THE ACCREDITATION PROCESS FOR AUSTRALIAN RESIDENTIAL AGED CARE HOMES: AN INSTITUTIONAL THEORY AND QUALITY PERSPECTIVE

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ABSTRACT

The purpose of this research is to determine the reasons why Residential Aged Care Homes (RACHs) undertake the accreditation process, and to evaluate the influence that the accreditation process has on the quality of services provided by RACHs. Therefore, this research addresses two research questions: 1) In addition to government funding, why do RACHs adopt accreditation standards? 2) What perceived influence does the adoption of accreditation standards have on the quality of RACHs? How is this viewed by different staff members of RACHs?

This research is exploratory in nature, using a descriptive research design with multiple case studies (six) conveniently sampled from New South Wales, Australia. Data collection from RACHs, using in-depth interviews, review of available RACH documentation, and surveys were applied in this research. This facilitated an examination of the data from two different perspectives: 1) from staff directly involved with the accreditation process, and 2) from general RACH staff. The data was analysed from institutional theory and quality perspectives, and propositions were mostly supported.

Findings demonstrate that the main reasons why RACHs adopt the accreditation program include: to improve the quality of services provided to residents, to respond to coercive pressures from the government, an RACH's commitment to quality management, for legitimacy reasons, and to ensure accountability. Concerning whether the adoption of accreditation standards does have an influence on the quality of services provided by RACHs, staff had diverse views. For instance, some staff believes that quality of care has improved, yet others believe that the accreditation process is purely for legitimacy purposes and that the workload resultant from accreditation can negatively affect the care provided to residents. Similarly, there was no consensus whether staff education has or has not increased. Nonetheless, quality of life appears to have been enhanced. Thus, based on the results, whether RACHs being legitimate with the accreditation standards also results in RACHs being legitimate by the government, other RACHs, staff, or residents and their families with regards to the quality of services provided to their residents, is evident only as it relates to quality of life.

DECLARATION

I certify that the work in this thesis entitled "The Accreditation Process for Australian Residential Aged Care Homes: An Institutional Theory and Quality Perspective" has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree to any other university or institution other than Macquarie University.

I also certify that the thesis is an original piece of research and it has been written by me. Any help and assistance that I have received in my research work and the preparation of the thesis itself have been appropriately acknowledged.

In addition, I certify that all information sources and literature used are indicated in the thesis.

The research presented in this thesis was approved by Macquarie University Ethics Review Committee, reference number: 5201000897(D).

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Gabriela Lopes Damiani

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1 INTRODUCTION

The nature and the dynamics of the ageing population is an area of growing concern in Australia, and is exacerbated by projections of decreasing fertility rates and higher life expectancy, which are important factors that will influence the future provision of health and aged care services. Additionally, aged care services expenditure continues to be a significant area of government spending. For instance, in 2009–10 the total Australian, state and territory government expenditure on aged care services was around $11.0 billion, with the majority (66%) of it being on residential aged care services (AIHW, 2011, SCRGSP, 2011). To ensure that residential aged care homes (RACHs) are providing quality care and service for this ageing population, the Australian government introduced an accreditation system in 1997, and the government made a decision to provide funding for RACHs, which meet the accreditation standards. The accreditation assessment of an RACH is performed by the Aged Care Standards and Accreditation Agency (ACSAA), an independent company that was appointed by the Department of Health and Ageing (DoHA) (ACSAA, 2012g), and the accreditation process is comprised of continuous announced and unannounced quality inspections[1]. As a result, the receiving of money by RACHs from the government is contingent upon being accredited. However, there are some issues and unanswered questions inherent in the current accreditation system, which are discussed in the following section.

1.1 Statement of the Problem

Firstly, there appear to be some extant cost management issues amongst RACHs. The fact that RACHs are spending time and financial resources trying to meet so many different, but similar standards amongst the various regulatory bodies they must comply with can divert resources from the care provided to residents, and apparently does nothing to improve the quality of care (ACSA, 2002). This was also noted in research undertaken by Campbell Research and Consulting (CR&C, 2007), which demonstrated that 91% of quality managers and 70% of care staff agreed that accreditation has increased the costs of running RACHs. In an evaluation made by DoHA (2009b, p.9), the Nurses Board of Western Australia noted that "the administrative and paperwork demands have a real cost in dollar terms and a cost on the emotional and morale demands on staff".

[1] These are further explained in section 3.4.1.2 of this thesis.

Secondly, accreditation comes from adherence to certain requirements. A binary score of "compliant" or "non-compliant" applies for each of the 44 expected outcomes; therefore, even though the standards have a stated focus on identifying continuous improvement, there is a limited capacity for measurement to directly report quality improvement. This criticism is supported by statements in a document released by ANHECA (Australian Nursing Homes and Extended Care Association Limited), such as "Evidence indicates that there is little systematic data that demonstrates how accreditation has impacted on quality of care", and that ACSAA "has not produced any material which would provide the sector or the community with any level of assurance that the overall intention of accreditation in improving service quality has been achieved" (ANHECA, 2005). CR&C (2007) also notes that while accreditation has improved quality in aged care homes by establishing minimum standards for quality and by undertaking assessment of compliance, and whilst it seems to enhance residents' quality of care and quality of life, the actual degree of improvement cannot be established given that there are no measures against which the degrees of quality can be determined across the sector.

Thirdly, the compliance assessment is subjective and open to abuse, given that it is assessed by an individual. According to CR&C (2007, p.30), "the most significant criticism made about the Accreditation Standards is that they lack specificity and are too open to interpretation."

Fourthly, it is unclear whether RACHs undertake the accreditation process because they believe it ultimately improves the level of quality of their services, or because they must do so to receive funds from the government and also gain legitimacy from their stakeholders. Therefore, this may lead us to ask the following questions: How do RACHs view compliance with the accreditation process? How do they view the effort that they have to undergo to achieve accreditation? Do RACHs believe that this effort is worthwhile as leading to the improvement of quality of care? If accreditation were not compulsory, would RACHs still be undertaking it? Furthermore, is there a relationship with the level of importance that different RACHs attach to the standards of the accreditation system?

The four broad issues listed above underpin the importance of the context of this research. They highlight that it is not clear whether the accreditation program managed by ACSAA does enhance the level of quality of services provided by RACHs. There are also suggestions that the adoption of accreditation may even augment the running costs of RACHs, which is a pertinent issue given the funding levels in the health services sector. Accreditation could

therefore provide a tension between the funding levels which are needed by the RACHs, and the increased costs brought about by its adoption; without necessarily leading to the improvement of quality of services, quality of care and quality of life.

1.2 Purpose of Research

The aim of this research is to determine the reasons why RACHs undertake the accreditation process and therefore adopt accreditation standards, and to analyse the influence that the accreditation process has on the quality of RACHs. This will be achieved using institutional theory. This study will survey six (6) RACHs in New South Wales (NSW), Australia. It will investigate the reasons why RACHs adopt the accreditation standards, and it seeks to find out if they implement them because they believe it will improve their quality level or because they need to receive funds from the government and also gain stakeholder legitimacy. This will allow the researcher to examine how important the accreditation process is for RACHs in terms of improving their level of quality.

1.3 Research Questions

The research questions are:

1. In addition to government funding, why do RACHs adopt accreditation standards?
2. What perceived influence does the adoption of accreditation standards have on the quality of RACHs? How is this viewed by different staff members of RACHs?

To address the research questions, the following propositions have been developed:

P1: Adoption of accreditation standards improves the quality of care provided to residents.

P2: Adoption of accreditation standards improves residents' quality of life.

P3: Accreditation standards are adopted by RACHs to influence the level of quality of their services.

P4: Accreditation standards are adopted by RACHs to ensure funding from the Australian government.

P5: Accreditation standards are adopted by RACHs to improve their standing in the eyes of stakeholders.

1.4 Motivation of the Study

This study is motivated by many aspects that, together, support the importance of this research. Firstly and most importantly, aged care is a major aspect of Australia's health care system, with the Australian government divulging a comprehensive aged care reform package in April 2012 ($3.7 billion over five years) that aims to "build a better, fairer, more sustainable and more nationally consistent aged care system", and which recognises the need for being more transparent with regard to the quality of aged care services (AIHW, 2012a, DoHA, 2012j, AIHW, 2012b). This, in conjunction with revisions of the Aged Care Act, demonstrates a government endeavour to exercise continuous improvement as it relates to quality in the aged care sector. Secondly, the majority of all government expenditure on aged care services is spent on RACHs which, combined with the fact that the Australian ageing population continues to grow, will result in the need to provide additional quality aged care services and RACHs to this cohort. It is also motivated by the need to determine whether the government funding provided to RACHs is being efficiently and effectively utilised with the current accreditation system in place, and ultimately achieving its objective of improving the quality of care and services in RACHs. Finally, given that the accreditation standards are currently under revision, this research may potentially provide recommendations with regard to the importance that RACHs attach to the accreditation standards, and on how they believe the process can be further improved. The Australian government has already recognised that there is a need to improve the accreditation process (with a revision currently in place), and also that currently little systematic data is available to demonstrate how accreditation has impacted on the quality of care (ANHECA, 2005). Hence, this study can also provide valuable insights and direction to Australian RACHs, to ACSAA and the Australian Government policies with regard to aged care.

1.5 Contribution of the Study

This research may potentially benefit the aged care system in Australia, and make contributions in terms of empirical, theoretical, and practical perspectives.

From an empirical perspective, this research has the potential to address paucity in the current literature as it relates to quality and accreditation in health care, more specifically in Australian aged care homes. This will be of great importance to the academic community as it will demonstrate how the accreditation process influences RACHs with regard to areas such as quality of services, continuous improvement, benchmarking, and cost.

From a theoretical perspective this research has the potential to (i) identify the reasons why RACHs adopt the accreditation process (e.g. gain stakeholders legitimacy, improve quality of services, because it is compulsory), (ii) determine how institutional pressures (i.e. coercive, mimetic and normative pressures) influence the adoption of the accreditation process by RACHs, and (iii) address the paucity of current literature (i.e. institutional theory as it relates to quality and accreditation in aged care). Therefore, this study has the potential to contribute to the theory as it relates to whether RACHs adopt accreditation to become isomorphic and therefore gain legitimacy from their stakeholders, to improve the quality of services provided to residents and consequently be able to attract more business and increase their revenue stream, or simply because it is compulsory. This study also has the potential to contribute to the theory by exploring: a) the coercive pressures faced by RACHs as it relates to quality in aged care; given that coercive pressures are present in regulatory accreditation standards; b) the normative pressures that arise from, for example, industry networks and associations; and c) the mimetic pressures resultant from, for example, benchmarking and how this is viewed by the industry.

From a practical perspective, this research has the potential to describe the nature and extent of the influence that the adoption of accreditation standards has and can have on the quality of RACHs. As the Australian population is ageing, more places need to be made available in RACHs. Therefore, it is important to determine how RACHs view accreditation with regard to how, and to what level, the accreditation process influences the quality of services provided by RACHs. Hence, this research has the potential to inform how improvements can be made with regard to (i) legislation relating to accreditation standards, and (ii) how compliance with

accreditation standards are assessed. These are valuable contributions, which directly influence the management practices of RACH, and particularly at a time where the accreditation standards are under revision.

1.6 Chapters Outline

The study consists of the following chapters:

- This chapter, chapter one, described the problem statement and purpose of research; presenting reasons why there is the necessity to undertake the proposed research and sets out the objectives of the study. It also described the research questions, propositions, motivation and contribution of this study.

- The literature review of this study consists of three chapters:
    - Chapter two constitutes the context for this study; it portrays the Australian ageing population and its trends, followed by a description of the aged care system in Australia and how the funding for RACHs is provided.
    - Chapter three concerns the nature of quality management and accreditation. It explores the foundation of quality management, quality management components, quality in the service industry, and quality management systems; which includes the accreditation process managed by the Aged Care Standards and Accreditation Agency, the focus of this study.
    - Chapter four focuses on the new institutional theory and its affect in organisations. It also examines the use of institutional theory in other research, highlighting possible areas that can be investigated in this research.

  Therefore, the literature review consists of these three chapters that together, provide support for the conceptual model. Collectively, they contribute to determining how quality, accreditation, and institutional theory influence residential aged care homes in Australia, and consequently its ageing population.

- Chapter five explores the research method that was used in this study.

- Chapter six concentrates on quality and accreditation to explain the results and findings related to the data collected.

- Chapter seven uses institutional theory to explain the results and findings related to the data collected.

- Finally, Chapter eight provides recommendations, conclusions and areas for future research.

2 AGEING POPULATION AND THE AUSTRALIAN AGED CARE SYSTEM

The motivation for this study is that aged care is one of the major aspects of Australia's health care system. Its importance is demonstrated by the money value of the reform unveiled in April 2012, $3.7 billion, to manage the growth of the Australian ageing population and its consequences for the Australian aged care system. Therefore, seeking to demonstrate the relevance and practical contribution of this study, this chapter commences by positioning and comparing Australia against other countries in terms of its projected population, fertility rates, and life expectancies. Then, a categorisation of the Australian aged care system is undertaken with the aim of clearly identifying the focus of this study, and of exploring how the Australian Government provides subsidies to Residential Aged Care Homes (RACHs). This understanding will assist in answering the research questions and determining the research propositions for this study. Hence, this chapter constitutes the context for this study, and it provides a constructive background to a discussion of the Aged Care Standards and Accreditation Agency in chapter three.

2.1 The Worldwide Ageing Population

This section provides a description of ageing populations around the world, focusing on the projected populations in several countries including Australia, fertility rates in Australia, and life expectancy in Australia.

The ageing population is becoming an increasing concern within developed countries. This is due to low fertility rates (which remain below the replacement level and mortality rates), an increasing life expectancy, and the retirement of the aged population from the workforce (Chaloff, 2008, Hagemann and Nicoletti, Martins et al., 2005, Productivity Commission, 2005, Turner et al., 1998). As a result, the provision of health services and appropriate housing and/or aged care facilities for the ageing population will need to be very well managed.

2.1.1 Projected Populations

Table 2.1 shows the past and projected population by age within different countries, providing a good comparative overview of the critical situation in developed countries.

Table 2.1 - Population Age Structure, International Comparison

Population age structure, International comparison(a) - at 30 June

	2010				2015(b)				2010 - 2015	
Selected countries	Aged 0-14 years %	Aged 15-64 years %	Aged 65 years and over %	Median Age years	Aged 0-14 years %	Aged 15-64 years %	Aged 65 years and over %	Median Age years	Total fertility rate(c) rate	Life expectancy(d) years
Australia	**18.9**	**67.5**	**13.6**	**36.9**	**17.6**	**66.0**	**16.4**	**39.9**	**1.9**	**82.0**
Canada	16.3	69.6	14.1	39.9	15.8	68.2	16.0	40.9	1.6	81.4
China (excl. SARs and Taiwan)	19.9	71.9	8.2	34.2	19.0	71.5	9.4	35.6	1.8	74.0
Hong Kong (SAR of China)	11.5	75.6	12.9	41.9	10.6	74.4	14.9	43.8	1.0	82.8
France	18.4	64.6	17.0	40.1	18.1	62.8	19.1	41.3	1.9	81.9
Greece	14.2	67.5	18.3	41.6	14.1	66.4	19.5	43.3	1.4	80.1
India	30.8	64.3	4.9	25.0	28.7	65.9	5.4	26.5	2.5	65.2
Indonesia	26.7	67.2	6.1	28.2	24.9	68.5	6.6	30.1	2.0	72.2
Italy	14.2	65.4	20.4	43.3	14.0	64.1	21.9	45.1	1.4	81.6
Japan	13.2	64.2	22.6	44.7	12.4	61.3	26.3	46.6	1.3	83.7
Republic of Korea	16.2	72.8	11.0	37.9	14.1	73.0	13.0	40.7	1.3	80.0
Malaysia	29.1	66.1	4.8	26.3	27.2	67.0	5.8	28.0	2.4	75.2
New Zealand	20.2	66.8	13.0	36.6	19.6	65.9	14.5	37.4	2.0	81.0
Papua New Guinea	39.5	58.1	2.5	20.0	37.4	59.8	2.8	20.9	3.8	62.3
Philippines	33.5	62.2	4.3	23.2	31.6	63.6	4.8	24.5	2.9	72.9
Singapore	15.6	74.2	10.2	40.6	12.9	73.6	13.6	43.4	1.3	81.0
South Africa	30.3	65.1	4.6	24.9	29.6	65.1	5.3	25.7	2.4	52.9
Sweden	16.5	65.2	18.3	40.9	17.0	63.0	20.1	41.6	1.9	81.6
United Kingdom	17.4	66.0	16.6	39.9	17.2	64.9	17.9	40.3	1.9	80.1
United States of America	20.2	66.8	13.0	36.6	19.8	65.9	14.3	37.2	2.0	79.9
Viet Nam	25.1	68.6	6.3	28.5	23.1	70.3	6.6	30.2	2.0	75.4
World	**26.9**	**65.5**	**7.6**	**29.1**	**26.0**	**65.8**	**8.2**	**30.2**	**2.5**	**68.9**

(a) Selected countries included major OECD countries, the world's most populous countries, our closest neighbours and trading partners.
(b) International data are United Nations medium variant projections. Australian data are ABS medium series (Series B) projections.
(c) Births per woman. United Nations are medium variant projections for the period 2010-2015.
(d) Life expectancy at birth. United nations are medium variant projections for the period 2010-2015, for males and females combined.
Source: All international data and Australian total fertility rate and life expectancy figures have been sourced from World Population Prospects, 2008 Revision. Australian 2010 estimates from this publication are from ABS, **Australian Demographic Statistics** (cat. no. 3101.0), Mar 2010 and Australian 2015 population projections are from ABS, **Population Projections, Australia 2006 to 2101** (cat. no. 3222.0).

Source: (Australian Bureau of Statistics (ABS), 2010)

As indicated in Table 2.1, Australia faces a very challenging future in relation to the age structure of its population, levels of fertility rates, and levels of life expectancy. This is due to 16.4% of the Australian population being expected to be aged 65 years and over by 2015, while having a very low fertility rate of 1.9 births per woman and the third highest life expectancy in the world of 82 years old. This positions Australia behind Hong Kong (Special Administration Region (SAR) of China) and Japan in terms of life expectancy, which are expected to be 82.8 and 83.7 years old in 2015 respectively. To further contextualise the Australian situation, the following comparisons from Table 2.1 (ABS, 2010) are noted:

- The United Kingdom (UK) has a fertility rate equal to Australia; however, people are expected to live 1.9 years less. Even though the UK's current percentage of people aged 65 years and over, is higher than in Australia, it is expected to increase by only 1.3 percentage points by 2015 compared with the same cohort in Australia, which is expected to increase by 2.8%.

- In New Zealand (NZ), the percentage of people aged 65 years and over is expected to increase by 1.5% of the total population, while in Australia this group is expected to increase by 2.8%. New Zealand has a lower life expectancy and a slightly higher fertility rate.

- The United States of America (USA) is also in a more manageable position compared to Australia. Even though it has a similar fertility rate, it has a lower life expectancy. Also, its percentage of people aged 65 years and over is expected to increase by 1.3%, which is 1.5% less than in Australia.

- Japan is the country facing the most challenging situation, with its life expectancy projected to be 83.7 years old (compared to Australia, whose life expectancy will be 82 years old) whilst having the second lowest expected fertility rate (only behind Hong Kong (SAR of China)). Japan is also predicted to have an increase of 3.7% of its 65 years and older population, increasing from 22.6% in 2010 to 26.3% by 2015.

Therefore, according to the information presented on Table 2.1, Australia is the country expected to have the 3rd highest increase in the number of people aged 65 years and over from 2010 to 2015, just behind Japan and Singapore; placing Australia on the top of the list of non-Asian countries.

In Australia, further projections in terms of its ageing population, levels of fertility rates, and life expectancy, illustrate an even more critical picture.

Table 2.2 illustrates that the population aged 65 years and over is expected to increase from 2.6 million people in 2004 to between 7.0 million to 9.0 million in 2051, and between 6.8 million to 12.8 million people in 2101. It also illustrates that the population aged 85 years and over is expected to increase from 295,000 people in 2004 to between 1.6 million and 2.7 million in 2051, and between 1.7 million and 4.3 million people in 2101, (ABS, 2006b). A combination of both populations in either Series A or Series C will represent approximately 35% of the total projected population.

Table 2.2 - Projected Population, By age group – Australia at 30 June 2004

PROJECTED POPULATION, By age group—Australia

	0–14 YEARS			15–64 YEARS			65 YEARS AND OVER			85 YEARS AND OVER		
At 30 June	*Series A*	*Series B*	*Series C*	*Series A*	*Series B*	*Series C*	*Series A*	*Series B*	*Series C*	*Series A*	*Series B*	*Series C*
					NUMBER ('000)							
2004(a)	3 978.8	3 978.8	3 978.8	13 507.9	13 507.9	13 507.9	2 604.9	2 604.9	2 604.9	295.6	295.6	295.6
2005	3 988.5	3 979.4	3 972.9	13 694.7	13 676.0	13 668.4	2 668.8	2 668.3	2 668.1	311.6	311.5	311.5
2006	3 998.2	3 975.9	3 958.6	13 883.1	13 844.2	13 820.9	2 736.2	2 735.2	2 734.7	332.7	332.7	332.7
2011	4 088.3	3 961.3	3 846.6	14 723.3	14 566.3	14 426.9	3 176.1	3 171.6	3 167.8	431.9	431.8	431.7
2021	4 515.1	4 038.7	3 585.8	15 809.1	15 360.7	14 945.6	4 554.2	4 472.0	4 457.0	608.8	584.4	583.7
2031	4 872.3	4 150.6	3 478.7	16 807.0	15 842.2	14 952.1	6 154.4	5 780.1	5 740.7	1 006.3	856.1	853.2
2041	5 074.6	4 200.4	3 416.4	17 911.9	16 272.0	14 771.1	7 656.7	6 696.9	6 592.5	1 810.0	1 293.7	1 287.0
2051	5 387.4	4 244.5	3 261.5	18 953.5	16 645.8	14 561.5	9 048.8	7 279.4	7 041.5	2 690.0	1 620.0	1 603.7
2091	6 535.0	4 477.4	2 915.9	22 918.0	17 496.6	12 988.4	12 181.3	8 267.0	7 059.6	4 093.1	1 983.7	1 824.3
2101	6 786.7	4 529.3	2 861.6	23 877.4	17 671.2	12 647.5	12 800.1	8 394.3	6 873.7	4 324.3	2 006.0	1 736.1

Source: (ABS, 2006a, p.42)

2.1.2 Fertility Rates

Three assumptions for Australia's future levels of fertility rates (which remains below the replacement level and mortality rates) can be made from recent trends in the total fertility rates (TFR), particularly those of the last decade (ABS, 2006a). The high fertility scenario assumes a fertility rate of 1.9 babies per woman, the medium fertility scenario assumes a rate of 1.7 babies per woman, and the low fertility scenario assumes a rate of 1.5 babies per woman. The medium and low fertility assumptions, for example, assume a continuation of factors associated with declining fertility, such as delayed childbearing due to the increased participation of women in education and in the labour force. Under the three scenarios, the age-specific fertility rates are assumed to continue declining for women below the age of 30 whilst increasing among women aged 30 years and over. As a consequence, the mean age of the fertility schedule has risen from 28.7 years in 1993 to 29.9 years in 2003, and is expected to increase to 31.9 years by 2018 if the trend continues (ABS, 2006a). Decreasing fertility rates will result in changes in the age structure, where the proportion of older people increases as the proportion of younger people declines; additionally there will be a distinct increase in the number of older people in the population. These changes are important factors that will impact on the future provision of income support and health and aged care services, as well as having implications for economic growth (Productivity Commission, 2005).

2.1.3 Life Expectancies

Life expectancy is also expected to increase. It is estimated that by 2050-51 life expectancy at birth will be 84.9 years old for males, and 88.0 years old for females (ABS, 2006a). This is a significant increase compared to the early 1900's and early 2000's, as Table 2.3 shows. Higher life expectancy for females is expected in all states and territories, except in the Northern Territory, which has a higher proportion of Indigenous Australians who seem not to have ready access to clean water and to quality care and have been found to suffer from the poorest health of all Australians (Steering Committee for the Review of Government Service Provision (SCRGSP), 2011; Reconciliaction, 2007). The phenomenon of higher female life expectancy will affect the demand for aged care services, since females tend to use them more than males do (particularly residential services). This is primarily due to the fact that they tend to live longer and therefore do not have a partner to care for them (SCRGSP, 2011).

Table 2.3 - Life expectancy at birth in Australia

	1901 – 1910	**2001 – 2003**	**2050-51**
Male	55.2 years	77.8 years	84.9 years
Female	58.8 years	82.8 years	88.0 years

Adapted from (ABS, 2006b, pg. 18 & 19)

Therefore, the ageing of populations will affect many different types of services, including aged care which is a major component of the Australian health care system. This will in turn affect how services are offered to this ageing population, and proper quality management will be essential. This is particularly important because, as will be seen in chapter four, managing quality in services is more challenging than in manufacturing and not properly managing it can add to the costs of services without necessarily improving the quality of services provided.

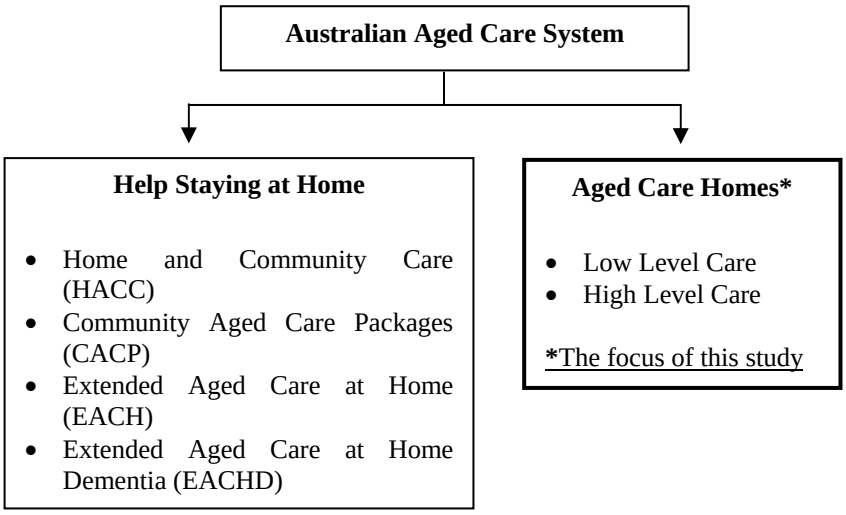
Nonetheless, even though many countries face similar concerns relating to an ageing population, they may have different approaches to the regulation of their aged care system. The different approaches utilised by other countries will not be examined in detail in this research, given that the focus of this study is "Residential Aged Care" within the Australian Aged Care System. However, at this point it is pertinent to mention that different countries employ different terms for "Residential Aged Care" than Australia. For example, the United Kingdom refers to "Residential Aged Care" as "Care Home", the United States of America as

"Nursing Homes", Japan as "Facility Services", and New Zealand is similar by referring to it as "Residential Care". In Australia, it is also referred to as "Aged Care Homes", "Aged Care Facilities", "homes", and "facilities". These terms will be used interchangeably in the subsequent chapters of this thesis when examining empirical studies that have utilised, for example, quality management and institutional theory in the area of health care. Meanwhile, the remainder of this chapter will concentrate on the aged care system in Australia to describe the context of this study.

2.2 The Aged Care System in Australia

As observed in the first part of this chapter, the ageing of populations will affect many different types of services. Under the categorisation of service activities provided by Dicken (1998), both personal services (house cleaning/maintenance, nursing, day care services) and health-related services (human health services such as hospital services, medical and dental services) are an element of the Australian aged care system. The Australian aged care system comprises services from a wide range of schemes where older people have a chance to live in their own homes and maintain their independence, through to aged care homes. Therefore, the aged care service provided by the Australian Government to its ageing population is divided into two main types of care, named "Help staying at home" and "Aged care homes" (DoHA, 2011g) in Figure 2.1. "Help staying at home" provides older people with the opportunity to stay in their own homes and to live independently in the community. On the other hand, "Aged Care Homes" (the focus of this study) are designed for those who are no longer able to live in their own home and therefore need to move into a residential aged care home (RACH). The services that comprise the Australian aged care system are further explained in more detail below.

Figure 2.1 - The Australian Aged Care System



Whenever older people require the support from any of the programs indicated in Figure 2.1 (except Home and Community Care) because they are no longer able to manage their lives without assistance, they firstly need to contact the Aged Care Assessment Team (ACAT[2]). ACATs are teams of health professionals (which may include geriatricians, nurses, social workers, occupational therapists, and psychologists or physiotherapists) that will, through an assessment of their care needs, assist aged persons to find out what style of care will best satisfy their needs (DoHA, 2011e). The assessment is free of charge, and will remain valid indefinitely if the person was approved for high level care in RACHs, or an EACH or EACHD package of care. A new assessment is needed for low level care in RACHs and CACP if the person has been approved but has not yet received care within 12 months (DoHA, 2011d, e). A brief overview of the programs indicated in Figure 2.1 is provided below.

2.3 Help Staying at Home

For those who need extra help at home, or for those who want to stay at home rather than go into an aged care facility, a wide range of services is available. The community care programs and services comprise four main components (HACC, CACPs, EACH, and EACHD), which are described below (DoHA, 2012h):

1. The Commonwealth Home and Community Care (HACC) Program provides some basic help with everyday tasks, and can assist by supporting people's independence at home and in the community. It is considered an ideal solution if long-term care in an aged care home is inappropriate and only low-level care is needed. "Under the new program, the Australian Government will take full funding, policy and operational responsibility for HACC services for older people in all states and territories (except Victoria and Western Australia). The state and territory governments will continue to fund and administer HACC services for people under the age of 65 or under 50 for Aboriginal and Torres Strait Islander people." (DoHA, 2012b)
2. The Community Aged Care Package (CACP) is for those who have complex care needs and would like to remain living in their own homes and provides a planned and managed package of community care services.

[2] In Victoria, ACAT is called ACAS (Aged Care Assessment Service)

3. The Extended Aged Care at Home (EACH) packages offers services to fulfil high-care needs through an individually tailored package whilst the person stays in their own home.
4. Extended Aged Care at Home Dementia (EACHD) packages are aimed specifically at frail older people with dementia related high-care needs and includes qualified nursing input.

Those who require CACPs, EACH, or EACHD assistance will need to pay fees for these services, which are agreed with the service provider. If the person is on the basic pension, they cannot be asked to pay more than 17.5% of the pension ($8.69 per day as at 20 March 2012 (DoHA, 2012i)), and if the person is on a higher income he/she will be asked to pay an additional fee of no more than 50% of that higher income. However, no one can be denied assistance by the government because of an inability to pay the requisite fees (DoHA, 2012g, 2011c, 2012f).

In addition to the services listed above, the government also provides services such as short-term care (which include respite care and transition care), and allied health services. Respite care is the provision of support either at the person's home or at an RACH. It is for older people and people with a disability who may need extra care for a short period, and also for their carers who may need a break to deal with their own matters (DoHA, 2011g, f). Transition care is for those who have just been to hospital and need a little extra help and therapy which is offered either in hospital, an aged care home or the person's own home; which then allows the care recipient to decide what level of care will best suit his/her care needs from thereon (DoHA, 2011f). Finally, allied health services assist people in maintaining their physical and emotional well-being and also with rehabilitation and adjustment to new limitations. These services include counselling, day therapy, physiotherapy, occupational therapy, speech therapy and podiatry (DoHA, 2011g).

The availability of Commonwealth-funded packages for those who are eligible for residential aged care has increased over the years, given that the Commonwealth-funded packages are an alternative intended to allow people to stay at home as long as possible, and in turn influences RACHs' occupancy rates (AIHW, 2011). The community care programs and services constitutes a more effective and efficient cost management of the government's funds as compared to RACHs. However, even with a significant increase in the demand for stay-at-

home care, there will also be an increasing demand for residential care, which the government has already recognised (DoHA, 2012j).

2.4 Aged Care Homes

Residential Aged Care Homes (RACHs) are for those people who can no longer live at home due to reasons such as illness, disability, bereavement, an emergency, the needs of their carer, family or friends, or because it is no longer possible for them to manage at home without assistance and therefore require a place where they will be taken care of (DoHA, 2011a). RACHs provide two broad types of permanent care; low care and/or high care, which are better described on Table 2.4. Some RACHs also provide extra services to their residents, which involve providing a "significantly higher than average standard of accommodation, services and food" (DoHA, 2011b, p.36). Residential care is provided on a permanent or respite basis; respite care being short term care on a planned or emergency basis (DoHA, 2011b).

Table 2.4 - Types of Residential Aged Care Accommodations

Type of Care	Description
Low level care homes	Formerly known as hostels. Generally provide accommodation and personal care, such as help with dressing and showering, together with occasional nursing care.
High level care homes	Formerly known as nursing homes. Care for people with a greater degree of frailty, who often need continuous nursing care.

Source: Adapted from (DoHA, 2011a, pg.1)

Table 2.5 demonstrates the trends in the number and size of residential aged care services in Australia from 1998 to 2010, and shows that the number of homes in Australia has reduced from 3,015 to 2,772 within this period. However, combining this information with the data presented on Table 2.6, it can be seen that even though the number of homes has reduced, the number of operational places[3] has significantly increased from 134,810 to 182,850; which means that the number of small homes is decreasing while the number of large homes is increasing.

[3] A place that is either occupied or available for the provision of aged care to an approved care recipient, (AIHW, 2011, p. 7).

Table 2.5 - Trends in the number and size of residential aged care services, 30 June 1998 to 30 June 2010

Places	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
							Number						
1–20	396	378	362	335	322	284	266	246	230	213	196	184	179
21–40	1,194	1,188	1,163	1,120	1,069	999	939	874	834	762	695	626	586
41–60	831	852	867	880	888	885	901	921	927	887	848	822	795
61–80	322	325	337	357	376	403	434	458	455	469	475	485	487
81–100	141	146	146	149	164	188	200	220	240	252	270	295	311
101–120	64	70	71	75	77	87	95	107	123	140	174	177	200
121+	67	59	59	61	65	81	97	107	122	149	172	194	214
Total	**3,015**	**3,018**	**3,005**	**2,977**	**2,961**	**2,927**	**2,932**	**2,933**	**2,931**	**2,872**	**2,830**	**2,783**	**2,772**
							Per cent						
1–20	13.1	12.5	12	11.3	10.9	9.7	9.1	8.4	7.8	7.4	6.9	6.6	6.5
21–40	39.6	39.4	38.7	37.6	36.1	34.1	32	29.8	28.5	26.5	24.6	22.5	21.1
41–60	27.6	28.2	28.9	29.6	30	30.2	30.7	31.4	31.6	30.9	30	29.5	28.7
61–80	10.7	10.8	11.2	12	12.7	13.8	14.8	15.6	15.5	16.3	16.8	17.4	17.6
81–100	4.7	4.8	4.9	5	5.5	6.4	6.8	7.5	8.2	8.8	9.5	10.6	11.2
101–120	2.1	2.3	2.4	2.5	2.6	3	3.2	3.6	4.2	4.9	6.1	6.4	7.2
121+	2.2	2	2	2	2.2	2.8	3.3	3.6	4.2	5.2	6.1	7.0	7.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: (AIHW, 2011, p.73)

Table 2.6 - Number of operational residential aged care, CACP, EACH, EACHD, and TCP places, 30 June 1995 to 30 June 2010

Year	Residential aged care[(a)]	CACP	EACH and EACHD	TCP	Total
1995	134,810	2,542	..	..	137,352
1996	136,851	4,431	..	..	141,282
1997	139,058	6,124	..	..	145,182
1998	139,917	10,046	..	..	149,963
1999	141,697	13,896	..	..	155,593
2000	142,342	18,308	..	..	160,650
2001	144,013	24,629	..	..	168,642
2002	146,268	26,425	..	..	172,693
2003	151,181	27,881	255	..	179,062
2004	156,580	29,063	860	..	186,503
2005	161,765	30,973	1,673	..	194,411
2006	166,291	35,383	3,181	595	205,450
2007	170,071	37,997	4,573	1,609	214,250
2008	175,472	40,280	6,240	1,963	223,955
2009	178,290	40,859	6,514	2,228	227,891
2010	182,850	43,300	8,167	2,698	237,015

(a) From 1999 the data in this table include places provided by MPSs, and those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP.

.. Not applicable.

Source: (AIHW, 2011, p.8)

Also, from the data presented on Tables 2.5 and 2.7, it can be noted that RACHs differ in their size (size is related to the number of operational places) and on the type of their organisations, which are divided into three main groups: not-for-profit, government, and private. The characteristics of each type of organisation within these groups are better described in Table 2.8. The characteristics of the different types of RACHs are described to provide context for this research, given that community-based, religious, local government, and private organisations were amongst the six RACHs that participated in this study.

Table 2.7 - Number of residential aged care facilities, by provider type and state/territory, 30 June 2010

Organisation type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Not-for-profit									
Charitable	217	55	60	36	62	15	8	1	454
Community-based	159	117	65	33	48	22	3	4	451
Religious	231	109	211	92	68	27	11	9	758
Total not-for-profit	*607*	*281*	*336*	*161*	*178*	*64*	*22*	*14*	*1,663*
Government									
Local government	21	13	8	8	6	2	0	0	58
State government	15	177	20	2	23	8	0	0	245
Total government	36	190	28	10	29	10	0	0	303
Private									
Total private	244	302	116	73	60	7	4	0	806
Total services	**887**	**773**	**480**	**244**	**267**	**81**	**26**	**14**	**2,772**
					Per cent				
Not-for-profit									
Charitable	24.5	7.1	12.5	14.8	23.2	18.5	30.8	7.1	16.4
Community-based	17.9	15.1	13.5	13.5	18.0	27.2	11.5	28.6	16.3
Religious	26.0	14.1	44.0	37.7	25.5	33.3	42.3	64.3	27.3
Total not-for-profit	*68.4*	*36.4*	*70.0*	*66.0*	*66.7*	*79.0*	*84.6*	*100.0*	*60.0*
Government									
Local government	2.4	1.7	1.7	3.3	2.2	2.5	0.0	0.0	2.1
State government	1.7	22.9	4.2	0.8	8.6	9.9	0.0	0.0	8.8
Total government	4.1	24.6	5.9	4.1	10.8	12.4	0.0	0.0	10.9
Private									
Total private	*27.5*	*39.1*	*24.2*	*29.9*	*22.5*	*8.6*	*15.4*	*0.0*	*29.1*
Total services	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Refers to the location of the facilities.

Source: (AIHW, 2011, p.76)

Table 2.8 - Organisation Type

Charitable	An organisation that intends social value or utility to the general community or an appreciable section of the public, and that is not established primarily to provide profit, gain or benefit to its individual owners or members.
Community-based	An organisation formed for a particular common purpose by members of an identifiable community based on locality, ethnicity or some other identifiable affiliation, whose activities may be carried out for the benefit of its members but which does not provide financial profit or gain to its individual owners or members.
Religious	An organisation whose objectives and activities reflect its character as a body instituted for the promotion of religious objectives and the beliefs and practices of whose members constitute a religion.
Local Government	A body established for the purposes of local government by or under a law of a State or Territory.
State/Territory Government	Includes State or Territory Government authorities, instrumentalities and local health authorities established under State or Territory legislation.
Private Incorporated Body	An organisation that is registered by the Australian Securities and Investments Commission other than as a publicly listed company. A private incorporated body conducts its activities primarily for the financial profit or gain of its owners, members or shareholders.

Source: Adapted from (DoHA, 2006, p.8)

Considering the Australian ageing population projection, lower fertility rates and improved life expectancy rates, the number of operational places available in RACHs in Australia will have to increase so that the growing demand for services can be supplied. All aged care services provided to older Australians, either in the community or in aged care homes, are funded by the Australian Government (funding is discussed in the following section) and they must meet Australian Government standards (DoHA, 2011h). These standards, along with specifications of the care and services[4] (please refer to Appendix 1) that an aged care home must provide, are set out in the Quality of Care Principles 1997 (2012) and include:

- The Accreditation Standards (please refer to Appendix 2)
- The Residential Care Standards (please refer to Appendix 3)

The accreditation standards contain all three standards[5] of the residential care standards in addition to one standard focusing on management systems, staffing and organisational development. The accreditation standards, which is the focus of this study, are further analysed in the next chapter.

2.5 Funding for Residential Aged Care

RACHs receive substantial funds from both the government and residents. Due to the fact that government funds are directly related to compliance[6] with accreditation standards (which will be discussed in chapter three), an overview of the funding distribution is important given the context of this research.

Funding and regulation[7] of aged care services[8] is provided by the Aged Care Act 1997.[9][10] The residential care subsidy is a payment by the Commonwealth to approved providers for

[4] Specifies hotel services and care and services to be provided for all residents of RACHs.
[5] Health and personal care, resident lifestyle, and physical environment and safe systems.
[6] This relationship results in coercive pressures being imposed in RACHs; further considered in chapter four.
[7] The Aged Care Act 1997 states that RACHs must "comply with the Accreditation Standards", and the Accreditation Standards (under the Quality of Care Principles, 1997) state that RACHs must "ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines about health and personal care".
[8] "Aged care service means an undertaking through which aged care is provided. Aged care means care of one or more of the following types: (a) residential care; (b) community care; (c) flexible care." Source: Aged Care Act 1997
[9] "This Act applies in all the (Australian) States and Territories" (Aged Care Act, 1997).

providing residential care to care recipients. This subsidy includes a combination of public (care payments) and private financing (accommodation payments) (DoHA, 2011b), which are described in the following sections. In Australia, more than 343,000 people receive some type of Australian Government subsidised aged care service; in 2010-11, 219,558 of them received permanent residential aged care (DoHA, 2012a, Aged Care Act, 1997). To support the provision of aged care services, the Australian Government's expenditure in 2009-10 was around $11 billion. Of this, 66% was spent on residential aged care services (SCRGSP, 2011, p.439), which represents approximately 70% of the total funding received by RACHs (DoHA, 2011b, p.39). The Australian Government provides subsidies for all types of aged care homes. To receive subsidies from the Australian Government, a Residential Aged Care Home (RACH) must (DoHA, 2007):

- "be operated by an organisation that has been approved by the Australian Government (an 'Approved Provider'[11] (DoHA, 2012e)),
- have an allocation of 'places' which entitles the provider to receive subsidy payments in respect of care recipients occupying those places,
- be accredited by the Aged Care Standards and Accreditation Agency[12]".

However, as observed in chapter one there are some issues in the current accreditation system, and unanswered queries intrinsic to it. Whether being legitimate in complying with the accreditation standards does in fact make RACHs legitimate in terms of enhancing the quality of their services is not yet known.

2.5.1 Care Payments (By the Government)

The provision of residential care to approved residents is generally subsidised by the Australian Government, with residents who have sufficient income being asked to contribute

[10] The Aged Care Act is constantly being amended to address legislative inadequacies and maintain effective regulatory safeguards, with the purpose of ensuring continuous improvement in the legislation with regards to high quality of care for Australians. DOHA 2009a. The Aged Care Amendment (2008 Measures No. 2) Act 2008 (FAQ). Canberra.

[11] "Approved Providers are organisations approved by the Australian Government, to receive subsidies for the provision of aged care, services and accommodation to residents within an aged care home, or care and services to people in the community".

[12] Further information on the Aged Care Standards and Accreditation Agency is provided in chapter three.

to the cost of their care through an income tested fee. Payment per resident comprises the basic subsidy plus any relevant supplements (DoHA, 2011b).

The basic subsidy is determined by the residents' care needs classification according to the ACFI (Aged Care Funding Instrument). The ACFI consists of twelve questions regarding assessed care needs within three different categories (Activities of Daily Living, Behaviour, and Complex Health Care), and each category consists of four levels (high, medium, low or nil) (DoHA, 2011b, 2009d). Notwithstanding, if the resident is able to contribute to the cost of their own care they will be asked to pay an income tested fee (which is based on the resident's income), so that the amount of basic subsidy that the government pays to the provider is reduced (DoHA, 2009d). Relevant supplements include for example: primary care supplement (oxygen supplement, enteral feeding supplement, etc), accommodation supplement (paid on behalf of residents who cannot meet their own accommodation costs), viability supplement (to assist rural and remote areas) (DoHA, 2011b). Receiving these payments from the government by an RACH is contingent on being accredited, otherwise sanctions may be imposed. This is discussed in more detail in chapter three.

2.5.2 Accommodation Payments (By the Resident)

When entering residential care, the resident signs an agreement with the approved provider which sets out the policies and practices that the provider will follow in setting fees for the resident. Even though the Australian Government does not determine the fees that residents pay to RACHs, it sets the maximum level[13] that RACHs can charge the resident. The majority of these fees are normally paid by the residents, with the government paying more where residents cannot afford them. Residents' fees fall into five categories, namely basic daily fees, income tested fees, asset tested accommodation payments, extra service fees, and additional service fees[14] (please refer to Table 2.9). However, not all residents pay all fees (DoHA, 2011b).

[13] "From 20 September 2009, the maximum basic daily fee for all permanent residents who entered an aged care home after 20 March 2008 is 84 per cent of the single basic age pension." DoHA (2011b, viii)
[14] Additional service fees were not described by DoHA (2011b).

