Controller and Auditor-General
Tumuaki o te Mana Arotake

Performance audit report

Effectiveness of arrangements to check the standard of services provided by rest homes

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Effectiveness of arrangements to check the standard of services provided by rest homes

This is an independent assurance report about a performance audit we carried out under section 16 of the Public Audit Act 2001.

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Auditor-General's overview

There are about 34,000 people living in 715 certified rest homes throughout the country. Older people who live in rest homes are some of the most vulnerable in our society, so it is important to have effective arrangements for checking the quality and safety of rest home services. The effectiveness and efficiency of such arrangements was the focus of a performance audit by my staff.

By law, rest homes have to provide residents with care that meets the *Health and Disability Services Standards* (the Standards). To provide residential care services for older people, rest homes must be certified by the Director-General of Health and, to remain certified, rest homes must be audited to check whether they meet the many criteria set out in the Standards.

The Ministry of Health (the Ministry) is responsible for the auditing and certification of rest homes. In my view, since its introduction in October 2002, certification of rest homes has not provided adequate assurance that rest homes have met the criteria in the Standards, and the Ministry did not respond quickly enough to address weaknesses and risks in the arrangements that it has known about since 2004.

The Ministry is actively trying to address shortcomings in the effectiveness of auditing and certification arrangements. For example, it has a certification improvement project and wider work programme that have been well managed, and the project has so far met most of its milestones. Communication between all those involved in overseeing rest homes has improved. The Ministry has also begun to manage risks more systematically.

However, more work remains to be done and it is still too early to tell whether the efforts to make the current arrangements work as intended will make a difference or whether certification is fundamentally unable to do what the legislation envisaged.

Auditing by designated auditing agencies has been inconsistent and sometimes of poor quality

Audits of rest homes can never eliminate the risk of poor care. Audits can only establish whether, at a particular point in time, rest homes have the systems and processes in place to minimise that risk.

The Ministry uses eight designated auditing agencies (DAAs) to carry out audits of rest homes.

The Ministry has known since 2004 that auditing by DAAs is inconsistent and sometimes of a poor quality. Notwithstanding its recent efforts, and evidence that DAAs are improving some aspects of their work, the Ministry did not respond to these problems quickly enough or with enough effect.

There are examples from 2008 and 2009 where DAAs have failed to find or report instances where rest homes have not met the criteria in the Standards. Serious failures in the care of residents have been identified later by other regulatory bodies. The frequency of these events may have been low, but they are significant because the failings are serious.

Progress reporting is a mechanism that is supposed to ensure that rest homes take action to fix problems identified by DAAs. Progress reporting is not always effective and is not leading to sustained improvements. Our file reviews showed that DAAs mostly rely on rest homes to report on their own progress and rarely make follow-up visits to verify that action has been taken. Some rest homes are repeatedly failing to meet the same or closely related criteria in the Standards, and some DAAs are behind in submitting progress reports to the Ministry.

Until its current programme of work, the Ministry's quality assurance of DAAs largely consisted of an evaluation of DAA audit reports (many of which were not properly completed). Except in times of crisis, the Ministry has given little feedback to DAAs on their performance, and it has never removed a DAA's designation despite evidence of sustained poor performance.

In my view, the Ministry must strengthen how it oversees the work of DAAs and how it deals with poor performance by DAAs. The Ministry's current programme of work has begun to address many of the weaknesses in auditing and certification. For example, the quality assurance system that the Ministry uses to oversee the work of DAAs has improved. There is now more stringent evaluation of DAA reports, closer scrutiny of DAAs known to be performing poorly, and the Ministry has begun to observe audits by DAAs. Communication between the Ministry and the aged care sector, including DHBs, has also improved. This work should have started sooner.

The Ministry has made efforts in the last two years to identify and address the problems with the current certification arrangements. Further, the need to improve the skill level and capacity of the HealthCERT team was recognised and restructuring began in 2008. A supporting information technology platform was put in place in 2008, enabling an accelerated work plan to continue throughout 2009.

Monitoring by district health boards

Rest homes are also monitored by DHBs. Most rest homes have a contract with their local DHB – the Age Related Residential Care Services Agreement (the age-related care contract). DHBs are required by law to monitor the delivery and performance of services by rest homes that they hold an age-related care contract

with. Although the age-related care contract is the same throughout the country, individual DHBs interpret and monitor the contract differently. I encourage DHBs to achieve consistency in this matter.

Most (65%) DHBs do not consider certification to be reliable. Fourteen DHBs carry out their own auditing of rest homes (usually through their shared service agency), which largely duplicates the auditing carried out by DAAs. This diverts scarce resources from other monitoring work that could focus more on improving the quality of care in those rest homes where the risk to rest home residents is greatest.

Monitoring of rest homes by DHBs has not been well co-ordinated with the work of the Ministry. Occasionally, DHB auditors and DAA auditors have audited a rest home within days of each other, or on the same day. The results of the audits are often quite different.

Variable risk management

Certification relies on audits. Auditor independence is integral to the audit. We identified various threats to auditor independence inherent in the system. In our view, the Ministry could have responded more quickly to risks identified in the certification arrangements.

The Ministry now has a risk register, and has plans for managing several of the most significant risks, including:

- the risk of conflicts of interest;
- the risk that rest homes might select the cheapest or most lenient DAA;
- the risk that commercial pressures might influence an auditor's independence;
- the risk that DAAs might interpret and audit the Standards differently; and
- the risk that auditors might have inadequate skills and expertise.

Rest homes can choose which DAA will audit them, and most of the auditors who work for DAAs are freelance contractors. My staff found evidence of DAA auditors offering and providing rest homes with services in addition to auditing. Until 2009, the Ministry had not closely scrutinised the pricing and other business practices of DAAs. It now has limited knowledge of audit fees that different DAAs charge rest homes.

Certification audits are arranged well in advance, which means that the audit team may not see the rest home as it usually operates. The audit team (usually two people) is expected to check more than 200 criteria for a certification audit.

Some criteria will take longer than others to check. For example, DAAs check that the records kept are legible. DAAs also check that rest home residents are actively involved in the planning of each stage of service provision, which requires interviewing rest home residents and sometimes their families.

Most audits are carried out with only two days on site, which leaves DAAs little time to check each criterion thoroughly. A DAA could lose the rest home's business if the price for the audit were too high, which creates a commercial incentive to carry out audits quickly.

Ongoing effectiveness of certification

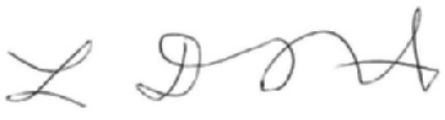
Rest home operators, DAAs, and DHBs agree that the introduction of the Standards and certification have raised standards in rest homes. However, there is evidence that the rate of improvement has slowed, and some rest homes consistently receive poor ratings for the same or closely related criteria. In addition, rest homes throughout the sector are often given poor ratings for some Standards - for example, the medicine management standard.

Overall findings

I am encouraged by the work the Ministry has done with DAAs and DHBs this year. However, it is too early to judge whether the changes being made will make the auditing, certification, and monitoring of rest homes more effective and efficient.

My Office will do more work in 2011 to look at whether the changes the Ministry is now making have improved the effectiveness of the overall certification process. More fundamental changes to the design of the auditing, certification, and monitoring arrangements may yet be needed. I recommend that the Ministry consider whether other arrangements would be more effective and reliable.

I thank the staff of the Ministry, DAAs, DHBs and their shared service agencies, rest home providers, and the organisations that provide advocacy services for the elderly, for helping my staff with this performance audit.



Lyn Provost
Controller and Auditor-General

15 December 2009

Our recommendations

Recommendations for the Ministry of Health

The first five recommendations for the Ministry are based on improving the existing certification arrangements. The sixth recommendation is significant, because we encourage the Ministry to reconsider the effectiveness of the existing certification arrangements.

We recommend that the Ministry of Health:

1. continue to strengthen how it oversees designated auditing agencies;
2. cancel the designation of audit agencies that continue to perform poorly;
3. continue to improve its use of auditing and certification information to identify common themes and trends in the rest home sector, and use that knowledge to identify how and where rest home residents are at greatest risk;
4. continue to improve how it manages risks in the certification arrangements, identifying the likelihood and severity of those risks and reviewing each year its risk management strategy;
5. begin to evaluate, by the end of 2010, the effectiveness of third-party accreditation and other work to strengthen the certification process, and share the results with district health boards, rest home operators, and organisations providing advocacy services for older people; and
6. **reconsider the design of the certification arrangements by examining alternatives and evaluating whether the alternatives would be more effective and more reliable.**

Recommendations for district health boards

We recommend that:

7. district health boards work together to ensure that they and their shared service agencies are interpreting the Age Related Residential Care Services Agreement consistently;
8. district health boards share information relevant to improving the safety and quality of services provided by rest homes quickly and freely with other agencies working in the rest home sector; and
9. once auditing by designated auditing agencies is effective and reliable, district health boards stop routine contract auditing and use their resources to work with those rest homes where improvements are needed most.

Part 1
Introduction

1.1 In this Part, we describe:

- the purpose of our audit;
- how we carried out our audit;
- what we did not audit; and
- the structure of this report.

Purpose of our audit

1.2 We carried out a performance audit of the arrangements designed to check that the care older people receive in rest homes meets the required standards of safety and quality.

1.3 In this report, rest homes are facilities that provide residential and long-term care for those older people (usually aged 65 and older) who are no longer able to live independently in their own homes. Rest homes accommodate three or more people unrelated by marriage or blood to the people providing the care and accommodation. Some rest homes provide care comparable to the nursing care a person would receive in a hospital. Rest home operators are paid for providing the care, by either the resident or by the Crown.

1.4 With increasing rates of dementia, and with more services available to support older people to stay at home for longer, people who move into rest homes often have more complex needs than in the past. This means that rest homes provide for some of the most vulnerable people in our society. It is essential that the systems designed to safeguard their care are effective.

1.5 In 2009, there were an estimated 34,000 rest home beds throughout the country. In May 2009, there were 715 certified rest homes.[1] By 2030, the population aged over 65 years is predicted to double and the population over 85 years is expected to treble. By 2051, older people will make up about a quarter of the total population.

Ministry of Health's role in rest home care

1.6 The Ministry of Health (the Ministry) administers the Health and Disability Services (Safety) Act 2001 (the Act). The purpose of the Act is to:

(a) promote the safe provision of health and disability services to the public; and

(b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely; and

(c) encourage providers of health and disability services to take responsibility for providing those services to the public safely; and

1 Technically, it is the services provided by the rest home operator that are certified, rather than the rest home.

(d) encourage providers of health and disability services to the public to improve continuously the quality of those services.

1.7 Under the Act, rest homes have to provide their residents with care that meets certain standards. Those standards are approved by the Minister of Health, and published by Standards New Zealand as the *Health and Disability Services Standards* (the Standards).[2] The Ministry ensures that the services provided in each rest home are audited against the Standards.

1.8 Much of the auditing is carried out by independent organisations that the Ministry has approved to do the work. The organisations are known as designated auditing agencies (DAAs). DAAs submit their audit reports to the Ministry's HealthCERT team. HealthCERT is responsible for:

> *... ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.*
>
> *HealthCERT's role is to administer and enforce the legislation, issue certifications, review audit reports and manage legal issues.*[3]

1.9 The Ministry uses the audit reports from DAAs (and other information) to decide whether a rest home can continue to operate, and for how long (from one to five years). The term used to describe the Ministry's permission for a rest home to operate is "certification". The auditing by DAAs is an integral part of the certification arrangements.

District health boards' role in rest home care

1.10 District health boards (DHBs) also have a role in monitoring the quality of the care that older people receive in rest homes. DHBs fund the rest home care of older people who are entitled to a subsidy. The rest homes that provide care for people entitled to a subsidy must enter into a contract with their DHB. Although the contract is the same nationally, it is monitored locally. DHBs have varying ways of monitoring the contract. In 14 of the country's 21 DHBs, the monitoring includes auditing that is similar to the auditing carried out by DAAs.

How we carried out our audit

1.11 We examined whether the Ministry's administration of the certification arrangements was effective in promoting the safe provision of services to the residents of rest homes, and encouraging rest home operators to continuously improve those services. To be effective, DAAs would consistently and reliably identify where rest homes were failing to meet the Standards. Rest homes would

2 Standards New Zealand (2008), *Health and Disability Services Standards*, NZS 8134:2008, Wellington.

3 See the certification section of the Ministry's website (www.moh.govt.nz/certification).

quickly make the necessary improvements, and certification periods would appropriately reflect the quality and safety of the services provided by a rest home.

