Controller and Auditor-General
Tumuaki o te Mana Arotake

Performance audit report

Effectiveness of arrangements to check the standard of rest home services: Follow-up report

Office of the Auditor-General
PO Box 3928, Wellington 6140

Telephone: (04) 917 1500
Facsimile: (04) 917 1549

Email: reports@oag.govt.nz
Website: www.oag.govt.nz

Effectiveness of arrangements to check the standard of rest home services: Follow-up report

This is the report of a performance audit we carried out under section 16 of the Public Audit Act 2001

September 2012

ISBN 978-0-478-38385-0 (print)
ISBN 978-0-478-38386-7 (online)

Contents

Auditor-General's overview

In December 2009, I published a report on the *Effectiveness of arrangements to check the standard of services provided by rest homes*. I found that, since its introduction in October 2002, certification of rest homes had not provided adequate assurance that rest homes had met the criteria in the *Health and Disability Services Standards*. I made six recommendations for the Ministry of Health (the Ministry) and three for district health boards (DHBs).

I noted in my 2009 report that the Ministry and the DHBs were making some progress in addressing the weaknesses and risks that I had identified. It was too early to say whether this progress would lead to long-term improvements. I also said that my Office would do more work in 2011 to look at whether the changes the Ministry was making had improved the effectiveness of the overall certification process.

Since my 2009 report, the Ministry has made good progress in strengthening how rest homes are certified and monitored. It has introduced an integrated audit approach, which combines audits previously done by DHBs and the designated auditing agencies (DAAs) that audit rest homes on behalf of the Ministry. It has introduced spot (unannounced) audits and requires more frequent audits when it assesses risks as higher. It has reintroduced third-party accreditation of the auditing agencies.

The consistency and quality of rest home audits have improved. Audits now provide better assurance that rest homes meet the criteria in the *Health and Disability Services Standards*.

The Ministry is shifting the focus of the auditing process towards ensuring that the documented policies and procedures deliver quality care to rest home residents, with the introduction of improvements such as a new tracer audit methodology. Overall, I consider that the recommendations I made in my 2009 report have been met.

However, there is still scope for certification and auditing to provide better assurance about the quality of care provided in rest homes, including better assurance to DHB planning and funding managers and rest home providers. My follow-up audit and the Ministry have identified further improvements that can be made. For example, the Ministry has identified that DAA auditors need further training in, and guidance in using, the tracer audit methodology.

In my view, new systems that the Ministry is introducing between now and 2015 provide an opportunity for the Ministry to consider how it might bring together and use clinical and audit information to continuously improve the quality of care provided in rest homes by:

- better assessing the quality of care being provided to rest home residents;
- making ongoing improvements to the Standards that rest homes must meet to provide residential care services for older people; and
- continuing to enhance the effectiveness and efficiency of auditing in providing assurance that the Standards are being met.

During the next 12 months, my Office will be working on the theme of *Our future needs – is the public sector ready?* As part of this work, I will look at the future needs of New Zealand's ageing population and how the public sector is planning to meet them. This will include further work with the Ministry, DHBs, and other government departments to explore the extent that older people's care and support services are integrated.

I would like to thank the staff of the Ministry, DHBs, and other organisations for their help and co-operation. I also extend particular thanks to the people who took time to complete my survey and share with my staff their experiences of rest home services.

Lyn Provost
Controller and Auditor-General

12 September 2012

Part 1
Introduction

1.1 In this Part, we describe:

- the purpose of our audit;
- how we carried out our audit; and
- the structure of this report.

Purpose of our audit

1.2 We carried out a performance audit to assess the progress that the Ministry of Health (the Ministry) and district health boards (DHBs) have made since we published our December 2009 report, *Effectiveness of arrangements to check the standard of services provided by rest homes*.

1.3 In that report, we stated that, since arrangements for certifying rest homes[1] had been introduced in October 2002, those arrangements had not provided adequate assurance that rest homes met the criteria in the *Health and Disability Services Standards* (the Standards).[2] We considered that the Ministry had not responded quickly enough to address weaknesses and risks in the arrangements that it had known about since 2004.

1.4 We noted that the Ministry was actively trying to address the shortcomings in the effectiveness of auditing and certification arrangements but that more work was needed. At the time of our audit in 2009, it was too early to tell whether the efforts to make the arrangements work as intended would make a difference or whether certification was fundamentally unable to do what the legislation envisaged.

1.5 We made nine recommendations in our 2009 report. Six were for the Ministry and three for DHBs. The recommendations are included in the Appendix. We stated that we would follow up on our audit.

1.6 This report sets out the findings of our follow-up audit. We have assessed what progress the Ministry and DHBs have made in addressing our recommendations. We have also identified the differences between the auditing and certification arrangements that we saw in 2009 and the arrangements that we saw during this audit. Also, we have assessed whether the changes the Ministry was making at

1 Aged Residential Care Providers, which are referred to throughout this report simply as rest homes, are funded under two separate standard agreements with DHBs. The first is the Age Related Residential Care Services Agreement: Provision of Age Related Residential Care, which covers the provision of rest home services, dementia services, and hospital-level (geriatric) services. This agreement is also known as the Age Related Residential Care contract (ARRC). The second is the Age Related Residential Care Services Agreement: Provision of Aged Residential Hospital Specialised Services, which specifically covers the provision of psychogeriatric services.

2 The *Health and Disability Services Standards* (NZS 8134:2008) are approved by the Minister of Health and published by Standards New Zealand.

the time of our 2009 audit and the work it has done since then have improved the effectiveness of the overall auditing and certification arrangements.

How we carried out our audit

1.7 Since our 2009 audit, as part of our continuous engagement with the Ministry, we have regularly met with Ministry staff and received updates on the progress it is making in addressing our recommendations.

1.8 As part of the fieldwork for this follow-up audit, the Ministry provided us with updated details of the work that it has done with DHBs and other major stakeholders to address our recommendations. We saw evidence and verified that this work has actually been done.

1.9 As well as our verification work, we wanted to find out whether the main participants involved in certifying and monitoring rest home services thought that the auditing and certification regime had improved. To do this, we interviewed staff from the Ministry, DHBs, and the Health and Disability Commissioner's Office. We interviewed directors of the two accreditation bodies overseeing the work of the designated auditing agencies (DAAs). We also interviewed a range of staff from the rest homes, including chief executives and managers, including quality managers. We also spoke to directors and auditors from the DAAs and people working for organisations that provide advocacy services for older people.

1.10 After we published our 2009 report, the Auditor-General was approached by some members of the public who gave their views about the report and about rest homes. For this follow-up audit, the Auditor-General decided to seek the views of rest home residents and their families and friends during the audit fieldwork. We carried out an online survey of rest home residents, their families and friends, and caregivers and staff of rest homes. On request, we provided hard copies of the survey for respondents to complete.

1.11 During April 2012, our survey was available to the public on our website, and a link to the survey was provided on the websites of Age Concern New Zealand and the Health and Disability Commissioner.

1.12 Fifty-three people responded to our survey. Although this means that the responses are not statistically significant and do not necessarily reflect the views of rest home residents, their families and friends, and staff and caregivers as a whole, they raised important issues and contributed to our overall findings.

1.13 We surveyed the 20 DHBs to find out their views on whether the work that the Ministry has done on auditing and certifying rest homes since our 2009 report has led to improvements. We had 18 responses.

1.14 We also analysed complaints that the Health and Disability Commissioner had received about rest homes from 2006 to 2010.

The structure of this report

1.15 Part 2 outlines the changes that the Ministry has made since 2009 to the process for designating auditing agencies and for auditing and certifying rest homes.

1.16 Part 3 discusses the improvements that the Ministry has made to the auditing and certification arrangements since 2009.

1.17 Part 4 discusses how the Ministry assesses the quality of auditing and certification and whether the changes to the auditing and certification arrangements since 2009 have improved the quality of care for rest home residents.

1.18 Part 5 discusses the further work that the Ministry is doing to improve the quality of care for rest home residents and our views on how the Ministry might use its new systems to encourage continuous quality improvement.

Part 2
The Ministry has changed its processes for designating auditing agencies and for auditing and certifying rest homes

2.1 In this Part, we describe:

- the process for designating auditing agencies (and how this process has changed since 2009); and
- the process for auditing and certifying rest homes (and how this process has changed since 2009).

The process for designating auditing agencies

Background

2.2 The Health and Disability Services (Safety) Act 2001 (the Act) requires rest homes providing health care services for three or more residents to be audited and certified by the Director-General of Health (the Director-General) to ensure that they are providing safe and reasonable care that meets the Standards.

2.3 The Act requires the Director-General to designate agencies (DAAs) to audit the provision of health care services. The Director-General must be satisfied that the DAA:

- *has the technical expertise to audit the provision of services of that kind;*
- *has in place effective systems for auditing the provision of services of that kind;*
- *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;*
- *will administer those systems and arrangements properly and competently, and in compliance with any conditions subject to which the designation is given; and*
- *will comply with* [the] *Act*.

How the designating process has changed since 2009

2.4 Since our 2009 audit, the Ministry has signed memorandums of understanding with two accreditation bodies – the Joint Accreditation System of Australia and New Zealand and the International Society for Quality in Healthcare. The Director-General requires DAAs to hold third-party accreditation with one of these accreditation bodies. This is a condition of designation as an auditing agency.

2.5 The accreditation bodies are required to assess the auditing agencies and prepare assessment reports. They must grant and renew accreditation in keeping with international standards and their procedures as an accreditation body.

