



Australian Government

Department of Health

REPORT ON THE OUTCOME OF CONSULTATIONS ON THE SINGLE AGED CARE QUALITY FRAMEWORK

July 2017





ACKNOWLEDGMENT

The Department wishes to thank everyone who participated in the broad consultation on the Single Aged Care Quality Framework, including those who participated in the webinar, forums, videoconferences or who contributed submissions. The feedback provided as part of the consultation will support the development of the Single Aged Care Quality Framework.

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PART 1 - CONTEXT AND PURPOSE OF THIS PAPER

A. Context

The Australian Government announced in the 2015-16 Budget its intention to work with the aged care sector to develop a Single Aged Care Quality Framework (Single Quality Framework) across aged care. The Single Quality Framework will include:

- a new set of quality standards that will apply to all aged care services
- a new process to assess organisations' performance against the new standards
- improvements to the information available to consumers to support them to make choices about their aged care.

In March 2017, the Department of Health (the Department) released two consultation papers seeking stakeholder feedback on key elements of a proposed new Single Quality Framework for aged care. The consultation papers sought stakeholder views about:

- the draft quality standards described in the *Single Aged Care Quality Framework – Draft Quality Standards Consultation Paper 2017* (the Draft Quality Standards Consultation Paper)
- options for improving the processes for assessing performance against the single set of quality standards described in *Single Aged Care Quality Framework – Options for Assessing Performance against Aged Care Quality Standards – Options Paper 2017* (the Assessment Options Paper).

In total, around 350 submissions were made. Over 250 consumers, carers, providers, peak organisations and other sector representatives also attended video conferences or forums held in Geelong, Townsville, Alice Springs, Canberra and Sydney. The Department also visited the community of Titjikala (located 130km south of Alice Springs) to seek the views of the local provider and Indigenous people receiving aged care services. A webinar was held on 29 March 2017, attracting 750 live log-ins. The webinar, transcript and live chat stream are available at <http://livestream.education.gov.au/health/29march2017>

Subsequent to the public consultation on the Single Quality Framework an independent review of Commonwealth aged care regulatory processes was announced. Further information regarding the review is available on the [Department's website](#).

The Department will consider the relevant recommendations of the review in the further development of the Single Quality Framework.

In addition, the Senate Community Affairs References Committee commenced an Inquiry into Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. Further information regarding the Senate Inquiry is available on the [Committee's webpage](#).

B. Purpose of this paper

The purpose of this paper is to:

- summarise the key outcomes of consultation in relation to both the draft standards and options for assessment. Please note, the paper is intended to generally capture the range of views put forward, noting that some competing views were received. This paper is not intended to capture every issue raised by individual respondents, however, every submission put forward has been read and carefully considered.
- outline the next steps in the process of progressing and finalising the draft standards and the quality assessment process.

PART 2 - DRAFT QUALITY STANDARDS

A. About the draft quality standards

The Draft Quality Standards Consultation Paper proposed eight draft standards:

1. Consumer dignity, autonomy and choice
2. Ongoing assessment and planning with consumers
3. Delivering personal care and/or clinical care
4. Delivering lifestyle services and supports
5. Service environment
6. Feedback and complaints
7. Human resources
8. Organisational governance.

Each of the draft standards included:

- a consumer outcome, such as 'I am treated with dignity and respect'
- an organisation statement, such as 'The organisation has a culture of inclusion, acceptance and respect for consumers'
- a set of requirements, such as 'The organisation demonstrates that each consumer's identity, culture and diversity is respected'.

For each draft standard, explanatory information detail the rationale for the standard and the evidence supporting the approach adopted. This information was intended to be explanatory only, noting that once the standards are settled, detailed guidance will be developed by the Australian Aged Care Quality Agency (the Quality Agency). This will provide further information for providers, quality surveyors and consumers about how performance against the standards may be evidenced and assessed.

B. Feedback on a single set of standards

There was support for a single set of standards, applicable across all aged care programs. Stakeholders noted that this would reduce duplication of effort for providers delivering more than one type of service and be of greater value to consumers.