1.12 We looked at the work that the Ministry does to decide whether, and for how long, rest homes should be certified. We included the way the Ministry designates agencies and oversees the performance of DAAs, and how it uses information from complaints and from DHBs to make decisions about certification.

1.13 We looked at the work that DHBs do to monitor the contract they have with rest homes, to see whether the monitoring is aligned and co-ordinated with certification.

1.14 We interviewed officials from the Ministry, DHBs, the Health and Disability Commissioner's office, and the shared service agencies[4] (SSAs) that carry out audits for some of the DHBs. We also interviewed managers of rest homes, directors and auditors of DAAs, and people working for organisations that provide advocacy services for older people.

1.15 We reviewed the Ministry's certification files for 73 rest homes, tracking the audit reports of each since certification was introduced in October 2002. We also observed two certification audits and an audit on behalf of a DHB to better understand what happens during these audits and the methods that are used.

1.16 Between June and August 2009, we surveyed all 21 DHBs on their methods for monitoring rest home contracts and their view of the certification process. We received responses from 20 DHBs.[5] We also surveyed Age Concern's regional offices for their views on how the Ministry and DHBs ensure the quality and safety of care provided in rest homes.

1.17 In 2009, the Ministry began a project to improve the way in which rest homes are certified and to work with DHBs to reduce duplication in auditing. We looked at the project, and the wider work the Ministry is doing, to consider whether it will lead to improvements.

What we did not audit

1.18 We did not set out to form a view on the adequacy of the Standards or the quality of the care provided to rest home residents. The certification of any health and disability services other than those provided in rest homes was also outside the scope of our audit.

4 Shared service agencies are owned by groups of DHBs. They carry out services on behalf of those DHBs.

5 In paragraph 1.10, we noted that 14 of the 21 DHBs carry out their own auditing to monitor their contract with rest homes. We found out through other means how the one DHB that did not respond to our survey monitors its contract with rest homes.

Structure of this report

1.19 Our report has six parts. In Part 2, we describe how the Ministry certifies rest homes and how DHBs monitor the contracts they have with rest homes.

1.20 In Part 3, we discuss how effectively the Ministry has managed the certification of rest homes since certification was introduced in 2002. We include how well the Ministry manages the process of designating audit agencies and how well it monitors their performance. We also discuss how effective certification has been in encouraging rest homes to continuously improve the quality of the services they provide.

1.21 In Part 4, we discuss how the Ministry manages risks in the certification arrangements.

1.22 In Part 5, we discuss the Ministry's recent efforts and further plans to improve certification, set out our views about whether this work will be sufficient, and identify other changes the Ministry could make.

1.23 In Part 6, we describe how DHBs meet their responsibility under the New Zealand Public Health and Disability Act 2000 to monitor their contracts with rest homes. We discuss the extent to which their work is co-ordinated with the Ministry's certification of rest homes.

Part 2
How rest homes are certified and monitored

2.1 In this Part, we describe the arrangements that are designed to promote and encourage the safe provision of the services that rest homes provide for their residents. We discuss:

- at a high level, how certification works and the legislation that governs it;
- the Ministry's role in designating agencies to audit rest homes;
- how those agencies audit rest homes against the Standards;
- how the Ministry uses the audit reports and other information to certify rest homes; and
- how DHBs monitor compliance with the national contract they each have with rest home operators.

2.2 When the Ministry has certified a rest home that has residents who receive a subsidy, the rest home enters into a contract with their local DHB. Through that contract, the rest home receives funding from the DHB to provide residential care services for older people. We describe how DHBs monitor a rest home's compliance with that contract.

Overview of how certification works

2.3 To provide residential care services for older people, rest homes must be certified by the Director-General of Health under the Act. To remain certified, a rest home is required to meet the Standards when it is audited against them.

2.4 Rest homes are audited by DAAs. DAAs audit more than just rest homes – they carry out certification audits throughout the health and disability sector. For example, they may also audit hospitals. There are eight DAAs, and rest homes can choose which one to use. Audit fees are paid by the rest home. DAAs are limited companies, and all except one are privately owned (one is a subsidiary of a Crown entity). To become a DAA, agencies must apply to the Ministry for designation. Agencies are designated for up to three years.

Audit reports

2.5 The audits of rest homes need to be carried out consistently, and the resulting audit reports need to be reliable, so that the Ministry can make informed decisions about whether and for how long a rest home should be certified.

2.6 Rest homes that provide services that meet the Standards can be certified for up to five years, which means five years before the operator of the rest home has to pay for another certification audit. The DAA is expected to carry out two surveillance audits, which are shorter and less expensive than a certification audit, before the end of the five-year certification period (see paragraph 2.18).

2.7 Each standard is made up of a number of criteria (rest homes are checked against at least 206 criteria, depending on the type of services that they provide). Rest homes that receive "partially attained" ratings for some of the criteria, but still meet the Standards overall, can face more frequent audits because their certification periods can be shorter.

2.8 Audits for certification are arranged between the rest home and the DAA. This means that the rest home knows when the audit is going to take place and has time to prepare for it.

The Health and Disability Services (Safety) Act 2001

2.9 The Act establishes the arrangements for certifying rest homes. It does not prescribe how the Ministry should carry out its role. For example, the Act gives the Ministry the power to designate auditing agencies but does not prescribe how the Ministry should do this. The Act states that the Ministry must satisfy itself that the person (the auditor or audit agency) has the necessary technical expertise and appropriate management and administrative systems in place to audit health services. The Act gives the Ministry the power to place conditions on a designation, but it does not prescribe what the conditions should be.

Designating agencies to audit rest homes

2.10 Section 33(b) of the Act states that the Director-General must designate someone to audit health care services of a certain kind if – and only if – the Director-General is satisfied that the person:

(i) has the technical expertise to audit the provision of services of that kind; and

(ii) has in place effective systems for auditing the provision of services of that kind; and

(iii) has in place effective arrangements to avoid or manage any conflicts of interest that may arise in auditing the provision of services of that kind; and

(iv) will administer those systems and arrangements properly and competently, and in compliance with any conditions subject to which the designation is given; and

(v) will comply with this Act.

Conditions of designation

2.11 Under Section 32 of the Act, the Director-General also publishes conditions of designation in the *New Zealand Gazette*. The conditions of designation change from time to time and are currently under review. The current conditions were published in May 2009 and include:

- compliance with the requirements of the *Designated Auditing Agency Handbook* (the DAA Handbook) issued by the Ministry;
- providing information that the Ministry requests about health care services;
- allowing the Ministry to conduct audits and reviews of the DAA;
- submitting internal audit reports to the Ministry;
- notifying the Ministry of changes in ownership and management personnel; and
- providing information that the Ministry requests about auditor competency.

Cancelling a designation

2.12 The Director-General of Health may cancel the designation of a DAA if the Director-General is no longer satisfied that the DAA meets the criteria under section 33(b) of the Act, if the DAA fails or refuses to comply with a provision of the Act or a condition of designation, or if the DAA asks for the designation to be cancelled.

Auditing against the *Health and Disability Services Standards*

2.13 The Standards are approved by the Minister of Health under section 13 of the Act, and set the minimum standard expected in health and disability services. The Standards, last revised in 2008, include a general standard, core standards, a restraint minimisation standard, and infection prevention and control standards. The core and general standards include consumer rights, organisational management, continuum of service delivery, and providing a safe and appropriate environment. Each individual standard is made up of one or several criteria.

2.14 The Standards apply to the whole of the health and disability sector, so auditors have to interpret how each of the standards would apply to rest homes.

2.15 DAAs carry out three types of rest home audit. These are:

- provisional audits of new rest homes (or when rest homes have changed ownership);
- certification audits; and
- surveillance audits.

2.16 Provisional audits of new rest homes check that there are appropriate policies and procedures in place to meet the Standards, and that the rest home has a building warrant of fitness. Provisional audits involve a site visit to make sure that the rest home will provide a safe and appropriate environment.

2.17 Certification audits check all criteria in the Standards (there are at least 206 that apply to rest homes). Typically, two auditors will carry out a certification audit and they are usually at the rest home for only two days. Before DAAs visit a rest home, the Ministry expects them to review the rest home's policies and procedures.

2.18 Surveillance audits check rest homes at the mid-point of their certification period. These are shorter audits that focus on known risk factors for the rest home, including those that required attention after the previous certification audit. They also cover some core standards. Typically, a surveillance audit is carried out by one auditor during the course of one day. (There is a pilot project under way to replace surveillance audits with unannounced "spot audits". We discuss this further in Part 5).

Certification audits against the Standards

2.19 Rest homes choose which DAA they will use. Certification audits – including the timing and the price that the rest home will pay – are arranged between the rest home and the DAA.

2.20 Auditors rate the services provided by each rest home against each criterion in the Standards, to decide whether the Standards are being met and what actions need to be taken to improve the care provided to residents of the rest home. The ratings are:

- continuous improvement;
- fully attained;
- partially attained; and
- unattained.

2.21 Figure 1 provides examples of what auditors check under each standard during a certification audit.

Figure 1
Examples of what the auditors check during a certification audit

Standard	Example of what the auditors check
Consumer rights	Auditing against this standard includes checking that residents in rest homes are well informed of their rights, that their personal privacy is protected, and that they do not suffer from any discrimination. Auditors will normally check the policies of the rest home to see whether the policies support the criteria under this standard. Auditors will interview the manager, staff, and residents to check whether the policies are being implemented.
Organisational management	This standard includes that there are enough staff with the necessary qualifications on duty at the rest home. This will vary according to the type of care the rest home is certified to provide. For example, if the rest home provides care for people with dementia or people who need hospital-level care, then a registered nurse should be available all the time. To check this, auditors will look at staff rosters and interview the manager and staff of the rest home. This standard also includes criteria on Human Resource Management. Auditors will check staff files and speak to staff to make sure that they received adequate orientation when they first started working at the rest home, and that they have adequate qualifications and training. Auditors will also check that rest homes have systems in place to manage risks and that the rest home regularly monitors its service, including asking residents and their families for feedback.
Continuum of service delivery	This standard is intended to make sure that residents receive care that is safe and appropriate to their needs. It includes making sure that, when residents move into a rest home, their needs are assessed and they are involved in preparing personal care plans. The standard also includes making sure that residents receive their medication in a safe way. Auditors will examine records and may observe medication being given to residents.
Safe and appropriate environment	Auditors check whether the rest home has a current building warrant of fitness and an evacuation plan approved by the New Zealand Fire Service. They will also check that the building is well kept, clean, and safe. This will normally include visiting the rooms of residents, the kitchen, bathrooms, and the laundry.
Infection control	Auditors check the policies of the rest home to see whether there are adequate procedures in place to prevent infections spreading between residents and staff. Auditors will also check staff files to see whether staff have received training in controlling infection. Auditors will examine records to see if there have been any outbreaks of infection and, if so, what the rest home did in response.
Managing restraint safely	Sometimes residents in rest homes have to be restrained to prevent them from harming themselves or others. This can mean providing belts on chairs and placing rails on beds to prevent falls. This standard is aimed at reducing the use of restraints so they are used only when absolutely necessary. Auditors will check the policies of the rest home, check staff files for evidence of relevant training, and may interview staff and residents to check that the policies are implemented properly.

Using audit reports and other information to certify rest homes

2.22 DAAs send audit reports to HealthCERT, which is the Ministry team responsible for certification. The reports are reviewed by HealthCERT staff, who review the evidence supplied for each criterion and check that the rating given by the auditor matches the evidence. They consider the findings of the audit report, and may also consider other information they might have about the rest home (such as complaints and information from DHBs or the Health and Disability Commissioner).

2.23 In 2008, the Ministry introduced a decision-making matrix for determining the period of certification. The matrix was revised in 2009 and, as a consequence, more information from other agencies is used to determine periods of certification. Senior advisors in the Ministry use the matrix to assess the level of risk associated with each rest home. After they have considered other information (such as complaints, a provider's past performance, and information that DHBs might have), they recommend to the manager of HealthCERT the length of certification for the rest home. Most rest homes (80%) are certified for three years.

2.24 For surveillance audits, the Ministry decides whether to add more conditions to the certification. For example, if an audit report shows that a rest home has not been rated as fully attaining one of the criteria in the Standards, the Ministry can add a condition that a written progress report be submitted to the Ministry on the actions the rest home has taken to address the problem. The DAA collects this information from the rest home and submits the report directly to the Ministry.

2.25 If the Ministry has particular concerns about the standard of care provided by a rest home, it can send its staff to carry out an inspection. These inspections can be either announced or unannounced, and will assess the rest home against the Standards that the rest home is suspected of failing to meet. Between 2007 and 2009, the Ministry carried out 44 inspections of rest homes.