2.6 Since our 2009 audit, the Ministry has revised the *Designated Auditing Agency Handbook* (the DAA Handbook). The DAA Handbook sets out the Ministry's requirements for auditing and audit reporting. The Director-General, in designating an auditing agency, must state the conditions subject to which the designation is given. All DAA designations are subject to the condition that they must comply with the requirements of the DAA Handbook.

2.7 The third-party accreditation body assesses each auditing agency against the Act and the Ministry's requirements (as set out in the DAA Handbook). The DAA provides the Ministry with a copy of the third-party accreditation assessment report. If satisfied that the agency meets the requirements, the Director-General then designates the agency to audit the provision of specified health care services, including rest home services. As at 1 June 2012, the Director-General had designated six agencies to audit the provision of the following health care services:

- hospital care in rest homes (as defined in section 4(1) of the Act);
- rest home services (as defined in section 6(2) of the Act); and
- residential disability care (as defined in section 4(1) of the Act).

2.8 The accreditation bodies are required to provide the Ministry with feedback on the ongoing performance of the DAAs. This is to ensure that DAAs continue to meet the requirements of the Act and the DAA Handbook. Also, the Ministry monitors the quality of the DAA audits and consistency in audit approach.

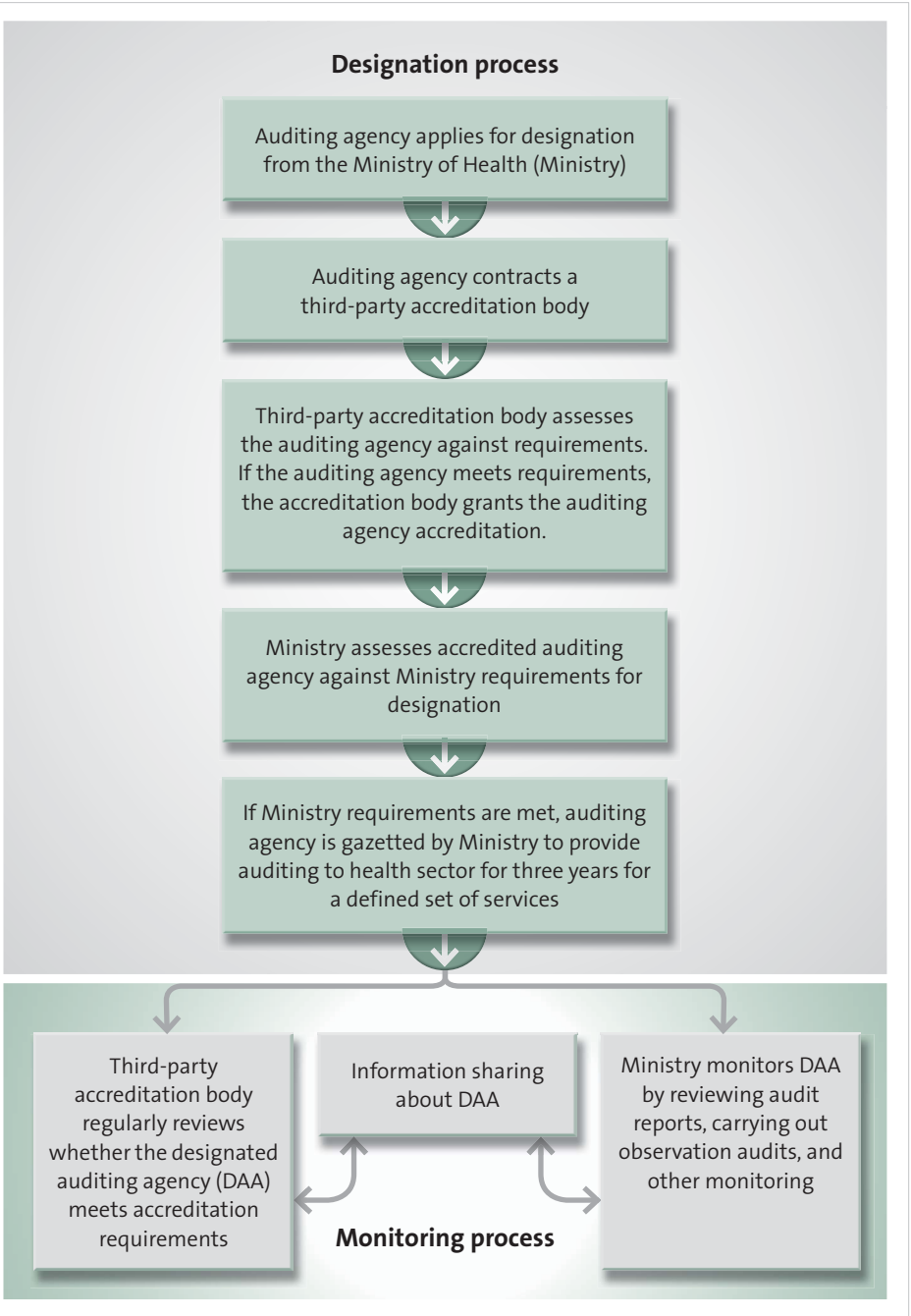
2.9 The Director-General may cancel the designation of a DAA if the Director-General is no longer satisfied that the agency:

- has the appropriate expertise;
- has effective audit systems;
- is able to mange conflicts of interest; or
- is complying with the conditions of its designation.

2.10 We discuss these changes in more detail in Part 3 and their effects in Part 4.

2.11 Figure 1 sets out the process for designating auditing agencies and monitoring DAAs.

Figure 1
Process for designating auditing agencies and monitoring designated auditing agencies



The process for auditing and certifying rest homes

Background

2.12 The DAAs audit whether rest homes comply with the Standards. The certification audit involves:

> *... a systematic, independent, objective and documented evaluation of the extent to which health care providers meet standards and processes, based on particular audit criteria.*[3]

2.13 The certification period can range from one year to five years, depending on how well the rest home provider complies with the Standards. However, the first certification period is always provisional for one year.

2.14 DAA auditing is designed to ensure that a rest home has adequate systems and processes that, if followed, should ensure that rest home residents receive safe, quality care. Although the rest home is expected to be compliant at all times, an audit is conducted at a point in time and can only provide assurance of meeting the Standards at that point in time. DAAs carry out five types of audits in rest homes. The two main types are certification audits and spot audits:[4]

- Certification audits establish whether a rest home[5] is meeting the relevant Standards. A successful certification audit results in certification for up to five years.
- Spot audits were introduced in January 2010. These are unannounced audits that are carried out about midway through the certification period (see paragraphs 3.52-3.54). These audits are meant to assure the Ministry that the rest home continues to meet all relevant Standards. The audit focuses on the continuum of service delivery,[6] and any criteria that were not fully attained (see paragraph 2.18) in the previous audit are reviewed.

2.15 Rest homes are responsible for ensuring that their certification remains current. The rest home applies for certification from HealthCERT, which is a part of the Ministry with responsibility for ensuring that rest homes (and other health service providers) "provide safe and reasonable levels of service for consumers".[7] The rest home is then responsible for engaging a DAA from HealthCERT's list of DAAs.

3 This description of a certification audit is from the DAA Handbook.

4 The other types of audit are provisional, partial provisional, and verification audits. These are done when a rest home changes ownership or introduces a new or reconfigured health service.

5 Most certified providers of aged care services are limited liability companies. The rest are incorporated societies, charitable trusts, or other legal entity types. Most providers own and operate one premises. However, there is a range in size, with the largest operating 52 premises.

6 Standards for the continuum of service delivery cover entry to the service, assessment, planning, medicine management and nutrition, safe food, and fluid management.

7 See "Clinical Leadership, Protection and Regulation Business Unit" at www.health.govt.nz.

2.16 When the rest home engages a DAA to carry out a certification audit, the DAA notifies HealthCERT.

2.17 The DAA Handbook requires DAAs to contact the relevant DHB at least 20 days before a certification audit or spot audit. The DHB specifies any issues related to the Age Related Residential Care contract (ARRC) that the DHB would like to be considered during the audit.[8] The DHB also advises the DAA of any concerns that it has about the rest home or any complaints it has received about the rest home. The DAA notifies the rest home of these matters seven working days before the audit, unless it is a spot audit.

2.18 DAA auditors rate the services provided by the rest home against each criterion in the Standards.[9] DAA auditors rate attainment levels against each criterion as "continuous improvement", "fully attained", "partial attainment", "unattained", or "not applicable" together with a risk rating. Each Standard is rated "met" or "not met". The auditors prepare an audit report using the standard audit report format provided by the Ministry.

2.19 The DAA submits the audit report electronically to HealthCERT, which makes the report available to the DHB via a secure website.

2.20 The DHB and HealthCERT jointly evaluate the audit report.

2.21 The DHB's evaluation focuses on ensuring that there is enough evidence that the ARRC requirements are being met and that the evidence is in line with the DHB's assessment of the provider's risk. Any changes that the DHB wants to the attainment levels against the audited criteria are discussed with HealthCERT, which, in turn, discusses the concerns with the lead DAA auditor.

2.22 HealthCERT staff review the audit report and check that the ratings that the auditor gives for each criterion match the evidence. HealthCERT staff (under delegation from the Director-General) certify the rest home for up to five years (see paragraph 2.13), based on the information provided in the audit report and any other information that HealthCERT has received (for example, complaints and information from the DHB or the Health and Disability Commissioner). Most certification periods are for three years. Figure 2 shows the percentage of rest homes that have been certified for a specified number of years, as at 11 June 2012.

