and providing a safe and appropriate environment.⁵¹ Each individual standard is made up of one or more criteria.

The MOH is responsible for the auditing and certification of rest homes. The MOH ensures that the services provided in each facility are audited against the Standards. Much of the auditing is carried out by independent organisations, known as designated auditing agencies (DAA), that the MOH has approved to do the work.⁵² Because the Standards apply to all health and disability service providers, auditors must interpret how each of the Standards will apply to each type of provider. DAAs are required to be accredited by one of two third-party entities, the International Society for Quality in Health Care or the Joint Accreditation System for Australia & New Zealand. The accreditation entities assess DAAs against the Act and the MOH requirements to ensure the DAAs are qualified to carry out the auditing work.⁵³

Auditors rate the services delivered by each aged residential care provider against criteria for each of the Standards to decide whether they are being met and what actions need to be taken to improve the care provided to residents of the facility. The rating levels for each of the Standards and each criterion that make up each standard are (from best to worst): continuous improvement, fully attained, partially attained, and unattained.

After an audit, DAAs submit their reports to the MOH-Health Certification (HealthCert) staff. The HealthCert staff's role is to administer and enforce the legislation, issue certifications, review audit reports, and manage legal issues. The MOH uses the audit reports from the DAAs to decide whether a rest home can continue to operate and for how long. In stark contrast to the US system, providers are allowed to choose which DAA they will hire for their audits. The DAAs carry out five types of rest home audits: (1) provisional, (2) partial provisional, (3) verification, (4) surveillance, and (5) certification.

Provisional audits occur when a change of ownership occurs. The purpose of the provisional audit is to assess the current status of the facility/services at the time of an ownership change and determine the preparedness and fitness of the new ownership. Partial provisional audits occur to determine the preparedness level of a certified provider to offer a new health and disability service and the readiness of a newly built facility.

⁴⁹ OAG (2009)

⁵⁰ OAG (2009)

⁵¹ Ministry of Health "Health and Disability Services Standards," (2013)

⁵² OAG (2012)

⁵³ OAG (2012)

Verification audits ensure that newly reconfigured service levels comply with a subset of standards that focus on staffing and environment. For example, a provider that is increasing capacity or changing the ratio of high to low level beds may require a verification audit before the service changes can occur.

Surveillance audits check rest home providers at the midpoint of their certification period. These audits are unannounced, shorter, and focus on known risk factors of the provider. Typically, a surveillance audit is carried out in one day. The result of the surveillance audit may require further audits if previously identified issues have not been resolved and or if new concerns related to clinical outcomes are found.

Certification audits check all criteria in the Standards. Typically, two auditors perform the audit, which may last between 2 and 3 days. Before the audit is conducted, the MOH expects the DAA's to review the provider's policies and procedures, prior audits, and to contact the local DHB to obtain any information they may have about the provider. The timing and price for the certification audit are arranged in advance between the provider and the DAA. A proposed schedule of all audits is provided by each DAA to the MOH, but it is subject to change.

After a certification audit, if the results show that a provider has not been rated as fully attaining one of the criteria in the Standards, the MOH can add a condition that a written progress report, known as a corrective action plan, be submitted to the DHB to indicate what actions the provider will take to address the problem. If a corrective action plan is required, the DHB is responsible for approving it and monitoring the provider's fulfilment of it. The DHB would also advise HealthCert staff about the progress of correcting critical and high risks or any unattained standards by a provider.

The completed audit report is submitted electronically to the HealthCert team. Once submitted, the audit report is available for DHB staff to review via a secure website. The DHB and HealthCert staff jointly analyse the report, but for different reasons. DHB staff analyse to ensure sufficient evidence that the age-related residential care contract requirements are being met and HealthCert staff review the audit reports for evidence to verify that the auditors' rating matches the evidence provided. Any changes that the DHB wants to the audit report are discussed with HealthCert staff and the lead DAA auditor. When considering the finding of an audit report, HealthCert staff also review other information they may have about the provider (e.g. complaints and information from DHBs or the Health and Disability Commissioner).

HealthCert staff use a decision-making matrix to assess the level of risk associated with each rest home and recommend to their manager the length of certification. The manager has final approval of the length of certification. The matrix was revised in 2009 to incorporate a risk assessment methodology. Most rest homes (80 per cent) are certified for three years.

Once HealthCert staff approve the rest home audit report, a summary of each audit is published on the MOH's website for consumers to use. The summary includes a colour-coded system that reflects the providers' achievement against the Standards. The achievement levels range from commendable, indicating achievement beyond the required levels, to major shortfalls, indicating significant action is needed to meet the required minimum standards. When a rest home is assessed as having major shortfalls, the MOH website displays a red box next to the provider's name. The red box can be removed after the rest home completes a corrective action and arranges a

DHB site visit to confirm that these changes have occurred.

Complaint investigations are conducted by DHBs and the MOH. Generally, the MOH responds to serious complaints. If the MOH has a particular concern about a standard of care provided at a facility, it will send HealthCert staff to conduct an inspection. These inspections can either be announced or unannounced and will assess the provider against the Standards that the rest home is suspected of failing to meet or issues identified in a complaint.

US Regulation of Nursing Homes

Significant Reform - Omnibus Budget Reconciliation Acts 1987

For decades improving the quality of care in nursing homes has been a lingering concern for all long-term care stakeholders. However, it was in the 1970s and 1980s when it started to attract policymakers' attention again.⁵⁴ In 1987, the US Congress enacted major reforms to improve the quality of care in nursing homes and their regulation. The Nursing Home Reform Act contained in the Omnibus Budget Reconciliation Act 1987, now referred to as OBRA 1987, was supported by broad coalitions of consumer, professional, and nursing home groups.⁵⁵ The reforms were based on recommendations by a 1986 Institute of Medicine (IOM) report that identified "serious, even shocking, inadequacies in the enforcement of then-current nursing home regulations."⁵⁶ Specifically, the IOM report pinpointed problems in four areas: (1) attitudes of federal and state personnel about the enforcement objectives and processes, (2) federal rules and guidelines for states, (3) variation among states in policies and procedures, and (4) resources to support enforcement activities.⁵⁷ OBRA 1987 changed the nursing home industry by establishing higher standards that were resident-focused, created an enforcement system for noncompliant facilities and provided states with a range of enforcement sanctions, and it merged standards for the Medicare and Medicaid programmes into a single system.

The new, higher standard set forth in OBRA 1987 was for facilities to support the achievement of each resident's "maximum practicable functioning". Empowering residents through the establishment of residents' rights was another achievement of OBRA 1987. Below are selected residents' rights established by the legislation:

- to be free from abuse or mistreatment,
- to be free from physical restraints,
- to have medical, physical, psychological, and social needs accommodated,
- to have privacy,
- to be treated with dignity,
- to exercise self-determination,
- to participate in one's care plan and be fully informed in advance of changes in care or treatment, and
- to voice grievances without reprisal.

⁵⁴ Walshe (2001)

⁵⁵ Institute of Medicine (IOM, 2001)

⁵⁶ IOM (2001) p. 141

⁵⁷ IOM (2001) p. 141

OBRA 1987 established staffing requirements for nursing homes. It required a registered nurse to be a facility's director of nursing and to be present 8 hours every day. However, licensed practical nurses are required to be on duty 24 hours a day, every day.⁵⁸ After OBRA 1987, nurse aides working in all nursing homes would have to be certified that they have completed a minimum of 75 hours of standardised training and passed a competency test.⁵⁹ OBRA 1987 did not establish staffing ratios.⁶⁰ However, the law advised that "sufficient" staff and services be present to help residents attain or maintain the highest level of physical, mental, and psychological well-being.⁶¹

OBRA 1987 changed the emphasis of the enforcement process and expected inspectors to go beyond "paper compliance" and focus on both the processes and outcomes of care. The new procedures required inspectors to interview residents, families, and ombudsmen about their experiences in the nursing home and to directly observe the delivery of care.

Consistent with the new regulatory focus on outcomes of care, OBRA 1987 required facilities to use a uniform resident assessment. This requirement was the impetus for the development of the, now widely used, International Resident Assessment Instrument or InterRAI (RAI). The RAI allows facilities to assess residents and develop individualised care plans that will act as the foundation for resident planning and care. The RAI has three components: the minimum data set (MDS), the care area assessment (CAA) process, and the utilisation guidelines. The MDS is a core set of screening, clinical, and functional status elements. The CAA process is designed to assist the assessor to interpret the information recorded on the MDS. It helps the clinician to focus on key issues identified during the assessment so that decisions as to whether and how to intervene can be discussed with the resident. The utilisation guidelines provide facility staff with instructions for when and how to use the RAI.

One of the key benefits to using a standardised assessment instrument is that it allows for consistent and uniform communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and other settings. The RAI was fully operational in all US nursing homes by 1990 and has been revised twice to date in the US. The MDS data have been collected electronically by the US government from nursing homes since 1998. Its collection makes it possible for selected health outcomes, like pressure ulcers, weight loss, and accidents to be used as quality indicators to compare facilities and to identify trends over time with resident-level data.

Current US Regulatory Structure

OBRA 1987 introduced sweeping changes to nursing home regulation that remain in place to date. State and federal governments share responsibility for the oversight of nursing homes as well as other residential care facilities. Assisted living facilities are regulated solely by state governments and requirements vary by state.

Nursing home standards are set by the federal government. The federal government contracts with state (government) survey agencies (SSA) to assess whether nursing

⁵⁸Kaiser Family Foundation "Nursing Home Care Quality," (2007)

⁵⁹Kaiser Family Foundation "Nursing Home Care Quality," (2007)

⁶⁰Kaiser Family Foundation "Nursing Home Care Quality," (2007)

⁶¹Kaiser Family Foundation "Nursing Home Care Quality," (2007)

homes meet the more than 150 standards.⁶² All nursing homes wanting to participate in the Medicare and Medicaid programmes must comply with federal and state standards.⁶³ States set licensing standards for nursing facilities while federal law certifies that facilities meet the minimum requirements to participate in the Medicare and Medicaid programmes.⁶⁴ State licensing standards may equal or exceed federal requirements.⁶⁵

According to federal law, SSAs' inspections, known as surveys, must be conducted no later than every 15 months and the average interval cannot exceed 12 months.⁶⁶ Surveys are always unannounced, last approximately three to four days, and are conducted by a team of professionals that must include at least one registered nurse. Typically, the survey team consists of three or four staff and may include physicians; physician assistants; nurse practitioners; physical, speech, or occupational therapists; dietitians; sanitarians; engineers; social workers; or other relevant professional staff. Architects or other fire safety specialists evaluate the facility for its compliance with fire and safety code standards. Figure 9 shows the steps of the survey inspection process of nursing homes.

Figure 9: Federal Nursing Home Survey Inspection Process, 2013

Step 1	Off-site preparation
Step 2	Entry conference and on-site preparation
Step 3	Initial nursing home tour
Step 4	Resident sample selection
Step 5	Information gathering: <ul style="list-style-type: none"> A. General observation of the facility B. Kitchen/food service observation C. Resident review D. Quality of life assessment E. Medication pass F. Quality assessment and assurance review G. Abuse prevention review
Step 6	Deficiency determination <ul style="list-style-type: none"> A. Determination of substandard quality of care records.
Step 7	Exit conference

Source: Centers for Medicare and Medicaid Services.

Upon entering the facility, the survey team leader meets with the administrator or designee while the other survey team members immediately go to a pre-assigned area to observe how staff deliver care and the interactions between staff and residents. During the federal inspection, state surveyors tour the nursing facility and observe the

⁶² Centers for Medicaid and Medicare Services “About Inspections” (2013)

⁶³ Government Accountability Office “Federal Monitoring Surveys,” (GAO, 2008)

⁶⁴ Walshe (2001)

⁶⁵ Walshe (2001)

⁶⁶ GAO “Federal Monitoring Surveys,” (2008)

care given to residents. The surveyors talk with residents and their families about what life is like in the facility, and meet with its residents' council or ombudsman. In addition to reviewing residents' records and other documents to ensure compliance, surveyors also meet with administrative staff and observe care provided by licensed and direct care staff. Two samples of residents are chosen based on historical regulatory data and current resident clinical information. The first survey sample is pre-selected with residents that represent concerns identified to review initially. The second sample is taken from the resident roster once the surveyors are in the facility and may have identified new concerns after their initial inspection. Through the resident samples the survey team determines whether residents are receiving care that meets their assessed needs.⁶⁷ Certain quality outcome measures are also reviewed. They include: the incidence of pressure sores, weight loss, and accidents.⁶⁸

The standards are grouped into 15 categories that focus on the quality of care provided. The standards require inspectors to review records, directly observe the provision of care, and communicate with residents and staff to determine what life is like in the facility. Categories of the standards include: resident rights, nursing services, infection control, quality of life, dietary services, and resident behaviour and facility practices.⁶⁹

If a deficiency is found, inspectors use their professional judgement to determine its scope and severity. To do this, inspectors grade the seriousness of each deficiency by assigning it a letter code, A through L. Deficiencies assigned "A" are the least serious, while those assigned J through L are more serious. Figure 10 shows the scope and severity grid used to make this determination.

Figure 10: Nursing Home Deficiency Scope and Severity Grid, 2013

Severity	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

Source: Centers for Medicaid and Medicare Services' Nursing Home 2010 Data Compendium.