Monitoring by district health boards

2.26 Most rest homes have a contract with their local DHB – the Age Related Residential Care Services Agreement (the age-related care contract). To help people pay for their care in rest homes, DHBs provide subsidies to those older people who are entitled to one. Most people in rest homes receive some level of subsidy to help pay for their care. All rest homes that care for people in receipt of a DHB subsidy must sign the age-related care contract with their local DHB. Section 23 of the New Zealand Public Health and Disability Act 2000 requires DHBs to "monitor the delivery and performance of services" by rest homes they hold contracts with.

2.27 The age-related care contract is the same in all DHBs but the way DHBs monitor the contract varies. Monitoring includes a wide range of activities, including:

- using information from other DHB functions, such as Needs Assessment and Service Co-ordination services[6] and hospital admissions of rest home residents;
- communicating with community services groups that work with rest home residents;
- providing clinical advice to rest homes;
- considering the content and number of complaints;
- establishing and strengthening relationships with rest home management; and
- considering the content of performance monitoring reports.

2.28 Fourteen DHBs carry out routine contract audits of rest homes, which are usually completed by an SSA on behalf of the DHB. The routine contract audits check that the rest home is complying with the requirements of the age-related care contract. The number and frequency of routine contract audits by DHBs varies. Some DHBs have a three-yearly cycle of audits. Other DHBs prioritise their routine contract audits according to factors that include:

- information they have about a rest home from complaints or other sources;
- when the rest home was last audited and what that audit found; and
- variations that have been made to the contract.

2.29 These routine contract audits cover very similar matters to the certification audits carried out by DAAs.

2.30 Six DHBs in the North Island pay DAAs to extend the certification audits so that the audits cover the DHBs' contract requirements as well as the Standards. This means that DHBs can use certification audits as one way of monitoring rest homes, and it reduces the need for them to carry out their own auditing. Using certification audits in this way is significantly cheaper. Routine contract audits cost from $3,500 to $7,500 each. Paying DAAs to extend their certification audits costs around $450.

2.31 If a DHB has evidence that a rest home is failing to provide care that meets the requirements of the age-related care contract, it can commission an unannounced audit. These are called issues-based audits, and are usually carried out by SSAs. DHBs used SSAs to carry out nine issues-based audits in 2008. Issues-based audits look in detail at the aspects of care thought to be most at risk.

6 Needs Assessment and Service Co-ordination services are organisations contracted to DHBs. Needs Assessment and Service Co-ordination services work with older people to identify their needs and outline the support services that are available. Older people have to be assessed by a Needs Assessment and Service Co-ordination service before they can receive a subsidy for rest home care from their DHB.

Part 3
Certifying rest homes

3.1 In this Part, we discuss:

- how well the Ministry oversees DAAs;
- the effectiveness of progress reports in encouraging rest homes to provide services safely;
- how well the Ministry uses and shares information about certification; and
- the effectiveness of certification in encouraging rest homes to improve the quality and safety of their services.

Our overall findings

3.2 Since its introduction in October 2002, certification has not provided a consistently adequate level of assurance that rest homes have met all the criteria in the Standards. The Ministry has been aware of weaknesses in auditing by some DAAs since 2004, but these weaknesses were not acted on quickly enough or with enough effect.

3.3 The effectiveness of certification has been compromised by inconsistent auditing by DAAs, which makes it hard for the Ministry to certify rest homes for appropriate periods. Certification is also not as effective as it should be because information has not been shared enough between the different organisations involved.

Overseeing the designated auditing agencies

The Ministry has known since 2004 that the auditing carried out by DAAs is inconsistent and, in some cases, of a poor quality. In our view, the Ministry did not respond to these problems quickly enough or with enough effect.

3.4 It is important that the auditing and reporting by DAAs is consistent and reliable. Poor auditing can mean that aspects of care where rest homes are not meeting the required standards are not identified. This creates a risk that the Ministry could certify rest homes for longer periods than it should, or certify a rest home that should not be certified.

3.5 The period of certification given to a rest home is one of the main ways of managing risks in the care of older people in rest homes. Rest homes that receive poor audit reports are certified for shorter periods, and are subject to more regular certification audits. The length of certification can also be used by DHBs to inform their monitoring activity.

3.6 At the time of our audit, 80% of rest homes were certified for three years, and another 14% for two years. Very few rest homes were certified for more than three years.

3.7 Figure 2 sets out a timeline of actions the Ministry has taken, between 2002 and 2009, to improve certification. It also shows the performance information that has been available to the Ministry.

Figure 2
Timeline of action taken to improve certification, and the performance information available, 2002-2009

Date	Actions	Performance information
2002	October: All new rest homes must be certified under the Health and Disability Services (Safety) Act 2001.	
2003	December: DAA Handbook is produced.	
2004	October: All existing rest homes must be certified under the Health and Disability Services (Safety) Act 2001 by this date.	October: Ministry-commissioned audit of five DAAs with the largest market share identifies significant weaknesses in their performance.
2005	June: DAA Handbook is revised. September: DAA Handbook is revised.	November: Ministry-commissioned audit of the other four DAAs concludes that there are serious weaknesses common to most, if not all, DAAs.
2006	September: Requirement for third-party accreditation is removed as a condition of designation for DAAs. Further designation conditions added by way of notice in the *New Zealand Gazette*.	
2007	March: DAA Handbook is revised. July: Ministry is restructured. October: HealthCERT manager resigns. December: HealthCERT prepares new audit tool and report for its unannounced inspections of rest homes.	July: Discussion paper about a review of the Health and Disability Services (Safety) Act 2001 is published. It raises concerns about conflicts of interest and inconsistency between DAAs, which makes certification decisions difficult.
2008	HealthCERT is restructured, experiences high staff turnover. January: Risk matrix to determine periods of certification is introduced. More use of information from other agencies is included in certification decisions.	

Date	Actions	Performance information
	May: Ministry starts process to implement new Standards, including a new standard audit reporting template and communication with DAAs about the transition period. July: Training begins for HealthCERT staff who will observe DAA audits. August: Revision of complaints process starts. A DAA is re-designated despite Ministry concerns about its performance. Ministry plans to commission an audit of a DAA with a large market share. September: Revised Standards are notified in the *New Zealand Gazette*. May, September, October: Cabinet papers raise concerns about risks in the certification process and the performance of some DAAs. October: New team of senior advisors appointed in HealthCERT. HealthCERT begins review of DAA Handbook and prepares tables comparing 2001 and 2008 Standards. November 2008: Revised Standards are introduced.	July: Belhaven Rest home (certified for two years) is shut down.
2009	February: Programme of seminars begins, explaining changes to the Standards. February: DAA "Train the Trainer" sessions begin, with the aim of greater auditing consistency. April: Ministry project to improve the effectiveness of rest home audits begins. May: DAA Handbook is revised and published in draft. *New Zealand Gazette* notice is revised to include a requirement to use the Ministry's reporting template, and to submit audit summaries that the Ministry will publish. Risk matrix is revised, contains a new quantitative element to support HealthCERT advisors. June: Electronic audit report template is introduced, all DAAs are required to use it. June: Ministry begins to publish summaries of audit reports. July: Risk matrix is revised again. August: Ministry works with DHBs to reach agreement that, once DHBs have increased confidence in DAA auditing, certification audits could meet DHB needs for monitoring.	

Date	Actions	Performance information
	September: Pilot project to carry out 23 unannounced audits begins. Risk matrix developed further. October: Enhanced DAA evaluation form is introduced to support monitoring of DAAs. Ministry begins to observe DAA certification audits. Draft DAA Handbook is revised. November: Ministry commissions an audit of a DAA with a large market share. Ministry starts analysis of "partially attained" ratings against medicine management standard.	September and October: Ministry analysis shows that, although there is evidence that some aspects of the performance of DAAs have improved, the auditing by DAAs is still of a variable quality.

The Ministry's response to the reports commissioned in 2004 and 2005

3.8 The Ministry has had concerns about the quality and consistency of auditing by DAAs since soon after certification was introduced in late 2002. In 2004 and 2005, the Ministry commissioned reports by an external organisation, The Systems 3 Group Pty Ltd (S3G). S3G looked at how well DAAs were auditing rest homes, and whether the information DAAs provided to the Ministry could be relied on when making decisions about how long rest homes should be certified. A senior staff member within HealthCERT at the time was actively involved in the work carried out by S3G.

3.9 The reports by S3G found serious weaknesses common to all or most DAAs. The weaknesses were in management controls, auditing practice, reporting, and auditor competency management. Figure 3 summarises the findings of the 2005 report.

Figure 3
Summarised findings of The Systems 3 Group report (2005)

Management controls: DAA management controls were not sufficiently robust to ensure that audit teams delivered valid and reliable reports. Internal audits by DAAs were carried out poorly, with a general lack of follow up of findings. Accreditation audits by external quality assurance organisations had failed to identify irregularities in audits against the Standards. Internal DAA management reviews were not followed up, and did not focus on the work DAAs do in the health and disability services sector.

Auditing practice: S3G concluded that "Audit teams do not perform the audit in a manner that delivers the most accurate information upon which a reliable report can be written." Deficiencies included inadequate planning, lack of audit evidence corroboration, inadequate sample size selection, and inadequate time spent on site.

Reporting: DAA reports did not have sufficient information for certification decisions. Data reliability was poor, ratings were inconsistent, and evidence did not align with ratings.

Auditor competency management: The way DAAs determined and managed the competency of their auditors varied considerably. DAAs were not always using personnel who were competent. There were deficiencies in technical skill, communication, and independence, with a "general failure" to declare conflicts of interest. DAAs were not publicising conflict of interest provisions. There was weak assessment of contract auditors, and variable support and guidance given to contract auditors.

3.10 The Ministry responded to the recommendations in the reports mainly by modifying the DAA Handbook and adding conditions to the designation of DAAs in the *New Zealand Gazette*.

3.11 Based on S3G's reports, the Ministry concluded that requiring DAAs to have third-party accreditation was not efficient:

> *The primary purpose of requiring third party accreditation was to provide HealthCERT with a reasonable level of confidence in individual DAAs' auditing systems and to achieve a reasonable degree of consistency between DAAs. HealthCERT shares S3G's view that third party accreditation is not providing this level of confidence or consistency.*

3.12 One of the accreditation bodies disputed S3G's findings about accreditation, but the Ministry kept to its decision and removed third-party accreditation as a condition of designation in 2006. In the Ministry's view, the third-party accreditation bodies should have identified the problems identified by S3G and the Ministry, and should have alerted the Ministry to the non-compliance with accreditation standards and Ministry guidelines.

3.13 A joint Ministry and DAA working group was established in 2006 to address the issues in the S3G reports, but there are few records of meetings of the group and it is not clear what the group has achieved.

3.14 The S3G reports identified some important DAA weaknesses, and the reports could have provided a useful benchmark for the Ministry to measure any improvements in DAAs. There is little evidence that progress in implementing the recommendations, or what effect they were having, was systematically tracked or that the performance of DAAs was measured to see if it was improving in the years after the reports were written. In our view, the Ministry's actions after receiving the reports did not have the necessary urgency or efficacy.

The Ministry's response to concerns raised in 2008

3.15 In September and October 2008, the Minister of Health, responding to concerns about whether all DAAs were functioning as expected in all circumstances, reported to the Cabinet Business Committee. The reports concluded that the safety and quality assurance processes in the aged care sector needed to be strengthened. The Minister of Health proposed a number of changes, including:

- changing the model whereby rest homes choose their DAA;
- introducing unannounced audits;
- that the Ministry begin witnessing audits; and
- that DAAs be subject to independent audits.

3.16 Some of the proposals, such as unannounced audits and independent audits of DAAs, are now being implemented.

3.17 Rest homes continue to choose their DAA. During interviews with us, the operators of multiple rest homes said that this gives them confidence that all their rest homes are being audited consistently.

Analysis and evidence of auditing practices in 2009

3.18 In 2009, there is evidence that the quality of auditing by DAAs continues to vary. However, there are also indications that DAAs are improving some aspects of their work. For example, recent analysis by the Ministry showed that DAAs were meeting the requirements for the skills and experience of their audit teams (see Figure 4).

3.19 Performance in other aspects of auditing remains variable and there is scope for improvement. In May 2009, an operator of many rest homes changed to a different DAA because of the operator's experience of poor auditing.

3.20 When the Ministry analysed DAA audit reports in October 2009, it found variation across a range of indicators (see Figure 4). Of the 44 audit reports analysed, 45% were incomplete.