8 The Aged Related Residential Care contract is the contract that the DHBs have with rest home or hospital owners (providers) to provide long-term residential care (contracted care services) to residents who are eligible for government funding through the residential care subsidy.

9 There are 206 criteria relating to the Standards. See paragraph 3.23.

Figure 2
Certification periods for rest homes, as at 11 June 2012

Period of certification (years)	Percentage of rest homes
1	3
2	21
3	72
4	4
5	0

2.23 The rest home is required to submit a "corrective action plan" to correct any partial attainment or non-attainment of the Standards and criteria. The DHB is responsible for approving the corrective action plan and monitoring the rest home's progress against the plan. The DHB advises HealthCERT about progress against any critical risks or progress against unmet Standards.

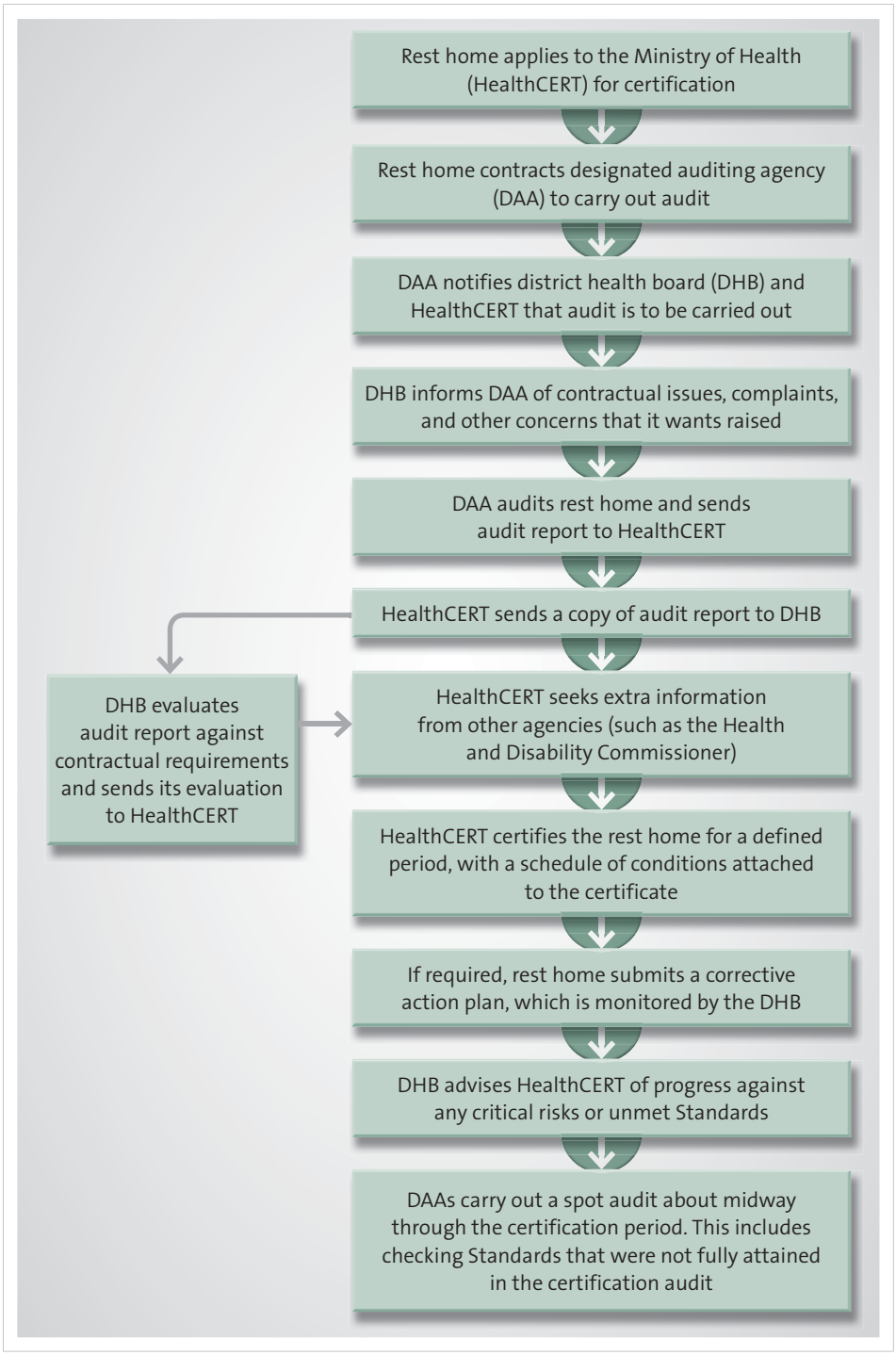
2.24 The Ministry's website includes a summary of each rest home's audit report. The summary includes a traffic light system that reflects the rest home's achievement against the Standards. The achievement levels range from "commendable elements above the required levels of performance" to "major shortfalls, significant action is needed to achieve the required levels of performance".

2.25 When a rest home is assessed as having "major shortfalls", the website shows this as a "red traffic light". The red traffic light can be removed after the rest home completes corrective actions and arranges a DHB site visit to confirm that these have been done. The DHB submits a report, which results in the red traffic light being removed. A summary of the DHB's report is published online.

2.26 The rest home is responsible for paying the cost of the audit.

2.27 Figure 3 shows the process for auditing and certifying rest homes.

Figure 3
Process for auditing and certifying rest homes



How the auditing and certifying process has changed since 2009

2.28 Since our 2009 audit, the following changes have been made to the process for auditing and certifying rest homes:

- the Ministry has provided a standard audit template to improve the content and consistency of the audit reports (see paragraphs 3.22-3.23);
- the Ministry is now observing DAA auditors doing audits as part of its ongoing monitoring (see paragraphs 3.26 and 3.44-3.45);
- an integrated audit approach has been introduced (see paragraphs 3.48-3.51);
- spot audits of rest homes have been introduced (see paragraphs 3.52-3.54); and
- DAA auditors are now required to use "tracer audit methodology". This methodology is an evaluation method where individual residents are selected to test the care and services provided to them. Using this method, the auditor retraces specific care pathways that the resident has experienced. To do this, the auditor observes, talks with others, and reviews records to assess compliance against the Standards (see paragraphs 3.60-3.66).

2.29 We discuss these changes in more detail in Part 3 and their effects in Part 4.

Part 3
Improvements to the Ministry's auditing and certification process since 2009

3.1 In this Part, we discuss the work that the Ministry has done since our 2009 report. In particular, we look at the Ministry's actions to improve:

- the quality and consistency of DAA audits;
- how it manages risks in the certification arrangements;
- certification audit methods; and
- how it analyses and shares information.

3.2 We also note that the Ministry reconsidered the design of the certification arrangements and decided to improve the current arrangements.

Our overall findings

3.3 When we carried out our audit in 2009, the Ministry was already addressing the shortcomings that it had identified in the auditing and certifying of rest homes. In 2008, the Ministry had prepared a work programme to improve the effectiveness and efficiency of the auditing and certifying of rest homes. At the time of our 2009 audit, the Ministry had begun work on this programme.

3.4 Since our 2009 report, the Ministry has continued its programme to strengthen arrangements. For example, it has reintroduced third-party accreditation, has updated the DAA Handbook, and is monitoring how well DAAs comply with the good practice auditing standards and audit practices in the DAA Handbook.

3.5 The Ministry has also continued to improve how it manages risks in the certification arrangements. For example, it is better at managing potential conflicts of interest and monitoring risks arising from rest homes selecting their own auditors.

3.6 These changes have improved the consistency and quality of DAA audits. However, the Ministry needs to do more to further strengthen auditors' competence (such as, auditors' use of tracer audit methodology).

3.7 The Ministry has continued to improve auditing methods. For example, DHBs' routine contractual audits have been integrated with the certification audits. Spot (unannounced) audits were introduced in January 2010, and tracer audit methodology at the end of 2010. These improvements have reduced duplication in the certification process and, with the introduction of the tracer audit methodology, the auditors' focus is beginning to shift towards assessing the quality of care.

3.8 The Ministry has continued to improve how it uses auditing and certification information that it has collected from rest homes. It identifies common themes

and trends and communicates this information to DAA auditors. It is using this information to improve its guidance to rest homes (for example, the *Medicines Care Guides for Residential Aged Care*).[10] It is identifying examples of good practice, which are being shared with rest homes. In our view, the Ministry needs to monitor that this information is being used:

- by rest homes to improve the quality of care; and
- by the DAAs to improve the quality of audits.

The quality and consistency of DAA audits have improved

Reintroducing third-party accreditation has allowed the Ministry to better assess and monitor the capability of DAAs to audit rest homes. Updating the DAA Handbook and monitoring DAAs' compliance with the standards and audit practices in the DAA Handbook have also improved the consistency and quality of audits.

Third-party accreditation has been reintroduced

3.9 Before 2006, accreditation by a third party was required for an agency to be designated as an auditing agency. In 2006, the Ministry removed third-party accreditation as a condition of designation. The Ministry did this in response to two external reports that it commissioned from The Systems 3 Group Pty Ltd (S3G) in 2004 and 2005. The reports by S3G found serious weaknesses common to all or most DAAs. The weaknesses were in management controls, auditing practice, reporting, and auditors' competency. Therefore, the Ministry considered that third-party accreditation was ineffectual.

