

**A QUALITY IMPROVEMENT
FRAMEWORK FOR
VICTORIAN ACAS**

WORKING DOCUMENT

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EXECUTIVE SUMMARY

Section One: Introduction

In recent years there has been considerable interest in ensuring that health services are delivered in accordance with agreed standards and in a manner which is accountable to its various stakeholders including consumers and carers.

This report documents the process of developing a quality improvement framework for Victorian ACAS with the aim of providing an appropriate tool to:

- Assist ACAS managers in the development of their individual service Quality Improvement Plans;
- Facilitate the provision of a high quality service to consumers and service providers; and
- Facilitate consistency in the application of service principles and service provision across teams.

The development of a quality improvement framework has involved a number of stages and tasks involving:

- A review of the quality improvement programs relevant to ACAS;
- A literature review of the range of client feedback mechanisms relevant to ACAS;
- A scoping exercise or survey of all ACASs' current quality improvement activities and their opinions about the content of an ACAS specific quality improvement framework;
- A series of workshops to identify the scope, rationale and mechanisms for performance review of the content areas or domains; and
- Development of a reporting framework for an annual ACAS Quality Improvement Report.

The process of developing the Quality Improvement Framework was overseen by a reference group comprising representatives of the Commonwealth Department of Health and Aged Care, the Department of Human Services and, ACAS managers. The process was also informed by the Commonwealth's draft Aged Care Assessment Program Operational Guidelines¹ (DHAC, 2000) and the newly developed Commonwealth Key Performance Indicators (KPIs). KPIs for the ACAP were developed in 2000 by the Australian Institute for Health and Welfare. KPI development was overseen by the ACAP Data Working Group, a working group consisting of State and Territory ACAP officers and a representative from the ACAP Evaluation Units. The KPIs were officially endorsed in May 2001 by ACAP officials.

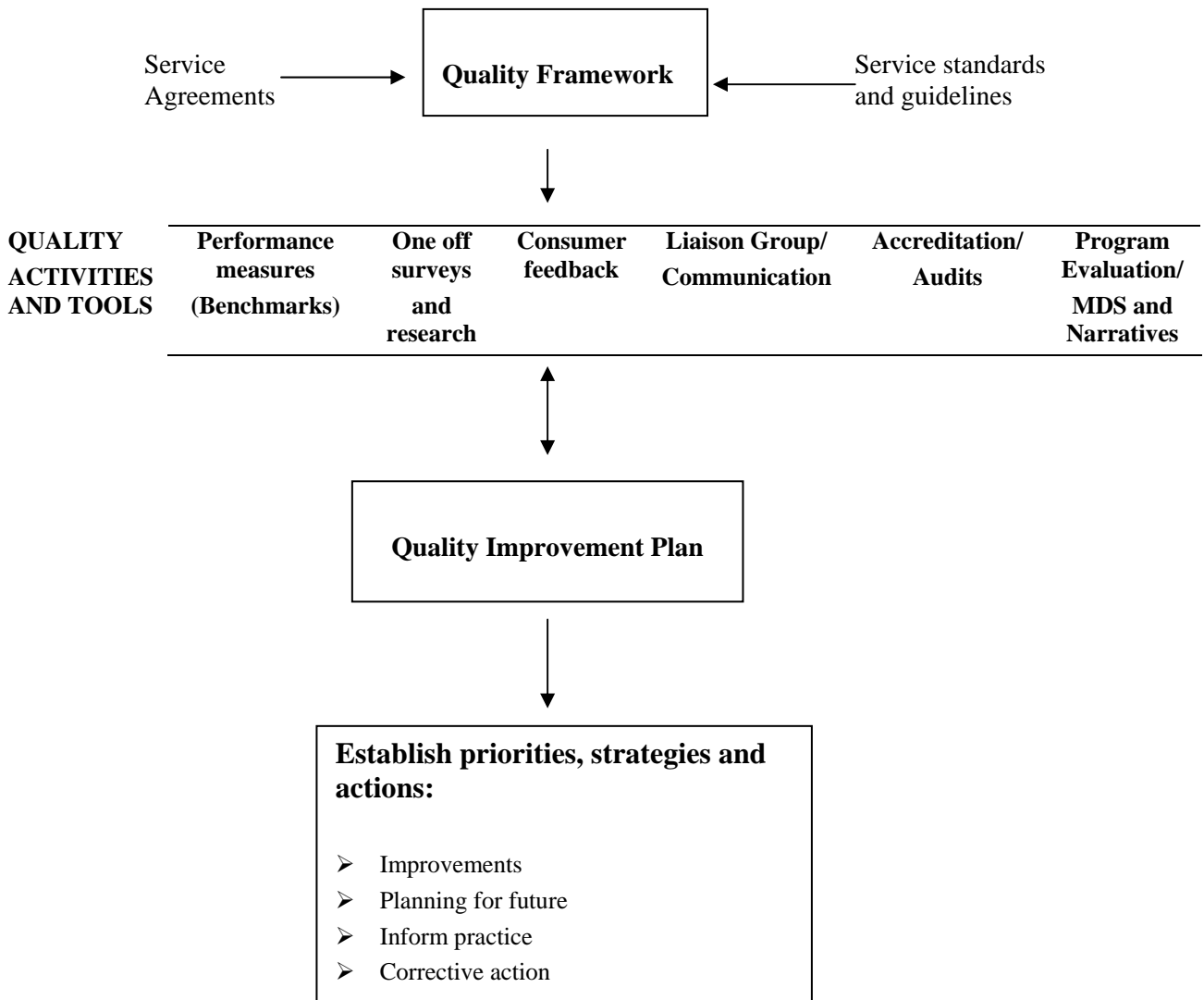
Section Two: Quality Improvement in the ACAS context

The quality literature reviewed presented a diverse range of potential structures for an ACAS Quality Improvement Framework. This ranged from a series of domains which should be considered in any review of a program to very specific and detailed standards of practice. However, it was clear that a quality improvement framework is not necessarily a mechanism for defining standards of practice. Instead, we perceived the quality improvement framework as a tool for guiding ACAS in their quality improvement activities and as a mechanism for ACAS to report to the Commonwealth and State governments on these activities.

¹ The draft Operational Guidelines for the ACAP are not yet finalised or approved. The Victorian quality improvement framework may need some revision to bring it into line with the Guidelines once they are formally approved and adopted.

Clarifying the purpose and expectations of the quality improvement framework also required establishing the relationship between the quality improvement framework and other facets of the ACAS program, including other program documentation. The following figure documents how this was conceptualised.

ACAS QUALITY AND EVALUATION FRAMEWORK



Section Three: ACAS and consumer feedback: A literature review

The literature review detailed in Section Three examined the range of approaches currently used in gaining consumer feedback from older people, and raised issues relevant to gaining useful and meaningful consumer feedback for the ACAS program. The following points summarise the recommendations from this literature review.

Use a range of methods

In general it is wise to employ qualitative methods first, in order to gain a better understanding of the issues from the consumer perspective, followed by more quantitative approaches which ensure that the information collected is representative of the specified client group.

Target specific issues

Methods that target specific issues of concern, or specific standards of practice tend to yield the best information for service improvement purposes. Examples of approaches for client groups with specific needs are illustrated below:

- ATSI clients usually prefer verbal responses over written. Interviewers need to be familiar to participants or to the community, and preferably from an ATSI background.
- Clients from culturally and linguistically diverse backgrounds respond better to focus groups than written or telephone surveys.
- Clients with dementia who are not able to provide direct feedback may be better represented by a focus group with carers of clients with dementia in order to begin to explore some of the issues involved.

Overcoming acquiescent responses

The literature review suggested a combination of approaches to overcome older people's desire to be acquiescent. For example, respondents should be allowed to communicate their satisfaction with a rating scale approach, but also asked open-ended questions so that they can give concrete suggestions about how the service can be improved.

Other issues raised in the review which require consideration prior to developing client feedback mechanisms include confidentiality, ethics approval and timing of client feedback.

The literature review concluded that consumer feedback approached as a 'one-off' annual event using a standardised 'tick box' format is bound to have limitations and will generally provide little guidance for actual service improvement. Instead, feedback from consumers should be utilised throughout the year as part of the review process for various elements of a service's quality improvement plan.

Section Four: Scoping exercise: ACAS quality survey

A survey of ACASs' current quality improvement activities and their opinions about the content of an ACAS specific quality improvement framework was sent to each team manager. Fifteen of the 18 teams responded, a response rate of 83%. Results revealed the following:

- Teams reported involvement most commonly in EQuIP, with two teams involved in QIC program and one accredited against ISO standards. Four teams also reported involvement with the Home and Community Care (HACC) National Service Standards.
- The majority of teams (80%) had developed a quality improvement plan using the different standards as a reference.
- Client satisfaction surveys had been conducted by 12 teams (80%) and referrer satisfaction surveys conducted by nine teams (60%). Eight teams (53%) had conducted both.
- Only two teams reported having developed/ reviewed a consumer charter of rights as part of their quality improvement activities.

- Thirteen teams (86%) review Lincoln Gerontology Centre ACAS Evaluation Reports but only four teams (26%) reported reviewing outcomes of appeals and seven teams (46%) reported conducting reviews of complaints as part of their quality improvement activities.
- The most useful elements of teams' quality improvement activities were reported as consultations with stakeholders (73%), and developing a quality improvement plan (60%).
- Three teams (20%) considered their team's quality improvement activities to be 'very effective' with the remainder providing a rating of 'somewhat effective'.
- Lack of time and staff resources were the most commonly listed barriers to implementing an effective quality improvement process.

Finally, the following general content areas were prioritised by teams for inclusion in an ACAS Quality improvement framework;

- Managing the quality improvement process and developing quality improvement plans;
- Access;
- Assessment policies and procedures;
- Client feedback mechanisms (complaints, appeals and consumer satisfaction surveys);
- Relationships with other service providers, including referrer satisfaction surveys;
- Staff development (including staff training, staff appraisals, ensuring competency);
- Information management; and
- Occupational health and safety.

On examination of the above list of content areas and comparison with the National Public Health Partnership's recently developed National Health Performance Framework (National Public Health Partnership, 2000) it was agreed that 'client outcomes' should be added to the ACAS list of framework elements.

Issues and concerns about the management of the quality improvement process including development of quality improvement plans were addressed in the workshopping process as part of the development of the framework. Discussions from this workshop are summarised in Section Five. However this issue has not been retained as a specific framework element in its own right.

Section Five: The Quality Improvement Framework

As a result of the information gathering exercises described above, the Reference Group identified eight core domains of the framework:

- Domain 1: Client Feedback;
- Domain 2: Team and Staff competencies;
- Domain 3: Assessment Processes;
- Domain 4: Service Access;
- Domain 5: Client Outcomes;
- Domain 6: Service Providers Relationships;
- Domain 7: Safety; and
- Domain 8: Information Management.

Workshops held in December 2000 with ACAS managers and staff shaped the content of each of these domains.

The rationale and objective of each domain are described briefly below. The body of the report contains detailed information on the scope of each domain and mechanisms for performance

review. A matrix or working tool for teams to record their activities in each domain is also included to assist teams to keep a cumulative diary of the quality activities in each area, which can then feed into the annual reporting template.

The Framework requires teams to report to state and commonwealth on their activities in seven domains of the Framework (domains 2-7) as these domains cover ACAS core business.

Domain 1: Client feedback is a *mechanism* for reviewing service performances in the other domains. As such there is no requirement to report separately on client feedback as this will be used as a tool to review activity in the other domains. Details of reporting requirement are contained in Section 6.

Domain One: Client Feedback

Client feedback mechanisms is one of the eight content areas within the framework, but also serves as a method for documenting service quality in other domains of the Framework. For example, client satisfaction surveys are one way of assessing a service's performance in the area of assessment processes. Despite its overlap with other domains, this area is dealt with as an independent element of the framework because of its critical role in gaining feedback about service quality.

Client satisfaction is a desirable outcome of any episode of service delivery. A key objective of gaining client feedback is to provide direction for service improvement.

Client feedback mechanisms might include written feedback; letters of thanks, complaints, verbal feedback; formal complaints and appeals; consumer surveys, paper and pencil surveys; face to face interviews; telephone surveys; focus groups.

Domain 2: Team and Staff competencies

ACAS staff need training and ongoing education to perform their role at a high level of competency. The competency of the team is also critical in the delivery of a high quality service. Team competency is based on the individual competencies of the staff as well as team composition and team processes. The key objectives are:

- To maximise the potential of individual staff and the quality of service delivered.
- To ensure that staff have the capacity to perform their delegation duties as described in the Aged Care Act 1997.
- To ensure that the approach and philosophy underpinning ACAS staff training and ongoing education is linked to the philosophy of each ACASs' auspice and the Victorian Primary Care Partnerships (PCP).

Domain 3: Assessment Processes

ACAS should carry out assessments in accordance with the key principles laid out in the 2000 Draft Commonwealth ACAP Operational Guidelines, the Best Practice Manual and the PCP Charter of Consumer Rights. Assessment processes should be described and evaluated for their quality and performance using the same terminology for assessment and assessment processes as those described in the *Better Access to Services (BATS)* assessment framework developed as part of the PCP initiative.

Key objectives of this domain of the Quality Improvement Framework is to ensure that ACAS assessment processes are:

- Independent of service provision and of the interests of the auspice agency;
- Client focussed;
- Respectful of clients' rights to privacy and confidentiality;
- Culturally relevant;

- Non-judgemental and supportive; and
- Empower clients through knowledge.

Domain 4: Service Access

Equity of access for all older people in the ACAS target population is a desirable goal for all services as is the timeliness of service delivery and the ease with which older people can find out about, and make contact with an ACAS.

A key objective is that older people in most need are accessing the service. In particular, objectives in the Commonwealth's KPIs state that the proportion of older people with severe or profound core activity restrictions, and older clients with dementia should be maintained or increased in the ACAS client population. The proportion of older people from ATSI (aged 50+) and culturally and linguistically diverse backgrounds (70+) should be consistent with the proportion of older people in the population from these specialist groups.

Domain 5: Client outcomes

The core objective of the ACAP program, as defined in the draft 2000 Commonwealth ACAP Operational Guidelines is to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their needs. The draft guidelines identify the following program specific objectives, which describe the desirable client outcomes from an ACAP intervention:

- To prevent premature or inappropriate admission to residential care facilities.
- To help frail older people live in the community.
- To facilitate access to the combination of services that best meets the needs of assessed clients.
- To actively encourage the involvement of clients and their carers, and other service providers in the assessment and care planning processes.

As the Commonwealth has identified six key performance indicators based on analyses of MDS recommendation patterns it is appropriate that quality activities in this domain focus attention on gaining a good understanding of team performance in this area.

Domain 6: Service Provider Relationships

Developing and maintaining effective working relationships with aged and community care service providers is a critical element of ACAS function. Developing and maintaining effective relationships, ensures that clients experience continuity of care, reduced duplication of information giving and assessment, and are assisted to gain access to recommended services.

The draft 2000 Commonwealth ACAP Operational Guidelines identify ACAS program objectives in relation to the interface with ACAS and service providers in the health and community sector. These objectives are, to

- Facilitate access to the combination of services that best meets the needs of assessed clients.
- Promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people.

Domain 7: Safety

Risks to ACAS workers carrying out their duties and the potential risks for consumers associated with ACAS assessments or interventions should be avoided or minimised. This domain incorporates safety for ACAS workers and risk minimisation for consumers including client and family/carers.

Domain 8: Information Management

ACAS are required to maintain information storage, record keeping and data collection systems that enable secure, efficient and effective collection, management, transmission and use of client based information.

One of the objectives of this domain is to ensure that ACAS comply with the requirements of the Commonwealth's Operational Guidelines as well as other state service requirements, namely, the Primary Care Partnership principles that are outlined in the *Information Management Discussion Paper: Primary Care Partnerships*. These documents include guidelines on consumer confidence about privacy and confidentiality, information sharing, IT management practice.