3.21 The analysis also showed that DAAs need to improve the way they quantify evidence – only 36% of the audit reports indicated how many files the DAAs had reviewed or how many interviews they had conducted. The S3G report in 2004 had highlighted this as an aspect of DAA auditing that needed to improve. Although the sample used for the analysis in 2009 was relatively small, it indicates that progress is still needed.

Figure 4
The Ministry of Health's analysis of audit reports from designated auditing agencies in 2009

	DAA 1	DAA 2	DAA 3	DAA 4	DAA 5	DAA 6	Total
Number of audit reports	2	2	3	9	14	14	44
Audit team met team composition requirements	100%	50%	100%	100%	100%	79%	91%
All of the audit report was completed	50%	50%	33%	78%	50%	50%	55%
Audit report was re-submitted	0%	0%	33%	0%	0%	29%	11%
Evidence was triangulated	100%	50%	67%	89%	64%	93%	80%
Evidence included resident/ relative interviews	100%	50%	67%	89%	93%	57%	77%
Terminology was not ambiguous	100%	100%	100%	100%	79%	79%	86%
Standards matched criterion	50%	100%	33%	100%	93%	93%	89%
Evidence matched attainment rating	0%	100%	100%	89%	93%	93%	89%
Evidence matched risk ratings	50%	100%	67%	89%	93%	100%	91%
Quantification of evidence (e.g. 4 of 5 staff interviewed, 3 files reviewed)	50%	50%	33%	56%	29%	29%	36%
Evidence was written in the present tense	100%	100%	33%	100%	71%	100%	86%
Information requested to match evidence and risk ratings	50%	0%	100%	11%	21%	14%	23%
Information requested for triangulation	50%	0%	0%	0%	7%	7%	7%
DAA responsive to Ministry requests (within 48 hours)*	100%	0%	100%	100%	100%	67%	34%

Source: Based on data from the Ministry of Health.

* These percentages can relate to fewer than the total number of audit reports, because the Ministry does not always make requests that DAAs need to respond to.

3.22 The Ministry has evidence of sustained poor auditing practice by one DAA in 2009. In interviews with us, staff within the Ministry and within DHBs raised concerns about the performance of another DAA. In the case of the former, the Ministry has written to the DAA setting out its concerns, which include conducting audits outside time frames described in the DAA Handbook, using auditors who did not have the required qualifications, and reporting positive results – since 2004 – for a rest home that the Ministry has inspected and found to be failing against many of the Standards. The Ministry has recently commissioned a separate audit of this DAA, to be conducted by S3G.

3.23 There are examples (from 2008 and 2009) where DAAs have failed to report or find instances where rest homes have not met the Standards, and where associated serious failures in the care of residents have not been identified (see Figure 5). These failures have later been found by other regulatory bodies. Although the frequency of these events may be low (we found five examples in our file reviews of the certification of 73 rest homes since 2003), they are significant because the failings are serious.

Figure 5
Examples of designated auditing agency failures to identify serious shortcomings in rest homes (2008 and 2009)

Organisation	Incident
District health boards DHBs and the SSAs that carry out audits on their behalf report that, in the course of their monitoring of rest homes, they have found failings that have required immediate action for criteria that had been rated as fully attained by DAA audits.	In 2008, after serious complaints about the conditions in a rest home (which included a shortage in the supply of oxygen and the maladministration of medicines), a DHB commissioned an issues-based audit. This audit was carried out on the same day that a surveillance audit was carried out by a DAA. Among other issues, the DHB's audit found serious failings with the medication management system. They included a failure to investigate errors and controlled drug counts not adding up. However, the DAA reported that "systems were in place for the safe management of medicines" and the criteria for medicine management were rated as fully attained.
Health and Disability Commissioner The Health and Disability Commissioner has substantiated serious complaints about the provision of care in rest homes. Those rest homes have received positive reports by DAAs.	A complaint was made to the Health and Disability Commissioner in 2008 by a woman unhappy about the care her husband had received in a rest home. The Commissioner discovered serious issues in the standard of care, staff training, communication, behaviour, risk management, and clinical records at the rest home. The matter was referred to the appropriate DHB, and the manager of the rest home resigned. A DAA had carried out a surveillance audit at the rest home five days after the complainant's husband had been admitted in 2008. The surveillance audit report said that the "organisation has established, documented and maintained quality and risk management systems in place."

Organisation	Incident
Ministry of Health Ministry inspections have discovered failings not identified in DAA audits.	In 2009, the Ministry received a complaint from a medical centre about a rest home. The complaint alleged that a resident from the rest home was taken to the medical centre by car after she was found to be in an unresponsive state. At the medical centre, she was diagnosed with hypothermia and a suspected fracture of her femur. The Ministry carried out an unannounced inspection of the rest home. The inspection report contains 21 corrective actions that are needed for the rest home to comply with the Standards. Later in 2009, the Ministry wrote to the chief executive of the DAA that audits the rest home. The Ministry said that it was concerned that, since 2004, audits of the rest home by the DAA had found that it had fully attained all relevant Standards. The audits had included a surveillance audit and a provisional audit carried out nine months before the Ministry's inspection. The Ministry said that the "nature of the partial attainments at the time of the unannounced inspection suggests that at least some of this evidence must have been present at the time of the surveillance and provisional audits."
	In another case, in 2008, a friend of a rest home resident made a complaint to the Health Consumer Service, alleging that the resident had been attacked by another patient and this was the latest in a string of incidents, including 10 falls in three months, and injuries including broken bones, lacerations, and bruising. A geriatrician who visited the resident was also very concerned about the treatment of this resident. A surveillance audit of the rest home in 2008 had not found any shortcoming in the safety and quality of care being provided to residents. In response to the complaint, the Ministry conducted an unannounced inspection of the rest home in early 2009. The inspection found evidence that substantiated the complaint as well as other failures in the standard of care. These failures included hot water temperatures that were too high and not monitored, a dirty fridge, skin tears that were not recorded, the facility was cold and residents were in summer clothing, hazardous chemicals were not stored appropriately, linen skips were uncovered, there were flies throughout the home, and intravenous fluids and urine testing strips were out of date. The Ministry inspection team concluded that there were 19 failings that needed attention and nine of these presented a high risk to the residents. The complaint was upheld and the manager of the rest home resigned.

3.24 In our view, the Ministry has to strengthen how it oversees the work of DAAs. There is scope for the Ministry to consult more regularly with DHBs and organisations providing advocacy services for older people, because they often have access to information about the quality of care provided in particular rest homes. There is also scope for the Ministry to observe more DAA audits, and to better benchmark DAA performance.

Recommendation 1

We recommend that the Ministry of Health continue to strengthen how it oversees designated auditing agencies.

3.25 As we noted in Part 2, the Director-General of Health is required by section 33(b) of the Act to designate external agencies if – and only if – the Director-General is satisfied that the external agency has the technical expertise needed, has effective auditing systems in place, and will administer those systems competently. Despite the information available to the Ministry, and the importance of consistent and reliable auditing by DAAs for certification, no DAA has ever had its designation removed, despite evidence of sustained poor performance.

Recommendation 2

We recommend that the Ministry of Health cancel the designation of audit agencies that continue to perform poorly.

Effectiveness of progress reports in encouraging the safe provision of services

Progress reports are not effective enough as a tool to encourage rest homes to safely provide services to their residents. The information that rest homes provide in progress reports is inadequately verified, and some DAAs are behind in supplying progress reports to the Ministry.

Progress reporting is not always effective

3.26 Where the services provided by a rest home do not fully meet the criteria in the Standards, the Ministry usually requires the rest home to submit a written progress report within a certain amount of time. Progress reports are supposed to set out what action the rest home has taken to meet the criteria. Rest homes send the progress reports to their DAA, which forwards the reports to the Ministry.

3.27 Our file reviews showed that DAAs largely rely on rest homes reporting their own progress. They rarely verify progress with visits to the rest home. Some of

the progress reports that we saw in our file reviews contained little detail about the progress that had been made, particularly in cases where the progress was reported by the DAA as satisfactory. In the files we reviewed, the Ministry accepted most progress reports and did not require the rest home to take any further action. The Ministry told us that it accepts most progress reports because the actions taken to fully meet the criteria are either complete or under way.

3.28 Progress reporting is not always effective in ensuring that improvements are made in rest homes. In our file reviews, we found that rest homes often fail in the same or closely related criteria. More than half of the rest homes in our sample received recurring "partially attained" ratings in one or more criteria. This indicates that progress reporting is not leading to sustained improvements.

3.29 In one case, a rest home was audited in November 2006 and found to not comply with the criterion that requires rest homes to securely store chemical products. The auditor rated this failure as high risk, and gave the rest home six weeks to fix the problem. When the Ministry issued the rest home with certification in January 2007, it required the rest home to submit a progress report on this issue within one month.

3.30 The rest home provided a report to the DAA claiming that all appropriate action had been taken to ensure that chemical products were securely stored. The DAA submitted this progress report to the Ministry within the month. The progress report did not indicate whether a site visit was made to verify that the problem was fixed.

3.31 A surveillance audit was carried out by the DAA in June 2008, and the problem of insecurely stored chemical products was found to have not been fixed. Another progress report was required. The DAA submitted the required progress report, stating that a lock had been fitted to the chemical storage cupboard in September 2008. The problem with the storage of chemicals in this rest home had continued for almost two years after it was first identified during an audit.

Progress reports are not always timely

3.32 DAAs are behind in submitting progress reports to the Ministry. In July 2009, one DAA had 80 progress reports overdue, dating back to November 2008. The Ministry was following up with several other DAAs that have overdue progress reports.

3.33 In 2009, the Ministry has worked with DAAs to strengthen progress reporting and a new system is being implemented. There will be more on-site verification of progress where there are issues considered to be high risk, and the Ministry will require better verification of the corrective actions that rest homes have reportedly taken.

Sharing and using information about certification

Until recently, information about rest homes has been poorly shared and used. Although we are pleased with the Ministry's recent efforts, we consider that it could do more with the information at its disposal to improve the effectiveness and reliability of certification.

Recent sharing of information with district health boards

3.34 In 2009, the sharing of information between the Ministry and DHBs improved markedly. DHBs have had access (since July) to full certification reports through a password-protected website. The Ministry has worked effectively with DHBs, along with providers of rest homes, on a pilot project to replace surveillance audits with unannounced (or "spot") audits.

3.35 Until 2008, there was little communication from the Ministry with DHBs in the course of making decisions on certification. Communication with DHBs has improved in 2008/09, with five DHBs stating in response to our survey that they are now regularly contacted by the Ministry on certification decisions (see Part 6) and there is greater sharing of audit reports between DHBs and the Ministry.

Better use of information

3.36 The Act allows the Ministry to use other information available to it when making decisions about the length of certification. Our survey of DHBs, our file reviews, and our interviews with senior advisors in the Ministry revealed that, until 2009, the Ministry had not made enough use of the information that DHBs have on rest homes.

3.37 For example, in our file reviews, only 4% of certification audit reports contained evidence that information from DHBs had been used in determining the length of certification. There are signs that this is now improving, especially with the new policy and procedure for recommending periods of certification that was introduced in May 2009, as well as the decision-making matrix introduced in 2008 (which was revised and improved in 2009).

3.38 Complaints systems and processes about rest homes provide a means, not only to right individual wrongs, but also to identify aspects of care that need to be strengthened and improved. Complaints also provide a useful means of assessing the level of risk associated with particular rest homes and they are referred to when the Ministry makes decisions on periods of certification. Complaints about rest homes can be lodged with rest homes, DHBs, the Health and Disability Commissioner, or directly to the Ministry. This could appear complicated to the public. The Ministry has worked with DHBs and the Health and Disability

Commissioner to improve the handling of complaints so that it is more co-ordinated, and to make better use of information from complaints to inform decisions about certification.

3.39 After seven years of certification, the Ministry holds a large amount of information on the performance of rest homes, DAAs, and the sector in general. Until 2009, the Ministry had not analysed this information in detail. Recently, with an analysis of attainment ratings in medicine management in November 2009, the Ministry has begun to analyse information more. This will help it to identify common trends or themes and aspects of care in the rest home sector that need improvement. The analysis will also help to measure how effectively certification leads to improvements in the care of elderly people living in rest homes.

3.40 In our view, the Ministry could make more use of information from other organisations when making decisions. In particular, using information from DHBs could help to manage some of the risks that come with using eight different audit agencies. DHBs have knowledge about the performance and risks in rest homes and this information could be compared more regularly with the findings of DAA audit reports.

Recommendation 3

We recommend that the Ministry of Health continue to improve its use of auditing and certification information to identify common themes and trends in the rest home sector, and use that knowledge to identify how and where rest home residents are at greatest risk.