3.10 The Ministry reintroduced third-party accreditation in 2010. In the new arrangements for accreditation, the Ministry appointed suitable accreditation bodies and better specified the requirements that DAAs had to meet to be accredited. Accreditation bodies audit DAA compliance with international standards for quality auditing. These standards are referenced to the DAA Handbook and check general auditing systems. This had not been done with the previous arrangements.

3.11 DAAs had until December 2010 to gain accreditation. In late 2009 and early 2010, the Ministry signed memoranda of understanding with two third-party accreditation bodies (see paragraph 2.4).

3.12 The memoranda require the third-party accreditation bodies to cover DAAs' capability to audit health services.

3.13 In June 2011, the Ministry evaluated third-party accreditation. This evaluation "indicates that several advantages of third-party accreditation have been realised despite there being no quantitative evidence to support this". The Ministry noted

10 See "Medicines Care Guides for Residential Aged Care", at www.health.govt.nz.

that most DAAs had to improve their systems and processes to gain accreditation, which better supports consistency in auditing.

3.14 The Ministry noted that the involvement of the third-party accreditation bodies has improved how it monitors and manages actual or emerging issues with DAAs. Accreditation bodies have provided feedback on changes to the DAA Handbook to ensure that it remains consistent with third-party accreditation requirements and best practice approaches to auditing. The Ministry also noted that the accreditation bodies have strengthened its ability to take a firm position when the Ministry and DAAs have disagreed.

3.15 The Ministry is planning another evaluation of third-party accreditation at the end of 2013.

The DAA Handbook has been updated

3.16 The main purpose of the DAA Handbook is to state the Ministry's auditing and audit reporting requirements against which DAAs audit health care services under the Act. DAAs must comply with the DAA Handbook as a condition of designation.

3.17 The DAA Handbook was revised in May 2009 to reflect changes in auditing requirements from the 2008 revision of the Standards. This was the first revision of the DAA Handbook for some time.

3.18 The DAA Handbook was revised further in February 2010 and August 2011. These revisions increased requirements for DAAs and were aimed at improving the quality of, and consistency in, DAA audit practice. Examples include extra guidance on resident sample sizes for the audit team's site-based interviews and the requirement for the DAA audit team to include a registered nurse with an annual practising certificate (and with aged care experience). DAA compliance with the DAA Handbook is monitored by the Ministry (in its review of the certification and spot audit reports) and the third-party accreditation bodies. This monitoring has been introduced since our 2009 report.

3.19 To support compliance with the revised DAA Handbook, the Ministry invited DAA consumer auditors to a training day in November 2010. The training covered:

- the role of the auditor;
- the Standards and the importance of the Standards and criteria;
- the role of the DAA Handbook;
- interviewing;
- analysing the information collected during the audit;
- record-keeping; and
- audit report writing.

3.20 We reviewed the course notes and course workbook. We consider that they provide good coverage of the basic audit principles.

3.21 Ongoing training workshops are held for other types of auditors (see paragraphs 3.71-3.73).

Audit reports have been standardised

3.22 Before 2009, the Ministry accepted audit reports from DAAs in various formats. This contributed to a lack of consistency in the reporting of audit evidence and findings.

3.23 A standard electronic reporting template was developed and released in June 2009. It requires DAA auditors to complete mandatory fields against every Standard and every relevant criterion (of which there are currently 206). The template is intended to provide the Ministry with a platform for consistent and comprehensive audit reporting.

3.24 The Ministry completes an internal evaluation form for each audit report received from the DAAs. The evaluation form includes a set of best practice criteria. Six of the criteria assess the quality of the audit,[11] and eight assess the quality of the audit report. The results are collated and fed back to the DAAs to help improve quality. Since 2009, the Ministry has also analysed and benchmarked the standard of DAA audit reports. The quarterly benchmark reports are published on the Ministry's website.[12]

3.25 In April 2010, the Ministry published an *Audit Report Writing Guide: A guide for writing audit reports to the Ministry of Health* to help improve the quality of the audit reports.

The Ministry monitors each DAA

3.26 The Ministry has set up a performance monitoring process for DAAs. The Ministry monitors each DAA by responding to concerns raised:

- by DHBs or rest homes;
- through assessment of audit reports;
- during observation audits carried out by the Ministry;
- when issues-based audits or inspections by DHBs are inconsistent with previous DAA audit findings; and
- by the annual declarations that DAAs complete and provide to the Ministry.

11 These criteria are the composition of the audit team, triangulation of audit evidence, rest home resident or relative interviews, that statements about the Standards match the criteria, that the evidence matches the level of attainment awarded, and that the sampling methodology included tracer methods.

12 See "Evaluation of auditing agencies", at www.health.govt.nz.

3.27 The Ministry offers rest homes the opportunity to comment on the audits done by DAAs. Rest homes are emailed a link to an electronic survey after each audit. The purpose of the survey is to allow rest homes to independently offer the Ministry feedback on the audit process. If the feedback directly relates to poor audit performance, the Ministry seeks further comment from the DAA as part of its performance management programme.

3.28 A DAA can have its designation cancelled under the Act if it does not meet the requirements of its designation.

3.29 During 2009, the Ministry commissioned a special audit of a DAA that had been consistently underperforming. This resulted in the DAA being required to "show cause" why its designation should not be cancelled. The Ministry closely monitored the DAA while the DAA took the required corrective actions, including a restructure of its organisation. The Ministry observed audits by the DAA in March, July, and September 2010. As a result, it issued a further "show cause" letter in October 2010. The Ministry continued to manage the performance of the DAA. It observed audits by the DAA in January, February, and March 2011. The DAA sold its health services auditing business to another DAA in April 2011.

3.30 The Ministry also commissioned an external audit programme for the other DAAs in early 2010 (before accreditation was reintroduced). Each DAA was given a copy of its audit report and the Ministry worked with the DAAs to prepare action plans to strengthen the DAA's performance. The Ministry monitored the DAAs against these plans and had regular meetings with DAAs.

3.31 DAAs are also required to have an internal audit. The details of what the internal audit covered, the results of the internal audit, and an action plan for the coming year have to be sent to the Ministry by the end of January each year as part of the DAA's annual declaration.

The management of risks in the certification arrangements has improved but auditors' competence needs to be strengthened further

The Ministry is better managing potential conflicts of interest and monitoring risks arising from rest homes selecting their own auditors. However, the Ministry needs to further strengthen the competence of DAA auditors.

Managing conflicts of interest

3.32 The Ministry has implemented a number of strategies to check that DAAs have adequate systems to prevent conflicts of interest.

3.33 The February 2010 revision (and subsequent versions) of the DAA Handbook include:

- a requirement for half of the auditors on the auditing team to change after each certification audit;
- a requirement for each auditor to complete a conflict of interest declaration for each audit;
- an annual declaration by DAAs that a conflict of interest process has been established that prevents auditors (whether staff or contractors) from providing consultancy services or education to a client that has a contract with the DAA for audit services; and
- the reintroduction of a code of conduct for auditors (which includes disclosing any current or previous working or personal relationship that may be seen as a conflict of interest or that may influence the auditor's judgement).

3.34 The Ministry's external audit programme of DAAs in 2010 (see paragraph 3.30) checked that each DAA had effective arrangements to avoid or manage any conflicts of interest. Issues raised during the audits were followed up with the relevant DAA.

3.35 The accreditation bodies check these conflict of interest arrangements for compliance with the DAA Handbook during their assessments of the DAAs.

3.36 The Ministry's optional online survey of rest homes after each audit (see paragraph 3.27) includes the question "Does your DAA provide any other services to your organisation and if so what services?"

Selecting the cheapest and most lenient DAA

3.37 To reduce the risk of rest homes choosing the cheapest and most lenient DAA, the Ministry regularly analyses the costs and results of audits. The Ministry has not been able to find a correlation between low-cost audits and fewer partial attainments and non-attainments against the Standards. This suggests that rest homes are not choosing their DAA on the basis of implied leniency.

3.38 The Ministry also monitors the movement of rest homes to different DAAs to ensure that the change is not to achieve more lenient auditing by a DAA. The Ministry is satisfied that movements are not because of the leniency of the DAAs carrying out the audits.

Improving auditor competency

3.39 The Ministry requires each DAA to ensure that the auditors they employ or contract with are capable of auditing quality management systems.[13] DAA auditors must have gained the New Zealand Qualifications Authority (NZQA) Unit Standard 8086 (Demonstrate knowledge required for quality auditing) qualification or completed an equivalent course recognised by the Ministry. The auditors must be able to show that they are able to carry out audits in keeping with the international standard *Guidelines for quality and/or environmental management systems auditing* (AS/NZS ISO 19011:2003).

3.40 The DAA also has to assess the competence of its auditors in keeping with another international standard, *Conformity assessment – requirements for bodies providing audit and certification of management systems* (ISO/IEC 17021:2011). The DAA Handbook says that auditors can show competence by successfully completing NZQA Unit Standard 8084 (Audit quality management systems for compliance with quality standards).

3.41 Each auditor has to:

- be deemed competent by the DAA they work for before starting any audit or work on behalf of the DAA;
- maintain their professional development by regularly participating in audits and completing at least eight hours each calendar year of professional education relevant to quality auditing (including knowledge of legislation and regulation, managing of common medical conditions in the service setting being audited, and knowledge of current nursing care management);
- take part in an annual performance review, which includes having at least one audit witnessed by another auditor from the DAA;

13 "Quality auditing" compares the auditee's activities against the auditee's quality management systems and applicable quality standards.