Table 2.9 - Residents' Fees

Basic daily fee	A standard contribution paid by all residents in aged care, which is used by the facility to cover costs such as cleaning, maintenance and laundry.
Income tested fee	As explained in the previous section, is paid by those residents who have sufficient income to contribute towards the cost of their care.
Asset tested accommodation payments	Include: • Accommodation bond (for low-level care and extra service) or accommodation charge (for high-level care). The money received from accommodation bonds and accommodation charges are utilised to improve accommodation and services. The average accommodation bond[15] agreed between the RACH and a new resident in 2010-11 was $248,850, compared with $232,276 in 2009-2010[16] • Accommodation charge (for high-level care): In 2010-11, the average daily charge to new residents was $25.14
Extra Service Fees (for RACHs with extra service status only).	Fee paid by resident for receiving extra services (i.e. significantly higher than average standard for accommodation, services and food).

Adapted from: DoHA (2011b)

The accommodation bond, which is described under the "asset tested accommodation payments" category on Table 2.9, is applicable to residents entering low-level care and extra service RACHs, and it is uncapped by the Government. However, DoHA imposes strict requirements related to the accounting and handling of bonds by RACHs, it carefully monitors how these requirements are being met, and how annual reviews of providers' prudential arrangements are conducted with the purpose of protecting the bonds (DoHA, 2011b). These measures were introduced by the Australian Government due to a substantial increase in the size of individual bonds over recent years (DoHA, 2011b).

Hence, the provision of a considerable amount of both public (government) and private (residents) funds to RACHs in Australia strengthens the importance of this research towards determining the reasons why RACHs adopt the accreditation standards; and to what extend the accreditation program improves the level of quality of services provided by RACHs.

2.6 Conclusion

This chapter provides some important demographical information that sets the context and challenging position which worldwide countries, including Australia, are currently

[15] "There are strict prudential requirements related to the accounting and handling of bonds collected by aged care providers. The Department closely monitors how effectively providers are meeting these requirements and conducts an annual review of providers' prudential arrangements". DoHA (2011b, p. 52)

[16] Bond can be paid as a lump sum, through regular periodic payments, or through a combination of both. This is negotiated between the approved provider and the resident DoHA (2011b).

confronting. The growth of the Australian ageing population and low fertility rates combined with a higher life expectancy, will all lead to the need for an expansion in the provision of residential aged care services. As such, the information above presented highlights the motivations and contributions of this study, by describing the context under which this study will be undertaken and demonstrating the current issues concerning residential aged care services in Australia.

In addition, the association between the subsidies provided to RACHs by the Australian Government and the accreditation program introduced as a system to ensure the quality of services provided by these RACHs, is also briefly introduced in this chapter. To assist in answering the research questions of this study and developing propositions, the fundamental characteristics of quality, a detailed description of the accreditation program, and the relationship between the two, will be further explained in the following chapter.

3 THE NATURE OF QUALITY MANAGEMENT AND ACCREDITATION

A motivation of this study stems from an extant and recognised need to improve the accreditation process for Australian residential aged care homes and, on the seemingly scant systematic data available, to demonstrate how accreditation has impacted on the quality of RACHs services. Thus, this chapter, which represents the second literature review chapter of this thesis, begins by briefly exploring the history of quality through the eyes of classic authors, such as Shewhart (1931), Juran (1988, 1989, 1993), Deming (1985, 1986), Crosby (1979, 1984), Ishikawa (1985, 1990), and Donabedian (1968, 1980, 2003). A reflection on the work of these authors is significant to this study because they not only build on each other but also provide the fundamentals of quality management and continuous improvement, which form the foundation for the accreditation process. To provide a better context for this research, this chapter continues by determining the components of total quality management, and describing unique characteristics of services and how they can affect the achievement of quality. Finally, it describes the role of quality management systems and provides a description of the Aged Care Standards and Accreditation Agency (ACSAA). The discourse presented in this chapter 'supports the identification of the gaps in the literature' that warrant the examination of the research questions ("In addition to government funding, why do RACHs adopt accreditation standards?" and "What perceived influence does the adoption of accreditation standards have on the quality of RACHs?") by describing key aspects of quality management and how they influence products/services and customer satisfaction.

3.1 The Foundation of Quality Management

Individuals' and organisations' preoccupations with 'quality' have existed for a long time. For instance, many years ago Shewhart (1931) wrote about establishing standards and controlling the quality of a given product, noting that there is a subjective side of quality as it relates to what we think, feel, or sense, independent of the product itself. Since Shewhart's contributions, the means and strategies used to achieving quality have changed over the years, with the process of quality management undergoing an extensive and continuous transformation. For example, prior to the twentieth century, quality was based only on product inspection by consumers and on the reputation of the craftsmanship. However, the twentieth century has brought a considerable growth of goods and services, both in volume and

complexity, and an increase in demand with respect to their quality (Juran, 1989). As a result, quality management systems were created with the purpose of focusing on quality-oriented activities; for example, quality accreditation bodies that provide organisations with a basis for standardisation and improvement, and then evaluate the organisation based on these standards.

ACSAA is such an accreditation body, and its aim is to improve overall quality in RACH services. Therefore, a brief discourse concerning the foundations of quality management is appropriate since it introduces the various themes that together, constitute quality as a notion. This is achieved through a review of the way quality has been considered by authors including Shewhart (1931), Juran (1988, 1989, 1993), Deming (1985, 1986), Crosby (1979, 1984), Ishikawa (1985, 1990), and Donabedian (1968, 1980, 2003); introducing the quality concepts individually presented by them. The identification and understanding of these concepts is important to the aim of this research, which is to learn how the adoption of accreditation enhances the quality of services provided by RACHs.

3.1.1 Walter Shewhart

The fundamental concepts of total quality management and continuous improvement originate with Walter Shewhart, who is considered the "grandfather" of quality (SkyMark, 2012c)[17]. In defining quality, Shewhart noted that it has two common aspects, namely objective and subjective aspects. His view was that the objective side relates to considering the quality of something independently to the existence of the individual; while the subjective side takes into consideration what the individual thinks, feels, or senses as a result of the objective reality. Hence, Shewhart's definition of quality takes both individuals' and organisations' perception of quality into consideration.

Shewhart (1931) also discussed the difficulties of control, believing that shortage of information significantly hindered the efforts of control and management processes in a production environment (SkyMark, 2012c). So, he developed Statistical Process Control (SPC) methods that supported managers in making scientific, efficient, and economical decisions. Shewhart was also responsible for creating the Shewhart Learning and

[17] SkyMark is a consultancy company for healthcare, education, industry, and other sectors. Its' work focuses on organisations' continuous improvement, and it is founded on the use of management resources which contemplate the various quality authors remarked on in this thesis; hence its applicability to this study.

Improvement Cycle, which combined both creative management thinking with statistical analysis, and which contains four continuous steps that he believed ultimately led to quality improvement: Plan, Do, Study and Act (SkyMark, 2012c).

As indicated in the sections that follow within this chapter, the ideas introduced by Shewhart were later expanded upon by other founding authors such as Deming, whom he taught, and are still implemented nowadays. The fundamentals of his work as it relates to quality control and continuous improvement[18] are directly related to this research, and viewing how his ideas have developed and are used at present will enhance the understanding of these concepts.

3.1.2 Joseph Juran

Joseph Juran who is considered the "father" of quality adopted the definition of "quality is fitness for use" (Juran and Gryna, 1988, p. 2.8, 1993), which has a focus on customer satisfaction. In this instance, a customer is someone who is influenced by a product or a process (i.e. internal and external customers); and a product has different categories: goods, software, services. Hence, customer satisfaction is achieved through two components: product features that meet customer needs,[19] and product freedom from deficiencies:

- Product features refer to quality of design, and it focuses on designing products that are according to customers' requirements. Therefore, the more sophisticated the quality of product design, the higher the costs.
- Freedom from deficiencies refers to quality of conformance, and it has a direct influence on the products' cost. Increasing quality of conformance usually results in lower costs, through a reduction on error rates, rework, waste, and customer dissatisfaction.

Therefore, by achieving quality of design and quality of conformance the organisation achieves fitness for use, and also customer satisfaction.

[18] "The ongoing search for improved methods to reduce or eliminate waste and improve performance areas such as cost, quality and customer service" (LANGFIELD-SMITH, K., THORNE, H. & HILTON, R. 2012. *Management Accounting: Information for creating and managing value,* North Ryde, Australia, McGraw-Hill.

[19] Need: "require (something) because it is essential or very important rather than just desirable" (OXFORD ENGLISH DICTIONARY 2006. "Concise Oxford English Dictionary." revised and edited by C. Soanes & A. Stevenson. *In:* STEVENSON, C. S. A. (ed.). Oxford: Oxford University Press.)

To address quality, Juran developed a methodological approach which is called the Juran Trilogy (Juran and Gryna, 1993). The Juran Trilogy demonstrates a model of how an organisation can enhance its products and business results by better understanding the three processes of the trilogy: quality planning, quality control, and quality improvement (Juran and Gryna, 1988, p.2.6).

1. Quality planning is the process of creating, designing and developing a product, service or process that will successfully achieve established organisational goals and meet required customers' needs. Quality planning involves several issues such as to:
    a. Establish quality goals.
    b. Determine who the customers are, and their associated needs.
    c. Develop product features that respond to customers' needs.
    d. Develop processes that are able to produce those product features.
    e. Establish process controls.

2. Quality control is undertaken to ensure that the organisation's processes run at optimal effectiveness and that goals are being achieved. It also ensures that any level of chronic waste, that is a cost of poor quality that may exist due to various factors including deficiencies in the original planning inherent in the process, does not worsen. Quality control involves choosing how control will be performed and measured, setting goals, evaluating real quality performance; comparing actual performance to quality goals; and then acting on the outcomes or results of the comparison.

3. Quality improvement is the process of raising quality performance to unprecedented levels by "breakthroughs", which encourage organisations to constantly challenge and improve their processes. Quality improvement comprises establishing the need, identifying projects, and organising teams with clear responsibilities for bringing the project to a successful conclusion. Finally, it is important to provide the resources, motivation and training needed by the teams to: diagnose the causes, stimulate establishment of a remedy, and establish controls to keep the profit.

All three trilogy processes are essential for organisational vitality, but independently they are insufficient. Hence, all three must be accomplished by managers. However, for the trilogy to

be a successful framework for achieving quality objectives, it is essential that the organisation's processes rely on a foundation of inspirational leadership and environment, with work practices deeply supportive of quality (Juran and Gryna, 1988, 1993).

Juran's concept of quality includes Shewhart's fundamentals of control and continuous improvement, and adds the importance of planning based on organisational goals and customer needs. Juran's definition of the quality concepts of design, conformance and control greatly contributes towards this research. For instance, quality of design relates to RACHs providing services that are according to residents' requirements, while quality of conformance relates to RACHs not only satisfactorily fulfilling customer requirements but also the accreditation requirements managed by ACSAA. Given that the accreditation standards have a strong focus on residents, and that the accreditation process is a type of quality management system that is used to control RACH processes, adoption of accreditation should therefore result in RACHs achieving quality of conformance.

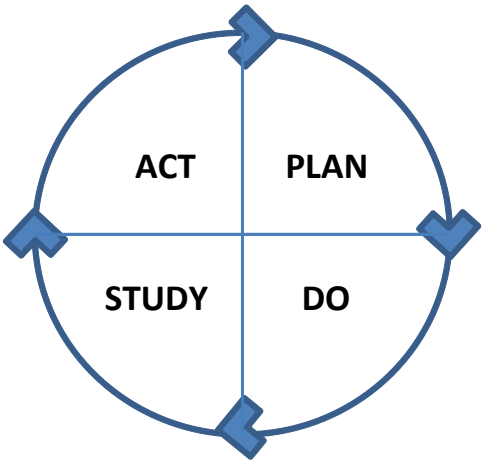
3.1.3 W. Edwards Deming

W. Edwards Deming was responsible for developing the "Fourteen Points" (please refer to Appendix 4), which was a key tool in leading Japanese industry into new principles of management, and which also provided direction to the management and transformation of American organisations (Deming, 1986, 1985). The "14 points" outline methods for achieving quality and productivity, and provide managers with a framework for action and a basis on which they can formulate a plan whenever they encounter a lack of experience with something in particular (Gitlow and Gitlow, 1987).

Deming observed that quality management is a theory of administration to improve quality, productivity and competitiveness, and that to achieve success everybody's best effort and everyone working together with a common aim is needed. However, he noted that without a method, a system of improvement, it is not possible to achieve the desired goals, not even to improve quality. Hence, Deming proposed a system of improvement, which is consistent with the implementation of the "Fourteen Points" mentioned above, and consistent with the removal of "Deadly Diseases" and "Obstacles" (please refer to Appendix 4) (Latzko and Saunders, 1995, Deming, 1986).

Deming also became known for proposing the utilisation of the Shewhart Cycle as a tool to assist organisations to make continuous improvements. The Shewhart Cycle is incorporated within the 14 points, and was widely utilised by Japanese organisations by the name of the Deming Cycle (please refer to Figure 3.1), and under which name it has been called by since then (Deming, 1986). The aim of the Deming Cycle is to place businesses processes in a continuous feedback loop, so that parts of the processes that need improvements can be identified and adjusted continuously (Gitlow and Gitlow, 1987).

Figure 3.1 - The Deming Cycle



Source: Adapted from (Deming, 1986)

The Deming cycle is composed of four steps (plan, do, study, act), which are listed below (Gitlow and Gitlow, 1987).

- **Plan** involves determining what needs to be accomplished, collecting data, developing a plan with actions that must be undertaken, and a timeframe for their completion.
- **Do** includes taking the necessary actions so as to execute what was planned in the first step.
- **Study** (also known as "Check") involves comparing the results of the actions to what was originally planned.
- **Act** consists of undertaking the necessary changes to the original plan so as to improve the process and better achieve customer satisfaction.

The ideas and systems introduced by Deming also proposed a transformation in the relationship between company and staff, and management and suppliers. They focused on an

open relationship, where the exchange of information about processes, their faults and possible solutions became more efficient. For instance, employees begin to know their job in detail and consequently the problems related to it, and so they are able to contribute to solutions to the problems. Suppliers also play an important role in the success of quality management within organisations, since they are the ones that will provide the necessary raw material (Latzko and Saunders, 1995).

Throughout Deming's work, it is observed that productivity increases with enhanced quality, given that rework lessens which in turn achieves waste reduction. And to enhance quality it is necessary to identify who the customers are, along with their needs, inputs and outputs. Additionally, a combination of new equipment, new technology and new ideas, together with adequate administration, results in an increase in productivity (Deming, 1985, 1986).

The contributions made by Deming are very important to this research. For instance, the Deming Cycle presented above is the model provided to RACHs by ACSAA as to be used for continuous improvement and revision of processes (ACSAA, 2009). Also, Deming highlights that productivity increases with enhanced quality, and so it will be interesting to learn whether RACH's adoption of accreditation standards does in fact enhance quality and as a result, increases RACH's staff productivity with regard to caring for the residents.

3.1.4 Phillip Crosby

Juran and Deming were the "great brains" of the quality revolution. Phillip Crosby, however, outshone them by uncovering a terminology for thinking about quality that was plain and simple to understand by everyone (SkyMark, 2012b). Additionally, Crosby was responsible for significant contributions which are considered foundational elements to the body of quality knowledge, such as the Four Absolutes of Quality Management listed below (Crosby, 1984, Phillip Crosby Associates, 2012):

- Quality is defined as conformance to requirements, not goodness: The organisation is placed in the position of investing in intellectual property, rather than operating with opinions and experiences only.
- The system for causing quality is prevention, not appraisal: It is possible to prevent something when the process of doing it is understood. The secret of prevention is to look at the process and identify opportunities for errors.

- The performance standard must be zero defects, not acceptable quality levels: Management must tell people what is expected from them, as people perform to the standard they are given.
- The measurement of quality is the price of non-conformance, not indexes: All the expenses involved in doing things wrongly.

Crosby (1979) also promoted the idea that quality is free, and that what costs money are the 'unquality' things; that is, all the actions that involve not doing jobs right the first time. He stated that quality management is a systematic method utilised to guarantee that organised activities happen the way they were planned. It means acting proactively, and creating attitudes and controls in order to prevent problems that might occur. Additionally, for effective quality management to be achievable and successful, it must start at the top. Quality professionals must guide the program, but its execution is the obligation and opportunity of the people who manage the operation (Crosby, 1979). To assist organisations in implementing a successful quality management program, Crosby developed the quality management maturity grid and a quality improvement program composed of 14 steps (please refer to appendix 5). The maturity grid assists managers in determining the exact status of their organisation's quality program, and can be used by all staff members to rate the company as they see it. From that point, managers can start introducing a quality management program based on the 14 steps.

Hence, quality implementation must start with top management; and achieving quality implicates achieving quality of conformance. Crosby's thinking is consistent with that of Juran given that he defined quality as conformance to requirements. Conversely, whilst Juran looks at quality of conformance according to the customers' requirements, Crosby is not specific and describes quality of conformance based on the organisation's perspectives; observing the importance of organisations having requirements clearly stated so that they cannot be misinterpreted.

Nonetheless, Crosby's thinking alongside that of Juran assists in providing a broader understanding of the notion of quality of conformance, which is a key concept to be used in this research. Crosby also highlights the importance of staff acting proactively to prevent problems, the importance of top management being directly involved in the pursuit of quality, and the importance of being clear on specific requirements so that employees know what to follow.

The notions of quality presented by Crosby emphasise the value of learning the views of RACH staff and managers as they relate to the influence of the accreditation program on the quality of their services. Looking at quality from their perspective demonstrates their commitment, or not, to the program.

3.1.5 Kaoru Ishikawa

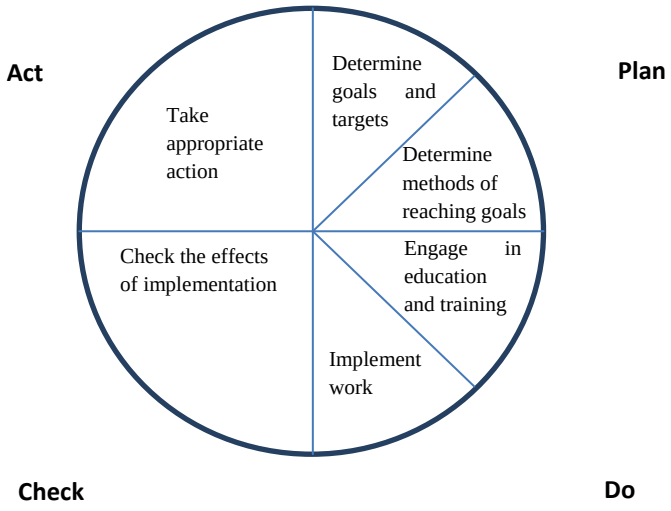
Kaoru Ishikawa was given the Shewhart Medal for "his outstanding contributions to the development of quality control theory, principles, techniques and standardization activities for both Japanese and world industry, which enhanced quality and productivity" (Quality Gurus, 2012). His book on quality control became a best seller in business books shortly after its publication in 1981; being adopted as the fundamental manual for starting and operating a sound total quality control program in organisations (Ishikawa, 1985, p.vi).

By total quality control, Ishikawa meant that every staff member in every department of an organisation must be educated on, perform, and contribute to quality control; which can "result in better products (or services) at a lower cost, increase sales, improve profit, and make the company into a better organisation" (Ishikawa, 1985, p.vi). Company-wide quality control also includes continuously improved customer service, given that a customer should continue receiving service after obtaining the product (SkyMark, 2012a).

Ishikawa was responsible for creating the cause and effect diagram (please refer to appendix 6), a tool that specifies all possible causes of a result so that management/staff can act on any imperfection. He also developed other quality tools that are still widely used: the control chart, histogram, scatter diagram, and Pareto chart (SkyMark, 2012a, Ishikawa, 1990).

The concept of quality circles was also explored by Ishikawa; he believed that quality control courses should constantly be taken by top level management given that their support is essential for quality management to be successful. Ishikawa portrayed and expanded on principles from other quality gurus, particularly Deming, by which means he developed on the PDSA cycle by including two additional steps (SkyMark, 2012a). These steps are, in the "Plan" phase, to determine methods for reaching goals and, on the "Do" phase, to engage in necessary education and training; as demonstrated in Figure 3.2 below:

Figure 3.2 - Control Circle



Source: (Ishikawa, 1985, p. 59)

Finally, Ishikawa strongly believed that creating quality standards is important because, to achieve good control, they must be constantly revised to meet consumers' wants and needs.

Ishikawa's contribution is important to this research to enhance our understanding of quality control as it relates to its being implemented company-wide, and also with regard to some key control tools that are widely used by organisations to fulfil accreditation standards. The author also highlights the importance of continuous improvement, along with constant revision of standards, both of which are fundamental aspects of accreditation.

3.1.6 Avedis Donabedian

Donabedian extended our understanding of quality from pure manufacturing into the area of health care, which transformed the way we think about health care systems (Frenk, 2000b); which is significant to the understanding of quality for the purposes of this research.

When defining quality of care himself, Donabedian (1980, p. 30) considered Brook's (1973, p. 114) definition of it: "*The phrase, quality of care, is vague and has acquired various emotional overlays. Some people use these words to be synonymous with quality of life. This means that ideals such as liberty, happiness, and individual autonomy become components of quality of care; consequently, any valid measurement of quality must take into account these*

different ideals…. For the purposes of this paper, only measures of that component of health which can be altered by the medical care system will be considered as indicators of quality of care. Quality of care then, differs from quality of life." Donabedian concurred with Brook's differentiation, observing that quality of care is not co-extensive with quality of life. However, in his definition of quality, Donabedian places emphasis on the need to include those aspects of quality of life to which medical care can make a contribution, observing that "some attributes that are part of the quality of life – for example, the maintenance of autonomy and self-respect – are also attributes of a desirable client-practitioner relationship and, in this way, become part of the definition of quality" (p.30).

Thus, Donabedian (2003) stated that quality of care is achieved as the product of two factors; the science and technology of health care, and the application of that science and technology in actual practice (p.4). The product of these two factors is characterised by numerous attributes, which include efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy, and equity (briefly described in Table 3.1). Donabedian further observes that these attributes, either singly or combined in several ways, establish a definition of quality; and their measurement will indicate its degree.

Table 3.1 - Attributes of Quality in Health Care

EFFICACY	The ability of the science and technology of health care to bring about improvements in health when used under the most favourable circumstances.
EFFECTIVENESS	The degree to which attainable improvements in health are, in fact, attained.
EFFICIENCY	The ability to lower the cost of care without diminishing attainable improvements in health.
OPTIMALITY	The balancing of improvements in health against the costs of such improvements.
ACCEPTABILITY	Conformity to the wishes, desires, and expectations[20] of patients and their families.
LEGITIMACY	Conformity to social preferences, as expressed in ethical principles, values, norms, mores, laws, and regulations.
EQUITY	Conformity to a principle that determines what is just and fair in the distribution of healthcare and its benefits among members of the population.

Source: (Donabedian, 2003, p. 6)

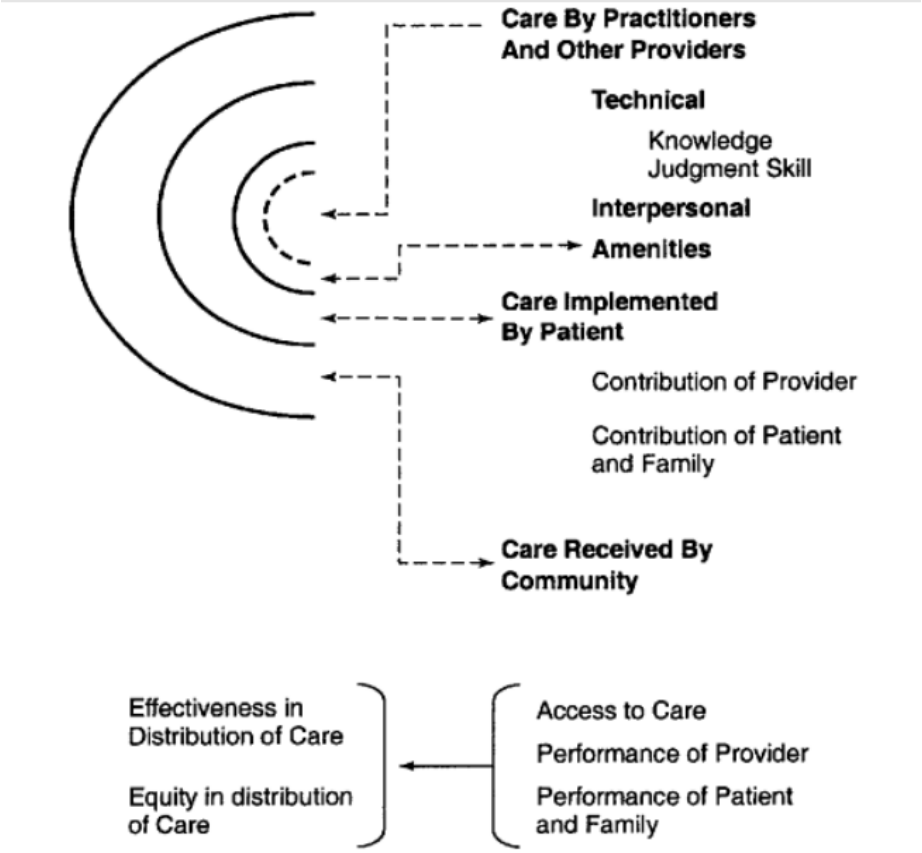
Quality of care is, therefore, defined by the many attributes mentioned above. Legitimacy is an important attribute in the quality of health care, as health organisations, to be deemed legitimate, must conform to ethical principles, values, norms, laws and regulations. Therefore,

[20] Expectation: "A strong belief that something will happen or be the case" (ibid.)

understanding RACHs' perceptions of the accreditation program will demonstrate whether they adopt it to gain resources and legitimacy from the government, staff, residents and their family members or other RACHs for example, or because they believe it in fact enhances the quality of their services; supporting the significance of this research.

Also, the relative priority[21] assigned to each attribute "depends on the context for assessment, based on what is most relevant, on what one is responsible for, on what one can control" (Donabedian, 2003, p. 25). In an illustration (please refer to Figure 3.3), Donabedian suggests the quality components which are most relevant at sequentially more comprehensive levels of attention in a health care organisation, having the patient-practitioner interaction as its core.

Figure 3.3 - Quality assessment at successively more inclusive levels



Source: (Donabedian, 2003, p.25)

[21] Because the adoption of accreditation is compulsory to RACHs, legitimacy most probably has a high relative priority as compared to other attributes.

In examining Figure 3.3, four main components of quality can be observed, which are explained below:

- Care by practitioners and other providers: The quality of care provided by practitioners and other providers is contingent on the effectiveness and efficiency of technical care (i.e., the knowledge, skills and assessment) of the professional offering the service; and also on the relationship between the patient and the practitioner.
- Amenities: The quality of physical amenities is usually not determined by the professional providing the service, unless the professional is also the owner of the organisation that is proving the service, or he/she can impact on it in some other way.
- Care implemented by patients: Patients (and their family members, when applicable) must do their part in improving care, as the care provided by the professional alone may be ineffective.
- Care received by community: In addition to the first three components of quality above mentioned, care received by a community also involves access to care, as it relates to effectiveness, equity, and specifications of optimality.

From Figure 3.3, the care received by a community as a whole can relate to the residents of an RACH in this research, as Donabedian (2003) observes that attention should also be given to access to care, with due regard given to effectiveness, equity, and specifications of optimality. A perusal of the framework provided in Figure 3.3 also indicates that technical skills similarly play an important role in achieving quality of care.

Donabedian (2003) suggested that there are three approaches to assessing the quality of care, they being structure, process and outcome (as demonstrated in Table 3.2); a triad which became the best known framework in health services research and which still remains the dominant paradigm for the evaluation of the quality of healthcare (Frenk, 2000a).

Table 3.2 - Donabedian's Triad

STRUCTURE	Designates the conditions under which care is provided, including: • Material resources, such as facilities and equipment. • Human resources, such as the number, variety, and qualifications of professional and support personnel. • Organisational characteristics, such as the organisation of the medical and nursing staffs, the presence of teaching and research functions, kinds of supervision and performance review, methods of paying for care and so on. The structure has an important influence on the way people behave and, consequently, on the quality of care offered and received.
PROCESS	Consists of activities involving health professionals and patients (including diagnosis, treatment, rehabilitation, prevention, patient education), based on accepted standards. The detailed characteristics of processes can provide sophisticated and valid judgements about the quality of care. The judgement of quality originates from the relationship between processes and outcome, being not inherent to the characteristics of the processes itself. The analysis can be made from a technical or an administrative point of view.
OUTCOME	The changes, desirable or undesirable, in individuals and populations that can be attributed to health care. Outcomes can include changes in health status, changes in knowledge acquired by and behaviour of patients and family members that may influence future health, and satisfaction of patients and their family members with the care received and its outcomes. The outcomes are a consequence of antecedent care.

Source: (Donabedian, 1980, 2003)

Quality of care, however, cannot be judged by one of these dimensions alone; all three must be combined to produce a comprehensive assessment (Donabedian, 2003). Additionally, similarly to Shewhart and Deming, Donabedian (2003) mentions the importance of monitoring quality of care through a cycle, which includes continuously observing, interpreting, acting, and assessing what needs to be done. Donabedian (1968, p. 181) also observed that medical care rests on a basis of "need", and that "the notion of need is far from simple, since it includes not only professional estimates of conditions or situations that require care, but also the clients' opinions, interpretations and expectations concerning care."

An examination of Donabedian's valuable contribution towards quality in health care reveals many attributes that health care organisations should take into consideration when assessing quality, including legitimacy. Additionally, quality cannot be judged by healthcare professionals alone, it must include the patient's views and preferences as well as those of society in general. Finally, quality should be monitored on a continuous basis as to ensure constant improvement.

Donabedian's work greatly improves our understanding of quality of care, which is a key concept being used in this research, given that the aim of the ACSAA accreditation program is to improve the quality of care provided to residents of RACHs. Donabedian's work also

highlights the importance of interpersonal and technical skills in a health care organisation towards quality improvement.

3.1.7 Concluding Comments

Reflecting on the work and contributions of these authors to the literature on quality, the emergence of the basic concepts of quality, that is quality of design, quality of conformance, continuous improvement, control, and quality of care were identified and understood. Many years later, contemporary authors concur and expand on the views presented above. Two examples (CR&C, 2007, Gitlow et al., 2005b) are provided in the following paragraphs.

As determined by Donabedian, quality of care and quality of life are two key aspects of quality in health care, and Donabedian concurs with Brook (1973) that quality of care is not co-extensive with quality of life. Even though Donabedian agrees that they are different, both aspects are included under his definition of quality of care, given that some attributes that are part of the quality of life are also attributes of a desirable client-practitioner. Campbell, Research & Consulting[22] (CR&C, 2007, p. xi) have a similar understanding to that of Donabedian and Brook concerning what constitutes quality of care and quality of life. However, in their report they separated these concepts and defined them as follows:

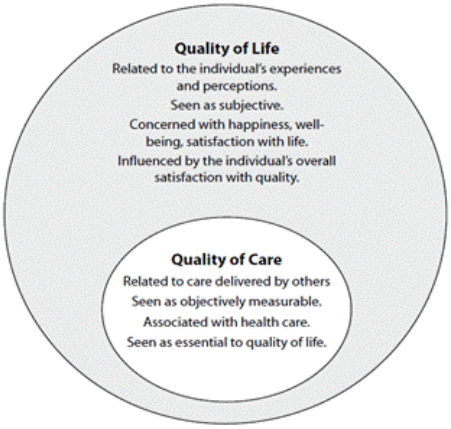
- Quality of care is the degree to which acceptable standards are met or exceeded in relation to:
    - Physical, personal, psychological, spiritual and socio-cultural care and support;
    - Medical, nursing and allied health care; and
    - Physical facilities.
- Quality of life is the degree to which:
    - An individual resident's overall well-being (including level of social activity, physical activity and health status) meets their personal expectations, the expectations of their carers or the expectations of the community; or

[22] Working with associates from DLA Phillips Fox Lawyers and Monash University, Campbell Research & Consulting (CR&C) led a project seeking to "evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes". This project was commissioned by the Australian Government Department of Health and Ageing in November 2004, hence its relevance to this study.

- A group of residents' overall well-being meets the expectations of the broad community.

CR&C (2007) also observed that the relationship between quality of care and quality of life varies according to the health status of the individual; as residents' health status declines, the quality of care provided by health service organisations makes a greater contribution to their overall quality of life. This relationship between quality of life and quality of care is presented in Figure 3.4 below.

Figure 3.4 - A model of the relationship between quality of care and quality of life



Source: (CR&C, 2007)

Hence, as shown in Figure 3.4, quality of care relates to the care delivered to residents by others, is more accurately measured and is essential to residents' quality of life (CR&C, 2007). Quality of life relates to the individual's experiences and perceptions of the services provided, with regards to the individual's happiness, well-being, and satisfaction with life (CR&C, 2007). Quality of life is, however, seen as subjective, given that it is subjective to the individual's overall satisfaction with quality. Research concerning quality of care and quality of life has been conducted. For instance, in their study Bartlett and Burnip (1998) identify the challenges encountered by nursing home managers in the delivery of quality of care. Findings suggest that care delivery is influenced by many factors: 1) residents with increasingly dependent demands which includes their needs for physical and psychosocial care[23], 2) recruitment and retention of staff, 3) education and training, and 4) funding constraints.

[23] Under CR&C specification these would be considered quality of life.

As described later in this chapter, quality in services has its specific characteristics and is dependent on the relationship between the person receiving the service and the person providing it. Given that this research is looking at the accreditation program managed by ACSAA which has "health and personal care" as a separate standard to "resident lifestyle" (which is described further in this chapter), the definition of quality of care and quality of life will be independently used in this research. This, therefore, leads to the development of the following propositions:

P1: Adoption of accreditation standards improves the quality of care provided to residents.

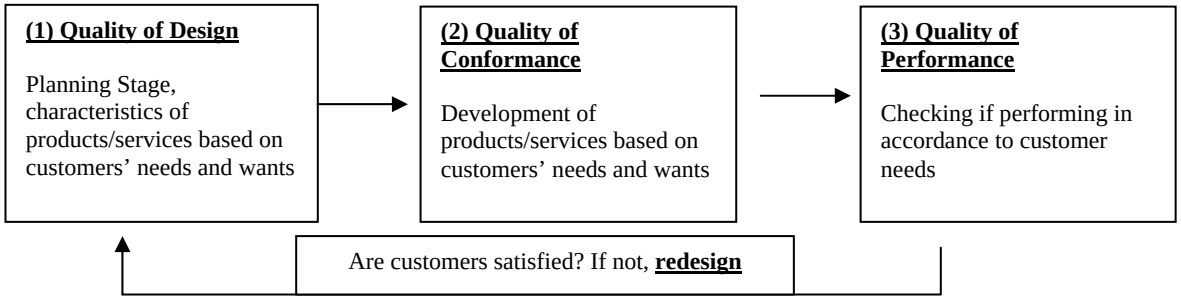
P2: Adoption of accreditation standards improves residents' quality of life.

Gitlow et al. (2005b) refer to Juran's concept of quality of design and quality of conformance, and expanded on them by adding quality of performance.[24] These three concepts relate to Juran's triad, as follows: Quality of design/redesign to quality planning; quality of conformance to quality control; and quality of performance to quality improvement. To ensure that products and services are being produced/offered with a predictable degree of uniformity and dependability, at low cost and suited to the market, Gitlow et al. (2005b) observed that organisations must implement quality of design/redesign, quality of conformance, and quality of performance (see Figure 3.5).

The quality of design is concerned with determining the quality characteristics of products/services that are suited to the needs and wants of the market at a given cost; that is, it develops products from a customer orientation. The quality of conformance is concerned with the organisation being able to produce products/services at a cost and in conformance with the quality characteristics that were determined in the quality of design study. Lastly, the quality of performance focuses on verifying how the quality characteristics identified in the quality of design studies are performing in the marketplace.

[24] Quality of performance focuses on "determining how the quality characteristics determined in the quality-of-design studies, and improved and innovated in quality-of-conformance studies, are performing in the market place". (p.8) GITLOW, H., OPPENHEIM, A. & OPPENHEIM, R. 2005a. *Quality Management: Tools and Methods for Improvement*, Sydney, Irwin.

Figure 3.5 - Types of Quality



Source: Adapted from Gitlow et al (2005b)

Finally, the two examples mentioned above demonstrate a strong focus on the customer and on satisfying their needs and wants, which is one of the key components of total quality management that will be described in the next section.

The discussion presented in the first section of this chapter is therefore summarized by the following proposition:

> P3: Accreditation standards are adopted by RACHs to influence the level of quality of their services.

3.2 Total Quality Management Components

Total quality management (TQM) is a body of ideas and philosophies which embraces many management components and can be used by top management to direct organisations towards improved performance. The key elements of TQM stem from the work of many authors (including Shewhart, Juran, Deming, etc), who have developed different models for quality management. Based on their review of quality models, Dotchin and Oakland (1992) present TQM under six key components (described below), which are applicable to both manufacturing and services sectors. The adoption of quality management systems (e.g. accreditation) is one of the six TQM components, and hence represents just a small part of it. Having said that, most of the other TQM components (e.g. customer orientation) are usually included in standards of quality management systems and, therefore, being accredited should indicate that all the other components are also being achieved. In this regard, a discussion of TQM is significant to this research as it contributes to providing an in-depth understanding concerning the fundamentals of an accreditation system. However, TQM is holistic, and for it

to be achieved every single person within an organisation must be involved. It must therefore, be entrenched in the culture of the organisation and not be implemented for limited purposes, such as legitimacy alone.

A. TQM is Holistic

Total quality management (TQM) is holistic; it is an approach to improve the effectiveness and flexibility of the business as a whole. Therefore, for an organisation to be truly effective with regard to TQM, every department, every activity, and every single person at every level must be involved (Oakland, 1989). In RACHs this is no different, and for TQM to be achieved all staff, including outsourced health service providers, must be involved.

B. Customer Orientation

Knowing customers and being responsive to them is fundamental to TQM. This is the essence of the writings of most of the authors mentioned in the first part of this chapter. For example, Ishikawa (1985) noted that organisations engage in quality to satisfy customer requirements, as expressed in his definition of quality control: "To practice quality control is to develop, design, produce and service a quality product which is most economical, most useful, and always satisfactory to the consumer" (p. 44). Additionally, he noted that because consumer wants and needs change constantly, organisations must continuously review their own quality standards, revise them, and improve them.

For instance, RACHs face an even more demanding situation given that they deal with two different types of customers all the time: the direct customer (i.e. the resident), and the indirect customer (i.e. family members). Family members have different demands and expectations than the residents themselves, and in some cases they also have the guilt of placing their loved ones in an RACH. Residents and their family members were not interviewed for the purposes of this research due to many reasons explained in section 5.4 of this thesis. Nonetheless, RACHs' staff were asked about their views on how the adoption of accreditation standards has resulted in the facility conforming to residents' needs and residents' expectations, and also in what way they believe the adoption of accreditation standards influence residents' level of satisfaction.

C. Empowering People to Achieve Quality

Crosby (1979) observes that top management must commit to quality, while having middle manager support so that employees feel motivated. Also, as noted by Oakland (1989), the organisation's quality objectives must be combined with a well-defined allocation of responsibilities within the management structure. This is because achieving TQM without the full cooperation and commitment of staff is not possible; staff must then be able to fully participate in the making and monitoring the arrangements for achieving their division's obligations. Therefore, if RACHs adopt accreditation, for example, only for legitimacy reasons, it will most probably be difficult to have all staff involved and as a result for TQM to be achieved.

Additionally, Ishikawa (1985, p.13) stresses that "quality control begins with education and ends with education", and that for an organisation to successfully implement TQM, continuous education must be constantly provided to all staff in the organisation.

D. Attention to the Process

For an organisation to improve its processes, it is essential to understand what determines its performance and outputs. Thus, it is important to work closely with suppliers in relation to inputs, and to understand how the whole process flows up to outputs (Oakland, 1989). Furthermore, it is important to have standards to identify whether tasks have been satisfactory completed; given that unless these standards are met, they are meaningless (Ishikawa, 1985). A standard is a document that provides requirements, specifications, guidelines or characteristics, and which can be used on a consistent basis to certify that processes, services, products and materials are appropriate for their purpose (ISO, 2012f). However, Morris and Johnston (1987) observe that it may not be possible to standardize some service processes given that a standard has a variation due to direct customer involvement. ACSAA provides RACHs with standards that they must follow up on in order to verify whether required tasks have been satisfactorily completed.

E. Quality Management Systems

The fundamental purpose of a total quality approach is to provide assurance that both the customers' and the organisations' requirements can be identified and met. For that, a good

management system (which must involve the consideration of all major areas of the organisation), statistical process control (SPC) and teamwork are all necessary. This is because a properly operated and detailed quality management system provides the essential basis for an effective application of SPC and teamwork (Oakland, 1989). However, as observed by Dotchin and Oakland (1992), even though quality systems are necessary, they should not be prescriptive and, instead, they should assist and be supportive of the organisation's objectives.

International standards, which are developed by organisations such as the ISO , can be used as a template for organisations to assess and document their activities, and also provide a basis for standardisation and improvement (Oakland, 1989). Standards that are developed for a specific industry, such as the accreditation standards managed by ACSAA, can also be used for the same purpose. However, Ishikawa cautioned: "quality control cannot be implemented by merely following national and international standards. These standards may be taken into consideration, but beyond these standards quality control must have the higher goals of meeting the requirements of consumers and creating quality which satisfies them" (Ishikawa, 1985, p.8).

Additionally, Ishikawa (1985) stresses the importance of controlling and revising standards on a continuous basis, saying that his slogan is "If standards and regulations are not revised in six months, it is proof that no one is seriously using them". This is important to ensure that they never become outdated (Ishikawa, 1990).

F. Continuous Improvement

Continuous improvement is a key factor in quality management. As noted by Dotchin and Oakland (1992) and seen in the beginning of this chapter, it is mentioned by many quality management classic authors (for example, the Juran trilogy that included quality improvement, and Crosby's 14 points with "Do it over again" as its final item). Continuous improvement is also a significant element of the accreditation program managed by ACSAA, and it is present in all of its four standards.

Hence, Dotchin and Oakland (1992) conclude that quality is most appropriately defined in terms of a capability to satisfy customer requirements, and it is also evident that quality management should be outlined as to the organisation's context. Finally, the authors also noted that TQM involves numerous aspects, including (p.141):

- Recognising customers and discovering their needs.
- Setting standards which are consistent with customer requirements.
- Controlling processes and improving their capability.
- Establishing systems for quality.
- Management taking responsibility for setting quality policy, providing motivation through leadership, and equipping people to achieve quality.
- Empowering people at all levels in the organisation to act for quality improvement.

As a result, the components mentioned above all have a direct impact as to contribute to manufacturing and services organisations in achieving total quality. However, given that this research focuses on aged care homes (which falls under the services category), it is important to review how services differentiate from manufacturing, given that these differences have a direct influence on the quality of services provided.

3.3 Quality in the Service Industry

Total quality management is a notion that is being implemented in numerous organisations worldwide, both in manufacturing (Zatzick et al., 2012, Challis et al., 2005, Tsuang et al., 2009, Matias and Coelho, 2002, Challis et al., 2002, Gunasekaran, 1998) and services industries (Ooi et al., 2011, Baird et al., 2011, Ueno, 2010, Alrgaibat and Alkhazali, 2011, David and Strang, 2006, Lam et al., 2011), including healthcare (which incorporates residential aged care homes) services (Pomey et al., 2010, Kim et al., 2008, O'Reilly et al., 2007, Boyer et al., 2012, Vanniarajan and Arun, 2010, Perides, 2003, Heras et al., 2008, Bartlett and Boldy, 2001, Iñaki et al., 2008, Thomas, 2009). As previously discussed, the components of TQM are applicable to both manufacturing and services sectors. Similarly, Crosby (1984) and Ishikawa (1985) observed that quality control activities are basically the same regardless of the industry an organisation fits into, and that the same principles can be applied to different industries.

However, services have unique characteristics to manufacturing, such as: intangibility, inseparability, variability, and perishability (described in Table 3.3), in addition to presenting some distinctive challenges relating to the customer, service recovery, and delivery and performance of service (please refer to Table 3.4) (Kotler et al., 2010). Since RACHs are part of the service industry, they are directly affected by these characteristics and challenges, not

only in the interaction between residents and staff, but also in the interaction between RACHs and accreditation assessors during an accreditation assessment.

Table 3.3 - Services Characteristics

Intangibility	Services cannot be seen, tasted, felt, heard or smelled before they are bought.
Inseparability	Services cannot be separated from their providers, as the interaction between provider-customer happens while the service is been delivered.
Variability	Services vary because they often depend on the actions of individuals. Even though training, manuals and management controls assist in reducing variability, staff may respond differently to unexpected situations, for example.
Perishability	Services cannot be stored for later sale or use, which presents a problem when demand fluctuates.

Source: Adapted from (Kotler et al., 2010, p. 307)

Table 3.4 - Service Challenges

The Customer	Customers have needs that are often difficult to identify or quantify, which may result in a gap between what is expected versus received by them. The challenge for organisations is to reduce this gap.
Service Recovery	Organisations should have procedures in place for employees to follow when dealing with failure on their part; procedures may include compensation, apologies, providing options, and taking responsibility. Additionally, staff must be empowered to deal with these situations.
Delivering and performing service	The challenge for service organisations is to ensure consistency of the services provided across time, people, and outlets.

Source: Adapted from (Kotler et al., 2010, p. 308)

These characteristics and challenges result in an impact on staff providing the services, the customer being serviced, the interaction between these two, and even these two in different ways, which influences and has a direct impact on the quality of services provided by a service organisation. This is no different in health care which constitutes a component of the service sector (see Dickens, 1998). This is demonstrated in a study by van den Heuvel et al. (2006, p. 138), where they observed how these characteristics impact the quality of services provided by health care organisations. For instance, health care appeared to have two “clients” with conflicting demands: the patient who expects all possible efforts to be done at a maximal quality, and the insurance company who wants the lowest possible prices. Additionally in health care, the patient is part of and participates in the process; storage time is equivalent to waiting time, which has a negative effect; and the patient interferes with and influences the progression of the health care process, which affects predictability and controllability of the health care processes.