"We commend the overall approach to having one, single framework for the standards for quality in aged care."

Stakeholders also broadly supported the content of the draft standards noting that they were:

- effectively structured (in terms of outcome, statement and requirement)
- better focused on consumer outcomes and goals
- not overly prescriptive (avoiding the risk of stifling innovation)
- drafted in appropriate language with the appropriate intent ("*It is language I would use*")
- likely to lead to better conversations between providers and consumers
- relevant and meaningful
- able to be scaled to the service/organisation.

Several stakeholders noted that while the draft standards reflect the standard of care that should be expected, not all aged care consumers currently experience this level of care.

C. Overall comments on the draft standards

While comments on the draft standards were varied and detailed, there were some consistent themes. Overall stakeholders:

- strongly supported the focus of draft Standard 1 on consumer dignity, autonomy and choice and the consumer-centred focus of the standards
- supported the focus of draft Standard 1 on dignity of risk, but acknowledged that there can be challenges in balancing this with the provider's duty of care to consumers and their staff
- expressed concern about the level of staffing in aged care services, with a number of stakeholders suggesting that the requirement relating to 'sufficiency' of staff was too uncertain and advocating the use of a more objective measure of sufficiency
- noted that effective communication between the consumer and the provider underpins quality care, and the importance of ensuring adequate supports for consumers who do not speak English or cannot verbalise
- emphasised the important role played by carers and others in the consumer's life
- suggested various ways in which the draft standards relating to personal/clinical care and governance could be strengthened. Stakeholders noted that strong clinical care (supported by effective clinical governance) is critical in aged care
- supported the references to the role of the provider's governing body (in overseeing the delivery of safe, quality care and services) but emphasised that governing bodies must be held accountable
- noted the need for guidance material to draw out the requirements of the standards and to describe the means by which requirements will be monitored and measured
- expressed concern about the capacity of National Aboriginal and Torres Strait Islander Flexible Aged Care Program and small volunteer-run organisations to meet the standards and the need for support for these providers.

A number of stakeholders also noted that the standards cannot achieve the outcomes sought in isolation – a cultural shift is required, including a commitment by the sector and the Quality Agency to shift from a focus on organisational systems and processes to a greater emphasis on consumer outcomes.

"The standards should assume that an older person has managed their life for many years, drawing on a range of supports over time as a new or unknown challenge presents itself and that their experience of aged care should be no different."

D. Specific suggestions regarding the draft standards

Comments made by stakeholders during forums, and via submissions, generally fell into four main categories:

- suggestions regarding additional detail that should be added to the draft standards
- aspects of the draft standards that require strengthening or further explanation
- identification of gaps within the draft standards

- wording changes to clarify the intent of a standard.

Following is a summary of the key issues that were raised in relation to each of the above points.

(i) Suggestions regarding additional detail to be included in the draft standards

In many cases stakeholders suggested highlighting in individual standards, particular groups, types of care or approaches to the delivery of care, based on the matters of importance to the respondent. For example, various respondents suggested that draft Standard 1 (consumer dignity, autonomy and choice) should expressly refer to: Aboriginal and Torres Strait Islander people; people with a disability; people from culturally and linguistically diverse backgrounds; people with a history of homelessness; people with dementia; carers; volunteers; advocates; people without family or community supports and people subject to guardianship orders.

Likewise, different respondents emphasised different matters that they thought should be expressly reflected in draft Standard 3 (delivering personal care and/or clinical care). For example, it was variously suggested that the standard should expressly reference: choking; continence; speech; nutrition and hydration; behaviour management; mobility, dexterity and rehabilitation; oral and dental care; infection; mental health; psychological safety; pain; urinary tract infections; hygiene; and skin safety.

While these matters are important, there was strong support for the draft standards to focus on the provider assessing the needs and preferences of each individual consumer and providing safe, quality care that is responsive to the needs and preferences of each individual.