Facilities that do not have deficiencies in categories "D" and above are considered to be in substantial compliance with the standards and are not subject to penalties, but are expected to correct any deficiencies. Those with deficiencies in categories "D" and above are subject to intermediate sanctions or termination from the Medicaid and Medicare programmes depending on the scope and severity of the problems. Intermediate sanctions include: directed plan of correction, state monitoring, directed in-service training, denial of payment for new admissions and for all residents, and

⁶⁷ GAO "Federal Monitoring Surveys," (2008)

⁶⁸ GAO "Federal Monitoring Surveys," (2008)

⁶⁹ Nursing Home Pro (2013)

civil monetary penalties ranging from US\$50 to 3,000 per day or US\$1,000 to \$10,000 per instance. Other factors used to decide whether sanctions will be imposed are a nursing home's prior compliance history, desired corrective action and long-term compliance, and the number and severity of the facility's total deficiencies.⁷⁰

⁷⁰ GAO "Federal Monitoring Surveys," (2008)

3 QUALITY IMPROVEMENT

Improving Nursing Home Care Quality in the US

Evolution of Defining Quality

Assessing the quality of nursing home care is difficult because quality has different meanings to different populations. Consumers and their families, policymakers, regulators, and providers each have an idea of what “quality” means and how it could be measured. Moreover, the assessment of long-term care quality is distinct from other healthcare services, such as acute care, because the goal of long-term care is not to restore people to good health, but is to prevent or slow further declines in health and functioning.⁷¹

The definition of what quality is as it applies to residential care continues to evolve. The dominant framework for measuring quality of healthcare services is the Donabedian model.⁷² The model gathers information about the quality of health services from three areas: structure, process, and outcomes. Structure represents the capacity of the provider to meet the needs of the patient. Process is the activities performed to meet the patient’s need and outcomes are the result of the provider’s activities that may include changes in physical, psychological, and functional status of patients.⁷³

In the US, the historical efforts to improve quality in nursing homes can be viewed through three cycles.⁷⁴ The first cycle emphasised improvement in physical structures to protect residents from fire hazards. Between 1957 and 1963, national efforts began to require nursing home providers to comply with basic fire and safety standards as a result of a series of fires that killed more than a 100 elders. Once facilities were determined to be structurally safe, the focus on quality of care began.

Throughout the 1970s, horrific stories of abuse and neglect occurring in facilities surfaced.⁷⁵ Among the factors blamed for the poor care was a regulatory system that emphasized structure and process over the care for residents.⁷⁶ As previously mentioned, the OBRA 1987 legislation ushered in regulatory changes that focused on the resident, such as standards that emphasised resident’ rights and resident quality of life. Eighteen federal standards specifically devoted to quality of life aspects are used in the annual inspection process. Facilities are reviewed on their efforts to promote and enhance quality of life, dignity, self-determination of residents, as well as a facility’s responsiveness to resident and family concerns or complaints.⁷⁷

With the concept of quality of life as an aspect to be monitored in the regulatory process, a new movement called “culture change” took root. It began with a small group of prominent professionals in long-term care who began to advocate for improved quality of life for nursing home residents through the use of person-centred care practices. Culture change gets its name from the idea that it is necessary to

⁷¹ IOM (2001) p. 30

⁷² Capitman *et al.* (n.d.). p. 8

⁷³ Capitman *et al.* (n.d.), p.8

⁷⁴ Capitman *et al.* (n.d.), p.8

⁷⁵ Walshe and Harrington (2002), p. 475

⁷⁶ Walshe (2001)

⁷⁷ Federal Code of Regulations (n.d.) “Requirements for Long-Term Care Facilities,”

change the organisational culture of nursing homes from an institution or staff-based culture to one that is person-centred. Engaging in person-centred care means that providers and caregivers assume that facility residents both need and want to be a decisive factor in their lives even if they are unclear and not able to articulate what this might mean in actual practice. The key factor to providing person-centred care is the caregivers' assumption to seek guidance from the resident about life and care decisions rather than relying on professionals or others to make these choices.⁷⁸ Person-centred is distinct from person-directed. Person-centred moves decision-making as close to the person as possible, while person-directed is decision-making done by the individual. Figure 11 shows that the concept of person-centredness and its impact on everyday activities, such as dining, exists on a continuum.

Figure 11: Continuum of Person-Centred Care, 2010

ACTIVITY:	STAFF-DIRECTED	STAFF-CENTRED	PERSON-CENTRED	PERSON-DIRECTED
Dining	Meals are served at fixed times. Residents who are independent eat in a dining room and others who require assistance eat in their rooms. Meals are brought on trays from central kitchen. Residents who do not prefer meal may choose alternate meal.	Meals are served during fixed periods of the day (i.e., breakfast 7 to 9:30 am). Meals are prepared from a main kitchen and each meal offers residents two choices for a main meal, except for breakfast which is buffet style. Residents who are independent eat in a dining room and the others who require assistance eat in their rooms.	Residents have input on meal times and the menu. Residents are served freshly-prepared food from a rolling steam table. The food is not prepared in large industrial kitchen, but a smaller residential one. Aides serve the food to residents on dishes and not trays. The steam table is taken to residents who cannot come to the dining room	Residents decide on the menu and where they want to eat and at what times. Meals are prepared in a residential kitchen near where the residents' rooms are located. Meals are served family style, where serving bowls and platters are placed on the table and residents, who are able, can help themselves. Those who require assistance receive it from staff.


Low **Person-centredness continuum** **High**

Source: Pioneer Network.

⁷⁸ Legislative Budget Board. (2011) "Modernize Care Delivery"

The third and current cycle of nursing home quality improvement efforts can be characterised by the important role data plays in the measurement of quality. Data is used not only to measure health outcomes but also to monitor subjective concepts such as quality of life. The data collected through the RAI is a major source for future monitoring of patient care and quality.⁷⁹ Data collection is the cornerstone to the federal government’s quality improvement strategy to provide information to consumers so that it will empower their decision-making and increase competition between providers.

Benefits of Using Objective Data

To temper both external and internal influences, like political influence and regulatory staff discretion, on the regulatory process, the use of objective data can be a valuable resource for both the regulator and the entities it oversees. For example, in the US the RAI is one of the major data sources used by the federal government for monitoring patient care and quality in nursing homes.⁸⁰ It can inform regulators of problem areas for specific providers as well as allow for trend analysis over the longer term. Data can assist providers to improve in deficient areas on a continual basis as well as to bring consistency to regulators’ use of professional judgement. As Day and Klein (1987) point out, data can indicate things are occurring that should not be occurring in facilities and alert regulators to look further at how care is delivered and what the possible causes could be. Specific examples of using data for quality improvement efforts will be discussed further in the next sections.

US Data Systems Used for Quality Improvement

Two information systems collect data and use it to monitor compliance with regulations and the quality of care offered in nursing homes. They are the On-line Survey and Certification Assessment Reporting System (OSCAR) and the Minimum Data Set (MDS) contained in the RAI. Figure 12 provides additional information about the data each system collects and their respective uses.

Figure 12: Major Information Systems for Monitoring Quality in Nursing Homes, 2013

Information System	Type of Data Collected	Purpose
OSCAR/CASPER	<ul style="list-style-type: none"> • Resident Characteristics • Facility Characteristics • Facility Staffing • Facility Deficiencies • Facility Complaints 	To report on a nursing home’s inspection results, patterns over time, and to allow for nursing home comparison.
MDS (3.0)	<ul style="list-style-type: none"> • Patient Identification • Hearing, Speech, and Vision • Cognitive Patterns • Mood • Behaviour • Personal Preferences for Routines/Activities 	To assess cognitive, functional, and affective levels of nursing home residents on admission and at least annually to develop individualised care plans.

⁷⁹ Capitman *et al.* (n.d.)

⁸⁰ Capitman *et al.* (n.d.)

	<ul style="list-style-type: none"> • Functional Status • Bladder and Bowel • Active Disease Diagnosis • Health Conditions • Swallowing/Nutritional Status • Oral/Dental Status • Skin Conditions • Medications • Special Treatments • Restraints • Other’s Assessment Participation 	
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Source: Institute of Medicine and Centers for Medicare and Medicaid Services.

OSCAR is a database that provides information about a nursing home’s past performance on annual inspections and provides state survey inspectors with background information about a facility. The facility information collected includes: facility size (number of beds), occupancy, ownership type, corporate information, percentage of residents receiving benefits through Medicare, Medicaid, and nurse staffing hours per resident.⁸¹ Some resident data is collected too. It consists of activities of daily living assistance, restraints, incontinence, psychological problems, and other special care needs of residents.

In 2010, the US government changed the name of the OSCAR database to the Certification and Survey Provider Enhanced Reporting (CASPER) database. The change is part of a larger initiative that began in 2009 and changes how nursing homes are inspected. The Quality Indicator Survey (QIS) is a revision to the inspection process to standardise how the survey process measures nursing home compliance with federal standards and the interpretive guidelines that define the standards.⁸² The QIS uses an automated system to guide inspectors on a personal tablet computer through a structured investigation of a nursing home. It is intended to allow inspectors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review.⁸³ Prior to the implementation of the QIS, state inspectors selected 20 per cent of the current nursing home census using several sources of information and their professional judgement.⁸⁴ The new QIS system and computer software allows inspectors to choose larger sample sizes and to electronically record observations and view regulatory guidance on their computers as they conduct the inspection.⁸⁵ The QIS is being phased in across the US; to date almost half the states have implemented it.⁸⁶

The MDS 3.0 is the third version of the original RAI that was intended to standardise and structure how assessments of nursing home residents occurred. The structured approach ensures that a comprehensive and consistent assessment results in an individualised care plan for each admitted resident. Based on answers provided by the resident, the assessor is directed to examine more deeply certain issues or ask about

⁸¹ CMS “Nursing Home Data Compendium” (2010)

⁸² CMS “Evaluation of the Quality Indicator Survey” (2007)

⁸³ CMS “Nursing Home Action Plan,” (2012)

⁸⁴ GAO “Nursing Home Quality: Implementation of the Quality Indicator Survey,” (2011) p. 22

⁸⁵ GAO “Nursing Home Quality: Implementation of the Quality Indicator Survey,” (2011)

⁸⁶ CMS “Nursing Home Action Plan,” (2012)

certain aspects of a resident's condition.⁸⁷ Using data from the MDS, 24 quality indicators were developed to identify potential problems in care delivery and that could be used by nursing home inspectors during the inspection process. In the new QIS, the 24 quality indicators are used with MDS data to generate a QIS report for each nursing home in a state. The report identifies a roster of residents that meet the criteria for possible quality of care issues for the inspectors to use during the annual inspection process. During a routine survey, teams of state inspectors evaluate nursing homes' compliance with federal quality standards, in part by measuring resident outcomes such as the incidence of preventable pressure sores, weight loss, and accidents.

Quality Improvement Information for US Consumers

In 1998 the US government began publicly reporting data to support consumer decision-making by creating the Nursing Home Compare website.⁸⁸ The website can be found at www.medicare.gov/nursinghomecompare. Since its inception, modifications to the web site continue to be made with the addition of more information. For example, quality measures were added for consumers and their families to guide their decision-making. The measures were created for short-stay residents and long-stay residents. Figure 13 shows the 13 quality measures reported publicly for long-stay residents.

Figure 13: US Nursing Home Quality Measures for Long-Stay Residents, 2013

1. Percentage of residents with a urinary tract infection.
2. Percentage of residents experiencing one or more falls with major injury.
3. Percentage of residents who self-report moderate to severe pain.
4. Percentage of residents with pressure ulcers.
5. Percentage of residents who lose control of their bowels or bladder.
6. Percentage of residents who have/had a catheter inserted and left in their bladder.
7. Percentage of residents who were physically restrained.
8. Percentage of residents whose need for help with daily activities has increased.
9. Percentage of residents who lose too much weight.
10. Percentage of residents who have depressive symptoms.
11. Percentage of residents assessed and given, appropriately, the seasonal influenza vaccine.
12. Percentage of residents assessed and given, appropriately, the pneumococcal vaccine.
13. Percentage of residents who receive an antipsychotic medication.

Source: Centers for Medicare and Medicaid Services.

In 2005, annual inspection results were added. And in 2007, nursing homes names that have poor inspection histories and were referred to a programme for more intensive regulatory screening (Special Focus Facilities) were included on the website.⁸⁹

⁸⁷ IOM (2001) p. 116

⁸⁸ CMS "Nursing Home Action Plan," (2012) p 1

⁸⁹ CMS "Nursing Home Action Plan," (2012) p 1

In 2008, the Five-Star Quality Rating System was added to the website with the goal of helping the public compare the quality of nursing homes more easily.⁹⁰ The rating system uses regulatory inspection data from CASPER and resident data from the MDS to assign a star rating to each nursing home.⁹¹ However, the use of a ratings system creates other issues in need of addressing. Research shows that the number of deficiencies cited in an annual regulatory inspection may not be a fair measure when comparing facilities to one another.⁹² Because the facility deficiency scores represent aggregate data of individual patient outcomes and facility developments, they are sensitive to the case mix at a facility.⁹³ In other words, the more complex the care needs of a resident are, the more likely that care deficiencies will be found,⁹⁴ which could result in these facilities receiving a lower rating solely because of their resident case mix.