When comparing quality in services to quality in manufacturing, Zeithaml et al. (1988) noted that “most services cannot be counted, measured, inventoried, tested, and verified in advance

of sale to ensure quality delivery" (p. 35), and that, instead, quality in services happens while the service is being provided to the customer. Therefore, differently from manufacturing, service is not mainly reliant on a manufacturing plant and finished goods but, instead, is conditional to the many factors just presented.

Nonetheless, manufacturing organisations all have to bear service in mind, and how service quality can be achieved, controlled and improved (Dotchin and Oakland, 1994). This is because customers buying hard goods are also concerned with the services received in relation to the purchase of a good (Crosby, 1984). For this reason, Morris and Johnston (1987) noted that the key differences between manufacture and service are with respect to the intangible dimensions, given that in manufacturing the customer gains the output at the end of the process, while in services the customer gains the output while it is being delivered.

As such, quality in services (as for example in RACHs) is contingent to the interaction between company and customer, as well as on the performance of employees. Hence, ensuring consistency and standards, and therefore controlling service performance, through quality management systems, is much more challenging to a service organisation.

3.4 Quality Management Systems

Quality management systems (QMS) are one component, and also the driving force, of TQM. Similarly to other industries, the adoption of QMS is expanding among healthcare organisations, as they serve as a reference and also assure a quality service to society, indicating that the institution is in conformity with the outlined standards (Øvretveit and Gustafson, 2003). For instance, ISQUA (2004) declared that being evaluated and accredited by an external body is in increasing demand in many countries by governments, healthcare managers, patients and communities.

To date, however, limited research appears to have been conducted concerning accreditation in aged care homes. For instance, Greenfield and Braithwaite (2008) conducted a study that identified and analysed 66 empirical studies that examined the impact or effectiveness of accreditation and accreditation processes in the health sector, categorising them in 10

categories.[25] Results indicated a complex picture, with diverse opinions and inconsistent findings in most categories, such as professional attitudes towards accreditation, organisational impact, financial impact, quality measures, and program assessment. For example, accreditation programs were supported for being an effective strategy for assuring quality, resulting in enhanced organisational performance, enabling collegial decision-making, and providing a guide to external stakeholders to how quality and safety is managed within an organisation. Conversely, concerns were expressed about the program being bureaucratic and time consuming, adding little value to patient care, involving high costs (direct and indirect), a lack of consistency among assessors, and problems with the accreditation standards.[26] In one study enhancements to patient care were reported due to new organisational strategies that were introduced as a result of accreditation. Results also indicated that the financial cost of accreditation is an under-researched area, although there were suggestions that the costs incurred in undertaking accreditation are seen as an essential investment in the organisation regardless of the program. It was also suggested that the validity of the accreditation program is doubtful, due to a need for improving and clarifying the accreditation standards. Finally, it appears that there is a positive relationship between adoption of an accreditation program and the development of health professionals. From these studies, however, only one appeared to be in nursing homes, and this is described in the following paragraph.

In their study, Grenade and Boldy (2002) aimed at evaluating the implementation of the accreditation process in RACHs in Western Australia in its first phase, that is just after the very first accreditation round, when accreditation was introduced in 1997. Similarly, to the present study, it evaluated the accreditation process from the RACH staff perspective. However, that study differed from the present research in a number of ways: (1) it evaluated RACH staff perceptions with regard to the implementation of the accreditation process as it relates to the first accreditation round; (2) consequently, it could not evaluate RACH staff views with regard to the enhancement of quality of RACHs' services due to the adoption of accreditation; and (3) it did not look at the subject from an institutional theory perspective. Hence, apart from examining the adoption of accreditation from an institutional theory perspective, this research contributes over and above Grenade and Boldy's (2002) study since

[25] "professions' attitudes to accreditation, promote change, organizational impact, financial impact, quality measures, program assessment, consumer views or patient satisfaction, public disclosure, professional development and surveyor issues" (p. 172).
[26] i.e. Assesors experiencing difficulties in conveying the core quality improvement concepts to professionals.

it examines the accreditation process after four rounds have been completed, where staff have an enhanced understanding of how accreditation impacts the quality of their services or not. That said, results demonstrated that: staff were supportive of the accreditation process; some RACHs were not clear on the concept of continuous improvement whereas others already had a system implemented; site audit was indicated as a positive experience; staff were more aware of their activities – "what they were doing and why"; and top management was increasingly involved in the streamlining of management structures and processes. However, it was revealed that the accreditation process resulted in staff feeling stressed and exhausted; high levels of documentation were required, with staff questioning whether this was the most suitable indicator of service quality; the accreditation process resulted in significant financial pressures on RACHs; and the conduct of site audits lacked consistency (in relation to depth and breadth of coverage, and also to different levels of expectations across standards).

Finally, another study was undertaken by Touati and Pomey (2009) to compare the adoption of accreditation in Canada where the program is optional, to France, where it is compulsory. Touati and Pomeys' (2009) empirical research evaluated accreditation as a bureaucratic measure, seeking to understand whether the accreditation process performed as a tool for coercion[27] as opposed to enabling.[28] Similarly to Australia, the adoption of accreditation in France is compulsory, the accrediting body is a public agency, targeting public and private-for-profit establishments,[29] and the outcomes of the accreditation process may be used for funding purposes. In France, results demonstrate that the legitimacy of the accreditation process is undermined by the prescriptive nature of the standards; less time was spent with patients and more on paperwork; and the demanding role of accreditation assessors. Additionally, the impact on managerial and clinical practices appears to be, amongst other factors, an improvement in the quality of services (especially patient information management) and also of patient security. Findings suggested that the French model is closer to a coercive approach, whereas the Canadian model is closer to an enabling approach, but that both systems are converging to a combined model. It was also indicated that excessive standardisation has a negative impact on the quality of care, and that autonomy and creativity should be encouraged. Finally, bureaucracy must remain as a "soft bureaucracy", and claiming that indicators and top-down legislation can result in reasonable quality levels is an over-generalisation.

[27] Coercive bureaucracies control users by limiting their contribution
[28] Enabling bureaucracies leverage user's intelligence
[29] RACHs in Australia are divided into three main types of organisations: not-for-profit, government, and private

Therefore, the studies above indicate that the views of aged care homes on the impact of the adoption of accreditation on the quality of services provided by them, has not yet been researched. Moreover, the study by Touati and Pomey (2009) draws attention to the importance of looking at quality and accreditation as a process when this process is heavily regulated, which is the case with RACHs in Australia.

There exist many different external accreditation bodies that have been created to ensure that health care organisations practise and maintain quality in their services; including for example: the International Organization for Standardization (ISO), Australian Council on Healthcare Standards (ACHS), Joint Commission International (JCI), and the International Society for Quality in Health Care (ISQUA). Additionally, some countries such as Australia, Canada, England, the United States of America, and New Zealand have designed quality management programs specifically for their aged care sector (please refer to Appendix 7). Compliance with any of these bodies' quality standards results therefore in an organisation achieving accreditation from them. The ACSAA accreditation body is considered below.

3.4.1 Aged Care Standards and Accreditation Agency (ACSAA)

As seen in chapters one and two, being accredited by ACSAA is one of the requirements that RACHs must fulfil to receive funds from the government. ACSAA is the body corporate which receives an accreditation grant under the Aged Care Act 1997, being appointed by DoHA to promote high quality care in Australian Government subsidised residential aged care homes (ACSAA, 2012g, ComLaw, 2011). As stated earlier, one of the aims of this research is to determine the influence that the adoption of accreditation standards managed by ACSAA[30] has on the quality of the services provided by RACHs in Australia. Therefore, this section will focus on analysing this accreditation program in detail.

[30] The accreditation standards are specified in Schedule 2 of the Quality of Care Principles 1997 (Quality of Care Principles 1997, 2012) (as per appendix 2)

3.4.1.1 Accreditation Overview

"Accreditation is about ensuring residential aged care homes meet a set of quality standards relating to the care provided to residents. These are set by the Australian Government. All homes must be accredited in order to receive funding from the Australian Government through residential care subsidies" (ACSAA, 2012k).

The main elements of the accreditation process are (ACSAA, 2012b):

- self-assessment by the home against the Accreditation Standards
- submission of an application for re-accreditation (with or without the self-assessment)
- assessment by a team of registered aged care quality assessors at a site audit
- a decision about the home's accreditation by a decision-maker (not part of the assessment team)
- issue of an accreditation certificate
- publication of the decision on the ACSAA website
- unannounced visits to monitor homes' on-going performance

In Australia, the Aged Care Act 1997 (the Act) provides for the regulation and funding of aged care services, and in 1998 the Aged Care Standards and Accreditation Agency (ACSAA) was appointed by the Department of Health and Ageing (DoHA) as the independent accreditation body under the Aged Care Act 1997 to assess RACH performance against a set of legislated Accreditation Standards. "As the accreditation body, the Company (ACSAA) promotes high quality care in the Australian Government subsidised residential aged care sector. We do this through our management of the accreditation program as set out in the Accreditation Grant Principles 2011 and a comprehensive industry education program" (ACSAA, 2012g). ACSAA's functions include (ComLaw, 2011):

a) managing the accreditation process using the Accreditation Standards (please refer to Table 3.5 on page 53); and
b) promoting high quality care, and helping industry to improve service quality, by identifying best practices and providing information, education and training to industry; and
c) assessing and strategically managing services working towards accreditation; and
d) liaising with the Secretary (of the Department of Health and Ageing) about approved providers that do not comply with the Accreditation Standards.

The accreditation standards are composed of four legislated "quality of care standards" (management systems, staffing and organisational development; health and personal care; residents' lifestyle; and physical environment and safety systems), each consisting of a principle and a number of expected outcomes. Across the four standards, there are 44 expected outcomes that RACHs must conform to. The accreditation standards "are intended to provide a structured approach to the management of quality and represent clear statements of expected performance. They do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents" (Quality of Care Principles 1997, 2012). Therefore, the Australian accreditation standards provide a defined approach without specifying how they should be met.

Therefore, receiving accreditation from the Federal Government means that RACHs not only maintain ongoing compliance with the legislated accreditation standards but also undertake continuous improvement.[31] Hence, by receiving accreditation the facility is considered achieving quality of conformance, and is therefore deemed to be providing quality care and services.

[31] "Continuous improvement is a systematic, ongoing effort to raise a residential aged care home's performance as measured against the Accreditation Standards". Whilst "quality assurance is concerned with the maintenance of systems and processes to ensure variances are managed; continuous improvement moves beyond this to lift the home's performance to a higher standard". ACSAA. 2012h. *Continuous Improvement* [Online]. Aged Care Standards and Accreditation Agency Ltd. Available: http://www.accreditation.org.au/accreditation/continuous-improvement/ [Accessed 11th January 2013.

Table 3.5 - Accreditation Standards

Item	Matter Indicator	Expected Outcome
1. Management systems, staffing and organisational development		
Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates. **Intention of standard:** This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.		
1.1	Continuous improvement	The organisation actively pursues continuous improvement.
1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
1.4	Comments and complaints	Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.
1.5	Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.
1.6	Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.
1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available.
1.8	Information systems	Effective information management systems are in place.
1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.
2. Health and personal care		
Principle: Residents' physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team.		
2.1	Continuous improvement	The organisation actively pursues continuous improvement.
2.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care.
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
2.4	Clinical care	Residents receive appropriate clinical care.
2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.
2.7	Medication management	Residents' medication is managed safely and correctly.
2.8	Pain management	All residents are as free as possible from pain.
2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained.
2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration.
2.11	Skin care	Residents' skin integrity is consistent with their general health.
2.12	Continence management	Residents' continence is managed effectively.
2.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively.
2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents.
2.15	Oral and dental care	Residents' oral and dental health is maintained.
2.16	Sensory loss	Residents' sensory losses are identified and managed effectively.
2.17	Sleep	Residents are able to achieve natural sleep patterns.

Table 3.5 - Accreditation Standards (continued)

3. Resident lifestyle		
Principle: Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.		
3.1	Continuous improvement	The organisation actively pursues continuous improvement.
3.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about resident lifestyle.
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis.
3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected.
3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.
3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
3.9	Choice and decision making	Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.
3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities.
4. Physical environment and safe systems		
Principle: Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.		
4.1	Continuous improvement	The organisation actively pursues continuous improvement.
4.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about physical environment and safe systems.
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements.
4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
4.7	Infection control	An effective infection control program.
4.8	Catering, cleaning and laundry Services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Source: (ACSAA, 2012c)

3.4.1.2 Receiving and Maintaining Accreditation

For new RACHs, the approved provider will need to apply for accreditation before any residents are admitted, and the RACH must be accredited before being eligible to receive Australian Government subsidies. The RACH must identify in its application how it will meet the Accreditation Standards when it is operating, and provide the Aged Care Standards and Accreditation Agency (ACSAA) with an agreement that the new home will undertake continuous improvement (ACSAA, 2012a). As seen earlier in this chapter, continuous improvement is one of the quality concepts mentioned by leading authors such as Shewhart, Juran, Deming and Ishikawa.

Accreditation is not a one-off event; once an RACH is accredited, the approved provider is required to maintain ongoing compliance with the legislated standards of care for residents and to undertake continuous improvement. However, as to be discussed in the following chapter, being compliant with the accreditation standards does not necessarily mean that RACHs are actually achieving good quality outcomes, and it also does not necessarily mean that continuous improvement is occurring.

To ensure that RACHs are complying with the standards over time, each RACH receives at least one unannounced visit each year from ACSAA accreditation assessors, and is required to apply for re-accreditation[32] before the accreditation period expires. An application for commencing a home and for its accreditation and re-accreditation involves a fee that RACHs must pay, based on the number of allocated places in the facility (as per appendix 8). The period of accreditation granted to each RACH is based on a number of factors, including the RACH's history and current level of compliance. RACHs can generally expect three years' accreditation if they have a good track record of compliance and continuous improvement, and if they meet all 44 expected outcomes. Otherwise, shorter periods of accreditation are granted (ACSAA, 2012a, k). When an RACH fails to meet the accreditation standards, ACSAA may put the RACH on a timetable for improvement (TFI), which determines the improvements required and the maximum time allowed to address the issues. ACSAA will then conduct a review audit, which may result in varying, revoking, or deciding not to revoke the RACH's accreditation. Additionally, ACSAA may recommend the Department of Health

[32] As opposed to the unannounced visits, the date of the accreditation visit that relates to re-accreditation is known by the RACH.

and Ageing to impose sanctions on the RACH. The possible outcomes of the review audits are briefly described in Table 3.6 (ACSAA, 2012i, l):

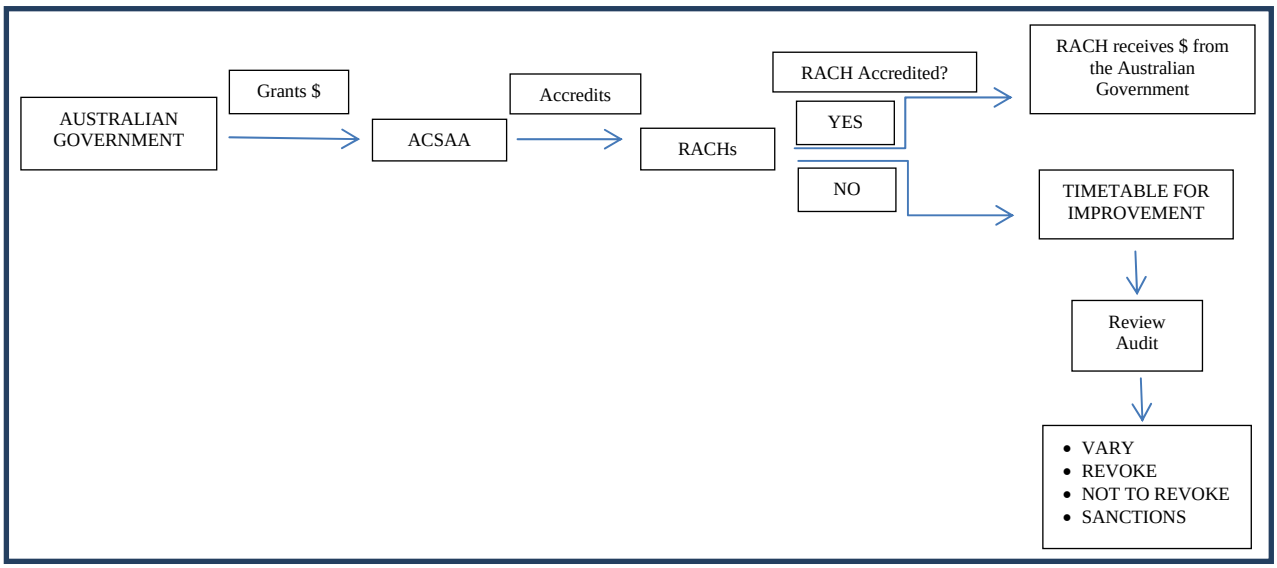
Table 3.6 - Possible Outcomes of Review Audits

Vary	If an RACH fails to meet the Accreditation Standards, its accreditation period may be varied by changing its expiry date.
Revoke	If an RACH has a significant number of expected outcomes not met or serious risk to the health, wellbeing and safety of residents, its accreditation may be revoked as of a specified date. The residential aged care home would no longer be eligible for Government subsidies (which may lead to the RACH having to close down).
Not to revoke	The RACH will continue to be accredited and its accreditation expiry date will remain the same.
Sanctions	If a home has serious risk or has been given a timetable for improvement and not succeeded in meeting all the expected outcomes by the end of the set period, ACSAA must inform the Department of Health and Ageing, which may then decide to impose sanctions (conditions) on the approved provider of the RACH. Different types of sanctions which are dependent on the circumstances of the non-compliance may be imposed on RACHs, which include revocation of approved provider status (unless an adviser is appointed for a period of 6 months), revocation of allocated beds, or loss of Commonwealth subsidies for new residents. To ensure that care for residents is not compromised and that progress is made against areas of non-compliance, the Agency continues to monitor residential aged care homes during the sanction period.

Source: Adapted from DoHA (2009c)

The review audit is an onsite assessment of the quality of care and services provided to residents by an RACH, and it involves a complete review of the RACH's practices against all 44 expected outcomes of the Accreditation Standards. The review audit may be "prior announced" to the RACH or "unannounced", and are conducted by an assessment team of at least two assessors (ACSAA, 2012i, l). Figure 3.6 visually depicts the accreditation process.

Figure 3.6 - The Accreditation Process



In addition to when an RACH is placed on a TFI, the review audit may also be conducted in other instances, such as (ACSAA, 2012i):

- as a result of an assessment contact, where ACSAA considers that the approved provider of the home may not be meeting the Accreditation Standards;
- there is a change to the home, for example, change in key personnel, number of "allocated resident places" or building;
- the Department of Health and Ageing directs the Accreditation Agency to undertake a review audit.

The accreditation and re-accreditation processes, along with the review audit, are carried out by an independent team of assessors who evaluate the RACH's achievements against the Accreditation Standards (as described in Table 3.5 on page 53), with a view to promoting continuous improvement and providing education (ACSAA, 2012f). For that, assessors use information gained from interviewing residents, observing the practices at the home, reviewing documented procedures, looking at resident records and other important documents such as staff rosters, incident reports, care plans and complaints registers (ACSAA, 2012b).

However, combining the fact that assessments are carried out by an independent team of assessors with the fact that the accreditation standards do not provide instructions for satisfying the outcomes expectations, may result in subjectivity of results. As observed earlier in this chapter, the services sector has unique characteristics that affect them because they often depend on the actions of individuals.

3.4.1.3 History of the accreditation process, reviews and criticisms

Historically, the accreditation process consisted of five rounds. The first round took place between September 1999 and December 2000, the second round was completed by 31 December 2003, the third round was completed by 31 December 2006, the fourth round was completed by 31st December 2009, and the fifth round was completed by December 2012. There has been an improvement in the number of RACHs meeting the expected outcomes since the commencement of accreditation. For example, as at 31st December 2009, 94.2 per cent of RACHs nationally were found to meet all 44 expected outcomes of the accreditation standards, compared to 91.8 per cent in 2006 and 63.5 per cent in 2000 (ACSAA, 2010,

2012d). Additionally, the accreditation standards were revised by the Department of Health and Ageing in early 2011, but have not been implemented to 1st March 2013 (DoHA, 2012l). During this period however, the accreditation process has received many reviews and criticisms.

For instance, The Australian Nursing Homes and Extended Care Association Limited (ANHECA)[33] (as cited in The Senate, 2005), observed that the accreditation standards have a limited capacity for measurement as to directly report quality improvement, given that they are based on a binary score of "compliant" or "non-compliant". It was noted that:

- "Evidence indicates that there is little systematic data that demonstrates how accreditation has impacted on quality of care" (ANHECA as cited in The Senate, 2005, p.34). Similarly, this was later observed by CR&C (2007) who mentioned that the actual degree of improvement cannot be established because, across the sector, there are no measures against which the degrees of quality can be measured.

It was also stated by ANHECA (as cited in SCARCS, 2005, p.72) that as a result of the adoption of accreditation, excessive administrative and paperwork demands were placed on staff. It was mentioned that:

- "… the current accreditation system does [not] in any way assist the sector to reduce administrative and paperwork demands on staff, in fact, the reverse. Because the Agency is so focused on the minutia of day to day activities and not on systems improvement, it is forcing residential aged care providers to focus on forms and ticking of boxes, rather than ensuring that the quality systems work effectively for overall service improvement."

Adoption of accreditation standards by RACHs may therefore result in being counter-productive due to the amount of paperwork involved. Additionally, it may also negatively impact the quality of care provided to residents given that completion of paperwork takes time away from caring for residents.

Hence, this suggests that the approach used to assess conformance with the accreditation standards does not provide the industry with grounded evidence, which could subsequently be used to indicate how accreditation has influenced quality of care. Additionally, the way

[33] A professional industry association for providers of quality residential and community aged care aged care services on a national level, (DoHA, 2012a).

compliance with the outcomes is evaluated seems to be, in fact, based on paperwork only rather than on observation of overall service improvement.

In another project, Campbell Research & Consulting (CR&C)[34] aimed to "*evaluate the impact of accreditation on the delivery of quality of care and quality of life to residents in aged care homes*" (CR&C, 2007, p.v). In their research, respondents (managers of Indigenous Australian aged care homes) were asked to mention the main factors they believe have contributed to improving quality in residential aged care, such as: accreditation, staff training and education, regulation/accountability, resident focus, management/structure, government funding, certification, competition, and other matters. Hence, CR&C's research differs from this study not only in their sample, which was Indigenous Australian aged care homes; but also that it focused on the main factors (accreditation being one of these factors) that contributed to the overall quality improvement in RACHs. Conversely, this research was aimed at RACH staff only; interviews were conducted in different RACHs in NSW; and it focused on learning the reasons why RACHs adopt accreditation standards, and the influence that the adoption of accreditation standards has on the quality of RACHs.

Nonetheless, CR&C's research identified some negative consequences from the accreditation process. This included increased paperwork, staff lack of time for residents, low levels of staff retention, and high levels of workplace stress. Additionally, it was suggested that there is a need for ongoing revision of the accreditation standards, a need to establish a measurement system so that the extent of quality improvement can be identified, and also that it has resulted in an increase in the cost of running RACHs. This is also consistent with an evaluation made by the Nurses Board of Western Australia, concerning which it was observed that "the administrative and paperwork demands have a real cost in dollar terms and a cost on the emotional and morale demands on staff": Senate Community Affairs References Committee (SCARCS, 2005, p.73). Therefore, even though findings from CR&C's research demonstrated that the level of quality in RACHs has improved over the 10 years since accreditation was introduced (e.g. increased customer participation and quality related initiatives), it appears that it also resulted in some negative consequences that directly affect the quality of care provided to residents.

Research conducted by the Productivity Commission[35] indicated some key issues relating to the accreditation process. Findings suggested excessive paperwork, and a focus on the

[34] Commissioned by the Australian Government Department of Health and Ageing

[35] It is an Australian Government independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. It provides the Government with reports containing a

RACHs' processes and inputs rather than improved outcomes for residents (Productivity Commission, 2011). The report suggested:

- "… the accreditation process should not require substantially more paperwork than is required for normal business, clinical and care management needs. We have some sympathy with the view that quality accreditation processes in the health and aged care sectors have placed too much emphasis on excessive paper trails rather than on actual outcomes being achieved." (Council on the Ageing (Australia), as cited in (Productivity Commission, 2011, p.128).
- Taking staff time away from residents to complete bureaucratic tasks fails both residents and staff. "Currently, documenting the minute details of a person's life seems to have become more important than actually helping them live their lives. Documentation and the keeping of records is an important part of care — as is developing well-formulated care plans. However, the current system is out of balance and the staff time spent on documentation rarely, if ever, appears to result in improved care." (UnitingCare Australia as cited in (Productivity Commission, 2011, p.128)
- Under the current accreditation process "aged care facilities that are delivering high quality care are disadvantaged because the process does not recognise this just as it does not recognise when poor quality care is given. Most facilities pass accreditation because managers and staff know how to subvert the process. It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms." (Maree Bernoth as cited in (Productivity Commission, 2011, p.128)

A review of the findings from CR&C and Productivity Commission research indicate some similarities, such as the considerable volume of paperwork and consuming staff time which would be otherwise spent on residents care. Additionally, it also suggests that the adoption of accreditation standards may not ensure that high quality care is delivered to residents of RACHs, given that assessment is predominantly based on having processes in place and on paper instead of the care given. Due to the above factors, ACSAA's function of promoting high quality care for the residential aged care sector may not be occurring as expected.

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review of the aged care sector and also detailed proposals for aged care reform, which are then considered as part of the Government's broader ageing agenda (Productivity Commission, 2011, The Gillard Labor Government, 2012).

Finally, the Department of Health and Ageing (DoHA) has recently conducted work in reviewing the accreditation standards for RACHs. The draft revised standards have increased focus on the resident, they encourage the provision of resident-centred care, and have a focus on articulating more clearly the requirements of care under the Aged Care Act 1997, aiming to reduce duplication across the four standards. DoHA has worked with a Technical Reference Group (comprised of individuals with expertise in health and aged care standards; residential aged care accreditation; and/or development and implementation of quality indicators for residential aged care), as to provide expert technical advice on the review of the residential aged care standards. Workshops were held around the country so that representatives from approved providers, peak bodies, unions, health professional organisations, consumer and carer groups and provider attendees, had that opportunity to comment on the draft Accreditation Standards. The feedback received resulted in further refinements to the revised standards, and once a further draft is made available, it is expected that a pilot of the new standards is undertaken in collaboration with ACSAA and aged care stakeholders (DoHA, 2012k). However, the pilot and subsequent implementation of the new standards still need to be considered in the context of the Government's response to the recommendations made by the Productivity Commission[36] (ACS, 2011).

The draft revised standards are different from the current standards as follows (ACS, 2011):

- Standards were reduced from four to three, and the term "expected outcomes" has changed to "expected performance statements";
- Current expected outcomes have not been removed, but reorganised across the new 3 standards;
- Three expected performance statements have been drawn out to reflect "person-centred care" and "practice informed by evidence care".

From the above, it appears that the draft revised standards are not too different from the current standards, and still do not address the issues presented in the research examined previously (e.g. CR&C, Productivity Commission).

[36] The focus of this thesis remains on the original accreditation standards because the revisions are still in draft format.

3.4.2 Other Accrediting Bodies

As previously mentioned, in addition to ACSAA several other extant accrediting bodies have standards that can be utilised by health care organisations, as for example the Joint Commission International (JCI), The Australian Council for Healthcare Standards (ACHS), and the International Organization for Standardization (ISO)[37]. These and other bodies constitute a potential substitute for ACSAA, if the Australian Government so desired.

With regard to the applicability of ISO 9001 standards to RACHs, Heras et al. (2008) conducted a study to evaluate the suitability of the ISO 9001 standard to the needs of the residential aged care sector in Spain. Using the Delphi methodology, fourteen (14) experts in the field (i.e. people familiar with both the residential aged care sector and several quality management models) were surveyed. In their study, they found that ISO 9001 would not be a suitable tool for all types of residential homes; in smaller homes that have fewer resources it would probably increase the workload on management and direct-care personnel, which could result in being counter-productive. The authors also found that some aspects of the organisation (such as the definition and standardisation of work procedures) may benefit from the adoption of the standards, and that these could have an indirect benefit on residents' quality of care. However, there was not enough evidence to support the conclusion that homes which have implemented ISO 9001 provide a higher level of quality of care than those who have not implemented it. As a result, it was concluded that residential aged care homes can have positive effects from the implementation of quality assurance programs (such as ISO), as these programs have the potential to enhance the systematisation of work routines. However, the efficacy of these programmes in relation to improving residents' quality of care is not evident. With regard to improving quality of life, the study demonstrated that ISO9001 can be a useful tool if (p.284):

- Its implementation has the objective of improving the quality of care;
- It is adapted to the needs of all stakeholders (residents, their families, employees, managers, public administration and so on);
- There are sufficient resources for effective implementation; and
- All persons directly involved in the care of residents participate in the implementation.

[37] The IWA 1:2005 are ISO guidelines for process improvements in health care organisations

Given that ACSAA has as its function to promote high quality care in RACHs, the findings of the study conducted by Heras et al. (2008) sustains the importance of the present research in learning about the influence the adoption of accreditation standards has on the quality of services provided by RACHs. Additionally, similarly to the Spanish study, the adoption of accreditation by smaller RACHs in Australia might have a counter-productive result.

In another study, aiming to achieve growth, efficiency, improvement, and optimizing quality of care in a hospital in the Netherlands, van den Heuvel et al. (2006) implemented and integrated an ISO 9001:2000 quality management system with Six Sigma, a quality improvement approach from the manufacturing industry. After the ISO's implementation it was observed that the hospital's quality management approach seemed to be working well, although the projects' management controls were not effective in many ways. Thus, it was decided to implement Six Sigma given that it assists in tackling performance problems, and also provides an organisational structure composed of project leaders who are trained in project management, problem-solving methodology, and statistical methods. Hence, the focus on data and statistical substantiation of conclusions performs as a counter-balance to the frequently subjective and intuitive way of working in health care. Finally, the results of the study indicated that ISO 9000 and Six Sigma are highly complementary in providing the instruments needed to achieve organisational improvement; given that both focus on processes, client wishes, continuous improvements, employee involvement, fact-based decisions, and a systems approach to management. Based on the study conducted by Heuvel et al. (2006), it may be suggested that the adoption of ACSAA accreditation standards may also not be effective for management control due to the "subjective and intuitive way of working in health care".

3.5 Conclusion

This chapter explored the foundations of quality management by introducing some fundamental quality concepts such as quality of design, quality of conformance, quality of performance, quality of care, and quality of life, amongst others. It described the attributes that, singly or combined, establish a definition of quality; which include efficacy, effectiveness, efficiency, optimality, acceptability, equity, and legitimacy; the latter being discussed in detail in the next chapter of this research.

It also discussed the components of total quality management; examined the unique characteristics of services and how they affect quality; and considered different quality management systems that have standards which organisations can utilise in order to improve their processes. This chapter also demonstrated the importance of quality management being present in every aspect of the organisation, so that total quality and customer satisfaction can be achieved. Additionally, it demonstrated the reasons why standards developed and/or managed by ACSAA should not be prescriptive and should, instead, provide a defined approach only.

4 THEORETICAL FRAMEWORKS

4.1 Introduction

Institutional environments "are characterised by the elaboration of rules and requirements to which individual organisations must conform if they are to receive support and legitimacy" (Scott, 1987, p. 498). Institutions can therefore be defined as regulatory structures, laws, certifications and accreditation bodies, governmental endorsement and requirements, public opinion, and professions, amongst others (Scott, 1987).

For instance, as it relates to this study, the Australian Aged Care Industry is heavily regulated. RACHs must be compliant with the Accreditation Standards (as discussed in chapter three), in addition to food service regulation to vulnerable people[38] (NSW Food Authority, 2011), building quality certification (Australian Government Department of Health and Ageing, 2005), and work health and safety regulation (WorkCover Authority of NSW, 2011), for example.

Therefore, the forces of the institutional environment that surround RACHs maintain an important role in influencing and modelling these organisations through the regulations imposed on them. For example, see chapter three, the accreditation program managed by ACSAA contains standards with which RACHs must comply in order to receive funds from the government, and to avoid sanctions. As a result, one could assume that RACHs adopt the accreditation program simply because they face coercive pressures from the government.

This said, would RACHs still adopt the accreditation system if it was not compulsory? What are the other reasons for RACHs adopting the accreditation standards? Do the coercive pressures levied on these organisations result in optimal or less than optimal delivery of quality care (i.e. through the implementation of standards and industry comparison); this is not yet known. For instance, do RACHs adopt the accreditation standards only because they are compulsory, or do they do so because they believe it improves their processes, the level of services they provide to residents, and to gain legitimacy from their stakeholders? If the program was no longer compulsory, and RACHs could choose whether they would still adopt it to improve their processes, services, and so forth, would they still do so? The adoption of

[38] Means a person who is in care in a facility, such as for example nursing homes for the aged, or a client of a delivered meals organisation, (WorkCover Authority of NSW, 2011).

accreditation standards certainly results in RACHs being legitimate in complying with the accreditation requirements, but does it truly make them legitimate in respect of improving the quality of services provided to their residents?

Thus, this research aims to understand the reasons why RACHs adopt the accreditation standards, and what influence they believe that their adoption has on RACH services. The utilisation of institutional theory is therefore expected to provide guidance and focus in conducting this empirical work, through providing an enhanced understanding of the relationship between adoption and quality and its outcomes.

Therefore, in this final chapter of the literature review a discourse concerning institutional theory and more specifically new institutional theory is provided, where the mechanisms through which institutional isomorphic pressures occur in an organisation and the pillars that underlie institutional order are described. Finally, the application of institutional theory in research (e.g. is the education, accounting and health sectors) is explored.

4.2 Institutional Theory

Institutional theory has evolved over a century and more, with contemporary scholars (Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Scott 1995) drawing inspiration from the contributions of the pioneers (Marx (1844; 1846), Durkheim (1893), Weber (1904; 1918; 1924), Parsons (1934; 1951), Mead (1934), Schutz (1934), Berger (1967), Luckmann (1967), Bourdieu (1971, 1973) (Scott, 2008b). Most of the early work on institutions elaborated upon by these authors was limited to the fact that little attention was given to organisations. Some theorists emphasised their investigations on wider institutional structures (constitutions and political systems, language and legal systems, and kinship and religious structures), while others focused on the development of common meanings and normative frameworks due to social interaction (Scott, 1995). However, few theorists regarded organisations themselves as institutional forms or gave attention to “the ways in which wider institutions shaped collections of organisations” (Scott, 1995, p.17).

Institutional theory then progressed from the “old” to the “neo” institutional theory, with John Meyer and colleagues (Meyer and Rowan, 1977, Meyer et al., 1978, Meyer et al., 1981) formulating the first arguments that the formal organisational structure reflected not only technological imperatives and resource dependencies but also institutional forces (Scott,

2008a), and supporting the idea that much of what occurred inside organisations had little to do with the objective tasks in which they were engaged (Palmer et al., 2008). The new institutionalism assisted in explicating why organisations are so similar and the reasons why managers would implement administrative practices from other industries. It recognised that the process of managing relates not only to achieving technical efficiency in performing the job but also in presenting the organisation and its management as “informed”, “up-to-date”, and “compliant” (Palmer et al., 2008, p. 739).

Hence, the new institutional theory was developed to emphasise legitimacy, structural decoupling, satisfying behaviour and symbols. It proposes that organisations are more homogeneous (i.e. isomorphic) as they react to external regulations, and as a result pursue ways to adapt to these pressures, yet not necessarily incorporating strategies, structures, and processes towards enhancing their performance (Frumkin and Galaskiewicz, 2004). In their work, DiMaggio and Powell (1983) argued that organisational changes are less driven by competition and the need for efficiency and that, instead, occur “as a result of processes that make organisations more similar without necessarily making them more efficient” (p.147). For instance, Meyer and Scott (1992) specifically noted that nursing homes properly fit the pattern of an institutionalized organization, by stating: ‘‘These organizations survive by concentrating their energies not on the effective and efficient performance of their technical work but on conforming to the requirements of regulatory agencies’’ (p. 125). This observation sustains the importance of the present research concerning our understanding of whether conforming to accreditation standards does or does not lead to an efficient and effective performance of the services provided by RACHs, which is the ultimate objective of an accreditation body.

Thus, given that the new institutional theory focuses on the institutional forces that shape organisations, it seems to be the most appropriate to be used in this research. As such, the new institutional theory will be examined in more detail theoretically, along with an overview of how it can be linked and assist in achieving the aims of this research.

4.2.1 The New Institutional Theory

In the early stages of the new institutional theory, Meyer and Rowan (1977, p. 340) observed that organisations incorporate institutional rules in order to gain legitimacy, resources,

stability, and enhanced survival prospects. Meyer and Rowan (1977) also note that being isomorphic with institutionalised rules, however, results in a decrease of internal coordination and control, which has some crucial consequences for organisations:

- Elements are incorporated due to being externally legitimated, instead of enhancing efficiency;
- The value of structural elements are outlined by external evaluation criteria; and
- Turbulence is moderated and stability sustained due to reliance on external institutions.

As a result, Meyer and Rowan (1977) observe that institutional isomorphism fosters the success and survival of organisations through qualifying them to remain successful by social definition, and therefore defending them from failure. However, Meyer and Rowan (1977, p. 341) suggest that "to maintain ceremonial conformity, organizations that reflect institutional rules tend to buffer their formal structures from the uncertainties of technical activities by becoming loosely coupled, building gaps between their formal structures and actual work activities". Hence, to protect their formal structures from the uncertainties of these rules, organisations' structures may become decoupled from each other. This occurs because conformity to these rules usually results in less efficiency and through decoupling, organisations can resolve this conflict, yet maintain legitimacy with stakeholders while preserving internal flexibility according to practical considerations (Meyer and Rowan, 1977). However, Boxenbaum and Jonsson (2008) observed Meyer and Rowan's (1997, p. 357) remark, that gaining legitimacy without really adjusting depends critically on the "logic of confidence and good faith", noting that inspection must be avoided by those organisations that decouple to prevent them being exposed as impostors. This, therefore, leads one to wonder if the criticisms of the RACH accreditation program in the Productivity Commission Report are deemed true (i.e. that "most facilities pass accreditation because managers and staff know how to subvert the process" noted in chapter three, page 60), how *do* RACHs successfully go through the processes and therefore achieve accreditation without accreditation assessors noticing decoupling? Is there perhaps a lack of consistency and/or efficiency in how and by whom audits are carried out? Therefore this suggests that institutional isomorphism supports the success and survival of organisations through an increase in their legitimacy and survival prospects, regardless of an immediate efficacy of the attained practices and procedures. One way of resolving conflict between ceremonial rules and efficiency is by utilising decoupling; which means that organisations maintain a gap between their actual work practices and formal

policies. As a result, organisations are able to gain legitimacy with their stakeholders while maintaining an internal flexibility according to practical considerations.

Later, DiMaggio and Powell (1983) employed a seminal distinction to address the three different mechanisms through which institutional isomorphic pressures occur: coercive, mimetic, and normative. Scott (1995, 2008a, b) further developed these mechanisms by differentiating the three pillars that underlie institutional order: regulative, normative, and cultural-cognitive components. These components are, therefore, directly related to the mechanisms that support institutionalisation, through providing three related but unique bases of legitimacy (Scott, 1995). The mechanism that supports the regulative pillar is the coercive isomorphism, the normative pillar is the normative isomorphism, and the cultural/cognitive pillar is the mimetic isomorphism. Accordingly, the mechanisms through which institutional isomorphic pressures occur in organisations are now described, followed by the three components that are vital for organisations.

4.2.1.1 The Three Mechanisms of Institutional Order and The Three Pillars

4.2.1.1.1 Coercive Isomorphic Pressures and the Regulative Pillar

Coercive isomorphism consists of the pressures that are applied on organisations by other organisations, such as governments, upon which they are dependent and which apply regulatory oversight and control over them (Powell, 2007). Coercive isomorphism is also a result of cultural expectations from the society within which organisations function. Such pressures might occur as force, persuasion, or as an invitation to join in collusion. As a result, organisations are increasingly identical within certain domains and increasingly organised around rituals of conformity to larger institutions, while decreasingly having their structure determined by the limitations imposed by technical activities and decreasingly held together by output controls (DiMaggio and Powell, 1983). Thus, the regulative pillar involves the capacity to establish rules, review others' conformity to them and (as necessary), manipulate sanctions (rewards or punishments) in an attempt to influence future behaviour (e.g. no accreditation, no money). Given that, force and fear and experience are central elements of the regulative pillar, and are moderated by rules and/or laws (Scott, 1995). The mechanism that supports the regulative dimension is this coercive isomorphism, and so those organisations that operate in conformity with legal or quasi-legal requirements (e.g. rules, laws, sanctions) are considered legitimate.

For instance, RACHs undoubtedly receive coercive pressures from the government given that in order to receive government funds they must adopt and successfully satisfy the quality requirements of the accreditation program managed by ACSAA; this is determined under the Aged Care Act 1997 (2008). Each of the four accreditation standards then state that RACHs must "ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines about health and personal care";[39] which consequently includes compliance with the State Food Authority, building quality certification, work health and safety regulation, and others (as, for example, specific council regulations).[40] These regulations are applicable to RACHs that receive funds from the government,[41] which includes not-for-profit, government, and private RACHs. As a result, from a government perspective, the notions of New Public Management (NPM) (Pollitt, 1995, Noblet et al., 2006, Dunleavy and Hood, 1994, Hood, 1995) could have resulted in RACHs facing these heavy regulations as a way of the government monitoring the quality of services being provided by them, and also as a way to monitor and support its accountability for public funding. This is because NPM emphasises an organisations' efficiency, effectiveness, and quality; forcing the adoption of new technologies and processes and also in making the organisation more result-oriented (Noblet et al., 2006, Kloot and Martin, 2007). The eight elements[42] that comprise NPM (as per Figure 4.1) have a strong focus on the organisation's performance and on the government's accountability with regard to tax payers' money. This includes, for example, an increasing emphasis on service quality through the decentralisation of management authority within public agencies. The accreditation agency is an example of a decentralisation of government authority that, through the management of the accreditation program, oversees and promotes the quality of care in RACHs on behalf of the government. However, does being legitimate in relation to the accreditation standards also result in RACHs being legitimate with regard to the quality of their services? Hence, given that this research aims at looking at the reasons why RACHs adopt accreditation standards from the RACH perspective, and not from the government perspective, NPM does not seem to be the most applicable theory to be used in this research.

[39] Please refer to the accreditation standards on section 3.4.2 on chapter three.
[40] Apply for those RACHs that are "local government" (section 2.4 of chapter two provides a description of the different types of RACHs.
[41] Presently, it appears that there exist no fully private RACHs (i.e. RACHs that do not receive funds from the government). DOCTOR, S. 16th January 2013 2013. *RE: Enquiry about aged care.* Type to DOHA.
[42] Not every element is present in every organisation (Pollitt, 1995).

Figure 4.1 - Elements of New Public Management

- Cost cutting, capping budgets and seeking greater transparency in resource allocation (including activity or formula-based funding and, most recently, a shift to accruals accounting).
- Disaggregating traditional bureaucratic organizations into separate agencies (‘executive agencies’; ‘government business enterprises’; ‘responsibility centres’; ‘state-owned enterprises’, etc) often related to the parent by a contract or quasi-contract (‘performance agreement’, ‘framework document’, etc.).
- Decentralization of management authority *within* public agencies (‘flatter’ hierarchies).
- Separating the function of providing public services from that of purchasing them.
- Introducing market and quasi market-type mechanisms (MTMs).
- Requiring staff to work to performance targets, indicators and output objectives (performance management).
- Shifting the basis of public employment from permanency and standard national pay and conditions towards term contracts, performance-related pay (PRP) and local determination of pay and conditions.
- Increasing emphasis on service ‘quality’, standard setting and ‘customer responsiveness’.

Source: (Pollitt, 1995, p. 134)

4.2.1.1.2 Mimetic Isomorphic Pressures and the Cultural/Cognitive Pillar

Mimetic pressures derive from uncertainty, a force that encourages imitation. Whenever organisations face problems that they find hard to solve, they model themselves on other organisations. In addition, the wider the number of personnel employed by the organisation or customers served by them, the stronger the pressure it feels to provide the same programs and services offered by other organisations (DiMaggio and Powell, 1983). The cognitive pillar comprises, therefore, the rules that constitute the nature of reality and the frames through which meaning is made. In the cognitive paradigm, what one does is, in large part, a function of one’s internal representation of one’s environment (D’Andrade as cited in Scott (1995). Symbols such as words, signs, and gestures, have their effect by shaping the meanings we attribute to objects and activities; the meanings arise from interaction and are maintained and transformed by human behaviour as they are employed to make sense of the ongoing stream of happenings (Scott, 1995). The cultural/cognitive dimension is supported by mimetic isomorphism. The cognitive view indicates that legitimacy results from the adoption of a conventional framework (e.g. prevalence, isomorphism). For instance, mimetic pressures may occur if RACHs model themselves on other organisations to satisfy the accreditation standards or, if one approved provider has more than one RACH, uses the same procedures to satisfy the accreditation outcomes across all of its facilities. Ashworth et al. (2009) find that mimicry can also happen through the formation of benchmarking, although Northcott and Llewellyn (2005) note that the practical significance of benchmarking, imposed by

government policy, appears to be still uncertain in so far as it relates to improvement of health care. Northcott and Llewellyn (2005) determine that this is because benchmarking occurs by means of indicators with standardised benchmarks for performance (i.e. control), instead of comparative ideas that would result in the sharing of best practice (i.e. learning).