- comply with the Ministry's code of conduct for DAA auditors (which includes requirements for competence and not acting beyond the scope of their qualifications);
- have all audit reports peer-reviewed before sending them to HealthCERT; and
- use work documents (for example, interview prompt sheets and tools) to support a standard of auditing consistent with the intent of AS/NZS ISO 19011:2003.

3.42 All newly qualified auditors must be supervised by experienced auditors for their first four audits.

3.43 The third-party accreditation assessment includes checking the DAA's human resource practices, its processes for appointing competent auditors, and its compliance with the DAA Handbook's requirements for individual auditors employed by, or contracted to, the DAA.

Observation audits

3.44 The Ministry carries out observation audits as part of its performance monitoring. These observation audits involve a HealthCERT advisor accompanying a DAA auditor on selected audits. This allows the Ministry to observe and compare audit practices across audits and also to check the competency of the individual auditors. The first two observation audits in early 2010 focused on higher-risk rest homes. Observation audits are now carried out when the DAA auditor is new, the Ministry is concerned about the competence of a DAA or their auditors, or the auditor has not been observed for some time.

3.45 We reviewed 16 of the Ministry's observation audit reports produced between March 2010 and December 2011. These audit reports covered the observation audits of 26 health service providers, 13 of which were rest homes (the rest were certification audits of DHBs and a hospice).[14] At least one certification audit was observed by the Ministry in each DAA during this period. We consider that these audits are a useful part of the Ministry's monitoring and provide useful feedback to help DAAs see where auditors can improve.

Other options to improve auditors' competence

3.46 The Ministry has considered a range of options to further strengthen auditor competence.[15] These include:

- An online auditor competence test, with newly engaged auditors required to meet a competence level before the Ministry accepts the auditor on a DAA's auditor register. This option was not pursued because of the amount

14 An observation audit may cover more than one health service provider.

15 This includes auditors' knowledge, skills, personal attributes, and the qualifications of an auditor to ensure that they meet the scope of certification.

of resources required. It was also beyond the scope of the Ministry's role as a regulatory body.

- An NZQA 8084 programme, offered by a DAA that is both an auditing and training organisation. The programme includes 45 hours of tutored courses, 20 hours of distance learning, and 25 hours of observed assessment. The programme costs more than $2,000. The Ministry chose not to pursue this option because of the potential conflict of interest for the DAA, as both a training agency and an audit agency.
- Working with an external agency to develop a competence programme that is administered by the external agency. At least two international agencies offer this type of service. The Ministry has looked at the programme provided by RABQSA International (an Australian and American partnered organisation). This programme includes an initial knowledge examination, a personal attribute assessment, and a skill assessment. The personal attribute and skill examinations are repeated every fourth year. Although the Ministry preferred this option, it had concerns about stakeholder acceptance of the programme because the costs (estimated to be an average of $140 an audit) would be likely to be passed on to providers.

3.47 The Ministry is still considering how it can further strengthen the competence of auditors.

Audit methods have improved but further training is required in tracer methodology and the reduced criteria project is not yet completed

The Ministry has improved its auditing methods. The routine contractual audit that was carried out by DHBs has been integrated with the certification audit. The frequency of audits is now in line with the Ministry's risk assessment of rest homes and spot audits have been introduced. There is more work to do to ensure that DAA auditors better understand tracer audit methodology. The reduced criteria project needs to be completed.

The integrated audit approach has been introduced

3.48 When we carried out our 2009 audit, we considered that there was unnecessary duplication between certification audits by DAAs and the audit of contract compliance (against the ARRC) by DHBs.

3.49 The Ministry introduced an integrated audit approach in August 2010. This approach incorporates the routine contractual auditing that was done by DHBs into the certification audit by DAAs.

3.50 This integrated approach means that DHBs are more involved at the start and end of the audit process. DAAs contact the relevant DHB 20 working days before the audit, which gives the DHB the opportunity to specify any contract-related issues that it wants to be considered. At the end of the process, the DHB and Ministry jointly evaluate the audit report and, if the rest home meets the Standards, the Ministry will issue a certificate to the rest home.

3.51 If necessary, the rest home submits a corrective action plan for the DHB to approve. The DHB then monitors progress by directly sourcing progress reports from the rest home. This is a change from the DAA submitting progress reports. The aim is to allow DHBs to focus on quality improvement in the rest homes rather than auditing processes.

Spot audits have been introduced

3.52 The Ministry introduced spot audits from 1 January 2010. These audits occur within a three-month period either side of the midpoint of the rest home's certification period. The audits focus on the delivery of care and include the relevant contractual requirements for the ARRC.

3.53 DAAs liaise with DHBs and the Ministry before and after the audit, using a defined process.

3.54 The audits are unannounced so that providers cannot prepare for the visits. The audits are intended to check the rest home's compliance with the Standards during the rest home's normal day-to-day business. However, during our audit, we were told that the spot audits were not as effective as they could be because rest homes are aware of the "window" when the audits would happen. We support the Ministry's use of spot audits as a method of ensuring that the Standards are maintained in rest homes.

There are more audits when risks are assessed as higher

3.55 Although rest homes can be certified for up to five years, the Ministry decides how long the certification period will be for based on an assessment of the rest home's risk. HealthCERT assesses that risk by using a risk matrix. This matrix has been improved in the last two years. Certification can be for only a year when the assessed risk is higher.

3.56 The Standards are grouped according to the consequence that the risk has for a rest home resident. For example, high risks are abuse and/or neglect, inadequate staffing levels, poor medicine management, and unsafe restraint use. General risks include quality and risk management systems, governance procedures and

systems, and operational systems. The number of Standards and criteria that are partially attained or not attained and their associated risk ratings determine a "score" on the matrix.

3.57 The Ministry considers other information that it receives – for example, the outcomes of any complaints to the Health and Disability Commissioner, information provided through the DHB's issues-based audits (see paragraph 4.20), changes in the management or ownership of the rest home, past issues and reports, and whether past issues have been corrected.

3.58 The matrix score and the Ministry's assessment of the other information determine the length of the certification period. The lower the matrix score, the shorter the certification period. Because spot audits are required to be carried out halfway through the certification period, the higher-risk rest homes are audited more frequently. For example, a rest home that gained a one-year certification is audited every six months, while a rest home with a four-year certification is audited every two years.

3.59 HealthCERT can conduct further spot audits as a condition of certification at any time if it considers the rest home has been performing poorly. For a new rest home, if HealthCERT has concerns about potential risks that cannot be evaluated before the service is fully operational, HealthCERT can require a spot audit as a condition of the provisional one-year certificate. There is a defined process that HealthCERT must follow to assess whether a condition of this type will be added to the certificate.

Tracer audit methodology has been introduced

3.60 As part of revising the DAA Handbook at the end of 2010, the Ministry introduced tracer audit methodology. Tracer methodology training was provided at the September 2010 and June 2011 workshops for DAA auditors.

3.61 Tracer audit methodology is an evaluation method that selects individual residents to test the care and services provided to them. Using this method, the auditor retraces specific care pathways that the resident has experienced by observing, talking with others, and reviewing records to assess compliance against the Standards. The method allows the auditor to follow processes to gain a clear sense of day-to-day issues affecting the care of individual residents. It is designed to shift the auditor's focus from examining written policies and procedures to include the quality of care delivered to residents.

3.62 The auditor is able to look for trends that might point to potential system-level problems within a rest home.

3.63 In March 2012, more than a year after tracer audit methodology was introduced, the Ministry reviewed a small sample of audits (one audit from each DAA) where this methodology had been used. This review of six audits highlighted several issues:

- important members of staff were not always interviewed;
- care planning was reported in only four of the six audits;
- residents' assessments were not recorded in one of the six audits; and
- only one DAA auditor was checking the observed practice against the rest home's policies and procedures.

3.64 The findings from the review indicate that DAA auditors need further training in, and guidance with, the use of tracer audit methodology.

3.65 The Ministry acknowledges that not all auditors attend the workshops and that DAAs are responsible for transferring knowledge to those in their audit team who do not attend the workshops. The Ministry notes that more work is needed to ensure that "train the trainer" approaches are effective and that third-party accreditation agencies monitor new methods.

3.66 In our survey of DHB planning and funding managers, one DHB noted its support of tracer audit methodology. The DHB noted, as a general comment, that this audit methodology provides a very useful tool for seeing whether policies and procedures are followed. The DHB would like to see this methodology used more widely – to cover the spectrum of residents, different levels of care, and different issues (for example, falls, wounds, clinical care, and palliative care).

A project to reduce the number of audit criteria is under way

3.67 DAA auditors currently assess rest homes against 206 criteria. Our 2009 report identified that it was a significant challenge for auditors to consistently check more than 200 criteria thoroughly on every rest home audit in the time allocated. In November 2011, the Ministry began a project to reduce the number of criteria audited within the Standards. The Ministry has made progress with the reduced criteria project but improvements and efficiencies could have been achieved earlier.

3.68 In January 2012, an Information and Discussion Document proposed a process for new certification and recertification audits from 1 January 2013. The new process would include:

- First, a document review (a "stage one audit"), which would involve the DAA completing a simple checklist and making it available to the rest home. This could reduce the time needed for reviewing policies and procedures on site.
- Secondly, an on-site audit (a "stage two audit"), which would involve auditors auditing at the Standard level, not at the criteria level. However, auditors will

consider the highly relevant criteria that sit under each Standard.

Reducing the number of criteria subject to audit ... is expected to allow auditors to take a more resident centred and holistic view of services. This approach is consistent with tracer methodology.