Zimmerman (2003) makes an important distinction about the difference between quality indicators and quality measures. He points out that quality indicators are only *indicators* of potential quality problems and that they are not measures of quality.⁹⁵ Further, he reiterates that measures of quality can identify aspects of care where there *definitely* (emphasis added) is a problem, while quality indicators can provide useful information as the starting point to investigate and evaluate the care quality.⁹⁶ In developing quality indicators and/or measures, the MOH may consider which is appropriate for the objective to be achieved. Zimmerman (2003) identifies that using indicators may allow for clinically based investigations to reveal problems and even go further and determine the source of the problem.⁹⁷ Quality measures require regulators and stakeholders to reach consensus as to what an acceptable level of outcome is (e.g. pressure ulcer rates) and the circumstances in which it occurs. Moreover, research demonstrates that it is critically important to conduct studies to determine the accuracy and validity of any quality measures⁹⁸

Obstacles in Publicly Reporting Data

Using data to inform consumers and drive improvement in residential care is not without obstacles or controversy. Research is on-going to identify valid and reliable measures that are meaningful to consumers and sensitive to facility issues like case mix.⁹⁹ Because there is not definitive agreement by researchers or stakeholders on what measures are valid and reliable indicators of quality, using data for this purpose can be problematic. For example, the MDS is a reliable and valid source of data to assess resident outcomes and status, but using the data it yields, as well as regulatory data, to rank and compare facilities remains controversial, according to Capitman *et al.* (2005).

Moreover, the idea to publish data for consumer-use is based on the premise that its

⁹⁰ CMS “Five-Star Rating User Guide,” (2013)

⁹¹ CMS “Five-Star Quality Rating System,” (2013)

⁹² Capitman *et al.* (n.d.)

⁹³ Capitman *et al.* (n.d.)

⁹⁴ Capitman *et al.* (n.d.)

⁹⁵ Zimmerman (2003)

⁹⁶ Zimmerman (2003)

⁹⁷ Zimmerman (2003)

⁹⁸ Zimmerman (2003)

⁹⁹ Capitman *et al.* (n.d.)

publication will spur competition among providers and drive quality improvement.¹⁰⁰ Other factors may impact consumer choice more than available quality and regulatory data. Stevenson (2006) points out that while adult children of elders may access quality data easily via the internet, this is not the case with elders. Research indicates that older and sicker consumers have difficulties using this type of data.¹⁰¹ They may not have internet access or be familiar with how to access this type of data.¹⁰²

Quality improvement and regulatory data is not worthwhile if consumers cannot act on it. A lack of providers in a geographic area may constrain consumers' choice. Regardless of what the data show, consumers who want their family member nearby may have few facilities from which to choose.¹⁰³ Limited choice impacts the potential effectiveness of public reporting to stimulate quality improvements.¹⁰⁴ Lastly, often choosing a nursing home is done in a crisis situation with severe time constraints. The stress of decision-making under these conditions may impact the extent to which quality and regulatory data is used. Consumers will likely not be able to analyse the data nor take the time to understand its limitations which may result in the data being misinterpreted or misunderstood.

US Initiatives

Public-Private Partnerships to Improve Nursing Home Quality

The federal social insurance programme, Medicare is the largest US purchaser of healthcare services. As of 2012, it insures 49.4 million persons.¹⁰⁵ Consequently, it has a responsibility and incentive to ensure quality healthcare services are provided to its beneficiaries.¹⁰⁶ To do this, the US government enacted legislation in Sections 1152-1154 of the federal Social Security Act to establish Quality Improvement Organizations (QIO).¹⁰⁷ QIOs are private, mostly non-profit entities, staffed by professionals, such as doctors, nurses, and other healthcare professionals, who are trained to review medical care and help beneficiaries with complaints and to implement improvements in care quality.¹⁰⁸ QIOs began working to improve the quality of care in nursing homes in 2002.¹⁰⁹

There are 53 QIOs; one for the District of Columbia, each state, and US territory.¹¹⁰ QIOs work under contract to Medicare for three years. The federal entity, CMS, within the U.S. Health and Human Services Department, reviews the contracts after three years to ensure that QIOs are doing their jobs effectively.¹¹¹ CMS selects QIOs on a competitive basis and whether an entity has the proper resources available to ensure proper peer review.¹¹² To become a QIO, an organisation must submit a

¹⁰⁰ Nedza (2005)

¹⁰¹ Stevenson (2006)

¹⁰² Stevenson (2006)

¹⁰³ Stevenson (2006)

¹⁰⁴ Stevenson (2006)

¹⁰⁵ Kaiser Family Foundation "Total Number of Medicare Beneficiaries," (2013)

¹⁰⁶ Medicare Payment Advisory Commission (MedPAC) (2010)

¹⁰⁷ US Social Security (2013)

¹⁰⁸ CMS "Quality Improvement Organizations," (2013)

¹⁰⁹ Stevenson and Mor (2009)

¹¹⁰ MedPAC (2010)

¹¹¹ CMS: Quality Improvement Organizations. (2013)

¹¹² Medicare News Group (2013)

proposal to CMS and prove through written certifications and documentation that it meets CMS's requirements.¹¹³ Each three-year contract cycle is known as a statement of work (SOW).¹¹⁴ Each SOW focuses on a different aspect of healthcare on which the QIO must focus and demonstrate results.¹¹⁵ In the ninth SOW (2008–2011) the Medicare programme spent US\$1.1 billion or \$366 per year to support the work of QIOs.¹¹⁶

Currently, QIOs work with the four major healthcare provider types (nursing homes, home health agencies, hospitals, and physician offices) that serve Medicare beneficiaries.¹¹⁷ Since their creation in the 1970s, their name and responsibilities have changed. Throughout the 1970s and 1980s, QIOs were named the Experimental Medical Care Review Organization and then later called the Utilization and Quality Control Peer Review Organization Program. Like their names imply, the QIO predecessors' responsibility was to review medical cases to reduce the provision of unnecessary services and contain costs.¹¹⁸ Bradley *et al.* (2005) identify several studies that conclude the peer reviews to "inspect and detect" had no significant impact on quality or controlling costs and generated an "acrimonious" relationship¹¹⁹ with healthcare providers.¹²⁰ By 1990 a new approach to quality improvement was needed. Per the recommendation of the Institute of Medicine, a collaborative approach with healthcare providers was called for after the previous adversarial approach had not yielded significant improvements. The new roles of QIOs shifted from identifying individual cases of unnecessary or substandard care to providing technical assistance, specifically in data collection and performance feedback and in fostering internal quality improvement.¹²¹ In recognition of their new role and mandate, in 2001, they officially became known as QIOs. Their current goals are to:¹²²

- Improve the quality of care that Medicare beneficiaries receive by collaborating with providers to help them meet professionally recognised, evidence-based standards and guidelines of care.
- Protect beneficiaries' rights, respond to their complaints, and investigate claims and evidence of substandard care.
- Protect the Medicare Trust Funds by reviewing claims patterns and suspicious cases for the inappropriate use of services or incorrect billing codes.

QIO Evaluation

The newness of the QIO's involvement in improving the quality of care in nursing homes is one factor limiting researchers' ability to draw conclusions about its effectiveness. Additionally, few studies have researched the effectiveness of the QIO

¹¹³ Medicare News Group (2013)

¹¹⁴ CMS: Quality Improvement Organizations (2013)

¹¹⁵ CMS: Quality Improvement Organizations (2013)

¹¹⁶ MedPAC (2010)

¹¹⁷ Sutton, Silver, Hammer, and Infante (2007)

¹¹⁸ Sutton *et al.* (2007)

¹¹⁹ Bradley, Carlson, Gallo, Scinton, Campbell and Krumholz (2005) p.461

¹²⁰ Sutton *et al.* (2007)

¹²¹ MedPAC (2010)

¹²² Sutton *et al.* (2007)

programme as a whole.¹²³ Those that have, found substantial improvements in some areas of care for Medicare beneficiaries after QIO activities were implemented.¹²⁴ However, these studies had methodological limitations such as a lack of a control group or other design flaws that limited their usefulness to draw conclusions about the QIO programme or the intervention used.¹²⁵

A 2007 Government Accountability Office (GAO) report evaluating the QIO programme noted that of the nursing homes they surveyed most attributed some of the improvement in the quality of care to their residents to QIO assistance.¹²⁶ Other studies assessing QIO impact on improving nursing home care demonstrate a positive impact, but had similar design flaws as national studies. Sutton, Silver, Hammer, and Infante (2007) highlight two Texas studies that show that, after QIO interventions, statistically significant improvements were identified in 8 of 12 performance measures and pressure ulcer incidence rates were reduced.¹²⁷ In the second study, researchers identified that interventions to reduce restraint use were successful, but the improvement could not be directly attributed to work the QIO conducted.¹²⁸ As a result of the inconclusive findings, work remains on-going to study and document the effectiveness of the programme.

Beginning in 2008 and as a result of a Government Accountability Organization (GAO) evaluation, QIOs were directed to focus their resources to working with nursing homes and clinical areas where the most improvement was needed. Medicare officials recognised that other tools to improve the quality of care, such as payment changes and public reporting, were not inducing quality improvement in certain providers as quickly as they would like.¹²⁹ They believed that technical assistance may help these nursing homes to change practice patterns and improve quality.¹³⁰ Also, Medicare officials recognised that additional assistance was needed to reach some nursing home providers who for a variety of reasons may not know how to improve care.¹³¹

Special Focus Facility

US regulators started the Special Focus Facility (SFF) initiative in 1998 to identify facilities with persistent serious quality issues. Such facilities would make short-term improvements but by the next annual inspection, significant problems would re-surface. Regulatory officials believe that these facilities that “yo-yo” in and out of compliance rarely address underlying systemic problems that give rise to the serious quality of care problems.¹³² The purpose of the SFF programme was to decrease the number of persistently poor performing nursing homes by directing more attention to those with a record of poor inspections. Nursing homes identified by the SFF initiative receive additional attention from state regulators, QIOs, and are identified to

¹²³ Sutton et al. (2007)

¹²⁴ Sutton et al. (2007)

¹²⁵ Sutton et al. (2007)

¹²⁶ GAO “Nursing Homes: Federal Actions Needed,” (2007)

¹²⁷ Sutton et al. (2007)

¹²⁸ Sutton et al. (2007)

¹²⁹ MedPAC (2010)

¹³⁰ MedPAC (2010)

¹³¹ MedPAC (2010)

¹³² US Health and Human Services Department “Assistant Secretary for Legislation Testimony,” (2013)

consumers on the national nursing home comparison web site.

According to federal regulators, the average number of deficiencies found during an annual nursing home inspection is between 6 and 7.¹³³ Nursing homes identified by the SFF programme had twice the average number of deficiencies, more serious problems that harmed or injured residents, and a pattern of serious problems that persisted over a long period of time.¹³⁴

Person-centred Care Initiatives

Relying solely on current data to inform clinical quality improvement efforts does not provide a complete picture of a nursing home's quality of care. The quality of life in a nursing home is an important and often overlooked aspect that can be more meaningful to residents. The current quality indicators used by US regulators to measure quality focus only on the clinical component of life in a nursing home. Measures such as rates of pressure ulcer incidence, flu vaccination, and catheter use do not identify if a facility promotes residents' independence and dignity, respects their privacy, or encourages their participation in residential life at the nursing home.

The 1986 Institute of Medicine report that was the basis for the OBRA 1987 nursing home reforms said that the participation of residents in nursing home decision-making and policy-making is essential to achieving high quality of care and life. During the implementation of the OBRA 1987 reforms that message got lost and attention focused on using the resident assessments instruments and implementing new technology and regulations. In 2005, the culture change movement experienced a rebirth.¹³⁵ Federal regulators endorsed the culture change movement as supporting one of the primary goals of the OBRA 1987 reforms, person-centred care.¹³⁶ Regulators encouraged facilities to examine and transform their organisation's values, structures and practices from traditional institutional approaches to those that are person-centred. To further support nursing home providers' efforts to become person-centred, regulators developed a 79-item questionnaire for nursing home staff to use to assess their progress to becoming more person-centred. Also in 2005, QIOs were tasked with assisting nursing homes to improve their organizational culture and become more person-centred.

Rhode Island Individualized Care Project

Building on this momentum to spotlight the importance of the quality of life in nursing homes, at least two states, Rhode Island and Texas, are using the regulatory process to educate nursing home providers about person-centred care and to increase the use of person-centred practices. Rhode Island pioneered the idea in 2007 and Texas is planning to implement its project based on the Rhode Island model in 2014.

The Rhode Island Department of Health implemented the Individualized Care Pilot (ICP) from November 2007 to April 2008. The pilot project used the annual survey inspection process to ask nursing home providers targeted, detailed questions about person-centred care, thereby accomplishing two positive results; educating state survey staff about the provision of individualised care and conveying the message to

¹³³ Medicare 'Special Focus Facility Initiative' (n.d.)

¹³⁴ Medicare 'Special Focus Facility Initiative' (n.d.)

¹³⁵ Rahman and Schnelle (2008)

¹³⁶ Rahman and Schnelle (2008)

providers that state regulators viewed quality of life as a priority.¹³⁷ Rhode Island officials consider the ICP's simple design to be one of its most powerful assets.¹³⁸

Specifically, the ICP project required state survey inspection staff during an annual inspection to ask additional questions of residents and staff and observe pre-selected quality of life indicators. After the inspection, facility staff could attend educational meetings with the Rhode Island QIO to receive information and resources about person-centred care. To help educate the providers about person-centred care practices, a confidential document, the *Summary of Survey Data* report, was prepared by inspectors and provided to surveyed facilities about data collected during the inspection process related to quality of life. The *Summary of Survey Data* report documented information from selected interviews and observations, including notations of practices that appeared to support person-centred care. This report was separate from the required report of compliance or non-compliance issued by the state regulators and was specific to each facility.