Effectiveness of certification in encouraging rest homes to improve the quality and safety of their services

People working in the sector agree that certification has improved the quality and safety of services provided in rest homes. The rate of improvement appears to have slowed, and the performance of some rest homes has remained largely static since 2006.

3.41 Rest home operators, DAAs, and DHBs agree that the introduction of the Standards and certification have raised the quality and safety of services in rest homes, because they have forced a greater focus on the outcomes for residents. However, there is evidence that the rate of improvement has slowed.

3.42 If the standard of care provided in rest homes is improving, then there should be fewer "partially attained" ratings given by DAAs. In our file reviews, we found that the average number of "partially attained" ratings has remained static since 2006.

In our interviews with representatives of the rest home sector, we were told that certification now has less influence over improvements. Our file reviews showed that some rest homes are consistently receiving "partially attained" ratings in the same or closely related criteria. Performance against some criteria – for example, medicine management – has been poor throughout the sector since 2003.

3.43 In our view, the Ministry needs to further analyse all the relevant information it holds to identify trends in the performance of rest homes. This trend information could be used to focus attention on those aspects of care where improvements are needed most.

3.44 Also, it is not clear that certification is still doing what the Act envisaged – encouraging rest homes to continuously improve the quality of their services, and encouraging them to take responsibility for providing those services to their residents safely. Therefore, in our view, the Ministry needs to reconsider whether the existing certification arrangements are the most effective it could use (see paragraphs 5.48-5.53).

Part 4
Managing risks in the certification arrangements

4.1 In this Part, we discuss the Ministry's management of:

- risks generally;
- the risk of conflicts of interest;
- the risk that rest homes might select the cheapest or most lenient DAA;
- the risk that commercial pressures might influence an auditor's independence;
- the risk that DAAs might interpret and audit the Standards differently; and
- the risk that auditors might have inadequate skills and expertise.

Our overall findings

4.2 The Ministry could have responded more quickly to risks identified in the certification arrangements – particularly risks to the independence of the auditors, because auditor independence is integral to the certification arrangements. The Ministry now has a risk register, and has plans for managing several of the most significant risks.

General risk management

The Ministry's risk management has not been thorough, particularly in relation to the many contractors who carry out the audits for DAAs. The Ministry's actions have also tended to be more reactive than proactive.

4.3 The design of the system for certification has some inherent risks. In 2008, the Ministry acknowledged that the risks in rest homes choosing their DAA, and the competition between DAAs for business, had the potential to create a "moral hazard". Managing the performance of the different DAAs is also a challenge for the Ministry, particularly because most of the auditors who work for DAAs are self-employed contractors. In September 2009, the Ministry developed a risk register for managing these and other risks. In our view, this should have been introduced sooner, given the level of risk that the Ministry had known about and acknowledged in Cabinet papers written in 2008.[7]

4.4 We are pleased that the Ministry now has a risk register to help it manage the risks associated with certification. In our view, the Ministry needs to continue to improve its risk management by working with DHBs and rest homes to identify the severity and likelihood of risks in certification. Because risks change over time, the Ministry will need to review its risk register each year.

7 The minutes of a Cabinet Social Development Committee meeting in 2008 stated that there "is an inherent risk of conflict of interest in having agencies auditing their own clients."

Recommendation 4

We recommend that the Ministry of Health continue to improve how it manages risks in the certification arrangements, identifying the likelihood and severity of those risks and reviewing each year its risk management strategy.

Risk of conflicts of interest

The Ministry's efforts to manage potential conflicts of interest have not been wholly effective. The Ministry intends to publish a code of conduct for DAAs and the contracted auditors they use. In our view, the Ministry should have done this sooner.

4.5 There is a risk that DAAs may offer services over and above certification auditing, which could compromise the objectivity of their audits. The likelihood of this risk is high because many DAA auditors provide consultancy and other services in addition to auditing. Also, most auditors are independent contractors and DAAs have limited control over what they do outside the audits they carry out on the DAAs' behalf.

4.6 We found examples, in our file reviews and interviews, of instances where:

- a DAA was advertising its consulting services in its auditing brochures;
- a DAA wrote to a rest home, offering consultancy advice on the Standards before the DAA carried out an audit; and
- a DAA contractor sold consultancy services to a rest home after carrying out a certification audit of that rest home.

4.7 The Ministry has written to one DAA, after discovering a conflict of interest, to request that the activity cease. The Ministry proposes, in the latest draft of the DAA Handbook (which is out for consultation), that all auditors complete a conflict of interest declaration before each audit.

How the Ministry manages this risk

4.8 To manage the risk of conflicts of interest, the Ministry checks each DAA's internal audit reports and corporate brochures when the DAA applies for re-designation.

Our view of the Ministry's management of this risk

4.9 In our view, the Ministry needs to check more thoroughly that DAAs have adequate systems in place to prevent conflicts of interest. The Ministry told us that it will implement methods of identifying and preventing conflicts of interest. We consider that the process needs to be in place quickly, and certainly before the end of 2010.

4.10 There is also scope for more regular monitoring of conflicts of interest. Better communication between the Ministry and rest homes could improve the Ministry's knowledge of the types of services DAAs provide or offer, in addition to auditing.

4.11 The Ministry has prepared a code of conduct, which is now in the draft DAA Handbook, that all auditors of rest homes will have to comply with. Again, we consider that this needs to be in place no later than the end of 2010.

Risk that rest homes select the cheapest or most lenient designated auditing agencies

The Ministry has found it challenging to manage this risk effectively. It has recently started to gather information from DAAs about their audit fees, and intends to use it to analyse market share and performance factors. In our view, the Ministry should have been doing this since certification was introduced.

4.12 Allowing rest homes to choose their DAA is intended to introduce competition among DAAs. The intention of competition is to provide an incentive to DAAs to improve quality and to help keep the costs down. But competition also brings risks. The relationship between rest homes and DAAs can become compromised. Rest homes might choose DAAs on the basis of cost rather than quality. DAAs, in an effort to win business, might offer consultancy services to rest homes, which would compromise the objectivity of future audits. To keep costs down, contracted DAA auditors might carry out audits in too short a time.

4.13 In 2008, a Cabinet Paper described these risks as a "moral hazard" that the Ministry has found difficult to manage effectively.

4.14 In our view, there is a high risk that rest homes might select their DAA based on price or leniency rather than on quality.

How the Ministry manages this risk

4.15 The Ministry has begun to collect information on audit fees from the DAAs, intending to compare this with market share and performance of DAAs, as well as information from rest homes.

Our view of the Ministry's management of this risk

4.16 In our view, the Ministry should continue to collect information about audit fees and attainment ratings. Analysing this information will help the Ministry to manage this risk by alerting the Ministry to any major inconsistencies in audit fees and ratings.

4.17 We would have expected the Ministry to have been collecting this information since certification was introduced in 2002.

Risk that commercial pressures might influence an auditor

The Ministry checks whether the evidence in audit reports corresponds to the ratings that auditors provide. The Ministry could do more, like comparing the ratings that different DAAs and different contracted auditors have given and looking for unusual trends.

4.18 There is a risk that commercial pressures might unduly influence an auditor. A DAA could provide the Ministry with a more positive report than a rest home's performance warrants, to retain the rest home as a client.

How the Ministry manages this risk

4.19 The Ministry checks the evidence in audit reports against the attainment ratings, to make sure that they match. The manager of HealthCERT writes to individual DAAs when there is evidence of poor auditing practice. Auditors are aware that their reports will be checked, and this approach should help to ensure that the ratings they give are well considered.

4.20 We note that by observing audits by DAAs, the Ministry will be able to compare the rigour and quality of auditing by different DAAs and their contracted auditors.

Our view of the Ministry's management of this risk

4.21 The Ministry needs to supplement its existing methods of managing this risk by analysing the information from past audit reports. It would allow the Ministry to compare the different levels of attainment given by different DAAs and their contracted auditors. This could reveal any unusual trends that might need to be investigated or managed more closely.

Risk that designated auditing agencies might interpret and audit the *Health and Disability Services Standards* differently

In our view, the Ministry could and should have managed this risk more actively and earlier. The number of criteria to be checked during an audit is likely to be adding to the risk of inconsistency.

4.22 There is a risk that DAAs might interpret and audit the Standards differently. For example:

- rest homes, DHBs, and Age Concern local offices all told us about inconsistency in the interpretation of the Standards by DAAs; and

- in our file reviews, we found that some DAAs reported on an exceptions basis – stating if a rest home did not meet a criterion, rather than providing evidence that all criteria were met.

4.23 An operator with multiple rest homes and the managers of rest homes we interviewed told us that different DAAs, and sometimes different auditors from the same DAA, interpret the Standards and criteria differently and apply different levels of judgement. This is supported by the results of our file reviews – when rest homes change auditors there is often a significant change in the number of "partially attained" ratings (see Figure 6). There is also large variation in the average number of "partially attained" ratings given by different DAAs – from 7 to 24.

4.24 We would expect to see some variation in the average number of "partially attained" ratings given by different DAAs. However, the extent of variation between the average ratings given by different DAAs indicates a degree of inconsistency that risks the reliability of decisions about periods of certification made by the Ministry.

Figure 6
Changes in ratings when rest homes change their designated auditing agency

When rest homes have changed DAAs, they have received markedly different attainment ratings than they were given in audits by their previous DAA.

In our sample, of the 13 rest homes that changed their DAA, seven experienced large differences in ratings:

- four experienced a significant increase in the number of criteria found to be "partially attained" rather than "fully attained"; and
- three experienced a significant decrease in the number of criteria found to be "partially attained" rather than "fully attained".

In four of these cases, there was only one year between audits by the different DAAs.

Number of criteria to be checked

4.25 The large number of criteria that must be checked for certification within the time that is normally provided creates risks to consistency. When a DAA audits a rest home for certification the auditors must check at least 206 criteria. The auditor needs to check each one and provide evidence supporting the level attained for each of the criteria.

4.26 The criteria are intended to be outcome-focused. This means that auditors are expected to check that policies and procedures are leading to the intended outcomes. For example, DAAs should check that rest homes have the correct procedures in place for staff training, but also check, through staff interviews, that staff have received adequate training and that they have the right skills as a result.

4.27 Some criteria take longer than others to check. For example, checking that the records kept about residents are legible (criterion 1.2.9.9) is straightforward. Checking that residents "and where appropriate their family/whānau of choice or other representative" are actively involved when different stages of service are planned for them (criterion 1.3.3.2) requires more in-depth work, including interviews with residents and their families. It is a significant challenge for auditors to check all criteria thoroughly in the time available to them (which includes, at most, two days on site).[8]

How the Ministry manages this risk

4.28 The Ministry manages the risk that auditors might interpret the Standards differently by producing revised versions of the DAA Handbook. The Ministry held workshops throughout 2009 on the latest version of the Standards. Ministry advisors also check the evidence in DAA audit reports against attainment ratings to judge if they match appropriately.

4.29 During 2009, the Ministry introduced a new audit reporting template to bring greater consistency in reporting. It introduced workshops and training sessions to support greater consistency in auditing and interpretation of the Standards. In September and October, the Ministry analysed its evaluations of audit reports.

4.30 The Ministry is planning to introduce audit-specific accreditation of DAAs in 2010, in an effort to bring greater consistency. All DAAs will have to be accredited by one of two organisations, which will be approved by the Ministry (see paragraphs 5.11-5.16).

Our view of the Ministry's management of this risk

4.31 In our view, the Ministry could and should have managed this risk more actively and earlier.

4.32 As well as the measures already under way and planned, the Ministry needs to continue its analysis of audit report evaluations and use it to benchmark the performance of DAAs. We also consider that the Ministry's information about DAA audit reports should be available to rest homes.

4.33 A risk-based approach to selecting which criteria to audit most closely would be helpful. For this to happen, greater knowledge and intelligence sharing between DHBs, DAAs, the Ministry, and non-governmental organisations will be needed.

8 The Ministry requires a two-stage audit process. In stage one, auditors review documents and policies (usually not at the rest home premises). In stage two, the auditors visit the rest home to check that the policies are complied with. Not all DAAs have followed this process.

Risk of inadequate skills and expertise

The Ministry has started to put measures in place to manage the risk that auditors of rest homes lack the necessary skills and expertise. In our view, the Ministry should have acted sooner.

4.34 There is a risk that auditors might lack the skills and expertise required to audit rest homes effectively.

4.35 In the files we reviewed, 21% of the evaluations carried out by the Ministry's senior advisors indicated that the audit report had failed to identify the technical expertise of the auditor. The Ministry is aware that some audits are of a poor quality.