(ii) Areas that require strengthening or further explanation/guidance

A number of stakeholders sought a strengthened focus across the draft standards on:

- language support services for consumers who do not speak English or otherwise have limited capacity to verbalise
- support for consumers, including access to advocates
- connection to community
- prevention and early intervention
- active support for consumer rights
- partnership with consumers.

Matters that were specifically mentioned as requiring further explanation in guidance materials included:

- key definitions such as the definition of consumers (and whether it also includes the representatives of consumers) and the definition of workforce (and whether it includes volunteers)
- guidance about finding the balance between dignity of risk and duty of care (draft Standard 1)
- stakeholders queried how the nature of any risks to the consumer or others will ultimately be interpreted and assessed
- clarification of key concepts such as 'partnering' (draft Standards 2 and 8), 'culture of inclusion' (draft Standard 1) and 'best practice' (draft Standard 3). Providers requested further guidance as to how these concepts might best be evidenced
- clarification of the word 'sufficient' (draft Standard 7) as it applies to the number and mix of staff required to provide quality care and services

- the concept of antimicrobial stewardship (draft Standard 3) and how it can be implemented in practical terms in the aged care context
- where a standard is necessarily subject to limits, how these limits will be articulated. For example, the capacity of a consumer to personalise their environment will necessarily be constrained by work health and safety considerations, and the impact of such personalising on others.

(iii) Gaps within the draft standards

Stakeholders were asked to comment on any gaps in the draft standards. The main areas that were consistently highlighted as being gaps in the standards related to:

- dementia care. Stakeholders noted that given the high and increasing prevalence of dementia (and that people living with dementia comprise more than half of all consumers of residential aged care), it is critical that aged care services are equipped and motivated to provide high quality, appropriate care to people with dementia. Stakeholders variously suggested that express reference should be made to: dementia care; communicating with people with dementia; and that services should be built with a dementia friendly design
- food, nutrition and meal services. Stakeholders noted that food plays a major role in physical, social, mental/psychological, cultural health and quality of life of aged care consumers and that the quality of food (and its nutritional value) should be expressly referenced in the standards
- minimal use of restraint. A number of stakeholders suggested that the standards should, like the National Standards for Disability Services, expressly require providers to utilise strategies that are based on the most minimally restrictive option in order to discourage the inappropriate use of restraint and psychotropic medications, particularly for people with dementia
- acknowledgment of the challenges faced by culturally and linguistically diverse (CALD) consumers who do not speak English and also others who do not have the capacity to communicate verbally. Stakeholders noted that consumers who cannot easily communicate can face additional challenges in terms of exercising choice, expressing their preferences and raising complaints. It was suggested that the standards be strengthened to ensure that providers adopt strategies to support such consumers (be it through access to advocacy and language support services, discussion with carers or utilisation of non-verbal communication tools)
- carers. Stakeholders suggested that carers should be explicitly acknowledged in the draft standards, noting the significant role that they often play in a consumer's life and wellbeing
- mental health. It was suggested that the draft standards have a disproportionate focus on clinical and physical care and do not adequately address the mental health or emotional wellbeing of consumers
- elder abuse. Stakeholders noted that consumer protection from abuse is a fundamental human right and the need to prevent, detect and report abuse should be articulated in the draft standards.

“The draft standards do not acknowledge or consider the high risk and prevalence of dementia and associated cognitive decline in any aspect of the wording, examples or specific clinical conditions that are highlighted.”

(iv) Wording changes

Various stakeholders made valuable suggestions for changes to the wording of individual draft standards to:

- improve consistency of terminology through the documents
- better align with disability standards and health standards
- make the standards more user friendly and consumer focused
- strengthen the wording and clarify the intent
- ensure that the consumer outcome reflects each of the main points reflected in the requirements.

E. Next steps

The feedback from consultation is being considered. The Department, working closely with a Technical Advisory Group (made up of consumer groups, service providers, academics and experts in the development of aged care or health standards), will work to incorporate the feedback, where appropriate, in order to strengthen and clarify the draft standards.