Section 6: Conclusion and action required for implementation

The State and Commonwealth's expectations of how Victorian ACAS will use and report on the Framework is outlined below. ACAS can broaden the application of the framework to meet their service specific and auspice needs.

- The Quality Improvement Framework will be used as a tool to guide the development of ACAS quality improvement plans and therefore the focus of ACAS quality activities.
- The draft elements of the Quality Improvement Framework and the proposals for reporting against the Framework were endorsed by the Quality Improvement Project Reference Group after consideration by the Narrative Report sub-committee. This sub-committee is reviewing other State/Commonwealth ACAS narrative reporting requirements (the revised Six monthly Narrative Reports) and was therefore well placed to consider how the reporting requirements for the Quality Improvement Framework should be incorporated into the annual cycle of reporting.
- The content of the draft Framework and interim reporting requirement will be communicated to ACAS via workshops or training sessions.
- From 2002/2003, ACAS will be expected to provide an annual Quality Improvement Report to both the State and Commonwealth governments which documents the achievements of their team's quality plan from the previous year, and their plans for the following year. The ACAS Service Agreement will require provision of this annual Quality Improvement Report to both the State and Commonwealth governments.
- The report will be contained in the two matrices on pages 9 and 10. However teams will need to be able to validate the entries in the tables by providing more than anecdotal evidence. It is also expected that each ACAS will have quality plans with greater level of detail and probably linked in with the staff members performance planning. Teams will also be required to report on broader issues that require state-wide attention as well as reviewing the utility of the Quality Improvement Framework itself.
- ACAS will be expected to develop an annual quality improvement plan that incorporates the seven domains (domains 2-7). ACAS are expected to obtain client feedback (domain 1) as a key method for reviewing their performance in appropriate areas, ie. assessment processes, service access, relationships with service providers, client outcomes.
- Teams will expected to report in September of each year on their activities from the previous financial year and on their plans for the coming year . However in the first year of implementation, (2001) teams will only be required to identify their quality plans for the 2001/2002 as the previous year's activities will not necessarily fit within the ACAS Quality Improvement Framework.
- The first year of full implementation (2002) will serve as a trial year. During this year, the ACAS will have the opportunity to work with the Quality Improvement Framework for a year, in draft form. Following this, the Framework will evaluated, refined where necessary, then formally endorsed.

- Once the Framework has been trialed and evaluated by Victorian ACAS in conjunction with the State and Commonwealth governments, ACAS auspices and accreditation agencies will be formally notified of the status of the Framework. Auspices will be notified of State and Commonwealth expectations regarding the implementation and reporting requirements against the Framework.

Annual Quality Improvement Report: Review of ACAS Quality Improvement Plan for the previous year:

Quality Improvement Plan Review (review of previous year)	Key areas identified in the previous year as requiring improvement	Achievements over the last twelve months in these key areas (include action/innovation in team practice as well as innovations in developing tools or systems for reviewing quality)
Team and staff competencies		
Assessment Processes		
Service Access		
Client outcomes		
Service provider relationship		
Safety		
Information Management		

Annual Quality Improvement Report : Forward planning for ACAS Quality Improvement Activities

Quality Improvement Plan: (for next 12 months)	Desired outcomes	What actions/quality improvement activities will occur to achieve these outcomes	How will these outcomes be measured? How can it be demonstrated that the desired outcome has resulted?
Team and staff competencies			
Assessment Processes			
Service Access			
Client outcomes			
Service provider relationships			
Safety			
Information Management			

Other questions to be included in the annual Quality Improvement Report:

- Please identify any broader issues that you believe require state-wide or regional attention.
- Were there other important quality improvement activities undertaken last year that did not fit within the parameters of the Framework?
- Please comment on the use of the Framework as a tool for reviewing and planning quality improvement activities. Any comments on refinements, additions?

A QUALITY IMPROVEMENT FRAMEWORK FOR VICTORIAN ACAS

SECTION 1: INTRODUCTION

In recent years there has been considerable interest in ensuring that health services are delivered in accordance with agreed standards in a manner which is accountable to its various stakeholders including consumers and carers. This has resulted in production of numerous discussion papers and sets of practice standards being developed for the various segments of the health sector. It is within this context that the Lincoln Gerontology Centre (LGC) was commissioned by the Commonwealth Department of Health and Aged Care and the Victorian Department of Human Services to develop a Quality Improvement Framework for Victorian ACAS.

In the absence of an agreed Quality Improvement Framework which is recognised in ACAS program protocols and guidelines issued by either the Commonwealth or the State governments, a range of quality improvement approaches have been adopted by Victorian ACAS teams.

The report documents the process of development of a quality improvement framework for Victorian ACAS with the aim of providing an appropriate tool to:

- Assist ACAS Managers in the development of their individual service Quality Improvement Plans;
- Facilitate the provision of a high quality service to consumers and service providers; and
- Facilitate consistency in service provision standards across teams.

Methodology

The development of a quality improvement framework has involved a number of stages and tasks, each of which is discussed in subsequent sections. In summary, this involved:

- Reviewing the quality improvement programs Victorian ACAS are either known to participate in through their auspice and other quality frameworks which they may become involved with as a result of the introduction of Primary Care Partnerships (PCPs).
- Conducting a literature review concerning the range of client feedback mechanisms which could be utilised by an ACAS, along with the limitations and other pertinent issues which need to be addressed in gaining client feedback an ACAS context.
- A scoping exercise which involved surveying all Victorian ACAS about their current quality improvement activities and ascertaining their opinions as to what is required in an ACAS specific Quality Improvement Framework.
- Identifying key domains of a quality improvement framework from the surveys and organising a series of workshops to explore each of these domains more fully. In particular, the workshops identified a rationale for the inclusion of each domain or element in an ACAS quality improvement framework, and identified the scope, performance measures and a matrix for recording the team's quality activities under each domain.
- Development of recommendations, and reporting framework for an annual quality report.

This process was overseen by a reference group comprising representatives of the Commonwealth Department of Health and Aged Care, the Department of Human Services and ACAS managers.

The process was also informed by the Commonwealth's draft Aged Care Assessment Program Operational Guidelines² (DHAC, 2000) and the newly developed Commonwealth Key Performance Indicators (KPIs). KPIs for the ACAP were developed in 2000 by the Australian Institute for Health and Welfare. The process of development was overseen by the ACAP Data Working Group, a working group consisting of Commonwealth officers from head office in Canberra, State and Territory officers, and a representative of ACAP Evaluation Units. The KPIs were officially endorsed in May 2001 by ACAP officials. Three performance objectives have been specified under the 'Quality' performance area. Further details of these objectives and their desired outcomes will be under review pending the development of appropriate quality standards and monitoring processes. The Victorian Quality Improvement Framework could inform these national developments.

² The draft Operational Guidelines for the ACAP are not yet finalised or approved. The Victorian quality improvement framework may need some revision to bring it into line with the Guidelines once they are formally approved and adopted.

SECTION 2

QUALITY IMPROVEMENT IN THE ACAS CONTEXT

Quality frameworks in health

No standardised approach to either the development of content of quality frameworks was apparent in our search of the literature about quality issues which may be pertinent in either ACAS or related agencies and fields of work. However, it is clear that quality frameworks are not limited to the area of assessment or service delivery and should extend to the management and routine operations of a service. This broader set of domains is apparent when examining the quality frameworks developed by the National Expert Advisory Group on Safety, the National Public Health Partnership Performance Indicator Framework, and for Victoria's Primary Care Partnerships. These are both outlined below.

National Expert Advisory Group on Safety and Quality in Australian Health Care

In 1997, the Health Ministers established a National Expert Advisory Group on Safety and Quality in Australian Health Care. While safety issues in acute care underpinned the establishment of the expert group, and its predecessor, the Taskforce on Quality in Australian Health Care, the expert group claims its recommendations apply "not only in the hospital sector, but across the whole spectrum of health care agencies, in public, private and community-based settings" (1999: vii) and presumably includes ACAS. The final report of the expert group recommended that:

The Health Ministers support the need for national actions for safety and quality enhancement in the following areas:

- Strengthening the consumer voice;
- Fostering best clinical practice;
- Learning from incidents, adverse events and complaints;
- Developing frameworks for quality improvement and management;
- Developing information systems to support quality; and
- Education and training for safety and quality improvement. (1999: ii)

National Health Performance Framework

The Australian National Health Performance Framework (National Public Health Partnership, 2000) was developed at the request of the National Health Performance Committee (NHPC). The Framework was adapted from a Canadian model and refined through a process of consultations with government and non-government providers, and consumers in 2000. The Framework describes health status and outcomes, determinants of health and health system performance. Dimensions of performance in health are categorised under the following nine headings. The nine headings map to the three performance areas, Equity, Effectiveness and Quality used in the development of performance indicators for the ACAP program by the Department of Health and Aged Care.

- Effective: care/ interventions achieve the desired outcomes
- Appropriate: care/interventions are relevant to client needs and based on established standards
- Efficient: services achieve the desired results with the most cost effective used of resources
- Responsive: services are respectful and client orientated;

- Accessible: people can obtain care at the right time and place, irrespective of income, geography and cultural background;
- Safe: potential risks are identified and minimised;
- Continuous: services provide uninterrupted care across program areas;
- Capable: service provision is based on skills and knowledge; and
- Sustainable: services have the capacity to provide infrastructure to meet emerging needs (National Public Health Partnership, 2000).

Primary Care Partnerships

In Victoria, the introduction of Primary Care Partnerships also has implications for the development of a quality improvement framework for ACAS. While the PCP quality framework has yet to be fully developed, preliminary information suggests that this framework will consider and build on the range of quality approaches and mechanisms currently utilised within the sector. This will include:

- A philosophy of continuous improvement supported by evidence based practice, systematised self assessment.
- Consideration of quality assurance mechanisms, such as standards, performance measures, service development monitoring and accreditation.
- Consideration of quality improvement initiatives, such as quality improvement strategies and the identification of 'best practice' initiatives.(DHS, 2000b: 36).

There is a strong emphasis on consumer and community participation in PCPs, with particular emphasis on service planning, monitoring and evaluation (DHS, 2000a). All PCPs will be required to develop a consumer charter which incorporates the following principles:

- **Access** based on need, with disadvantaged and vulnerable groups specifically targeted.
- **Consumer privacy** through policies and procedures on privacy, confidentiality, provision of information and access to personal information.
- **Consumer choice** embedded in all levels of service delivery, including the assessment process. Where possible, consumers should have a choice of provider and the flexibility to change provider if desired.
- **Flexible and responsive service delivery** that addresses the diverse needs of the catchment population. Flexible, consumer-focused models such as outreach, extended hours of service and consumer-responsive times of service should be offered wherever possible and seamlessly linked to related services.
- **Identified grievance procedures** where the grievance policy is documented and accessible to consumers and carers. Grievance processes should include both internal and external avenues of redress (DHS, 2000b: 37).

The principle which has been most advanced at this stage is grievance and complaints resolution procedures (DHS, 2000b).

Quality Improvement

To varying extents, both the National Expert Advisory Group on Safety and the Quality Framework for PCPs reflect the idea that quality improvement extends far beyond assessing the performance of individual staff members. Indeed it encompasses all aspects of the work of a health agency and not just the service delivery aspects. Thus quality improvement programs cover the following:

- Policies and procedures;
- Implementation of policies and procedures;

- Processes and strategies for good communication with consumers;
- Strategies for consumer participation in quality activities;
- Service delivery processes;
- Management processes (such as financial management, planning processes and human resource development);
- Quality strategies. (Disability Services, undated: User Guide, 4)

Either an individual or a 'quality team', which could include a range of stakeholders, can be appointed to oversee a quality improvement program and the development of a quality plan which may be an outcome of such an exercise. These key concepts are outlined below.

Stakeholders

A key underpinning in the quality improvement literature is that there should be opportunities for the views of stakeholders to be made known and contribute to the ongoing quality improvement activities of a health agency. In the case of an ACAS, there are many potential stakeholders including:

- Auspice;
- ACAS management and staff;
- CACP providers;
- Clients/ carers;
- Community services;
- Consumer groups;
- Division of General Practice;
- Local general practitioners;
- Hospitals;
- Aged care facilities;
- PGAT;
- RDNS/ home nursing service;
- Department of Health and Aged Care; and
- Department of Human Services.

It is important to recognise that the perspective of stakeholders may differ considerably in what they consider to be important elements of quality. In particular, consumers differ from health care professionals and may place more emphasis on their feelings towards service providers rather than focussing on assessing technical skills:

Consultations with consumers about acute care have suggested that they define quality not only in terms of the technical standard of care provided but also in terms of the process of care. Key components of quality care that consumers identify include effective communication, opportunities for active participation as partners in care, continuity of care and respect for human needs such as dignity and privacy. This does not mean that consumers are not concerned with the clinical effectiveness of treatment—rather that they view quality as something that encompasses the way in which they are treated as well as the outcome of that treatment. (National Expert Advisory Group on Safety and Quality in Australian Health Care, 1999: 5-6)

The next section comprises a literature review which considers further the issues for ACAS in ascertaining the views of stakeholders, particularly clients and carers.

Quality team

The appointment of a quality team to oversee an agency's range of quality activities could include a range of stakeholders. For example, a quality team could consist of the quality manager of the auspice, coordinator/ manager, direct service staff, consumers, family members and other interested members of the community. However, to ensure that all those appointed are able to act effectively as members of the quality team, some training around the quality processes and relevant standards may be required. It is also important that the quality team is provided with the authority to undertake the quality activities on behalf of the agency (Disability Services, undated).

Quality Plan

Responsibilities for a Quality Team will often include the development of a Quality Plan. A Quality Plan involves a regular planning process utilising information gathered from quality improvement activities and sets priorities and actions for quality improvements for the next planning period. As such quality plans incorporate components of both quality assurance and quality improvement:

A Quality Plan is a document that sets out necessary quality improvement activities. It includes:

- The areas identified for action to improve service delivery;
- Clear strategies for each action; and
- Priority setting.
- The plan should also set out:
 - Who will be responsible for the implementation of quality improvement activities;
 - A time schedule for completion of each action;
 - A schedule of monitoring and review of plan implementation. (Disability Services, undated: Quality Plan, 3)

The extent to which there is consultation with stakeholders in the development of a Quality Plan, as well as consultation about the evidence that will be used to demonstrate improved practice should also be considered.

Quality improvement in ACAS

Over the previous five years, a range of evaluation activities have occurred, primarily the ongoing evaluation and monitoring of the program by the Lincoln Gerontology Centre and a state-wide review carried out by Brian Elton in 1995. As a result of this review, program documentation such as the Best Practice Manual and Orientation Manual have been developed. These activities identify a range of areas of ACAS practices central to the ACAS program which should be subjected to quality improvement through a quality improvement framework.

Brian Elton and Associates Review of the Aged Care Assessment Program in Victoria

In 1995, a team from Brian Elton and Associates conducted a *Review of the Aged Care Assessment Program* in Victoria which was funded by the Department of Human Services and Health. The authors concluded that

... effectiveness of ACATs in delivering responsive, high quality services to older people is governed by ACATs' capacity to efficiently manage four inter-related areas of their work. These are:

- Management by the ACAT of human and financial resources, assessment policies, practices and procedures;
- Management of relations with their auspice;

- Management of relations with clients and carers, consumer groups and advocates; and
- Management of the complex interactions with the network of agencies providing services to older people. (Brian Elton and Associates, 1995: v)

The areas in which this review recommended improvements were team management, assessment processes, management of strategic directions, auspice relations, client relations, and service provider linkages (Brian Elton and Associates, 1995).