At the end of the ICP project, inspectors completed a questionnaire about various topics related to the ICP. Compared to before the ICP project, 95 per cent of inspectors agreed or strongly agreed that they have a greater understanding of the regulations related to person-centred care and 68 per cent agreed or strongly agreed that the ICP project helped them do a better job of assessing regulatory compliance in all areas. According to The Commonwealth Fund, the results of the ICP project indicate that it successfully helped facility staff to understand, consider, and implement person-centred care.¹³⁹ Pre- and post-test surveys were sent to all nursing facilities in Rhode Island. Fifty-three per cent of nursing facilities responded to both surveys and half were participants in the ICP project.¹⁴⁰ Facilities participating in the ICP project did better than those that did not participate.¹⁴¹ Accordingly, residents' access to person-centred care activities increased significantly across six of the eight surveyed areas between the pre-and post-tests.¹⁴²

Culture Change Best Practices Development

The US government is maintaining its commitment to helping the culture change movement to spread to more nursing homes across the country. In 2010, the Patient Protection and Affordable Care Act authorised a demonstration project to develop best practices for nursing homes involved in the culture change movement. Federal grant funding will be awarded on a competitive basis to selected nursing homes for up to a three year period. A report on the project's results is due after the first year of the project's implementation. No results have been published to date.

¹³⁷ Legislative Budget Board. (2013) "Leverage State Inspection Process to Increase Person-centered Care"

¹³⁸ Legislative Budget Board. (2013) "Leverage State Inspection Process to Increase Person-centered Care"

¹³⁹ Stevenson and Gifford (2010)

¹⁴⁰ Stevenson and Gifford (2010)

¹⁴¹ Stevenson and Gifford (2010)

¹⁴² Stevenson and Gifford (2010)

New Zealand Initiatives

Key Components: Legislation, Contracts, Government Ministries, and Crown Entities

Ensuring quality in the health and disability sector is a shared responsibility among many entities and supported by legislation and contractual agreements, as well as by voluntary adaption of good practice and continuous improvement efforts.¹⁴³ Two main legislative acts are the basis for the regulatory framework that supports continuous quality improvement in healthcare services: the Health and Disability Services (Safety) Act 2001 (HDS Safety) and the Health Practitioners Competence Assurance Act 2003 (HPCA Act). The HDS Safety Act ensures the safety of services through the enforcement of minimum standards for hospitals, age-related residential care facilities, residential disability care facilities, and fertility providers. The HPCA Act ensures the competence of certain healthcare professionals through specified standards.¹⁴⁴ A third piece of legislation, the Health and Disability Commissioner Act 1994 established the role of the Health and Disability Commissioner and required the commissioner to establish a code of consumer rights.

Several contractual arrangements/funding agreements are meant to support continuous quality improvement efforts through reporting requirements and contractual language. Two contracts affect aged residential care. One is the Crown Funding Agreement between a Crown entity and local district health boards (DHB). The other, which is specific to aged care, is the aged-related residential care (ARRC) services agreement; this is between the local DHB and age-related residential care providers. The Crown Funding Agreement is the contract between the DHB and the Minister of Health which links the DHB's annual plan to the funding provided by the Ministry of Health and the performance required from the DHB to provide all health services to the country's population.¹⁴⁵ The ARRC contract includes rest home, dementia and geriatric hospital level care provided in a residential-care setting. The contract ensures that there is a national standard of services that are provided to residents in long-term residential care.¹⁴⁶ Figure 14 shows the contractually-mandated reporting requirements and/or quality measures in each contract.

Figure 14: Contractually-Mandated Reporting Requirements and Quality Measures, 2013

Contract	Quality Measures/ Reporting Requirements
Crown Funding Agreement	<ol style="list-style-type: none"> 1. Shorter stays in emergency departments. 2. Improved access to elective surgery. 3. Shorter waits for cancer treatment. 4. Increased immunisation rates. 5. Better help for smokers to quit. 6. Increase heart and diabetes checks.

¹⁴³ Andrew (2011)

¹⁴⁴ Andrew (2011)

¹⁴⁵ Canterbury District Health Board (2013)

¹⁴⁶ Ministry of Health "Age-related residential care services agreement" (2013)

Contract	Quality Measures/ Reporting Requirements
Age Related Residential Care Services Agreement (including Dementia care)	<ol style="list-style-type: none"> 1. Number of beds occupied by long-term non-subsidised residents. 2. Number of beds occupied by long-term subsidised residents. 3. Total number of beds at facility. 4. A narrative report detailing actual or potential changes and the dates the changes will take effect to modify the total number of beds at facility.

Source: Ministry of Health

No one entity is solely responsible for determining and monitoring quality improvement and safety for all healthcare services. Several entities have varying responsibilities that affect the quality of aged residential care, as described below.

Health Quality and Safety Commission

The Health Quality and Safety Commission (HQSC), a newly formed government entity, takes a high-level approach to improving the quality of healthcare. According to its enacting legislation in 2010, the HQSC coordinates work across the entire health and disability sector by monitoring and improving the quality and safety of health and disability support services and assisting providers to improve their services.¹⁴⁷ At present the HQSC does not have an initiative specific to aged care, but several of the sector-wide programmes implemented to improve the quality of care may affect care in age-related residential care facilities. These programmes include: medication safety, infection prevention and control, reducing falls, and adverse event reporting.

The HQSC recently developed health quality and safety indicators to measure a broad array of aspects of the country's health system. The HQSC will use them to track progress in the health and disability sector over time and compare New Zealand with other countries. Similar to its programmes, the indicators are not specific to aged care, but may impact the quality of care older adults receive. The indicators are:

- Cancellations of elective surgery by hospital after admission.
- Deaths potentially avoidable through healthcare (amenable mortality).
- Occupied bed-days for older people admitted two or more times as an acute admission per year.
- Planned day case turns into unplanned overnight stay.
- Emergency readmission to hospital within 28 days of discharge.
- Eligible population up to date with cervical screening.
- Age-appropriate vaccinations for two-year-olds.
- Healthcare cost per capita (US\$ purchasing power parity per capita).
- Healthcare expenditure as a proportion of gross domestic product.

¹⁴⁷ New Zealand Legislation “Public Health and Disability Amendment Act,” (2010)

Ministry of Health

The Ministry of Health is responsible for the management and development of the country's health and disability system. The Ministry is a funder, purchaser and regulator of national health and disability services. They include: public health interventions (e.g. immunisation, disease outbreak), disability support services, screening services (e.g. cervical screening), maternity services, and ambulance services.¹⁴⁸ The health system's funding comes mainly from general taxation and is estimated to be \$14.6 billion in 2013–14. More than 75 per cent of the public funds are allocated to district health boards to plan, purchase and provide health services, including public hospitals and the majority of public health services.¹⁴⁹ In 2013–14, the Ministry is estimated to purchase \$2.8 billion worth of health and disability services.¹⁵⁰ Within the MOH, the Clinical Leadership, Protection, and Regulation (CLPR) business unit contains the offices of the Directors of Public Health and Mental Health and other functions related to promoting and protecting the health of New Zealanders from communicable diseases and environmental hazards.¹⁵¹ CLPR is also responsible for the regulation of the local distribution chain of medicines and controlled drugs, medicines and medical devices, providers of health and disability services (e.g. age-related residential care), and compliance with international requirements for radiation, and managing a contract with the National Radiation Laboratory.

District Health Boards

The New Zealand Public Health and Disability Act 2000 established 21 DHBs. DHBs are Crown entities responsible to the Minister of Health and funded via a population-based formula by the MOH. DHBs are responsible for planning, funding and ensuring the provision of health and disability services to a geographically defined population.¹⁵² Their priorities include: reducing inequalities in their populations, prioritising health services within the budget, and providing access to disability support, mental health services, and primary healthcare. They are required to develop partnerships with Māori by establishing formal iwi relationships in their region. DHBs range in population size from about 30,000 to nearly 500,000.¹⁵³ Their governance is by an 11 member committee; seven locally elected, and up to four ministerial appointees. Each board must have at least two Māori members regardless if they are appointed or elected.

DHBs provide age-related residential care to those in their district who are eligible. All DHBs have contracts with age-related residential care facilities to provide long-term residential care for those who qualify for a government subsidy. The local DHB is also responsible for assessing individuals to determine if they qualify for age-related residential care services. As needed, DHBs assist in handling and/or resolving complaints against age-related residential care providers and may provide clinical and technical assistance to providers if problems are identified during a regulatory audit. DHB staff are responsible for monitoring the implementation of a provider's

¹⁴⁸ Ministry of Health "Statement of Intent 2013 to 2016," (2013)

¹⁴⁹ Ministry of Health "Statement of Intent 2013 to 2016," (2013)

¹⁵⁰ Ministry of Health "Statement of Intent 2013 to 2016," (2013)

¹⁵¹ Ministry of Health "Clinical Leadership "Protection and Regulation Business Unit," (2013)

¹⁵² New Zealand Parliament "New Zealand Health System Reforms," (2009)

¹⁵³ New Zealand Parliament "New Zealand Health System Reforms" (2009)

certification audit correction plan to ensure regulatory issues identified during the audit are rectified.

Office of the Health and Disability Commissioner

The Health and Disability Commissioner (HDC) Act 1994 created the Office of the Health and Disability Commissioner that is responsible for promoting and protecting the rights of consumers accessing health and disability services and facilitate resolution of their complaints. The HDC Act required the commissioner to establish a code of consumer rights. The code extends to any person or organisation providing a health service to the public regardless of whether payment for the service is received. It applies to institutional providers (e.g. age-related residential care, hospitals) and all traditional registered health professionals, like doctors, nurses, and dentists, as well as to holistic health professionals, such as naturopaths, homeopaths, acupuncturists, and similar providers. HDC staff do not investigate all service complaints, but only those suspected as violations of the code. The Code of Consumer Rights comprises:¹⁵⁴

- Right 1: The right to be treated with respect.
- Right 2: The right to freedom from discrimination, coercion, harassment, and exploitation.
- Right 3: The right to dignity and independence.
- Right 4: The right to services of an appropriate standard.
- Right 5: The right to effective communication.
- Right 6: The right to be fully informed.
- Right 7: The right to make an informed choice and give informed consent.
- Right 8: The right to support.
- Right 9: Rights in respect of teaching or research.
- Right 10: The right to complain.

The HDC Act also established the nationwide Health and Disability Advocacy Service. It operates independently of government agencies, the Health and Disability Commissioner, and the funders of health and disability services. Trained advocates assist consumers to resolve complaints about health or disability services. While some complaints are resolved directly between the consumer and the provider, the advocacy service provides free advocates to assist consumers, if needed. If the complaint remains unresolved or is serious, it may be formally investigated by HDC staff and, in some cases, may result in a prosecution being taken against a provider by the independent Director of Proceedings in the Health Practitioners Disciplinary Tribunal and/or the Human Rights Review Tribunal.

Advocates have been visiting age-related residential care facilities for six years. They visit facilities to make it easy for residents to speak with an advocate and to provide free education sessions for provider, residents, and whānau/family members. As of 2012, all but one of the rest homes in New Zealand has had at least one contact with an advocate and 506 rest homes have had at least two contacts.

In an effort to coordinate information about the quality of health and disability services, the HDC provides a twice yearly report to DHBs about the amount and types

¹⁵⁴Health and Disability Commissioner (HDC) “Annual Report” (2012)

of complaints received about healthcare services under their purview, like age-related residential care.¹⁵⁵

If a consumer's complaint is not resolved with assistance of an advocate and is of a serious nature, HDC staff may start a formal investigation into the complaint. After the investigation, the HDC staff may ask a health and/or disability expert to review the information and to advise whether the health and/or disability services provided met the expected standards. The Health and Disability Commissioner (Commissioner) will use this advice and the other evidence to decide if the code of rights has been violated. When deciding a complaint, the Commissioner acts impartially and considers the totality of the information and then makes a final decision. The final decision is a written report on the case.

When published, the final decision may or may not identify the health and disability providers involved in the complaint. Since 1996, when the Code of Consumer Rights originated, the HDC published investigation reports without naming the health and disability providers involved. The rationale for the policy was to focus on educating the providers in the hope that name suppression would ensure greater provider co-operation. However, in 2006, the HDC became concerned that this level of secrecy was undermining public confidence in the health professions and complaint handling procedures.¹⁵⁶ Consequently, the HDC reversed their procedures and decided to name DHBs in decisions where violations of the code had occurred. The rationale for the new policy established that DHBs should be publicly accountable for the quality of care they fund or provide.¹⁵⁷ Moreover, it was believed that consumers were being denied information that could influence their choice of health practitioner or facility and there was a "growing public desire for openness."¹⁵⁸ In 2007, the new openness policy was extended to include other group and some providers. However, the new openness policy prompted a strong negative response from the providers, particularly in relation to the HDC naming group providers such as rest homes, private hospitals, residential care facilities, medical centres and pharmacies.¹⁵⁹ Because of the backlash, the Commissioner reverted back to not identifying providers that had violated the consumer code. The name suppression policy was reviewed again in 2008. Currently, the rationale to identify a provider who seriously violated the consumer code is decided on a case-by-case basis.¹⁶⁰ The general principles used to guide the Commissioner's naming decisions, regardless of provider type, are based on whether the public interest to identify the provider outweighs the potential harm to the provider and the consultation of relevant parties.¹⁶¹

¹⁵⁵ HDC "Annual Report 2012" (2013)

¹⁵⁶ HDC "Naming Providers" (2013)

¹⁵⁷ HDC "Naming Providers" (2013)

¹⁵⁸ HDC "Naming Providers" (2013). p. 1

¹⁵⁹ HDC "Naming Providers" (2013)

¹⁶⁰ HDC "Naming Providers" (2013)

¹⁶¹ HDC "Naming Providers" (2013)

4 SUPPORTING QUALITY IMPROVEMENT IN NEW ZEALAND

Regulations are the minimum standard set by governments that age-related residential care providers are required to meet. While the assurance of quality does not solely rest on the shoulders of regulators, examining regulations and the structure in which they operate are natural starting points for consumers and stakeholders to begin to form a judgement whether the care provided is of adequate quality. Below are ten recommendations that are grouped into five themes to address gaps and strengthen current efforts to support quality improvement efforts.