4.2.1.1.3 Normative Isomorphic Pressures and the Normative Pillar

Normative pressures originate primarily from professionalization, through formal education and intellectual base shaped by university specialists, and also through professional networks. Even though professionals within an organisation may differ from one another, they possess to a great extent similarities with their professional counterparts in other organisations. Normative isomorphism occurs through the filtering of personnel, as individuals are hired from firms within the same industry (DiMaggio and Powell, 1983). Hence, the normative pillar focuses on a prescriptive, evaluative, and obligatory dimension in social life, and includes both values and norms. Values are conceptions of the desirable along with the development of standards to which existing structures or behaviour can be compared and assessed, while norms specify the means to achieve the ends. Conceptions are prescriptions (normative expectations), and not simply anticipations or predictions of what is supposed to be done. Therefore, normative systems not only define goals and objectives, but also designate the appropriate ways to pursue them (Scott, 1995). The mechanism that supports the normative dimension is normative isomorphism; it emphasises the moral base for evaluating legitimacy. Normative controls are, therefore, much more likely to be internalised than regulative controls, and the incentives for conformity are likely to include both intrinsic and extrinsic rewards (e.g. certification, accreditation). Normative pressures may also occur if; new personnel are employed to provide assistance in the fulfilment of the accreditation requirements, if an employee from another RACH is hired and as a result makes changes to the RACH's processes, through staff membership of a professional association, or also through the influence of professional communities.

4.2.1.2 Concluding Comments

The three types of institutional isomorphic pressures (coercive, mimetic, and normative) reward organisations for being similar to other organisations in their fields. This, however, does not ensure that they are more efficient than organisations that are deviant from the process. As recognised by (DiMaggio and Powell, 1983, p.153), "It is important to note that each of the institutional isomorphic processes can be expected to proceed in the absence of evidence that they increase internal organisational efficiency."

Moreover, an examination of the previous discussion demonstrates that each component of the three pillars provides a basis for legitimacy. From an institutional perspective, legitimacy is a condition that reflects cultural alignment, normative support, or conformance with relevant rules or laws (Scott, 1995). Therefore, organisations incorporate institutional regulations with the purpose of gaining legitimacy, resources, stability, and enhanced survival prospects. Organisations are driven to incorporate the practices and procedures defined by predominant rationalised concepts of organisational work so that they become institutionalised in society; they do this in order to increase their legitimacy and their survival prospects (Meyer and Rowan, 1977). Meyer and Rowan (1977) state that institutional isomorphism is responsible for promoting the success and survival of organisations, and that incorporating externally legitimated formal structures increases the commitment of internal participants and external constituents. Further to this, they argue that the use of assessment criteria can enable the organisation to remain successful by social definition, protecting it from failure.

In environments that are institutionally elaborated, organisations become sensitive to and adopt external assessment criteria, which legitimate them with internal participants, stockholders, the public, and the state. They succeed in becoming isomorphic with these environments and gain the legitimacy and resources needed to survive (Meyer and Rowan, 1977). However, this can result in organisations becoming more similar without necessarily making them more efficient. DiMaggio and Powell (1983) suggest that early adopters of organisational innovations are commonly driven by a desire to improve performance, and that as innovation spreads, the limit is reached to a point that its adoption provides legitimacy rather than improves performance. Therefore, as it relates to this study, the ACSAA accreditation program contains standards, against which RACHs are assessed to gain

legitimacy, amongst other reasons.[43] As such, the adoption of accreditation standards may be important to RACHs in order to improve their standing in the eyes of their stakeholders (e.g. residents, families, government, staff, allied health professionals). RACHs being legitimate with the accreditation standards might for example enhance the enthusiasm of their staff and allied health professionals, which can result in better services provision to their residents. Consequently this may also result in RACHs attracting more business and as a consequence increasing their revenue stream; providing RACHs with stability, financial resources, and enhanced survival prospects.

Consequently, the three pillars are all associated with this research in some way. For example, from a regulative perspective, to receive funds from the government, RACHs must conform to the accreditation requirements imposed by government and sanctions are imposed upon RACHs if they do not conform to all standards. The normative process is characterised through the individual approach that each RACH uses to fulfil the standards of the accreditation program (given that ACSAA does not specify a designated way), and decide whether they want to comply with these standards on a minimum level or on an optimal level. Finally, the cognitive pillar is represented by how staff of different RACHs interpret and comply with the accreditation outcomes as compared to their peers and even to RACHs from the same group.

Hence, through the use of institutional theory it will be possible to identify, describe, and explain some of the pressures RACHs face in relation to accreditation, and the extent to which these pressures positively affect the quality of the services provided by RACHs to their residents. Institutional theory will also assist in understanding the main reasons why RACHs adopt accreditation, and how its adoption influences the quality of RACH services. For instance, do RACHs adopt accreditation standards to gain legitimacy from its various stakeholders? If adoption of accreditation was not compulsory as to receive funds from the government, would RACHs still adopt it? If so, is it because they believe it improves the quality of their services or to gain legitimacy? Do RACHs observe the processes of other RACHs so as to fulfil the accreditation requirements? Do staff improve RACH processes based on their previous work experience? Does decoupling occur with regard to fulfilling accreditation standards? Does the adoption of accreditation result in the care provided to patients being foregone due to the documentation that is involved to demonstrate compliance with the standards? Ultimately, does the adoption of accreditation, which results from a

[43] As observed in chapter two, the Aged Care Act 1997 provides for the regulation (accreditation standards) and funding of aged care services.

governmental pressure, result in RACHs being more efficient and therefore legitimate in terms of the quality of services provided to their residents? Thus, the discussion of this section leads to the construction of the following propositions:

P4: Accreditation standards are adopted by RACHs to ensure funding from the Australian government.

P5: Accreditation standards are adopted by RACHs to improve their standing in the eyes of stakeholders.

Thus, through the observations made above, it appears that this strand of institutional theory is particularly appropriate for the current study because it provides a number of suitable analytical tools to address the aims of this research. Institutional theory has also been used in other studies from diverse areas, and in some cases it has been used in combination with quality and/or accreditation. As such, to demonstrate how it has been utilised, the following three sections of this chapter will provide an overview of some of these studies. Yet, it should be noted that an extensive evaluation of publications relating to institutional theory and quality and/or accreditation is not the exclusive purpose of this research and as such, a limitation of this study may be that some works might have been overlooked. However, this does not invalidate the importance of examining some of the research undertaken and their findings; given that this will assist in providing a reasonable representation of the primary thrusts as to support a critical review. Please note that the methodological review of the existent literature that was conducted in this research is detailed in the next section prior to each Table.

4.2.2 The Application of Institutional Theory in Research

Institutional theory has been widely used in different contexts to explain how rules, norms, and shared strategies shape human behaviour. It has been used in studies in the public sector (Crank, 2003, Giblin and Burruss, 2009), private sector (Pioch et al., 2009, Mesquita et al., 2007), health sector (Covaleski et al., 1993, Broadbent et al., 2001, Lemieux-Charles et al., 2003), accounting (Carpenter and Feroz, 1992), finance (Merkl-Davies and Brennan, 2007), information systems (Currie, 2009), human resources management (Boon et al., 2009, Chow, 2004), and education (Ogawa, 1993, Reed, 2009, Almog-Bareket, 2012), amongst others.

Exploring some of this prior research provides insights on the applicability and utilisation of institutional theory in the health care sector. For example, Covaleski et al. (1993) argue that case-mix accounting systems are used by U.S. hospitals administrators as a means of showing conformity with institutionalised rules and expectations of external constituents, as an advocate to the hospital and to assist in generating resources. These authors expanded on the issues of power and decoupling, and found that case-mix accounting systems may play a significant role in not only supporting but also establishing and perpetuating the social structure of legitimacy. Also, it has the potential to penetrate and modify the internal operating processes of financially strained hospitals. Furthermore, Kirby et al. (1998) employed institutional theory to observe how the business success of managed care organisations[44] (MCOs) can be influenced through adherence to several "institutional" and "technical" environmental forces. Kirby et al. (1998) identified institutional forces as socially accepted procedures for delivering care, and technical forces are identified as the industry standards for cost control and the utilisation of financial and medical resources in an efficient manner. As a result of their investigation, they concluded that MCO executives who want to be successful must understand the external environment in which they operate, placing an equal emphasis on both technical and societal demands. Finally, (Zinn et al., 1998) utilised a combination of resource dependence and institutional theories to examine the contextual attributes that influence the adoption of total quality management (TQM) by nursing homes in the Commonwealth of Pennsylvania. From the survey, it was found that attributes that significantly affect TQM adoption include perceived competition, the influence of the Medicare program on the market level, and the proportion of Medicare recipients in a facility.

Therefore, since institutional theory was the theoretical framework chosen for this study, and that quality and accreditation are also a main focus of this research, as discussed in chapters two and three, the next section concentrates on examining studies that have utilised institutional theory whilst looking at quality and/or accreditation and that are relevant to this research (indicated in Tables 4.1 and 4.2). The review of the literature was undertaken through searching EBSCOhost and ABI/Inform Global Proquest electronic databases using keywords appropriate to this research.

[44] an organization that combines the functions of health insurance, delivery of care, and administration" THE FREE DICTIONARY 2010. Managed Care Organization. Retrieved 29th April 2010 from: http://medical-dictionary.thefreedictionary.com/managed+care+organization.

Table 4.1 - Institutional Theory and Quality

Area	Author	Purpose	Major Findings
Education	(Coburn and Talbert, 2006)	Examines how individuals in one urban school district respond to demands of using evidence-based practice to guide their educational improvement efforts.	Illustrates the ways that individuals perceive high-quality evidence, appropriate evidence use, and high-quality research. It then explains variation in conceptions.
Management	(Martínez-Costa et al., 2008)	Examines the internal and external motivations for implementing TQM and ISO 9000 in Spanish industrial companies.	The implementation of TQM affects companies' performance in a positive manner, while the implications of implementing ISO 9000 still need to be further studied.
Public Sector	(Bowerman, 2002)	Uses isomorphism to explain the progress of a Business Excellence Model in the UK's public sector service.	Government must be aware of its ability to create coercive isomorphic pressures, and only embark on new initiatives if they are convinced they will bring a practical benefit to the organisation.
Health	(Zhang and Wan, 2007)	Explores the effects of the institutional mechanisms on the isomorphism of nursing home quality.	Findings indicate that the quality of nursing homes is more responsive to the coercive mechanism than the normative and mimetic.
	(Zinn et al., 1998)	Had an objective of examining the contextual attributes that have an influence on the adoption of total quality management (TQM) by nursing homes in the Commonwealth of Pennsylvania.	The findings provided limited support for the association between TQM adoption, institutional factors, and some rational adaptation in nursing homes.

Table 4.2 - Institutional Theory and Accreditation

Area	Author	Purpose	Main Findings
Public Sector	(Giblin, 2006)	An exploratory study that examines the influence of institutional factors on the elaboration of organisational structure in police organisations in the United States.	Institutional factors, in particular accreditation standards, can have several roles in shaping organisational structures.
Education	(Menassa et al., 2009)	To examine professors' and students' perceptions on accreditation, more specifically on its meaning and perceived advantages and disadvantages.	Accreditation was related to various factors such as: quality assurance and continuous improvement, school/program image, positively affecting the educational level of the school.

Tables 4.1 and 4.2 provide a brief summary of some results obtained when searching the databases earlier mentioned. These studies are further explored in more detail given that they provide insights into how institutional theory combined with quality and accreditation can be useful when applied to this research, in terms of considering possible results and what can be explored. However, these studies either considered institutional theory whilst looking at quality and/or accreditation from a different perspective (e.g. looking at contextual attributes that influence the adoption of TQM by nursing homes in Pennsylvania) and/or in a different context (e.g. education, information technology, management, private sector, or other area in health care) when compared to this research. Therefore, the following two sections explore the use of institutional theory when applied to quality and/or accreditation and are followed by concluding comments, which provides a clearer context for this research.

4.2.2.1 Institutional Theory and Quality

As mentioned above, this section examines studies that utilised institutional theory combined with quality in diverse industries. Examining these studies provides an enhanced understanding of how institutional theory has been used, and into possible issues that, from an institutional theory perspective, can occur within RACHs when adopting quality programs. This section presents five case studies, which consider the following themes (in this order): 1) legitimacy and the reasons for adopting the ISO 9000 quality program (Martínez-Costa et al., 2008); 2) institutional isomorphic pressures and decoupling to explain the progress of a local business excellence model (Bowerman, 2002); 3) institutional isomorphic pressures to investigate factors that affect quality of care (Zhang and Wan, 2007); 4) using institutional theory to investigate how schools respond to government policies (Coburn and Talbert, 2006); and 5) using institutional theory to examine which attributes influence the adoption of total quality management (Zinn et al., 1998).

Martínez-Costa et al. (2008) used institutional theory and the resource-based view of the firm to consider the internal versus external motivations for implementing the quality certification program ISO 9000 in Spanish industrial companies. As such, a survey was conducted to determine whether organisations were internally or externally motivated to implement ISO 9000 and to determine whether this impacted on the performance improvement from before to after certification. Findings suggested that companies which implement ISO 9000 due to internal motivation (because they want the implementation to have an effect on internal business processes) do continue to improve after receiving certification and have better performance outcomes. Companies that apply for ISO 9000 due to external motivation (because they want the implementation to have an effect on external perceptions of the company) fail to show improvement after receiving certification. Therefore, companies that obtain certification motivated by internal reasons achieve better final results than those motivated by external reasons because decoupling does not occur. As noted by Meyer and Rowan (1977), isomorphism can have some critical consequences for organisations given that it results in elements being incorporated because they are legitimate externally, rather than in terms of improving an organisation's efficiency. In Australia, it is evident that the adoption of accreditation standards by RACHs is due to external motivations, given that this is a requirement from the government. This, however, may result in RACHs not achieving superior final results, and therefore not being legitimate with regard to the quality of their services to residents. Thus, learning from RACHs' managers whether they would still adopt

accreditation standards if it was not compulsory, reveals whether they ultimately adopt the program for internal or external reasons.

Bowerman (2002) draws on coercive, mimetic and normative isomorphisms and decoupling to explain the progress of the European Foundation for Quality Management (EFQM) Business Excellence Model in London's local government. The author observes that although isomorphism is closely intermingled with the gaining of legitimacy, adopting widely accepted rational practices does not guarantee the conferral of legitimacy. For instance, Bowerman (2002) refers to the work of (Edwards et al., 2000, Lapsley and Pallot, 2000, Lawton et al., 2000) who observed that "studies suggest that there is a reasonably good fit between the theory and the empirical evidence, but they do not explore the question of whether the goal of legitimacy is attainable" (Bowerman, 2002, p. 2). Consequently, Bowerman (2002) concludes that government must be conscious of its ability to apply coercive isomorphic pressures in organisations and, as such, should only put in place new initiatives when they are convinced it will provide the organisations with a practical benefit. Given that the successful compliance of the accreditation standards managed by ACSAA is a pre-requisite for receiving government funds, Bowerman's observation draws attention to the issue of whether adoption of accreditation standards does in fact improve the quality of RACHs. Similar to Bowerman's study, this research will demonstrate whether RACHs' being legitimate (in the eyes of government, residents and family members, for example) in terms of receiving accreditation does also promote legitimacy in terms of continuously enhancing quality.

Zhang and Wan (2007) utilise institutional theory to investigate the factors that affect the quality of care in nursing homes in the U.S. Data variables were analysed according to the isomorphic pressures and include for example reimbursement (coercive), licensed nurses ratio (normative), and rehabilitation orientation (mimetic). The measurement model of "isomorphic quality"[45] consisted of eight quality indicators, ranging from isomorphism of quality of care to isomorphism of nursing home administration. Findings suggest that the isomorphic quality of nursing homes is motivated by regulatory and payment constraints. Normative and mimetic mechanisms have less influence in explaining isomorphic nursing home quality. Zhang and Wan's (2007) study supports the fact that the quality of nursing homes is more responsive to regulatory and payment constraints. If this is the case, then the adoption of accreditation standards by RACHs must result in enhanced quality given that it is a regulation which is directly related to government funds.

[45] The authors use the term "isomorphic quality" to refer to "the trend of changes in the quality of care being so similar in most nursing homes facilities" (Zhang and Wan, 2007, p.381).

Utilising case study research, Coburn and Talbert (2006) apply sensemaking and institutional theory to investigate how school districts respond to policies (in particular the No Child Left Behind Act – NCLB) that require them to use evidence to guide their educational improvement efforts. However, the way districts respond to these policies is likely to be affected by how individuals in each district comprehend what it means to use evidence. The NCLB follows on from and coexists with other reform efforts that also promote evidence use, although with a rather different emphasis. As a result, there are sometimes multiple and conflicting norms of evidence use that coexist, and understanding how they coexist in a particular district is an important concern when developing local reforms that aim to use evidence to improve educational quality and equity. Even though Coburn and Talbert (2006) have a different focus from the present study, reflecting upon their findings provided some considerations: 1) Is it clear for RACH staff how they should provide evidence for each of the 44 accreditation expected outcomes? 2) Do RACH staff believe that there is consistency amongst the accreditation assessors when evaluating RACH compliance with the required outcomes? 3) Is there consistency between the standards of the various bodies that RACHs must be compliant with (e.g. WorkCover Authority of NSW (relating to Occupational Health and Safety laws (OH&S[46]), and Food Authority)?

Finally, Zinn et al. (1998) utilised both resource dependence theory (RDT) (rational adaptation) and institutional theory (IT), to examine the contextual attributes that influence the adoption of total quality management (TQM) by nursing homes in the Commonwealth of Pennsylvania. Five hypotheses were developed taking into consideration four key aspects: the influence of competition on TQM adoption; the influence of the nursing home's size on TQM adoption; the influence of Medicare and managed care (HMO) market penetration on TQM adoption, and the experience with Medicare programs and TQM adoption. The last two aspects relate to the fact that hospitals (Medicare patients) and managed care organisations refer their patients to nursing homes and so, in order to ensure their own reputation, TQM may become a selection criterion. To test the five hypotheses, data was collected from three sources: a survey with nursing homes administrators; Medicare and Medicaid Annual Certification Survey data file; and the Area Resource File. From the five hypotheses, one was partially supported (influence of competition), two were supported in full (Medicare market penetration and proportion of Medicare recipients), and two were not supported (facility size and HMO market penetration). Thus, results provided limited support for the association

[46] OH&S laws are administered and overseen by the WorkCover Authority of NSW. During the course of this study OH&S has changed to Work Health and Safety (WHS), however it will be referred to as OH&S throughout this thesis for consistency purposes with the accreditation outcomes.

between rational adaptive and institutional factors and TQM adoption in nursing homes. Institutional theory was used as a conceptual basis for predicting an association between TQM adoption and the extent of participation in a Medicare program in an individual facility. Nursing homes that had greater involvement with the Medicare program and as a result more direct contact with hospital practices were predicted to be more likely to conform to hospital quality improvement standards through TQM adoption. Those nursing homes that adopted TQM cited improvements in resident outcomes and employee relations as a motivation for quality improvement. Zinn et al.'s (1998) study differentiates from this one in many aspects. Firstly, it looks at the attributes that influence the adoption of TQM by nursing homes in Pennsylvania, while this study looks at the reasons why RACHs in Australia adopt the accreditation program managed by ACSAA and the influence of its adoption in the quality of RACHs. Additionally, it uses surveys, secondary data and hypotheses, whilst this study is an embedded multiple case study with interviews, analysis of documentation (where possible) and propositions. Finally, it uses a combination of resource dependence and institutional theory whereas this study focuses on institutional theory only. Regardless of these differences, contemplating the work of Zinn et al. (1998) as it relates to this research prompts the consideration of some issues. For example, should a combination of institutional and resource dependence theory be used (this is discussed further in this chapter)? Do small RACHs have different views from large RACHs with regard to the accreditation program? Does the adoption of accreditation improve RACH residents' outcomes (residents' quality of care and quality of life)?

4.2.2.2 Institutional Theory and Quality Accreditation

This section examines two studies in different industries that utilised institutional theory combined with quality accreditation. An examination of these studies and their findings provide an understanding of staff perceptions and of matters that can occur when organisations adopt quality accreditation programs; providing an understanding of issues that may also occur within RACHs when adopting the ACSAA quality accreditation program. These studies are presented below, and they look at the following themes (in this order): 1) the influence of institutional isomorphic pressures when incorporating a crime analysis unit into a police organisation's structure (Giblin, 2006), 2) the perceptions of professors and students of an accreditation process (Menassa et al., 2009).

Using a combination of institutional and contingency theories, Giblin (2006) examines the influence of institutional factors on the incorporation of a crime analysis unit into a police organisation's structure. Findings of that research suggest that organisational structures are shaped by many institutional factors, particularly accreditation under the normative pressures. This is because CALEA's (Commission on Accreditation for Law Enforcement) standards require large agencies to have a formal crime analysis unit. Even though decoupling is not specifically mentioned by Giblin (2006), it appears that it occurred since two respondents mentioned that standards required a crime analysis function yet all they did was to collect data. Mimetic isomorphism is also present due to the adoption of specific programs on crime analysis that most agencies are part of. Funding (coercive pressures) appear to have limited effect given that there is minimum influence of external funding. Giblin's study differs from the present research given that it focuses on factors that influence organisational structure (e.g. accreditation), while this project aims to examine how accreditation either does or does not impact on the quality of services provided by RACHs. Nonetheless, Giblin's study gives attention to how decoupling can happen in organisations, and to whether the adoption of accreditation standards might lead to decoupling between RACH processes and accreditation standards.

Finally, Menassa et al. (2009) used institutional theory when conducting a study on Lebanon's business schools, which examined professors' and students' perceptions of the accreditation process, focusing on meaning and perceived benefits and disadvantages. Findings suggest that accreditation was associated with quality assurance and continuous improvement; would strengthen the image of the school/program; and positively affects the educational level of business schools. Improved image was also associated with better mobility and job prospects for both professors and students. Menassa et al.'s (2009) study is similar to the present one given that it examines students' and professors' views on accreditation (as compared to RACHs in this study), yet it differs in its main purpose. This research focuses on learning from RACH staff whether they believe the adoption of a specific accreditation program (and not accreditation in general) does in fact enhance the quality of their services. Nonetheless, it highlights some key staff perceptions that are associated with an accreditation process, and so it will be interesting to determine whether RACH staff also associate adoption of accreditation to quality assurance, continuous improvement, legitimacy purposes and service enhancement.

4.2.2.3 Concluding Comments

An examination of the studies previously discussed has a twofold purpose as it relates to the present study. Firstly, they highlighted concerns from an institutional theory and quality/accreditation perspective that may occur in RACHs when adopting the ACSAA accreditation standards, which should be considered when conducting this research. Secondly, this investigation provided evidence that these studies serve different purposes and occurred in differing contexts compared to this research; with the exception of Zinn et al. (1998) and Zhang and Wan (2007) studies, which focused on aged care homes. Hence, none of the presented reviews of empirical studies utilises institutional theory to examine how accreditation impacts quality in Australian RACHs or supports the motivation and contributions of the present research, suggesting that there is a gap in the literature in this regard. Consequently, institutional theory will be used in this research to analyse how the Australian accreditation system managed by ACSAA influences quality and shapes RACHs.

4.3 Conclusion

This chapter focused on neo-institutional theory, which was deemed to be the most suitable to assist in answering the research questions. It highlighted the three mechanisms of institutional order (i.e. coercive, mimetic, and normative), along with the three pillars (i.e. regulative, cultural/cognitive, and normative), and explored how these might be applicable to this research. It then examined the utilisation of institutional theory in recent research, more specifically as it relates to quality, and quality and accreditation. The findings of these empirical studies provided insights into the application of institutional theory in the health care sector and also assisted in developing interview questions for this study. Thus, this chapter constituted the final chapter of the literature review, along with chapter two that portrayed the ageing population and aged care systems, and chapter three that explored the nature of quality and accreditation. These three chapters combined clearly position the context of this research as it relates to understanding the influence of quality and accreditation into RACHs from an institutional theory perspective. The method used to conduct this research is, therefore, discussed in the following chapter.

5 RESEARCH METHOD

This research aims to determine the influence of the adoption of ACSAA accreditation standards on the quality of RACH services, and to determine the reasons why RACHs undertake the accreditation process. It seeks to clarify whether RACHs adopt accreditation standards aiming to improve the level of quality of their services to residents, or because they must do so to receive funds from the government and also gain legitimacy from their stakeholders. It also seeks to clarify whether the accreditation process does ultimately improve the level of quality of RACHs or whether it simply represents the achievement of minimum standards of quality.

To achieve the aims of this research many aspects were considered in previous chapters, namely the ageing population and the context of the Australian aged care system, the nature of quality and accreditation, and the theoretical frameworks to be used as a foundation for this research. As specified in chapter one, the research questions that this study seeks to answer are:

1. In addition to government funding, why do RACHs adopt accreditation standards?
2. What perceived influence does the adoption of accreditation standards have on the quality of RACHs? How is this viewed by different staff members of RACHs?

And the propositions identified for this study are:

P1: Adoption of accreditation standards improves the quality of care provided to residents.	Research Question 2
P2: Adoption of accreditation standards improves residents' quality of life.	Research Question 2
P3: Accreditation standards are adopted by RACHs to influence the level of quality of their services.	Research Questions 1and 2
P4: Accreditation standards are adopted by RACHs to ensure funding from the Australian government.	Research Question 1
P5: Accreditation standards are adopted by RACHs to improve their standing in the eyes of stakeholders.	Research Question 1

The purpose of this chapter is to describe the methodology utilised in this study that is appropriate to support answering the research questions and to determine whether the

propositions are supported or not supported. Hence, this chapter comprises the following sections: research method, population and sampling, development of research instruments, method of data collection, data analysis and communication of findings, and validity and reliability.

5.1 The Research Method

To serve the purpose of this research a qualitative research design is utilised; the justification thereof is presented next.

In this study, the nature of the research process is a holistic study with multiple-case design, with results emerging from the data leading to context-bound information. The data is both qualitative and quantitative, and it will consist of a small informative sample. Data will be analysed by searching for themes and categories, seeking to understand the main reasons why RACHs undertake the accreditation process, and to learn whether the adoption of accreditation process does improve the quality of the services provided by RACHs. Findings will be communicated through a written report, using narratives and individual quotes to describe any possible commonalities and/or discrepancies between RACHs.

Based on the information presented above and on the characteristics of a qualitative approach as defined by Leedy and Ormrod (2005), the qualitative approach is the most suitable to be used in this study. Within the context of a qualitative approach, an exploratory-descriptive research design and a multiple case study approach will be utilised.

5.1.1 The Design

Three different research designs can be used by a researcher in a project, namely, exploratory, descriptive, and explanatory designs (Saunders et al., 2007, p.133); here, a combination of both exploratory and descriptive designs is used. An exploratory study is an effective method to “find out what is happening; seek new insights; ask questions; assess phenomena in a new light; and generate ideas and hypotheses for future research” (Robson, 2002, p.59). A descriptive research design has as its purpose “to portray an accurate profile of persons,

events and situations" (Robson, 2002, p.59). As such, through the exploratory-descriptive design it will be possible to demonstrate RACHs' judgments and perceptions with regard to the accreditation process, in terms of how it influences the quality of services provided by them, the reasons why they adopt accreditation standards (other than that they are compulsory), and seeking new insights in terms of how the process can be improved and/or simplified.

5.1.2 Justification of Case Study Approach

The case study approach will be used to achieve the aim of this research; more specifically an embedded multiple-case study. The objective of a case study is to search for the reasons why a given decision was taken, how it was executed, and what the final result was. This was noted this way by Schramm (1971, p.6): "The essence of a case study, the central tendency among all types of case study, is that it tries to illuminate a decision or a set of decisions: why they were taken, how they were implemented, and with what result." Utilising the case study method permits the researcher to obtain the holistic and meaningful characteristics of real-life events, as for example organisational and managerial processes (Yin, 2009). In addition, Eisenhardt (1989) observes that a case study allows a comprehension of the existing dynamics within single cases.

The use of case studies is demonstrated empirically in research that investigates the influence of institutional theory in public sector organisations. For example, Erakovic and Wilson (2006) used a case study to examine how institutional theory combined with resource dependence theory influenced organisational change in the public sector in New Zealand. Hoque (2005) also used a case study in a large Australian local authority to research whether organisations have restructured themselves to improve internal efficiency and effectiveness, or to have their business legitimised in respect of the several forms of institutional influence. The foundation of Hoque's work has some similarities to the present research, which aims to find whether adoption of accreditation standards is to contribute to quality management, and/or for RACHs to legitimate themselves as organisations. Brignall and Modell (2000) also use this research approach to investigate whether the successful implementation of multidimensional performance measurement and management in the public sector is influenced by institutional theory.

However, in using case studies, five components are especially important to ensure that an appropriate research design is developed (Yin, 2009). Hence, these five components are further considered as they relate to the present research.

1) The case study strategy is most likely to be appropriate for "how" and "why" questions (Yin, 2003, p.22), which occur in one of the research questions of this study. Please refer to page 84 of this chapter.

2) Propositions will be used instead of hypotheses, given that this research does not seek to reveal patterns within the data or to recognise relationships between categories (Cooper and Schindler, 2008, Saunders et al., 2007). As observed by Yin (2009), the proposition of a study directs attention to something that should be examined within the scope of the study. Examples of studies that have utilised propositions include (Ashworth et al., 2009, Brignall and Modell, 2000, Lai et al., 2009, Meyer and Rowan, 1977, Sila, 2007, Stan and Joan, 1996, Tsai et al., 2006, Zsidisin et al., 2005). The main propositions of this study, as they relate to the research questions, are stated on page 84 of this chapter.

3) Properly defining the unit of analysis: NSW Aged Care Sector with sub-units constituting individual RACHs.

4) The different analytic techniques that can be used to link the data to the propositions, such as: pattern matching, explanation building, time-series analysis, logic models, and cross-case synthesis (Yin, 2009, p.136). Given that this study analyses multiple cases (i.e. six RACHs in NSW), a cross-case synthesis technique will be utilised. For that, as suggested by Yin (2003), word tables will be utilised to analyse each interview question. This will allow the researcher to draw cross-case conclusions as they relate to similarities and/or discrepancies. However, a limitation of doing a cross-case combination is that the examination of word tables for patterns across cases relies greatly on the researcher's argumentative interpretation, instead of numeric records (Yin, 2003).

5) Finally, similar descriptions of the findings will be classified and addressed in order to interpret the study's findings according to the main propositions (please refer to page 84). Data analysis and communication of findings is detailed in section 5.5 of this chapter on page 101.

Additionally, case studies can comprise single or multiple-cases, and each of these can further contain one (holistic) or multiple (embedded) units of analysis (Yin, 2009). That author suggests that whenever possible, researchers should prefer multiple-case designs over single-case designs, noting that the researcher will have better chances of doing a good case study and that the analytic benefits from having two or more cases may be substantial. Furthermore, Miles and Huberman (1994, p.29) observe that "multiple-case sampling adds confidence to findings", as a single-case can be better understood by looking at a range of similar and contrasting cases. Also, the evidence collected from multiple cases is usually regarded as being more convincing, and therefore the overall study is considered more solid (Herriott and Firestone, 1983, Yin, 2009). For the purposes of this research, a multiple-case study will be utilised given that it includes six RACHs in NSW. This will provide analytic benefits to the researcher, adding confidence to the findings and resulting in a more solid study.

Yin (2003) also observes that in multiple-case studies an embedded design might be necessary to address one of the research questions that will not be answered by the holistic case, and this may demand a survey to be conducted at each case study site. However, Yin (2003) notes that a major pitfall of embedded designs is that the researcher might focus only on the subunit level of analysis and does not return to the larger unit of analysis. As it relates to this research, a survey will be valuable to learn the views of different members of staff within each RACH with regard to the accreditation process. This is important because the adoption of accreditation standards directly impacts those staff members who have immediate contact with residents. To avoid the embedded design pitfall mentioned above and to provide results from the organisation as a whole, results from staff surveys will be used concurrently with results from the interviews. Therefore, results obtained in the staff surveys will only be compared with the results of the interviews within each RACH, and not across different RACHs. As observed by Yin (2003), if survey data are pooled across cases the investigation is likely to be using a survey rather than a case study design.

Therefore, conducting an embedded multiple-case study will provide the researcher with substantial data with which to understand the views of different RACHs (according to their types and sizes) and of different staff within each RACH. Thus, the nature of this research process is a case study with embedded multiple cases. Examples of research on accreditation that have utilised an embedded multiple-case study design include Pomey et al. (2010), where the authors explored the kinds of organizational changes introduced as a result of the accreditation process within Canadian healthcare organisations. See also Ferrara (2007) who also utilised an embedded multiple-case study design in her doctoral thesis to investigate how

the requirements imposed by accrediting bodies were used by university leaders as a leveraging mechanism to institute and improve student learning outcomes assessment programs.

Case studies also have the potential to contribute to the current literature and to provide a set of hypotheses for future empirical testing, where results are then generalisable to theoretical propositions. This was observed by Yin (2009) when he wrote that "case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes" (p.15). Thus, in doing a case study, the researcher's goal is "to expand and generalise theories (analytic generalisation) and not to enumerate frequencies (statistical generalisation)" (p.15). Through the organisation of evidence gathered from research, a case study can (1) suggest hypotheses for testing or (2) provide a foundation of facts and suggestions for possible application to decision making (Schramm, 1971). As such, the results of the present study will provide well-grounded suggestions to policy makers, ACSAA, and researchers on how improvements can be made with regard to legislation and the assessment of the accreditation standards.

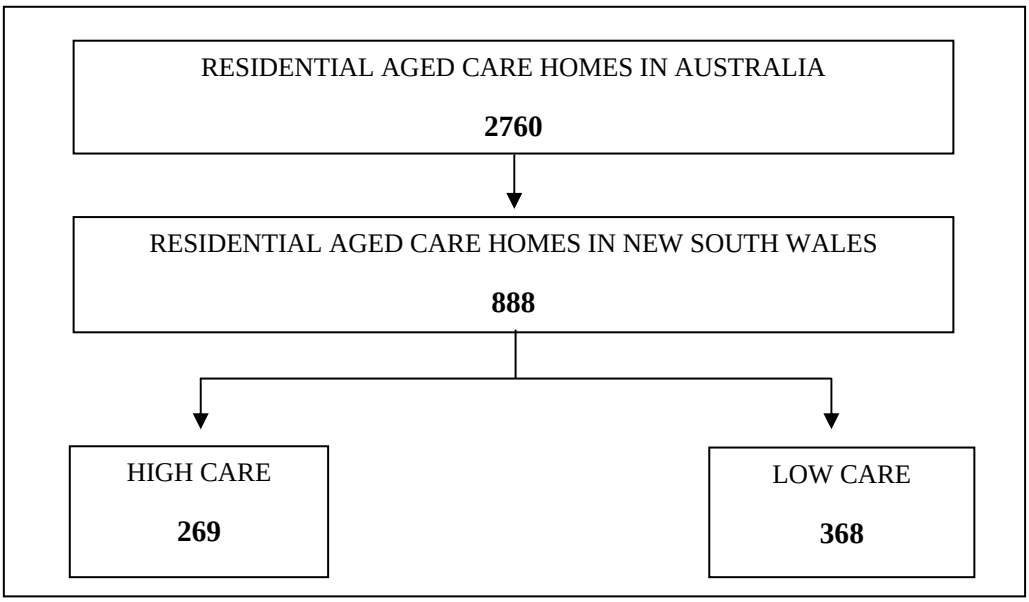
Examples of exploratory multiple-case studies include: Järvinen (2009) interviewed management accountants in five public hospitals to learn how they perceived their professional role was influenced by a change in management accounting and control systems as well as the underlying management agenda; Moxham and Boaden (2007) studied the applicability of performance measurement frameworks in 4 voluntary organisations; Qui and James (2010) analysed the dissemination and adoption of quality management in six manufacturing industries in China; and Martínez and Martínez (2007) investigated fourteen organisations so as to analyse future implications of ISO 9000:2000 for company performance in Spain.

Hence, the utilisation of a case study with an embedded multiple-case design sample will provide substantial in-depth data to answer research questions one and two and support a comparison of the RACHs. For instance, whether perceptions differ based on RACHs type of facility, level of care the RACH provides, RACHs number of beds (indicative of size), and RACHs funding received (see Table 5.1 on page 101). Moreover, the extent to which the views of different personnel within each facility differ (please refer to section 5.5 for additional details) as it relates to the influence of the adoption of accreditation standards on the quality of RACHs, may compare or contrast.

5.2 Population and Sampling

Currently, there are 2,760 RACHs in Australia, 888 of them in New South Wales (NSW) (DoHA, 2012d); see Figure 5.1 for the distribution of these homes.

Figure 5.1 - Number of Residential Aged Care Homes in Australia



Source: (DoHA, 2012d)

5.2.1 The Sample

Non-probability sampling, specifically convenience sampling, was used in this study. They were chosen based on my subjective judgement and therefore not all of them had the probability of being included in the sample. The means through which convenience sampling was applied in this study are further described in sections 5.4.1 and 5.4.2 of this chapter. Additionally, to ensure the confidentiality of RACHs and staff participating in this research, coding will be utilised to identify the respondents.

5.3 Research Instruments Development

All research instruments were newly developed; they were based on a thorough review of the literature which also included some key issues that RACHs currently face. This resulted in significant considerations that were raised throughout the previous chapters, and which led to the development of the research instruments to assist in answering the research questions of this study. Additionally, a couple of questions were developed after the researcher undertook an accreditation course (please refer to Appendix 9). As explained in section 5.3.4, a pilot study was conducted with staff of an RACH (interviews were conducted with three staff on a management level, and a survey was available to other staff members) to assess these questions so that the researcher could develop them further prior to conducting the main study. An overview of each of the final research instruments used in the main case studies, and an overview of the pilot study, is detailed below.

5.3.1 Interview Questionnaire (Appendix 10)

The interview questionnaire, administered to three staff members in each RACH, comprised of 17 open questions, categorised as follows:

A. Residential Aged Care Home Processes (questions 1-4)
B. Residents (questions 5-6)
C. Quality (questions 7-10)
D. Financial Aspects (questions 11-12)
E. Benchmarking (questions 13-14)
F. The Accreditation Process (questions 15-17)

Section A focuses on learning how the adoption of accreditation has improved the processes of RACHs, on how it has provided more guidance for staff, and whether it has increased the volume of administrative work.

Sections B and C align accreditation to some of the quality components including:

- RACHs' staff perceived impact of accreditation on residents' quality of care and quality of life;
- whether RACHs' staff believe the adoption of accreditation results in the RACH conforming to residents' expectations and needs; and
- whether RACHs' staff perceive that adoption of accreditation influences residents' satisfaction with regard to residence and care.

Sections B and C also concentrate on determining whether accreditation standards are reflective of minimum levels of quality, on whether it is clear how evidence should be given for each of the standards, how quality improvement is measured, and if the accreditation standards are similar to the standards of other bodies (e.g Occupational Health and Safety (OH&S), Food Authority).

Sections D and E concern institutional theory. These relate to the accreditation process being compulsory, whether RACHs observe the processes implemented in other RACHs in order to fulfil the accreditation standards, and to whether there are high costs involved in supporting the preparation for accreditation.

Lastly, section F gives attention to the accreditation process itself; to how the assessment is received by RACHs by way of different teams of assessors, and on how the accreditation process can be simplified and improved.

5.3.2 Pre-Interview Questionnaire (Appendix 11)

The pre-interview questionnaire concerned institutional theory; it comprised four questions (being two open questions and two closed questions) that related to:

- The reasons why the RACH decided to adopt the accreditation program managed by ACSAA,
- Whether the RACH seeks any external assistance in order to fulfil the accreditation requirements,
- Whether the organisations belong to any professional association which require that accreditation or other type of quality program be adopted, and

- Whether any of the accreditation standards/outcomes are believed not to be applicable for the organisation.

This questionnaire was developed to be sent via email to participants before the interview, so that they could complete it and send back to the researcher. This would then allow the researcher to properly read the answers and ask any queries in relation to them on the day of the interview.

5.3.3 Staff Survey (Appendix 12)

The staff survey was available to all staff of the RACHs that were part of this research project. It comprised 27 questions which were divided into two main sections: part A and part B. The survey was developed based on the interview questionnaire and on the pre-interview questionnaire. It therefore contained most of the questions comprised in these two questionnaires which were, however, represented as follows:

- Part A (questions 1-2) concerns general information relating to the respondent, in terms of the staff member's role and the extent of their involvement with the accreditation process. These are closed questions.
- Part B concentrates on the accreditation process, with questions relating to quality, accreditation and institutional theory. It is constituted by open questions, multiple-option questions, and Likert scale questions (on a seven-point scale from strongly agree to strongly disagree).

Applying a staff survey, in addition to the interviews conducted, allowed the researcher to also obtain the views of other staff within each RACH, and then to compare the results so as to identify any similarities and/or discrepancies. Within the six RACHs, there were 388 potential respondents in total[47]. The total number of completed surveys returned was 39, which included: RACH 1 (4 surveys), RACH 2 (10 surveys), RACH 3 (10 surveys), RACH 4 (4 surveys), RACH 5 (8 surveys), and RACH 6 (3 surveys). This resulted in an overall response rate of 10%.

[47] The total number of potential respondents (i.e. staff) per RACH is not provided to ensure that RACHs are not individually identified.

5.3.4 The Pilot Case Study

Prior to conducting the main case study, a pilot case study was undertaken with one facility in March 2011. The aim of the pilot case study was to enhance the questionnaires developed for this research, to find out who the main staff of RACHs involved with the accreditation program are, and to perceive whether RACHs are open to a survey being given to staff. As observed by Yin (2003), the pilot case study assists the researcher in improving the data collection plans with respect to both the content of the data and the procedures to be followed. Hence, a description of how the pilot case study was undertaken, along with modifications made on the structure of the interviews, questionnaires, and staff surveys, are detailed below.

5.3.4.1 Approaching the RACH for the Pilot Case Study

The RACH that participated in the pilot case study was identified through informal discussions with a friend who worked at that RACH at the time. Through this informal discussion, the Director of Care (DOC) of the RACH was identified. The DOC was contacted by phone in June 2010 and agreed to participate in the study. A basic outline of the project along with the consent form was emailed to the DOC. In the meantime, ethics approval from Macquarie University was also obtained. However, due to the fact that the researcher undertook 6 months off for maternity leave, the pilot case study did not take place until March 2011, when the DOC was contacted again. Once the interview was finally booked, a copy of the questionnaires were sent via email so that the DOC could familiarise herself with the questions. The ethics approval, consent forms, and information letter were also sent via email. The questionnaire questions that were supposed to be completed prior to the interview were in fact completed afterwards, due to the fact that the DOC had herself to go into the hospital for one week.

5.3.4.2 Learning Outcomes of the Pilot Interview and Modifications on the Interview Questionnaire

When booking the interview, the appointment was made with the DOC only. When arriving for the meeting, the General Manager (GM) and the Deputy Director of Care (DDOC) were also there for the meeting; a decision which they made without telling me prior to the interview. I explained that it would be preferable that the interview was performed individually and that I was bound by ethics that it should be performed that way, given that the interviews were supposed to be confidential. They insisted on doing this interview as a group. I said that I would leave the decision in their hands, and if they really wanted to perform the interview as a group (given that they all had already designated the time for the interview), I would have to record on tape their decision. They decided to go ahead all together with the interview, noting that the DoC and the DDoC would provide me with similar answers as they worked together for accreditation, and that the GM would be able to better respond to the questions relating to financial issues.

Throughout the interview, two important aspects were noticed. One was a comment received in relation to the questionnaire itself. It was pointed out by the DOC that some of the questions were overlapping, and that by answering some of the questions others would also be answered. The second important aspect was that having the three staff members together at the interview was not beneficial. The respondents "cut across" each other and it was hard for the researcher to keep track of topics. Additionally, the fact that there were three people together, one being the manager of the other two, may have resulted in them not answering the questions genuinely.

After the meeting, the interview was transcribed by the researcher herself, so as to have a better comprehension of the responses, and to also ensure that the responses obtained answered the questions appropriately. This demonstrated a need for re-writing some of the questions and for re-structuring them in such a way that they would flow more smoothly. As a result, questions were re-structured and organised under six main headings.

As a result of the interview, the following was observed:

- Interviews cannot be carried out in a group;
- The way the interview questions were structured was a little confusing, given that they were not structured under headings (e.g. residents, quality, benchmarking)

- Some of the questions (i.e. 1, 2, 3, 11) were too long[48] and needed to be re-written to be clearer and more specific; and
- An introductory question was needed.

5.3.4.3 Learning Outcomes of the Pilot Surveys and Modifications on the Surveys

Prior to starting the interview, I asked the DOC if a survey could be given to all staff. I explained what would be involved and the DOC accepted with no problems. The consent letter was signed by the DOC and the DDOC offered to put up all the advertisements in key locations, as well as place the ballot box in the staff room. After four weeks, only one staff member had answered the survey. The box was left there for an additional two weeks, and other seven more staff members answered the survey. Therefore, with a total of 125 staff available to potentially complete the survey, a response rate of 6.4% was achieved.