Aged Care Assessment Service Best Practice Manual

One outcome of the Elton review was the development of *The Aged Care Assessment Service Best Practice Manual* which was developed for use by Victorian ACAS. This incorporates 28 standards, 21 of which relate to client services, and seven concerned with management functions. Each of these standards have a number of criteria and associated guidelines:

A. Client Services	A. Client Services cont.	B. Management
<p>Assessment process</p> <ol style="list-style-type: none"> 1. Approach to assessment 2. Pre-assessment and intake 3. Assessment procedures 4. Clinical investigations 5. Assessment in the home 6. Assessment in residential care 7. Assessment in hospital 8. Continuing assessment 9. Assessment and Aboriginal people 10. Assessment, language and cultural identity 11. Assessment and dementia 12. Younger people with disabilities 13. Complaints and appeals 	<p>Coordination and networking</p> <ol style="list-style-type: none"> 14. Psychogeriatric Assessment and Treatment Services 15. Hospitals 16. General practitioners 17. Residential care providers 18. Community aged care service providers 19. Aged care service planning <p>Community education and information</p> <ol style="list-style-type: none"> 20. Community education 21. Information 	<p>Assessment team</p> <ol style="list-style-type: none"> 22. Assessment team composition 23. Team competency 24. Induction training 25. Continuing education <p>Service management</p> <ol style="list-style-type: none"> 26. Leadership and management 27. Policy and procedures 28. Data management

The Best Practice Manual contains a quality improvement program including both self assessment and peer review of ACAS, although it is unclear how often each ACAS undertake these performance reviews. During 2000, the Liaison Group endorsed the continued use of the manual, with the only changes relating to clarifying sections of the quality improvement section.

The extent to which Victorian ACAS utilise the Best Practice Manual is unclear. The manual was developed by the Liaison Group and has no formal status in individual service agreements, which means that ACAS are under no obligation to use it in their quality improvement strategies. Nevertheless, the recent decision of the Liaison Group in relation to the Best Practice Manual suggests that there is considerable support for the idea of such a manual existing.

ACAS client rights

Client rights and consumer input into the assessment process is a fundamental principle of good practice. The *Aged Care Assessment Teams: Giving You the Choices* brochure published by the Commonwealth Department of Health and Aged Care (1999) is far stronger on client rights than the ACAS Best Practice Manual. This brochure which was designed for distribution to ACAS clients also tells consumers that they have the right to appeal any assessment decisions.

ACAS service agreements

Purchasing frameworks and individual service agreements have the capacity to identify areas where quality assurance or quality improvement activities are required by the State or Commonwealth. For example, the 1998-99 Purchasing Framework for Aged, Community and Mental Health Division of DHS included in its requirements for ACAS to undertake to undertake two quality assurance projects which were to be described in six month reports. Other quality improvement measures outlined included delivery of four in-service programs,

development of an orientation program for new staff and implementing the recommendation of the 1995 review conducted by Brian Elton and Associates (DHS, 1998).

Accreditation processes

ACAS services in Victoria are auspiced by a range of health agency types including extended care and rehabilitation centres and community health centres. These are agencies which typically conduct quality assurance or quality improvement activities as part of their effort to seek agency wide accreditation. It is not uncommon for ACAS to report involvement in these agency wide quality exercises in their six monthly reports. The most frequently reported of these is EQuIP, which is a program of the Australian Council on Health Care Standards but there may also be some auspices which undergo accreditation by the Quality Improvement Council (QIC, formerly known as CHASP) or the International Standards Organisation (ISO) 9000 series standards.

The *Best Practice Manual* was designed to be compatible with both EQuIP and QIC accreditation standards, and thereby confines itself to standards which are ACAS specific, assuming that the more generic standards required by any health agency will have been accounted for by these more generalised continuous quality improvement processes (Aged Care Assessment Service Liaison Group Victoria, 1998).

Accreditation standards

Sets of standards which are not ACAS specific which individual ACAS may be required to address, either currently or in the future, by their auspice or in funding agreements, include EQuIP, QIC, ISO, Home and Community Care (HACC) and the Victorian Standards for Disability Services. These are outlined below.

EQuIP

The Australian Council on Healthcare Standards (ACHS, 1998) has developed the EQuIP accreditation system which is primarily used in institutional health settings. There are 27 standards which are arranged into six functions. These functions are:

1. **Continuum of care**—Access, Entry, Assessment, Care planning, Implementation of care, Evaluation, Separation and community management;
2. **Leadership and Management**—Operation of the governing body, Patient/ consumer rights, responsibilities and ethical issues, External services;
3. **Human resources**—Human resources planning, staff recruitment, selection appointment and responsibilities, Staff training and development, Industrial relations, Employee assistance;
4. **Information management**—Planning information management systems, Data collection, aggregation and use, Record management, Information technology management;
5. **Safe practice and the environment**—Patient/ consumer and staff safety, Infection control, Equipment and supplies, Functional design and layout, Maintenance, Energy and waste; and
6. **Improving performance function.** (Australian Council on Healthcare Standards, 1998)

QIC

The Australian Health and Community Services Standards have been developed by the Quality Improvement Council (QIC, formerly known as CHASP) for use in community based health services. A core module for all services has been developed which groups standards into six categories, which are somewhat similar but with distinct differences from the EQuIP categories, especially in its emphases on consumer rights and participation. These categories are:

1. Management and leadership—Governing body, Accountability, Effective management, Leadership, Efficient administrative and personnel systems;

2. Planning, quality improvement and evaluation—Planning, Evaluation, Quality improvement, Information technology structure, Information management;
3. Training and development—Appropriate training and development, Orientation;
4. Work and its environment— Work satisfaction, Occupational health and safety, Appropriate facilities, Appropriate equipment, Environmental responsibility;
5. Consumer rights—Policy and resources, Confidentiality and privacy, Fair investigation of complaints
6. Consumer and community participation—Understanding and informing the community of interest and other stakeholders, Addressing barriers, Support for participation. (QIC, 1998)

In addition to the core module, QIC have a number of service delivery modules which can be used by services, depending on their core business. Modules developed to date include those for community and primary health care services, home based care services, integrated health services, maternal and infant care services, and alcohol, tobacco and other drug services.

International Standards Organisation

Standards Australia develops generic standards utilising standards promoted by the International Standards Organisation (ISO). ISO standards were originally developed for manufacturing and engineering industries, and use the language associated with these industries rather than of the health sector. It has been suggested that with their focus on concrete products, they are not optimal for assessing health services where the service provided must be tailored specifically to the needs of each client (Skok et al., 2000)

Quality Measures for Home and Community Care

It is currently unknown whether any Victorian ACAS are being assessed with the quality measures developed for the Home and Community Care (HACC) Program but there is some potential for overlap. The HACC National Service Standards have a strong emphasis on consumers and are grouped around seven objectives as follows:

1. Access to services;
2. Information and consultation;
3. Efficient and effective management;
4. Coordinated, planned and reliable service delivery;
5. Privacy, confidentiality and access to personal information;
6. Complaints and disputes; and
7. Advocacy. (Jenkins, Butkus and Gibson, 1998)

The HACC National Standards have more overlap with QIC than with Equip and is essentially a stand-alone instrument for completion by services. Nevertheless, the developers note that after a first full appraisal using their instrument, service providers could in future use only those elements of the HACC instrument which address standards not addressed by other appraisal methods (Jenkins et al., 1998).

Victorian Standards for Disability Services

A standalone set of standards are required to be adopted by all funded disability agencies in Victoria. Agencies will be required to conduct self assessments against these standards until 2003 and after then be subjected to regular external audits.

The nine standards which agencies will be required to meet are:

1. Service Access;
2. Individual Needs;
3. Decision making and choices;
4. Privacy, dignity and confidentiality;

5. Participation and integration;
6. Valued status [of consumers];
7. Complaints and disputes;
8. Service management; and
9. Freedom from abuse and neglect. (Quality Improvement Reference Group, 1999)

Developing a quality improvement framework for Victorian ACAS

Before developing a quality improvement framework for Victorian ACAS, a number of questions first needed to be addressed. These included:

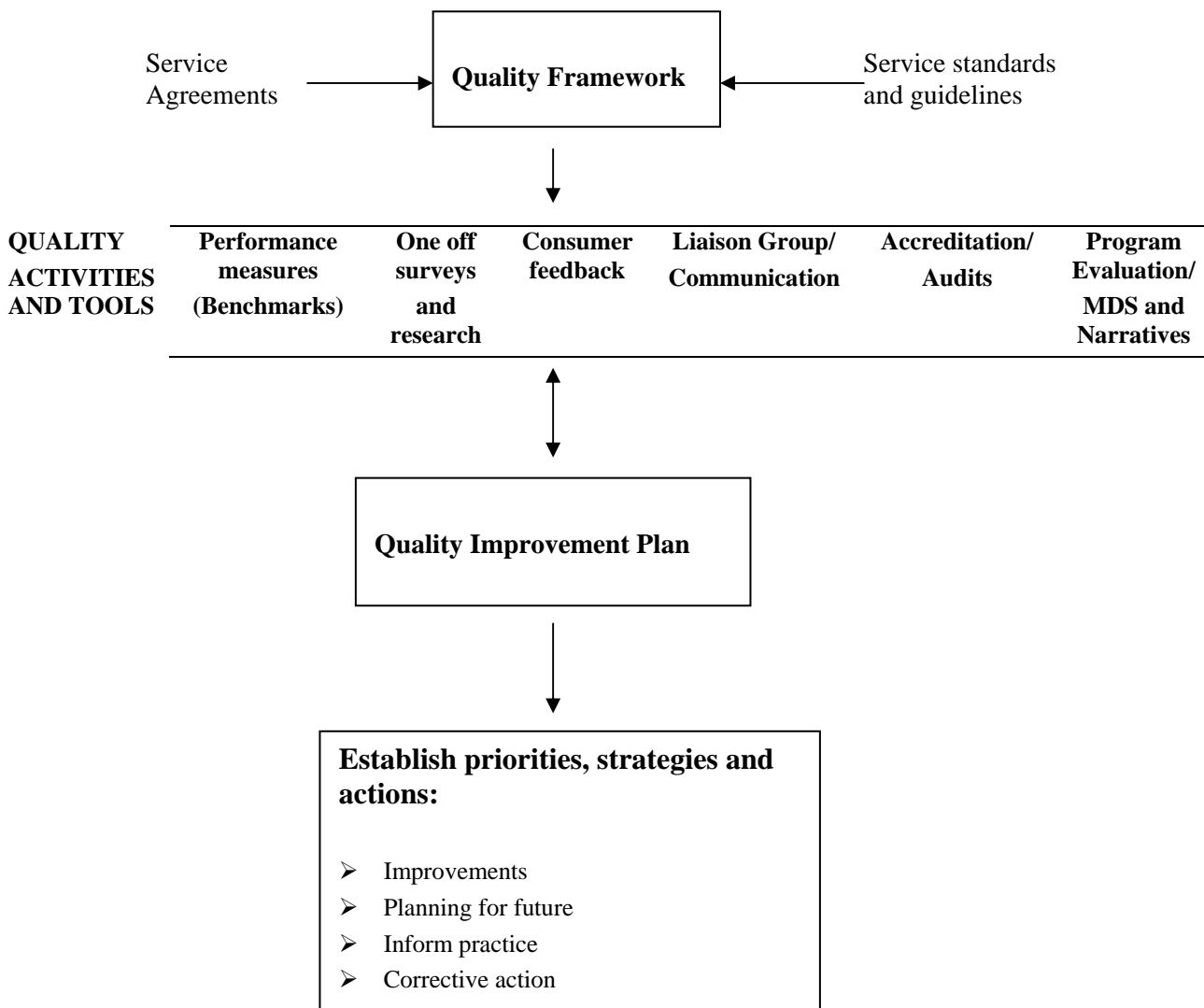
1. Purpose and expectation of the quality improvement framework;
2. Identifying key elements of a quality improvement program;
3. Ensuring that implementation is not overly burdensome on ACAS; and
4. Implementation practicalities.

Purpose and expectation of the quality improvement framework

The quality literature reviewed presented a diverse range of potential structures for an ACAS quality improvement framework. This ranged from a series of domains which should be considered in any review of a program to very specific and detailed standards of practice. However, it was clear that a quality improvement framework is not necessarily a mechanism for defining standards of practice. Instead, we perceived the quality improvement framework as a tool for guiding ACAS in their quality improvement activities and as a mechanism for ACAS to report to the Commonwealth and State governments on these activities. The workshops which are reported in Section 5 confirmed this expectation.

Clarifying the purpose and expectations also required establishing the relationship between the quality improvement framework and other facets of the ACAS program, including other program documentation. Figure 1 documents how this was conceptualised.

FIGURE 1. ACAS QUALITY AND EVALUATION FRAMEWORK



Expectations about quality are included, although sometimes implicitly, in both service agreements, and the service standards and guidelines to which ACAS are aligned. The latter includes the Commonwealth ACAP Guidelines, the Victorian Liaison Group's Best Practice Manual and the Commonwealth/State KPIs. The Best Practice Manual is not officially recognised by either the Commonwealth or State governments.

The ACAS program already has several sources of data which can be used to inform and/ or evaluate quality initiatives. These include the six monthly reports of the Lincoln Gerontology Centre which contain information from both the Minimum Data Set (MDS) and narrative reports prepared by each team. Other sources of quality data are one off surveys and research conducted either by the Lincoln Gerontology Centre or individual teams, consumer feedback, and reports from accreditations/ audits. Performance measures and participation in the Liaison Group also potentially provide teams with feedback as to the quality of their service.

The various sources of quality data, along with other quality activities, logically feed into the development of a Quality Improvement Plan which established priorities, strategies and actions for ongoing quality improvement.

Identifying key elements of an ACAS quality improvement program

Drawing on the literature previously summarised, the range of elements which could be considered for inclusion for a quality improvement framework for Victorian ACAS is as follows:

Client related assessment policies and procedures

- Service access
- Assessment and care planning
- Care planning implementation and follow up
- Consumer rights and responsibilities
- Consumer dignity, privacy and confidentiality
- Culturally relevant practices
- Ensuring client involvement/ choice
- Consumer's rights and access to advocates
- Statutory delegation activity

Client related activities post assessment

- Case management/ ongoing case coordination

Other ACAS functions

- Community education and information
- Regional service coordination(eg management of waiting lists)

Management of stakeholder liaison/relationships

- Management of auspice relationships
- Relationships with other service providers
- Complaints procedures
- Obtaining consumer feedback
- Appeals processes

ACAS management and administration

- Management and governance
- Strategic planning
- Development and review of policies and procedures
- Human resources planning/ staff recruitment
- Staff training and development
- Orientation training
- Industrial relations
- Employee assistance programs
- Information management
- Occupational health and safety
- Environmental responsibility
- Quality improvement and evaluation plan/ strategy

The relevance for these elements, along with ascertaining whether there were any additional elements for inclusion into an ACAS quality improvement framework was established by surveying ACAS managers. Details about this survey are presented in Section 4 of this report.

Ensuring that implementation is not overly burdensome on ACAS

It was important to ensure that the implementation of a quality improvement framework is not overly burdensome on ACAS, as most, if not all, will still be required to undertake a range of other quality activities, which in many cases could require reporting on similar, if not identical, standards. The National Expert Advisory Group on Safety and Quality in Australian Health Care noted that in the submissions it received, there was:

... a strong call ... for improved linkages and coordination between the range of quality improvement approaches, in order to minimise duplication and confusion for health service organisations about expected standards of care. For example, a number of multi-purpose organisations highlighted the confusion and duplication involved in seeking accreditation, where the agency has to meet a range of different standards and accreditation requirements. (1999: 13)

In Victoria, the Disability Services Division of the Department of Human Services has indicated that it will approve alternate assessment strategies to processes designed specifically for the Victorian Standards for Disability Services, providing agencies can demonstrate that their alternate approach enables progress toward meeting the standards to be identified, and a quality plan will be developed which will lead to increased capacity to meet these standards. Alternate accreditations which DHS may approve include EQUiP, QIC and ISO 9002 (Disability Services, undated).