Incentivise Person-Centred Care in the Regulatory Process

Observation: The Ministry of Health currently defines quality in the aged residential care sector by audit findings (e.g. amount of continuous improvements awarded), certification length, and the number of provider complaints. This narrow definition of quality does not encourage or support on-going quality improvement efforts among providers resulting in limited high-quality providers from which consumers can choose.

Recommendation 1: Link the use of person-centred care practices to a longer certification length.

Since person-centred care began in long-term care settings it has emerged as a priority across the healthcare continuum across the world. However, New Zealand and US healthcare providers continue to delay or resist its implementation. Age-related care providers from both countries struggle to start the process to become person-centred for a variety of reasons ranging from not knowing how, or fear of regulatory reprisal, to assuming that providing person-centred care is too costly.

Booth, Miller, & Mor (2008) surveyed New Zealand long-term care experts and learned that most reported being “not at all,” “slightly,” or only “moderately” familiar with the concept of person-centred care. Despite their lack of knowledge about person-centred care, most of those surveyed said that cost and resistance from rest home leadership and staff were the three most important barriers preventing the widespread adoption of person-centred care.¹⁶² Booth *et al.* (2008) suggest that the survey results indicate that the lack of knowledge and implementation of person-centred care could be remedied by the central government taking the lead for its implementation by adding person-centred care principles in the *Health of Older People Strategy*. Additionally, they recommend that using aged residential care regulations, as the US government has, may be another approach to increasing the adoption of person-centred care practices in New Zealand’s long-term care sector.¹⁶³

Concurring with the Booth *et al.* (2008) proposal, Recommendation 1 would link the implementation of person-centred care to a longer certification length for age-related residential care providers. The rationale for connecting certification length to person-centred care is to offer additional motivation to providers who have yet to implement a person-centred model of care and reward those who already have but do not have it recognised on their certification audits. Because providers pay for all audits, the

¹⁶² Booth *et al.* (2008)

¹⁶³ Booth *et al.* (2008)

benefit to them in obtaining a longer certification period is that they will incur less cost because they will be audited less often (e.g. 4 years instead of 2 years). The benefit to regulators and consumers is that this incentive may act as motivation to providers who have yet to make this change and may continue to drive providers that are further along the continuum of person-centred care to maintain a longer certification period.

The Health and Disability Services Standards (Standards) created in 2001 and most recently amended in 2008 are the minimum requirements with which health and disability service providers must comply. The Standards are outcome-based which means they are designed to allow flexibility for providers to meet them in a variety of ways and foster innovation and creativity in obtaining the desired outcome. The Standards were designed to reflect the provision of person-centred care.

In an effort to demonstrate whether person-centred care ideas and principles were contained in the Standards, I created an inventory of person-centred principles and requirements from established organisations known to have developed person-centred frameworks and train or credential others to provide person-centred care. These organisations included: Eden Alternative, Picker Institute, Selwyn Foundation, and Planetree International. Many of the principles, with minor wording differences, were shared across two or more of the organisations, but all principles were included on the inventory list resulting in duplication of ideas. A total of 67 principles were identified.

Next, I identified relevant criteria from the Standards that represented each person-centred principle in the inventory. If more than one criterion represented the principle, then all were listed in the inventory. If no criterion was found to be representative of a principle, then none was listed. To ensure its accuracy, two MOH HealthCert senior advisors and I reviewed the Standards' criteria that I believed represented person-centred principles on the inventory list. Next, the advisors and I began the process to reduce the number of inventoried person-centred principles and eliminate any duplication. To do this, the HealthCert advisors and I used two questions to guide our decision-making:

1. If the principle was not implemented in a facility, would person-centred care be present?
2. Could rest home auditors determine if the principle was implemented in a facility?

Through this process, the HealthCert advisors and I reduced the list from 67 to 24 principles. Using the categories developed by Planetree International for their self-assessment tool, I grouped these remaining 24 principles into the following categories:

- Structures and Functions Necessary for Culture Change
- Human Interactions/Independence, Dignity, and Choice
- Promoting Patient/Resident Education, Choice, and Responsibility
- Family Involvement
- Healthy Food Choices
- Healing Environment: Architecture and Design
- Arts Programme/Meaningful Activities and Entertainment
- Spirituality and Diversity

- Integrative Therapies/Paths to Well-being
- Healthy Communities
- Measurement

Each category contained at least one person-centred principle. The final inventory of person-centred principles can be found in Appendix 1.

Of the 24 principles, seven do not relate to any current Standard or its criteria. However, some person-centred principles relate to more than one Standard and its criteria. Conversely, some Standards' criteria were broad enough to relate to more than one person-centred principle. Of the remaining 17 principles:

- 4 relate to criteria in the Organisational Management Standard,
- 11 relate to criteria in the Continuum of Service Delivery Standards,
- 6 relate to criteria in the Consumer Rights Standard, and
- 3 relate to the Safe and Appropriate Environment Standard.

This exercise seems to confirm that the Standards do reflect person-centredness. This is one suggested way for the MOH to identify relevant person-centred values to establish a measure when determining if facilities have a person-centred care foundation on which care is delivered. Soliciting input from various stakeholders, especially rest home residents and their families, should also be considered. Once meaningful person-centred principles are chosen, the MOH would educate and train the DAA auditors about person-centred care, its principles, and how to view the Standards and associated criteria as being fulfilled in a person-centred way. Lastly, the MOH may consider adding standards or additional criteria to existing Standards to better represent person-centred principles or those principles not represented by the current the Standards.

Assist Providers with Quality Improvement

Observation: The Ministry of Health has not developed quality indicators and/or measures to identify and track quality improvement efforts within the aged residential care sector and to assist all stakeholders in monitoring quality improvement efforts and activities.

Recommendation 2: Identify and create quality indicators and/or measures for multiple stakeholder groups to track progress of quality improvement efforts.

In the Office of the Auditor-General 2012 report, *Effectiveness of arrangements to check the standard of rest home services: Follow-up report*, it identified an opportunity provided to the MOH through the introduction of the PRMS and interRAI systems.¹⁶⁴ The Auditor-General recommended that the MOH identify ways to bring together data from the new systems and identify uses for the data to encourage continuous quality improvement efforts in age-related residential care.

Recommendation 2 would have the MOH identify and create quality indicators and/or measures from data collected by the PRMS and interRAI systems. It is suggested that a variety of measures that represent the interests of the various stakeholder groups be created so all stakeholder groups could track the progress of quality improvement

¹⁶⁴ OAG (2012)

efforts in the aged residential care sector.

Aged residential care is a multidimensional concept and therefore requires indicators and measures to assess its quality from many different angles. Different stakeholder groups will each find value in different measures. For example, providers, policymakers and regulators may find value in clinically-based measures (e.g. medication usage, weight loss, and urinary tract infections); consumers and their family may want measures assessing quality of life (e.g. dignity, community interaction, resident choice-making, food quality and choices); while advocates may find use in a combination of both (e.g. responsiveness to resident requests, staff turnover rates, use of interdisciplinary team). According to Zimmerman (2003), quality indicators could be used in the following ways: as part of an external quality assessment or review process, by providers as part of their internal quality improvement activities, to educate consumers and to compare facilities, and to assist policymakers in allocating resources or informing future policy decisions.¹⁶⁵

New Zealand has an enviable opportunity to elevate quality of life to the same level as quality of care when creating performance measures and quality indicators. One of the shortcomings of the US system is the lack of measures or indicators assessing patient autonomy and quality of life.¹⁶⁶ Despite the intent of OBRA 1987, the US regulatory system continues to struggle with elevating quality of life to the same level as quality of care. The US system remains primarily focused on accountability, minimising selected adverse outcomes, and the avoidance of mistakes, resulting in its focus on facilities, rather than the needs and wants of the individual people in their care.¹⁶⁷ Measures and indicators of quality of life are of equal, if not greater, value to residents in age-related care facilities. As Higginson and Carr (2001) point out, the use of quality of life measures ensures that treatment and evaluation focus on the patient rather than the disease.¹⁶⁸

While the HQSC may seem like the appropriate entity to convene a discussion and gather input about appropriate quality indicators and measures specifically for aged residential care, consideration should be given to keeping this task within the MOH or at a minimum create a partnership between the two entities to oversee this project. The importance of subject matter expertise can prove to be extremely useful as to whether a proposed aspect of life in residential care is worthy of measurement and if its measurement could occur without adding additional burden or cost to providers or their caregiving staff.

The MOH HealthCert team has age-related residential care experts who are experienced and knowledgeable about quality of care and quality of life in age-related residential care facilities. Their subject-matter expertise should not be dismissed. It is valuable because it is “real world” and practical insight that comes from fieldwork and regular interaction with providers, residents, and aged care staff.

Observation: The lack of a public-private partnership between the Ministry of Health and aged residential care providers limits the sector’s ability to promote best practices and evidence-based standards of care amongst its stakeholders which impedes the dissemination of quality improvement efforts.

¹⁶⁵ Zimmerman (2003)

¹⁶⁶ Kane (2001)

¹⁶⁷ Capitman et al. (n.d.), p. 29

¹⁶⁸ Higginson and Carr (2001)

Recommendation 3: Create regionally-based quality improvement organisations to assist providers and disseminate quality improvement research and best practices.

Quality Improvement Organizations (QIO) were created because the US government is the largest healthcare payer and it has a vested interest in the quality of care provided to almost 50 million Americans. Before QIOs, some providers may have had limited choices in where to seek assistance to correct regulatory issues or pursue continuous quality improvement activities. Likewise, regulators' initial approach to confront and punish for the delivery of poor quality did not prove successful in increasing the use of continuous quality improvement practices. Prior to the creation of QIOs, a void in the regulatory framework existed. A government-approved organisation to assist providers with quality improvement practices did not exist. A similar void exists in New Zealand's aged residential care regulation structure. No one responsible and qualified entity exists for regulators to refer or require troubled providers to seek technical assistance for on-going compliance or quality of care concerns. Although DHBs give technical assistance to providers, it is done as staff and resources allow. Moreover, the capacity of DHBs varies and as more persons enter aged residential care, DHB resources and priorities may not be able to keep up with the demand for this type of assistance.

Recommendation 3 would create regionally-based QIOs to assist providers and disseminate quality improvement research and best practices. Multiple regionally based QIOs would fill this void and allow regulators to maintain their neutrality and independence and not offer advice or promote specific care practices to foster quality improvement. Creating regionally-based QIOs around the country allows for a public-private partnership to be established for the benefit of all aged residential care stakeholders. Multiple regionally-based organisations would allow for local relationships to be formed to foster trust among QIO staff and DHB staff, health practitioners and providers, as well as to easily disseminate quality improvement practices and research.

QIOs would be established based on the US model that a non-governmental, non-profit organisation with qualified health professionals experienced in aged residential care would contract with the central government to provide specified quality improvement activities for a defined period of time. The QIOs' contract would specify what type of problems or recurrent issues with which to assist providers. Data from the PRMS and interRAI systems could be used to identify the trends and areas with which providers may need assistance. Regulators or DHBs could also require or refer troubled providers to QIOs as a condition of certification or to fulfil a corrective action plan. Additionally, providers could self-refer to a QIO to seek assistance before a small problem becomes significant enough to become a compliance issue to be addressed by regulators.

Providers with longer certification periods are perceived to provide better care because they are determined to be a lower risk of not complying with the Standards, and therefore require less frequent audits. Data as of May 2013 from the Ministry of Health indicates a need for technical assistance to age-related residential care providers and for continual quality improvement efforts to take root with more of them. Two-thirds of all aged-related residential providers (67 per cent) received a 3-year certification and 21 per cent received a 2-year certification. This represents a decline in the per cent of providers achieving 3-year certifications. According to the

OAG in 2009, 80 per cent of rest homes were certified for three years and 14 per cent for two years.¹⁶⁹ Furthermore as of May 2013, eight DHBs had 21 per cent or more of aged-care providers within their geographic boundary receive 2-year certifications and four DHBs had over half or nearly half of their providers fall into this category.

As of May 2013, 45 or 6.8 per cent of all age-related residential care facilities hold a 4-year certification. The three DHBs with the most providers earning 4-year certifications are: Auckland, Canterbury, and Southern. Nine DHBs did not have any aged care providers with a 4-year certification. Figure 15 shows the distribution of certification length for all DHBs.

Two obstacles confronting the regionally-based QIO concept are funding and staffing. Funding for the QIOs could be based on a three-share concept where the central government and/or DHBs, provider organisations, and providers (those who self-refer) contribute to the organisation's budget. Sharing funding responsibility among stakeholders is meant to promote "buy-in" from each contributing organisation so each has a vested interest in ensuring that the QIO concept succeeds.