An examination was made of the completed surveys to find out the reasons why not many people responded to them. After careful consideration, it was noticed that some of the questions on "Part A - General Questions" when combined, could jeopardise anonymity. For instance, the first question which related to the staff's role at the facility was broken down into 5 categories (director, manager, supervisor/coordinator, registered nurse, care staff); in addition to a second question that asked how long the staff member had been working in the facility. These two questions combined could potentially reveal the respondent's identity. Additionally, there was the fact that the survey was only aimed at those staff directly involved with accreditation; with question three asking whether they were/are involved with the accreditation process. If they answered "no", there was no need to further answer the questionnaire, which probably as a result limited the number of participants.

As a result of the observations described above, the following modifications were made:

- question one was reduced to three categories (supervisor, registered nurse, care staff),
- question two was deleted, and
- question three was modified by asking the respondent to indicate their extent of involvement with accreditation (a great deal, quite a lot, a moderate amount, some, little or none).

[48] E.g. Question 11: Do you believe it is clear from the Accreditation Agency how evidence should be given for each of the standards, (*or do you believe it is subjective to each RACH's understanding)?
* deleted

5.4 Method of Data Collection

For the main study, data from each of the six RACHs were collected from staff directly involved with the accreditation process and also from general RACH staff. This was accomplished through the following means:

- Three (3) staff members directly involved with the accreditation process were individually interviewed; being the RACH's manager, and two other staff who were designated by the RACH's manager. The designated staff was usually an area manager, a deputy manager[49], a nurse, a certificate III, or a certificate IV staff member significantly involved with the accreditation process. The interview comprised the interview questionnaire described in section 5.3.1 of this chapter, and the duration the interviews were of approximately one hour for management staff and approximately 45 minutes to other staff members.
- The three (3) staff members who participated in the interviews were also asked to complete the pre-interview questionnaire, described in section 5.3.2 of this chapter.
- Within all RACHs that were part of this project, a staff survey was available to all other staff members who did not participate in the interviews. To ensure that the highest number of returned staff surveys could be reached, 5 advertisements were placed by a staff member in key areas of the RACH, such as lifts, staff room, toilets, etc. A ballot box was placed in the staff room so that the completed surveys could be returned. A staff survey in this kind of research project allows an examination of the data from two different perspectives, one from that of the staff involved with the accreditation process and the other from a general staff perspective.
- Knowledge of some of the documents utilised by these RACHs to fulfil the accreditation requirements was attained. One RACH was happy to allow the researcher to personally peruse them and make notes, while the others simply referred to them and showed them holding them in their hands without letting the researcher study them closely. This allowed some learning about the methods used by these RACHs to satisfy the accreditation requirements, and will also assist in identifying any similarities or discrepancies across them.

[49] All deputy managers that participated in the interviews are also qualified nurses.

It should be noted, however, that understanding how RACHs view the accreditation process and its influence on the quality of service provision is the ultimate objective of this study, and therefore the opinions of ACSAA and RACHs' residents and their family members were not considered in this research. ACSAA's opinions were not included because they are the ones who conduct RACHs' accreditation assessments, and therefore their views were not the aim of this study. Additionally, even though the decision of accreditation along with an ACSAA final accreditation report are published on the ACSAA website, these reports were also not analysed because they provide ACSAA's assessors views of the RACH, which again is not the aim of this research. Concerning residents and their families, three significant constraints supported the decision not to include them in this study:

- Family members may interpret things differently to residents themselves;
- Many residents of RACHs, especially those receiving high level care, would have considerable limitations in participating in an interview;
- Obtaining an ethics approval to include residents as part of the sample would therefore prove very difficult.

5.4.1 Primary Case Studies

After undertaking the pilot case study, analysing all the questions and answers from both the interviews and the surveys, and taking into consideration comments made by participants, the following adjustments took place before the main case study could commence:

- Questionnaires were revised and amended (as detailed in section 5.4.1);
- An amendment form was completed in May 2011 and sent to the Ethics Research Office at Macquarie University;
- Approval from the Ethics Research Office was received in two working days.

The main case study was undertaken in the period of one year, from July 2011 to July 2012, and the approach utilised to select RACHs to participate in the study is detailed below.

5.4.1.1 Approaching the RACHs for the Main Case Study

As a PhD candidate, the researcher undertook an accreditation course in July 2010 (as described in Appendix 9). The main reasons for undertaking this course were to:

- gain a better knowledge of the accreditation process,
- gain insights into the accreditation process from both ACSAA's and RACHs' perspectives,
- learn more about RACHs and how they operate,
- know people from RACHs and make possible contacts in order to find prospective RACHs to participate in the main study (given that the researcher is not involved with any RACH or the aged care sector).

Initially, from the contacts made in the accreditation course previously mentioned, six RACHs managers were contacted via email and invited to participate in the main study. The result of this approach was:

- One RACH in a remote area in NSW agreed to participate straight away; and the meeting was booked for July 2011.
- Another two RACHs accepted within a few days. However, none of these facilities went ahead and participated in the study. The first one simply did not respond to the emails and phone calls any more, and the second one booked and re-booked the interview meeting twice. That participant cancelled the interview 2 hours before the booked time, and asked for the questionnaire to be sent via email. As requested, the questionnaire was sent but never returned (even though a follow up email was sent).
- The other three managers were no longer working at the same RACH.

Hence, from the contacts made in the course, only one RACH manager accepted to participate in the study, As a result, the contact details of all existing RACHs in NSW had to be obtained from the Department of Health and Ageing's website (DoHA, 2012c) to find other five prospective RACHs to participate in the study. These prospective RACHs were contacted as follows:

- Three separate emails were sent to each of five different RACHs. These RACHs were all in the South East Sydney area for reasons of convenience to the researcher, and the emails were selected by alphabetical order. From the fifteen RACHs that the email was sent to, only one response was received from a CEO and that was to apologise for not being able to participate in the study.

Given that the emails did not reach a satisfactory result, a different approach was undertaken. Cold calls were made; still with RACHs in the South East Sydney area. Personally visiting each RACH, speaking with the manager and explaining the research project resulted in a great outcome. From this approach, four RACHs accepted to participate in the project, two of them being part of the same group.

However, the interview conducted with the first RACH was not suitable. The responses received from two staff members were exceptionally short and even paraphrasing and developing on the questions did not assist in the answers being expanded. Additionally, the third person interviewed had very poor English skills and could hardly understand and answer the questions. As a result, it was decided that this RACH would not be used for analysis purposes but, instead, as a pre-test for the final interview questionnaire. In a pre-test the data collection plan is used by the researcher adhering as faithfully to the final plan as possible (Yin, 2003). Consequently, two other RACHs still needed to be obtained to participate in the study.

The approach used for selecting the final two RACHs became more focused. Cold calls were still made, although the choice of which RACHs to target was based on the characteristics of the RACHs which had already agreed to participate in the project. Hence, the final two RACHs did not necessarily need to be located in the South East Sydney Area. Given that the characteristics of the first 4 RACHs were high and low care, low care, high care, and high care, it was then decided that the other two RACHs should be one of the three types: low and high care, low care, or one RACH which has already had problems with the accreditation process in the past (e.g. it had received sanctions). This would then allow any significant comparisons across similar RACHs to be found, and/or also consider how the perception of a previously sanctioned RACH differs or not to the others. Finally, a low care, and a high care RACH with previous sanctions agreed to participate.

Table 5.1 presented below provides a list and description of the final six RACHs that are part of this study. The researcher was careful to ensure that the description provided is such that it

allows comparison yet ensures confidentiality. The list is not necessarily in the same order of how the RACHs were selected and/or interviews conducted. Additionally, the RACH which has previously been sanctioned is not specified in Table 5.1 to ensure that confidentiality is not jeopardised. Instead, any significant observations from interviews and surveys will be referred to separately to the main analysis of the RACH itself, but still compared to the other RACHs.

Table 5.1 - List and Description of RACHs

	TYPE OF FACILITY	**LEVEL OF CARE**	**NUMBER OF BEDS**	**SIZE***	**AUSTRALIAN FUNDING****
RACH 1	Local Government	Low care	<50	Small	<$1m
RACH 2	Private	High care	<99	Medium	<$6m
RACH 3	Private	Low and High care	>100	Large	<$6m
RACH 4	Private	High Care	<99	Medium	<$3m
RACH 5	Religious	High Care	>100	Large	<$6m
RACH 6	Community	Low care	<50	Small	<$1m

* For the purposes of this study, sizes are considered according to the number of beds: <49 (Small); <99 (Medium); >100 (Large)
** Australian funding is described in "less than (<)" amounts to ensure that RACHs cannot be identified.

5.5 Data Analysis and Communication of Findings

The data for this study is primarily qualitative, and consisted of a small informative sample, being six RACHs in NSW. Each of the six case studies were carefully selected to ensure a representation of case (RACH) taking into account the type of facility (private, religious, community, local government), the level of care (low, high and low and high care), number of beds to support size (small, medium, large) and category of government funding received. Each RACH was individually analysed to obtain a holistic view of the accreditation issues prevalent within each organisation; evidence of the individual case analysis exists without which it would have been extremely difficult to do the cross-case analyses given the large volume of data that was collected. Thereafter cross-case analyses occurred, using themes, 1st level coding, and 2nd level coding followed by pattern matching (see chapter six and seven). The sheer volume of data collected did not support a presentation of each individual case followed by a cross-analysis within the boundary of the word limit permitted. The cross-case analysis occurred within the context of the themes, coding and pattern and the subsequent results and findings presented accordingly. The qualitative data collected from case studies

(research method) using interviews are subject to researcher interpretation so an interpretive paradigm (methodology) was used in this research.

When undertaking qualitative research different sources of information can be relied on, such as: documentation, archival records, physical artifacts, direct observation, participant observation, interviews, and focus groups (Salkind, 2003, p.208). In this study, the researcher acquired knowledge about documents used to fulfil the accreditation process, such as continuous improvement logs, activities planners that are used to expose residents' monthly activities, and benchmarking documents which are developed by an outsourced organisation. Access to these documents was gathered through different means; some documents, as for example activities planners, were exposed in common areas in most RACHs, and other documents, continuous improvement logs and benchmarking documentation, for example, were usually only shown by the manager. Additionally, interviews were undertaken with three staff members in each RACH, and questionnaires were available to all other staff members who wished to participate.

When analysing qualitative data, different techniques are available. The following paragraphs describe the techniques suggested by leading authors in qualitative research; Miles and Huberman (1994) and Yin (2011). Miles and Huberman (1994) suggest that qualitative data analysis should start with first-level coding (e.g. Institutional Theory; Coercive Isomorphism), followed by pattern coding (e.g. formal pressures, government mandate, external perception, etc). The authors suggest that clear operational definitions of codes are indispensable, "so they can be applied consistently by a single researcher over time and multiple researchers will be thinking about the same phenomena as they code" (p.63). First-level coding is "usually a single term" and used to summarise segments of data (p.63, 69). Pattern codes, which are explanatory codes, identify emergent themes within each first-level code. Miles and Huberman (1994) note that pattern coding has essential functions for the qualitative analyst:

1. Reducing large amounts of data into a smaller number of analytic units.
2. Data analysis can commence during the data collection period, so that subsequent fieldwork can be more focused.
3. For multiple-case studies, pattern coding sets the foundation for cross-case analysis through the emergence of common themes and directional processes.

Yin (2011) also notes that when analysing qualitative data it is important to disassemble it using a method. The author suggests that there are different ways to do this, one of them

being “coding data”. The author explains that codes are used as to move methodologically to a somewhat “higher conceptual level”, which will later allow the researcher to classify notes from different records in different ways, as for example into similar and dissimilar groups (p.187). Yin (2011) also uses Level 1 coding (the same as Miles and Huberman’s (1994) first-level coding) which the author also refers to as “initial codes” or “open codes”. The author then suggests that the researcher should progress to a second and higher set of codes, which is Level 2 coding, where the categories within which Level 1 codes may fall are recognised.

Therefore, this research used first-level coding to examine the interview transcripts and other textual research records such as monthly activities planners (residents’ activities, e.g. bingo, religious services, etc). Then, pattern codes, that are explanatory codes, were applied to identify emergent themes/explanations from the collected data. Given that this research is qualitative and that a large amount of data from multiple-case studies was collected, pattern coding seemed to be the most appropriate for this study as its assisted the researcher to understand the main reasons why RACHs undertake the accreditation process in the first place, and also to learn about the influence the adoption of accreditation has on the quality of RACHs services.

SPSS, a computer program for statistical analysis, was used to input data relating to the staff surveys, so that a statistical data analysis could be generated. Due to the number of surveys returned, this data was descriptive in nature and therefore pattern coding was used to generate statistical trends and patterns. This then allowed the researcher to corroborate results from the surveyed staff with results from interviewed staff within each RACH.

Yin (2009) suggests that there are four main different formats for writing case study report, which can be arranged in the following categories: traditional narrative single-case study; traditional narrative multiple-case study; non-traditional narrative for single or multiple-case study; and individual report of each cross-case issue. In this study, the non-traditional narrative for multiple-case study was utilised. Following Yin (2009), this format is structured by questions and answers, based on the questions of the interview questionnaire.

Throughout the communication of results and findings in the following chapters of this thesis, RACHs are identified with the numbers 1-6 so that confidentiality is ensured (as per Table 5.1 on page 101). Also, narratives and individual quotes are used to describe commonalities and any possible discrepancies between RACHs. It also includes hypotheses generated from the

theoretical propositions of this study, which can be utilised in future research for empirical testing.

5.6 Validity and Reliability

Many definitions of the terms validity and reliability relate to the properties of measurement instruments used (McKinnon, 1988). For instance, Saunders et al. (2007) observe that internal validity in relation to questionnaires refers to the ability of your questionnaire to measure what you intend to measure. However, McKinnon (1988) observes that validity and reliability may be defined at a wider level with regard to their applicability to research in general:

- Validity relates to whether the researcher is in fact examining the phenomenon proposed to be studied
- Reliability relates to whether the researcher is acquiring data which can be relied on.

Relevant specifically to case studies, Yin (2003) observes that the quality of research design is judged based on four tests, namely: construct validity, internal validity, external validity, and reliability. These four tests will therefore be explained in the following paragraphs, along with a description of how they have been fulfilled in the present research.

Construct validity relates to "establishing operational measures for the concepts being studied" (Yin, 2003, p.34). To increase construct validity, there are three tactics that can be used by the researcher: (1) use multiple sources of evidence; (2) establish a chain of evidence; (3) have the draft case study report reviewed by key informants. Firstly, the use of multiple sources of evidence[50] in case studies allows the researcher to triangulate the results obtained from different sources, which leads to more accurate and convincing findings and conclusions. Despite its strengths, triangulation also has some limitations. It may result in data collection being more expensive than when using a single source; and also the researcher is required to know how to carry out a variety of data collection techniques. Secondly, maintaining a chain of evidence requires that all important data be included under the results and findings; and it should also allow the reader to read from the initial research questions to the conclusions and follow the steps in either direction. Maintaining a chain of evidence

[50] Documentation, archival records, interviews, direct observations, participant-observation, physical artifacts (Yin, 2003)

increases both the validity and reliability of the case study. Finally, the third tactic involved having the draft results of the case study reviewed not only by peers but also by key participants of the case study. For the purposes of this research, tactics 1 and 2 were utilised to increase its construct validity. For instance, multiple sources of evidence were utilised, through open-ended interviews and verification of documents when permitted. Additionally, surveys were available to staff members who did not participate in the interviews. The collection of data from these multiple sources will allow a triangulation of results and therefore increase construct validity. Also, a chain of evidence will be maintained throughout the chapters of this thesis, which will allow the reader to logically follow the content from introduction to conclusion and vice-versa. Tactic 3, however, which involves the draft results being revised by participants of the case study, was not utilised due to time restraints.

Internal validity relates only to causal (or explanatory) case studies. It is not applicable to descriptive or exploratory studies given that they are not concerned with cause-and-effect relationships (e.g. determine whether event x led to event y) (Yin, 2003). External validity relates to the extent that the conclusions drawn by the researcher can be generalised to other contexts beyond the case study. However, Yin (2009, P.43) notes that, different to surveys which rely on statistical generalisation, case studies rely on analytical generalization, where the researcher attempts to generalise the results to a broader theory. Therefore, in this study, the researcher does not seek to generalise the results to other types of RACHs or to other sections of the health system, but to the broader institutional theory.

Finally, reliability concentrates on demonstrating that the same results can be obtained by another investigator when repeating the procedures utilised in an initial study (Yin, 2003). To maintain reliability were possible in this study, a general protocol was prepared at the beginning of the study. This included: the project overview (i.e. research questions, research propositions, theoretical framework, phenomena to be assessed), research method (number and types of RACHs to be visited, data collection techniques, questionnaires development), and the framework of the thesis.

5.7 Conclusion

This chapter presented a description of the research method that will be utilised in this study. It justified the employment of an exploratory-descriptive research design and a case study

research method to assist in answering the research questions and propositions of this study. It also detailed the population and sample, method of data collection, how data was analysed and findings communicated, and also the means through which validity and reliability were ensured.

6 RESULTS AND FINDINGS: QUALITY AND ACCREDITATION

As described in chapter five, case studies were conducted in six RACHs in NSW (see Table 5.1, page 101 for the profile of these RACHs). Therefore, this chapter focuses on examining answers to the pre-interview questions, interview questions, surveys, and analysis of RACH documentation relating to quality and accreditation. Nonetheless, it should be noted that insights to some quality management issues are informed through a new institutional theory lens (the focus of chapter seven); these insights are clearly indicated when they occur and are further discussed in chapter seven. Hence, this chapter seeks to assist in answering the research question: "*What perceived influence does the adoption of accreditation standards have on the quality of residential aged care homes (RACHs)?*", and to establish the extent to which propositions 1, 2, and 3 (see below) are regarded as supported or not supported based on the results of the data analysis.

> P1: Adoption of accreditation standards improves the quality of care provided to residents.
>
> P2: Adoption of accreditation standards improves residents' quality of life.
>
> P3: Accreditation standards are adopted by RACHs to influence the level of quality of their services.

Access to documentation was limited, and so data gathered from it was used to supplement results from the interview questions. Then, survey results were utilised to compare and contrast with the interview results. To present these results, questions were organised in major themes according to the relevant literature, namely: customer orientation, staff, processes, and quality management systems (Aged Care Standards and Accreditation Agency), which were examined using levels 1 and 2 coding (see Table 6.1), then pattern matched. It should be noted, however, that the results presented in this chapter do at times present a lack of clarity from the respondents, and that the answers to some questions can address different themes. For example, answers related to quality of care were provided when asked about quality of life, replies about administrative work referred to customer orientation, and so forth. Consequently, results from different constructs overlap throughout this chapter. Then, findings are presented and compared with the literature, and propositions are deemed supported or not supported. Finally, an overall conclusion is presented, where preliminary answers to the research question are provided.

Table 6.1 - TQM and Accreditation Coding

TOTAL QUALITY MANAGEMENT AND ACCREDITATION		
Themes	**1st level coding**	**2nd level coding**
CUSTOMER ORIENTATION	• Quality of Design	• Expectations • Needs
	• Quality of Conformance	• Evidence • Measurement • Monitoring • Control
	• Quality of Performance	• Satisfaction • Continuous Improvement
	• Quality of Care	• Physical, personal, psychological, spiritual and socio-cultural care and support • Medical, nursing and allied health care; and • Physical facilities
	• Quality of Life	• Resident's overall well-being (including level of social activity, physical activity and health status)
STAFF	• Guidance	
PROCESSES	• Process Improvement • Administrative work • Standards	
QUALITY MANAGEMENT SYSTEM (ACSAA)	• Quality level • Accreditation Assessors	

6.1 Customer Orientation

6.1.1 Quality of Design

To comprehend the influence of the adoption of accreditation standards on RACH quality of design, two questions were asked, the first being:

1. *In what way does the adoption of accreditation standards result in this facility conforming to residents' expectations?*

Answers to this question varied substantially, and were categorised in three key patterns and one individual belief: 1) The means through which adoption of accreditation results or not in RACHs conforming to residents' expectations; 2) residents not really having an expectation (individual belief); 3) RACHs setting out what residents can expect; and 4) residents and family members having unrealistic expectations. These are discussed in the following paragraphs.

RACHs 1, 2, 3, and 4 indicated that adoption of accreditation standards results in the RACH conforming to residents' expectations through providing assurance to residents that the

RACH is doing things correctly, allowing an opportunity to have feedback around whether people's expectations are being met, ensuring that more information is available to residents and family members concerning their rights, setting out residents' rights and responsibilities in the accreditation handbook, and assisting in conforming to some of the residents' expectations such as oral and dental care, palliative care, physiotherapy, and pain management. Conversely, at RACH 5 it was evident that the adoption of accreditation only assists RACHs in fulfilling residents' expectations "to a degree"; it seems that accreditation is not the main precursor of everything that happens in an RACH and therefore it is not the full reason why expectations are met. Finally, in RACH 6 it was mentioned that the adoption of accreditation standards appears not to result in the facility conforming to residents' expectations. The interviewee noted that this is due to the facility been recently taken over by another group of facilities, and so what used to be a home-like environment no longer is.

One interviewee (RACH 2, Manager) suggested that residents do not really have any expectations due to the fact that they are in a high level care RACH and most suffer from dementia. This, however, was not cited by any other staff member within RACHs 4 and 5 which also only provide high level care.

Interestingly, RACHs 1, 2, 4, and 6 revealed that the RACH sets out what residents can expect when they first enter the home, by explaining and providing them with a residency agreement stating what services the RACH can offer. It outlines *"most of the expectations that they can expect to receive from us"* (RACH4, Deputy Manager). This ensures that residents and family members know what to expect and therefore do not have a high level of expectations. As noted (RACH 2):

> *"In some meetings that we've had with families and relatives, we've even said, this is what we can offer, this is what we can do for you. If it's not up to your expectations, then maybe you might have to find another facility, because this is the maximum that we can go to, this is the maximum we can give. Sometimes that might not be what they're expecting."* (RACH2, Deputy Manager: 1)

This said, at least one staff member from each of the six RACHs stated that either the residents themselves or (usually) their family members have very high expectations, which are sometimes unrealistic. For instance, they expect RACHs to provide rehabilitation services, one-on-one care, a shuttle bus, home cooked style meals, or the same level of access to

medical staff that is received at a hospital. With regard to one-on-one care, it was stated that *"Everybody's equally worthy of care and being treated respectfully, but some family members will actually think that their family member is more important"* (RACH5, Deputy Manager: 2). Some of them even expect their relatives to get better and perhaps do things that they were no longer able to do.

> *"There seems to be an expectation that people are going to come in and we're going to rehabilitate them and make them better in a number of cases, which is just not possible"*. (RACH3, Manager: 3)

Staff survey results, however, reveal that the majority of staff believes that adoption of accreditation standards has resulted in the RACH being better able to conform to residents' expectations.

The second question was:

2. *In what way does the adoption of accreditation standards result in this facility conforming to residents' needs?*

When answering this question, some staff responded with regard to residents' expectations (RACH 1 and 2) and also with regard to residents' satisfaction (RACH 2); these responses were then included in the section pertaining to the appropriate question. With regard to residents' needs, answers are discussed in the following paragraphs and include: 1) means through which adoption of standards assists the RACH in conforming to residents' needs, 2) difficulty with ACSAA's administrative expectations (individual), and 3) fulfillment of residents' needs not being related to the adoption of accreditation standards (individual).

RACHs 1, 3, 5, and 6 noted that the adoption of accreditation standards assists the RACH in conforming to residents' needs through determining the rules and guidelines for the things RACHs must accomplish, which includes residents' needs. These needs have to be identified (RACHs 1, 2, 4, 5 and 6), and the RACH must provide residents and their families with a plan on how it will be working on these needs (RACH 1). Then, during the accreditation assessment, RACHs must prove how residents' needs are being fulfilled, and this is verified by assessors through talking with residents and family members and also through evidence presented by the facility (RACHs 2, 3, 5, and 6).

However, the difficulty lies in the Accreditation Agency's administrative expectations of accurately reflecting in writing how residents' needs are being met (RACH 3). This is due to the fact that RACHs are employing staff with Certificate III[51] in Aged Care thus experiencing limited levels of education with inadequate literacy and language skills. Moreover, many of these staff have very challenging social backgrounds (but see pages 124, 127 and 132 of this chapter). As a result, RACH compliance is sometimes dependent on the "*extent assessors consider verbal input as well as written input*" (RACH3, Manager: 4).

Yet, one respondent believes that fulfilling residents' needs has nothing to do with the adoption of accreditation standards (RACH 6, Certificate IV). Interestingly, the staff surveys reveal a very mixed content with regard to the answers to this question; this is because even though a large number of staff members believe that the adoption of accreditation standards has influenced how the RACH conforms to residents' needs, the majority of respondents believe it has not and some were unsure.

Findings

The questions above were aimed at exploring how the adoption of accreditation standards results in the RACH conforming to residents' expectations and needs. As indicated in chapter three, "customer expectation" relates to a belief that something should be achieved, whereas "customer needs" relate to something that is required because it is essential instead of desirable (Oxford English Dictionary, 2006).

With regard to residents' expectations, interview responses suggest that the adoption of accreditation assists RACHs to fulfil residents' expectations only "to a degree"; by providing assurance to residents that things will be done correctly in terms of the care and services that they will receive. However, residents and family members also have very high expectations with regard to the care provided by an RACH, which may not always be feasible. On the other hand, the majority of staff who responded to the survey believes that the adoption of accreditation standards assists in better conforming to residents' expectations. This inconsistency in the views with regard to residents' expectations is probably due to the fact that RACHs' staff at a management level are those who conduct the initial interview with residents when they enter an RACH, and therefore they are the ones who have a clear idea of

[51] Certificate III "is the standard entry qualification for workers in this sector". AUSTRALIAN REDCROSS. 2013. *Certificate III in Aged Care (CHC30208)* [Online]. Available: http://www.redcross.org.au/certificate-iii-in-aged-care-chc30208.aspx [Accessed 17th January 2013.

what residents' initial expectations are. As such, results suggest that "acceptability",[52] which is one of the seven attributes of quality in health care[53] mentioned by Donabedian (2003), appear not to be a high priority for RACHs given that they, based on the accreditation standards, are the ones who determine what residents' expectations are. This is done through "managing (residents') expectations", when someone seeks "to prevent disappointment by establishing in advance what can realistically be achieved or delivered" (Oxford English Dictionary, 2006). Therefore, differently from the theory and from other health settings, such as hospitals, the expectations of RACHs residents are determined by RACHs. This distinction however, may occur because residents' and their family members appear to have unrealistic expectations, and also because family members have the guilt of leaving their loved ones in an RACH. From the residents' perspectives however, this may negatively affect their perception of quality of life. This is because as observed by CR&C (2007), quality of life relates to the extent that individual residents' overall well-being[54] meets their personal expectations or the expectations of their carers. Nonetheless, equity[55] which is another attribute, seem to have a higher priority. This is due to the fact that care appears to be equally provided amongst residents, as mentioned by an interviewee of RACH 5 that "*Everybody's equally worthy of care and being treated respectfully* (RACH5, Deputy Manager: 5)."

Concerning customers' needs, interview responses provided distinct results from the staff survey. These responses largely proposed that the adoption of accreditation standards assists in RACHs conforming to them, through the various requirements of the accreditation agency as they relates to rules and guidelines, identification of residents' needs, and proving that those needs have been fulfilled. However, staff survey results presented diverse opinions with the majority of respondents believing that accreditation standards do not fulfil residents' needs. This distinction in the responses may be due to the level of involvement with accreditation amongst these two groups, as staff who are not directly involved with accreditation may not know the reasons why procedures are improved and/or implemented. Nonetheless, it seems that to an extent the adoption of accreditation standards does assist RACHs in identifying and conforming to residents' needs, through the rules and guidelines imposed. This is consistent with the quality that authors discussed in chapter three, and who

[52] Conformity to the wishes, desires, and expectations of patients and their families.
[53] Seven attributes of quality: Efficacy, Effectiveness, Efficiency, Optimality, Acceptability, Legitimacy, and Equity (please refer to chapter three, page 34)
[54] including level of social activity, physical activity and health status
[55] Conformity to a principle that determines what is just and fair in the distribution of healthcare and its benefits among members of the population.

expressed a definite view that organisations must understand their customers' needs in order to conform to them.

6.1.2 Quality of Conformance

To identify the influence of the adoption of the adoption of accreditation standards on the RACHs' quality of conformance two questions were asked, which are now discussed.

1. *In your opinion, does the Accreditation Agency make it clear to you how evidence should be provided for each of the standards?*

The results, based on the interviews, do not provide clarity on how evidence should be provided for each of the accreditation standards; the responses to this question varied amongst interviewees within each RACH. Interviewees also commented on whether or not ACSAA should provide more specific requirements for each of the standards; this is also not evident. As a result of this ambiguity, the presentation of the results is structured as follows: 1) the reasons why it is clear that RACHs know how evidence should be provided; 2) the reasons why it is not clear how evidence should be provided; 3) explanations of why ACSAA should provide more specific requirements; 4) suggestions that were given at the end of the interview on how the accreditation process could be simplified and/or improved (related to how evidence should be provided); and 5) explanations why ACSAA should not provide more specific requirements.

For those who believe that it is clear that RACHs know how evidence should be provided (RACHs 1, 2, 3, 4, 5 and 6), it was mentioned that information is available through: the results and processes handbook, ACSAA's website, cards provided by ACSAA on specific topics, the accreditation course, manuals, guidelines, and also feedback from assessors during their visits. Continuous improvement was also cited as a way of demonstrating evidence of conformity, which can be done in many ways as long as there is evidence that the circle has closed out: "*there's always those loops and those close outs.* (RACH3, Area Manager 1)" Importantly, RACHs 1 and 2 indicated that staff must have clinical expertise and knowledge of the Aged Care Act to be able to properly satisfy the accreditation standards: "*You need to have good clinical expertise. If you don't have it you should try and get some or you should ask someone else.* (RACH1, Care Coordinator: 6)" However, comments within RACHs 1 and

3 indicated that reading and comprehending all the information available requires a lot of time, and time is limited.

In contrast, many staff (RACHs 1, 2, 3, 4, 5 and 6) also believed that it is not clear how evidence should be provided.

> *"… because they've got defined rules. They've got rules but they're not actually that clear. They have these standards and sub-standards, but they don't actually tell you how to do it. It's only through working in aged care facilities, you actually pick up on what's expected of you and then by going through the process."* (RACH5, Deputy Manager: 7)

Some standards are too broad, the evidence required is not determined, and the accreditation handbook "*is still very airy fairy*" (RACH 6, Manager: 8). This was supported by RACH 1, were it was said "*Their hydration really is just a cup of tea at breakfast, morning tea, lunch, afternoon tea and dinner time. So I guess is tea shown as hydration?* (RACH1, Certificate III: 9)" The Agency only provides guidelines but the standards are open for interpretation and, therefore, evidence is demonstrated according to the RACH's policies and procedures (RACH 3). In some cases staff appear not to understand what the standard/outcome requires, as noted by the manager at RACH 3:

> *"But clinical care in terms of the standards … providing very clear cut guidelines around what's expected - they don't. People struggle with understanding exactly what's - even the qualified staff, our registered nurses don't understand exactly what the expectations are… So the RACH must have internal systems in place and provide education so that staff can meet the level of care established by the RACH which easily conforms to the accreditation standards."* (RACH3, Manager: 10) (but see page 132)

Moreover, accreditation assessors are quite different in respect of the evidence that they want (RACH 6) although, if assessors are not happy about how the RACH fulfils the standards, there is nothing they can do because they cannot always be specific about how things should be changed (RACH 5). Hence, it was suggested that it would be beneficial if at least one assessor was the same as from a previous visit (RACH 5), as noted:

> *"What I would feel would be beneficial is if say, even if one of the team was somebody that had come on the previous visit. So they could actually see what improvements we've made or if they have been able to see if we have maintained what we are doing and if we have improved on that."* (RACH5, Supervisor: 11)

It also appears that the lack of specific requirements results in some facilities not providing residents with adequate treatment and somehow passing accreditation, while other facilities that run well appear to have problems with satisfactorily achieving all standards (RACH 5).

> *"No (clear indication) because I've been in a lot of nursing homes and every nursing home does it differently, but I've seen places that have got terrible treatment. I mean, the way - I wouldn't call their facilities run well or - I've done a lot of agency work and I wouldn't call some facilities run well at all and - I don't know. They seem to get through their accreditation process, but then I've seen other ones that are run really well and they get a really hard time, so ..."* (RACH5, Deputy Manager: 12)

Interestingly, the reason why the above mentioned fact happens is not clear and not really known; it was stated by the same respondent that:

> *"I'm not sure really, but it's because it's maybe the people that are going there to assess at the time, whether the organisation's just a huge organisation and they rely on just rolling over policies, their own policies in the facility and just signing off on them every three years, whatever it is. I can't really answer that, but I just know that it's sometimes not - like I said, it's not objective, it's subjective."* (RACH5, Deputy Manager: 13)

RACHs 3, 4 and 6 suggested that ACSAA should specify how standards can be achieved. As an example, ACFI[56] and the National Competences[57] were cited:

> *"If they expect certain things, to say they expect certain things rather than leave it for people to work out."* (RACH3, Manager: 14)
>
> *(Regarding ACFI) "It will have a competency and then it will say you must be able to do this to achieve this competency." Accreditation Standards should then have "the next step after - when it does outline what the expected outcomes are then it should have the next column…"* (RACH4, Deputy Manager: 15)
>
> *"I would like to have with these standards - to say yes, we need this documentation to prove that you're doing your maintenance. We want this documentation to make sure you're doing this care for this resident … if they can give you a guideline of what forms they want or what pieces of paper,*

[56] As seen in section 2.5.1 of chapter two
[57] A minimum standard that registered nurses have to have to be able to practice and to be registered

then it could be all prepared for them so when they come you say right, that's all the paperwork that you're needing." (RACH6, Manager: 16)

Similarly, in RACHs 2, 5 and 6 it was said that more specific guidelines on how to provide evidence for each of the standards should be given.

"Standards are good as they are, but perhaps the agency should have a pending document going into further detail." (RACH2, Manager: 17)

"Absolutely, they should have a tick list of what they want. What are the expected criteria for this? You basically have got a little bit of - it doesn't have to be black and white, it can be a grey area, but you can have flexibility. But there should be guidelines. It's almost like working with a phantom group of people or phantom group of rules." (RACH5, Deputy Manager: 18)

Furthermore, at the end of the interview, staff were asked to suggest how the accreditation process can be simplified and improved. It was also proposed that forms (e.g. accidents and incidents, bowel charts, continence charts, resident surveys) should be provided by the government (RACHs 4 and 6), and that the Accreditation Agency should provide a bit more direction on what they want (RACH 6). Having standard forms would make things more uniform across different RACHs, would replace RACHs having to use external benchmarking companies, would allow the Accreditation Agency to monitor and get more accurate readings, and would also assist with ACFI validations (in terms of them not needing to ask for evidence and backups).

"The forms should come out from the government you know, that they perhaps should give you a bit more direction what they want … you'd have to make sure whoever is putting the forms out is really current and knows what goes on … (because) ACFI that's come from government too and some of the things that they laid a claim for at the ACFI are ridiculous and outdated." (RACH4, Manager: 19)

"Why doesn't the Accreditation Agency have their own (benchmarking system) and give them to all facilities? And free of charge because it is something that is required." (RACH6, Manager: 20)

Conversely, staff in RACHs 1, 5 and 6 believed that the Accreditation Agency should not provide specific requirements. Each person interprets the standards in a different way, and

currently the standards allow creativity. Also, RACHs have entirely different residents who come from different socioeconomic areas, different cultural backgrounds, etc. The quality manager at RACH6 also noted that the outcome is what matters, not the process:

> *"One of the first things you learn (at the course to be an aged care assessor) is what I do in my house is different to the way you do things in your house… we're both doing things the right way, but it's different. What we have to focus on is the outcome. So it's not so much about the process, it's the outcome."* (RACH6, Quality Manager: 21)

Findings

The above results suggest conflicting views concerning whether it is or is not clear how evidence should be provided to meet the accreditation standards. There also appears to be an existing tension amongst staff whether the Accreditation Agency should or should not provide more specific guidelines on how to fulfil the accreditation requirements. Some RACHs think that they should be provided with more specific guidelines, yet it was also said that they must be given room to be creative. This is similar to the findings of Touati and Pomey's (2009) study where it was suggested that standards cannot be excessive to the point of discouraging the organisations' creativity and autonomy. Nonetheless, from an institutional theory perspective, results demonstrate that mimetic isomomorphism is present in that some RACHs are demanding that the accreditation agency provide more and better guidelines on how to fulfil the accreditation standards (further discussed in chapter seven). However, this evident difference of opinions and interpretations reveals that there is a need for the Accreditation Agency to continuously improve how the accreditation assessment is carried out, including how information is gathered, to ensure quality of performance, and on how continuous improvement is verified. This is consistent with CR&C's (2007) research, where the need for continuous revision of the accreditation standards and the need to establish a measurement system to identify the degree of quality improvement, were identified. This is significant given that the intention of the accreditation standards is to "*enhance the quality of performance under all accreditation standards … It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality"* (RACH3, Manager) (please refer to Table 3.5 on page 53 of chapter three).

2. *How do you measure the degree of quality improvement for each of the standards? How do you provide evidence for each of the standards?*

At RACHs 1, 4, and 5 it was evident that quality improvement is measured through a continuous quality improvement plan. Observed by the manager at RACH 5 however, was the need for the RACH to have more sustainable and analytical evidence to really examine the quality activities that are occurring; and so a quality manager had been appointed. The analytical evidence appears to be more apparent at RACHs 2, 3, and 6, where it was reported that the degree of quality improvement is measured through audits and surveys, through participation in benchmarking (on a monthly and quarterly basis), and by talking to residents. It was also indicated that some standards are easier to measure than others due to a lack of guidelines from the Department of Health and Ageing (RACH 3):

> *"Look that's mainly done through audits and basically benchmarking. It's more difficult in some standards versus others. I mean we have got clinical indicators - that's pretty straightforward. But in terms of - I mean most standards have some sort of indicator attached to them which you can relate to the outcome." "Human resources - appropriate staffing. There's no benchmark set. There's not guidelines set by the department around what you have to spend on staff, what mix of staff or anything at all like that. So that's a very difficult one. But basically in terms of demonstrating that, basically it's talking through your rosters, it's looking at your resident mix. But that's not something easily - you can't really measure that on a day to day basis because there are no guidelines set."* (RACH3, Manager: 22)

Two respondents (Certificate III RACH 1, and Certificate IV RACH 6) did not understand the first part of the question (despite the researcher trying to clarify the question several times), which may be due to a construct that they do not use in their everyday language being imposed on them:

> *"I don't know."* (RACH1, Certificate III: 23)
>
> *"How do you measure the degree? What's that mean?"* (RACH6, Certificate IV: 24)

Relating to the second part of the question, evidence for the accreditation standards is provided through: continuous improvement, audits, progress notes, benchmarking, indicators,

documentation, care plans, action plans, meeting photos, surveys, and talking to residents. For example, at RACH 2, indicators are used to provide evidence relating to some of the standards, while evidence to other standards relies on documentation; for example levels of infection control and wounds care are used to demonstrate compliance with clinical care.

Data suggests that continuous improvement is the main method used by all RACHs to provide evidence (but see page 152). Continuous improvement folders were displayed by most managers during the meeting, and it could be noted that they all follow a similar pattern containing the following information: issue, the accreditation outcome the issue relates to, action required, expected outcome, by when, by whom, and outcome. The continuous improvement folder is completed based on information gathered at meetings, forms, complaints, verbal suggestions, etc.

Internal audits are carried within different timeframes (monthly, annually) across RACHs. The types of audits include food policy, cleaning, infection control, surveys, among others. At RACH 5 it was revealed that internal audits assist in providing a more sustainable and analytical type of evidence for assessors. However, whether or not the assessor looks at this information depends on the assessor's background:

> *"Like if you've got somebody that comes from a mathematics or science background they look at that kind of stuff, whereas the nursing staff tend not to look at it as much."* (RACH5, Manager: 25)

Benchmarking data is also used to provide evidence for the accreditation standards. Benchmarking (RACH 2, 3, and 6) occurs with other facilities within the same group and also with other RACHs, which provides RACHs with an internal and external comparison. External benchmarking is conducted through an outsourced organisation and is not associated with accreditation (this will be further discussed in chapter seven).

Findings

As it relates to quality of conformance, RACHs use many different sources to provide evidence for the accreditation standards. These different sources are also used as quality

control[58] tools, and include continuous improvement, audits, progress notes, benchmarking, documentation, surveys, interviews with residents, etc. From the sample, with the exception of one small RACH, all the others utilise an external benchmarking company (which is further discussed in chapter seven). The continuous improvement folder seems to be one of the main sources used by RACHs to demonstrate evidence about and, therefore, compliance with the accreditation outcomes. As seen earlier, however, continuous improvement appears not to be properly evaluated by accreditation assessors, which may result in the quality efforts of RACHs not being properly monitored. Interestingly, in their study Heuvel et al. (2006) found the ISO9001:2000 accreditation program to be lacking an effective management control system for organisations, which may suggest that the same is happening with the accreditation standards managed by ACSAA. Furthermore, it seems that for some standards it is difficult to have an associated indicator due to a lack of guidelines from the Department of Health and Ageing. Although from a quality perspective, quality measurements must be established for each area of activity (Crosby, 1979). Therefore, as it relates to the Australian environment this study indicates a need for consistency amongst accreditation assessors when evaluating continuous improvement, and the need for more guidelines from the Department of Health and Ageing to RACHs as it relates to the measurement of quality indicators. Additionally, there appears the existence of a need for small RACHs to benchmark with other RACHs, which is something that the accreditation agency could intermediate.

6.1.3 Quality of Performance

1. *In what way does the adoption of accreditation standards influence residents' level of satisfaction?*

Answers to this question had varied responses, and so results were classified in two main patterns: 1) The adoption of accreditation standards being considered to influence residents' satisfaction; and 2) residents' satisfaction not being related to adoption of accreditation. Interestingly, results from those staff members who responded to the survey reveal that the majority believes that adoption of accreditation has influenced residents' level of satisfaction, though some respondents were unsure about this positive association.

[58] Quality control involves choosing how control will be performed and measured, setting goals, evaluating the real quality performance; comparing actual performance to quality goals; and then acting on the outcomes or results of the comparison. (Juran and Gryna, 1988, p.2.6).

For those who believe that adoption of accreditation does influence residents' satisfaction, which at least one respondent did in each facility, it was mainly proposed that this occurs through looking at residents' needs and wants individually (RACHs 1, 2, 3, 5, 6); and ensuring that residents' satisfaction is being monitored and that RACHs demonstrate how non-satisfaction is being addressed (RACH 1, 3, 6). Although in a high level care facility it may be difficult to measure residents' satisfaction (RACH 2), residents nowadays appear to be happier in nursing homes than they used to (RACH 2, 4). The adoption of accreditation standards has influenced residents' satisfaction by providing them not only with rights but also with responsibilities (RACH 1, 5). Yet, by seeing that there is an accreditation agency, residents can sometimes push the boundaries by knowing that they can keep "everybody on their toes" (RACH 3, Area Manager 2: 26).

Many other respondents, however (RACHs 2, 4, 5 and 6), believe that the adoption of accreditation standards is not related to residents' level of satisfaction. The Accreditation Agency only ensures that RACHs meet residents' needs and that care is properly delivered (RACHs 2 and 5); what enhances residents' level of satisfaction are the facility itself and the care it provides to residents (RACHs 2, 4, and 5), and also the government's complaint system through which residents are obtaining positive results (RACH 5). It was also noted that RACH staff provide residents with the best possible care regardless of accreditation (2, 4, and 6). Additionally, one staff member said that with accreditation *"we can make our documentation better"* and get funding from the government (RACH 6, Certificate IV: 27). Finally, one respondent (RACH 6) believes that the adoption of accreditation has negatively influenced residents' level of satisfaction, by saying: *"The residents don't like the institutionalised way. That's what they've said. They don't like it because it's not homely anymore. But you can't have homely and meet the standards at the same time.* (RACH6, Manager: 28)*"* One manager noted that when this RACH was taken over many changes to processes and renovation of the physical structure were made, residents' satisfaction was influenced negatively. Besides, accreditation standards provide RACHs with a duty of care with regard to residents' choices and decision making which can sometimes conflict with standards of different regulations, such as the Food Authority, and can result in residents being dissatisfied (RACH 1). For example, it was mentioned that, "*one resident grows things in the garden, but staff are not allowed to use it in the kitchen because of the Food Authority regulations*[59]*, and then the resident gets really upset.* (RACH1, Manager: 29)"

[59] The validity of this quote was not verified with the NSW Food Authority.

Findings

All things considered, findings are mixed concerning whether or not staff believe the adoption of accreditation standards influences residents' level of satisfaction. This is expected, given that residents' satisfaction is directly related to the fulfillment of quality of design (i.e. residents' expectations and needs), and there were mixed responses in this regard too. As such, staff's beliefs on the accreditation program and staff's level of involvement with the accreditation requirements are most probably the reason for these conflicting views. Nonetheless, in their study Greenfield and Braithwaite (2008) indicated that the limited work conducted on the relationship between patients' satisfaction and accreditation found no association between the two. On the positive side and consistent with the quality authors addressed in chapter three, accreditation standards require that residents' satisfaction be monitored and non-satisfaction addressed by RACHs. Nonetheless, it was suggested that there are other factors that also influence residents' satisfaction, such as the government complaints system; the care provided by staff to residents; and that the adoption of accreditation standards is simply for legitimacy purposes so that RACHs can get funds from the government (the latter will be further discussed in chapter seven). In some instances, even a negative influence was believed due to:

- Conflicting regulations and therefore conflicting coercive pressures from different government bodies (further discussed in chapter seven);
- The many changes in the RACH's processes and physical structure resultant from the RACH being taken over by another RACH.[60] This is due to the mimetic and/or coercive pressures that the taken over RACH faces in order to be legitimate to the new parent company (further discussed in chapter seven). Due to a significant reduction in the number of small stand-alone RACHs happening in Australia, this finding suggests that residents' satisfaction should receive special attention in the instance of a takeover.