A similar approach in recognising existing accreditation programs or quality awards schemes was considered for the ACAS quality improvement framework to ensure:

- there is not duplication in approach or inconsistency in desired outcomes; and
- to ensure the framework aligns with current agency accreditation requirements.

Implementation practicalities

An important aspect of developing a quality improvement framework is determining how it will be used. Key issues which will need to be determined are the timing, assessment and the reporting processes.

Agencies which are required to comply with the Victorian Disability Standards need to report annually, while QIC and EQUiP involve three and four yearly cycles of quality activities, some of which may be undertaken annually, and others, such as external assessment perhaps once in the cycle. As such, the literature provides no clear guidance as to the frequency which ACAS should either review specific aspects of quality or report on it. Nor does the literature provide clear recommendations as to how agencies might report on their quality improvement activities.

Most quality frameworks employ some aspect of self assessment, and in addition there may be some form of external assessment. If external assessment is to be incorporated into the quality framework, then questions such as who is eligible to be an assessor and how external assessors are appointed will need to be addressed.

The workshops in Section 5 provided opportunities for ACAS to have input as to how these implementation practicalities could best be resolved.

SECTION 3

ACAS AND CONSUMER FEEDBACK: A LITERATURE REVIEW

Obtaining consumer feedback is increasingly becoming an expected norm of health agencies and often considered an integral aspect of a quality improvement framework. However, results of satisfaction surveys are not necessarily a good measure of program effectiveness and should only be one of many elements in a quality improvement framework (O'Neal, 1999). Furthermore, consumer satisfaction studies have often been conducted by public relations departments independently of quality assurance mechanisms, and may collect information which helps a health agency maintain its public image rather than in-depth information which might lead to quality improvement (Vuori, 1991). This brief discussion paper summarise some of the issues for ACAS in obtaining consumer feedback.

Scope of issues

In their review of 24 Australian consumer studies, Cooper and Jenkins (1998) found considerable differences as to which of the following topics were included, with no topic included in every study:

- Satisfaction quality;
- Patient outcomes;
- Characteristics of consumers;
- Needs of consumers;
- Need for improvement/ expectations;
- Service experiences; and
- Consumer knowledge of health issues.

While satisfaction is a multidimensional concept and may be associated with factors such as ease of access, information provision, service provision, participation in decision making, staff behaviour and the ability to make complaints, it is the quality of interaction with staff that predominantly affects satisfaction (E-Qual, 1998).

Respondents

Respondents may differ significantly in their determination of the quality of a service because of differential expectations. For example, quality ratings by hospital patients may differ from those in community settings despite receiving services of ostensibly similar quality (Vuori, 1991). Similarly, persons being assessed may have very different goals and perceptions of the assessment process than family caregivers (Bradley et al., 2000) and family members who act as proxies rate patient care more negatively than do samples of patients (Walker and Restuccia, 1984; E-Qual, 1998). Nor should the views of other service providers such as general practitioners be accepted as an adequate proxy for the views of clients (Jordan et al., 1998), although their views may be quite valid and worth collecting within a quality improvement process.

Research techniques for obtaining client feedback

The following summary of the strengths and weaknesses of various approaches to gaining consumer feedback is taken from the Cooper and Jenkins review of consumer feedback approaches carried out for the HACC program (Cooper and Jenkins, 1998). The Department of Human Service booklet 'A Guide to Participation by Older Victorians' (Department of Human Service, 1999) also provides a useful overall perspective on strengths and weaknesses of various participation techniques appropriate to older people. This booklet describes older people's participation in a much wider sense than the HACC literature review, focussing on techniques for involving older people in regional planning and service development as well as gaining consumer feedback on service quality and improvement. The booklet outlines the following general factors or approaches which should be avoided when consulting with older people:

- Unnecessarily complex information
- Issues that are not part of older people's experience
- Impersonal research techniques
- Large meetings, where possible.

Methodology for gaining consumer feedback	Strengths	Weakness
Questionnaires- self completion surveys	<ul style="list-style-type: none"> • Allow clients time to reflect • Allow selection of specific client groups • Allow targeting of specific aspects of service delivery or service standards • Less expensive than face to face contact 	<ul style="list-style-type: none"> • Questions are decided in advance therefore response are limited. Ratings or ‘closed’ questions gives limited information for service improvement • Possible low response rates and risk of sample bias
Telephone surveys	<ul style="list-style-type: none"> • Can reap the highest response rates, with repeated call backs. <p>Can allow for probing of more indepth information</p>	<ul style="list-style-type: none"> • Can occur at inconvenient times and not allow time to consider responses. • Difficult for people with communication difficulties, cognitive impairments and who have insecure housing
Personal interviews	<ul style="list-style-type: none"> • Allows probing of in depth information • Compensates for some reading and writing difficulties 	<ul style="list-style-type: none"> • Time consuming, high cost, Difficulties with representative sample • Can be intimidating for clients
Focus groups	<ul style="list-style-type: none"> • Allows for in-depth discussion of two or three issues at a time. • Interaction between participants can expose issues that the researchers have not thought about and gives confidence to participants to voice concerns • Good for exploring the dimensions of a particular issues prior to devising a standard questionnaire which is sent to a representative sample. 	<ul style="list-style-type: none"> • Gaining a representative sample is difficult • Time consuming to organise and analyse results • Cost of independent facilitator • Consider who is facilitating the group eg a group designed to gather feedback from ATSI clients may need an ATSI facilitator
Comment cards	<ul style="list-style-type: none"> • Good for a quick rating of service quality in specific areas. • Returned in the mail or into a box prior to departure • Relatively inexpensive and easy to collate results 	<ul style="list-style-type: none"> • May not provide much room for suggestion about service improvement. • Responses may not be representative

Aboriginal and Torres Strait Islander consumers

Issues around obtaining feedback from Aboriginal and Torres Strait Islander clients were examined by Cooper and Jenkins (1998). Key issues include:

- the lack of homogeneity in ATSI communities,
- the lack of appropriateness of conventional interviewing practices for many people who live in indigenous communities;
- a preference for individual interviews over written questionnaires; and
- the need for researchers to spend time in communities getting to know people rather than just conducting interviews and leaving as soon as data collection is complete.

Consumers from culturally and linguistically diverse backgrounds

Users of health services from culturally and linguistically diverse backgrounds (CLDB) are typically under-represented in consumer feedback studies (Brown and Lumley, 1997) and are more likely to withdraw from health services than complain about poor quality service (Cooper and Jenkins, 1998). Lack of interpreter services (especially after hours) may be compounded by a reluctance to use these services because of concerns about the quality of interpreting or that client confidentiality may be breached by interpreters (Cooper and Jenkins, 1998). Where there are few interpreters for a language group, the appropriateness of clients using the same individual interpreters when receiving a service (including assessment) and providing consumer feedback needs to be considered. Focus groups have been used successfully with older CLDB clients and are a more effective method for obtaining consumer feedback than mail or telephone surveys (Cooper and Jenkins, 1998).

Consumers in rural and remote communities

Clients from rural and remote communities may have little in common apart from the fact that they share restricted access to a range of health services. This restricted access may lead to these clients being less willing to provide negative feedback to health providers than those from major urban centres who may be able to access alternative services (Cooper and Jenkins, 1998). The costs of bringing consumers together for focus groups may render this option unfeasible, as may the cost of travelling to clients in rural and remote communities to conduct individual face to face interviews (Cooper and Jenkins, 1998).

Interpreting results of consumer feedback studies

In general, very high levels of satisfaction with health services are recorded among the elderly (Dent et al., 1999). These very high rates of reported satisfaction with health services, often over 90 percent, has led to the argument that “While some patients critically evaluate their care the majority of studies suggest that most service users are very uncritical of it, allowing care to be of extremely poor quality before expressing dissatisfaction” (Williams, 1994: 513).

Numerous studies have found that patient satisfaction is positively associated with being older and female (Aharony, and Strasser, 1993) though among a sample all aged 75 and over no age or sex differences in satisfaction with health services was recorded (Dent et al., 1999). It has been argued that older people are less likely to be critical of health services (Williams, 1994) and that high levels of satisfaction among the elderly may reflect high levels of dependency on care rather than be evidence of a high quality service (Owens and Batchelor, 1996). High degrees of reported satisfaction may reflect factors such as respondents providing what they believe to be socially desirable answers rather than based on their actual experiences, acquiescent responding to positively worded statements, fear of reprisal from service providers,

gratitude for services received which renders recipients unwilling or unable to provide critical feedback and low expectations as to the quality of care one may be entitled to (Cooper and Jenkins, 1998).

The question format can also influence consumers' apparent satisfaction with a service. Studies in which satisfaction was obtained in open-ended questions produced much lower ratings of satisfaction than standardised rating scales (Williams, 1994). For example, in their study of women who had given birth in Victorian hospitals, Brown and Lumley found that only 10 percent rated their care as 'mixed', 'poor' or 'very poor' on a standardised instrument but over 30 percent wrote comments on an open ended question as to how the service could be improved (Brown and Lumley, 1997). This suggests that satisfaction ratings and suggestions for improvement gather quite different types of information.

The extent to which non-responders are followed up may also be critical. In Victoria, early responders to a patient satisfaction survey of women who had given birth were significantly more positive than those whose responses were received after follow up letters were sent (Brown and Lumley, 1997).

Utilisation of findings

After conducting a consumer satisfaction survey, the information should inform an agency's quality improvement program and the results should be fed back to key stakeholders (Meister and Boyle, 1996). However, surveys of client satisfaction have frequently not resulted to quality improvement in health services (Cleary, 1999) and once consumer opinion is obtained, there is the possibility that it may only be incorporated into plans to improve aspects of a service if it concurs with professional priorities (Jordan et al., 1998).

Summary and recommendations

The following recommendations about the best approaches for ACAS in gaining useful and meaningful consumer feedback reflect the key findings of the literature described above.

Use a range of methods

Firstly the literature review suggests that a range of methods should be utilised as there is no one method which can capture the views of a representative sample and, at the same time, collect sufficient level of detail to inform service improvement. Qualitative methods should be employed first, in order to gain a better understanding of the issues from the consumer perspective, followed by more quantitative approaches which ensure that the information collected is representative of the specified client group.

Target specific issues

Methods that target specific issues of concern, or specific standards of practice will yield the best information for service improvement purposes.

Target specific groups of clients

Design feedback studies around specific client groups to ensure the most appropriate methodology is used. Different client groups such as clients from culturally diverse or ATSI backgrounds require different feedback techniques compared to older people from non-ATSI or English speaking backgrounds. Also the extent that these groups know and understand the role of the ACAS in the aged care system, and their expectation of the service, may be much lower than for other clients. The following points should be considered when devising methodologies for special needs groups

- ATSI clients usually prefer verbal responses over written. Interviewers need to be familiar to participants or to the community, and preferably from an ATSI background.

- Clients from culturally and linguistically diverse backgrounds respond better to focus groups than written or telephone surveys.
- Clients with dementia who are not able to provide direct feedback may be better represented by a focus group with carers of clients with dementia in order to begin to explore some of the issues involved.

Focus groups as a starter

Focus groups are time consuming but yield a large amount of information that can then be investigated more thoroughly using other more cost efficient approaches. Consider carefully who runs the group in order that participants can be frank and honest without fear of reprisal or withdrawal of service.

Overcoming acquiescent responses

The literature review suggested a combination of approaches to overcome older people's desire to be acquiescent. To overcome older people's desire to be acquiescent, either because of their sense of gratitude or their low expectations, the following approaches into self completion questionnaires or telephone surveys can be built in:

- Allow respondents to communicate their satisfaction with a rating scale approach, but follow this with an open-ended question such as *In what way could the service be improved for other older people?* In this way respondents are not appearing to be overtly critical, but can give concrete suggestions about how the service can be improved.
- Build into the question, a statement about the standard of service that the client *should* have received eg. *Did you feel that you participated actively in the assessment and decision making process?*
- Include some negatively worded statements, as such statements acknowledge that negative things can happen.

Other issues to consider when developing client feedback mechanisms

- Confidentiality and ethics approval –clients should be fully informed and consent gained prior to their involvement. Anonymity must be ensured throughout the feedback process.
- Before standard surveys are developed for gaining feedback from a large sample of clients, questions should be piloted to ensure that they are being correctly interpreted.
- Timing of client feedback is a difficult issue for ACAS when the service is not an ongoing 'hands-on' service. Feedback should be sought directly after the face-to-face component of the assessment or at the very end of the process, following discharge from the service. The decision about the timing of the feedback will depend on the particular aspect of the service that is being investigated.
- Consideration should be given to the other types of feedback ACAS clients are exposed to, in order to minimise consumer 'fatigue' with satisfaction surveys.

Conclusion

There are many methodologies for gaining consumer feedback on service quality. Gaining meaningful and useful feedback from older people is well known to be particularly difficult. There are various methodologies commonly used in the health and welfare field and each one has its strengths and weaknesses. Services need to be aware these when they develop their feedback mechanisms, and when analysing and interpreting results.

Consumer feedback approached as a 'one-off' annual event, using a standardised 'tick box' format, is bound to have limitations, and will generally provide little guidance for actual service improvement. Instead, feedback from consumers should be a mechanism utilised throughout the

year as part of the review process for various elements of a service's quality improvement plan. If different consumer feedback mechanisms are used services will build up a cumulative picture of consumer opinion about different aspects of service quality with results feeding back on themselves or triangulating to confirm or discount earlier work and to inform future quality activities. In this way ongoing feedback will continually be informing service development and change.

SECTION 4: SCOPING EXERCISE

The literature reviews reported in the previous two sections of this report highlighted areas where further information was required before development of an ACAS quality improvement framework could occur. In particular, we were aware that many (if not all) ACAS teams were already involved in a range of quality improvement activities, but unclear as to how adequate these were perceived to be. Consultation was also considered essential to identify the elements for inclusion in an ACAS specific quality improvement framework and any issues or barriers that ACAS teams envisaged in implementing quality improvement processes.

Method

In consultation with the project reference group, a survey was developed which sought information on the identified issues from ACAS managers. The survey instrument, which is reproduced in Appendix 1, included a mixture of pre-coded and open ended questions, and began with the following introduction:

The aim of quality improvement activities within ACAS is to improve quality of service and continually strive for best practice. While this includes quality assurance activities such as meeting standards at accreditation reviews, a quality improvement framework may include a much broader set of activities which have the aim of improving a service's policies and procedures through a process of continual review and evaluation. The results of this survey will be used to inform the development of a quality improvement framework for all Victorian ACAS.

The survey forms were emailed and posted to all 18 Victorian ACAS on 24 October 2000, requesting written responses by 10 November. Fifteen of the 18 teams responded, a response rate of 83%.

Results

Quality improvement processes used

Although all teams report being engaged in some quality improvement activities, there was considerable diversity as to the type and number of these:

- All teams reported involvement in generic quality improvement programs, most commonly EQuIP, but two teams involved in QIC program and one accredited against ISO standards.
- Four teams (27%) also reported involvement with the Home and Community Care (HACC) National Service Standards.
- Twelve teams (80%) teams had developed a quality improvement plan.
- Only two teams reported having developed/ reviewed a consumer charter of rights as part of their quality improvement activities.
- Thirteen teams (86%) review Lincoln Gerontology Centre ACAS Evaluation Reports but only four teams (26%) reported reviewing outcomes of appeals and seven teams (46%) reported conducting reviews of complaints as part of their quality improvement activities.
- Client satisfaction surveys had been conducted by 12 teams (80%) and referrer satisfaction surveys conducted by nine teams (60%). Eight teams (53%) had conducted both.
- Six teams (40%) reported conducting other research that informs their quality improvement program.

- Staff meetings, case conferences, staff appraisal, staff training and meetings with other stakeholders are other quality improvement mechanisms.
- Most quality improvement mechanisms were considered to be ‘useful’ or ‘very useful’ by the majority of those who use them.