Work will also be undertaken by the Quality Agency to develop an education program and guidance material for consumers, quality surveyors and providers to support the implementation of the standards and the new assessment process. The development of the education program and the guidance material will take into account the feedback provided by stakeholders and will be co-designed and tested with key stakeholders throughout the development phase.

Prior to implementation, the draft standards will be tested and piloted. This will provide valuable insight into the application and assessment of the standards and guidelines to support their refinement.

Government agreement and amendments to the legislation will be sought after the draft standards are finalised.

PART 3 – OPTIONS FOR ASSESSING PERFORMANCE AGAINST THE QUALITY STANDARDS

A. Options described in the Assessment Options Paper

The Assessment Options Paper presented three options for reforming the process for assessing an organisation's performance against the proposed draft quality standards. In summary, these options included:

- Option 1: Assessment process based on care setting, with different approaches for residential settings and home/community-based settings (similar to the status quo)
- Option 2: Single risk-based assessment process applicable to all aged care settings
- Option 3: Safety and quality declaration by organisations providing low-risk services readily available to the broader population (noting that this proposal could be combined with Option 1 or Option 2).

The Assessment Options Paper also proposed improvements to the assessment process, regardless of the preferred option(s) including:

- a wider range of methods for assessing performance against the aged care standards
- continued use of data and intelligence to inform the risk-based assessment
- greater consumer involvement in the assessment process
- capacity for the Quality Agency to recognise compliance with other similar quality standards
- better information available to the consumer about the outcomes of the assessment.

Views were sought on other ways the assessment process could be improved and streamlined as part of the new quality assessment arrangements.

The paper also emphasised that the draft aged care standards and quality assessment arrangements would continue to operate as part of a broader aged care regulatory framework that includes:

- the charters of care recipient rights and responsibilities for residential care, home care and short-term restorative care
- an independent complaints body, the Aged Care Complaints Commissioner (Complaints Commissioner)
- the sharing of regulatory intelligence across the Department, Quality Agency, and Complaints Commissioner and other relevant agencies to inform proportionate, risk-based assessment and monitoring
- compliance action against organisations that are non-compliant with either the standards or any other provider responsibilities relating to quality of care, user rights or accountability.

B. Summary of Feedback Received

The majority of input from stakeholders on the options for assessing provider performance supported adoption of a single, risk-based assessment process applicable to all aged care settings (Option 2), combined with use of a safety and quality declaration by organisations providing low-risk services readily available to the broader population (Option 3).

The following provides an overview of the feedback received.

(i) Option 1 compared to Option 2

There was overwhelming support for Option 2 (single risk-based assessment process applicable to all aged care settings) compared with Option 1 (accreditation for residential care services and quality reviews for services in the home/community-based settings).

Respondents stressed that a single assessment process needed to be proportionate to the type, size, location and other associated risks, including performance of the service. Feedback reinforced that the primary concern for the quality arrangements must remain on consumer safety, with the regulatory burden placed on the provider being of secondary concern.

It was suggested that a single risk-based assessment process would:

- provide benefits for consumers by simplifying the quality arrangements across aged care, removing complexity for those transitioning between services
- provide continuity for consumers along the continuum of care, noting that the gap between home care and residential care is closing
- better enable a risk-based approach to be adopted
- reduce fragmentation and duplication inherent in the current system by adopting a single process across all aged care services
- be more efficient and reduce the regulatory burden for providers delivering care across multiple aged care programs
- enable an organisational approach to continuous improvement
- provide greater opportunity for combined assessments of co-located aged care services
- support flexibility within the aged care workforce, enabling staff to more easily move across aged care settings and provide greater organisational and staffing flexibility
- better accommodate future changes in aged care service delivery than the current arrangements.

“A risk-based approach enables increased monitoring and support to be targeted as needed whilst at the same time recognises and rewards services that are consistently performing above the expected standard. This in turn increases the industry’s drive to achieve more! Both approaches would obviously result in improved outcomes for residents which is our goal.”