6.1.4 Quality of Care and Quality of Life

> *Accreditation Standards are standards for quality of care and quality of life for the provision of residential care on and after the accreditation day. Quality of Care Principles 1997 (as amended 2012)*

[60] As seen in chapter two, the number of smaller stand-alone RACHs is significantly reducing

As seen in chapter three, ACSAA "promotes high quality care in RACHs through the management of the accreditation program and through a comprehensive industry education program" (ACSAA, 2012f). Therefore, to explore how the adoption of accreditation standards enhances residents' quality of care and quality of life, two questions were asked:

1. *In what way has the adoption of accreditation standards enhanced the level of quality of care provided to the residents of this facility?*

Responses from the staff interviewed varied considerably. These variations occurred concerning their belief that the adoption of accreditation standards has or has not improved the level of quality of care, and also in terms of how they believe either of these aspects occurred. To strengthen the interpretation of the data, responses were broken down into two main groups: reasons why the adoption of accreditation has enhanced the level of quality of care provided, and reasons why the adoption of accreditation has not enhanced the quality of care.

A careful examination of the results from the six RACHs revealed six key patterns through which it is believed that the enhancement of quality of care occurred due to the adoption of accreditation standards, namely: legislation and guidelines, services, continuous improvement, safety, resident satisfaction, and training and education.

Four out of the six RACHs (RACHs 1, 3, 5 and 6) agreed that the adoption of accreditation standards has assisted in enhancing the quality of care through providing legislation and guidelines for RACHs. For instance, adoption ensures that the level of quality of care required by the accreditation standards is provided to residents, and it guarantees that all residents receive the same amount of care. Also, a quality manager has added that quality of care was enhanced not only due to the guidelines but also through ensuring that RACHs must comply with the 44 outcomes. Comments also indicated that the standards are imperative for aged care as they provide expectations and legislation for RACHs to follow to remain viable, thus assuring that quality of care is delivered and that those facilities not following the regulations are either sanctioned or shut down. It was stated that:

> *"I think it (accreditation standards) has (improved quality of care). I think now that they've got expectations and legislations and things like that - if that doesn't happen then nursing homes are not going to stay viable. So I think those standards are imperative for aged care. It's not for us because I love my residents. They're my residents. But you see other facilities and you hear on the news - as you do - those negative things about - and some of*

them are really quite horrible. But they don't last long because they either get sanctioned or shut down." (RACH3, Area Manager 1: 30)

RACHs 1 and 3 suggest that the adoption of accreditation standards has enhanced the level of quality of care through the services provided to residents. The standards ensure that allied health services[61] such as physiotherapists, speech pathologists, and podiatrists, and so forth, are provided to residents when necessary. Additionally, it was said that RACHs are more aware of the different types of residents and their care needs.

RACHs 1, 2, 3 and 5, suggested that continuous improvement is entrenched through the adoption of accreditation standards, thus allowing the RACH to constantly reflect upon its processes and look for ways to improve them. Continuous improvement also assists in highlighting when things are not working properly so that the RACH can focus on those areas. Finally, the adoption of accreditation standards results in enhanced staff understanding of continuous improvement, which has a direct benefit to the resident.

Safety according to comments from RACHs 1, 5 and 6 is considered to refer to food and nutrition (food being properly processed and cooked), and security of tenure (e.g. high standard of cleanliness so that residents do not get sick through cross-contamination).

RACHs 1, 2, and 3 believe that the adoption of accreditation standards resulted in residents appearing to experience enhanced satisfaction with the quality of the services provided. RACHs are more aware of residents' and their relatives' expectations relating to service provision which supports an improvement in the quality of care.

Finally, adoption of accreditation also seems to have enhanced residents' quality of care through an increase in staff training and education, indicated by RACHs 3, 4 and 5 (but see pages 111, 135, 145). Comments indicated that the auditing process and the continuing monitoring highlights the service need areas (e.g. pain management, medication management), which gives the RACH an opportunity to focus education and resources in these areas to make any necessary changes to local practices and systems to achieve improvements. The auditing process and continuing monitoring has also stopped "bad nurses working in the industry".

Conversely, not all staff interviewed believed that the adoption of accreditation standards has enhanced the level of quality of care provided to residents. Staff across five different RACHs

[61] See chapter two quoting on allied health services

(1, 2, 4, 5, and 6) believe that the quality of care provided to residents has not been enhanced due to the adoption of accreditation standards. They contend that nurses have a duty of care and their work practices have remained constant regardless of adoption of accreditation, and that adoption of accreditation standards is simply for the facility to 'display' the good care RACHs provide and residents receive. Additionally, one care staff member criticised the accreditation program, providing a hesitant opinion by saying:

> *"I'm a little bit cynical of the accreditation process, because I actually think at times they can be overly - to give an example, there was a complaint made by a family member and it was a very old woman - over 100 years old - and it was about a nursing care plan not being basically updated. So from that, the threat was made that that nursing care plan was - if it wasn't done within a timeframe of three days, that they were going to come out and assess the building and maybe find us non-compliant. Now these are the sorts of things - I don't believe that the standards that this organisation - accreditation agency - necessarily enhance the quality of care of residents. I think that being in the nursing profession and being for this organisation, being in a (religious) organisation, that we would have provided that anyway. So I don't actually think that they've been the main precursor to everything happening here."* (RACH5, Deputy Manager: 31)

Moreover, in RACH 1 it was mentioned that in some cases residents do not receive the proper care that they should be receiving. For instance a resident ended up getting her ear infected because it was not properly looked after. This may possibly be due to clinical care being a challenge for every organisation because RACHs currently have very unskilled workforces while residents are coming up with more complex needs, as observed by the manager at RACH 3: *"I think that clinical care is a challenge for every organisation because we've got a very unskilled workforce. We've got reducing numbers of qualified nurses because you can't get them. We've got residents I guess that are coming to us with more and more complexity in their needs. We've got expectations up here (very high).* (RACH3, Manager: 32)*"* People going into aged care are a lot sicker and older now than before and the importance of having the right mix of staff to the current care needs, was also noted by managers at RACHs 5 and 6.

Interestingly, it was also considered that what varies amongst different RACHs is the work load due to staff ratio per resident, given that accreditation has resulted in added documentation relating to the residents' progress (RACH 4). Staff comments suggested that the care received in a charitable organisation is better than in a private one, because all the

money is reinvested into the home, whereas in a private organisation "someone else" is getting all the money (RACH 2, 6). The issue of private RACHs being profit driven was also raised during the accreditation course undertaken by the researcher, where the manager complained that she had to pay for the course herself because the RACH would not do so.

Therefore, the data presents mixed results concerning the issue of whether adoption of accreditation has or has not enhanced the quality of care provided to residents, as per the quote presented in the previous page where it was said "*I don't actually think that they've been the main precursor to everything happening here* (RACH5, Deputy Manager: 33)". Additionally, it appears that registered nurses and care staff[62] are the majority amongst those who believe that the care provided to residents has not improved as a result of the adoption of accreditation; and believe that the care has always been the same regardless of accreditation. This result was supported by those staff who responded to the survey, where more than half of registered nurses and care staff believe that the adoption of accreditation standards has not enhanced quality of care. Curiously, medication management that was explicitly asked about in the staff survey was not mentioned by interviewees as having improved with the adoption of accreditation standards. Nonetheless, many staff who responded to the survey believe that medication management has improved as a result of the adoption of accreditation, with some being unsure.

2. *In what way has the adoption of accreditation standards enhanced the level of quality of life of residents of this facility?*

An examination of the responses gathered from the staff interviewed suggested that the majority believes that the adoption of accreditation has enhanced residents' quality of life, although some staff believed otherwise. A thorough examination of the responses provided by staff believing the adoption of accreditation standards has enhanced residents' quality of life revealed six key themes, namely: lifestyle, residents' rights, food, cleanliness, social wellbeing, and building.

Data indicates that the adoption of accreditation standards has considerably enhanced residents' quality of life in terms of their lifestyle (RACHs 1, 2, 3, 4, 5, 6), focusing on the whole person, looking at their clinical care, environment, food and nutrition. Numerous staff members also indicated that residents have more activities (RACHs 1, 3, 4, 5, 6) (e.g. meeting

[62] Care Staff corresponds to staff that have completed Certificates III and IV in Aged Care. These certificates prepare people to work as a carer in a residential aged care facility.

with a community group every week, music afternoon, movie, religious services, crosswords, quizzes, bingo, bus trip, etc.), and that activities are certainly better after adopting accreditation standards given that before they would only play bingo (RACH 5). For instance, RACHs 4, 5 and 6 had the activities calendar placed either on the notice board or at the reception desk. Additionally, the standards ensure that residents' capabilities, spiritual care, cultural needs, and things that were part of residents' history are taken into consideration (RACH 5).

Concerning the residents' rights (RACHs 3, 4, 5 and 6), which also play an important role in enhancing residents' quality of life, it appears that there is a greater customer focus, and residents currently contribute more than ever before in indicating and selecting which activities (as for example the ones cited in the above paragraph) they would like to participate in. RACHs in turn, must take into consideration residents' needs and wants, which results in a greater focus on resident involvement and consultation. Also, residents' interests and their independence are maintained. For example a staff member said:

> *"Years ago, everyone used to be showered at a set time, breakfast was served at a set time and they had a set routine. Well, now everyone - there's choice. People have got choice and there's an expected outcome."* (RACH5, Deputy Manager: 34)

Other themes were also raised relating to residents' quality of life. Residents getting the right quantity and a good variety of food (RACH 6); residents' rooms and washing being pretty clean (RACH 1), and the physical building and environment (RACHs 3 and 6) have all improved. Also, residents have allied health services provided for podiatry, dental, glasses, hearing aids, and other services that make a difference to their life (RACH 2), even hairdressing. Additionally, some respondents from the staff survey believe that the physical structure has enhanced welfare generally, with a few unsure.

Interestingly, it was mentioned that quality of life has been enhanced not only due to the adoption of accreditation, but also to the fact that staff are better educated (RACH 2); and that quality of care is directly related to quality of life (RACH 6). It was said that: "*But it doesn't, it's not only because of accreditation. It's because the people who are doing it (caring for residents) are better educated.* (RACH 2, Deputy Manager: 35)" (but see pages 111, 135, 145).

Not all staff, however, believe that residents' quality of life was enhanced due to the adoption of accreditation standards, as found in RACHs 1, 4, and 6. At RACH 1 it was indicated that not enough activities appear to be occurring; the RACH has very few outings and there are no activities on the weekends and on holidays. It was said that:

> *"Like at the moment the ladies all need their nails done and we don't - nobody's picking up that at the moment."* (RACH1, Certificate III: 36)
>
> *"There's meant to be where you're working out something for everybody to do, and there's paperwork to make sure that that's being followed, but I don't see those things happening so much here." "So I don't know how they say that that meets the accreditation standard. But that's just here, and it's because - I can see why. It's a small facility and we're paid by the council."* (RACH1, Certificate III: 37)

This concern was also raised by one interviewee from RACH 5, who added that reducing activities is a good way for RACHs to save money:

> *"I know of someone (who said) until I am told by the accreditation standards that I have to deliver this (more activities), I'm not going to do it. So they are not doing it because it's for the better of the residents, they are doing it only because they have to… (and) they still get accredited, so where's the fairness? … Whereas to me it's the heart and soul of your facility, it's the heart and soul of what makes your place and what makes it, it gives the residents purpose… but if they have got nothing to look forward to … it's like you may as well sit them in a chair… ."* (RACH5, Supervisor: 38)

Also, when reflecting about training as it relates to activities provided to residents, the following was affirmed:

> *"We'd spent heaps of time on it. It was a waste of time. If we didn't have accreditation, I wouldn't have spent as much time on it I guess, as a group."* (RACH 4, Deputy Manager: 39)

The comments above provide a clear illustration of the issue with the accreditation standards being the same for all facilities regardless of their size and type of care provided. For instance,

RACHs needs to prove that activities are happening; however, the accreditation outcomes do not specify how many days/times per week activities should be provided to residents.

Finally, at RACH 6, it is believed that residents' quality of life is the same as before the adoption of accreditation; the changes relate only to documentation with regards to ensuring that everything is correct.

Overall, it appears that the adoption of accreditation standards has enhanced residents' level of quality of life, mainly through their rights of choice and involvement in existing activities. This is also consistent with the results from the staff survey, where the vast majority of respondents believe that the adoption of accreditation standards has enhanced residents' level of quality of life. Though in RACH 1 it was believed that activities appear not to be occurring as they should, this may be due to the fact that this is a small local government RACH in a regional area. Staff survey returns within RACH 1, however, indicate that the adoption of accreditation standards does enhance residents' quality of life.

Findings

In suggesting that quality of care has been enhanced with the adoption of accreditation standards, different quality components from the literature were remarked on. For instance, one of Donabedian's attributes of quality in health care, effectiveness,[63] is being achieved through ensuring that allied health services are offered and also through continuous improvement. Residents' needs and expectations, which are referrable to the acceptability attribute, and an increase in staff training and education, were also mentioned as leading to better quality of care. Findings also indicate that quality of care was enhanced due to the coercive pressures faced by RACHs, with regard to having to follow legislation with required levels of quality of care to stay viable and facing sanctions if not compliant to the accreditation standards (further discussed in chapter seven). Yet it is also believed that adoption of accreditation has not enhanced the quality of care provided to residents. In this instance, adoption of accreditation was related to: 1) stakeholders' legitimacy reasons (i.e. government, accreditation agency, residents, family members), with adoption of accreditation being simply for the facility to 'display' the good care provided to residents (further discussed in chapter seven), and 2) normative reasons (i.e. being in the nursing profession), that enhanced quality of care would have been provided anyway (further discussed in chapter

[63] The degree to which attainable improvements in health are, in fact, attained.

seven). Similarly, Greenfield and Braithwaite's (2008) research findings indicated that accreditation is perceived to add little value to patient care. It was also mentioned that RACHs have always provided the best possible care to residents regardless of adoption of accreditation standards, and that the workload resultant from accreditation requires time to complete and therefore directly negatively affects the care provided to residents. Based on these findings, proposition 1 "*Adoption of accreditation standards improves the quality of care provided to residents*" is only partially supported.

Quality of life is believed to have enhanced due to the adoption of accreditation standards by most respondents, through increased activities, food, physical environment and so forth. Yet it is not clear whether all RACHs are in fact being sincere with wanting better quality of life for their residents or whether these are provided mainly due to coercive pressures, as results demonstrate that there is conflict with this regard. For instance, one staff member indicated knowing someone who would not provide more activities until being told by the accreditation agency, and another staff member affirming that less time would have been spent in training relating to activities if it had been known that assessors would only look at them quickly. Additionally, concerning residents' activities, another staff member mentioned "*So I don't know how they say that that meets the accreditation standard*" (RACH 1, Certificate III: 40). This latter comment, however, may be due to the accreditation standards not specifying minimum requirements in relation to the number of activities that an RACH must have. This facility may only provide a few activities because it is a small facility, and it is considered compliant because activities, even though only few, exist. Nonetheless, even if staff have different views on what is considered a proper number of activities and whether or not they are being truthful in wanting better quality of life for their residents, it can be said that activities have improved with the adoption of accreditation standards and so proposition 2, "*Adoption of accreditation standards improves residents' quality of life*", is deemed supported.

By combining the results obtained regarding quality of care and quality of life and comparing it to Campbell's Research and Consulting CR&C's[64] (2007) definition of these terms, results demonstrate that the adoption of accreditation standards meets the basic requirements enumerated by them. However, from the answers gathered in the interviews it can be noted that staff's understanding of the meaning of these terms is not the same as that stated by those authors. For example, physical facilities and spiritual care were indicated when asked about residents' quality of life, and not quality of care; and allied health is cited both as quality of

[64] Please refer to section 3.1.7 of chapter three

care and as quality of life. However, when combining the answers of these two questions (quality of care and quality of life) it can be seen that all requirements listed by the authors are mentioned. This is therefore consistent with Donabedian's definition of quality of care, which incorporates quality of life. Nonetheless, to the extent that ACSAA is fulfilling its function of promoting high quality care in Australian RACHs, this is evident only as it relates to quality of life. Therefore, findings indicate the need for ACSAA to streamline the paperwork relating to accreditation, as this may be negatively affecting the quality of care provided to residents. Findings also suggest a need to amend the requirements relating to residents' activities, perhaps having different standards according to the size, type, and resources of facilities.

6.2 Staff

6.2.1 Guidance

With regard to staff guidance, the following question was asked:

1. *How has the adoption of accreditation standards provided more guidance for staff in undertaking their tasks?*

Some staff believed that the adoption of accreditation has provided more guidance for general staff, while others believe it has only provided guidance on a managerial level. For the general staff level (RACHs 1, 2, 4, 5, and 6), accreditation standards:

- Provide a better understanding of what staff are doing, why things are done in a particular way, and of the expectations of accreditation, rules and regulations (RACHs 1, 4 and 6). This is important *"Because they (staff) all come from different backgrounds, they just come in and think they just have to do it this - they just have to shower someone or whatever. They don't realise that showering someone leads onto this, which leads onto that."* (RACH1, Manager: 41)
- Provide a "tick box" so that staff knows what to remember and ensures that everyone does the same thing whilst performing their job (RACH 1). *"It just gives them – like I say – like a tick box: things that you must remember while you're doing your job, to make sure that you keep things at a reasonable standard, rather than just relying on individual people to do what they think. It means that everybody's doing – or should be doing – the same thing."* (RACH1, Certificate III: 42)

- Clearly states what is expected from everyone, making staff more aware of their tasks and responsibilities (RACH 2);
- Remind staff of being accountable (RACH 5);
- Ensure that staff have more training and education when the accreditation round is approaching (RACH 6); (but see pages 111, 135, 145)
- Has resulted in a better level of care to the residents, and also improvement in the comprehensiveness of progress notes (RACH 6).

At RACH 6, the quality manager noted that the accreditation outcomes are clearly outlined, which provides staff with guidelines particularly in relation to clinical care (but see page 114).

> *"Because it's clearly outlined, particularly in relation to clinical care. There's a number of outcomes in clinical care. So they know by adhering to those outcomes - they know that we can deliver care in what's deemed best practice for the residents. So there's more structured guidelines there, so that we know that we are providing the best care for residents."* (RACH6, Quality Manager: 43)

RACH 2 indicated that accreditation provides general staff with more encouragement given that they are more involved with the accreditation process nowadays than used to be the case when it first stated. Conversely, data from RACH 3 which is part of the same group as RACH 2, indicates that staff are not aware of the accreditation process, and are not involved when accreditation assessors are at the facility. Furthermore, at RACH 5 it was suggested that accreditation standards do not provide any guidance for care staff, as per quote:

> *"Look at the ground roots level I don't think accreditation really impacts on the care staff at all, except for the fact that they know when the accreditation is on that they've got to be on their best behaviour and try working with it."* (RACH5, Manager: 44)

On a managerial staff level (RACHs 1, 2, 3, and 5), it was suggested that more guidance is provided through:

- The events supported by ACSAA such as the Better Practice Conference, the Standard newsletter, and the feedback received from the unscheduled visits. These assist with

RACH's planning and preparation for the accreditation round, and also provides the enthusiasm needed to employ new ideas (RACH 1);

- Indicating what needs to be focused on besides caring for the residents and providing guidelines about what needs to be demanded from staff (RACH 2);
- Mapping out better practices for processes and expected outcomes (RACH 5).

However, RACH 1's manager complained that even though the Quality Education on the Standards (QUEST)[65] training to staff has been requested from ACSAA, it has never been provided.

Comments also indicated that the accreditation process results in RACHs being more accountable (RACH 5). For instance, prior to accreditation RACHs had their own rules and were not governed by anything, not being questioned on the care provided, the state of the facilities, staffing levels, and other matters (RACH 6). As a result, the accreditation process stopped those RACHs who were not providing proper care (RACH 6).

> *"Even though everybody looks at the fact if you don't get accredited you can't get your funding, it's also more the fact is that these people are due to have this care. They have that right to have this care. This is a good way to monitor it and make sure the residents are getting it by having these standards. These standards are quite high so it makes it more exceptional for us to be able to get there to actually pass. So it is the best that we do have them but I just think they need to be adjusted."* (RACH6, Manager: 45)

Differently to what was suggested by all other interviewees and mentioned above, inclusive of RACH 2 which is part of the same group, the manager at RACH 3 indicated that accreditation standards do not provide any guidance for staff whatsoever, due to the fact that the outcomes can be achieved in many ways by different organisations. Instead, the accreditation standards sets out the expected outcomes, and it is the RACH's responsibility to tell staff, based on the organisation's policies and procedures, what needs to be done in order to achieve the outcomes.

> *"To meet a clinical care outcome in pain management, you know that I need to do x, y and z. They (staff) wouldn't piece that together. It's the organisational policies and procedures that guide people to be able to achieve that outcome."* (RACH3, Manager: 46)

[65] Consists of free education sessions in six different topics delivered by an aged care quality assessor at the RACH. ACSAA. 2012j. *Quality Education on the Standards (QUEST) education for homes* [Online]. Aged Care Standards and Accreditation Agency. Available: http://www.accreditation.org.au/education/quest/ [Accessed 30th January 2013.]

That manager then added that prior to accreditation the government had another monitoring system which, differently from the current system, clearly stated what RACHs were expected to do.

> *"People knew that if they had someone on pain management it was expected that they do x, y and z at these frequencies. It's a bit greyer now and it's really up to the organisation."* (RACH3, Manager: 47)

Those staff who responded to the survey were asked to describe the influence that the accreditation standards have on the way they perform their job. Results indicated positive and negative influences. Positively, the adoption of accreditation has influenced staff's work by:

- Providing paperwork to be completed with regard to residents' needs, behaviour and social interaction, and which results in staff better observing residents;
- Resulting in a high standard of work ethic in the workplace,
- Ensuring that staff are accountable;
- *"The monitoring of an Aged Care facility ensures that the staff are reminded of the importance in caring for residents to the best of their abilities."* (RACH5, Receptionist: 48)

Negatively, it results in staff working under a lot of pressure close to an accreditation round. It was noted that:

> *"Too much pressure to be perfect when frankly, managers do not care on normal occasions"*. (RACH4, Care Staff: 49)

Comparing the results from the staff survey to those from the interviews, it can be seen that accountability and better care to residents were cited in both as an outcome of the adoption of accreditation standards providing more guidance to staff.

With regard to staff, some concerns were cited at the end of the interview when staff were asked the following:

2. *In what ways, if any, do you believe the accreditation process could be simplified and improved?*

Interestingly, the answers to this question led to major issues that relate to RACHs as a whole, and not directly to the accreditation process. Yet, these are issues that RACHs staff believes that the accreditation agency should intervene within so that the quality of services provided

to residents can be further improved. These comments and/or suggestions were classified in four patterns (some of these will also be discussed under normative pressures on chapter seven): 1) a governing body for care staff; 2) better salaries for care staff; 3) turnover of RACHs managers; and 4) staff ratios.

Firstly, it was suggested that the industry would be more professional if the Accreditation Agency encouraged the government to impose a governing body for care workers, who are the majority of the workers in RACHs (RACH 1).

> *"They don't have a governing body that says okay so now you're Cert III, so next year we'll be sending you a little form. You need to pay an annual licence fee to keep in the know. You'll have some paperwork you need to fill out … You need to show that you've kept your first aid up to date and your CPR and … You've done some personal development. Put down all the courses you've done in the last year… They don't need to do anything. There is nothing that governs them. There is nothing to make them grow as a body. I find that's a really bad thing for the industry."* (RACH1, Care Coordinator: 50)

Having said that, it was also commented that care workers in aged care are paid a very low salary, which results in them not being able to develop professionally and in RACHs often employing unskilled people (RACH 1) (but see pages 124, 127 and 132), as per quote: "*pay pathetic wages and therefore only attract pathetic people*" (RACH1, Manager: 51). Nurses working in aged care are also paid a very low salary, a third less than nurses in hospitals (RACH 1). Another issue cited in RACH 1 is that RACHs come under the welfare bracket. As a result, many people are required to undertake a Certificate III TAFE course and start working in aged care only to keep receiving the dole or single parent's pension. However, the manager notes that it is difficult to properly look after residents when being forced to do a course: *"These people don't have the heart, the soul in it.* (RACH1, Manager: 52)*"* Similarly, it was said that aged care is such a specialty area that unless people are really suited to it they do not stay (RACH 5). Likewise, in RACH 3 it was revealed that staff are recruited based on their experience, but as importantly based on personalities as this directly affects residents' quality of care and quality of life.

> *"So to have legislation to say well you have to provide this, this and this, but you still need someone that's going to provide them with that empathy and that support and all the rest of it … I mean that's huge … their care is part of their quality of life. The environment is part of quality of life. Their food, all*

> *of those sorts of things you've got to - the people that surround them."* (RACH3, Area Manager 1: 53)

Another matter revealed is the level of turnover of RACHs' managers (RACH 5). This was also noticed by the researcher when contacting RACHs to participate in the interviews. For instance, the majority of RACH managers that were met at the accreditation course were no longer working at the same RACH at the time of contact. Additionally, four managers from the RACHs in the sample were relatively new in the facility, and when returning to conduct the interview with the third staff member at one of the RACHs, the manager was no longer working there. It was suggested that this is due to several reasons, as follows:

- Managers get paid low salaries;
- Managers are on call 24 hours a day, every day of the week;
- Work impacts on managers' personal lives;
- Managers do not have sufficient support from CEO and owners;
- There appear to be many young managers who do not have the experience and do not know how to handle stress.

> *"If you get sick and you want to take a day off because you've got a cold, all you can think of is all the things you've got to do so you may as well come to work and get it done because otherwise you're going to get more stressed."* (RACH5, Manager: 54)

Finally, it was mentioned that there is no nursing ratio or carer ratio in NSW (RACH 1). That is, a fixed ratio between nurses and residents. It was also mentioned that RACHs do not receive any additional government funding to do the necessary paperwork, as per quote: *"That's where it's difficult because you have to find a way where you can achieve both (do the paperwork and provide care to residents) and use the same number of staff that you've always been using. You have to be a little bit creative.* (RACH1, Care Coordinator: 55)*"* However, at RACH (3) it was indicated that it is difficult to have guidelines set in terms of the number of staff for an aged care facility, due to residents' needs being different and staffing changing from time to time based on the residents' needs. *"Somebody that looks after 10 residents in one unit may have an easier workload than someone that looks after five in another area. So that whole ratio of one to whatever I don't think works.* (RACH3, Manager: 56)*"* So, it was suggested to consider the *"income that's provided and a percentage of income being spent on staffing* (RACH3, Manager: 57)*"*, that is, to build up and maintain staffing levels. At RACH 5 it was suggested that RACHs should have person-centred care: *"that is like one person for so*

many people. They then check that they are showered, they are dressed, they have had their morning tea, you've got that little group. (RACH5, Supervisor: 58)*"*

Yet it is believed that there is nothing that accreditation can do to interfere in this, as accreditation simply makes sure that the care is properly given to residents (RACH 6). At the moment, staff funding is governed by the ACFI funding. *"If you have so many high care residents, then you'll get extra staff. The majority of places (high care) will have one staff member to eight residents … they need full care, as in showering, toileting, feeding, and you've got one nurse to do eight of them.* (RACH6, Manager: 59)*"*

Findings:

All RACH managers and staff on a supervisory level and registered nurse levels are, as per staff survey, directly involved with accreditation. This is consistent with the views of most quality management authors explored in chapter three who state that management must be directly involved with quality management implementation. However, most authors also proposed that all staff in the organisation must be involved with quality; and not all RACH general staff seem to be involved with accreditation. Interestingly, it appears that staff's level of involvement with accreditation is different amongst RACHs 2 and 3, which are part of the same group. This suggests that there is no mimetic isomorphism happening with this regard amongst these organisations, which in turn means that the way quality is managed in these places is different (further discussed in chapter seven). It should be noted, however, that not being involved with accreditation standards does not necessarily mean that staff are not educated in quality management and do not contribute to it.

An important concern relates to the apparent turnover of RACH managers. "Mobility of management" is considered one of the "deadly diseases of quality management" by Deming (1986), as per appendix 4. The author indicates this to be a concern because managers do not stay long enough to understand the organisation, and so are not able to implement and follow through on changes that are vital for quality and productivity. This, however, may significantly impact on the continuous improvement of the RACH as it relates to the quality of its services provided by them to residents, and therefore indicate an important area that the Government should be attentive to.

Although accreditation requirements are "a bit greyer now" (as per quote 47 on page 134), findings also suggest that the adoption of accreditation standards has provided guidance (in

terms of regulations, required outcomes, education) for staff both on general and managerial levels. This finding is consistent with that of the research conducted by Grenade and Boldy (2002), where it was noted that the adoption of accreditation resulted in staff being more aware of their activities. Guidance also appears to result in some mimetic isomorphism happening at RACHs, as it was noted that adoption of accreditation standards has resulted in a "tick box" being established so that staff know what to remember whilst performing their jobs (further discussed in chapter seven). Moreover, staff education was raised by many authors:. Ishikawa (1985) noted that "*quality control begins with education and ends with education*"; Deming (1986) said that an organisation needs people who improve with education; and in their study Bartlett and Burnip (1998) suggested that care delivery is directly influenced by education and training, amongst other factors. Guidance can, however, be challenging. Results presented on page 131 indicate that guidance is appreciated and also appears to be sought by staff, but whether the specifications are sought, is contentious. As indicated earlier, on a management level, guidance is provided through the Better Practice Conference, the Standard newsletter, and the feedback received from the unscheduled visits. This is consistent with one of ACSAA's functions which is to "help the industry to improve service quality, by identifying best practices and providing information, education and training to the industry" (ACSAA, 2012f). However, it seems that ACSAA is falling short through not providing training for frontline staff, as indicated by RACH 1. The implementation of this, however, may result in a direct negative impact on the quality of services provided to residents of this facility. Additionally, this finding calls attention to the quality of services being provided by ACSAA to small stand-alone facilities that are in a remote area, which is the case of RACH 1.

6.3 Processes

6.3.1 Process Improvement and Administrative Work

Two questions were made to examine whether the adoption of accreditation has influenced RACH processes and administrative work.

1. *How has the adoption of accreditation improved the processes of the running of this organisation?*

It was suggested that the adoption of accreditation has improved RACH processes in many ways. Common patterns included RACHs being more accountable (RACHs 1, 3, 5), the provision of guidelines for both staff and management (RACHs 1, 2, 3, 4, 5), a focus on continuous improvement (RACHs 2, 3), and more efficient processes due to having goals and standards to be achieved (RACH 1, 2 and 4). Data indicates that suggestions made by assessors during the accreditation audits also leads to improvement in processes (RACHs 2 and 4) and benefits for residents (RACH 4). With regard to accountability, it was noted that accreditation is important to ensure that RACHs conform to regulations. *"I mean it's legislation. It's like driving a car isn't it? You know you drive your car and you know that if you speed that (you will be fined) … We all need rules."* (RACH3, Area Manager 1: 60)

Additionally, at RACH 1 it was commented that adoption of accreditation standards has positioned the facility up to a standard as compared to other organisations, has increased staff training, and also resulted in the implementation of an audit system in accordance to the 44 accreditation outcomes (please refer to chapter three). Infection control is a process that appears to have benefited to a greater extent.

At RACH 3, which is a relatively new organisation (i.e. came into operation after accreditation standards took effect), it was said that the adoption of accreditation standards provided the RACH with a framework to establish everything from the beginning, as for example looking at all aspects of care, environment, safety and leadership.

At the time of the interview RACH 6 had recently been taken over, and so staff responses were based on changes that occurred in this regard. Improvements were made in the organisation's processes to more appropriately reflect compliance with the accreditation standards, such as a new electronic care system to record residents care needs, progress notes, and care plans, refurbishment, and restructure of the work environment amongst other things.

On the contrary, however, some staff believed that adoption of accreditation standards has not improved RACH's processes. For instance, it was stated that *"No. I wouldn't say improved as much, but there's more focus on documentation. So we can actually show that we are fulfilling the standards* (RACH 2, Manager: 61)"; while one staff member in RACH 3 believes that the adoption of accreditation standards does not impact on the RACH's processes. RACH 1, being a small Council-run facility, the accreditation process is *"stressful and daunting*

(RACH1, Manager: 62)" due to the council not actually understanding the accreditation requirements. It was noted that:

> *"Even now a lot of the council laws still have a lot of trouble trying to come to terms with the accreditation standards and what's expected of us here. Because they're like country councillors they just think it's just a nice little place where you put someone in, the meals get cooked for them and you look after them." … "I've had to teach them about why we provide palliative care to our residents. Then they had to vote to give me permission whether I'm allowed to do it here or not."* (RACH1, Manager: 63)

Additionally, the fact that a small stand-alone RACH has to meet all 44 accreditation outcomes across the 4 standards was noted as very challenging.

The staff survey had four Likert scale questions relating to process improvement. Results from these four questions were all very similar. The vast majority of staff either strongly agree, agree or slightly agree that the adoption of accreditation standards has somehow improved RACHs' processes.

Findings:

On balance, findings suggest that the adoption of accreditation standards has, to an extent, assisted in improving RACHs' processes, through RACHs having goals and standards to be achieved and a focus on continuous improvement which are consistent with the TQM component "attention to the process" and the Deming cycle, respectively. This is also consistent with the study by Greenfield and Braithwaite (2008) which observed that accreditation programs have resulted in better organisational performance. Staff surveyed also revealed that processes have improved through better information systems, guidelines, professional standards, policies, and learning about the organisation's vision, values, philosophy and objectives. Findings also indicate that RACHs believe it is important that the government imposes regulations as a method of output control to ensure RACH accountability. In fact, CR&C's (2007) research found that the introduction of accreditation has resulted in an increased level of accountability of providers. However, it was mentioned by one of the RACHs that the adoption of accreditation standards is simply for the RACH to demonstrate legitimacy to the government (further discussed in chapter seven). Additionally, the coercive pressures (further discussed in chapter seven) faced by a small stand-alone council facility of having to fulfil all the 44 outcomes, combined with distinct perceptions

from two different government bodies to which it must report, can be overwhelming. Hence, findings of this study reveal a need for more support given to small stand-alone RACHs in fulfilling the regulations imposed on them, especially when they face conflicting regulations from different governing bodies.

2. *Can you comment on whether the volume of administrative work has increased in this facility as a result of the adoption of accreditation?*

It is evident that the volume of administrative work has significantly increased; this fact was concurred in by all staff across all homes. Few staff believe that paperwork is positive, whilst the majority considers it overwhelming and leads to other problems within RACHs.

An increase in paperwork is positive because RACHs can demonstrate how issues have been resolved (RACH 4), it makes staff more attuned in terms of getting the details correct (RACH 4), it makes RACHs and staff more accountable (RACH 3), and it also enables staff to learn the needs and problems of residents and work on them (RACH 4).

> *"Because I think it does make you more attuned to sort of get the detail right. Following up on things you know - like accidents and incidents. They have to be brought to a conclusion. You have to sort of resolve it one way or the other. So if - probably if the accreditation standard was different you might not - you might just sort of fill in a form and put it aside. But the way the accreditation people like it now is that you actually have to follow it through or make sure something's done about it. Then show what was done. Sometimes I think there's a little bit too much involved."* (RACH4, Manager: 64)

Additionally, paperwork is deemed important as to make the process transparent (RACH 1) and so that the government can ascertain what RACHs are doing (RACHs 2, 6). It also ensures that RACHs are accountable to the funds received from the government (RACHs 3).

> *"Paperwork is necessary as to make the process transparent."* (RACH1, Care Coordinator: 65)

> *"It's a difficult thing to juggle because in terms of the subsidies that we receive to provide the care to the residents. I guess that everyone would tell you that funding's not enough to do what we need to do. So it does make it difficult in terms of trying to juggle what resources you use for the administrative side of things versus the on the floor care delivery side of*

things … Having said that I guess that we're all accountable though. We receive large amounts of government funds and there needs to be some level of accountability. I guess it's about - it can become difficult for places if their systems are cumbersome and I guess not streamlined that well." (RACH3, Manager: 66)

Conversely, as indicated by at least one staff in every RACH, paperwork is considered overwhelming and negative for many reasons. Information provided with regard to paperwork was extensive, and so they were grouped in four main patterns: 1) volume of administrative work having increased substantially; 2) staff not having enough time to complete the required administrative work; 3) paperwork being the main source of evidence used by assessors; and 4) paperwork taking time away from residents.

Firstly, data reveals that the volume of administrative work has increased substantially and it seems to be really demanding on staff. This is due to the level of evidence that is required to fulfil each of the accreditation standards, and also due to the fact that most evidence appears to be paper based. It was indicated that:

- The amount of paperwork significantly increases leading up to an accreditation assessment (RACHs 2 and 4).

- The level of evidence required appears to be exaggerated due to a lot of repetitive work (RACHs 5 and 6), as for example:

"You need to have all these - the same documentation in, for example, the progress notes and then you need to go to a care plan and then you need to have that care plan in your cupboard, and it's just all repetitive stuff that you really need to have, and stuff that's not applicable." (RACH5, Deputy Manager: 67)

"*Progress notes, doctor's notes, dressing chart and then - for example, with a wound. Then the wound's healed, just enter in the progress notes, "wound healed". That's it. You don't have to go through all these other processes, and come in and go through all this stuff that just is a whole day process or sometimes up to a week process and then coming and doing that."* (RACH5, Deputy Manager: 68)

- Yet many aspects are looked at only briefly by accreditation assessors, and it appears that staff would have appreciated a more thorough revision of their hard work; as per quote below:

> *"I found a lot of things that we were spending a lot of time on weren't necessarily targeted by the Accreditation Agency … We did a lot of training with the staff around the aromatherapy program, and massage and all this sort of stuff. The Accreditation Agency basically looked at it and said they were happy with it all, but it was only a one or two minute, yes that's good, tick. We'd spent heaps of time on it."* (RACH4, Deputy Manager: 69)

Secondly, data suggests that there is not enough time to complete all the required administrative work (RACHs1, 3 and 6) which, combined with a lack of staff and resources, results in staff having to work additional hours (unpaid), and not being able to provide a proper amount of clinical care. For instance, one interviewee observed that at another RACH were she also works three staff left due to the administrative work required to fulfil accreditation standards, in addition to other issues with the RACH. As it relates to a lack of resources, it appears that the industry faces some serious issues. It was quoted:

> *"You just need more time to be able to do it. If you're going to maintain the same amount of actual clinical care, and that's where people get really frustrated and get cranky with the system, because they feel like, you know, this hour I'm sitting here doing all this work, I could be doing an hour with the residents … I could be doing something else rather than sitting here filling out these seemingly endless assessments. Look they're necessary. To make the process transparent, they are necessary. Wherein lies the problem is there is no extra time allotted to do it. Everyone's been doing more with less kind of thing. They're (the accreditation agency) under the umbrella of the government. It's really important that we - the whole idea of having Certificate III and Certificate IV aged care carers was to make life cheaper. Okay so they've done that but so if you've made it cheaper, don't make it worse, you know what I mean. Like you need to have the right amount of time to do your job. Most people I've ever known always go above and beyond in their hours because they can't achieve what they need to achieve in the set times they have … Who's going to pay overtime? If you're asked to stay back for something or you're asked to come to a staff meeting or training, yes you'll get paid. If you just stay back an extra 20 minutes to finish off something, you're not going to get paid. No-one does. The industry can't afford it. You'd be taking the food off the residents' plate then*

basically. You know, it's where does it start and where does it end." (RACH1, Care Coordinator: 70)

Thirdly, paperwork appears to be the main source of evidence used by accreditation assessors to ensure compliance with the standards, which when not properly recorded may lead to sanctions (RACHs 1, 5 and 6). The amount of paperwork also seems to confuse staff in terms of how to prioritise their tasks with regard to residents versus paperwork.

"They're (staff) going well, I don't have time to fill out all those forms. I'm saying you have to or we're not going to get the money, we're not going to get accreditation. We won't get our ACFI. Then staff responds: *Well what comes first, paperwork or residents?"* (RACH1, Care Coordinator: 71)

"Well, you're depending on the fact that you've got to get through this process … Otherwise you run the risk of non-compliance, and then you run the risk of sanctioning, and then no money, and a bad name for the facility - everything that comes with it … I've spent four hours with a lady looking for a wound, tracking a wound, one wound." (RACH5, Deputy Manager: 72)

"The problem is that the Accreditation Agency only focuses on documentation as to prove that activities have been happening … As far as the agency is concerned, if they come and if you don't have the documentation, if it's not written down, they don't consider that you actually do it. How do you prove it? You have got to have time for your documentation. A lot of that is in your own time with activities." (RACH5, Supervisor: 73)

"(The only way that paperwork can be reduced is if accreditation assessors become) more lenient with their standards. Nowadays there is so much evidence that needs to be produced, and if the RACH does not have it then they will get really scrutinised by accreditation assessors." (RACH6, Manager: 74)

However, paperwork may not always be accurate, as commented by two staff members (RACH 1).

"Documentation is great but I don't believe it's the be all and end all. I don't believe it always tells the true story." (Care Coordinator: 75)

"What is shown on paperwork not necessarily relates to what is actually happening on the ground." (Certificate III: 76)

Additionally, the administrative expectations from the Accreditation Agency may be an issue given that paperwork may not always be properly recorded due to an apparent number of unqualified staff working in RACHs. For example, staff with low literacy, staff from non-English speaking backgrounds, and staff who do not know how to work in teams and abide by the rules (RACHs 1, 3 and 5).

> *"A lot of the stuff, too, they expect certificate three staff to be able to do. The basic reality of it is certificate three staff, their English and literacy and numeracy skills are often times - they're well below - English is their second language, so they're not going to necessarily understand what's going on. So the majority of work is therefore left on the registered nurses, for example, and they're underpaid in this industry as it is. So the example there is, I would say, in the expected documentation of requirements that they do actually find you non-compliant on. That's how serious it is."* (RACH5, Deputy Manager: 77) (but see pages 124, 127 and 132)

At RACH 2 it was also suggested that the way assessors look at the information could be improved, by reducing the reading of care plans and looking at paper based evidence and, instead, having more competency-based assessments and eyeballing of things.

Fourthly and most importantly, it is evident from the data collected that paperwork takes time away from caring for residents (RACHs 1, 3, 4, 5, 6). One manager indicated that she hardly has enough time to do one round of visits to residents due to paperwork. It was also noted:

> *"There's so much documentation that it takes away from … I think they (accreditation agency) need to understand that we're about caring for residents. You do need your paper trails and your documentation. But everything is such a paper trail … You have to document everything - every single little thing - whether it's the resident didn't have their morning tea or - all of those sorts of things… I think there's too much - too much … To document every little single thing just worries me. We spend a lot of time writing when we should be out there caring … I think that we need to concentrate more on care and more on our residents instead of the paper trails."* (RACH3, Area Manager 1: 78)

It should be noted, however, that other systems which RACHs must also be compliant with were similarly associated with the increase in paperwork (RACHs 1 and 5), as for example

building guidelines and food safety. It was also suggested that this results in the director of nursing role being more of a coordinator's role than ever before. It was mentioned:

> *"Because it's not only the accreditation standards, it's the food handling and the other guidelines that you've got to meet as well. We're also run by our shire, so we've got to meet our local government guidelines as well."* (RACH1, Manager: 79)

> *"So it's balancing the regulations and the laws and the paperwork and still trying to achieve the personal care and the clinical care that you need to do"*. (RACH1, Care Coordinator: 80)

> *"I think that the role of director of nursing, care manager, whatever you want to call the position has become much more a coordinator's role than ever before. If I get up and do one round a day I'm doing well to get round all my residents … But I do believe that we're much more tied to the desk than ever before and I don't think that's just accreditation, I think it's business in general."* (RACH5, Manager: 81)

In one RACH, an IT system was introduced to deal with most of the issues mentioned above. With the IT system, once a clinical file is updated the information populates to all other associated areas. It is simpler for staff who are from non-English speaking backgrounds and the system is also used to demonstrate the requisite evidence to accreditation assessors.

Findings

Paperwork is important to ensure accountability, to make the process transparent and so that staff can learn and work on satisfying residents' needs. However, paperwork appears to be the main source of evidence used by accreditation assessors, which may be an issue for diverse reasons. Firstly, it was suggested that there are many unqualified staff working at RACHs, which may result in paperwork not always being properly completed. This in turn may lead to the RACH being non-compliant with all standards, thereby facing coercive pressures from the government through sanctions being imposed (further discussed in chapter seven). Finally, paperwork (which appears to be a result not only of accreditation standards) may negatively impact the quality of care provided to residents by taking time away from caring for them. Paper can only capture the reality to an extent, and so paperwork being the main source of evidence used by accreditation assessors may result in the value of the standard, and of the

whole accreditation process, being lost. Excessive paperwork was also a finding of the study undertaken by Grenade and Boldy (2002), where high levels of required documentation were indicated, in addition to staff inquiring whether paperwork is the most appropriate indicator of service quality. Additionally, paperwork was also indicated to be an issue in other research, such as CR&C (2007) and the Productivity Commission (2011). Therefore, the extent in which paperwork is used as a source of evidence to the fulfilment of the accreditation standards may need to be reconsidered, especially given that it may be negatively affecting the quality of care provided to residents.