Most useful elements of team’s quality improvement plans

The most useful elements of teams’ quality improvement activities were reported as consultations with stakeholders (73%), and developing a quality improvement plan (60%).

Changes associated with quality improvement processes

All except one team report improvements in processes and outcomes for clients as a result of quality improvement processes.

Evidence of providing a quality service

Respondents were asked what evidence they had that their team was providing a quality service. As few teams conduct research which they use to determine quality of service and only one team mentioned meeting key performance indicators. Consumer feedback—either unsolicited or obtained in client surveys—was considered evidence of providing a quality service by most teams.

Effectiveness of team’s quality improvement activities

Three teams (20%) considered their team’s quality improvement activities to be ‘very effective’ with the remainder providing a rating of ‘somewhat effective’. Lack of resources to devote to quality improvement activities was an issue for some teams.

Barriers to implementing an effective quality improvement process

Almost all teams listed lack of time and staff resources as the barrier to implementing quality improvement processes.

Issues to be included in a Quality Improvement Framework for Victorian ACAS

The priority rating for including previously identified potential elements for the quality are presented in Table 1.

Table 1 Priority ratings for potential elements of an ACAS Quality Improvement Framework

	Essential	High Priority	Medium Priority	Low Priority	Not required
Client related assessment policies and procedures					
Service access	9	3	1		1
Assessment and care planning	11	1	1		1
Care planning implementation and follow up	8	3	2		1
Consumer rights and responsibilities	9	2	2		1
Consumer dignity, privacy and confidentiality	10	2	1		1
Culturally relevant practices	7	3	2		1
Ensuring client involvement/ choice	8	3	2		1
Consumer's rights and access to advocates	8	3	2	1	
Statutory delegation activity	10	1	2	1	
Client related activities post assessment					
Case management/ ongoing case coordination		5	5	2	2
Other ACAS functions					
Community education and information	5	4	4		1
Regional service coordination(eg management of waiting lists)	3	4	3	3	2
Management of stakeholder liaison/relationships					
Management of auspice relationships	3	7	3	1	1
Relationships with other service providers	9	2	1		1
Complaints procedures	8	3	2		1
Obtaining consumer feedback	8	1	4		1
Appeals processes	5	4	3	2	
ACAS management and administration					
Management and governance	7	4	1	1	1
Strategic planning	5	6	1	1	1
Development and review of policies and procedures	7	1	4	1	1
Human resources planning/ staff recruitment	5	4	4	1	1
Staff training and development	8	3	2		1
Orientation training	8	2	3		1
Industrial relations	3	5	2	3	1
Employee assistance programs	3	3	4	2	2
Information management	8	3	2		1
Occupational health and safety	7	1	4	1	1
Environmental responsibility	3	4	3	3	1
Quality improvement and evaluation plan/ strategy	8	2	3		1

Analysis of the quantitative data as well as comments provided by some teams suggested the following clusters were priority elements for an ACAS Quality Improvement Framework:

- Managing the quality improvement process and developing quality improvement plans;
- Access;
- Assessment policies and procedures;
- Client feedback mechanisms (complaints, appeals and consumer satisfaction surveys);
- Relationships with other service providers, including referrer satisfaction surveys;
- Staff development (including staff training, staff appraisals, ensuring competency);
- Information management; and
- Occupational health and safety.

This list, developed in consultation with ACAS managers, was then compared to the list of nine dimensions in the National Health Performance Framework developed in 2000 by the National Public Health Partnership (NPHP). These nine dimensions are described in Section Two of this report.

On examination of this list it was agreed that the elements identified by ACAS incorporated or covered most of these NPHP areas, with the exception of 'Effective.' The 'Effective' element was defined by NPHP as 'Care, intervention or action achieves the desired outcome'. As a result, 'client outcomes' was added to the ACAS list of framework elements.

Issues and concerns about the management of the quality improvement process including development of quality improvement plans were addressed in the workshopping process as part of the development of the framework. Discussions from this workshop are summarised in Section Five. However this issue has not been retained as a specific framework element in its own right.

SECTION 5: THE QUALITY IMPROVEMENT FRAMEWORK

Introduction

As a result of the ACAS Quality Improvement survey, eight elements (or domains) were identified as core domains in the framework:

Domain 1: Client Feedback

Domain 2: Team and Staff Competencies

Domain 3: Assessment Processes

Domain 4: Service Access

Domain 5: Client Outcomes

Domain 6: Service Providers Relationships

Domain 7: Safety

Domain 8: Information Management

Eight Quality Improvement Framework workshops were conducted in December 2000 by Lincoln Gerontology Centre to develop each of the eight domains of quality listed above. Lists of participants are contained in Appendix 2. This section uses the content of each of these eight workshops to describe each domain of the framework in detail.

The Framework requires teams to report to state and commonwealth on their activities in seven domains (domains 2-7) of the Framework as these cover ACAS core business. Domain 1: Client feedback is a *mechanism* for reviewing service performances in the other domains. As such there is no requirement to report separately on client feedback as this will be used as a tool to review activity in the other domains. Details of reporting requirement are contained in Section 6.

Managing the Quality Improvement Process

At the first workshop, the following points were raised as issues of concern with regard to developing and managing an ACAS Quality Framework. These points were considered and added to in each workshop, to ensure that all workshop participants were given the opportunity to raise issues.

- Duplication between Quality Improvement Framework and accreditation processes (primarily Equip and QICSA) should be avoided or minimised.
- The Framework needs to be realistic about how much time can be allocated to quality improvement activities.
- Teams operate in very different contexts and demographic catchments. As ACAS provide an individualised assessment it is difficult to define a 'standard' client or 'standard product'. This is a strength of ACAS. Therefore, the Framework should be based on principles and outcomes not on standardising processes/procedures.
- The Best Practice Manual is a useful reference and should be recognised as such and improved and up dated through the use of the Quality Improvement Framework.
- If auspice, State, and Commonwealth Key Performance Indicators are not linked or aligned, this will cause additional work for teams.
- The Framework needs to sit comfortably with the PCP quality framework.
- If Service Agreements are a vehicle for imposing requirements of the Quality Improvement Framework on ACAS then there has to be a realistic process of consultation with ACAS managers and DHS officers responsible for drawing up the Service Agreements. Past processes

have been inadequate and need to be improved before they are used to implement the Quality Improvement Framework.

- Leadership, Strategic Planning and Management are not identified as a separate domain in the Framework. However, these dimensions of quality should underpin each of the eight domains in the framework if the domains are used effectively as a management tool. The evaluation of the Framework following its full implementation in 2002/3 should review whether this is an ongoing area of concern.

Defining each element of the ACAS Quality Improvement Framework

Each of the eight Framework domains identified above is described according to the following headings:

Rationale and Objective

The rationale and objectives describes why each element is included in the framework and what should be achieved through quality improvement in this area. These were identified in the workshops and have since been augmented with references to relevant program documentation.

References are made to the Draft 2000 Aged Care Assessment Program Operational Guidelines (Department of Health and Aged Care, 2000), the Best Practice Manual (ACAS Liaison Group, 1998) and the Commonwealth's newly developed Key Performance Indicators which have been developed for high level national reporting purposes only. The Performance Indicators are contained in the Aged Care Assessment Program Data Dictionary Version 1.0 (AIHW, 2001; unpublished working document) and are reproduced in summary form in Appendix 3.

Scope

The scope describes the range of issues considered by workshop participants to be critical for inclusion in each domain.

Performance Review

Performance Review identifies the data that workshop participants reported as currently having access to, and the methodologies/systems that they currently use to review their performance in each area.

Keeping a record of quality activities

A summary matrix is provided for each element of the framework as a working tool for ACAS to use as they are progressing through the year with their quality activities to ensure that they are keeping a record of quality activities performance reviews and actions taken.

This cumulative record of activities can then be summarised for the Annual Quality Report which will be required by the state and commonwealth governments.

Reporting requirements

Discussion occurred at several workshops about the level of reporting and documentation that could or should be provided. The general consensus from State officers and ACAS participants was that reporting on quality activities via a Quality Improvement Report should occur on an annual basis and be kept to a minimum. However, reporting should be sufficient to be useful for strategic planning and program development at the State and Commonwealth levels. The suggestion was made that tick boxes identifying that certain activities had taken place, may be sufficient.

Annual visits to teams by state officers was suggested as an adjunct to a Quality Improvement Report. Evidence of quality activities that have been reported in the Quality Improvement Report could be requested and discussed.

The requirement that each team develop and submit a Quality Improvement Plan was also suggested as a basic reporting requirement. The ACAS Quality Improvement Survey showed that three of the 15 teams who responded to the survey had not developed a quality plan. For others that had, the Quality Improvement plan may be embedded in the auspice's Business Plan. It was suggested that the development of a quality plan should be a basic requirement of the Quality Improvement Framework, and that it could be very informative for State program managers to view these plans.

Quality Improvement Plans

If the Quality Improvement Framework establishes the requirement that each ACAS has a Quality Improvement Plan, the content of the plan should link to both the ACAS Quality Improvement Framework and the outcomes of auspice accreditation processes.

Participants in Workshop One identified the following elements of a good Quality Improvement Plan. A Quality Improvement Plan is:

- Based on standards, both auspice accreditation standards and the domains identified in the ACAS Quality Improvement Framework, which incorporate the draft DHAC operational guidelines and the Best Practice Manual.
- Based on the need for corrective action. That is, the plan is based on evidence that improvement may be required in certain identified areas, eg. through an analysis of complaints, anecdotal comments/consultation with stakeholders, staff forums, review of MDS data including comparison with other 'like' teams.
- Based on requirements of the service agreements.
- Identifies actions required eg. the development and analysis of data collection systems to mentor performance in certain areas of activity.
- Identifies time frames for the actions.
- Identifies who will be responsible for actioning various elements of the plan.

The final reporting requirements of the Quality Improvement Framework are detailed in *Section 6: Conclusion and action required for implementation*. The formal reporting requirement for the Funding and Service Agreement will consist of two tables or templates.

The next part of this section of the report describes the scope and content of each of the eight domains of the ACAS Quality Improvement Framework. Each element includes an individualised matrix for recording quality activities that occur during the year and the outcomes or actions that resulted. These matrices are intended as working tools only and are not templates for formal reporting purposes.

Domain One: Client Feedback

This section of the Framework deals specifically with gaining feedback from older people and the carers. A literature review of recent research into the most effective methods of gaining feedback from older people in the health and community service sector is contained in Section 3 of this report. The literature review contains specific suggestions for ACAS on how to make client feedback activities as meaningful and useful for service improvement purposes as possible.

Client feedback mechanisms (clients in this context meaning clients and their carers or families) is one of the eight content areas within the framework, but also serves as a method for documenting service quality in other content areas or domains of the Framework. For example, client satisfaction surveys are one way of assessing a service's performance in the area of assessment processes. Despite its overlap with other content areas, this area is dealt with as an independent element of the framework because of its critical role in gaining feedback about service quality.

It is well documented that standard 'tick box' surveys generally result in clients, especially older people, expressing very high levels of satisfaction. Investigating client satisfaction for ACAS, a service which is often a 'one-off' encounter and often tucked in between other health and community services providers is even more challenging.

A methodology for investigating client satisfaction for ACAS therefore needs to be carefully developed and the results carefully interpreted. The techniques for gathering information about client's opinion of a service should also result in information that can be used to improve the service.

Services will also gather information from other stakeholders or consumers of ACAS services as part of their quality improvement processes. Service providers such as GPs, community service providers, residential care providers and hospitals are a few of the other key consumer or stakeholder groups. Gaining feedback from these groups is dealt with in Domain 6: *Relationships with Service Providers*.

Rationale

Client satisfaction is a desirable outcome of any episode of service delivery. Finding out about a client's opinion of services received - whether the service met the client's expectations and whether the outcomes were the outcomes the client wanted, are extremely useful signposts that a service is a quality service.

Objective

A key objective of gaining client feedback is to provide direction for service improvement. Investigating clients' opinion of a service must generate information which enables the service to make changes and improvements. The feedback mechanisms must focus on clients' opinions about how individual staff practice and team processes could be improved, not just on how satisfied they are.

Client surveys should also be used as a mechanism to find out about client outcomes. This is dealt with in Domain 5: *Client Outcomes*

Scope

The draft 2000 Commonwealth ACAS Guidelines (DHAC) and the Best Practice Manual (BPM) identify fundamental principles of ACAS assessment. According to these principles, ACAS assessment should be:

- Client focussed: that is, clients (and carer/family where appropriate) are involved in the assessment process and ACAS facilitate clients to have control over their own life choices, even if those choices are limited.

- Respectful of clients' rights to privacy and confidentiality;
- Culturally relevant ;
- Participate in decision making;
- Empower clients through knowledge;

The principles described above are intangible aspects of a service that can only be evaluated through directly asking the client for their opinion. With regard to each of these principles the following points were made by workshop participants.

- Client opinion about team processes at all levels of the services should be investigated: access; intake/initial needs identification; assessment; care planning/ care plan implementation/follow up.
- Feedback from carers should be sought separately to feedback from clients.
- Feedback from clients assessed in all settings should be investigated.
- Feedback from specialist client groups should be sought: eg. ATSI clients and clients from culturally and linguistically diverse backgrounds.

Performance Review

Client feedback mechanisms might include:

- Written feedback: letters of thanks, complaints, verbal feedback;
- Formal complaints and appeals;
- Consumer surveys, paper and pencil surveys, face to face interviews, telephone surveys;
- Focus groups;
- Internal surveys/ checking with staff; and
- External consultants conducting surveys/ focus groups.

Comments on these approaches from workshops participants are summarised below.

Quantitative data: Brief client surveys have been handed out on the day of assessment identifying whether a client is satisfied, not satisfied, or has any complaints. This is useful for benchmarking team performance.

Qualitative paper based surveys have been used to elicit information that will lead to service improvement, but they are more time consuming to collate. One ACAS has found that paper and pencil surveys gather more 'honest' and useful information than face to face interviews.

There are many issues that arise in the development of client surveys for the ACAS clients and carers. Workshop participants queried whether a standardised state-wide ACAS client feedback survey should be devised. This could then be developed by teams to suit their individual needs.

Focus groups are very useful for collecting in-depth information and for exploring areas of service quality that the service itself may not have thought of asking about. Clients/carers also get something out the process for themselves through hearing about other people's experiences. Focus group participants may have different levels of understanding of the service itself, so most are likely to come away informed by what they hear from other participants and from information provided by the focus group facilitator.

Consideration needs to be given to who runs the focus groups to ensure maximum participation and honesty.

Table 2 Domain 1: Client Feedback.

This matrix is a working tool for recording activities for gaining client feedback throughout the year.

Client feedback activities	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Review complaints (if any)			
Review appeals (if any)			
Standardised client satisfaction survey			
Qualitative surveys			
Focus groups			
Carer feedback			
Other client feedback activities (please specify)			

Quality improvement objectives for the following year:

Domain 2: Team and staff competencies

Rationale

ACAS staff need training and ongoing education to perform their role at a high level of competency. The competency of the team is also critical in the delivery of a high quality service. Team competency is based on the individual competencies of the staff as well as:

- team composition, the range of disciplines employed, access to other disciplines as needed, and the competency of the manager.
- team processes such as case conferences which enhance individual staff capacity.

The rationale, standards and guidelines for developing and maintaining high level of staff and team competencies are described in the following documentation:

- Best Practice Manual;
- 2000 Draft Guidelines ie specification core disciplines for ACAS teams;
- ACAS Orientation Manual;
- Accreditation systems: EquiP and QIC; and
- Competencies for ACAS Managers Report (ACAS Manager Project, 1998)

Objective

The key objectives of this domain are:

- To maximise the potential of individual staff and the quality of service delivered by the team;
- To ensure that staff have the capacity to perform their delegation duties as described in the Aged Care Act 1997;
- To ensure that approach and philosophy underpinning ACAS staff training and ongoing education is linked to the philosophy of each ACASs' auspice and the PCP;
- To improve staff competency by linking common issues arising from the Quality Reports to staff training organised through the state-wide Training Committee.