- Finally, reporting on the audit results would be at the Standard level and against all relevant criteria.

3.69 The Ministry has identified a number of potential benefits of this approach:

- a reduction in the number of criteria by 50%;
- a time saving of 20% associated with having to audit fewer criteria;
- an improved focus on quality-of-life outcomes for residents;
- a time saving of 50% on reporting because of reduced reporting requirements;
- streamlined audit reports because of a focus on relevant criteria; and
- removal of duplication of evidence from audit reports.

3.70 The Standards must be reviewed within five years of their introduction. Therefore, the Ministry is planning to review the Standards by 2013. In our view, the timing of the Standards review and introducing the revised audit process that incorporates the reduced number of criteria in January 2013 presents the Ministry with an opportunity to further improve rest home audits. As discussed in Part 5, instead of compliance checking, the focus can be on connecting clinical and audit information to continuously improve the quality of care provided in rest homes.

Analysis and sharing of information is improving and needs to lead to changes across the rest home sector

The Ministry is beginning to use auditing and certification information from the rest home sector to identify common themes and trends. It has more work to do to ensure that this information is improving the quality of care, auditing, and certification.

DAA workshops have been held regularly

3.71 The Ministry has held workshops for DAA auditors about every three months. The workshops have covered a variety of topics. These topics include:

- dementia care;
- auditing informed consent and advanced directives;
- the tracer audit methodology;
- DAA Handbook changes;
- an update on the integrated audit process;

- publication of audit summaries; and
- guides for nutrition, safe food, and fluid management.

3.72 The DAA staff we spoke to generally support the workshops. They considered them a useful forum for introducing changes, disseminating information to DAAs, and clarifying any common issues arising in the certification audits.

3.73 The Ministry evaluated the DAA workshops in June 2011. Twenty-three workshop participants responded to the Ministry's survey. Generally, the results were positive, with:

- 65% of the participants finding the workshops generally useful and a good opportunity to network and clarify issues; and
- 61% of participants thinking that the frequency of the workshops was appropriate.

The HealthCERT Bulletin has been published regularly

3.74 HealthCERT publishes a newsletter (*HealthCERT Bulletin*) about every four months and sends it to DAAs. The *HealthCERT Bulletin* provides auditors with updates (for example, DAA Handbook updates and changes in the sector), news about research, and answers to commonly asked questions.

3.75 The topics covered in the DAA workshops are reported in the *HealthCERT Bulletin*. This is done so that DAA auditors who were not able to attend the workshops have access to the information provided.

3.76 We have reviewed the newsletters and consider that they provide useful information. The usefulness of the *HealthCERT Bulletin* was tested as part of the June 2011 evaluation of the DAA workshops. Of the attendees at the June workshop, 78% thought that the *HealthCERT Bulletin* was useful.

Common themes are identified from available information

3.77 In our 2009 audit, we had concerns about how the Ministry was using the available information to improve aged-care residential facilities.

3.78 The Ministry now analyses the information in the audit reports to identify common problem areas. This involves analysing the number of partial attainments and non-attainments against each criterion and Standard. The analysis has identified areas that need to be improved and has led to three projects: publishing the *Medicines Care Guides for Residential Aged Care* (see paragraph 3.8), the continuous quality improvement project, and the continuum of service delivery project.

Medicines Care Guides for Residential Aged Care

3.79 In November 2009, the Ministry analysed the results of 320 audits. In 140 of these audits (117 of which were of rest homes), the provider received a partial attainment for medicine management.

3.80 The Ministry contracted a gerontology nurse practitioner/senior lecturer to write a guide on safe management of medicines for residential aged care and residential disability services. The guide was published in May 2011 and provides a quick clinical reference to common conditions and topics encountered in the care of older people.

3.81 A hard copy of the guide was sent to every rest home provider. The guide is available on the Ministry's website.[16]

Continuous quality improvement project

3.82 The Ministry intended that the continuous quality improvement project would identify examples of innovation and improvements made by rest home providers. A panel of experts has already selected examples of good practice, which are published on the Health Improvement and Innovation Resource Centre website.[17]

3.83 The Ministry provided us with several examples of innovative practice that it had identified. The rest home providers have an access code and password for the site. The Ministry told us that it would make the good practice examples available to all providers of health and disability services soon.

Continuum of service delivery review

3.84 The Ministry analysed the issues identified in rest home certification audits between March 2009 and July 2011 (636 audits of 493 facilities). It published the results of this review in December 2011.

3.85 The review established that the highest levels of non-compliance (noted in at least 30% of the reports) involved five criteria of the Standards.

3.86 The review identified the following main themes within those five criteria:

- time frames for care planning and reviews were not met;
- a lack of documented assessments;
- all needs were not recorded in the care plans;
- some interventions documented in the care plans were insufficient or not clearly documented;
- some care plans were not complete;
- care plans were not updated to reflect changes in residents' needs; and
- short-term care planning was insufficient.

16 See "Medicines Care Guides for Residential Aged Care", at www.health.govt.nz.

17 See www.hiirc.org.nz.

3.87 The Ministry noted that this analysis identified a number of opportunities for improvement and change throughout the sector. It has presented the findings to rest homes as part of a general awareness-raising activity. However, the extent to which rest homes have acted on these opportunities is unclear. Therefore, we cannot determine how much positive change has resulted from this awareness-raising activity.

The Ministry reconsidered the design of the certification arrangements

3.88 In our 2009 report, we recommended that the Ministry reconsider the design of the certification arrangements by examining alternatives and evaluating whether the alternatives would be more effective and more reliable.

3.89 The Ministry has considered this recommendation and decided to strengthen the current arrangements rather than redesign them.

Part 4
Quality of auditing and certification has improved but the effect on the quality of care is less certain

4.1 In this Part, we discuss:

- what the Ministry is doing to assess and continue to improve the quality of certification audits;
- further audit work we have done to assess whether the Ministry's changes to certification arrangements have improved the effectiveness of those arrangements; and
- what the Ministry's and our analyses indicate.

Our overall findings

4.2 There are indications that the quality of the auditing and certification process for rest homes has improved during the last two years, because:

- third-party accreditation has improved DAAs' systems and processes;
- the integrated audit approach has resulted in better communication between the Ministry, DHBs, and DAAs;
- the Ministry, DHBs, and DAAs respond more quickly and effectively when issues in rest homes are identified; and
- the Ministry consistently monitors the quality of DAA audits.

4.3 The effect that these improvements have had on the quality of care delivered to rest home residents is less certain. There is scope for certification and auditing to provide better assurance about the quality of care provided in rest homes, including better assurance to DHB planning and funding managers and rest homes. The Ministry needs to keep shifting the focus of rest home audits towards ensuring that documented policies and procedures result in safe quality care being delivered to residents, as it has started to do by introducing tracer audit methodology.

How the Ministry assesses the ongoing quality of the certification audits

The Ministry has a number of ongoing activities to assess the quality of rest home certification audits.

4.4 The Ministry monitors DAAs by observing auditors on-site, evaluating each audit report completed by DAAs, and asking for feedback from rest homes.

4.5 During 2011, the Ministry reviewed the quarterly benchmark reports. It collected this information to find out whether DAAs' compliance with the best practice

criteria had improved (see paragraph 3.24). The evaluation covered the last quarter of 2009, the last quarter of 2010, and the first quarter of 2011.

4.6 At the end of 2011, the Ministry analysed the 108 responses it had received from a survey of rest homes that it carried out between 12 August 2011 and 25 October 2011. The responses covered the five DAAs that operated during that period.

4.7 In June 2011, the Ministry carried out a preliminary evaluation of the effectiveness of accrediting the DAAs. This was to find out how effective third-party accreditation had been in strengthening the certification process. This evaluation was inconclusive, largely because the Ministry had introduced third-party accreditation only at the end of 2010. The evaluation took place in June 2011 to meet one of our 2009 report recommendations. The Ministry has told us that it will carry out another evaluation of DAA accreditation during 2013. This evaluation should provide more useful information.

What we did to find out whether quality has improved

We surveyed rest home residents, their families, and friends, and surveyed DHB planning and funding managers. We analysed complaints to the Health and Disability Commissioner.

4.8 We carried out three pieces of work to find out whether the changes to the certification arrangements had improved the effectiveness of the arrangements to check the standard of services provided by rest homes.

4.9 For the first piece of work, we published a survey on our website. A link to the survey was also published on the Health and Disability Commissioner's website and Aged Concern New Zealand's website. Our questions focused on any quality improvements or concern that rest home residents and their families and friends had noted during the last two years. We received 53 responses to our survey.[18] The responses are not statistically significant and do not necessarily reflect the views of all rest home residents, their families and friends, staff and caregivers. However, they raise important issues and contribute to our overall view.

4.10 Our second piece of work was a questionnaire asking the DHBs' planning and funding managers about their views on the quality of the arrangements for certifying rest homes. In particular, we sought the managers' views on:

- their DHB's involvement in the certification process;
- how audit findings are communicated to the DHB;

18 Of those who responded, more than half (53%) were either caregivers in the rest home or members of staff other than caregivers. Almost a quarter (24.5%) of respondents were family members or friends of residents. The last group of respondents classed themselves as "others". This group included a range of people who visited rest homes, such as registered nurses or advocates.