How the Ministry manages this risk

4.36 In 2003, a senior advisor raised concerns about the quality of audits carried out by a particular DAA contractor. The Ministry did not write to the DAA about these concerns until 2006. The Ministry told the DAA that the auditor did not have the appropriate clinical qualifications to carry out health and disability audits on their own. The auditor could be part of an audit team that included a member with appropriate clinical qualifications. The auditor continued to conduct certification audits in the meantime. In our file reviews, this auditor was the sole auditor on three audits before the letter was sent to the DAA. After the letter, the auditor carried out at least one more audit on their own for a different DAA.

4.37 To manage the risk that auditors used by DAAs do not have the necessary skills and expertise, the Ministry has issued guidelines for auditor competency, based on AS/NZS ISO 19011:2003: *Guidelines for quality and/or environmental management systems auditing*. This standard describes the training and performance management requirements DAAs should have in place to manage the competency of the auditors they employ, which should include an evaluation of auditors while they carry out an audit.

4.38 The latest draft of the DAA Handbook includes a requirement that DAAs employ or contract with auditors who have gained a qualification in auditing quality management systems. The qualification is based on a five-day training course, and does not include a work-based assessment or examination.[9]

4.39 In 2009, the Ministry established a register to monitor the work of DAA auditors more closely. DAAs must now provide the Ministry with evidence that each of their auditors has had their performance reviewed at least once a year. The Ministry has clarified in the draft DAA Handbook the requirements for minimum qualifications and ongoing competency.

9 Unit 8086, *Demonstrate knowledge required for quality auditing*, New Zealand Qualifications Authority.

Our view of the Ministry's management of this risk

4.40 In our view, the competency and qualification requirements for DAAs could be clearer. The assessment of skills and competencies needs to be more rigorous. It could include a qualification that requires an examination and a work-based assessment.

Part 5
Recent efforts and plans to improve certification

5.1 In this Part, we discuss:

- a review of the Act in 2007;
- the Ministry's overall work programme to improve certification; and
- other changes the Ministry could make to improve certification.

Our overall findings

5.2 In 2008, the Ministry began to address the issues with certification more thoroughly. In 2009, it has quickened the pace of improvements, working closely with DHBs, DAAs, and rest homes.

5.3 It is too early to judge whether the Ministry's work will lead to more consistent and more reliable certification of rest homes, or whether other, more fundamental, changes are needed to the certification arrangements.

Review of the Health and Disability Services (Safety) Act 2001

The Ministry reviewed the Act in 2007, identifying risks and weaknesses that needed to be addressed.

5.4 In 2007, the Ministry reviewed the Act to improve the processes and enforcement that assure the Director-General of Health that services are safe, and to look at which services the Act should cover. The review's findings included concerns about:

- the quality and consistency of the performance of some DAAs;
- an inherent risk of conflicts of interest in having DAAs auditing their own clients;
- the Act giving the Ministry little control over the quality and number of DAAs;
- the limited range of sanctions available to the Ministry where DAA performance is poor, except cancelling the designation; and
- the processes of gaining, retaining, and losing certification being unclear, and in some cases incoherent.

5.5 After the review, the Cabinet Social Development Committee concluded that the concerns identified in the review could be managed by the Ministry without changing the Act. Some changes would be needed, to make clear that auditing expertise and knowledge of the service sector (in this case, rest homes) is required.

Work programme to improve certification

The Ministry's work programme to improve certification is extensive and well managed. It is too soon to determine whether the various projects will produce the desired results.

5.6 In 2008, the Ministry prepared a wide-ranging and extensive work programme to improve certification. Within that work programme, it has a project to improve the effectiveness and efficiency of the certification of rest homes, which includes:

- improving the quality of DAA auditing by again requiring third-party accreditation;
- publishing summaries of DAA audits on the Ministry's website;
- introducing unannounced surveillance audits;
- improving complaints management;
- improving information sharing throughout the sector; and
- reducing multiple audits and removing duplication.

5.7 After a period of high staff turnover in the HealthCERT team, the Ministry has recruited staff with experience in the care of older people and from the wider health care sector. There are now five senior advisors, supported by two analysts and two co-ordinators. The team is led by a team leader and the manager of the Ministry's Quality and Safety team.

5.8 The Ministry has begun to analyse the information it holds on rest homes and DAAs, and has commissioned research to determine more clearly the type of expertise and skill that should be required of auditors. Recently, the Ministry has started to:

- introduce a programme of observing audits by DAAs;
- benchmark the performance of DAAs;
- provide more education sessions to DAAs; and
- evaluate more thoroughly the compliance of DAAs with the DAA Handbook.

Unannounced surveillance audits

5.9 As noted in Part 2, audits for certification are arranged between the rest home and the DAA. This means that the rest home has time to prepare for the audit and knows when it is going to take place. There is a risk that what auditors see on the day of an audit may not necessarily reflect the standard of services normally provided by that rest home.

5.10 To manage this risk, the Ministry is working closely with DAAs, rest homes, and DHBs to introduce a different approach to surveillance audits. Surveillance audits will be unannounced and will focus largely on the care that is provided to the rest home residents. Unannounced surveillance audits are being piloted in 12 DHBs and will be introduced nationally in 2010. Certification audits will continue to be pre-arranged.

Plans to re-introduce third-party accreditation

5.11 When the Ministry has focused on rest homes, its staff have had to attend to the inconsistencies in DAA auditing and the poor performance of some DAAs. This reduces the Ministry's ability to focus on the quality and safety of the services provided in rest homes.

5.12 The Ministry proposes that the Act be amended in 2010 to include a requirement that all DAAs be accredited by a Ministry-approved body. Although the Ministry removed the accreditation requirement in 2006, six of the eight DAAs remain accredited by an accreditation body. The current arrangements check general auditing systems and do not focus specifically on health and disability auditing.

5.13 The Ministry has worked with two accreditation organisations, the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) and the International Society for Quality in Health Care (ISQua), to prepare a health and disability component that DAAs will have to comply with to be designated. This means that they will be subject to more, and more regular, reviews. The reviews will check that the auditing of DAAs meets international standards of good practice and that the DAAs are well-managed organisations.

5.14 If a DAA passes the accreditation review, it will be accredited for four years and will be subject to regular monitoring, progress reporting, and surveillance auditing. The frequency of monitoring and auditing will depend on the level of confidence the accreditation body has in the DAA, but will include at least a two-yearly surveillance audit (including witnessed audits) and annual reporting requirements.

5.15 The Ministry expects third-party accreditation to help to reduce the amount of time it spends on overseeing DAAs. The accreditation organisations will be responsible for monitoring the quality and consistency of DAA's auditing and their management systems.

5.16 The Ministry also expects an improved system of third-party accreditation to provide more stringent checks of DAAs (see Figure 7). Better communication between the Ministry and DAAs is expected to help all parties to be clear about

the expected standard of auditing. The improved communication between DHBs and the Ministry is also expected to enhance decision-making about periods of certification.

Figure 7
What third-party accreditation is expected to mean for designated auditing agencies

By the end of 2010, all DAAs will have to be accredited by either JAS-ANZ or ISQua. The Ministry has worked with both organisations to develop an extension to their current accreditation requirements so that there is a focus on the quality of auditing of health and disability service providers, such as rest homes.

To be accredited, each DAA will be audited by a team from JAS-ANZ or ISQua. The accreditation audit will review the systems, policies, and procedures of the DAA. This will include checking that the DAA has annually reviewed the performance of each of its auditors, and that DAAs have procedures for determining their ongoing competency. JAS-ANZ or ISQua teams will also observe at least one audit by the DAA of a rest home.

If the DAA passes the accreditation audit, it will be accredited for four years and will be subject to regular surveillance audits, beginning with every six months but becoming less regular, depending on the level of confidence in the DAA.

Source: Ministry of Health.

5.17 We note that, in 2006, the Ministry decided that third-party accreditation was ineffective. It remains to be seen whether the new third-party accreditation arrangement will improve the consistency and quality of DAA auditing. In our view, the Ministry needs to gather and evaluate information as soon as possible about the effectiveness (or otherwise) of third-party accreditation.

Recommendation 5

We recommend that the Ministry of Health begin to evaluate, by the end of 2010, the effectiveness of third-party accreditation and other work to strengthen the certification process, and share the results with district health boards, rest home operators, and organisations providing advocacy services for older people.

Our view of the Ministry's work programme

5.18 The Ministry's wider work programme has made good progress. There is better communication between the Ministry, DAAs, and DHBs, and plans for third-party accreditation are well advanced. The Ministry has also been monitoring more closely those DAAs where performance is known to be at risk. In one instance, it has commissioned an external audit of a DAA's management systems and auditing practice.

5.19 The improvement project has been well managed. The rest home sector has been consulted through a reference group that includes representatives from rest homes, DHBs, organisations that act and speak on behalf of older people (Age Concern and Grey Power), and DAAs.

5.20 The different streams of work the Ministry has carried out in 2009 are important steps towards improving the quality and consistency in auditing rest homes for certification. However, it is too early to determine how effective the Ministry's improvement programme will be in making certification more effective and reliable.

Other changes the Ministry of Health could make

In our view, the Ministry needs to do more than the measures planned for its project to improve the certification of rest homes. We encourage the Ministry to consider whether the current certification arrangements are the most effective it could use.

5.21 Contracting auditing to private firms is not unique to the health sector. For example, our Office, which is responsible for auditing more than 4000 entities, contracts some of our auditing responsibilities to private audit firms. We use four steps to manage the contracts we have with private audit firms. These steps are:

- appointing auditors;
- setting standards for auditing;
- providing technical advice and assistance; and
- carrying out quality assurance reviews.

5.22 The Ministry has been carrying out each of these four steps, but there is scope for the Ministry to improve how it does so.

Designating the auditors of rest homes

5.23 Only designated auditors can audit rest homes for certification purposes. Audit companies apply to the Ministry for designation and must meet the criteria set out in section 33(b) of the Act. The Ministry conducts desk-based checks to verify that DAAs comply with these criteria when they apply to renew their designation.

5.24 The Ministry has found problems with DAAs that could have been prevented if the systems DAAs are required to have had been properly implemented. No DAA has been refused re-designation, even when there has been evidence of poor performance.

5.25 Rest homes choose which DAA to use for certification audits and there are no requirements for them to change their DAA after a specified period. In our file reviews, 82% of the rest homes had used the same DAA since certification was introduced in 2002.

How designation could be improved

5.26 In our view, the Ministry needs to make more stringent and rigorous checks of DAA systems and processes – including systems to assure the auditor's independence and identify and manage potential conflicts of interest – at the time of re-designation. DAAs will have little incentive to improve unless sustained poor performance or an inadequate regard for proper systems and processes leads to the Ministry cancelling a DAA's designation.

5.27 Requiring rest homes to change the DAA they use after a specified period would help to manage the risk of conflicts of interest and the risks to auditor independence. It would also help the Ministry to identify inconsistencies in how auditors interpret the Standards and in their auditing practices.

Setting standards for auditing

5.28 The Ministry publishes the Standards, which are not specific to rest homes but apply to the whole health and disability sector. The Ministry produces guidance in the form of the DAA Handbook, to help DAAs interpret and apply the Standards when they audit rest homes. DAAs must comply with the DAA Handbook as a condition of their designation.

5.29 The latest version of the DAA Handbook has been in draft form since May 2009. It requires that audits be carried out in keeping with AS/NZS ISO 19011:2003. This is a standard that covers quality and environmental management systems auditing.

5.30 Lead auditors[10] must meet the skill and competency requirements of AS/NZS ISO 19011:2003. The Ministry will also require DAA auditors to have a qualification in auditing quality management systems (see paragraph 4.38). When third-party accreditation is reintroduced, audit teams will have to comply with ISO/IEC 17021:2006 (an international standard that will provide assurance that DAAs have suitable management systems in place). There is also a requirement that teams auditing rest homes include at least one registered nurse.

5.31 DAAs have sought clarification on auditor competency since the introduction of certification.

5.32 Most auditing is carried out by freelance auditors contracted to DAAs. This makes it difficult for the Ministry to measure compliance. In 2009, the Ministry introduced a new register of all auditors to help it oversee auditor competency.

10 The lead auditor in an audit team manages the audit and is responsible for authorising the audit report before it is submitted to the Ministry.

How the setting of standards could be improved

5.33 In our view, the DAA Handbook would be more useful if it contained more detailed information about the standard of auditing expected of DAAs, and how DAAs will be measured against these auditing standards.

5.34 Third-party accreditation is expected to make the standard of auditing more consistent and clear. DAAs will have to comply with ISO/IEC 17021:2006. In the draft DAA Handbook, the Ministry has included further qualification requirements (see paragraph 4.38). However, the Ministry will need to provide DAAs with greater clarity about the competency requirements of auditors.