Scope

Activities in this area may encompass training at a team level, regional level and state level. Training and development activities should include all staff employed by ACAS: assessment, administration, and management. The team should meet ongoing training needs through the development of a staff development and training plan which includes financial and time allocation to implement the plan. This plan should encompass:

- Discipline specific training;
- Recruitment procedures, including reviews of position descriptions.
- Induction and orientation procedures.
- Individual staff appraisals.
- Appraisal of team performance including a review of whether the team has access to the most appropriate range of disciplines, culturally relevant expertise and experience through a range of mechanisms (eg. secondment of staff).
- Maintaining and keeping staff up-to-date with the aged care policy context, particularly in relation to residential aged care.
- Delegation training to ensure delegates are meeting the requirement so the Aged Care Act.
- Training on the legal aspects of the 2624 approval form.

Performance Review

Staff and team competencies can be reviewed using the following mechanisms:

- Staff appraisals, which identify individual staff competencies and the need for further training in the key areas including:
 - delegation;
 - professional disciplines;
 - ACAS assessment practices;
 - legal responsibilities; and
 - the Aged Care policy context.
- Review of the annual staff development plan. Information for the staff development plan review would be gathered from a variety of sources such as staff appraisals, staff satisfaction surveys, monitoring consumer feedback, staff career moves.
- Staff review of their team competency, ie. skills mix, experience, appropriate levels of expertise.

Consideration at a state level

Further work identified in workshops that could occur at a state-wide level was the development of a standardised tool for carrying out staff appraisals. It should be recognised that each auspice could have their own process which the Quality Improvement Framework can assist with. The development of core competencies for assessors was also considered to be a useful tool for evaluating staff competency however it was reported that this work may be carried out as a development of the PCP initiative.

Table 3 Domain 2: Team and Staff Competencies.

This matrix is a working tool for recording quality improvement activities in team and staff competencies throughout the year.

Team and Staff competencies:	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Staff training and development plan			
Staff appraisals			
Review of team competency/skills mix			
Staff satisfaction survey			
Review of orientation processes			
Review recruitment procedures			
Other activities (please specify)			

Quality Improvement activities for the following year:

Domain 3: Assessment processes

Rationale

ACAS should carry out assessments in accordance with the key principles laid out in the 2000 Draft Commonwealth Guidelines (DHAC), the Best Practice Manual (BPM) and the PCP Charter of Consumer Rights. DHS officers present at the workshop stated that ACAS assessment processes should also be described and evaluated using the same language as described in the *Better Access to Services (BATS)* assessment framework developed as part of the PCP initiative (Department of Human Services, 2000).

Objectives

Key objectives of quality improvement in this domain are to ensure:

- Independence of the ACAS services from service providers imperatives and of the interests of ACAS' auspice agency (DHAC, BPM);
- A client focussed approach: that is, clients (and carer/family where appropriate) are involved in the assessment process and ACAS facilitate clients to have control over their own life choices even if those choices are limited. (DHAC, BPM);
- Respect for clients' rights to privacy and confidentiality (DHAC);
- Cultural relevance (DHAC);
- A non-judgemental and supportive approach (BPM); and
- Empowerment of clients through knowledge (BPM).

Scope

Quality improvement activities must demonstrate that assessments are carried out in accordance with the fundamental principles described above. In addition to these, assessments must also be:

- Timely;
- Holistic/multidisciplinary;
- Comprehensive (incorporating physical, medical, psychological, social aspects);
- Take a restorative/preventative approach;
- Resolving;
- Include the needs of carers; and
- Involve a delegate where required.

Performance Review

As outlined above, assessment processes in the Quality Improvement Framework need to be described using the same terminology as described in *Better Access to Services* (Department of Human Services, 2000). DHS officers requested that the various components of assessment and access to services be described in the following manner:

- **Initial contact:** This function is the consumers first point of contact with the service system where accurate service information is provided, basic contact details are recorded and direct access to initial needs identification is facilitated. Depending on the partnership model, staff providing this service may be reception staff, volunteers or professional staff.
- **Initial needs identification:** This is an initial assessment where consumer's needs and health promotion opportunities are identified. Consumers are informed about service options, service availability and referred to the appropriate range of services to meet their needs.
- **Care planning:** This is a process that ensures that consumer needs are discussed with other relevant parties and subsequently worked through to an agreed strategy. Strategies to ensure the most effective service response to the consumers needs may also include monitoring and review; referrals/ feedback to other stakeholders; self-management and care co-ordination/case management.

- Service specific assessment (not applicable to ACAS);
- Specialist assessment (not applicable to ACAS);
- Comprehensive assessment: This service is provided to consumers with multiple, complex or unclear needs and /or who require long term and/or intensive service provision.

Teams can review their performance in these areas using a number of approaches and data sources. These include:

- MDS data analysis

MDS analysis can include a review of the following data items:

- Timeliness of ACAS assessment;
- Recommendation patterns for key client groups eg. people with different levels of disability, people assessed in hospitals, people assessed in low level care;
- Reassessment numbers and characteristics; and
- Analysis of withdrawals.

- File audits

Case file audits can cover many aspects of a client's assessment. Key areas for this domain of the Quality Improvement Framework are:

- Numbers and types of people involved in the assessment process;
- Types of recommendations/assistance/interventions;
- Care plans; and
- Extent of monitoring, case plan implementation/review/case co-ordination.

- Consumer feedback mechanisms

Consumer feedback mechanisms should gather information on the extent to which key principles were present in the assessment process. Mechanisms appropriate to the ACAS client groups are:

- Client surveys/interviews/focus groups;
- Carer surveys/interviews/focus groups; and
- Referrer feedback.

- Individual case reviews

Individual case reviews can occur through:

- Case presentations;
- Peer review;
- Mentoring/ professional supervision (in some ACAS the clinical coordinator's role is to supervise assessment staff);
- Analysis of complaints/appeals; and
- Delegation procedures as a performance review procedure.

- Review of policies and procedures
- Review of assessment tools

Consideration on a state level:

Workshops identified that further work in this area could investigate the development of a standardised peer review tool and a standardised case file audit tool that would be specific to reviewing ACAS functions. However it should be recognised that each auspice could have their own process which the Quality Improvement Framework can assist with.

Table 4 Domain 3: Assessment Processes.

This matrix is a working tool for recording quality improvement activities in assessment processes throughout the year.

Assessment processes:	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
MDS data reviewed			
Case File audits			
Individual case reviews or peer review/supervision			
Consumer feedback			
Review of policies and procedures			
Review of assessment tool			
ACAS Victoria, networking			
Other: Include activities associated with accreditation or one-off research as part of the Lincoln state-wide evaluation			

Quality Improvement activities for the following year:

Domain 4: Service access

Rationale

Equity of access for all older people in the ACAS target population is a desirable goal for all services as is the timeliness of service delivery and the ease with which older people can find out about, and make contact with an ACAS.

Objectives

Key Commonwealth objectives of this domain are that older people in most need gain access to ACAS. In particular, the proportion of older people with severe or profound core activity restrictions and older clients with dementia should be maintained or increased in the ACAS client population. The proportion of older people from ATSI (aged 50+) and culturally and linguistically diverse backgrounds (70+) should be consistent with the proportion of older people in the population from these specialist groups. (See Commonwealth KPIs: 1.1; 1.2; 1.3; 2.1, 2.3; 2.4;2.5: See Appendix 3).

Scope

For ACAS, this domain of the framework should encompass a range of issues which are outlined below.

- Physical location and contactability, including:
 - geographical access and travel time for assessors;
 - street location for ‘walk- in’ access;
 - ‘black spots’ in rural areas , ie. areas which are difficult to access;
 - appropriateness of hours of operation; and
 - community base versus institutional base.
- Client experience of the initial contact and needs identification process, including
 - reception function/mobile phone access;
 - quality of the initial needs identification; and
 - quality and appropriateness of data collected at the initial contact.
- Accessibility for special needs groups:
 - People from ATSI backgrounds, culturally and linguistically diverse backgrounds and from more remote areas gaining equal access to the service consistent with their proportion in the population.
- Knowledge base within the community:
 - The degree to which ACAS are assessing proportions of the 70+ population in their catchment equivalent to other teams;
 - Potential referring agencies understanding of ACAS role, target group and appropriate referral processes.
- Managing workloads:
 - Determination of access, equity across the client group, and across all referral agencies;
 - Timeliness of assessments. Are some assessments carried out too early or too late?
 - Management of workload when staff are on leave.

Performance review

Review of six monthly MDS data and trend data enables a review of performance in the following areas:

- Level of access of ATSI and people from culturally and linguistically diverse backgrounds;
- Level of penetration into the 70+population for the whole catchment;
- Level of penetration based on LGAs;
- Timeliness of referral to assessment in the community and in hospital settings; and

- Reason for referrals.

Review of service access policies and procedures should include:

- Review of ACAS brochures/publicity;
- Review of reception function;
- Review of intake/initial needs identification procedures; and
- Review information systems and client records (See also Domain 8: Information Management).

Other data collected by ACAS (but not in six monthly MDS reports) which can be used for performance review includes source of referrals and referrals that are withdrawn before the assessment takes place.

Possible initiatives at a state level

Workshop participants suggested that the training of a pool of locum ACAS assessors to cover staff leave in rural areas would assist in managing workloads. Further work and understanding is required to determine how this might be implemented.

Table 5 Domain 4: Service Access.

This matrix is a working tool for recording quality improvement activities for Service Access throughout the year.

Service Access	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Program Evaluation: MDS data reviewed including review of performance measures			
Review of team results of one- off surveys and research			
ACAS Victoria, networking, communication			
Accreditation/audits			
Other relevant data collected/reviewed			
Consumer feedback with a focus on access issues			
Review of policies and procedures			
Other activities:			

Quality Improvement Objectives for the following year:

Domain 5: Client outcomes

Rationale and objective

The core objective of the ACAP program, as defined in the draft 2000 Commonwealth Guidelines, is to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their needs. The draft guidelines identify the following program specific objectives, which describe the desirable client outcomes from an ACAP intervention:

- To prevent premature or inappropriate admission to residential care facilities.
- To help frail older people live in the community.
- To facilitate access to the combination of services that best meets the needs of assessed clients.
- To actively encourage the involvement of clients and their carers, and other service providers in the assessment and care planning processes.

Whilst these objectives are reflected in Commonwealth KPIs (Commonwealth KPIs 3.1, 3.2, 4.1, 4.2, 4.3, 4.4, 7, and 8; See Appendix 3), further work on the quality of client outcomes is being developed at the Commonwealth level.

Some of these objectives overlap with other domains of the Quality Improvement Framework. For example, in this element, client involvement in the assessment process is considered as an outcome, whereas in Domain 3 (Assessment Processes) it was considered as an underlying principle.

Scope

The Commonwealth has identified six KPIs based on analyses of MDS recommendation patterns. It is appropriate that the Quality Improvement Framework focus attention on gaining a good understanding of team performance in this area.

However, the scope of this element of the Quality Improvement Framework need not be limited to the objectives or client outcomes as defined by recommendation patterns described above. Other indicators of client satisfaction with assessment outcomes may be identified through client feedback and follow up studies. Other outcomes measures may be identified by the auspice body, such as a decreased rate of admissions to acute care. Such measures are appropriate outcomes measures for ACAS as long as the results can be attributed back to the ACAP program.

Performance review

Reviewing recommendation patterns

The MDS is a critical tool for measuring many of the objectives of this element of the framework. The current MDS (version 1) cannot measure all the Commonwealth KPIs as they are currently defined. The new MDS (which is intended to roll out in June 2002) will be able to identify outcomes for particular clients groups such as clients 'at risk' and clients with dementia. Until that time, the focus of performance review should be on performance that is measurable through the current MDS. That is:

- The percentage of clients assessed in the community who are recommended long term care in the community;
- The percentage of recommendations from low to high care for people living in residential care;
- ACAS recommendations for younger clients;

- Recommendation patterns for clients assessed in hospitals.

Whilst client outcomes (as reflected in care plans) should reflect clients' wishes, in reality, a care plan is a balance between service availability, assessed risk, or what is considered 'safe' for the client, as well as carer, family and referrer wishes. Reviewing and interpreting MDS data on care plan recommendations should take into account these different factors.

In addition, there may be other demographic, systemic and organisational factors which influence the profile of an individual ACASs' client population, and which may impact on a team's rate of community versus residential care recommendations. The demographic makeup of catchments such as high proportions of people aged over 85, or high proportions of people from culturally and linguistically diverse backgrounds can impact on the targeting of clients and therefore, on long term care recommendation patterns.

ACAS needs to be aware of how their own teams' recommendation patterns compare to other 'like' teams and state averages. If there are substantial differences, careful analysis is required to determine the extent to which local circumstances are the cause of the differences or whether team processes and practices are impacting on performance. Recommendation patterns are likely to be the result of a combination of factors.

Reviewing levels of service take-up

Understanding the extent to which clients take up services that ACAS recommend is an important element in evaluating client outcomes. ACAS can use the Victorian Quality Improvement Framework to capture information that is not covered by the MDSV2. In the future, linkages to other client data bases such as the HACC MDS should enable this information to be analysed. In the meantime, understanding the level of take-up or non take-up of recommended services (and the reasons behind this) is best achieved through client feedback mechanisms such as surveys. Once PCPs are in operation, this type of quality evaluation would occur in conjunction with the broader PCP quality improvement processes.

Other performance review processes in this domain could include:

- Reviewing complaints and appeals;
- Reviewing policies and procedures which impact on care plan recommendations, service take-up.

Table 6 Domain 5: Client Outcomes.

This matrix is a working tool for recording quality improvement activities for Client Outcomes throughout the year.

Client Outcomes	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
MDS data reviewed including review of performance measures			
Review of team results of one- off surveys and research			
ACAS Victoria, networking, communication			
Accreditation/audits			
Other relevant data collected/reviewed			
Consumer follow up and feedback			
Review of policies and procedures			
Other activities, including those associated with auspice accreditation processes and state wide ACAP evaluation			

Quality improvement activities for the following year:

Domain 6: Service Provider Relationships

Rationale

Developing and maintaining effective working relationships with aged and community care service providers is a critical element of ACAS function. Developing and maintaining effective relationships ensures that clients experience continuity of care, reduced duplication of information giving and assessment, and are assisted to gain access to recommended services. These issues are also fundamental to the Victorian PCP initiative.

Objectives

The draft 2000 Commonwealth Guidelines identify program objectives in relation to the interface with ACAS and service providers in the health and community sector. These objectives are to:

- Facilitate access to the combination of services that best meets the needs of assessed clients.
- Promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people.

Two Commonwealth performance areas, *Effectiveness* and *Quality* reiterate these objectives (KPIs 5& 8). However, the manner in which these objective can be measured by way of a performance measure, and the desired outcomes have yet to be identified. The Commonwealth's ACAP Data Working Group will progress this area over the coming year.

Scope

The Commonwealth Guidelines and Best Practice Manual identify that ACAS have a co-ordination and networking role with the following generic providers – PGATS, GPs, hospitals, residential care providers and community care providers.

Within the generic services listed above, ACAS maintain relationships with a range of primary health and community providers including: GPs, HACC, PGATs, CACPs, Respite Centres, CDAMS, RDNS, ADASS, and Safetylink. Commonwealth Carelinks and DVA Home Care will soon be added to this list.

Other providers include providers of sub acute services, rehabilitation services, GEM services, and the Guardianship Board.

The scope of the relationship will be different for each service provider. Guidelines for some of these key relationships are described in the Commonwealth draft Guidelines and the Best Practice Manual. These relationships are also highly relevant to the effective development of primary care partnership models.