- whether the DHB receives enough information to allow it to follow up on audit findings;
- whether auditors are interpreting the Standards consistently;
- whether DHB issues-based audits (see paragraph 4.20) identify issues that should have been identified during the certification audits;
- how satisfied DHBs are that certifying rest homes provides reliable assurance of safety and quality; and
- whether the arrangements for certifying and monitoring rest homes have improved.

4.11 In our third piece of work, we analysed complaints data held by the Health and Disability Commissioner.

What the Ministry's and our analyses indicate

Although there are indications that the quality of the certification process for rest homes has improved during the last two years, some concerns remain. The effect that the improvements have had on the quality of care delivered to residents is less certain.

4.12 We have looked at the results of the Ministry's evaluation and analysis, as well as the results of the work that we did.

Third-party accreditation has provided benefits and improved DAA processes

4.13 The Ministry's evaluation of third-party accreditation included looking at whether accreditation had:

- identified areas for improvement that affect the standard of auditing done by DAAs; and
- resulted in DAAs changing how they operate.

4.14 The Ministry's survey of DAAs (which was carried out as part of its evaluation of third-party accreditation) suggests that third-party accreditation has encouraged DAAs to identify and implement improvements to their processes. In response to the survey, DAAs said that they had reviewed and revised their quality system documentation before their third-party accreditation assessment. Five of the six DAAs said that the third-party accreditation assessment process identified areas for improvement in their audit process, business practices, and management of auditors.

The standard and consistency of audits have improved but they still do not identify all issues

4.15 DAAs were less positive about the effect that third-party accreditation had had on the standard and consistency of auditing. Two of the six DAAs felt that the standard and consistency of auditing had improved with the introduction of third-party accreditation requirements, one was not sure, and the other three did not think that the introduction had had any effect.

4.16 Planning and funding managers in DHBs were more positive. Thirteen of the 18 managers who responded thought that the process for auditing and certifying rest homes had improved significantly during the last two years; three thought that it had improved slightly, one thought it had deteriorated, and one did not answer the question. This may reflect the introduction of the integrated audit approach. Half of the managers thought that DAA audits and auditors have become more consistent in applying the Standards.

4.17 The planning and funding managers thought that communication before and after the certification audits was good. The managers were asked to provide feedback to the DAA on any issues that the DHB would like investigated during the audit, such as complaints that needed to be followed up or concerns with the levels of service provided in the rest homes.

4.18 Most of the DHB managers thought that the findings from the certification and spot audits were sent to them in a timely manner. They were sent or had access to a draft report and have access to the final report.

4.19 Some of the planning and funding managers thought that there is still room for improvement in the audit approach. For example, they thought auditors needed to shift their focus towards higher-risk areas such as individual care plans, infection control, medicines management, falls, nutrition, restraint, workforce development, diversion therapy, and quality assurance.

4.20 We were concerned to note that issues-based audits[19] are still identifying issues that planning and funding managers believe should have been picked up during the certification audits. Four of the seven issues-based audits that DHBs carried out during the year ended 30 June 2011 identified major safety and quality issues that should have been picked up during the certification audits. In another instance, where the issues-based audit was done because of the findings in the certification audit, the issues-based audit found many instances of unsatisfactory patient care that were not picked up in the DAA's certification or spot audits. The

19 An issues-based audit is carried out by a DHB after identification of immediate and serious concerns with the care being provided within a rest home and/or there has been an unsatisfactory response by the rest home to address serious concerns about that rest home. These audits are usually more targeted than contractual audits and there is no notification to the rest home. The audits are still focused on meeting contractual and Standards' requirements.

manager in this DHB noted that certification audits are more of a systems' and processes' audit rather than an audit of individual care. It is our view that the improvements the Ministry is planning (as discussed in Part 5) should help to address these issues.

The quality of audit reports is still variable

4.21 The Ministry's evaluation of third-party accreditation looked at whether third-party accreditation had improved the standard and consistency of auditing and audit reporting. The evaluation found that no DAAs had achieved full compliance with HealthCERT's audit reporting requirements from year to year. The most common criteria where DAAs were not meeting the expected benchmarks were:

- reports requiring resubmission (five of six DAAs);
- terminology not being explicit (five of six DAAs);
- requirement for additional information to ensure triangulation of evidence (four of six DAAs);[20]
- HealthCERT advisors needing to request further information more than once (four of six DAAs); and
- audit reports not submitted on time (five of six DAAs).

4.22 The Ministry's analysis of the quarterly benchmarking results found that all DAAs are now achieving 100% compliance for the composition[21] of the audit teams and all have improved how they quantify and organise evidence. However, all but one DAA continue to submit completed audit reports that require resubmission.

4.23 The Ministry noted that HealthCERT still has to contact DAA auditors for further information to ensure that evidence was triangulated and to ensure that the evidence matched the risk ratings given by the auditors. For some DAAs, these benchmarking results had worsened since the end of 2009.

4.24 The DHB planning and funding managers commented on the quality of the audit reports. Half of the managers considered that the audit reports contained enough information to allow them to follow up on the findings. The other managers thought that the DAAs need to increase the amount of information provided in the audit reports so that the managers did not have to go to the DAA to clarify the findings.

20 Triangulation of evidence is a process for gathering reliable evidence by drawing information from three sources – interviews, observation, and documentation.

21 The composition of the audit team must reflect the characteristics of the service and its users – for example, in terms of background and service type. Every audit team must include a person with clinical and technical expertise relevant to the service being audited who holds a relevant annual practising certificate and an auditor with appropriate qualifications and experience as a lead auditor or team leader.

The effect of changes on quality of care is less certain

4.25 Seventeen planning and funding managers were fairly satisfied or very satisfied that certification provides a reliable assurance of safety of care. Eleven managers were either fairly satisfied or very satisfied that certification provides a reliable assurance of quality of care in rest homes (the other six managers were neither satisfied nor dissatisfied). This may indicate that there is scope for certification and auditing to provide better assurance about the quality and safety of care provided in rest homes.

4.26 Figure 4 shows DHB planning and funding managers' responses to questions about safety and quality of care.

Figure 4
Responses from 18 district health board planning and funding managers to our questions about safety and quality of care provided in rest homes

	Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied
Certification provides reliable assurance of safety of care provided in rest homes	5	12	1
Certification provides reliable assurance of quality of care provided in rest homes	2	9	6

4.27 Nearly half of the respondents to our public online survey noted improvements in the quality of services in rest homes since 2009. These largely related to improved communications between the rest homes, residents, and their families and friends and improved communication among staff. Respondents considered that the way that the rest home dealt with concerns or problems had improved.

4.28 Forty-two of the 53 respondents to our survey still had concerns about the quality of services provided in rest homes. The concerns most often cited were:

- the quality of one-to-one care provided (34 of 42 respondents); and
- the housekeeping, including food (23 of 42 respondents).

Analysis of complaints to the Health and Disability Commissioner is inconclusive

4.29 We analysed the complaints received by the Health and Disability Commissioner between 2006 and 2011. We note that the number of complaints increased from 2006 to 2009 but have declined since 2009. We note that the proportion of complaints that have been upheld or had further action taken has increased. It is difficult to work out the reasons for these changes.

4.30 The Health and Disability Commissioner told us that the volume of complaints did not necessarily reflect the quality of care and that different factors can influence the volume of complaints. For example, when a complainant has used a rest home's internal complaints procedure and been satisfied with the investigation of their complaint, they are less likely to escalate their concerns to the Health and Disability Commissioner.

4.31 We note that some significant changes to rest home certification, such as third-party accreditation, were not introduced until late 2010, so the effects of these changes may not yet have affected the number of complaints to the Health and Disability Commissioner.

More focus needs to be placed on auditing rest home practices

4.32 Although most respondents (87%) to the Ministry's survey of rest homes (see paragraph 4.6) wanted no change to the amount of time that auditors spend on observing actual rest home practices, a notable minority (13%) wanted auditors to increase the time that they spend observing the rest home's actual practices. We also received this feedback in our interviews with rest homes and from DHB planning and funding managers. We support this approach.

4.33 Respondents to our online survey felt that the certification process was generally too paper-based. It was described as an exercise more concerned with compliance than outcomes for residents. Suggestions included spending more time with residents and their families rather than looking at files, and actively observing staff behaviour. These responses support other evidence about getting the balance right between checking on policies and procedures and examining their practical application.

4.34 In our DHB survey, six of the DHBs chose to give us additional comments that they would like to see the current audit processes changed to focus on the quality of care rather than documented processes. One DHB commented that:

> *The audit does not measure the effectiveness of care delivered – it manages compliance with documented processes to achieve certification. In some instances the audit report has been very positive, but the standard of care delivered has been found to be poor.*

4.35 A second commented that:

> *The quality measures that we currently use such as certification do not reflect the standard of care provided in ARRC. This mismatch can create misunderstandings and disbelief. Now that the integrated audit is embedded in the contracting obligations of health of older people services in ARRC, there is an urgent need to develop quality measures alongside this national infrastructure.*

4.36 A third commented that:

> *The current approach addresses the systems required for the provision of safe services. However, there is minimal assessment of the client experience of delivery of client focused, quality services.*

4.37 In Part 5, we discuss how the Ministry might connect clinical and audit information to continuously improve the quality of care provided in rest homes.

Part 5
Connecting clinical and audit information to continuously improve the quality of care provided in rest homes

5.1 In this Part, we discuss two initiatives that the Ministry is implementing to improve the quality of audit and clinical information, namely:

- the Provider Regulation and Monitoring System (PRMS); and
- the international resident assessment instrument (interRAI).