Finding proper staff may be a bigger and more time-consuming issue to solve. Anecdotally, various long-term care stakeholders recognised and identified to me that it may be difficult to find quality improvement and technical experts in the health sector. Since providing technical assistance to providers is not a typical role of doctors, nurses, or other health care specialists, it is unknown at this time how many qualified professionals may exist or be able to work in this capacity. Staffing QIOs with experienced and knowledgeable experts is critical to the concept's success.

While quality improvement organisations exist within the government health sector, they are not the appropriate entity to provide this type of service. For example, the HQSC promotes quality practices at a high level across the health sector, but its mission is not suited to giving specific technical assistance to providers of aged residential care. Nor is it a proper role for a government entity to take on without diminishing their objectivity or neutrality.

Regional quality improvement organisations exist through cooperation and collaboration of multiple groups. For example, Ko Awatea is a collaborative venture between Counties Manukau District Health Board, Manukau Institute of Technology, Auckland University of Technology, the University of Auckland, the Institute of Healthcare Improvement, National Health Service Wales, and the Better Value Health Care. Ko Awatea implements quality improvement programmes, but also at a high level that is meant to affect the entire health sector. Moreover, and similar to the Health Quality and Safety Commission, its advisors and programmes are not specific to aged residential care.

¹⁶⁹ OAG (2009) p. 24

Figure 15: Certification Length by District Health Board, 2013

	Auckland DHB		Bay of Plenty DHB		Capitol & Coast DHB		Canterbury DHB		Counties Manukau DHB		Hawkes Bay DHB		Hutt Valley DHB	
<1 year	1	1.35%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
1 year Prov	6	8.11%	2	6.25%	0	0.00%	3	3.49%	0	0.00%	0	0.00%	1	6.67%
1 year	1	1.35%	0	0.00%	0	0.00%	0	0.00%	1	2.50%	0	0.00%	0	0.00%
2 year	10	13.51%	5	15.63%	4	12.50%	22	25.58%	2	5.00%	6	22.22%	1	6.67%
3 year	46	62.16%	23	71.88%	27	84.38%	51	59.30%	34	85.00%	21	77.78%	12	80.00%
4 year	10	13.51%	2	6.25%	1	3.13%	10	11.63%	3	7.50%	0	0.00%	1	6.67%
Total	74		32		32		86		40		27		15	
	Lakes DHB		Mid Central DHB		Northland DHB		Nelson / Marl. DHB		South Canterbury DHB		Southern DHB		Tairāwhiti DAHB	
<1 year	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	1.56%	0	0.00%
1 year Prov	2	14.29%	0	0.00%	1	4.35%	3	11.54%	0	0.00%	2	3.13%	0	0.00%
1 year	0	0.00%	0	0.00%	1	4.35%	1	3.85%	0	0.00%	0	0.00%	0	0.00%
2 year	2	14.29%	7	18.92%	10	43.48%	3	11.54%	1	7.69%	14	21.88%	4	57.14%
3 year	10	71.43%	30	81.08%	10	43.48%	18	69.23%	12	92.31%	40	62.50%	3	42.86%
4 year	0	0.00%	0	0.00%	1	4.35%	1	3.85%	0	0.00%	7	10.94%	0	0.00%
Total	14		37		23		26		13		64		7	
	Taranaki DHB		West Coast DHB		Waitemata DHB		Whanganui DBH		Waikato DHB		Wairarapa DHB		ALL	
<1 year	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	0.30%
1 year Prov	1	3.45%	0	0.00%	3	5.17%	0	0.00%	2	3.85%	1	6.67%	27	4.07%
1 year	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	3.85%	0	0.00%	6	0.90%
2 year	16	55.17%	2	40.00%	16	27.59%	2	14.29%	9	17.31%	0	0.00%	136	20.51%
3 year	12	41.38%	3	60.00%	35	60.34%	12	85.71%	34	65.38%	14	93.33%	447	67.42%
4 year	0	0.00%	0	0.00%	4	6.90%	0	0.00%	5	9.62%	0	0.00%	45	6.79%
Total	29		5		58		14		52		15		663	

Source: Ministry of Health

Expand Penalty and Sanction Options for Regulators

Observation: Regulators have limited options when imposing sanctions on noncompliant providers. Without a range of penalties, Ministry of Health staff cannot match the lack of compliance with an appropriate penalty, and this reduces their effectiveness as a regulator.

Recommendation 4: Create new sanctions and/or strengthen current sanctions to assist regulators to gain provider compliance.

At present, MOH regulators have limited options with which to coerce or strongly urge an age-related residential care provider to comply fully with Standards that have been partially obtained or unfulfilled. For non-serious and non-urgent Standards' violations found during an audit or complaint investigation, providers would be required to fulfil a corrective action plan submitted to their local DHB. The corrective action plan would identify the actions the provider agrees to take to fix the Standards' violation and the period of time in which the actions will occur. The DHB would be responsible for confirming the corrective action plan had been fulfilled and, if it is not, the DHB could notify the MOH or continue to meet with the provider until the matter is resolved. For example, at times MOH regulators and DHBs encounter providers who are slow to comply with corrective action plans or continue to have repeated violations of the same Standard because they did not address the root cause of the violation. In these cases, no penalty options exist that match the level of noncompliance for the MOH or the DHB to gain the provider's satisfactory compliance with the Standards. In these instances, an assessment of a financial penalty, mandatory training, or other intermediate sanction may be the measured response to elicit a meaningful and productive response from the provider.

It would be rare that a serious Standards' violation would occur during a certification audit because the providers know when the auditors will conduct the audit. However, when serious or multiple violations are found, MOH regulators have the two options to use: either to appoint a temporary manager to a facility to oversee its improvement, or to revoke or not renew the provider's certification. Without a certification, the provider would not be allowed to receive government funding. MOH has the ability to assess a financial penalty of up to \$50,000¹⁷⁰ for a provider's noncompliance and up to \$1,000¹⁷¹ can be levied against a provider for prohibiting MOH staff to inspect a facility. However neither is used, except rarely, and in practice they are not regarded as serious regulatory penalty options.

Recommendation 4 would create additional sanctions and/or strengthen current sanctions to allow regulators to have more options to ensure provider compliance. A range of penalty options is a key characteristic of a modern responsive-based regulatory system because without them the regulator's effectiveness is reduced which can lead to frustration among consumers, thereby diminishing their confidence in the abilities of regulators.

In the US, financial penalties are used regularly to ensure that serious or urgent

¹⁷⁰ New Zealand Legislation (2001) Health and Disability Services (Safety) Act 2001, Part 4, Section 54.

¹⁷¹ New Zealand Legislation (2001) Health and Disability Services (Safety) Act 2001, Part 4, Section 54.

regulatory deficiencies found in nursing homes are addressed in a timely manner. These sanctions are known as civil money penalties (CMP). US federal regulations authorise per day CMPs in two categories: US\$50 to \$3,000 per day for non-jeopardy deficiencies (boxes D-I) and US\$3,050 to \$10,000 per day for immediate jeopardy (boxes J-L).¹⁷² Refer to Figure 10 in this report for definitions of deficiency severity. Other US sanctions include: denial of payment for new Medicare or Medicaid admissions, a directed plan of correction, additional state monitoring, temporary management, and termination from the Medicare or Medicaid programme. Each of the US sanctions is worthy of consideration for implementation in New Zealand.

Observation: Ministry of Health regulators have few options and resources to deal with age-related residential care facilities that continue to provide substandard care or do not address the systemic causes of problems identified during an audit.

Recommendation 5: Create a special focus facilities programme.

When a provider delivers substandard care to its residents, their failure puts residents' lives at harm and causes regulators to act quickly to ensure residents' safety. A more difficult problem to manage is when providers "bounce" in and out of compliance because the root cause of the noncompliance is not adequately addressed. While revoking a provider's certification is the most extreme option available to regulators, it may not be the easiest or best option for many reasons. For example, other providers in the area may not have the capacity to accept new residents, relocating frail residents may put their health in greater jeopardy, and relationships between residents and staff will be disrupted. It is in the interest of consumers, providers, and regulators to ensure that facility closure is prevented. To do this, Recommendation 5 would create a Special Focus Facilities (SFF) programme within the Ministry of Health so that providers with a pattern of poor compliance can be monitored closely and consistently to ensure the systemic cause of issues identified during an audit are addressed and to avoid sudden and immediate facility closures.

The programme could be based on the US's programme of the same name. The US Special Focus Facility (SFF) Program is limited to only 136 facilities nationwide due to resource constraints. Nursing homes are selected for the programme by state regulators who use the annual survey inspection results and other data. Nursing homes assigned to this programme are among a state's fifteen worst performing facilities. Once identified as a SFF, these facilities are inspected twice as frequently as other nursing homes and are subject to more robust enforcement, including termination from the Medicare and Medicaid programmes for providers that fail to improve within 18 months.¹⁷³

New Zealand is well-positioned now to establish a SFF programme because of the introduction of the PRMS and interRAI systems. The MOH will have access to more data than in the past to identify patterns of poor care and noncompliance with the Standards. A SFF programme enhances MOH regulators' efforts to ensure quality care is provided because it creates an intermediate option rather than immediate closure. It allows regulators to intervene with providers before a closure would

¹⁷² GAO "Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction," (2009)

¹⁷³ GAO "Special Focus Facilities Are Often Improving, but CMS's Program Could be Strengthened," (2010)

become necessary and it may help to ensure that no facility's care ever becomes so poor that an immediate closure is warranted because this programme would allow regulators to identify and track the worst providers earlier and more closely. Furthermore, it would put noncompliant providers on notice sooner to correct deficient practices.

Use Data and Technology to Support Quality Improvement Efforts

Observation: The Ministry of Health lacks vision and a plan to guide the health sector beyond the implementation of the international Resident Assessment Instrument in the aged-residential care sector. Without foresight and planning, the wealth of health sector data provided by the assessment may not be used in strategic and thoughtful ways to inform quality improvement practices, policy decisions, resource allocations, and clinical services.

Recommendation 6: Dedicate staff and resources to the interRAI New Zealand Governance Board to ensure a strategic vision for interRAI's use is implemented.

New Zealand has a unique opportunity as a late adopter of interRAI. It has the advantage of learning from more than 20¹⁷⁴ countries' experience instead of navigating through time-consuming trial and error approaches to determine how using the data can improve the quality of care.

InterRAI has the potential to benefit the entire New Zealand health sector. In the US, it has been in use since the 1990s to assist healthcare staff, specifically nurses, to gather definitive information on a patient's strengths and needs and subsequently addressed in an individualized care plan. According to the OAG, DHB chief executives endorsed a recommendation to roll-out the use of interRAI in phases with all age-related residential care providers using it by 2015. Participation for interRAI was optional until October 2012, when the Minister of Health made it mandatory for all age-related residential care facilities to use to assess residents. As of May 2013, 122 out of 663 rest homes have sent staff to attend the interRAI training and 119 more facilities are scheduled to be trained by July 2013.¹⁷⁵ The use of interRAI in aged residential care follows the successful implementation of its roll-out for clients accessing home-based support services that was completed 2012.¹⁷⁶

Introducing interRAI to the New Zealand health sector allows for standardized data to be collected about persons living in age-related residential care facilities that will be used to formulate individualised care plans, thereby creating a link between the assessment of a resident and the implementation of the care plan. Collecting data about elders benefits the health sector because it will allow clinicians and all stakeholders to understand the aged residential care population, their needs, and whether the services provided meet their needs.

In 2011, the interRAI New Zealand Governance Board was formed to guide the implementation of interRAI in the aged residential care sector.¹⁷⁷ It is a group composed of clinicians and professionals from the MOH, DHBs, academic

¹⁷⁴ Ikegami, Hirdes, and Carpenter (n.d.)

¹⁷⁵ Meehan, B. pers. comm. 6 June 2013.

¹⁷⁶ Goodhew (2012)

¹⁷⁷ InterRAI New Zealand Governance Board (2011)

institutions, Health Information Technology Board, residential care, advocates, interRAI fellows, and others.¹⁷⁸ It meets every four months. Its objectives are to provide leadership and ensure successful implementation of interRAI, provide strategic advice for the full use of the interRAI suite of instruments, act as a resource and communication centre within New Zealand and internationally, and ensure the performance of the national software host service and national training service.¹⁷⁹ Despite the importance of the Board's mission their progress has been slow to address the issue of strategic planning and how the interRAI data will be used to improve the quality of care. In July 2013, the Board initiated a 5-year strategic plan that may provide direction for how interRAI's data may be used in the future.¹⁸⁰ A lack of dedicated staff to carry out the Board's day-to-day work may be one explanation for the planning not advancing more quickly. Owing to the scope and size of implementing interRAI, it requires that it have constant attention and dedicated resources to ensure its successful completion.

The introduction of interRAI is at a critical juncture. Training and implementation are under way, but plans have not been confirmed on how the assessment data will be used beyond its original, clinical purpose. Data collection has also started on a national software platform, but nationally agreed processes and protocols need to be established so that the MOH and DHBs can begin to work collaboratively with the data. Establishing processes and protocols cannot begin until it is determined how the data will be used to benefit the health sector and more specifically, how the interRAI data will be used to inform the certification/regulatory process for aged-residential care facilities. To complete this critical step in the interRAI implementation, Recommendation 6 would have all the appropriate Governance Board member entities dedicate adequate staff and resources to the project.

Observation: Without consistent data reporting and analysis, MOH regulatory staff cannot determine emerging trends or negative patterns of provider compliance, or demonstrate advances in quality improvement. This information gap prevents staff from staying ahead of regulatory issues and supports reactionary responses and short-term solutions.