6.3.2 Standards

With regard to the accreditation standards and outcomes, RACHs were asked the following:

1. *From the accreditation standards/outcomes listed below, please indicate with an "x" (on the checkbox provided on the left hand side of each outcome) those outcomes that you consider not applicable to your organisation.*

All respondents believe that all outcomes are applicable to their organisations however; suggestions on restructuring and rewording the outcomes were provided, as follows:

- Outcomes[66] 1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 4.3 (Manager RACH1 and Deputy Manager RACH4): It was observed that these outcomes are repeated within each standard (e.g. outcome 1.1 is the same as 2.1, 3.1 and 4.1), and therefore they should be combined in three main outcomes to cover all standards.
- Outcome 2.14 – Mobility, dexterity and rehabilitation: *"Optimum levels of mobility and dexterity are achieved for all residents"*: It was suggested that the wording (i.e. rehabilitation) should be amended, given that many residents and family members expect RACHs to provide rehabilitation services. It was noted that "*This one here is probably a lot interesting - people often think that we're a rehab facility and that's certainly not the case … - and it says in rehab… we can't provide that level."* (RACH3, Area Manager 2: 82)
- Outcome 2.17 - Sleep: "*Residents are able to achieve natural sleep patterns*" (RACH3, Area Manager 1: 83). It was found that this outcome is not appropriately written and it is open for interpretation. Manager said that "*I sleep differently to the*

[66] A description of these outcomes is provided in Table 3.5 on page 53 of chapter three

way you sleep … I might go to bed late, they might go to bed early … and how do you achieve that (the outcome)? Paperwork."

- Outcome 3.10 - Resident security of tenure and responsibilities: "*Residents have secure tenure within the residential care service, and understand their rights and responsibilities.*" (RACH2, Deputy Manager: 84): It was suggested by the deputy manager that the way this outcome is written should be changed, because "*when the medical condition requires the person to be put in a secure unit … we (RACH) should have preferences to do so even if the family says no because we look after that person … when the person deteriorated to that stage that he's going outside or that he's a danger to the others, you can't reason with him because of the brain, it's not functioning, and the family says no, I want him to stay here next to room number 1 which is close to the road*. (RACH2, Deputy Manager: 85)" Therefore, it was suggested by the nurse that this standard should be changed to include that "when the medical conditions change in that resident…that we (staff) can't look after the resident on the general ward that he needs to go the dementia, we can change". The assistant care manager noted that this will allow "*We (nurses) (to) have the right to do it because the doctor and me say that this is what is needed to keep this person safe*" (RACH2, Deputy Manager: 86). To demonstrate evidence of this outcome to accreditation assessors, staff indicated that it is written on the paperwork that "*this person is wandering all the time…. I spoke to the family that we should transfer him to the dementia unit but family says no.*" (RACH2, Deputy Manager: 87)

Findings

As described chapter Two, The Aged Care Act receives continuous amendments to address legislative inadequacies and maintain effective regulatory safeguards, with the purpose of ensuring continuous improvement in the legislation with regard to a high quality of care for Australians. Therefore, the above observations raised by staff may assist in further enhancing the accreditation outcomes. Specifically, the observations made from a deputy manager in RACH 2 with regard to resident security of tenure and responsibilities indicates that there is a strong need to revise the rights of RACH with regard to dealing with residents' security. Also, the wording of outcome 2.14 seems to be a source of residents and family members expectations with regards to rehabilitation, therefore rewording of this outcome may assist in solving this issue.

6.4 Quality Management System (Aged Care Standards and Accreditation Agency)

6.4.1 Quality Level and Accreditation Assessors

Interviewed staff were asked three questions relating to their RACH's processes and to the Aged Care Standards and Accreditation Agency. These will be discussed separately and include:

1. *Before adopting the Agency accreditation standards, did this facility have any established operational standards or quality management systems in place?*

This question was of an introductory nature, so that the researcher could have an overall idea of the status of quality management at each of the RACHs where interviews were conducted. At RACH 1 it was stated that there were operational standards, although not as many as there are nowadays. RACH 2 already had internal audits, self-assessments, and information systems. RACHs 4 and 5 both mentioned that the Australian government[67] already had different systems in place before accreditation. At RACH 6 it was noted that quality management as it relates to residents' care and needs has improved in the organisation since it was taken over by another facility.

At RACH 3 comments were related to the organisation's current quality management systems, of it incorporating things that must be measured due to accreditation, as well as other indicators that are key to the organisation's goals and objectives. It was affirmed that the "quality auditing" and the "care management systems" that the organisation has cover more than what is required in the accreditation standards. The RACH also has a quality framework within the organisation's group, which includes quality improvement (a strategic continuous improvement plan), an auditing schedule, and a performance measure matrix. The organisation also subscribes to QPS benchmarking, which comprises clinical and managerial indicators. The answers provided at RACH 3 are similar to those provided at RACH 2, which is part of the same group.

However, some staff (RACHs 1, 3, 5, 6) were unsure and could not answer the question as they were not at the facility prior to accreditation being introduced.

[67] Australian Standards Monitoring Process (BRAITHWAITE, J. 1998. Regulation and Quality in Aged Care: a Cross-National Perspective. *Australasian Journal on Ageing*, 17.)

Findings:

Crosby (1979) refers to quality management as a systematic method used by organisations to guarantee that activities happen as planned. However, in their study, Greenfield and Braithwaite (2008) indicated that the impact of accreditation programs in organisations remains unclear; although it was identified that larger hospitals received more significant recommendations than others, which may be due to them already having a more sound quality management system than smaller hospitals. Similarly to Greenfield and Braithwaite (2008) study, data suggests that the sample of medium/large RACHs appears to have more sound quality management systems than the sample of small RACHs. This is evident from the information provided by RACHs 2 and 3, which are large facilities and part of the same group, with regard to their current quality management system capturing more than what is required by accreditation. Also, data indicates that the adoption of accreditation standards has resulted in additional operational standards in RACH 1 (a small stand-alone facility), and that RACH 6 is facing significant improvements due to the recent takeover. This is consistent with Heras et al.'s (2008) study, where it was found that quality assurance programs (ISO9001 in that case) have the potential to improve the systematisation of work routines. Nonetheless, results from this research suggest that for medium and large RACHs the adoption of accreditation standards may only represent minimum quality standards; differently from small RACHs were it has a greater impact. Therefore, results strongly indicate that different levels of accreditation standards can be imposed on RACHs based on their size, type, and resources available. Having different levels of accreditation requirements will significantly contribute in improving the quality management systems of all RACHs.

2. *In what way do you believe that accreditation standards are reflective of minimum levels of quality?*

The vast majority of respondents believe that accreditation standards are reflective of minimum levels of quality (RACHs 1, 2, 3, 4, 5 and 6), with only very few respondents (RACHs 4, 5, 6) believing that they are reflective of high levels of quality.

RACHs' lack of money was cited as a reason for standards having to be kept as a minimum (RACH 1), yet this was considered to be an acceptable level as it is based on rules, laws, and government acts (RACH 1). RACHs can then decide if they want to go above and beyond that

level, which many claim they do (RACHs 2, 3 and 4). Contradictorily, at RACH 3 it was stated that the minimum is not enough, as per quote:

> *"I think they provide the minimum, I think nursing care across the board is very stretched. I don't think it's enough by any means. We could all probably provide better – most definitely."* (RACH3, Area Manager 2: 88)

Similarly, at RACH 4 it was also suggested that accreditation standards *"set a minimum level for quality care, which are really a minimum"* (RACH4, Deputy Manager: 89), further criticising this state of affairs by adding that for other things (as per quote below) their minimum level can be too high, where they expect really difficult things to be achieved. These requirements, however, do not improve residents' level of quality of care; it is only paperwork which in fact takes time away from caring for residents.

> *"I'm a firm believer that a care plan should just be purely about a plan of care, not so much as a running update of what's happening in the lives of the residents. Sometimes I feel that the Accreditation Agency expects that every little change, everything the doctor says, everything that anybody has said, needs to find its way to the care plan, and I think that's a bit overkill. That's something that they always expect."* (RACH4, Deputy Manager: 90)

This was supported, yet also contradicted, by a statement made at RACH 5, where it was noted that:

> "*It is basic, but at the time we're going through the process, I believe that the individual accreditor has higher expectations and they'll actually prompt you to pull out all this stuff, but at the end of the day, they probably can't do anything about what they think that we should be doing, because they've got these basic standards."* (RACH5, Deputy Manager: 91)

It was also mentioned that as part of the accreditation process RACHs are required to undertake continuous improvement and therefore none should be sitting at a minimum level (RACH 3). Having said that, it appears that continuous improvement is not appropriately verified by accreditation assessors (RACH 5), as per quote below:

> "*I'm not sure that they do that very well (verification of continuous improvement) because in my experience they only really look at your quality improvement for the last 12 months. So I've never had anybody actually come out and look back over the three year period and in fact most of them*

> *only look back about three months. So I think that's where your minimum standard comes in, minimum level. If they were to really look at that seriously they'd go back over the three-year period. But accreditation would end up being six weeks instead of three days or whatever it is.*" (RACH5, Manager: 92) (but see page 119)

Interestingly, RACH 6 is the only one where the majority of staff believe that accreditation standards represent high standards of quality. This, however, may be due to the fact that this RACH was recently taken over and perhaps there were many improvements to its processes in order to comply with the accreditation standards, as it was said that:

> *"So the residents were very disgruntled by all the changes that had to be done because it wasn't up to standard when (the company) took over."* (RACH6, Manager: 93)

Findings

Overall, it appears that accreditation standards are reflective of minimum levels of quality; it was suggested that the reason why the government maintains quality at a minimum level is due to RACHs' lack of resources. Even though the minimum level may be considered to be an acceptable level, most medium and large RACHs from the sample claim that they go above and beyond what is required by accreditation. This may therefore suggest that the accreditation requirements are only minimal to large groups, and that there is scope for different levels of accreditation requirements to be applied to the different types and sizes of RACHs. Also, the accreditation standards being kept at a minimum may result in the accreditation agency not successfully achieving its task of promoting high quality care in RACHs. Moreover, accreditation standards are based on continuous improvement (as seen in chapter three [68]), and the fact that this is not properly evaluated by accreditation assessors may result in the whole accreditation assessment being dubious. Similarly, Greenfield and Braithwaite (2008) indicated that in four cases the validity of the accreditation program was questioned, and arguments raised with regard to a need for improvements in or clarification of standards.

[68] "*Receiving accreditation from the Federal Government means that RACHs not only maintain ongoing compliance with the legislated accreditation standards but also undertake continuous improvement*" (chapter three, page 52)

3. *Did you take part in more than one accreditation round? Was the assessment you received different from one team of assessors to the other? In what way?*

RACHs 2 and 3 indicated that assessors are very consistent. One staff member (RACH 1) said that assessors try to encourage and educate staff, and that their intention is to help the system and help the RACH to be a better place ultimately for the residents by ensuring that they have the best possible care. It was also commented that the accreditation process is good as it makes RACHs accountable (RACH 5):

> *"I think the accreditation system is great for the residents. We have to have something that we are accountable for, for the people that we care for. They deserve that. As I said, it could be us, it could be our relatives. To weed out those people that are bullies and that do abuse people because it happens and it happens under your nose and you don't know."* (RACH5, Supervisor: 94)

Conversely, most staff believe that the assessments are different (RACHs 1, 3, 4, 5, and 6), and sometimes unfair (RACH 3). Some view these differences as a natural factor, whilst others really criticise the degree of inconsistency. RACHs 1, 3, 4 and 5 noted that assessors are different, they tend to focus in different areas and perceive things differently, and a lot depends on their personality. It was suggested that assessors need to understand that every facility works differently, according to their residents' needs and the quality of staff that it has.

> "*We've had periods, times where people have come out and said look we'd prefer that you do it this way. Then other people go no, we'd prefer that you do it that way. It's about having the confidence and maturity to not just jump every time they say jump."* (RACH3, Manager: 95)

Additionally, significant inconsistency amongst the accreditation assessors themselves was noted: *"I just found that her standards were up here and his were down here"* (RACH5, Deputy Manager: 96). It was also said that what makes the process difficult is that assessors have their own preferences and biases as it relates to the accreditation standards, and when the RACH is being assessed those biases come across (RACHs 1, 3, 4 and 5). For example, some assessors have an acute focus on a certain area (e.g. infection control, pain management, information systems) and will assess that very closely, while others will be broader across the board.

Data also indicates that assessors' backgrounds and the way the accreditation assessment is carried out also appear to be issues (RACHs 1 and 5). Whilst some assessors have worked in aged care and many of them are registered nurses, others do not have a clinical background.

> *"I can remember once we had a guy who was an engineer and he was doing an assessment. Engineers are head people, they don't think with their heart, they think with their head and we had this particular demented guy who was quite psychotic at times and this particular day that the assessment was on … the guy that was doing the assessment actually believed everything he said. It was all total bunkum. He took it as being true and then wanted to make us non-compliant so I had to appeal that. Then they sent out another assessor who did have a clinical background and she interviewed the gentlemen and then it was fine."* (RACH5, Manager: 97)

Although assessors are different, they have guidelines that they must follow. However, even with the guidelines there appears to have been a substantial difference amongst assessments conducted (RACHs 1, 3, 4, 6).

> *"Some person may want this documentation but another person may want that. Each individual is very different when they come out to do their accreditation. Even though they have their guidelines, some may want more evidence and some might be just happy with just the simple documentation to say that you're doing it."* (RACH6, Manager: 98)

At RACH 4 it was noted that a previous group of auditors spent a lot of time talking to and interviewing people, whilst on another occasion the auditors compiled all the documentation, went into an office to read it and interviewed one or two people only. One staff (RACH3) said that assessors being different is not the problem; the problem is whether they are following their guidelines or not.

> "*They all perceive things differently … They still have their guidelines that they have to look at. It's just whether they're ticking all the boxes in regards to their guidelines as to what they've got to look at."* (RACH3, Area Manager 1: 99)

One manager (RACH 3) questioned the credibility of the accreditation process:

> *"I think it very much depends on the assessor and how valid the accreditation is."…"They (assessors) have a set of things that they're meant to actually gather and report on. But I guess to what extent they look at those things can vary from team to team. Some teams will come in and be happy*

> *with a sit down discussion on certain aspects. Others will want to look at every fine detail. So I guess the accuracy of the assessment really depends on the person doing it."…"I think it can make it (the accreditation process) unreliable. But I also think that it can make it unfair for homes too. It can either go one way or the other. There's times where - accreditation is based around continuous improvement. So it's based around having systems in place and things to identify deficiencies and address deficiencies. I think some people get really caught up on the - or there was a problem on that day. Not necessarily recognising that within the framework of the system. Others may not even detect that. It is very subjective."* (RACH3, Manager: 100)

The credibility of the accreditation process was also indirectly mentioned on another occasion (RACH 4):

> *"… Each auditor has their little pet that they like to pursue in each home….So for some people it might be the pain management, or some people it might be the information systems or something, and they just really hone in on that one point. I think that's the nice bit about being in a group. We can speak to each other about who audited the home and what did they look at, and you can see a pattern in the auditing. They say, oh, it's her, she's going to look at 1.8 or it's him, he's going to look at 2.10 or something. So I guess it's good in a way, but as far as the whole accreditation process goes, that's probably not what they're looking for.* (RACH4, Deputy Manager: 101)

In one instance (RACH 5), it was found that the assessments relayed from one team of assessors to the other were vastly different, not helpful at all, and that the accreditation process is not more supportive now than when it started.

> *"It's a process that is supposed to be here to help us. Well, I have never found it … I have found it a very stressful experience every time. They all have different agendas … I was grilled relentlessly for four days and this woman was here to find anything that was wrong."* (RACH5, Supervisor: 102)

Finally, when asked to provide suggestions on how the accreditation process could be simplified or improved, it was suggested that the number of assessment days for large RACHs should be reduced (RACH 5), and that unannounced visits be no longer conducted (RACHs 3 and 4). Unannounced visits were referred to as time consuming, with assessors needing

assistance to find the paperwork. It was also indicated that it can happen at an inconvenient time, when there is for example a staff shortage, activities happening on that day, a sick resident, and so on. The reasons behind unannounced visits are appreciated, however, they are "a little bit of nuisance" (RACH4, Manager: 103). Additionally, it was noted:

> *"They do understand that aged care is a full on, busy environment. But do they actually take that into consideration when they do unannounced (visits)?"* (RACH3, Area Manager 1: 104)

Similarly, it was said (RACH 5):

> *"I think realistically if the Agency knows what they're talking about when they come into a home - particularly to do a spot check - then they're going to realise that there is so much happening and a good manager will be behind in their paperwork because they're up on the floor … So I think if that's accepted by the Agency that would make life a lot easier rather than come down and breathe hell fire and brimstone at people for not having something done because there are assessors like that."* (RACH5, Manager: 105)

Also, a flaw perceived in the accreditation process is that assessors only pick "*one or two points from each standard … Because if a facility really was falling down in one of the Standards, and that just happened to be one of the Standards that they just checked and moved across really quickly, then there's a huge problem I guess*" (RACH 4, Deputy Manager: 106). This was supported by a statement made by a manager at RACH 3, who noted that leisure and lifestyle was not audited by accreditation assessors during their last round, as they focused mainly on medication. However, at RACHs 3 and 5 it was noted that the accreditation assessment would take more than 3 days if assessors had to look at "every single" accreditation outcome. Conversely, other staff (RACHs 4 and 6) believe that assessors do look at all accreditation outcomes during the assessment round.

An interesting fact learnt was that there is a high turnover of accreditation assessors (RACHs 4 and 5), which can directly affect the quality of accreditation assessments.

Findings:

Considering the above, most staff believed that accreditation assessments are different from one team of assessors to the other, which is consistent with the services characteristics (variability[69]) and challenges (delivering and performing service[70]) noted by Kotler (2008). However, the issues raised lie in the fact that assessors do not always follow the guidelines provided by ACSAA to them, and they seem to have preferred areas of interest when assessing an RACH. This is favourable to those RACHs that are part of a larger group, where mimetic and normative isomorphism are present in the fact that they can exchange information on assessors' areas of interest, and can benefited from this information as they know what assessors will be focusing on (further discussed in chapter seven). Significantly, it was suggested that the subjectivity of the assessors can result in the accreditation process being unreliable. This is similar to the study undertaken by Grenade and Boldy (2002), who found that there is inconsistency and subjectivity in the conduct of site audits, and also different levels of expectations from assessors. Likewise, Greenfield and Braithwaite's (2008) study also indicated a perceived lack of consistency amongst assessors. Finally, it was also suggested that the accreditation assessment is both time consuming and can happen at an inconvenient time, which is also consistent with Greenfield and Braithwaite's (2008) research where it was found that the program was bureaucratic and time consuming. Therefore, results clearly suggest the need for additional training to be provided to accreditation assessors. This will assist in reducing the discrepancies amongst assessors and the potential advantages faced by RACHs that are part of a group.

6.5 Conclusion

This chapter focused on exploring the influence that the adoption of accreditation standards has on the quality of residential aged care homes. For that purpose, results from the case studies were discussed based on the main themes examined in the literature review chapters. These themes include customer orientation, staff, processes, and quality management system (Aged Care Standards and Accreditation Agency).

[69] Services vary because they often depend on the actions of individuals. Even though training, manuals and management controls assist in reducing variability, staff may respond differently to unexpected situations, for example. (Kotler et al., 2010, p. 307)

[70] The challenge for service organisations is to ensure consistency of the services provided across time, people, and outlets. (Kotler et al., 2010, p. 308)

From the results and findings presented throughout this chapter, it is apparent that there were varied responses for the majority of questions. For example, some staff believes that the adoption of accreditation standards has enhanced residents' quality of care, while others believe it has not. These contrasting views could be attributable to the level of staff involvement with the accreditation process, and also due to staff having varying beliefs on whether the accreditation system actually has a positive impact on the quality of services provided by RACHs. Nonetheless, these overall and conflicting views suggest that the accreditation standards, since their implementation in 1999, has assisted in enhancing the level of quality of services provided to residents of RACHs. However, even though the accreditation standards require RACHs to undertake continuous improvement, the program itself and the accreditation standards[71] have not been revised and, therefore, not continuously improved. For instance, even though accreditation assessors do interview staff and residents during an accreditation assessment, the preponderant evidence is still paper based, which (it was affirmed) takes time away from caring for residents. This may possibly be due to the fact that there is a high turnover of accreditation assessors, which means that beginner assessors will have limited experience for this role and may therefore rely more on paper based documentation; in addition to many of them being from a different industry. Also, many staff believe that there are inconsistencies from one assessor to the other, many having preferred areas of interest and different levels of requirements.

Another fact relates to the introduction of Certificate III care workers which initially was good to the system yet it too appears not to have evolved in time. Staff with this qualification do not have a governing body to which they can respond, and due to them being in an low-paid industry they basically rely on the RACH to provide them with further training. This of course is a factor not dependent on the Accreditation Agency but is an issue that the industry faces and it was suggested that the Agency could liaise with the government to improve on it.

The lack of improvement on the assessment of the accreditation standards combined with issues like the ones mentioned above results in residents' quality care, which is the foundation of this system, being somehow left secondary in the whole process. The government appears not to be acting on major issues that the industry is currently facing, and improvements made almost 15 years ago remain intact and therefore have not continuously improved. Even though accreditation standards are currently being revised by the Australian Government they have not yet been implemented. Additionally, this is not an issue in isolation. Standards will mean very little and quality will barely be enhanced if the industry continues to be low-paid, count

[71] As noted in chapter three, accreditation standards are currently under revision by the Australian Government.

on staff with limited education, and have residents with more and more demanding needs. It is a continuous cycle.

Different expectations from families and residents will be a permanent fact. Quality of design is a challenge in the service industry, difficult to implement, and there will always be complaints. However, this can be minimised, and quality of conformance and increased satisfaction continuously achieved if there is an improvement in the system as a whole.

7 RESULTS AND FINDINGS: NEW INSTITUTIONAL THEORY

7.1 Overview

This chapter focuses on examining answers to the pre-interview questions, interview questions, surveys, and on analysing some RACH documentation in relation to new institutional theory (insights to some quality management issues informed through new institutional theory which were referred to in chapter six, are further discussed here). Results were examined using level 1 coding and pattern matching, although, exceptionally, the first question presented in this chapter was examined using descriptive statistics, with percentage results exhibited in a bar graph. This question was the only one identical in both the staff survey and interviewee's questionnaire questions, and so the combined number of responses allowed the statistical analysis to be conducted. Questions are organised under six main themes, namely: reasons why RACHs adopt accreditation standards, coercive pressures, mimetic pressures, normative pressures, legitimacy, and decoupling; followed by a conclusion. These questions will assist in (1) answering the two research questions for this research: "*In addition to government funding, why do residential aged care homes (RACHs) adopt accreditation standards?*", "*What perceived influence does the adoption of accreditation standards have on the quality of RACHs?* and *How is this viewed by 'different' staff members of RACHs?"*, and (2) determining whether RACHs undergo the accreditation process due to the coercive pressures encountered from the government, to gain legitimacy from their stakeholders, and/or to enhance the quality of their services. It will also assist in determining whether propositions 3, 4 and 5 are to be deemed supported or not supported.

> P3: Accreditation standards are adopted by RACHs to influence the level of quality of their services.
>
> P4: Accreditation standards are adopted by RACHs to ensure funding from the Australian government.
>
> P5: Accreditation standards are adopted by RACHs to improve the standing in the eyes of stakeholders.

7.2 Reasons why RACHs adopt ACSAA's accreditation program

All staff who were interviewed, and all staff who responded to the survey were asked three distinctive questions with regard to the reasons why they undertake the accreditation program managed by ACSAA. The first question was:

1. *"Why has this residential aged care home decided to adopt the accreditation program managed by the Aged Care Standards and Accreditation Agency?"* (staff survey and interviewees' questionnaire questions)

To answer this question, respondents were asked to indicate with an "*x*" which of the option(s) listed best described their opinion, and they were able to choose as many options as they wished. The options were:

- ☐ To improve the level of quality of services provided to residents
- ☐ To improve the standing in the eyes of the following stakeholders:
  - ☐ a) Residents
  - ☐ b) Government
  - ☐ c) Staff
  - ☐ d) Other Residential Aged Care Homes
  - ☐ e) Other, please specify_____
- ☐ To receive funds from the government
- ☐ To indicate minimum levels of quality to residents
- ☐ To improve residents' general level of satisfaction of the services provided by us
- ☐ None of the above
- ☐ Other, please specify_____

Due to this question being posed in both the pre-interview questionnaire and staff survey, the data collected was combined, for each RACH, to provide a stronger examination of results. The outcome of this combination is presented in Figure 7.1 in the following page.

Figure 7.1 - Reasons why RACHs adopt the Aged Care Standards and Accreditation Agency's Standards

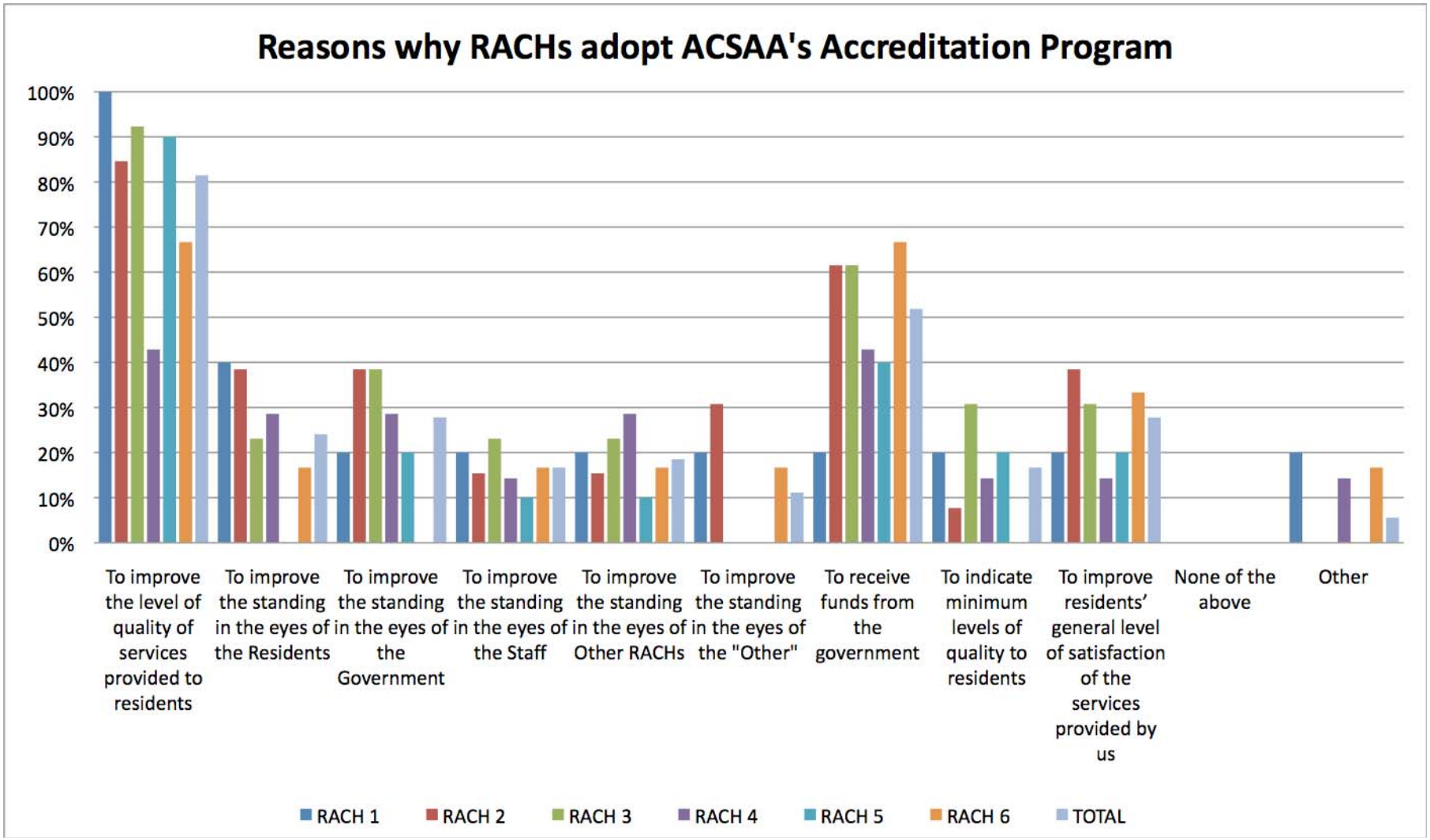


Figure 7.1 indicates per RACH, followed by a cumulative total, the percentage of responses for each of the options provided. Results show receipt of funds from the government as a reason why RACHs adopt the accreditation program, which was indicated by 52% of respondents. Other reasons suggested by the results are as follows:

- Overall, with a total of 81%, the main reason why staff believe the accreditation program is adopted is to improve the level of quality of services provided to residents. More than 65% of staff across RACHs 1, 2, 3, 5, and 6 indicated this to be one of the reasons, although in RACH 4 less than 50% believed this to be the case.

- With a total of 28%, the third reason was to both improve the RACH's standing in the eyes of the government and also to improve residents' general level of satisfaction with regard to the services provided by RACHs.
- To improve an RACH's standing in the eyes of the residents came fourth (24%), followed by improving the standing in the eyes of other RACHs fifth (19%), and to indicate minimum levels of quality together with to improve the standing in the eyes of staff came sixth (17%).
- To improve an RACH's standing in the eyes of others came seventh (11%), where family/relatives (RACHs 2 and 6), visitors (RACH 2), and the community (RACH 1) were also named.

2. *"Why do you think RACHs adopt accreditation standards?"* (staff survey)

The results from the first question above were supported by the outcomes of this second question, which was an open question at the end of the survey. Similarly to the results above, the main reasons cited were to improve the services and quality of care provided to residents, and to receive funds from the government. Additional reasons also included the adoption of accreditation standards being compulsory, to ensure that all RACHs have the same standards, to demonstrate the practice of good care to the public, and providing guidelines to improve quality of services.

3. *"Are there any other important additional details you would like to make on the reasons why this RACH has decided to adopt the accreditation program?"(pre-interview questions)*

Additional reasons indicated were to support benchmarking relating to quality of care, to ensure that the organisation is doing what is expected, to ensure that standards of care are delivered in accordance with the 4 standards, because it is compulsory, because the group is committed to quality management, to gain more funding and as a result being able to employ more staff, and because "*reputation of the (RACH's) owners is extremely important*" (RACH5, Deputy Manager).

Findings

Findings suggest that quality, along with different institutional pressures (i.e. coercive, mimetic, and normative), are the reasons why RACHs adopt the accreditation program. Improving the level of quality of services provided to residents was the main reason cited by those staff who answered the above questions; which supports proposition 3 *"Accreditation standards are adopted by RACHs to influence the level of quality of their services"*. Yet the improvement of residents' general level of satisfaction was indicated by less than 40% of respondents within each RACH. Coercive pressures and legitimacy were also strong motives for RACHs adopting the program. Relating to coercive pressures, comments confirm that "to receive funds from the government" is a very strong reason, along with government mandate by making it compulsory. Interestingly though, at RACH 1 which is the only small low level care, stand-alone RACH in the sample, and appears to be in greater need of financial resources, only 20% of respondents believe the reason why they undergo the accreditation process is to receive funds from the government, and 100% believe it is to improve the level of quality of their services. Hence, even though accreditation is compulsory to receive government funds, it is interesting to learn that the main reason why RACHs adopt accreditation is to improve the quality of their services. Output control (relating to assurance that the RACH is doing what it is expected to do) as a form of coercive pressure, was also mentioned. Legitimacy (in the eyes of the government, residents, other

RACHs, staff, family members) appears to be another reason, although it was referred to in a lesser degree.

These findings are consistent with Meyer and Rowan's (1977) observations that organisations incorporate institutional rules in order to achieve legitimacy and resources stability. Nonetheless, the findings of this research complements to Meyer and Rowan's observations, in that enhancing quality was indicated as the main reason why RACHs adopt accreditation standards. These findings are also, to an extent, consistent with those of the study conducted by Menassa et al. (2009), where it was found that professors and students perceive accreditation as positively affecting service enhancement, improving the university's image, and providing legitimacy (discussed in chapter four). Similarly, RACH staff indicate service enhancement and legitimacy as some of the reasons why they adopt accreditation. Menassa et al.'s (2009) study had many other variables which were not specifically inquired about in this study and therefore a direct comparison to them cannot be made.

7.3 Coercive Pressures

The literature review in chapter four shows that the aged care industry and therefore RACHs, are heavily regulated. To understand how these different regulations can affect their processes, interviewees were asked the following:

1. *"Apart from the Agency, there are other bodies that have standards with which your organisation must also be compliant with (e.g. DoHA, Occupational Health and Safety[72] (OH&S), Food Authority). Are their standards based on or similar to the standards managed by the Accreditation Agency?"*

The responses with regard to this question varied. Staff at RACHs 2, 3, 4, 5 and 6 believe that the standards across different bodies are similar. Conversely, staff at RACHs 1, 2, 3, 4, and 5 believe that they have different levels of requirements, that regulations can sometimes conflict and can

[72] As noted on page 80, OH&S laws are administered and overseen by the WorkCover Authority of NSW.

also have a different focus. Some staff members (RACHs 2, 3 and 6) were unsure and therefore could not answer the question.

At RACHs 2, 3, 4, 5 and 6 results showed that the standards across different bodies are similar and inter-related. The Accreditation Agency incorporates standards relating to other bodies that legislate for RACHs, yet there is no need to have different reporting mechanisms. For example, the RACH has an OH&S manual which has the rules and regulations relating to organisational health and safety and injury management. The manual is more detailed, yet the standards are linked together and therefore acceptable for both ACSAA and Occupational Health and Safety (OH&S). Similarly, the Food Authority is a lot more thorough with regard to the food standards in the kitchen than is the Accreditation Agency, given that the RACH is dealing with the aged and therefore more vulnerable people. Nonetheless, it was suggested that even though the standards are similar these different bodies work independently from each other (RACH 5), and it would be preferable to have one main body dealing with all areas of RACHs.

> *"It gets all complicated when you're dealing with three different government agencies and different departments. It just over complicates things."* (RACH5, Deputy Manager: 1)

Another suggestion was that the Accreditation Agency should leave standards relating to WorkCover Authority of NSW (Occupational Health and Safety) and the Food Authority for these bodies to deal with, given that they are specialised areas. For instance, accreditation assessors might not pick up on something that a person from the Food Authority will, such that the RACH could be at risk of infecting or food poisoning someone, for example. The importance of having governing bodies to ensure that RACHs are compliant with defined standards is recognised, however, it was also acknowledged that the aged care industry can sometimes be "overly governed", which directly affects the care provided to residents (RACH 3).

> *"I think there's a reason for that and I support that reason. But yeah I think that they need to look at more the resident and the resident's care needs and quality of life instead of the paperwork."* (RACH3, Area Manager 1: 2)

Conversely, some staff believed that different bodies have divergent standards and conflicting regulations relative to the Accreditation Agency (RACHs 1, 2, 3, 4 and 5). Nevertheless, it is also believed that it is important that RACHs have to be consistent across the board with standards from different bodies (RACH 5). However, these conflicting regulations do not always correspond with residents' choices and decision-making and expectations. For example, it was noted:

> *"I've got a resident that loves gardening. Where is my duty of care then to him with his choice and decision making and making his living here enjoyable by providing a garden if I'm not allowed to use it in the kitchen? Because then he gets upset because we're not using the stuff."* (RACH1, Manager: 3)

Also, results showed that the Food Authority is "much tougher" than the Accreditation Agency (RACH 1). This may result in the RACH believing that its food handling is according to the standards after an accreditation round, only to find out sometime later from the Food Authority that is it not, as per quote:

> *"So there is - in some ways there's a lag between different governing bodies, I suppose or different - agencies that have different interests in the same sort of facility. That makes it a bit hard because one minute you think you're doing okay or really well. Then someone comes along and goes no, no you're not."* (RACH 1, Care Coordinator: 4)

This, however, may be due to the fact that the Accreditation Agency standards are *"quite simple and is easy to read but then again it's kind of - the actual meaning is lost of what they want you to do."* (RACH 2, Manager: 5)

It was suggested that if all different bodies had interrelated standards, streamlined and combined together, with one body over them all, it would be easier for RACHs and would also reduce a significant amount of paperwork (RACHs 1, 4 and 5).

> *"We do get a lot of people doing the same thing."* (RACH 4, Manager: 6)

> *"If they were all linked together it would be a hell of a lot easier. If you had one main body that overhung … if they had a government umbrella that dealt with home and community services and aged care facilities all in one … I think they should streamline it and combine them all together and not make it so difficult … I think they're just so scared they're going to be sued or something.*" (RACH 1, Manager: 7)

Nonetheless, different governing bodies also appear to have a different focus. For instance, the Food Authority will spend a long time in the kitchen looking at cleanliness, temperatures, charts, and records, whereas the Accreditation Agency will look at it from the residents' perspectives. For example, the way the food is handled, infection control as it relates to food, Occupational Health and Safety (OH&S) in the kitchen, and the quality of the food. Hence, it was suggested that standards should not be similar due to the fact that, for example, the Food Authority looks at documentation such as the food safety plan and how this plan works in the kitchen; whereas the Accreditation Agency does look at that but not in as much depth as the food authority does.

Additionally, there appears to be some communication problems amongst different government bodies. It was noted that "*the communication between the department (DoHA) and the Accreditation Agency isn't always the best … I don't think they conflict in any way, I just feel like they're definitely two different bodies"* (RACH 4, Deputy Manager: 8). Although at RACH 2 conflict amongst DoHA and Occupational Health and Safety (OH&S) was perceived: "*say the Accreditation Agency you see something on their (on the standards) and you're not really sure so you might go to the OHS document on it. But then you might also see the Department of Health and Ageing document on it. That might be different, those two (Occupational Health and Safety (OH&S) and DoHA).* (RACH 2, Manager: 9)*"*

At RACH 1, which is a local government facility and therefore run by the council, it was stated that the council does not have a comprehensive understanding of the accreditation requirements, of the role of an RACH, and of quality of care.

> *"A lot of the council laws still have a lot of trouble trying to come to terms with the accreditation standards and what's expected of us here … I've had to teach them about why we provide palliative care to our residents. Then they had to*

vote to give me permission whether I'm allowed to do it (palliative care) here or not." (RACH1, Manager: 10)

2. *Is there a high cost involved to support the preparation for accreditation? And if so, do you think there would be a more efficient use for this money? (e.g. facilities' improvements, fulfilment of specific needs residents may have, etc). In what way?*

Answers to this question generated different opinions. Some staff believe that there is a high cost involved (RACHs 1 and 4), whilst others believe that there is not a high cost involved (RACH 2, 5 and 6), and others were unsure (RACHs 1, 2, 3, 5 and 6). The quality manager of RACH 6 indicated that there is not a high cost involved, given that accreditation is about having systems that are sustainable. Therefore, there should be no costs except for the application fee, which was also cited as a cost by RACHs 4 and 5. Yet, at RACH 5 it was noted that usually there is a high cost involved, but this is because RACHs prepare for the accreditation assessment round, instead of working towards it all the time.

However, in addition to the application fee there were other costs associated with preparation for the accreditation process, such as hiring additional staff, added pressure on the workforce, and renovation and neatness of the RACH. It was also suggested that money related to some of these costs could be spent in other things; nonetheless it is important that RACHs demonstrate accountability. One staff member believes that there are some unnecessary costs. Each of these additional costs will be discussed in the following paragraphs.

RACHs 1, 3, and 4 noted that additional staff are hired when preparing for accreditation. At RACH 1, one person was employed for the last accreditation round to assist with administrative matters, to go through all the policies and procedures and to ensure that all systems were in place. At RACH 3 it was observed that extra staff were hired to free up key people to assist with gathering data. At RACH 4 responses were to an extent controversial. One staff said that the facility has the documentation done all the time but that a couple of additional staff work on the actual day of accreditation so that all residents are up and showered and dressed and looking pretty by the time the assessors come. Another staff member, however, noted that there is a high cost in terms of man hours, which includes hours that staff put in, especially management, head

office, and other homes (from the same group) that assist, such as education coordinator and property manager to ensure that everything is satisfactory before accreditation. At RACH 4 it was also suggested that some RACHs hire external consultants before an accreditation round.

RACHs 1 and 3 both noted that accreditation results in a high cost on the workforce and on the management team, as relates to psychological and unpaid working hours. At RACH 1 it was noted that in the last accreditation round a staff member had a stress attack feeling that she could let the RACH down. RACH 3 observed that:

> *"Prior to a major accreditation round it's a lot of work getting applications in and gathering evidence … those things should be in place, but we're all flat out day to day and you don't have time every day to sit down and add to your continuous improvement plan and gather evidence … it is not necessarily a cost to organisations given that close to an accreditation round many staff, particularly management team, goes above and beyond working hours for nothing."* (RACH3, Manager: 11)

The manager at RACH 2 however, believes that staff time, preparing documentation, and printing out things, for example, are all part of the management role.

Costs associated with sprucing the place up, for example, painting, repairing curtains, and shampooing the carpets, as well as refurbishments were also mentioned (RACHs 2, 4 and 5). However, it was also noted that these are costs that should be incurred regardless of accreditation and so that the organisation maintains a high standard.

At RACH 1 it was suggested that the money used to prepare for an accreditation round could be more efficiently used for things such as the infrastructure of the place, electric beds, pressure area mattresses, education and training, and other things to benefit the resident. Similarly, at RACH 3 it was also mentioned that this money could be spent in direct care with residents. Nonetheless, both RACHs also believe that there needs to be a governing body to ensure that RACHs are accountable; and that it is important that RACHs review their business plans which is not necessarily a waste of money.

> *"There's no doubt that accreditation comes with a cost. Yes you could argue that that would be better spent on direct care to the residents. But then where's your accountability in reviewing your systems and monitoring your performance as well? There's an argument either way I guess. I see the benefits in both. I think that it's not good business just to say we want to deliver care to the residents and not look at ourselves."* (RACH3, Manager: 12)

One staff at RACH 4 believes that the money spent on things such as training done before accreditation is unnecessary. It was noted that the Accreditation Agency likes that RACHs have some training done before the accreditation round, which can be difficult and expensive:

> *"I think some of the training that we as a group try to do before accreditation, I think is unnecessary. The Accreditation Agency do look at the training records and see what you've done, and see where you're going, and what you are going to do, but as far as making sure everything is done before accreditation, rather than spreading it out over the whole year…"* (RACH4, Deputy Manager: 13)

Findings

Undoubtedly, RACHs face coercive pressures[73] from the different bodies as discussed above through formal pressures (e.g. local councils and federal government), output controls and conformity (to accreditation standards, WorkCover Authority of NSW (OH&S), Food Authority), regulations (e.g. the Aged Care Act), and government mandate and dependency (e.g. government funds contingent to being accredited). This is clearly demonstrated by the quotes 6, 7, and 10 presented in the results section above. From an institutional theory perspective this is, therefore, consistent with DiMaggio and Powell's (1983) description of coercive pressures. However, results demonstrate that staff have different views concerning whether these coercive pressures from different bodies conflict or not. For example, some staff believed that standards do not conflict and therefore there is no need to have different reporting mechanisms. On the other hand, it was suggested that the requirements of these bodies do conflict to some extent, which interferes with the RACH accomplishing its duty of care with regard to residents' choice and decision-

making, as per quote 3 from RACH 1manager. On balance, however, results suggest that some bodies have more demanding standards than others. These different views, the researcher believes, may be due to these standards being open for interpretation and also based on staff level of experience with fulfilling the standards. Nonetheless, the diverging responses to this question clearly indicate that the way RACH's staff comprehend what evidence is required to fulfil the standards from each of these bodies is different. This difference in comprehension is consistent with Coburn and Talbert's (2006) study, where it was determined that the NCLB[74] policies support and coincide with other reforms that are also evidence based, although they have a different emphasis. As a consequence, there can be multiple and conflicting forms of evidence use that coexist; similarly to what was suggested by some RACH staff. Coburn and Talbert (2006) drew attention to the importance of understanding how these multiple and conflicting regulations coexist when developing local reforms that use evidence to improve service quality. For instance, Grenade and Boldy (2002) suggested in their study that accreditation should be structured and operated in conjunction with the other components of the aged care system (e.g. complaints system). Additionally, results from chapter six indicated that quality of care has been enhanced as a result of the coercive pressures imposed on RACHs; because the legislation imposes a requested level of quality of care that RACHs must comply in order to avoid sanctions. Similarly, Zhang and Wan (2007) found that quality of nursing homes is motivated by regulatory and payment constraints. Therefore, these findings suggest that the coercive pressures imposed on RACHs are important to enhance residents' quality of care. However, the coercive pressures and conflicting requirements from different government bodies can be overwhelming on staff and negatively impact residents' quality of care, due to the significant amount of time taken away from residents in order to complete paperwork. As such, the Federal government should find a way of unifying these requirements/bodies, as suggested in quotes 6 and 7. Even so, it was noted that conformity to different bodies is important for the RACH to demonstrate compliance, yet again it was suggested that it would also be good to have one main body dealing with all areas of RACHs to ensure more consistency across them and reduce paperwork. Even though respondents suggested having one main body dealing with all areas of RACHs as an ideal situation, it should be noted that accreditation runs on a 3-year cycle, whilst food handling and OH&S run on a

[73] Please also refer to the findings section on page 164 for additional findings relating to coercive pressures.
[74] NCLB: No Child Left Behind Act

different basis. However, providing RACHs with a comprehensive map of the various standards across these regulatory bodies so that staff can clearly identify which standards overlap and which standards are distinctive, appear to be sought. Moreover, as discussed in chapter six the coercive pressures and relative conflicting regulations can be overwhelming for small stand-alone RACHs, and as such results from this research indicate that there is an opportunity for different level of regulatory requirements to be imposed on different types and sizes of RACHs. Alternatively, more support in terms of training and staff should be given to these small stand-alone RACHs.