5.2 We also discuss the opportunity that the PRMS and interRAI present for the Ministry to consider how it might bring together and use clinical and audit information to encourage continuous improvement in the quality of care for rest home residents.

Our overall findings

5.3 The Ministry expects the PRMS to improve the quality and use of data from certification and monitoring audits, including identifying areas where auditor education needs to improve. The Ministry expects the first phase of the PRMS to be complete by April 2013.

5.4 The clinical data from interRAI should allow better assessment of rest home residents and show quality of care. The Ministry anticipates that interRAI will be phased into rest homes over the next three years. The Ministry told us that the current focus is on uptake of interRAI across the residential care sector by 2015.

5.5 During our audit, we were not able to establish how the audit data that the Ministry currently collects from its existing information technology (IT) systems feeds into monitoring of the actual quality of care delivered to rest home residents. We consider that the introduction of the PRMS and interRAI over the next two to three years provides an opportunity for the Ministry to consider how it might bring together and use clinical and audit information to continuously improve the quality of care provided in rest homes by:

- better understanding the quality of care being provided to rest home residents;
- making ongoing improvements to the Standards that rest homes must meet in order to provide residential care services for older people; and
- continuing to enhance the effectiveness and efficiency of auditing in providing assurance that the Standards are being met.

The Provider Regulation and Monitoring System should further improve the effectiveness and efficiency of auditing

The Ministry expects that the PRMS will enable better use of data from certification and monitoring audits to continuously improve the effectiveness and efficiency of auditing. The Ministry expects that the first release of the PRMS will be complete by April 2013.

5.6 The Provider Regulation Group (PRG) in the Clinical Leadership, Protection and Regulation section of the Ministry regulates 2400 providers of health care services. As the Group's functions have grown during the last 10 years, it has inherited the computer systems from each new function it has acquired. The Ministry describes this as a "patchwork of systems". The PRMS is an IT system that is designed to bring together existing IT systems into one new system and strengthen HealthCERT's ability to monitor the health care sector, including DAAs.

5.7 The PRMS was identified as a priority in PRG's business plan and approved in 2009/10. It was further considered in December 2010 and in November 2011. A further business case was provided in January 2012, after the Request for Proposal process.

5.8 Subject to contract negotiations, the Ministry expects the first phase of the PRMS to be complete by April 2013. The Ministry expects that the PRMS will:

- help get better data directly from DAA auditors;
- deploy business intelligence tools that can work out statistical distributions and trends;
- provide better information to support decisions about the performance of DAAs;
- result in better ability to use audit data to identify cross-sector areas of concern;
- support the direction of the reduced criteria project (see paragraphs 3.67 to 3.70) by focusing on particular and relevant audit criteria based on a risk analysis, as opposed to the current focus on all criteria; and
- improve communications to the health care sector, such as providing better information to DHBs and more information online.

The international resident assessment instrument should improve assessment of quality of care but will not be fully implemented in rest homes until 2015

interRAI is being phased into rest homes over the next three years. The clinical data from this computer-based system should allow better clinical assessment of rest home residents and show the quality of rest home care. Uptake of interRAI throughout the entire residential care sector is expected by 2015.

5.9 In October 2009, the Minister of Health directed the newly formed National Health IT Board to create the first National Health IT Plan for the overall health sector.

5.10 The National Health IT Plan was written in 2010. It aimed to establish an integrated health care model during the next five years, so that:

> *New Zealanders will have a core set of personal health information available electronically to them and their treatment providers regardless of the setting as they access health services.*

5.11 The National Health IT Plan does not explicitly describe comprehensive clinical assessment or interRAI by name. However, the plan discusses patient-based information that sets out the plan for the patient's course of care and that helps in a multidisciplinary approach to support patient care.

5.12 In the National Health IT Board's priority programmes list for 2011/12, interRAI for aged care was one of the IT Board's five "National Solutions". interRAI was developed in the United States and is now used in more than 30 countries.

How the data from interRAI can be used

5.13 The latest version of interRAI includes the assessment, care planning, and reporting of changes in resident well-being and the resources needed to care for rest home residents. The assessment covers 19 domains, including cognition, functional status, health conditions, and activity pursuits. Twenty-four quality indicators are then used to assess the rest home's performance against the domains. The indicators include accidents, clinical management, infection control, nutrition and eating, and skin care.

5.14 The data from the interRAI system can be used to monitor the quality of care provided to rest home residents at the following levels:

- "resident over time" – an individual resident's health status can be monitored over time to find out whether it is improving or deteriorating and how it is being managed;

- "rest home over time" – the quality indicators of care in the rest home can be monitored from quarter to quarter or from year to year to establish any positive or adverse trends; and
- against other rest homes – the quality indicators can be compared to other care homes in the local area or nationwide.

5.15 Therefore, the data could be used to monitor and assess the quality of care provided in rest homes.

5.16 In December 2010, the chief executives of all DHBs endorsed a business case recommending a phased roll-out to all aged care providers in New Zealand by 2015. All DHBs use interRAI when assessing older people for home-based care.

5.17 The current focus is on uptake of interRAI across the residential care sector by 2015. By June 2012 there were 82 rest homes whose staff had attended interRAI training and 50 of those had nurses who were competently using the interRAI system to help them work out their residents' care plans.

5.18 The national roll-out of interRAI follows a successful pilot in the Canterbury and Bay of Plenty DHBs. The project has the support of the Ministry, the DHBs, the New Zealand Aged Care Association, and a number of rest homes. Representatives from these organisations form the project steering group. During 2012, the Ministry expects 110 rest homes to implement the system. In each rest home or group of rest homes,[22] there will be a lead practitioner who will teach the registered nurses how to use the tool in a consistent manner. HealthCERT advisors have done interRAI training and a HealthCERT advisor will be a member of an interRAI user support group.

5.19 At the time of our fieldwork, there was not yet a structured plan for rolling out interRAI throughout rest homes and the wider health and disability sector because the focus had been on ensuring that implementation of interRAI for home-based care was completed by 30 June 2012. The Ministry has also told us that interRAI is going to be voluntary.

22 When referring to a group of rest homes, we mean a rest home provider that has more than one rest home. For example, Ryman Healthcare, Oceania Group, and Presbyterian Support.

An opportunity to bring together audit and clinical information to encourage continuous improvement in the quality of care for rest home residents

In our view, the Ministry should take the opportunity to consider how it brings together and uses data from the PRMS and the clinical data collected through interRAI to continuously improve the Standards that rest homes must meet and the quality of care that rest homes provide.

5.20 Under the current auditing and certification arrangements, the Ministry audits rest homes to ensure that they have the capability and capacity to meet the Standards and provide safe, quality care to their residents. The rest homes' ongoing ability to do this is checked through the audit and certification process. The introduction of the PRMS will allow the data collected from the audit process to be analysed to better monitor and assess rest homes and continuously identify where audit effectiveness and efficiency can be improved.

5.21 We noted that the Ministry monitors the quality of care provided in rest homes by measuring the number of complaints, setting the time that rest homes are certified for, and assessing the number of and type of audit findings. We do not consider this is enough to measure the quality of care provided to residents, particularly clinical care. We support the introduction of the PRMS and interRAI to improve the quality and use of data from certification and monitoring audits to improve the quality of rest home care.

5.22 In our view, the Ministry should take the opportunity presented by the introduction of these new systems to consider how it brings together and uses data to encourage continuous improvement in the quality of care for rest home residents.

Appendix
Our 2009 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.

Publications by the Auditor-General

Other publications issued by the Auditor-General recently have been:

- Inquiry into aspects of ACC's Board-level governance
- Education for Māori: Context for our proposed audit work until 2017
- How the Far North District Council has administered rates and charges due from Mayor Wayne Brown's company, Waahi Paraone Limited
- Reviewing financial management in central government
- Realising benefits from six public sector technology projects
- Annual Plan 2012/13
- District health boards: Quality annual reports
- Fraud awareness, prevention, and detection in the public sector
- Institutional arrangements for training, registering, and appraising teachers
- New Zealand Qualifications Authority: Assuring the consistency and quality of internal assessment for NCEA
- Statement of Intent 2012–2015
- Public entities' progress in implementing the Auditor-General's recommendations 2012
- Inquiry into how Christchurch City Council managed conflicts of interest when it made decisions about insurance cover
- Overview of the Auditor-General's work in the transport sector
- Local government: Results of the 2010/11 audits
- Severance payments: A guide for the public sector
- Health sector: Results of the 2010/11 audits
- Central government: Results of the 2010/11 audits (Volume 2)

Website

All these reports, and many of our earlier reports, are available in HTML and PDF format on our website – www.oag.govt.nz. Most of them can also be obtained in hard copy on request – reports@oag.govt.nz.

Notification of new reports

We offer facilities on our website for people to be notified when new reports and public statements are added to the website. The home page has links to our RSS feed, Twitter account, Facebook page, and email subscribers service.

Sustainable publishing

The Office of the Auditor-General has a policy of sustainable publishing practices. This report is printed on environmentally responsible paper stocks manufactured under the environmental management system standard AS/NZS ISO 14001:2004 using Elemental Chlorine Free (ECF) pulp sourced from sustainable well-managed forests. Processes for manufacture include use of vegetable-based inks and water-based sealants, with disposal and/or recycling of waste materials according to best business practices.

Office of the Auditor-General
PO Box 3928, Wellington 6140

Telephone: (04) 917 1500
Facsimile: (04) 917 1549

Email: reports@oag.govt.nz
Website: www.oag.govt.nz