Recommendation 7: Ensure that regulator staff conduct on-going analysis of PRMS and interRAI data.

Recommendation 8: Require the publication of an annual performance report by the Ministry of Health.

The second of the two new data collection systems to be implemented is the Provider Regulation Monitoring System (PRMS). PRMS is a MOH database that collects and stores audit report information on age-related residential care providers. Provider audit report information is already collected now, but through the computer software, Lotus Notes, which requires MOH staff to transform the data into a form that can be used for analysis. Transforming data into a usable form and format is time-consuming and inefficient for staff when current technology exists that could perform the work with greater accuracy and in less time.

¹⁷⁸ InterRAI New Zealand Governance Board (2011)

¹⁷⁹ InterRAI New Zealand Governance Board (2011)

¹⁸⁰ Meehan, B. pers. comm. 11 July 2013.

According to the MOH, it expects the new PRMS system to improve the quality and use of data from certification and other types of audits. PRMS is also anticipated to assist in identifying areas where auditor education could be enhanced. New functions of PRMS that are anticipated to improve the efficiency and effectiveness of regulators include:

- Electronic assignment of tasks to appropriate staff and groups of staff who may require collective access to the same regulatory data.
- Additional on-line options for providers to communicate and comply with reporting requirements and legislative mandates.
- Access for DHB staff to update and record the progress of providers' corrective action plans.
- Automatic notification of high-risk providers to appropriate MOH staff.
- Pre-populated templates to assist auditors when writing results of an inspection.
- Increased ability for MOH staff to create reports to improve their analysis of data.
- Ability to analyse the cost of each audit in relation to the audit result.

Analysis of PRMS and interRAI data is vital to monitoring the quality of care in aged residential care facilities. The OAG emphasised this point in its 2012 performance audit follow-up report. The OAG concluded that “the introduction of PRMS and interRAI over the next two to three years provides an opportunity for the MOH to consider how it might bring together and use clinical and audit information to continuously improve the quality of care provided in rest homes...”¹⁸¹

Despite the addition of interRAI and PRMS, the MOH has not indicated that it would add additional staff to ensure regular data analysis occurs. While the addition of two full-time equivalents (FTEs) is not mandatory to implement Recommendation 7, it would be desirable, given the current workload and capacity of HealthCert staff. Whether additional staff are added, the critical issue is to ensure that data analysis occurs on a continual basis by staff who have expertise in data analysis and aged residential clinical care. An equally important goal is to ensure that the PRMS and interRAI data are sufficiently incorporated into regulatory, budgeting, and policy decisions.

Presently, 5.5 full-time staff are responsible for the certification of aged residential care facilities. Three of the five HealthCert staff are dedicated to aged residential care certification and two divide their time between reviewing aged residential care, DHBs, and disability residential care audits. The HealthCert staff dedicated to aged residential care perform unannounced audits; respond to DHB, consumer, and provider enquiries; oversee and review DAA audits; and recommend the length of certification for more than 600 age-related residential care providers. Even though audits are performed by DAAs, a significant portion of the HealthCert staff workload comes from overseeing the work of the DAAs. As pointed out by the OAG 2009 report, *Effectiveness of arrangements to check the standard of services provided by rest homes*, multiple DAA companies perform audit work which requires HealthCert

¹⁸¹ OAG (2012) p. 41

staff to continuously monitor them for inconsistent assessments against the Standards due to conflicts of interest, inadequate skills and expertise, commercial pressure, and other external influences.¹⁸² The HealthCert staff provide the necessary oversight to ensure DAAs' audits are consistent, objective, and truly measure providers against the Standards. Otherwise because providers pay for their audits, the certification system could easily become automatic instead of one with checks and balances.

The HealthCert staff workload for aged residential care is consistently full. In 2012, 569 audit reports for aged care facilities were reviewed and processed or the equivalent of 126 audits per HealthCert advisor.¹⁸³ The certification audit reports read and reviewed by HealthCert advisors average 100 pages in length with information that will determine if the provider is in compliance with 50 standards. The certification process requires the HealthCert advisor to read through the auditor's report, complaint data, and other information they may have received that bears on the provider's ability to comply with the Standards. The HealthCert advisors analyse the evidence and observations of the auditor to make an informed recommendation as to the length of time a provider's certification should be.

Recommendation 7 would have the MOH ensure that ongoing data analysis of PRMS and interRAI data occurs and ensure its use is sufficiently incorporated into regulatory, budgeting, and policy decisions. Implementing this recommendation would not only allow for regular analysis to occur, but could allow existing staff to conduct more unannounced MOH audits if data analysis was the sole responsibility of other FTEs within the HealthCert team. It would also position the MOH favourably to manage the ever-increasing demand for aged residential care. Complaint inspections and other non-certification audits could benefit from using standardised clinical data and data analysis too. Data analysis will enable the MOH to establish a Special Focus Facility programme and identify facilities in need of attention. (Recommendation 5).

MOH staff have identified several types of reports they could and/or plan to generate with the new PRMS system. To ensure the widest dissemination of all the new data and analysis, Recommendation 8 would propose the publication of an annual performance report by the MOH, similar to the US's Centers for Medicaid and Medicare Services Nursing Home Data Compendium that details its actions to regulate age-related residential care providers. The MOH annual regulatory report could be published on the Ministry's web site for all stakeholders to access. Some of the recommended contents of the report would include: an analysis of provider compliance by DHB, provider certification length by DHB, top 10 most cited "partial attainments" of Standards, top 10 complaints by provider type, data for any performance measures established by the MOH, as well as other current or emerging regulatory trends identified through data analysis. The Australian Department of Health and Ageing has published a similar report, *Report on the Operation of the Aged Care Act 1997*, since 1997.¹⁸⁴

Observation: When working outside of the office, Ministry of Health regulatory staff are unable to access regulatory data and information that is pertinent to their job because of out-dated technology and ministerial policies. Accordingly, staff are unable to work efficiently and respond in a timely way to regulatory enquiries.

¹⁸² OAG (2009). pp. 37-42

¹⁸³ Thompson, R. pers. comm. 21 June 2013.

¹⁸⁴ Australian Government Legislation (2013)

Recommendation 9: Invest in new technology to improve the efficiency and effectiveness of Ministry of Health regulatory staff.

Recommendation 9 builds upon the previous recommendation. It would have the MOH upgrade its hardware and software technology by investing in new mobile tablet PC or similar technology to improve regulators' ability to be responsive and accessible when away from the office. Presently, MOH staff are unable to access regulatory data or work products remotely while travelling on MOH business. Working with out-dated technology creates an additional burden for staff and reduces their efficiency and responsiveness to enquiries. Affordable technology exists to provide staff access to work-related information and data systems in a mobile format while ensuring the security of the data. Mobile Tablet PC technology is widely used in many countries to improve staff productivity and ensure data access regardless of staff's location. In Texas, similar technology was used to improve the ability of caseworkers for children and families to spend more time in the field with clients while being able to remain current with their report filings. According to caseworker survey data, 52 per cent of caseworkers were able to spend more time in the field as a result of using the Tablet PC.¹⁸⁵

Observation: The Ministry of Health does not use its web site to its full capabilities; thereby missing an opportunity to improve consumers' and providers' knowledge about aged residential care and its regulation.

Recommendation 10: Use ministry's web site to regularly publish information and data meaningful to all stakeholders.

The MOH is missing an opportunity to improve communication with its stakeholders by not providing more information about its activities on its web site and with its current outreach activities. The web site pages for rest home regulation are not dynamic or informative in that the information does not change with regular frequency for it to be used as a reliable resource by consumers, providers, and advocates. While current outreach efforts conducted by the MOH are valuable, they could be improved to educate the public too. For example, the MOH advertises in the quarterly Grey Power publication. The advertisement identifies to readers that rest home certification audit reports are available on the MOH web site. To improve its message to consumers, the MOH should consider going beyond this, and instead identify what information in the audit report is pertinent and whether it should or should not inform consumers' decision-making.

The MOH web site does not provide consumer-friendly information that could assist older adults and their families when making a major life decision, such as choosing a rest home. For example, information such as "Questions to Ask When Choosing a Rest Home," or a "Rest Home Checklist" could be added to educate consumers about topics to get more information about providers to ensure the facility will be a good match for them or family member. Identification of current best practices in age-related residential care would be helpful. More importantly, no information is present on the MOH web site about how to file a complaint, how to report suspected elder abuse or neglect, or how to contact HealthCert staff or appropriate DHB staff regarding a quality of care concern.

¹⁸⁵ Computerworld Honors Program Case Study (2006)

The certification audit summaries currently published on the MOH web site give basic information about a provider's last audit; however, the summaries are not easy to read for the average consumer. Using bullet points and additional subject headings may improve their readability by helping readers to hone in on information most important to them. Also, adding a glossary to help consumers understand words like "restraint," "assessment," "care planning," "risk management system," and others may help to educate them about the language of aged residential care.

The web site could also be used as a resource for providers too. For example, the HealthCert staff conduct presentations around the country about rest home regulation activities. It would be valuable to publish these presentations on the web site for providers to access later.

Recommendation 10 would have the MOH add and regularly update information on its web site that is meaningful to consumers, providers, researchers, and policymakers. Once the PRMS and interRAI data systems are operational, the MOH will have access to more data about the quality of care occurring in age-related residential care facilities and could identify what information would be most useful to various stakeholder groups to ensure only the most pertinent information is published.

Prior to adding more information to their web site, the MOH may consider seeking feedback through focus group interviews from key stakeholder groups, such as consumers and their families, providers, policymakers, media, and advocates, to ascertain what type of information may be most useful to them. Focus group research would allow for in-depth questioning and responses that a survey would not provide. Focus groups would ensure MOH obtains information from the target audience who would use the MOH web site to obtain aged residential care information. Once new information is published on the web site, MOH should consider using various media to announce its availability. The following are ideas the MOH may consider using to raise consumers' awareness about available age-related residential care information: (1) use appropriate social networking sites, (2) request DHBs, providers and advocates include a MOH link to relevant aged residential care information on their web sites, (3) post information in residential care facilities, and (4) distribute information to doctors and their staff.

5 FUTURE ISSUES TO MONITOR

Funding for New Zealand's long-term care system will likely remain the country's most important policy issue to address in the short- and long-term future. It is an issue many countries will revisit again and again over the next 20 years because there are no easy solutions. However, despite the importance and seriousness of how to finance long-term care, governments should not let it monopolise the policy agenda.

In New Zealand, at least three other issues all related to safety are equally grave and if left unaddressed could significantly impact the long-term care system even if the issue of finance is solved. Each issue discussed below was often repeated both in stakeholder interviews and literature reviews in my research. Since the US and other countries have already started to address these issues, policymakers have years of experience and research to use to identify solutions that will work in New Zealand.

Formalise Investigations and Data Collection on Elder Abuse, Neglect, and Exploitation

The most concerning and disturbing revelation about the New Zealand long-term care system is that no government entity is responsible for collecting data about incidents of elder abuse/neglect/exploitation (hereafter collectively referred to as abuse). According to a literature review about elder abuse conducted by the Ministry of Social Development in 2006,

“It is widely acknowledged in the literature that, although there is very limited systematic gathering of statistical data on elder abuse and/or neglect, a range of other sources, including criminal records, media reports, social service records and small-scale research projects, provide evidence that the abuse, neglect and financial exploitation of older people are much more common than the public is aware.”¹⁸⁶

The prevalence of elder abuse in other countries varies. In 2003 it was reported in Australia to be between 1 and 4 per cent, in Norway, the US, and Canada 5 per cent, while Finland and Sweden reported a 17 per cent abuse rate.¹⁸⁷ Based on 2003 data, there were an estimated 478,000 people age 65 and older in New Zealand. Using the lowest prevalence range from other countries (2 to 5 per cent), it could be assumed that between 9,560 and 23,900 New Zealanders may have been victims of abuse.¹⁸⁸

Various entities through the course of their work may come across suspected or actual abuse of an elder; however, there is no central organisation responsible for notifying, investigating, or keeping records of abuse. Reporting of abuse, when it is suspected, is fragmented and inconclusive because different entities, including DHBs, providers, MOH, Age Concern, HDC, or the police, may receive these reports. Also, because no formal or standard investigation protocols exist outside of a police investigation, the suspicion of abuse may not ever be substantiated and therefore, accurate recordkeeping is prohibited.

Age Concern, a non-profit organisation assisting and advocating for older adults, offers education and prevention services about elder abuse through its Elder Abuse

¹⁸⁶ Fallon (2006). p. 2

¹⁸⁷ Fallon (2006)

¹⁸⁸ Fallon (2006)

and/or Neglect Prevention (EANP) programmes. Twenty-two EANP programmes exist across New Zealand.¹⁸⁹ Unfortunately, without data, it is uncertain if education and prevention programmes have been successful. Furthermore, it is unclear how informed policy decisions can be made without data to determine the size and scope of the problem and if current resources are adequate.

Abuse, like other forms of violence, may go unreported or under-reported for many reasons including: fear of retaliation, ignorance, or incapacity of the victim. To improve reporting, many countries, like the US, have established a legal requirement for all persons to report suspected elder abuse. This is not currently possible in New Zealand because there is no specific government entity to report the abuse to. If abuse occurs in a residential care facility, it could be reported to the facility manager; however, this may resolve issues on a case-by-case basis, but it does not ensure the future safety of other older adults because the offending employee could change jobs and work in another residential care facility.