Providing technical advice and assistance

5.35 From 2002 to 2008, communication between the Ministry and DAAs was poor, and DAAs received patchy and inconsistent responses to requests for technical advice. This has improved in 2009.

5.36 Until recently, Ministry staff spent most of their time checking audit reports rather than providing advice. This was a cause of frustration for some staff, who felt that their experience and expertise was not being used. There was a period of high staff turnover but the Ministry's HealthCERT team is now fully staffed. The senior advisors within the team have experience relevant to their roles.

5.37 In 2009, the Ministry introduced a programme of quarterly "train the trainer" workshops for DAAs. These workshops include technical advice and guidance.

How the technical advice and assistance could be improved

5.38 In our view, the Ministry needs to continue to maintain communication with DAAs. We also consider that the HealthCERT team needs to continue to build its skills, given the number of new staff in the team.

5.39 We note that the DAA Handbook has been in draft format since May 2009. The Ministry's support for DAAs would be improved if the guidance that DAAs rely on was properly published and authorised.

Carrying out quality assurance reviews

5.40 The Ministry's monitoring of DAAs mostly happens when DAAs send in their audit reports. The Ministry has recently started to observe DAA audits to check whether the audits meet the expected standards, and seeking feedback from rest homes and DHBs on the quality of DAA auditing.

5.41 From 2002 to 2008, there was little regular communication between the Ministry and DAAs. DAAs received little feedback on the quality of their auditing. In our

file reviews, the Ministry had completed evaluation reports for 30% of the audit reports. Of these evaluation sheets, 21% record that the technical expertise of the auditors was not identified, but there is no evidence that this information was communicated to DAAs or to the New Zealand Association of Designated auditing agencies (the NZADAA).[11]

5.42 In October and November 2009, the Ministry observed two DAA audits and plans to observe more in 2010. The Ministry is evaluating audit reports more thoroughly, and has improved its evaluation template.

How quality assurance could be improved

5.43 The Ministry expects third-party accreditation to introduce more rigour to the quality assurance of DAAs. It will include observing the audits that DAAs carry out.

5.44 DAAs told us that they would like to receive more regular feedback from the Ministry. The Ministry has responded to this by communicating more regularly with the NZADAA, and now meets with the NZADAA every two months.

5.45 In October 2009, the Ministry analysed a sample of the information recorded on the new evaluation sheets. In our view, the Ministry needs to continue this work and use the information it has to compare and benchmark the different DAAs.

5.46 The quality assurance of DAA auditing would also be improved if the Ministry checked DAA auditing more rigorously, and observed DAA audits more regularly.

5.47 In our view, the Ministry cannot rely solely on third-party accreditation to ensure the quality of DAA auditing.

Considering other ideas or approaches to certification

5.48 We are pleased that the Ministry has increased its efforts to improve the effectiveness of certification, and appears committed to making many changes. However, because the weaknesses in the certification arrangements are only now being adequately addressed, we have not been able to form a view about whether the current arrangements are the most effective and reliable.

5.49 For example, we have noted our views on having more than 206 criteria to check during the time available for a certification audit. We have also noted that, in the sample of files we reviewed, the average number of "partially attained" ratings for each audit has hardly changed since 2006.

5.50 There are currently eight DAAs. If the Ministry were to cancel the designation of every DAA that has failed to meet the criteria in section 33(b) of the Act, the consequences for certification auditing, and the wider health and disability sector, might be serious.

11 The NZADAA is made up of representatives from each DAA, and represents the interests of DAAs.

5.51 We also note that our Office changed several years ago from a competitive model to an allocated audit model, to encourage greater sharing of information among auditors and with us – which is essential to effective risk identification and management.

5.52 Although the existing legislation appears enabling and permissive, it is possible that the Ministry may not be able to make the certification of rest homes more effective and reliable without legislative change.

5.53 We encourage the Ministry to remain open to other ideas or approaches to the certification of rest homes.

Recommendation 6

We recommend that the Ministry of Health reconsider the design of the certification arrangements by examining alternatives and evaluating whether the alternatives would be more effective and more reliable.

Part 6
Monitoring by district health boards

6.1 In this Part, we discuss:

- the different methods that DHBs use to monitor the services provided to elderly people whose care in rest homes the DHBs fund;
- the duplication between DHB audits and certification audits by DAAs;
- reducing reliance on routine contract auditing as a quality assurance tool; and
- communication and co-ordination with the Ministry.

Our overall findings

6.2 Although the age-related care contract is the same throughout the country, DHBs interpret and monitor the contract differently. Most DHBs do not feel that they can rely on the findings of certification audits. They carry out their own auditing, which duplicates the auditing by DAAs.

6.3 Communication and co-ordination between DHBs and the Ministry has improved significantly in 2009. DHBs now have access to the Ministry's online database of certification reports, and have worked with the Ministry to improve the processes for dealing with complaints. They have also worked with the Ministry, and others, on a pilot project to replace surveillance audits with unannounced (or "spot") audits.

6.4 Some DHBs have begun to change the way they monitor rest homes, by providing rest homes with more targeted help and assistance. There are early signs that this approach can be effective. Greater communication and co-ordination among DHBs would help to share the lessons learned about the most effective means of monitoring rest homes.

Methods that district health boards use to monitor rest homes

DHBs use a range of methods to monitor the age-related care contract, and these methods vary from one DHB to the next.

6.5 The age-related care contract that DHBs have with rest homes is agreed at a national level every year. It covers rest home, dementia, and hospital-level care provided in a residential care setting. Although the age-related care contract between DHBs and rest homes is the same throughout the country, the way in which DHBs monitor the contract varies.

6.6 DHBs have a wide range of activities available to them to monitor contracts, including routine auditing, informal visits, liaison with community groups that provide advocacy services for older people (such as Age Concern), consulting

DHB clinical staff who provide services to people living in rest homes (such as general practitioners and geriatricians), monitoring of complaints and concerns to identify any trends, and drawing on the knowledge of their Needs Assessment Co-ordination Services agency.

6.7 DHBs do not have many staff available for monitoring contracts with rest homes. They employ on average one full-time equivalent member of staff for monitoring and, on average, the ratio of DHB monitoring staff to rest homes is around 1:25. There is a wide variation among DHBs, with the ratio ranging from 1:7 to 1:80.

6.8 In most cases, DHBs commission their SSA to audit rest homes against the contract. There are four SSAs that provide services to DHBs:

- South Island Shared Service Agency Limited, owned by the South Island DHBs (Southland, Otago, West Coast. South Canterbury, Canterbury, West Coast and Nelson Marlborough);
- Technical Advisory Services, owned by the central region DHBs (Capital and Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui, and Hawke's Bay);
- HealthShare, owned by the midland DHBs (Taranaki, Lakes, Waikato, Tairawhiti, and Bay of Plenty). This agency also provides audit services to the Northern DHBs (Auckland, Waitemata, Counties Manukau, and Northland); and
- Northern DHB Support Agency. Although this SSA does not carry out audits, it carries out research and analysis on behalf of northern DHBs. It is owned by Auckland, Counties Manukau, and Waitemata DHBs, and provides services to Northland DHB.

6.9 SSAs support DHBs' funding of health and disability services by carrying out research, analysis, and audits on the DHBs' behalf. They use a combination of employees and contractors to conduct audits and may also use clinical expertise available from DHBs (such as geriatricians and pharmacists) to assist audits when this is necessary. Some of the contractors who work for SSAs also carry out certification audits on contract to DAAs.

6.10 DHBs conduct regular reviews of SSAs to make sure that their work is of a satisfactory quality. DHBs have received largely positive reports about the work of SSAs, although issues of timeliness, internal auditing within the SSAs, management of contractors, and auditor competency have been raised during these reviews.

6.11 DHBs are largely satisfied with the work of their SSAs and, in general, find that audit reports from SSAs accurately reflect the status of the rest homes. One DHB commented:

> *The quality of audits from the shared services agencies is comprehensive and gives a clear picture of providers' ability to provide a required standard of care at an individual provider level.*

6.12 SSAs do not have third-party accreditation, although they will be able to apply for accreditation under the same arrangements the Ministry is putting in place for DAAs.

Duplication with certification audits by designated auditing agencies

Most DHBs use routine contract audits of rest homes to monitor rest home compliance with the age-related care contract. These routine contract audits largely duplicate the audits that are carried out by DAAs for certification purposes.

6.13 Fourteen of the 21 DHBs carry out routine contract audits that check whether rest homes are meeting the requirements of the age-related care contract. The number and frequency of audits by DHBs varies. Some DHBs have a three-yearly cycle of audits. Other DHBs prioritise audits according to factors that include:

- information they have about a rest home from complaints or other sources;
- when the rest home was last audited and what that audit found; and
- variations that have been made to the contract.

6.14 In 2004, an SSA carried out some analysis to identify duplication, overlaps, and gaps between the Standards and the age-related care contract. The analysis found a strong overlap between the approach used for certification audits and the approach used for routine contract audits. Because there is a high degree of overlap between the Standards and the age-related care contract, the routine contract audits cover many of the same aspects of care as the audits conducted by DAAs for certification. In the SSA's analysis, only 26% of the items covered by the routine contract audit were not covered during a certification audit.

Clip-on audits

6.15 To reduce duplication, the central region DHBs (Capital and Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui, and Hawke's Bay) pay a fee to DAAs to extend the audits they do for certification to include the aspects of the age-related care contract not covered by the Standards. This is called a "clip-on" or "tag-on" audit. Clip-on audits reduce the auditing burden on rest homes because their compliance with the Standards and the age-related care contract are checked at the same time.

6.16 Clip-on audits are cheaper for DHBs than routine contract audits. Clip-on audits cost DHBs around $450. The cost of routine contract audits ranges from $3,500 to $7,500 (more expensive audits include the monitoring of the rest home's progress in implementing recommendations and requirements arising from the previous audit report).

6.17 As we noted in Part 3, DHBs have agreed that cerfication audits could help with the DHBs' monitoring of rest homes. The confidence of DHBs in DAA auditing needs to increase first. If all DHBs had confidence in the auditing by DAAs and used clip-on audits, significant sums could be redeployed to other means of assuring the quality of care provided in rest homes. For example, in 2007/08 DHBs (or their SSAs) carried out 118 routine contract audits. If the DHBs had felt able to use clip-on audits instead, collectively they would have saved around $600,000.

Lack of confidence in audits by designated auditing agencies

6.18 Despite the lower cost of paying DAAs, most DHBs continue with their own routine contract audits because they do not have confidence in the consistency and reliability of DAA auditing. The lack of confidence in DAA auditing is widespread among DHBs. Only four DHBs out of the 20 that responded to our survey consider certification to be reliable in assuring the safety of residents. Only six responded that the regime is reliable in providing assurance about the quality of care that rest homes provide. Many DHBs told us that they find inconsistencies between DAA audits and the audits carried out by SSAs.

6.19 One of the DHBs that uses clip-on audits is carrying out much of its own auditing in 2009 because of its concerns that clip-on audits are not reliable enough to monitor the age-related care contract. This DHB commissioned nine contract audits in the 2008/09 financial year, which were additional to its scheduled nine clip-on audits. The DHB plans to carry out a similar level of contract auditing in 2009/10.

6.20 In the course of their monitoring work, DHBs say that they find failures in care that were not detected by DAA auditors (see Figures 9 and 10). They are also aware, through complaints and through information they get from staff in hospitals, that the standard of care provided by a rest home is not always reflected in DAA audit reports. Figure 8 includes some of the responses from DHBs to our survey.

Figure 8

Survey responses – district health boards' concerns about the rigour of certification audits

"In [DHB] experience DAA audits generally rate provider service provision, quality and safety as being higher than audits performed by the DHB's audit agency. For example, in the 2007 year two providers who had recently undergone DAA audits and received good audit reports were found soon after by the DHB's auditors to be seriously defective in terms of the quality and safety of service provision."

"We have seen instances where a provider received three years' certification and then needed significant attention and help through an issues-based audit or in one extreme case in 2008, through a Temporary Manager. In other cases, providers were said by HealthCERT to have few or no issues outstanding and yet the providers needed a comprehensive service assessment and follow-up from a clinician such as a Registered Nurse experienced in aged care to make changes to ensure resident safety and service quality. This is an area of significant concern for the DHB. When the certification and contractual audits have very different findings against the same criteria it can be a source of tension, mistrust and other difficulties between the provider and the Planning and Funding team, and affects the credibility of both Planning and Funding and DAAs."