For those favouring Option 1, it was argued that:

- the current approach works well and appropriately accommodates differences in risks between the types of aged care services
- the difference in risk between services provided by the Commonwealth Home Support Programme and residential care justifies different assessment processes, although there were suggestions from some supporting Option 1 that home care services should be subject to accreditation
- concern that a move to accreditation for home/community-based services could shift the emphasis from continuous improvement to compliance, may be too arduous for some services, particularly National Aboriginal and Torres Strait Islander Flexible Aged Care Program services in remote settings, and could result in additional costs for community services.

(ii) Option 3

Varied views were expressed about Option 3, whereby providers of very low-risk services (such as cleaning and garden maintenance) could submit a declaration of compliance and be subject to less frequent contacts by the Quality Agency.

On the one hand, some argued Option 3 was not supported given:

- the inherent vulnerability of older people, regardless of the nature of the service being delivered, warranted quality assessment of all aged care services
- consumers may assume that all Australian Government funded services were subject to the same oversight when this would not be the case, and that going forward, all services should be subject to the same quality requirements
- creating this arrangement for certain services could devalue the role that these services play and increase the risk of these providers failing to identify and connect consumers to increased supports when these are required
- the proposal could result in an influx of new providers who are commercially competitive but do not have high service delivery standards
- a declaration process would not provide sufficient information about the quality of services to enable consumers to make an informed choice of provider.

On the other hand, others argued Option 3 was desirable given:

- the low-risk associated with these services should drive the level of regulation without unduly increasing risk for consumers
- the risk associated with using such services is readily understood in the general community for these low-risk services
- there are already consumer protections in the law to protect aged care consumers should the provider not deliver services to an acceptable standard
- it is paternalistic to think that older people (who are not all vulnerable) cannot select and manage these low-risk services for themselves just as other members of the community
- where there are limited Government resources for assessment and monitoring, resources should not be applied evenly to all but should target higher-risk services
- there is already a level of verification achieved through the competitive allocation of contract funding to these providers that requires providers to demonstrate matters such as experience, qualifications and the ability to deliver the services
- applying unnecessary accreditation requirements on providers of these types of service drives up the cost, such that people receiving these services via aged care programs may be charged a higher amount than people purchasing these services directly in the market place
- consumers are as likely to select these services based on considerations such as cost of service and quality of service based on consumer feedback and experience and other information generally available in the market place
- a similar model is proposed to be adopted by the National Disability Insurance Scheme whereby providers delivering lower-risk services such as household assistance meet a verification requirement which would include demonstrating relevant insurances and qualifications, and has incident management and complaints handling systems in place.

“From a consumer perspective, the risk of using such services is already understood in the fee for service, non-government-subsidised market. When we pay for a house cleaner or a gardener, we understand the risk of the commercial transaction. If we are not happy, we stop using the service.”

Suggestions were made that should this option be adopted:

- services eligible for this option would need to be clearly identified
- services eligible for this option should be able to opt-in to the accreditation process
- should also be clearly identified on My Aged Care as having undertaken a declaration process (rather than being accredited).

(iii) Other suggested options

Respondents were also given the opportunity to suggest alternative quality assessment approaches. Suggestions made were based largely on aged care adopting an alternative quality system, such as health, disability, or ISO 9001 quality systems, or moving to a decentralised, local community-based, regulatory system. Some respondents also suggested the quality assessment process should be undertaken by an agency independent of government.

Additionally, it was suggested that aged care quality assessments could be modified to include granting an ongoing accreditation, with subsequent monitoring based on data used to trigger subsequent site visits.

Many other suggestions were made for improving current quality assessment processes. These are in Section (v), 'Improvements to the assessment process'.