In the US, each state has established an Adult Protective Services (APS) programme with federal funding from the Older Americans Act 1965. The purpose of APS programmes is to develop, strengthen, and carry out programmes for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation (including financial exploitation).¹⁹⁰ APS investigators are not police investigators, but are specially trained to investigate suspected incidents of abuse that are reported to a central state government-operated call centre. All US states have a mandatory legal requirement for healthcare providers to report confirmed elder abuse.¹⁹¹ If abuse is confirmed, the elder may be referred to social service programmes for assistance. In extreme cases, the confirmed abuse case may be referred to the court system for prosecution. State and federal government healthcare employment registries also exist to track workers who have had a substantiated allegation of abuse and are now prohibited from working in long-term care facilities.

Make Public the Names of Deficient Providers

The goal and mission of the Health and Disability Commissioner (HDC) is to be a champion of consumer's rights and to resolve consumer complaints, protect consumer rights, and encourage providers to learn from complaints to improve the quality of care.¹⁹²

HDC's current naming policy is incongruent with its mission. Once a complaint investigation is completed, HDC does not automatically identify providers that have violated the Code of Consumers' Rights. When information is withheld, it is not information that is frivolous or unsubstantiated. Only 3.2 per cent of complaints were serious enough to receive an investigation in 2011/12.¹⁹³ Investigations result when complaints show "significant departures from a reasonable standard of care," according to the HDC.¹⁹⁴ Of the 1,380 complaints closed in 2011/12, 44 were resolved

¹⁸⁹ Fallon (2006)

¹⁹⁰ Administration on Aging "Older Americans Act 1965" (2013)

¹⁹¹ Medscape Reference (2013)

¹⁹² HDC "Annual Report" (2012)

¹⁹³ HDC "Annual Report" (2012)

¹⁹⁴ HDC "Annual Report" (2012)

through an investigation. Of the 44 investigations, 29 or 65 per cent determined that the Code of Consumers' Rights had been violated.¹⁹⁵

Part of the HDC's mission is to encourage providers to learn from complaints. The aim to educate providers is worthwhile, but the protection and education of consumers should not come second to the education or preference of providers. Letting the public know about offending providers creates additional assurance that both providers and consumers will learn from the complaint.

Releasing the names of providers in HDC decisions is not the same as "report card" data widely used in the US to inform consumers about doctors' practices, hospitals' surgical infection rates, and other measures that can be misunderstood without the proper context. HDC decisions are factual information obtained through a structured investigatory process. Obscuring the names of offending providers from the public also does a disservice to the patients who were harmed by the provider. Their complaints of wrongdoing may be validated on paper by the HDC's decision, but without the public release of the information, a stigma or question as to their validity will remain.

A suggested better measure to use when deciding whether to publicly identify a provider may be to ask if *not* naming the provider would do more harm to consumers instead of requiring the public interest to outweigh the harm to the provider. After all, it is worth remembering that it is the provider that has already been found to have caused serious harm.

Standardise Healthcare Assistants' Training Requirements

Instrumental in the ability to provide long-term care is an adequate, skilled, and diverse workforce. Doctors, registered nurses, licensed vocational nurses, nurse aides, healthcare assistants, and informal caregivers (family and friends) are all a part of the long-term care workforce. Nurse aides are known as healthcare assistants in New Zealand, while in the US, they are also known as nurse assistants, personal care workers, orderlies, attendants, home health aides, and certified nurse aides. In most countries, they are direct-care workers who provide the bulk of bedside care for elders in aged residential care. Their duties include providing assistance with eating, bathing, housekeeping, and observing and reporting changes in a client's condition.

New Zealand and the US are among many countries facing a growing concern about the current and future supply of nurse aides.¹⁹⁶ Many aspects of a work environment that affect workforce shortages are magnified in the long-term care sector. Previous research points to many interrelated factors contributing to high rates of turnover including low wages, emotionally taxing and physically daunting work, limited opportunities for advancement, and inadequate and outdated training.¹⁹⁷

Inadequate training may lead to high turnover according to a growing body of research. According to the Paraprofessional Health Institute, 40 to 50 per cent of all US nurse aides leave the job within the first six months because they have not learned to manage competing demands on the job. Research also demonstrates trainees resign out of frustration or disillusionment because what they are taught in class does not

¹⁹⁵ HDC "Annual Report" (2012)

¹⁹⁶ OECD "Help Wanted: Providing and Paying for Long-Term Care" (2011).

¹⁹⁷ Legislative Budget Board (2009), 'Strengthen CNA Training'.

prepare them for the realities of direct-care work. Higher levels of training for direct-care workers can help employers both find and keep employees. The belief is that more effective training may reduce turnover rates by giving new workers much needed confidence to know that they are doing the job properly.

In the US, federal law requires nurse aides who work in nursing homes participating in the Medicare or Medicaid programme to be certified. To become a certified nurse aide (CNA), one must complete a state-approved training programme, pass a competency test, and be listed in the state's CNA registry. The federal CNA training programme must consist of a minimum of 75 hours of training, of which 16 hours must be supervised practical or clinical training. States have the option to require more training hours than the federal minimum, and more than 25 states do.

In New Zealand, per the Age Related Residential Care Services Agreement, healthcare assistants who work with residents receiving a government subsidy in a dementia care facility are required to have completed four New Zealand Qualifications Authority unit standards about dementia care. New Zealand healthcare assistants working in other age-related residential care facilities are required to complete training within six months of being hired related to the ageing process, communication skills, residents' rights, cultural issues, and practical care skills. However, the training is not standardised and may be provided by staff at the workplace. Without standardised training, it is difficult to determine if all workers are receiving the same and adequate training and learning proper skills.

Raising the qualifications by requiring standardised training ensures all who receive the training have the same basic foundation of knowledge when entering the workplace which can contribute to improving the quality of care. It allows for career ladders to be created and elevates the importance of the work in the long-term care system in the eyes of stakeholders. Standardising and requiring training for all New Zealand healthcare assistant staff may incentivise a job that is very difficult work.

There is an immediate need to develop a committed, stable pool of direct-care workers who are willing, able, and prepared to provide quality care to people with long-term care needs. Training is the first step to improving the stability of the long-term care workforce. If training does not adequately prepare a worker for the job, no amount of money, benefits, or work schedule flexibility will be able to compensate for its inadequacy.

CONCLUSIONS

Regulators are not solely responsible for the quality of care in rest homes. They and the standards used to measure providers are one method to ensure proper care is present. Providers have a legal duty to comply with government regulations, but also an innate obligation to strive to surpass them. The work of researchers and clinicians is to inform regulators and providers of their findings and first-hand experiences so that standards and expectations can continue to evolve and reflect the latest evidence-based research. This combination of entities and knowledge creates a framework to reinforce continuous quality improvement efforts in aged residential care.

Each entity needs the proper tools to carry out its part. Regulators need a range of sanctions to ensure noncompliant providers are sufficiently motivated to maintain minimum standards. Aged care providers need recognition and reward of achieving outcomes that exceed minimum requirements. Both providers and regulators need to be accountable to regulators, advocates, and consumers about their actions and methods. All of these entities can benefit from data and research to inform their actions and measure their level of success.

Improving the quality of care in rest homes is not typically at the top of the policy agenda despite demographers, statisticians, aged residential care providers, and advocates announcing the imminent arrival of the wave of aging “baby boomers” and its effects on the long-term care system. Nor is it in the media unless it means reporting horrific stories about the mistreatment of elders or other scandalous events. Kane (2001) puts forward several reasons for its backburner status, the most basic being that among elders, there is no constituency for what quality care is. Without agreement about what quality care should look like, how can one advocate for its improvement. Further, Kane (2001) points out that, as a society, without answering the most basic question of what good rest home quality care is, research and evaluation cannot occur to measure its progress. This is the intersection where the New Zealand aged care sector finds itself with its recent adoption and on-going implementation of its new data systems.

The influx of new data has something to offer almost all New Zealand stakeholders. Regulators can more easily identify lapses in conforming to regulatory standards and incentivise quality improvement efforts through performance measures in clinical and quality of life outcomes. Providers may use it to assess its internal care processes, and policymakers may use it to identify cost effective ways to align payments to the cost of providing care with case-mix adjusted formulas. For elders, the use of a standardised assessment is meant to be a leap forward towards improving the quality of care that they receive in rest homes. However, without a robust discussion and agreement among stakeholders as to what quality care is or looks like and the development of a plan to achieve it, the data gained from new technologies cannot be maximised to the benefit of those who need it the most – the elders.

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APPENDIX: PERSON-CENTRED PRINCIPLES INVENTORY

	Person-centred Principle	Associated Standards' number and/or Criteria
1	STRUCTURE AND FUNCTION	
1a	The organisation's commitment to patient-/resident-centred care extends to all stakeholders and includes regular use of an orchestrated methodology to gather meaningful information from stakeholders.	1.2.1.2, 1.2.3.2, 1.2.3.5, 1.2.3.6, 1.2.3.7, 1.2.4.1, 1.2.4.3
1b	Processes for coordination and integration of care are used.	1.3.3.4, 1.3.10.1, 1.3.10.2
1c	An interdisciplinary task force meets regularly and oversees and assists with implementation and maintenance of patient-/resident-centred practices. The task force is site-based and includes clinical and non-clinical staff and a mix of non-supervisory and management staff.	1.3.3.4
1d	Shared services of a geriatric nurse practitioner (GNP), who develops training materials and teaches staff at the facility how to apply nationally recognised clinical guidelines.	None

2	HUMAN INTERACTION/INDEPENDENCE/DIGNITY/CHOICE	
2a	Open and direct communication is demonstrated among all members of the organisation. This includes having a formalised process in place to fully and empathetically disclose unanticipated outcomes to patients/residents (and family members as appropriate.)	1.1.9.1, 1.2.3.9, 1.2.4.4 1.3.8.3
2b	Continuity of care and accountability for patients/residents is maximised and maintained for the duration of one's care, including during transitions between levels of care and across discrete episodes of care.	1.3.3.4, 1.3.6.4, 1.3.9.1, 1.3.10 - entire standard 1.3.5.3, 1.3.6.2,
2c	Systems are in place that provide opportunities for staff to meaningfully influence how patient-/resident-centred care is delivered (either unit-based or organisation-wide).	1.3.3.4 1.2.4.3 1.2.3.8 1.2.3.9
2d	Systems are in place to maximise the independence, dignity and choice of patients/residents. Patients'/ residents' personal preferences are honoured, and their customary daily habits and routines are upheld.	1.1.3.6, 1.1.3.2, 1.3.4.2, 1.3.7.1 1.3.5.1, 1.3.7.2, 1.3.7.3
2e	The organisation balances safety considerations with being supportive of patient/resident empowerment, independence, and dignity.	None

3	PROMOTING PATIENT EDUCATION/RESPONSIBILITY/CHOICE	
3a	Patients/residents participate in the decisions regarding their care and their decisions are respected. Family is involved in decision-making as appropriate, based on patient/resident need and/or desire.	1.1.9.1, 1.1.9.2, 1.1.10.2, 1.1.10.6, 1.3.1.4, 1.1.10.3
3b	Patients/residents and family members (with patient/resident consent) are involved in the care planning process.	1.1.10 - entire standard 1.3.3.2
4	FAMILY INVOLVEMENT	
4a	Systems are in place that provide opportunities for staff to be responsive to the physical, emotional and spiritual needs of those who are the patient's/ resident's support system.	1.3.3.4, 1.3.4.2, 1.3.6.1, 1.3.7.1, 1.3.7.2
5	HEALTHY FOOD CHOICES	
5a	Patients/residents have access to healthy food choices that accommodate their personal preferences and routines.	1.3.13.1, 1.3.13.2, 1.3.13.3

6	HEALING ENVIRONMENT / DESIGN	
6a	Patients/residents have choices or control over their personal environment, including personalisation, electrical lighting, access to daylight, noises and sounds, odours, thermal comfort and visual privacy.	1.4.2.5
6b	Physical access to the building is barrier-free and convenient for those served.	1.4.5.1, 1.4.5.2, 1.4.5.3
6c	The environment is designed to accommodate privacy needs in a culturally appropriate way and provides for patient/resident dignity and modesty.	1.4.5.3, 1.1.3.1, 1.1.3.2, 1.1.4.4, 1.1.3.5
7	ARTS/MEANINGFUL ACTIVITIES/ENTERTAINMENT	
7a	Staff, patients/residents, and families are engaged and involved in providing meaningful activities and entertainment.	1.3.7.1
8	SPIRITUALITY / DIVERSITY	
8a	The spiritual needs of patients/residents, families and staff are supported.	1.1.6.2, 1.1.3.2

8b	A broad range of healing modalities, including those considered complementary to Western or traditional modalities, are offered to meet the needs of patients/residents.	None
9	INTERGRATIVE THERAPIES	
9a	The organisation contributes to the health of its external community.	None
10	HEALTHY COMMUNITIES	
10a	The organisation welcomes the involvement of its external community in the life of the internal community.	None
11	MEASUREMENT	
11a	Creating a person-centred community is a never-ending process.	1.2.3.5, 1.2.3.6, 1.2.3.7
11b	Empowerment of all staff to make decisions that affect the quality of resident care and the work environment.	None
11c	Continuous reviews by CEOs, executive leadership, and all staff of performance data on resident outcomes and environmental factors relative to other facilities.	None
Note: Red denotes highly relevant criteria that are a part of the new streamlined auditing process.		