"Of the DAA audits done for certification we received about half of them at the DHB. In general, quality of care delivery issues are not picked up. At times complaints received regarding care arrive around the same time as the audit is done. At times we have found complaints investigations have led to the DHB undertaking a special audit and having to appoint a Temporary Manager when the provider holds a recent certification or has had a recent certification or surveillance audit that hasn't identified significant issues, or hasn't identified the same issues."

"We have recently had two instances where providers have received certification audits with no concerns identified. Subsequent spot audits were undertaken by [the Ministry] following complaints which identified serious quality and safety issues in both cases."

"A DAA report for one facility resulted in three-year certification, only to require a temporary manager within three months of certification."

6.21 Failures in the care of the elderly in rest homes that have not been picked up by DAA audits are often found during DHB-commissioned issues-based audits. DHBs ask their SSAs to carry out an issues-based audit when risks in a particular rest home have been identified, or when serious complaints have been made. These audits are normally unannounced and they focus on the specific issues or risks that have come to the DHB's attention. Where necessary, clinical and managerial experts, such as specialist geriatricians, general practitioners, and accountants (where there are governance and financial risks) are used and the audit teams can be larger than those used in either routine DHB contract audits or DAA certification audits. Figure 9 provides an example of an issues-based audit.

Figure 9

Example of an issues-based audit

In late 2008, a resident at a rest home had, in the course of two weeks, become ill and died. The family complained to the company operating the home that their relative had not received the medical intervention he needed, his room was dirty and messy, and a nurse was rude and derogatory to family members who were concerned at the man's declining health.

The company operating the rest home carried out an investigation and most of the allegations were accepted. A plan was prepared to introduce a number of procedures to ensure that there was no repetition of poor care.

The District Health Board had been informed of this incident and commissioned its SSA to carry out an unannounced audit of the rest home.

What the SSA did

The audit was carried out six months after the company's improvement plans were to have been implemented. It was an unannounced audit. A lead auditor and an auditor with clinical skills and experience spent two days reviewing the rest home. This included:

- Examining 10 files of residents who had been recently admitted – they checked if long-term plans had been completed in time and that they were evaluated and reviewed, liaison with GPs, if the residents had been regularly weighed and if unexpected weight loss had been referred to the GP. The review found gaps in care planning, clinical records, and monitoring.
- Reviewing all staff files. They found that most staff had not had their performance reviewed and most staff files did not have records of training.
- Checking staff rosters from a two-month period. The home complied with its obligations.
- Reviewing 13 internal audits and found weaknesses in the documentation in the audits.
- Inspecting the building, including the kitchen, which was found to be clean and well kept.

What the SSA audit team concluded

The audit found that, of the 10 planned improvements, three had been introduced. In addition, the audit found that there had been a lack of regular review of clinical practices at the rest home. There was a lack of consistent documentation recording the provision of the care provided to residents who had become unwell. This created a risk of inaccurate reporting and the risk of gaps existing in the provision of clinical services, exposing residents to possible harm. Soon after this audit, the clinical services manager at the home was suspended.

Responsible management actions

The company operating the rest home in this example had behaved responsibly. It had commissioned an investigation into this case where poor care was suspected, but staff of the rest home did not implement the improvement plan. The failings were then identified by the SSA. The rest home had been audited several times by the DAA, and the problems had not been identified.

6.22 Because issues-based audits concentrate on particular parts of the age-related care contract, auditors are able to inspect those aspects of the care given in rest homes in more depth and detail than DAAs do. This may explain some of the inconsistencies between DAA audit reports and those by SSAs after issues-based audits.

6.23 Some of the inconsistency may also be because of the different levels of detail between the Standards and the specifications of the age-related care contract. The age-related care contract is more specific than the Standards. For example, with staffing levels, Standard 2.7.3 states that the organisation (in this instance, the rest home) should ensure "the appointment of appropriate service providers [care staff] to safely meet the needs of consumers". The age-related care contract is much more specific, setting out the minimum number of staff required depending on the number of residents and their level of need.

6.24 The age-related care contract is also more specific about:

- the content of admission agreements;
- the content, timing, and amount of staff education;
- having policies for aspects of care such as personal grooming and hygiene, wound care, continence, and management of challenging behaviour; and
- the provision of dressing and continence supplies.

6.25 The contradictory nature of findings in audits of the same rest homes conducted by different organisations is a serious concern. Examples such as those given in this report cannot be explained by differences in the way that specifications and standards in the age-related care contract and those required for certification are written.

Inconsistent interpretations

6.26 There is also evidence of inconsistency in the way in which the age-related care contract is interpreted by different DHBs. Some companies that have rest homes in different DHBs find that different DHBs interpret the contract differently and place greater emphasis on different aspects of the contract. For example, one rest home operator, which has the same admission agreement in all its rest homes throughout the country, had the experience that some DHBs found the admission agreement did not fulfil the contract while other DHBs found that it did.

6.27 Consistency is important, not just for rest homes to know what is expected of them, but also to provide assurance to the public that they or their relatives will receive the same standard of care regardless of where they live.

Recommendation 7

We recommend that district health boards work together to ensure that they and their shared service agencies are interpreting the Age Related Residential Care Services Agreement consistently.

6.28 Greater sharing of experience, knowledge, and lessons learned between the different DHBs and their SSAs would help to improve consistency and provide the assurance the public needs when making choices about where they or their relatives should live once they can no longer live independently. Although the Health of Older People General Managers of DHBs meet quarterly, we consider that there is scope for more shared learning, especially between the SSAs, which do not communicate regularly.

Recommendation 8

We recommend that district health boards share information relevant to improving the safety and quality of services provided by rest homes quickly and freely with other agencies working in the rest home sector.

6.29 In 2009, DHBs agreed in principle to reduce contract auditing and work more closely with DAAs. This agreement is conditional on evidence that DAAs are providing more consistent and reliable information as a result of the Ministry's improvement project and wider programme of initiatives. DHBs would also like to have a role in the appointment of auditors.

6.30 It is inefficient for different public entities to spend their resources duplicating each other's efforts. In our view, DHBs should stop auditing rest homes as soon as they have confidence in the efficacy of auditing by DAAs. Using the information from certification audits (as well as clip-on audits) as one of the means to monitor the age-related care contract will release resources so that DHBs can target their monitoring of rest homes to where the risk to the safety and quality of residents is greatest.

Recommendation 9

We recommend that, once auditing by designated auditing agencies is effective and reliable, district health boards stop routine contract auditing and use their resources to work with those rest homes where improvements are needed most.

Moving away from auditing as a monitoring tool

Auditing is one means of monitoring the age-related care contract and some DHBs are beginning to shift their monitoring to focus more on quality improvement.

6.31 Some DHBs are beginning to question the effectiveness of relying on audits to monitor the age-related care contract. The information that audits provide is limited to a period of a few days (during business hours) and is collated after the rest home has had several months (or longer) to prepare for the audits (see Figure 10).

Figure 10

Survey responses – district health boards' concerns about the usefulness of audits

"It is becoming increasingly concerning that neither Contract auditing and/or certification audits are adequate mechanisms to monitor the quality of services provided or the outcomes for clients. They are "snap-shots" undertaken with the Provider having had long lead in times to ensure that on the day the necessary steps have been taken to meet the requirements of either audit."

"On a couple of occasions we have found that neither type of audit has produced evidence of problems that our monitoring and intelligence has indicated were present and that the passage of time has confirmed."

"Because the certification audits are scheduled and notified audits there is a risk of gaming to a higher quality of care for that occasion. The audit process is based on trust that the providers won't enhance their service during the audit, but anecdotally we hear this happens often e.g. by having a higher number of [registered nurses] on site than there are normally etc."

"There are many aspects of 'real-time' care an audit cannot assess as the practical nature of these are beyond the scope of the ... certification audit in terms of time and attention to detail e.g. reviewing paper policy and procedures rather than watching care being provided – this is an inherent problem of audit methodology reinforced by the anecdotal finding that the more notice a provider has for an audit the better the outcome of the audit – whereas an audit of 'actual practice' may highlight more quality issues."

6.32 Some DHBs have moved away from audit-based monitoring to provide more clinical support to rest homes where opportunities for improvement are identified. For example, Waitemata DHB does not carry out routine contract audits or clip-on audits. Instead, the DHB contracts an Aged Residential Care Support and Quality Advisor who visits all the rest homes every six months to provide them with support to meet the level and quality of services required in the contract. If the Aged Residential Care Support and Quality Advisor becomes aware of poor practice or the DHB receives complaints about a rest home, Waitemata DHB will arrange for an issues-based audit of the rest home. Some providers told us that this DHB provides the most effective monitoring.

6.33 Another DHB employs a contractor to check the compliance of rest homes against the age-related care contract when it has received complaints or has concerns about the care provided by the rest home. These assessments are used in place of issues-based audits. In some cases where problems are identified, the contractor, with the knowledge of the DHB, has offered their services to the rest home to help remedy the faults. A rest home operator that we spoke to about these arrangements said that they felt compelled to accept and pay (more than $10,000) for the services of the contractor, even though they believed that such an arrangement would seem to represent a conflict of interest.

6.34 In our view, such an arrangement impairs the independence of the contractor. It may also lead to the perception that the contractor has an incentive to find problems, because the rest home will then hire them to provide advice on how to remedy those problems. DHBs need to ensure that there are rules in place to limit any perception that contractors might have a financial incentive to identify problems when checking the compliance of rest homes against the age-related care contract.

Communication and co-ordination with the Ministry of Health

Communication and co-ordination between DHBs and the Ministry has been poor. There are signs that communication and co-ordination are improving.

6.35 As we have described, the auditing of rest homes for certification is similar to the audits many DHBs commission to monitor the age-related care contract. The monitoring of rest homes could be more efficient if there was more collaboration between the work of the Ministry, DAAs, and DHBs and SSAs. The auditing by DHBs is not well co-ordinated with that carried out by DAAs. There have been occasions when DHB auditors and DAA auditors have audited a rest home within days of each other. In one of the files we reviewed, the DHB auditors and the DAA auditors arrived at a rest home on the same day to carry out separate audits.

6.36 Recently, with the implementation of the Ministry's improvement project, there is better co-ordination between the different organisations involved in regulating rest homes, most notably with the development of a new approach to surveillance audits (see Figures 11 and 12).

Figure 11

Survey responses – communication between district health boards and the Ministry of Health

Some DHBs still find communication poor

"HealthCERT will notify us when there are serious concerns regarding a provider, but not as a matter of routine. As a general rule, information sharing is very limited if at all. We believe there are opportunities for all auditing agencies to work more closely together for the benefit of residents, providers and funders."

"As DHBs are not informed of the results of DAA audits, and what issues influence a certification decision, it is not always clear on what basis a certification decision has been made. Also it is not always clear how the length of the certification period is determined, and how it relates to the quality issues identified."

"We would find closer communication and collaboration between DAAs and HealthCERT and the DHB to be of significant value. At present neither HealthCERT nor DAAs contact the DHB to discuss any issue we might have with a facility prior to undertaking an audit. This is not a difficult undertaking and would provide a large value add to the process. Additionally, it would be useful for the DHB to have a copy of any audits undertaken by these parties to form part of their overall understanding of the quality of service being delivered by a facility."

Others find that it is improving

"This year, HealthCERT has communicated regularly with [the DHB] on complaints received, and on certification matters. There is evidence that where HealthCERT and the DHB work collaboratively on a provider's quality issues, and when this is aligned with timely communications from [the Health and Disability Commissioner], the agencies gain a comprehensive picture of a provider's quality issues. We [are then] able to target our responses in a more effective manner."

"It would be beneficial to have greater dialogue/interaction between DHBs and HealthCERT, however we acknowledge the activity taking place at a national level in this regard."

Figure 12

Example of collaboration between the Ministry of Health, district health boards, and designated auditing agencies

The spot audit pilot project

The Ministry-led spot audit pilot project is part of the Ministry's rest home audits improvement project. The spot audit pilot project aims to improve public confidence in the care provided by rest homes by introducing unannounced (or "spot") audits and also reducing duplication between DHB and DAA audits. The Ministry has been working with DHBs, DAAs, consumer advocates, and rest home providers to put this project in place. The spot audits will replace the current surveillance audits, carried out by DAAs as a condition of certification.

Spot audits will have a clinical focus and will also include consideration of DHB contractual requirements. DHBs will have the opportunity to be involved in the audit process. They will be able to share information with the DAA about a rest home before the DAA carries out the audit, be involved in following up any issues found during the audit, and receive the final audit report. Because of the DHB's involvement with the audit before it takes place, the chances of spot audits being carried out at the same time as DHB audits should be reduced.

Twenty-three spot audits are being piloted and will result in an evaluation report that will inform the national roll-out of spot audits, planned for January 2010. As at November 2009, 14 spot audits had been completed.

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