(iv) Strengths of the existing assessment process

Stakeholders acknowledged the value of the following elements of the existing quality assessment framework:

- consumer and representative involvement and input in the assessment process
- self-assessment and assessment through site audits/visits
- triangulation of evidence during site visits using interviews with consumers and staff, documentation and observation
- monitoring and assessment contacts being based on the service's performance against the standards
- the appropriateness of the current quality assessment cycle typically being three years
- the transfer of information that takes place during a quality visit and the educative opportunity this provides for the aged care service
- the focus on continuous improvement, including plans for continuous improvement
- publication of the accreditation decision and report
- the guidance and support material available to support implementation of the standards
- that any non-compliance must be rectified within a set timeframe
- the Quality Agency's independence.

"The current service self-assessment is useful, both in terms of providing a structure to review progress between visits and to guide preparation before a site visit."

(v) Improvements to the assessment process

Numerous suggestions were made about how the assessment process should be conducted. The following provides an overview under themes of consumer focus and assessment methodology.

Consumer focus

Many of the submissions emphasised that, along with the quality standards, the whole assessment process needs to shift to be more consumer centred. Suggestions included:

- the publication of more consumer focused reports
- reports be published for all site visits in all residential and home/community-based settings (ie site audits/visits, announced and unannounced assessment contacts involving a site visit, and review audits)
- use of a randomised approach when selecting consumers interviewed during site audits
- use of multiple methods to allow consumers to provide input on provider performance (eg individual and group face-to-face meetings during site visits, surveys undertaken by the provider, and feedback collected electronically from the Quality Agency or some other independent organisation)
- use of a standardised consumer feedback tool used across the sector
- enabling greater community involvement in the assessment and monitoring of aged care services
- access to interpreters during surveyor interviews
- adoption of appropriate communication tools for non-verbal consumers
- publishing a list of providers that meet all expected outcomes
- published consumer feedback reports for each service
- published information on direct care hours available to each resident per day/week.

“Consumers need to be able to gauge how well a particular facility is performing compared to others and to understand how many facilities are meeting or not meeting particular outcomes.”

Assessment methodology

Many stakeholders emphasised:

- the importance of the Quality Agency observing delivery of care and not just relying on documents prepared by the provider
- the need for standardisation in how the standards are assessed, encouraging consistency in interpretation by services and quality surveyors
- the desirability of greater information sharing between the Quality Agency, Complaints Commissioner and Aged Care Funding Instrument assessors
- the need for quality surveyors to be appropriately qualified and with expertise in the type of service being reviewed
- desirability of the quality assessment report including greater recognition of good practice and innovation
- support for retaining a three-year accreditation cycle, however some argued for extending the period of accreditation (particularly for organisations with strong history of good performance), while others suggested each service be visited each six to 12 months.

Additional comments and suggestions:

- varied views regarding unannounced site visits, some noting that they can be disruptive to the provision of care. However, overall there was strong support for unannounced site visits, as an important regulatory safeguard, with some respondents suggesting

unannounced visits should be conducted more frequently and/or all site visits should be unannounced

- support for increased regulatory oversight of providers with poorer performance, while those with stronger performance being monitored less frequently and/or granted extended accreditation periods
- the suggestion that the frequency of monitoring, including unannounced site visits, should be based on the service's performance history using data to identify alerts
- the need for assessments to be undertaken in a culturally safe manner, in particular, taking into account the cultural safety and specific cultural needs of Aboriginal and Torres Strait Islander care recipients and staff
- support for assessment of some standards (for example, organisational governance), at a provider or organisational level rather than at a service level noting that the verification of the standard would still be required at the service level
- improving the assessment process of larger organisations by:
 - combining quality assessments of co-located services
 - assessing a group of services simultaneously
 - sampling several individual services for assessment rather than assessing each individual service
- various complementary and additional ways to measure provider performance – including performance against benchmarks, and quality indicators. Overall, there was support for objective quality indicators and validated tools to be used, and for performance against these indicators to be published
- that it is crucial that the compliance framework supports the assessment process and that timely action needs to be taken in the event of non-compliance
- the need for resources and guidance for consumers and providers to support their understanding of the aged care quality assessment arrangements, including the application and interpretation of the draft standards in different types of aged care services
- an electronic tool for use by both services and quality surveyors, and information from this tool be used in subsequent assessments to enable assessment of continuous improvement
- ratings be changed from met/not met to allow for a wider range of performance ratings, in order to provide consumers with better information about providers' performance and to recognise excellent performance
- publication of information on trends and areas that providers should focus on the analysis of current issues and identified risks to allow providers to respond to these areas of concern
- concerns about the capacity of National Aboriginal and Torres Strait Islander Flexible Aged Care Program and small volunteer-run organisations being able to meet the standards and the requirement for accreditation. A number of stakeholders emphasised the importance of supports for these providers and also the need for adequate transition time
- various ways in which other quality systems could be recognised. For example, it was variously suggested that:
 - acknowledgement of current certificates held from competent authorities (eg compliance with food safety standards), removing the need for these areas to be reassessed by the Quality Agency