The following issues are fundamental to ACASs' relationship with each provider:

- Joint processes and protocols (eg. referral forms, joint assessments, care planning, case conferences) to reduce duplication and to streamline processes where possible;
- Up-to-date directories of service providers, service availability and eligibility criteria for services;
- Provision of comprehensive assessment summaries to relevant agencies and referrers;
- Procedures and protocols which define communication and collaboration mechanisms.

In relation to the expectation that ACAS operate regional waiting lists, the draft 2000 Commonwealth Guidelines state that:

‘The operation of waiting lists for residential places, CACPs and for residential respite beds can assist ACATs in matching client needs and preferences with vacancies in their region. ACATs may be well placed to develop and co-ordinate regional waiting lists, however, this requires the absolute co-operation of all facilities and CACP providers to be workable’ (ACAP Draft Operational Guidelines, p 35).

To this extent and given that many ACAS in Victoria devote considerable resources to this activity for both residential care services and CACPs, the operation of wait lists systems is an important aspect of this element of the Quality Improvement Framework.

Performance review

Data sources which enable the review of relationships with service providers would largely be based on:

- Provider/referrer satisfaction surveys;
- Individual cases reviews;
- Updating policies and procedures;
- Reviewing complaints and appeals;
- Anecdotal feedback through discussions at provider meetings, case conferences;
- Specific research activities conducted through Lincoln Gerontology Centre or ACAS specific research; and
- Reviewing effectiveness of ACAS systems: ie. resources, directories and wait lists systems.

Given the breadth of this element of the Framework, workshops participants identified three key aspects to performance review in this area:

1. Understanding the extent of ACAS relationships

Carrying out a mapping exercise to determine the extent of ACAS links with provider agencies is a useful way to document the range and volume of activity, and identify any gaps in relationships with service providers, potential referrers etc.

2. Service provider/stakeholder satisfaction with their relationship with ACAS

Whilst the details of collaborative relationships with individual providers will differ, there are common broad areas which should be included in any service provider survey to ensure that ACAS is responsive to their needs. Broadly, these areas are:

- Strategic planning and management.
- Service access and referral processes.
- Individual case coordination and collaboration.
- Education and Training.

3. Providing effective assistance for clients needing to access services.

This occurs primarily through though up-to-date ACAS regional service directories (residential and community) and the operation of regional wait lists for specific services. Review of this activity should ensure that information data bases are providing accurate and appropriate information to clients who are seeking services and that regional waiting lists are comprehensive and up-to-date.

Consideration at a state level

Workshop participants considered that the development of a standardised stakeholder survey would assist the quality improvement process at the team level.

Table 7 Domain 6: Service provider relationships.

This matrix is a working tool for recording quality improvement activities for service provider relationships throughout the year.

Service Provider relationships	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Review of team results of state wide ACAP evaluation, one- off surveys and research			
Stakeholder surveys			
Reviewing complaints and appeals			
Review of policies and procedures			
Review effectiveness of systems for assisting clients to gain access to services, eg. resource directories and wait list systems			
Other activities including ACAS Victoria, networking, communication			

Quality Improvement objectives for the following year:

Domain 7: Safety

Rationale and Objective

Risks are associated with the ACAS assessment process and recommendations, interventions or actions for staff, clients and carers. The objective for this domain is that risks to ACAS workers carrying out their duties and the potential risks for consumers associated with ACAS assessments or interventions are avoided or minimised. Risks to service provider staff may also be considered in this domain.

Scope

Safety incorporates safety for ACAS workers and risk minimisation for consumers including client and family/carers. Identified risks in the workplace can sometimes affect client service access from other providers. During home visits, ACAS workers have the potential to be exposed to a range of risks including:

- Road conditions, driving accidents, weather conditions, fires;
- Environmental hazards: e.g. condition of home/caravan parks/high rise flats/local neighbourhood, dogs, firearms, addresses with no Melways reference;
- Communication: no mobile communication/fire maps;
- Physical environment - client/carers in house (unknown); and
- Staff returning-checking/notification.

Risks to staff that arise during the assessment process itself, include the handling of clients/transfer during assessment e.g. walking, trialling equipment (back injuries of staff) and the manual handling of equipment. These risks can be minimised through the use of commercial carriers for transporting equipment and setting limits to the size and weight of equipment that one person carries. Risks can also be minimised through:

- Regular training in identifying and assessing risk factors (refer to Domain 2: Staff development);
- Dress code during visits for manual handling;
- Appropriate equipment (ramps, trolleys); and
- Documentation of known risks for staff safety and others service providers.

High workloads and workload pressures were identified as posing additional risks to staff. High workloads were identified as being associated with:

- High rates of referrals, types of clients referred and the fact that there is no alternative provider;
- Hospital expectations and auspice pressures;
- Lack of replacement staff;
- Pressure of paperwork;
- No choice of provider;
- Keeping up-to-date with all the changes in aged care policies and service provision environment;
- Lack of IT support;
- Office space, office conditions, data entry; and
- Burnout leading to staff turnover.

Client/carer safety issues that should be identified during the assessment process include environmental risks, 'at risk' practices used by client/carers, and possible elder abuse – physical, financial or emotional.

Risks are also associated with ACAS recommendations and interventions/actions. Risk assessments and the identification of safety issues should occur before ACAS recommend a care plan or carry out an intervention. This involves:

- Identifying duty of care – balancing risk and client preferences.
- Identifying risks associated with the care plan. For example, a high care recommendation may have an element of risk associated with ageing- in- place within a specific facility.
- Risks associated with adhering to confidentiality principles eg. confidentiality versus duty of care, confidentiality versus staff safety, confidentiality versus client/carer safety.

- Recognising the potential for conflict between client needs and carer needs (ie. balancing client and carer needs).

Performance review

Mechanisms for reviewing staff safety include the following data sources and approaches:

- Reviewing staff workload (refer Domain 2: Staff development). This can be carried out in a variety of ways including
 - Reviewing professional and personal development strategies. This should link to, but be a separate part of the staff appraisal process.
 - Reviewing individual staff processes for managing workloads, as well as group processes for managing workloads (within an ACAS).
 - Review strategies for stress management including reviewing the level of resources allocated to cover sick leave, long service leave and holiday leave, and for managing worker health both physical and emotional.
- Reviewing Incident Reports, both auspice and ACAS specific. Protocols for making reports, debriefing procedures and the reports themselves should be reviewed.
- Review workcover claims.
- Review opportunities for staff to discuss safety concerns. For example, safety could be an agenda item of staff meetings.
- Review Policies & Procedures Manual to ensure relevant policies are in place (ACAS specific policies) and are updated where necessary.
- Review staff orientation manual and procedures (general auspice and ACAS specific).
- Review safety audits/procedures for checking on staff movements and knowledge of equipment use e.g. mobile use.
- Equipment review including
 - Car maintenance: including reviewing accident reports and procedures.
 - Mobile phones – identify and review minimum standards, review knowledge of use.
- Consumer safety and risk minimisation.
 - Review polices and procedures manual for risk assessment tools and documentation procedures.
 - Review complaints and appeals, anecdotal feedback.
 - File audit/case reviews.

Consideration at a state level

Workshop participants considered that the collaborative development of ACAS specific occupational health & safety policies and minimum standards would assist teams to achieve quality improvement in this area. For example, standards could be developed for the number of assessments that should be carried out per week. Once these standards are developed teams would need to review current resource utilisation to identify their capacity to meet the standards. This capacity could then be reviewed at the state level.

Table 8 Domain 7: Safety.

This matrix is a working tool for recording quality activities associated with improving Safety throughout the year.

Safety	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Staff safety: Policies and procedures developed/reviewed Eg. out of office protocols, manual handling, office environment			
Review of equipment standards eg car, mobile phones			
Review of client/carer risk assessment processes and documentation			
Workload management review			
Other activities			

Quality Improvement Objectives for the following year:

Domain 8: Information management

Rationale and Objective

ACAS are required to maintain information storage, record keeping and data collection systems that enable secure, efficient and effective collection, management, transmission and use of client based information.

Scope

ACAS are required to comply with the Commonwealth's Operational Guidelines for ACAP as well as other state service requirements, namely, the Primary Care Partnership principles that are outlined in the *Information Management Discussion Paper: Primary Care Partnerships*. These documents include guidelines on consumer confidence about privacy and confidentiality, information sharing, IT management practice. These principles, and other ACAS specific issues that were raised during the workshop are identified below.

PCP principles for information management include:

- Consumer participation: ie. meeting consumer needs for information in an appropriate manner.
- Consumer confidence about privacy and confidentiality of their information: This includes issues of client access to their files, privacy, informed consent and security.
- Understanding of how to navigate the PCP system: ie. the development of navigation guides to assist clients to find out about services themselves.
- Agreed planning and service delivery models: ie. where data is used for planning purposes, there is a need for increasing certainty in the accuracy of that data.
- Confidence between the parties sharing information: ie. confidence that the data is accurate, secure and meets quality standards. For example is e-mail transfer secure? Is intra net secure?
- Sound management practices: ie. Services should have established IT management practices and sufficient IT infrastructure. This includes ensuring that staff are competent and trained in all IT and IM issues, and that IT and IM standards are met.

Other ACAS issues regarding information management include:

- The right to withhold information, e.g. the right to refuse to complete a MMSE
- Issues around the definition of consent, minimum standards for consent (written versus verbal), obtaining consent from clients with dementia.
- Information flow within the ACAS, e.g. to and from geriatricians.
- Case file management: hospital versus auspice files and the flow of information or repetition across these two areas.
- Information sharing to reduce or prevent repetition by clients which respects confidentiality.
- Confidentiality and privacy issues: How should this be addressed when verbal information is given about clients at service provider meetings?
- ACAS need to be informed about standards for obtaining client consent. This includes the legal standards, minimum standards, PCP standards and national standards.
- 'At risk' clients and safety issues for staff during home visits need to be addressed. How should information be documented and transmitted in order to maintain confidentiality and to cover duty of care and occupational health and safety concerns.

Data management issues (MDS data) are an important element of quality in this domain. This includes:

- data entry issues, data accuracy (coding and data entry), validation, double entry (for auspice and ACAS MDS), and data entry for outposted workers.
- data aggregation and transmission, including timeframes for delivery of monthly AIMS data and six monthly MDS data.
- Data use and access issues such as a service's capacity to generate service statistics and the capacity to interpret this data for service improvement purposes. For example, identifying progress towards performance targets, and local planning.

- Staff training, both training in MDS data definitions, codes and in computer competency.

Performance Review

Policies and procedures for information collection, management, transmission and use should be reviewed. All ACAS teams should have policies and procedures in line with PCP, EQuIP and QIC generic standards for Information Management, which incorporate privacy, security and confidentiality principles.

In addition to reviewing policies and procedures, performance can be reviewed in relation to four key areas:

1. Client record systems and systems for obtaining client consent. Processes can include:
 - Reviewing processes for client agreement to sign consent forms;
 - Examine complaints and appeals for issue relating to data management;
 - Client satisfaction surveys focussing on data collection and management issues; and
 - Review client record keeping processes and content through file reviews, documentation reviews and case discussions.
2. Information sharing

This includes auditing the accuracy and appropriateness of the information provided by ACAS to other agencies, and to referees. This could occur through service provider satisfaction surveys.
3. Data collection and use should be reviewed using the following approaches:
 - Review procedures for MDS data collection and monthly/six monthly data delivery.
 - Review error rate in the MDS through validation and accuracy checks against client files and examination of six monthly reports ie. does the information in the six monthly report reflect team performance?
 - Review levels of missing and 'unknown' data.
 - Review timeliness of data delivery for AIMS and for six monthly MDS collection.
 - Review data use. Who interprets the data, reads six monthly reports, reports back to staff?
 - Review training/in-service activity.
4. Information Technology systems should be reviewed, both staff IT needs through staff meeting/staff forums and/or the development of an IT plan.

Consideration at a state level

It was considered that a state-wide review and/or staff training in relation to client documentation, record keeping and confidentiality would improve quality in this area. For example, training around expectations of ACAS in relation to Guardianship Board applications, and legal issues regarding minimum standards for client consent (including consent for clients with dementia) would be valuable.

Table 9 Domain 8: Information Management

This matrix is a working tool for recording quality activities associated with improving Information Management throughout the year.

Information Management	Activities carried out in the previous year	What areas were identified as in need of improvement?	What action resulted? Please include any evaluation of your service improvements.
Policies and procedures reviewed to ensure team complies with generic principles of confidentiality, privacy, security.			
Review client record keeping systems			
Review Information sharing processes			
Review MDS data collection processes, accuracy, timeliness			
Information Technology plan developed, reviewed			

Quality Improvement Objectives for the following year:

SECTION 6: CONCLUSION AND ACTION REQUIRED FOR IMPLEMENTATION

The ACAS Quality Improvement Framework is a tool to guide the development of ACAS quality improvement plans and therefore the focus of ACAS quality activities. The Framework is a tool which will sit alongside the Commonwealth Operational Guidelines, the Best Practice Manual and individual DHS service agreements as a document which defines key areas of quality for the ACAP in Victoria, and thus will be a key reference in the development of ACAS quality improvement plans. (See the ACAS Quality and Evaluation Framework flow chart in Section 2). ACAS use of the Quality Improvement Framework, and the reporting requirements which flow from it will help to set priorities, strategies and actions at both a state-wide and individual team basis.

In keeping the above in mind, the ACAS Quality Improvement Framework was developed through a 'bottom up' approach with the framework domains being agreed on by a Reference Group consisting of ACAS managers, State and Commonwealth officers. The detailed content was predominantly provided by Victorian ACAS team members themselves through the workshopping process. Contributions were also made by the State and Commonwealth officers.

The emphasis throughout the development process was that the quality improvement framework needed to be based on principles of service delivery not on individual processes or procedures. In this way the framework is flexible enough to be relevant and applicable to ACAS across all organisational settings. However, it is also expected that a minimum standard of service is provided to ACAP clients. The framework domains are the minimum requirement.

The approach employed in developing the framework is not dissimilar from the recommended approach to developing standards. That is, it should be:

- Flexible to individual institutions;
- Related to quality of care and the environment;
- Built on consensus;
- Be based on clear objectives;
- Achievable; and
- Measurable. (Hayes and Shaws, 1995, in Skok et al., 2000)

The Framework however, is clearly not a set of standards and therefore there is no expectation that the Framework will be used as a tool for 'measuring' or 'rating' the quality of each ACAS service. Rather it is a tool to guide ACAS quality activities and the development of ACAS quality improvement plans. That is, it is a tool for ensuring that ACAS engage in a systematic process of quality improvement in areas that have been generally agreed as core ACAS business. The framework will facilitate the identification of areas of concern, requiring improvement and demonstrating innovation. It will identify areas requiring development and program attention at the state-wide level. It will also assist in the prioritisation of actions.

The ACAS Quality Improvement Framework is not a substitute for ACAS participation in their auspice accreditation systems. There is no formal accreditation process attached to the Quality Improvement Framework. ACAS will still be required to participate in their auspice accreditation processes. However, once the Framework is finalised and endorsed by the Commonwealth and State governments, government officials are then in a position to inform the accreditation agencies (those predominantly utilised by ACAS auspices, namely EQuIP and QIC) that the ACAS Quality Improvement Framework is an officially endorsed framework within Victoria which should form the basis for ACAS quality planning and activity.

How should the Framework be used?

The State and Commonwealth's expectations of how Victorian ACAS will use and report on the Framework is outlined below. ACASs can broaden the application of the framework to meet their service specific and auspice needs.