- providers accredited against health, disability or business standards should be automatically accredited against the aged care standards, particularly for lower risk home and community services
- assessment visits could be co-ordinated between accrediting bodies (to minimise the impact on providers required to meet multiple accreditation requirements).
- questioned whether the proposed implementation date from 1 July 2018 is achievable, noting transitional arrangements need to provide sufficient time for the sector to prepare, including modifying their current quality frameworks and educating staff and consumers about the changes.

C. Next steps

The feedback from public consultation is being considered in further developing the preferred option(s) for quality assessments. In addition, consideration is being given to whether further consultation will be undertaken on implementation of the preferred approach.

Where appropriate, aspects of the new quality assessment arrangements may be piloted prior to implementation. Government agreement and amendments to the legislation will be sought after the preferred quality arrangements are finalised.

Visit the [Department's website](#) to subscribe to announcements and the eNewsletter to keep up to date with important messages affecting the aged care sector, including updates on the Single Quality Framework.

ATTACHMENT A – PROFILE OF RESPONDENTS RESPONDING TO ONLINE SURVEY

Respondents to the online survey were asked to choose the role that best describes them, and the responses are grouped below.¹ Respondents were able to choose more than one role.

Table 1 Role of Respondents to Online Survey

Category of Respondent	Online survey responses Draft Quality Standards Consultation Paper	Online survey responses Quality Assessment Options Paper
Aged care consumer, including family and/or carer	32	12
Aged care service provider	63	55
Aged care worker/professional	42	23
Aged care advocate	16	11
Peak body – consumer	13	8
Peak body – provider	22	12
Peak body – professional	19	7
Other	42	14
Not answered	3	2

¹ A number of respondents ticked more than one category from the lists, so the total number of responses in each table exceeds the total submissions made.

The location where the respondents who completed the online surveys lived/operated was as follows- respondents were able to choose more than one location. ²

Table 2 Location Respondents to Online Survey Lives or Operates

Location of Respondent	Online survey responses Draft Quality Standards Consultation Paper	Online survey responses Quality Assessment Options Paper
Metropolitan	141	84
Regional	105	72
Rural/Remote	80	53
Not Answered	5	5

Aged care providers who responded to the online submission were asked to nominate the type of care their service delivers.³ Respondents were able to choose more than one type of service.

Table 3 Type of Service Delivered by Aged Care Providers Responding to Online Survey

Type of service	Online survey responses Draft Standards Consultation Paper	Online survey responses Quality Assessment Options Paper
Residential care	58	41
Home care	52	43
Commonwealth Home Support Programme services	71	58
Transition care	27	16
National Aboriginal and Torres Strait Islander Flexible Aged Care Program services	9	7
Multi-purpose services	17	10
Innovative care services	7	2
Short term restorative care services	16	11
Not answered	90	63

² A number of respondents provide services in more than one location so the total responses does not equal the number of submissions made.

³ A number of respondents provide services in more than one type of service so the total responses does not equal the number of submissions made.