- The Quality Improvement Framework will be used as a tool to guide the development of ACAS quality improvement plans and therefore the focus of ACAS quality activities.
- The draft domains of the Quality Improvement Framework and the proposals for reporting against the Framework were endorsed by the Quality Improvement Project Reference Group after consideration by the Narrative Report sub-committee. This sub-committee is reviewing other State/Commonwealth ACAS narrative reporting requirements (the revised Six monthly Narrative Reports) and was therefore well placed to consider how the reporting requirements for the Quality Improvement Framework should be incorporated into the annual cycle of reporting.
- The content of the draft Framework and interim reporting requirement will be communicated to ACAS via workshops or training sessions.
- From 2002/2003, ACASs will be expected to provide an annual Quality Improvement Report to both the State and Commonwealth governments which documents the achievements of their team's quality plan from the previous year, and their plans for the following year. The ACAS Funding and Service Agreement will require provision of an annual Quality Improvement Report to both the State and Commonwealth governments on the previous year's annual quality plan describing achievements from the last annual plan and key areas requiring improvement, and on their forward planning for the next year.
- The report will be contained in the two matrices on pages 67 and 68. However teams will need to be able to validate the entries in the tables by providing more than anecdotal evidence. It is also expected that each ACAS will have quality plans with greater level of detail and linked in with the staff members performance planning. Teams will also be required to report on broader issues that require state-wide attention as well as reviewing the utility of the Quality Improvement Framework itself.
- ACAS will be expected to develop an annual quality improvement plan that incorporates some of the seven domains (domains 2-7) but not necessarily all the domains. ACAS are expected to obtain client feedback (domain 1) as a key method for reviewing their performance in appropriate areas, ie. assessment processes, service access, relationships with service providers, client outcomes.
- Teams will expected to report in September on their activities for the previous financial year and on their plans for the coming year . However in the first year of implementation, (2001) teams will only be required to identify their quality plans for the 2001/2002 as the previous year's activities will not necessarily fit within the ACAS Quality Improvement Framework.
- The first year of full implementation (2002) will serve as a trial year. During this year, the ACAS will have the opportunity to work with the Quality Improvement Framework for a year, in draft form. Following this, the Framework will evaluated, refined where necessary, then formally endorsed.
- Once the Framework has been trialled and evaluated by Victorian ACAS in conjunction with the State and Commonwealth governments ACAS auspices and accreditation agencies will be formally notified of the status of the Framework. Auspices will be notified of State and Commonwealth expectations regarding the implementation and reporting requirements against the Framework.

Table 10 Annual Quality Improvement Report: Review of ACAS Quality Improvement Plan for the previous year:

Quality Improvement Plan Review (review of previous year)	Key areas identified in the previous year as requiring improvement	Achievements over the last twelve months in these key areas (include action/innovation in team practice as well as innovations in developing tools or systems for reviewing quality)
Team and staff competencies		
Assessment Processes		
Service Access		
Client outcomes		
Service provider relationships		
Safety		
Information Management		

Table 11 Annual Quality Improvement Report : Forward planning for ACAS Quality Improvement Activities

Quality Improvement Plan: (for next 12 months)	Desired outcomes	What actions/quality improvement activities will occur to achieve these outcomes	How will these outcomes be measured? How can it be demonstrated that the desired outcome has resulted?
Team and staff competencies			
Assessment Processes			
Service Access			
Client outcomes			
Service provider relationships			
Safety			
Information Management			

Other questions to be included in the annual Quality Improvement Report:

- Please identify any broader issues that you believe require state-wide or regional attention.
- Were there other important quality improvement activities undertaken last year that did not fit within the parameters of the Framework?
- Please comment on the use of the Framework as a tool for reviewing and planning quality activities. Any comments on refinements, additions?

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APPENDIX 1:

Survey of Quality Improvement Practices in Victorian ACAS

The aim of quality improvement activities within ACAS is to improve the quality of service and continually strive for best practice. While this includes quality assurance activities such as meeting standards at accreditation reviews, a quality improvement framework may include a much broader set of activities which have the aim of improving a service's policies and procedures through a process of continual review and evaluation. The results of this survey will be used to inform the development of a Quality Improvement Framework for all Victorian ACAS.

ACAS: _____

Which of the following activities (use of standards and accreditation systems, development and review of ACAS policies and practices, and reviewing or conducting research) has your team engaged in during the last 12 months to improve the quality of your ACAS service?

Standards and Accreditations

- ACAS Best Practice Manual
- EQuIP (Australian Council on Health Care Standards)
- Quality Improvement Council (QIC, formerly known as CHASP)
- ISO 9000 Series Standards
- Home and Community Care (HACC) National Service Standards
- Disability Services Standards
- Other standards/ accreditations _____

Development or review of ACAS policies and practices

- Development of a Quality Improvement Plan *Please provide a copy*
- Development/ review of a consumer charter of rights and responsibilities *Please provide a copy*
- Review outcomes of appeals *Please provide details*
- Review of complaints/ complaints procedures *Please provide details*
- Convene meetings of ACAS consumer advisory group *Please provide terms of reference*
- Development/ review of other policies/practices _____

Research

- Reviewing team performance in ACAS minimum data set reports
- Reviewing team performance in six monthly published narrative reports
- Reviewing team performance in other research projects conducted by the Lincoln Gerontology Centre (eg Waiting Time Study)
- Client satisfaction surveys conducted by your team *Please provide documentation (eg survey form)*
- Referrer satisfaction surveys (eg general practitioners or residential care providers) conducted by your team *Please provide documentation (eg survey form)*
- Other research _____

What other mechanisms do you have for reviewing your practice activities and improving the quality of your service?

How useful are these standards and accreditation systems, ACAS policies and practices, and research data for analysing and improving on your team's performance?

	Very useful	Useful	Somewhat useful	Not at all useful	Not used
Standards and Accreditations					
ACAS Best Practice Manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EquiP (Australian Council on Health Care Standards)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality Improvement Council (QIC, formerly known as CHASP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ISO 9000 Series Standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home and Community Care (HACC) National Service Standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability Services Standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other standards/ accreditations _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development or review of ACAS policies and practices					
Development of a Quality Improvement Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development/ review of a consumer charter of rights and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review outcomes of appeals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of complaints/ complaints procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convene meetings of ACAS consumer advisory group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development/ review of other policies/practices _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Research					
Reviewing team performance in ACAS minimum data set reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing team performance in six monthly published narrative reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing team performance in other research projects conducted by the Lincoln Gerontology Centre (eg Waiting Time Study)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client satisfaction surveys conducted by your team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrer satisfaction surveys (eg general practitioners or residential care providers) conducted by your team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other research _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you consider to be the most useful elements of your team's quality improvement activities? (eg, developing a quality improvement plan, consulting with stakeholders, conducting research, reviewing policies and procedures etc)

What ACAS processes have improved as a result of your team's involvement in these quality improvement activities?

What outcomes for ACAS clients have improved as a result of your team's involvement in these quality improvement activities?

What evidence do you have that you provide a quality service?

Overall, how effective do you believe your team’s quality improvement activities to be?

- Very effective
- Somewhat effective
- Somewhat ineffective
- Very ineffective

Please comment on your rating

It is very important that an ACAS Quality Improvement Framework focuses on the key issues of importance to the delivery of a high quality assessment service, and does not duplicate areas that are adequately covered by more generic processes and procedures (eg EQuIP or QIC accreditations).

Please indicate your priority rating for inclusion of each of the following elements in a Quality Improvement Framework for Victorian ACAS

	Essential	High Priority	Medium Priority	Low Priority	Not required
Client related assessment policies and procedures					
Service access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment and care planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care planning implementation and follow up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer rights and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer dignity, privacy and confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culturally relevant practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensuring client involvement/ choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer’s rights and access to advocates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Statutory delegation activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client related activities post assessment					
Case management/ ongoing case coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other ACAS functions

Community education and information

Regional service coordination(eg management of waiting lists)

Management of stakeholder liaison/relationships

Management of auspice relationships

Relationships with other service providers

Complaints procedures

Obtaining consumer feedback

Appeals processes

ACAS management and administration

Management and governance

Strategic planning

Development and review of policies and procedures

Human resources planning/ staff recruitment

Staff training and development

Orientation training

Industrial relations

Employee assistance programs

Information management

Occupational health and safety

Environmental responsibility

Quality improvement and evaluation plan/ strategy

What are the key issues or other elements not addressed above that you would like to see incorporated into a Quality Improvement Framework for ACAS, ie., what information would be most useful to improve quality practice in your team?

List any barriers to implementing what you believe to be an effective quality improvement process?

Is there anything else you believe should be considered in developing a Quality Improvement Framework for Victorian ACAS?

Are there any members of your ACAS team who have particular expertise in Quality Improvement who would be prepared to contribute to the development of a Quality Improvement Framework for Victorian ACAS? If so, list name and area of expertise (eg Jim Smith, client satisfaction surveys)

APPENDIX 2:**Workshop Participants**

Topic	Time and place	Participants
Workshop 1: Managing the quality improvement process	9.30-12.30, 5 December @ Training Room 1, 7 th Floor, Commonwealth Department of Health and Aged Care, 2 Lonsdale Street Melbourne	Shirley Carvosso (Wangaratta) Carolyn Sargood (St Georges) Bernard Street (Bendigo) Laura Poole (Bendigo) Tricia McKeown (Caulfield) Vicki Hill (Mt Eliza) Lorraine Daly (Grampians) Liz Stewart (DHAC)
Workshop 2 Client feedback mechanisms	1.30-4.30, 5 December @ Training Room 1, 7 th Floor, Commonwealth Department of Health and Aged Care, 2 Lonsdale Street Melbourne	Shirley Carvosso (Wangaratta) Bernard Street (Bendigo) Laura Poole (Bendigo) Vicki Hill (Mt Eliza) Penny Houghton (North West) Tricia McKeown (Caulfield) Lorraine Daly (Grampians) Liz Stewart (DHAC)
Workshop 3 Staff and team competency/staff development	9.30-12.30, 6 December @ Senior Citizens Centre, Ground Floor, Department of Human Services 555 Collins Street Melbourne	John Matthews (Bendigo) Rob Herni (Gippsland) Denise Bromley (Gippsland) Monica Harte (Caulfield) Liz Stewart (DHAC) Judi McKee (Mt Eliza) Helen Page (Mt Eliza) Juliet Thorn (Heidelberg) Viki Perre (DHS)

Topic	Time and place	Participants
Workshop 4: Assessment processes	1.30-4.30, 6 December @ Senior Citizens Centre, Ground Floor, Department of Human Services 555 Collins Street Melbourne	John Matthews (Bendigo) Rob Herni (Gippsland) Denise Bromley (Gippsland) Vicki Hill (Mt Eliza) Judi McKee (Mt Eliza) Rita Felicissimo (Heidelberg) Liz Stewart (DHAC) Adri van der Knijff (Ballarat) Jill Taylor (North West) Kirsten Rodger and Heather Lawson (DHS)
Workshop5a: Access Workshop 5b: Client outcomes	9.30-12.30, 7 December @ Centre for Older Person's Health, 75 Maude Street Shepparton	Debbie Gook, Tony Crowe, Gwen Smith, Jan Brown (Shepparton) Jennifer White, (Wangaratta) Shirley Caravasso (Wangaratta) Alison White (Bendigo) Maree Santilla (Bendigo)
Workshop 6 Relationships with other service providers	1.30-4.30, 7 December @ Centre for Older Person's Health, 75 Maude Street Shepparton	Debbie Gook, Tony Crowe, Gwen Smith, Jan Brown (Shepparton) Jennifer White (Wangaratta) Alison White (Bendigo) Maree Santilla (Bendigo)

Topic	Time and place	Participants
Workshop 7 Safety	9.30-12.30, 12 December @ Room 204, Peribolos West Building, La Trobe University, Bundoora	Sharon Barrie (Bundoora) Pat Balsillie (Bendigo) Helen Page (Mt Eliza) Juliet Thorn (Heidelberg) Lorraine Daly (Grampians) Shelley Faulks (Mildura via teleconference)
Workshop 8: Information management	1.30-4.30, 12 December @ Room 204, Peribolos West Building, La Trobe University, Bundoora	Pat Balsillie (Bendigo) Annette Marslen Gippsland Helen Page (Mt Eliza) Lorraine Daly (Grampians) Shelley Faulks (Mildura via teleconference) Jenk Akyalcin (DHS) Kirsten Rodger (DHS) Janette Collier, Sue Humphries (LGC)

APPENDIX 3

ACAP objectives, performance indicators and desired outcomes

(AIHW, 2001: p123 –124; unpublished working document)

Performance area	Objective	Performance indicator	Desired outcome
Equity	1 To ensure that older persons who belong to the following groups have equitable access to Aged Care Assessment Team (ACAT) services: <ul style="list-style-type: none"> • Aboriginal and/or Torres Strait Islander people; • Culturally and linguistically diverse people; • people living in rural and remote areas • <i>(Note: veterans have recently been identified as a special needs group)</i> 	1.1 % older ACAT clients who are of Aboriginal and/or Torres Strait Islander origin 1.2 % older ACAT clients from culturally and linguistically diverse backgrounds 1.3 % older ACAT clients living in rural/remote areas <i>Note: a performance indicator related to veterans will be developed in the future</i>	1.1—1.3 The % of older ACAT clients belonging to these groups is consistent with the % of older people in the population belonging to these groups.
	2 To ensure that access to ACAT services is based on need.	2.1 % ACAT clients receiving timely assistance 2.2 % older people assessed by ACATs 2.3 % older people with a severe or profound core activity restriction assessed by ACATs 2.4 % younger ACAT clients with severe or profound core activity restriction 2.5 % older ACAT clients with dementia	2.1 All clients are assisted within the timeframe specified by the Priority category allocated to the client's assessment. 2.2 Maintain or increase the % of the older population assessed. 2.3 Maintain or increase the % older population with a severe or profound core activity restriction assessed. 2.4 Reduce % of younger clients assessed without a severe or profound core activity restriction. 2.5 To maintain or increase the % older clients with dementia.

Table 4.1 (continued): ACAP objectives, performance indicators and desired outcomes

Effectiveness	3	To prevent premature or inappropriate admission to residential care facilities.	3.1	% ACAT recommendations for long term residential care for clients not 'at risk'	3.1	Maintain or reduce % recommendations for long term care in residential aged care services for clients not 'at risk'.
			3.2	% ACAT recommendations for long term residential care for younger clients	3.2	% recommendations for long term care in residential aged care services for younger clients decreases over time.
<i>Note: In the future consideration will be given to the development of a performance indicator measuring ACAT recommendations from low to high residential care</i>						
	4	To help frail older people live in the community.	4.1	% older ACAT clients with dementia recommended for long term care in community settings	4.1	To maintain or increase % older clients with dementia recommended for long term care in community settings.
4.2			% older ACAT clients 'at risk' recommended for a Community Aged Care Package	4.2	Maintain or increase % 'at risk' clients recommended for a Community Aged Care Package.	
4.3			% ACAT recommendations for long term care in community settings for clients assessed in community settings	4.3	To maintain or increase the % of clients who are assessed in community settings and are recommended for long term care in community settings.	
4.4			% ACAT recommendations for long term care in community settings for clients assessed in hospital	4.4	To maintain or increase the % clients assessed in hospital who are recommended for long term care in community settings.	
<i>Note: Future consideration will be given to developing a performance indicator for ACAT recommendations for residential respite care</i>						

	5	To facilitate access to the combination of services that best meets the needs of assessed clients.	<i>None identified to date. May be explored through cross-program data linkage in the future.</i>	
Quality <i>Quality objectives will be reviewed in the light of the development of appropriate quality standards and monitoring processes.</i>	6	To ensure that assessments of the care needs of frail older persons are comprehensive, incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care need.	6.1 % multidisciplinary assessments for clients 'at risk'	6.1 100% assessments of clients 'at risk' of admission to residential care involve input from more than one discipline.
	7	To involve clients and their carers, and other service providers in the assessment and care planning process.	<i>Needs development of appropriate quality standards and monitoring process. Measurement of performance against these objectives may not be suited to MDS reporting.</i>	
	8	To promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people.	<i>As above.</i>	