Even though the adoption of accreditation standards represents a coercive pressure imposed from the government on RACHs, some staff believed that it is important to ensure that RACHs are accountable, as per quote 12. However, as it will be seen later on this chapter, it was declared that "*Legislation is not a bad thing. It just needs to be implemented properly* (RACH3, Area Manager 1)."Additionally, consistent with Greenfield and Braithwaite's (2008) study, the results suggested that some of the costs associated with the adoption of accreditation standards are positive as they ensure, for example, physical neatness of RACHs and business plan revision, which are factors that directly and positively benefit and impact on the residents. This said, the paperwork that is involved with accreditation appears to provide additional costs as, for example, the hiring of extra staff (which was also cited in chapter six). Moreover, consistent with the findings from Grenade and Boldy's (2002) study, the accreditation process appears to result in costs associated with psychological and unpaid overtime hours on staff. Consequently, it seems that some of the costs associated with the paperwork and hiring of additional staff, which partly relate to normative isomorphism, may be undesirable for a low-paid industry.

7.4 Mimetic Pressures

To determine whether the coercive pressures imposed on RACHs may result in industry comparisons to best satisfy the accreditation requirements (in this instance, mimetic pressures could be construed as coercive pressures given that coercive pressures are the primary drivers of accreditation), interviewees were asked:

1. *In seeking to satisfy the accreditation outcomes, do you observe or have you observed the processes implemented in other residential aged care homes that have achieved accreditation?*

2. *What other types of benchmarking do you utilise/have utilised?*

It was evident across all RACHs that they do observe the processes implemented in other RACHs to satisfy the accreditation requirements. Examples mentioned include:

- Obtaining support from another RACH when undergoing the last accreditation round (RACH 1);
- Liaising with staff from other RACHs at conferences (RACH 1);
- Liaising with friends whose parents are going/have gone into other RACHs;
- Monitoring of other RACHs by Head Office (RACH 4);
- Comparing processes across organisations within the same group (RACHs 2 and 5);
- Subscribing to external benchmarking[75] organisations such as QPS and Moving On Audits (RACHs 2, 3, 4, 5, and 6). It was observed in RACH 1 that due to it being a small stand-alone facility it cannot afford the services of the larger organisations;
- Benchmarking key performance indicators with other facilities in the same suburban area (RACH 6).

With regard to external benchmarking organisations (QPS or Moving On Audits), it was observed by the manager (RACH 3) that most RACHs subscribe to either of them, as there is an *"expectation that as a minimum"* (RACH 3, Manager: 1*)*, RACHs monitor and measure themselves against others. However, *"how well they use the information I think varies from organisation to organisation"* (RACH 3, Manager: 2). This is supported by an observation made by the manager at RACH 5: *"Look I don't think anybody really pays that much attention to it (benchmarking), we haven't got time to"* (RACH5, Manager: 3). The manager added that benchmarking is a *"waste of time"*, organisations like QPS and Moving On Audits are an *"absolute waste of money"* and *"it only covers the bare minimum"*. It was also raised that the external benchmarking organisations do not even cover what is in their guidelines, and as a result

[75] Benchmarking, when mentioned in answering this question and also mentioned on the findings of this question, relates to results/outcomes.

the RACH has to have its own system plus their system. At RACH 3 it was further added that benchmarking *"analyses our performance within the outcomes … with those sorts of things (sharing of best practice) that's not something that you would be working out through the benchmarking as such. It's probably more things that you'd be picking up via other industry networks and conferences and things like that …"* (RACH3, Manager: 4) (Also noted in the following section, normative isomorphism).

Access was provided by two RACHs to the external benchmarking documentation. To fulfil the requirements there are many indicators that RACHs must measure and, interestingly, each of them are directly related to the accreditation outcomes (please see Table 7.1). These indicators, along with the definitions on how they should be measured (i.e. numerator and denominator) are provided to the RACH. For the comparison, the results of the lowest and highest organisations on the ranking (without citing RACHs names) and how the RACH in question is performing compared to those, are provided.

Table 7.1 - Examples of indicators from external benchmarking organisations

Accreditation Outcome	Indicator
1.6 Human Resource Management	***1.6.***2 Absenteeism
2.7 Medication Management	***2.7.***2 Medication Audit Staff Responsibilities
4.5 Occupational Health and Safety	***4.5.***1 Resident Accidents – General
4.5 Occupational Health and Safety	***4.5.***2 Staff Accidents
4.5 Occupational Health and Safety	***4.5.***5 Resident Accidents – Dementia Specific
4.7 Infection Control	***4.7.***5 Infections with and without Pathology

Findings

From an institutional theory perspective, mimetic isomorphism originates from uncertainty, which leads organisations to model themselves on other organisations (DiMaggio and Powell, 1983). Mimetic isomorphism can be clearly seen across the six RACHs as they work to satisfy the accreditation outcomes. This is characterised through the examples provided, which include staff liaising with staff from other RACHs, comparing processes with RACHs from the same group, subscribing to external benchmarking organisations, and sharing of best practice (as per quote 4). As seen in chapter six, except with RACH 1 which is a small stand-alone RACH, all other RACHs from the sample utilise a paid benchmarking organisation to analyse how they are

performing across the many outcomes that are measured. Also in chapter six it was discussed that these benchmarking organisations are not associated with the accreditation agency. Yet, as demonstrated in Table 7.1, the indices measured by them are all related to the accreditation outcomes, and these indices are then used by RACHs to provide evidence for the accreditation standards. In spite of this, it is also believed that benchmarking can be a waste of money, and that how well RACHs use the information emanating from it varies from one to the other. Also, supporting Northcott and Llewellyns' (2005) observation, it was noted that benchmarking is used for control instead of learning. Nonetheless, similarly to Giblin's (2006) study,[76] mimetic isomorphism is also present in RACHs given that they are part of an external benchmarking organisation because it is an expectation that they monitor themselves against others; which further leads to legitimacy considerations. Hence, given that all indicators from these external benchmarking organisations are associated with the accreditation outcomes and RACHs must pay for this service, the researcher believes that there is an opportunity for ACSAA to develop its own benchmarking system with indicators to suit each of the required outcomes. This would be very beneficial to RACHs, especially for small and/or stand-alone RACHs (as for example the one in the sample) which appear to have limited resources for this type of service as compared to larger organisations. This information could then be used for RACHs to compare themselves against others RACHs with similar characteristics, and then share best practice information. Additionally, as indicated in chapter six, mimetic isomorphism appear to be sought after in that some RACHs are requiring that the accreditation agency provides additional and better guidelines on the fulfilment of the accreditation standards.

Mimetic isomorphism also occurs within RACHs that are part of the same group. For instance, RACH 6 which was taken over by another RACH, appears to have restructured its processes to ensure that they satisfy the accreditation requirements. Furthermore, a contribution of this study lies in learning that, as a staff member at RACH 4 declared, mimetic isomorphism also emerges in the RACHs that are part of the same group as they can exchange information regarding accreditation assessors. This allows them to learn about assessors' areas of interest and reduce their chances of being non-compliant to the accreditation outcomes (as seen in chapter six, and represented by quote 101 on page 155). However, mimetic isomorphism may not always occur

[76] As indicated in chapter four, mimetic isomorphism was present in police crime analysis units due to them adopting specific programs on crime analysis because other police stations also adopted them.

amongst RACHs that are part of the same group; it was noted in chapter six that the way quality is managed with regard to staff involvement differed between in RACHs 2 and 3.

7.5 Normative Pressures

To identify whether normative isomorphism occurs in RACHs to fulfil the accreditation requirements, three questions were asked. These are stated and discussed below, followed by the findings.

1. *In seeking to satisfy the accreditation outcomes, do you observe or have you observed the processes implemented in other residential aged care homes that you have worked at, if any?*
2. *Does this organisation seek any external assistance (e.g. hiring of additional staff, hiring of specialised staff, etc) in order to fulfil the accreditation requirements? If yes, what sort of assistance?*
3. *Does this organisation belong to any professional association which requires that accreditation and/or other type of quality program be adopted? If so, please list which professional association(s) and the quality program required by them.*

With regard to question 1, the majority of staff interviewed indicated that they have definitely brought ideas from other places where they worked in order to improve the processes and better satisfy the accreditation outcomes of the RACH they currently work at. However, two staff at RACH 6 observed that they do not incorporate ideas from other places given that the RACH already has all processes set in place.

Suggestions on how to improve processes are also brought from conferences and training that staff attended, for example, the Better Practice Conference which is organised by ACSAA (please refer to quote 4 presented under the mimetic pressures results section. It was commented that some facilities are pleased to share their documentation so that other RACHs can improve their processes. Organisational processes are also improved through many other means, such as: mystery shoppers (RACH 3), ideas gathered from professionals (e.g. physiotherapists) who also

work in other RACHs (RACH 3), and medication audit by a clinical pharmacist (RACH 6). Ideas are also gathered through other industry networks and conferences. Manager of RACH 3 noted that the RACH won an award, and as a result was approached by many people from other RACHs to share what was done. The manager then suggested that *"benchmarking is probably not something that would reflect necessarily the best practice"* (RACH 3, Manager: 1), but it provides an indication of how the RACH is performing in the industry.

The second question asked whether the RACH seeks any form of external assistance to fulfil the accreditation requirements. Except for RACH 6, at least one staff member in each of the other RACHs indicated that external assistance is sought in order to fulfil the accreditation requirements. Examples of assistance include: 1) allied health services (podiatrist, dentists, physiotherapist, speech pathologist, dietician), clerical work, and consultants for policy and documentation evaluation. However, one staff member at RACH 4 noted that "all staff are continually hired by our group to achieve optimal levels of care and satisfaction", and therefore no external assistance was sought. Yet, the RACH has external auditors that are hired when necessary, in order to observe things from another perspective and also to assist in solving problems. At RACH 1 it was noted that in the past the organisation did hire external staff to assist with accreditation, although it no longer does due to a lack of resources.

In answering the third question, three RACHs mentioned an association they belong to, as follows:

- Local Government Association
- Australian Business Excellence Framework
- Aged Care Association

Findings

DiMaggio and Powell (1983) indicate that normative pressures occur through professionalisation, professional networks, filtering of personnel, and individuals being hired from other organisations. Therefore, normative pressures can, to an extent, be seen in RACHs. This is through the filtering of personnel, through external professional assistance to fulfil the

accreditation requirements (e.g. clinical pharmacist, physiotherapists), professional networks that staff attend to, the high turnover of RACH staff, and professional associations. Filtering of personnel occurs not only with hiring new permanent staff but also in hiring additional staff when preparing for an accreditation round. Discussed in chapter six and represented by quote 31 (page 125), professionalisation (in this case the nursing profession) and not accreditation, is responsible for the good quality of care provided to residents. However, also discussed in chapter six is the lack of a governing body for care staff (please refer to quote 50 on page 135), and the low salaries paid to RACHs staff resulting in them not being able to develop professionally. It was also mentioned that RACHs rely on care staff to complete daily paperwork, and that they may not always have high levels of literacy skills. Furthermore, there appears to exist an excessive turnover of RACH staff. As a result, numerous normative pressures might be having a negative influence in the quality of services provided by RACHs. Hence, regulating these issues, and therefore positively increasing the influence of the normative pressures on RACHs through required levels of education and training and having a governing body to oversee care staff, would certainly lead to further improvement in the quality of services provided to residents of RACHs.

The external benchmarking organisations, discussed in the mimetic pressures section of this chapter, also result in normative pressures on RACHs. This is through designating the appropriate way for measuring indicators, which is the "norms"[77] element of Scott's (1995) normative pillar. The researcher believes that there is a strong opportunity for the accreditation agency to develop a benchmarking system, so that all RACHs regardless of their type and size could have access to other results/outcomes. This would allow RACHs to compare themselves to other RACHs that are similar to them (in terms of size, type, and resources) and exchange knowledge on enhanced practices; and this would be particularly beneficial for small stand-alone RACHs.

[77] Norms specify the means to achieve the ends (as in chapter four).

7.6 Legitimacy

Adoption of accreditation is compulsory by RACHs in order to receive funds from the Government. However, whether RACHs would still adopt accreditation if it was no longer associated with receiving funds from the Government, and the reasons why it would or would not do so, are not yet known. Seeking to comprehend whether achieving legitimacy (as an outcome from coercive, mimetic, and/or normative isomorphisms) is one of the reasons why RACHs adopt the accreditation standards, the following question was asked:

1. *If it wasn't compulsory to achieve accreditation in order to receive funding from the government, do you believe this organisation would still go through the process? Why?*

Except for two staff members (Certificate III RACH 1 and Manager RACH 2) who think that the organisation would no longer undergo the accreditation process, and for one other staff member who is unsure (nurse RACH 2), all other staff interviewed believe the RACH would still undergo the accreditation process if it was no longer compulsory.

Those who think the RACH would no longer undergo the process cited the following reasons: 1) the process is time consuming and involves significant paperwork; 2) it would receive less emphasis if the RACH was not so reliant on the funding; and 3) the RACH would not due to the cost involved. Moreover, it was suggested that the RACH would either have an internal accreditation process or appoint an external body (e.g. consulting firm) as the RACH already has in some levels. One staff member who was unsure observed that it would depend on the people running the facility whether they would still undergo the process or not.

Conversely, all other staff interviewed believed that the organisation would still undergo the process. Various reasons were cited, such as: continuous improvement (RACHs 1 and 3), indication of staff performance (RACH 1), to ensure a transparent process (RACH 1), due to the accreditation process being already established (RACHs 1 and 2), providing managers with guidelines and stopping them from being complacent (RACHs 4, and 5), to ensure that quality service is delivered to residents (RACHs 2, 3 and 5), and for legitimacy purposes (RACHs 2, 3, 4, 5, and 6).

Legitimacy appears to be a very strong reason why RACHs would still undergo the accreditation process as it was suggested, along with other reasons, by most staff. It was noted that:

- The RACH has very high standards and has always had a good name. The facility's name, brand and reputation are really important to the people who run it;
- It provides a good standing in the eyes of the society;
- The group is very strong on showing that they are of a high standard, so they would still like to have a governing body to approve the RACH as a reputable place;
- An accreditation program is a way to demonstrate to potential customers that the organisation is quality focused;
- It is a "*good hallmark*" for RACHs (RACH5, Manager: 1);
- *"Simply to display our level of care and what we're giving, and make that known to the public"* (RACH 4, Deputy Manager: 2)*;*
- *"I wouldn't say keep up appearances, but it's kind of what people expect. So we'd just keep doing it just for that"* (RACH 2, Manager: 3).

The quality manager at RACH 6 commented that the RACH would still undergo the accreditation process because "*it's indicated that that's a good way of structuring how you manage your operation systems and deliver resident care*" (RACH 6, Quality Manager: 4).

Finally, one area manager from RACH 3 was noted that if accreditation was not compulsory RACHs would have as many problems as there were years ago, adding that "*Legislation is not a bad thing. It just needs to be implemented properly* (RACH3, Area Manager 1: 5)."

The staff survey, however, presented very mixed results. The majority of respondents perceive that the RACH would still undergo the process, although a considerable number of respondents perceive the RACH would not. Some were unsure and others did not answer. Those who perceive the RACH would still undergo the process consider it to be a "*good tool to judge where improvement is needed* (RACH2, Care Staff: 6)", to "*improve services provided* (RACH 3, Supervisor: 7)", because the RACH "*prides itself in giving the best standard of care towards its residents* (RACH 5, position not described: 8)", and "*to show the community how good we are* (RACH6, Supervisor: 9)", amongst other reasons. Those who perceive that the RACH would not continue undergoing the process perceive so because the process "*seems like a hassle every time*

(RACH4, Care Staff: 10)*", "because they are only interested in making money* (RACH3, Care Staff: 11)*", "this company and a lot of aged care facilities I work in seem to be more about profit and less about resident care* (RACH6, position not described, 12)*"*. Curiously, one staff member who was unsure about what the RACH would do stated that:

> *"I don't know any other industry where staff are required to tick boxes and sign each hour on forms to "prove" they did their job. Obviously the government don't think organisations would be trustworthy – but it's an insult to hardworking and caring staff."* (RACH5, Care Staff: 13)

Findings

Overall, complementing these findings with the findings from the first section of this chapter, legitimacy as a result of the coercive, mimetic and normative isomorphisms appears to be a solid reason why RACHs adopt the accreditation process. It also appears to have a high priority for RACHs based on Donabedian's (2003) attributes of quality in health care[78] seen in chapter three. The results above clearly demonstrate that many staff believe the RACH would still undergo the accreditation process if it was no longer compulsory, as a way of demonstrating that the organisation provides quality services; this can be seen through quotes 2 and 9 above. Being accredited by a government body and the organisation's reputation were also some of the reasons mentioned for still adopting the program. Due to this decision then being an internal decision, it would lead to RACHs having better final results with regard to quality improvement and reducing the chances of decoupling occurring (according to Martínez-Costa et al.'s (2008) study). Having said that, one could argue that legitimacy being a sound reason why they would still undergo the process can represent more of an external reason than an internal one. Legitimacy was signalled in the first question of this chapter as a reason why RACHs currently adopt the accreditation standards, and improving their standing in the eyes of different stakeholders (government, residents, other RACHs, staff, and others) was indicated by many respondents. Yet, there are still some staff, particularly those who responded to the staff survey, who believe the organisation would no longer undergo the processes due to it being time consuming, involving significant paperwork, and the organisation being focused on profit rather than resident care (please see quotes 11 and 12). This difference in perceptions amongst those staff who participated

in the interview and those who answered the survey, may be because they deal with different tasks (strategic versus operational) relating to the accreditation standards. Additionally, some results from chapter six indicated that adoption of accreditation has not enhanced the quality of care provided to residents, and it is simply for the RACH to demonstrate legitimacy to the government and receive funds.

7.7 Decoupling

Whether decoupling does or does not occur in RACH processes when fulfilling the accreditation standards was not directly asked during the interviews. Yet it was indirectly asked by having staff commenting on the following quote:

> *"The way the accreditation process works currently, the aged care facilities that are delivering high quality care are disadvantaged because the process does not recognise this just as it does not recognise when poor quality care is given. Most facilities pass accreditation because managers and staff know how to subvert the process. It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms." (Maree Bernoth as cited in (Productivity Commission, 2011, p.128))*

The reason for having an indirect question was so that there was no misunderstanding in terms of staff, perhaps, supposing that an affirmation was being directed towards their RACH. Through the quote, staff could provide their views on the industry as a whole. Anyhow, comments from the above quote were diverse, with some staff completely agreeing with it, others believing some of it to be true, and others completely disagreeing with it. Each of these will be discussed in the following paragraphs.

Staff at RACHs 2, 3, 4, 5, and 6 agreed with the comment, believing that there are nursing homes that manipulate the paperwork by providing inaccurate evidence to demonstrate compliance with the accreditation standards.

[78] Legitimacy: "Conformity to social preferences, as expressed in ethical principles, values, norms, mores, laws, and regulations."

> *"I would say that's pretty much correct … places that are not very good get approved by the accreditation agency … It's because they do know how to - on the day or the week - make manipulative changes to the system, so if they don't actually ever get down to the actual care of a resident really - all they want to see is this paperwork, but that doesn't mean that actually - I could write anything in the notes."* (RACH5, Deputy Manager: 1)

On the other hand, it was observed that if an RACH has no evidence to demonstrate to assessors how it fulfils the accreditation standards, then it is deemed non-compliant. One staff member (at management level) considers that the accreditation standards are not the problem as they cover many things, and that what needs to be improved is the way assessors look at the evidence so that it is not so much paper based.

> *"So maybe their evidence should be not that it is on paper. Maybe their evidence should be that they sighted the personal carer and they did that. Same as we would do for - say if we do a competency assessment on a staff member, we don't just ask them a question and say, can you do this, and they say yes, and we tick them off as being competent. We actually have to watch them do it, and then they can be assessed as competent. So I guess that would be good for aged care facilities."* (RACH4, Deputy Manager: 2)

One staff member, who initially disagreed with the comment, after reading it in more detail then said:

> *"It's not the fact that we don't give high quality care to our residents and provide a quality of care and give them quality of life. One mistake can absolutely kill us … I suppose when you look at it in that way - like I've looked at it (at the comments) and gone wow - but when you start talking about it, she's probably right. The disadvantages are that we don't have enough time to - you take out 45 minutes out of your day or two hours out of your day doing documentation - when that two hours can go into looking after the residents."* (RACH3, Area Manager 1: 3)

However, it was also observed by one staff member that even though accreditation is about having systems in place and on paper, the process appears to be changing given that on the last accreditation round assessors were watching staff while working.

It was suggested that the only way the Accreditation Agency could have an accurate report on what actually happens in an RACH would be by having a private investigator; having someone, without anyone knowing, working at the RACH and reporting back to the Agency (RACHs 2, 6).

> "*Which is a deceiving way of doing it but then you'll get your true care - you'll get them document what is actually happening.*" (RACH6, Manager: 4)

RACHs 1, 2, 4 and 5 had mixed considerations with regard to the statement, agreeing with it to some extent. It was noted that: 1) accreditation assessors cannot really recognise when poor quality care is given; 2) the accreditation process "*sometimes forces you to focus on the paper work*" (RACH2, Manager: 5); 3) RACHs delivering high quality care are disadvantaged because the Accreditation Agency "*averages it out and I don't think that's fair because if you're doing a good job, you should be recognised doing a good job. If you're doing a bad job well then you should - you need to pick your heels up* (RACH 1, Manager: 6)". As a result, organisations that are providing an excellent service will equally conform to the accreditation standards as those that are just scraping by. A star rating system was suggested as an appropriate approach to differentiate amongst different levels of service provided by RACHs. It was also agreed that the accreditation process "*is about having systems in place, things on paper and that draws you away from delivering tangible outcomes which is the care and attention* (RACH 1, Manager: 7)". One manager was offended by the words "subvert the process", noting that subvert is quite a strong word and that the majority of managers do their best to pass accreditation.

Conversely, some staff (RACHs 2, 3, 4, 5, and 6) completely disagreed with the statement; their reasons included: the system works all the time; during an assessment accreditation assessors go to the bedrooms; assessors talk to residents and to staff; assessors look at residents' care needs and ask RACHs to demonstrate how those needs are being monitored and addressed; and that the process does recognise when high care is given (otherwise it would reflect on residents' appraisal forms, comments and complaints).

Additionally, it was said that accreditation assessors do go to the bedrooms, although they certainly do not check bathrooms as this would be a privacy issue, and that managers need to be trusted that they are monitoring what happens in an RACH.

> *"It would be terrible for a resident to have to be fully naked in a bathroom having a shower and an assessor walks in. I mean that's not realistic, that's ridiculous … Somewhere along the line the process has to trust that management and the senior staff are monitoring that that's being done ... But if the systems aren't real and they're not functioning properly then there will be tangible outcomes and those tangible outcomes will be negative ones because they falling down and letting the side down."* (RACH 4, Manager: 8)

It was also mentioned that accreditation is a transparent process; when assessors suspect that an issue could indicate non-compliance, a meeting is conducted with managers and staff involved to deliberate over what has been highlighted and to comprehend what the facility will do to overcome the issue.

The manager at a facility that was previously non-compliant with the accreditation standards disagreed with the comment, saying that accreditation is not only about having systems on paper because if nobody knows how to use them then everything falls down, which is what happened at this RACH previously.

> "*The systems that they had here weren't effective and lots of things got missed and then they ended up in a real mess*." (RACH[79], Manager: 9)

Finally, it was suggested that perhaps this statement would be true at the beginning of the accreditation process but not now, as residents and their family members are openly consulted about their satisfaction with the services of an RACH.

[79] This RACH will not be identified to ensure that anonymity is maintained.

Findings

Meyer and Rowan (1977), note that decoupling is a consequence of institutional isomorphism, which leads to organisations building gaps between their formal structure and real work activities. The comments with regard to the statement presented suggest that decoupling appears to exist in some RACHs. Even though many interviewees disagreed with the comment, many others agreed with it in a variety of ways, as for example through indicating that some RACHs manipulate paperwork to demonstrate evidence with the accreditation standards (please see quote 1). Similarly, Giblin's (2006) study also suggested that decoupling was present through some police units, which had a crime analysis unit, yet all they did was to collect data.

Furthermore, suggested by more than one interviewee was the fact that in general, private RACHs are the ones where quality of care is not so optimal, that have most staffing problems, and where paperwork does not provide an accurate reflection of the facts. This represents a concern as to how accreditation assessments are being conducted in RACHs and to how evidence is being collected, and once again indicates that there is an opportunity for different levels of standards to be applied to RACHs based on their type, size, and resources.

7.8 Conclusion

This chapter concentrated on examining the reasons why RACHs adopt the accreditation process, and the influence that institutional pressures have on RACHs with regard to fulfilling the accreditation standards. Findings confirm that RACHs adopt accreditation standards due to coercive pressures, and also suggest that there are many other reasons why RACHs adopt the accreditation standards, amongst which are to enhance the quality of services provided to residents and for reasons of legitimacy.

Most staff indicated that one of the reasons they undertake the accreditation process is to improve the level of quality of services provided to residents. Interesting, however, was the fact that only a few respondents indicated that they would not undergo the accreditation process if it was no longer compulsory. Most respondents indicated that they would undergo the accreditation process

for the purpose of ensuring continuous improvement and that quality service is delivered to residents.

Combining the responses of all questions, legitimacy also suggests a sound reason why staff believe the RACH would still undergo the process. Improving a RACH's standing in the eyes of different stakeholders is one of the reasons why RACHs undertake the accreditation process. Additionally, many respondents believe their RACH would still undergo the process if it was no longer compulsory to: 1) demonstrate that the organisation is quality focused and so to be able to display the level of care provided; 2) to maintain the RACH's name, brand and reputation; and 3) to improve its standing in the eyes of stakeholders.

Obviously, coercive pressure is another reason, given that RACHs must undergo the accreditation process in order to receive funds from the government. Over 50% of respondents mentioned that they adopt the accreditation program simply to receive funds from the government, which therefore suggests that proposition 4 *"Accreditation standards are adopted by RACHs to ensure funding from the Australian government"* to be supported. Moreover, many staff also believe that having a governing body is important to ensure that RACHs are being accountable, and coercive pressure in this regard seems to be sought rather than not. Also, RACHs receive coercive pressures from other governing bodies as well, which it was sometimes suggested can be in conflict with the accreditation requirements.

To a lesser extent, the presence of mimetic and normative pressures was also reflected; by staff observing the processes implemented in other RACHs that have achieved accreditation, and also other RACHs where staff have worked. Mimicking occurs through participating in benchmarking groups, liaising with staff from other RACHs, and with other RACHs from the same group. Normative isomorphism happens through the turnover of RACH staff, professional qualifications, and industry associations. Similarly to the study conducted by Zhang and Wan (2007), the mimetic and normative mechanisms have less impact in explaining isomorphic quality of nursing homes. Nonetheless, the search for these benchmarking organisations and liaison with staff from other RACHs, for example, combined with some staff believing that more specific guidelines should be provided with regard to the fulfilment of the accreditation

requirements,[80] suggests that RACHs may be lacking some of the mimetic and normative isomorphisms. Therefore, Proposition 5 *"Accreditation standards are adopted by RACHs to improve the standing in the eyes of stakeholders"* is deemed to be partially supported.

Finally, it appears that the main problem lies in the fact that the accreditation assessment is still strongly based on a large volume of paperwork. Respondents believe that paperwork distracts them from providing service to residents when required, which can therefore negatively affect the care provided to residents.

[80] Please refer to section 6.1.2 of chapter six

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Overview

The general purpose of this research was to examine the reasons why RACHs adopt the accreditation process managed by ACSAA, and also how RACH staff believe the accreditation process influences the quality of services provided by RACHs. This study was motivated by various aspects, including aged care being a major segment of Australia's health care system, the Australian Government contributing significant funds into the segment, specifically in RACHs, an acknowledged need for more evidence concerning the quality of services provided by RACHs, and a growing ageing population. Also, it is motivated by the need to determine from an RACH's perspective whether it is believed the adoption of accreditation standards does in fact enhance the quality of services provided by them. The particular purpose of this research was to investigate two research questions: (1) In addition to government funding, why do RACHs adopt accreditation standards? (2) What perceived influence does the adoption of accreditation standards have on the quality of RACHs? How is this viewed by different staff members of RACHs?; and also to find out whether the five propositions were supported or not supported. Hence, using a case study approach, six RACHs in New South Wales were investigated, using multiple methods, which allowed a triangulation of information from different sources. Institutional theory and quality perspectives were adopted in the interpretational framework of this study to guide the analyses of the data in relation to the aims of this study. Therefore, this chapter will present the findings and conclusions of the thesis, the contribution of the thesis, limitations of the thesis, and recommendations for future research.

8.2 Findings and Conclusions of the Thesis

The findings and conclusions related to the research questions are described in the following subsections; followed by a brief overview of whether the propositions are supported or not supported.

8.2.1 Reasons, in addition to government funding, why RACHs adopt accreditation standards managed by ACSAA

As per chapters six and seven, RACHs adopt accreditation standards for many reasons. These reasons include: to enhance the quality of services provided to residents, an RACH's commitment to quality management, the coercive pressures received from the government, for legitimacy reasons, to ensure accountability, to assist with benchmarking, being the most important ones.

The analysis indicated to improve the level of quality of services provided to residents to be the main reason why RACHs adopt the accreditation standards.

Legitimacy is also a sound reason why RACHs undertake the accreditation process, with a view to improving their standing in the eyes of stakeholders such as the government, residents, other RACHs, relatives, visitors, and the community. Additionally, staff also suggested that their RACH would still undergo the accreditation process if it was no longer compulsory with the intention of demonstrating that the organisation is quality focused, and to maintain the RACH's name, brand and reputation. Moreover, on diverse occasions it was suggested that the adoption of accreditation standards is simply for the facility to display the level of care provided to their residents.

Finally, to receive funds from the government was also indicated by slightly more than a half of respondents. Nonetheless, it was suggested that the accreditation process is necessary to ensure transparency, and it is important that RACHs are accountable especially because they are dealing with vulnerable people.

Therefore, propositions 3 *"Accreditation standards are adopted by RACHs to influence the level of quality of their services"* and 4 *"Accreditation standards are adopted by RACHs to ensure funding from the Australian government"* are supported.

8.2.2 The views of staff members on the perceived influence of the adoption of accreditation standards on the level of quality of services provided by RACHs

This research clearly demonstrated that one of the main reasons why RACHs adopt the accreditation process is to improve the level of quality of services provided to their residents. Yet the results demonstrate that there is no consensus amongst different staff interviewed whether or not this objective is being fulfilled efficiently. This inconsistency was present in almost every question asked, although some to a larger and others to a lesser extent, and they exist probably due to staff's occupation and their type and level of involvement with the fulfilment of the accreditation standards. For instance, staff have significantly different perceptions as to whether adoption of accreditation has assisted in enhancing the quality of care provided to residents or not. Quality of life on the other hand appears to have improved, although results demonstrate slightly that this can be due to the coercive pressures being imposed on RACHs. Staff education is another dubious area, with many staff mentioning that staff are more educated while many others mention that there are many unqualified staff with literacy and language issues. There are also suggestions that continuous improvement, which is a fundamental concept of the accreditation standards, may not be properly evaluated by the accreditation agency.

From an institutional theory perspective, it appears that the coercive, normative and mimetic isomorphisms also contribute, to different extents, to the level of quality of services provided by RACHs. Coercive isomorphism has resulted in RACHs implementing the accreditation process in the first place, and is therefore directly related to the ideas presented in the previous paragraph. Mimetic isomorphism also occurs in RACHs in order to fulfil the accreditation standards. For instance, RACHs participate in benchmarking, compare processes with other RACHs from the same group, and also liaise with staff from other RACHs. Mimetic isomorphism also appears to occur in that RACHs exchange information regarding the preferred areas of assessment of accreditation assessors. Normative isomorphism also has a direct impact on the quality of services provided by RACHs. To improve processes and better fulfil the accreditation standards RACHs obtain suggestions from external professionals through the filtering of personnel, and professional networks such as conferences and trainings that staff attend.

The overall notion is that the adoption of accreditation standards did provide and still provides some guidelines to RACHs, although it appears that this occurs at different levels between different RACHs. For instance, the sample investigated suggested that the adoption of accreditation standards has a greater influence on small RACHs than medium and large ones, and that it only represents minimum levels of quality for the latter ones. Yet, for a small stand-alone RACH, the standards can be overwhelming. As a result, the fulfilment of the accreditation requirements by small stand-alone RACHs appears to be more challenging than for medium and large RACHs, based on the sample. Additionally, there appear to exist some issues about how the accreditation assessment is carried out; it not only overwhelms staff but it also may not represent an accurate reality of the care provided to residents. For instance, if paperwork is not properly completed this may lead to sanctions being imposed on RACHs. Most importantly, paperwork seems to be so substantial that it takes time away from caring for residents, when an enhancement in the quality of care provided for residents is the purpose of the accreditation process in the first place. Therefore, it is not evident whether RACHs being legitimate with respect to accreditation standards also means that they are being legitimate with regard to the quality of services provided to their residents.

Finally, the findings of this thesis which were presented in section 6.1.4 indicate that proposition 1 "*Adoption of accreditation standards improves the quality of care provided to residents*" is partially supported; and proposition 2 "*Adoption of accreditation standards improves residents' quality of life*" is deemed supported.

8.3 Contribution of the Thesis

8.3.1 Empirical Contribution

This thesis makes an important contribution to the body of literature that has investigated quality and accreditation studies in the health care sector, more specifically in the Australian aged care sector where research has been very limited. It provides the academic community with insights into how the accreditation process influences the quality of services provided by RACHs, as it

relates to quality of design, quality of conformance, quality of performance and continuous improvement, residents' quality of care and quality of life, staff guidance, and RACH processes.

8.3.2 Theoretical Contribution

From a theoretical perspective, this thesis contributes to the quality accreditation literature in three main ways. Firstly, it analyses how institutional pressures influence the adoption of the accreditation process by RACHs, by providing empirical evidence on how RACHs view the accreditation process, and on the reasons why they adopt it. It provides a comprehensive examination as to whether they do so to improve the level of quality of their services, due to legitimacy reasons, or simply because it is compulsory. From this examination, it was found that these reasons are all factors, however, with improving the level of quality of services appearing to be the strongest reason; which supports Meyer and Rowan's (1977) observations that organisations incorporate institutional rules to achieve legitimacy and resources stability.

Secondly, this research investigates from an institutional perspective the methods used by RACHs to fulfil the accreditation standards. In addition to the evident coercive pressures, mimetic and normative isomorphisms are also influential factors in RACHs that seek to be legitimate not only to the accreditation standards, but to the aged care system as a whole. For instance, under mimetic isomorphism it was suggested that benchmarking is used not only to fulfil the accreditation standards but also because it is an expectation that RACHs should do so (consistent with Giblin's2006 findings). It was also implied that information emanating from benchmarking may not always be efficiently used by RACH managers, and that benchmarking is only used to compare results performance instead of sharing of best practice. These findings are consistent with Northcott and Llewellyn's (2005) observations that benchmarking is used for control instead of learning in organisations. A new finding from this research is that managers are not comparing results obtained from their benchmarking activities to other RACHs. Consistent with DiMaggio and Powell's (1983) indication of how normative pressures occur in an organisation, normative isomorphism also influences the fulfilment of accreditation standards. This occurs through RACHs gathering information from industry networks and conferences, and

is also due to the apparently high turnover of RACH staff. Also, consistent with Zhang and Wan (2007), mimetic and normative pressures have less influence in explaining isomorphic nursing home quality than the coercive pressure. However, findings of this research indicate that the lack of a professional association for care staff, in some instances the lack of education for care staff, and the excess of staff turnover may in fact, have a negative influence in the quality of services provided by RACHs. Finally, coercive pressures are evident in RACHs. Similar to the findings from Grenade and Boldy (2002), where it was suggested that accreditation should be structured and operated in conjunction with the other components of the aged care system, findings of this research argue for the existence of one main body providing a comprehensive map of the various standards across the different regulatory bodies that RACHs must comply with. This is because the various regulatory agencies with which RACHs must be compliant may result in conflicting coercive pressures being imposed on them; this was more evident in the small local government RACH from the sample.

Thirdly, this research addresses paucity in the current literature with regard to studies that have looked at quality and accreditation in the aged care sector from an institutional theory perspective. As a result, the findings sections throughout chapters six and seven emphasise how the adoption of accreditation standards enhances the quality of services provided by RACHs. It also identifies the difficulties encountered by RACHs as it relates to the fulfilment of the accreditation standards, and the heavily regulated sector to which they belong. By examining other studies that have looked at the adoption of accreditation in the health care sector broadly, some results could then be generalised to the theory.

Finally, results indicate that institutional pressures are important to ensure the enhancement of the quality of services provided by RACHs, and that in some cases these pressures even appear to be sought after. For instance, coercive pressures are regarded as important to ensure RACH accountability, and that it has also assisted in terminating those RACHs that did not provide good care. Additionally, coercive and normative pressures are currently sought with a governing body being identified as needed for RACH care staff. Even though regulation is coercive, it does not necessarily have to be. As described in the next section (i.e. practical contribution), Government can liaise with RACH staff when next amending the regulation to involve more of the mimetic and normative isomorphisms. For instance, it was indicated that guidance is being sought with

regard to fulfilment of the accreditation standards. Finally, regulation is important and needed, however it needs to be properly implemented. Hence, proposition 5 *"Accreditation standards are adopted by RACHs to improve their standing in the eyes of stakeholders"* is deemed to be partially supported.

8.3.3 Practical Contribution

From a practical perspective, this thesis provides insights on how RACH staff view the influence that the adoption of accreditation standards has on the quality of services provided by them. These perceptions may be deemed useful in two main ways. First, in providing direction to the Australian Government when introducing new policies for both the aged care system and accreditation standards. Second, for the Aged Care Standards and Accreditation Agency when conducting an accreditation assessment in RACHs. An improvement in these two areas will directly assist in enhancing management practices in RACHs.

This thesis provides insights into a number of elements that the Australian Government should take into consideration when introducing changes to the aged care system. For instance, it was suggested that there should be one main body overseeing all regulatory bodies that comprise the aged care system, and the system should be structured in such a way that the regulations and standards are combined and streamlined. The researcher therefore interprets this as the RACHs being overwhelmed with all the requirements from the different regulatory bodies, including accreditation. Consequently, there is a need for one main body that would provide RACHs with a comprehensive map of the various standards across these regulatory bodies, so that RACHs staff can clearly identify which standards overlap and which standards are distinctive. This would assist RACHs staff in creating efficiency in terms of how they manage the coercive isomorphisms that are coming from these different standards given that they might not always have the necessary resources (in terms of for example skills, staff, knowledge, time, and money), to do so, and therefore RACHs staff would have more time to focus on the quality of services being provided to their residents. Also, there appears to exist scope for different accreditation requirements to be imposed for both low level and high level care RACHs. Nonetheless, there is

a clear need for a reciprocal conversation between the Accreditation Agency and RACHs with regard to how the accreditation standards can be improved, although this seems to be lacking. Additionally, significant issues were raised with regard to RACH staff, such as: (i) RACH staff are low paid. This results in RACHs often employing unskilled people, in staff not being able to develop professionally, and also leads to high levels of staff turnover; (ii) The lack of a governing body for RACH care staff.[81] Care staff represent the majority of RACH workers, and not having a governing body results in them having no requirement to continuously improve their skills which can therefore directly affect the quality of care provided to residents; (iii) There is no existing government staff ratio per resident in RACHs. Even though results were unclear whether a staff ratio would be the best approach to govern the number of staff per residents in RACHs, results clearly indicated that RACHs are understaffed and that there is a need to have a regulation in this regard.

This thesis also contributes to how improvements can be made on the accreditation assessment conducted by the Aged Care Standards and Accreditation Agency. There are concerns about how the accreditation process is carried out and on how evidence is collected, which leads to a myriad of drawbacks. For instance, accreditation assessors appear to have different levels of knowledge and different assessment criteria when assessing an RACH, in addition to not always following the guidelines provided to them by ACSAA. It was also suggested that accreditation standards are open for interpretation, and that guidance seems to be sought as it relates to expectations on how they should be fulfilled. Moreover, unannounced visits result in some key staff having to provide assistance to accreditation assessors instead of residents. Therefore, the accreditation agency should have additional care staff as part of their assessment teams when conducting unannounced visits, so that residents' care is not affected. Finally, even though paperwork is an output of an accreditation system, it still seems to be the main source of evidence used by accreditation assessors. As suggested by many interviewees, there are many repetitive and irrelevant instances of paperwork (e.g. the tracking of a wound) that could be significantly reduced. This would therefore substantially improve the work of aged care staff, allowing the devotion of more time to the care of residents. Therefore, this issue needs to be revisited by the accreditation agency given that it not only takes time away from caring for residents, but may not always represent an accurate reality of the care that is provided to residents. As a result, and as

[81] Certificates III and IV aged care carers (please refer to chapter six)

suggested by some interviewees, more time should be spent by accreditation assessors in observing the tasks undertaken by RACHs staff and in interviewing residents These alternatives would provide "non-paperwork" and "non-staff-based" views respectively, thus portraying more realistic levels of quality of care and quality of life provided by RACHs to their residents.

8.4 Limitations of the Thesis

This study presents two potential limitations, namely, the sources of data and the interpretational framework, which are discussed in the following sections.

8.4.1 The Sources of Data

This thesis is based primarily on interviews conducted with staff from RACHs who are involved with the accreditation process, in addition to staff surveys conducted and the analysis of relevant documentation when allowed. However, this thesis has some potential limitations:

- The fact that only eighteen interviews were conducted;
- "Subjective judgment" and "convenience" sampling were used to select the six RACHs;
- A brief review of documentation relating to accreditation was permitted only in some instances, when additional reviews could possibly have provided a deeper understanding with regard to answering the research questions and propositions of this study.
- Although it was specifically requested that the interviews be conducted with staff directly involved with the accreditation process, the impression was that in some cases staff could not answer to all the questions as they did not have an in-depth involvement with the accreditation process.
- Due to interviewed staff and survey staff having different levels of involvement and understanding of the accreditation process, triangulation of results was not always possible.

- Not all types of RACHs were investigated, and different types of facilities may have unique opinions with regard to the accreditation process.
- The fact that interviews were recorded, may have resulted in the answers being somewhat biased as staff may have felt intimidated, and therefore not been absolutely truthful in their answers.
- Finally, the utilisation of a case study only allows the findings to be generalised to the theoretical propositions and not to populations.

8.4.2 Interpretational Framework

Institutional theory was the theoretical framework selected to guide the examination of quality and accreditation in this research. The combination of both assisted in learning the views of RACHs with regard to the accreditation process, examining some of the different pressures faced by RACHs, and also identifying areas for further improvement. Therefore, a limitation is that only the views of staff working in RACHs were considered; the views of ACSAA (which includes accreditation assessors), RACHs' residents, and their families were not included in this research.

Additionally, findings suggested that the dearth of financial resources in RACHs is also directly related to the quality of care and quality of life provided to residents, and so it appears that redefining the framework to include resource dependence theory could have resulted in a more effective understanding of how this pressure impacts the quality of services provided for residents.

8.5 Recommendations for Future Research

Some of the limitations presented in this study may potentially be addressed in future research. For instance, whilst undertaking this research it was observed that financial resources are the trigger to many other problems that RACHs face, more specifically as they relate to the quality

and quantity of staff that RACHs rely on. Hence, the management of funds received both from the government and residents by RACHs is clearly an area for future research. Also, future research can investigate the generalisability of this study by replicating it to a larger number and to a wider variety of RACHs.

9 APPENDIX

APPENDIX 1 – Quality of Care Principles Schedule 1

Quality of Care Principles 1997

SCHEDULE 1 Section 18.6

SPECIFIED CARE AND SERVICES FOR RESIDENTIAL CARE SERVICES

PART 1—HOTEL SERVICES—TO BE PROVIDED FOR ALL RESIDENTS WHO NEED THEM

Col. 1 *Item*	*Column 2* *Service*	*Column 3* *Content*
1.1	Administration	General operation of the residential care service, including resident documentation
1.2	Maintenance of buildings and grounds	Adequately maintained buildings and grounds
1.3	Accommodation	Utilities such as electricity and water
1.4	Furnishings	Bed-side lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw-screens (for shared rooms), resident wardrobe space, and towel rails Excludes furnishings a resident chooses to provide
1.5	Bedding	Beds and mattresses, bed linen, blankets, and absorbent or waterproof sheeting
1.6	Cleaning services, goods and facilities	Cleanliness and tidiness of the entire residential care service Excludes a resident's personal area if the resident chooses and is able to maintain it himself or herself
1.7	Waste disposal	Safe disposal of organic and inorganic waste material

Source: Aged Care Act (1997)

SCHEDULE 1—continued

PART 1—HOTEL SERVICES—TO BE PROVIDED FOR ALL RESIDENTS WHO NEED THEM—continued

Col. 1 *Item*	*Column 2* *Service*	*Column 3* *Content*
1.8	General laundry	Heavy laundry facilities and services, and personal laundry services, including laundering of clothing that can be machine washed Excludes cleaning of clothing requiring dry cleaning or another special cleaning process, and personal laundry if a resident chooses and is able to do this himself or herself
1.9	Toiletry goods	Bath towels, face washers, soap, and toilet paper
1.10	Meals and refreshments	(a) Meals of adequate variety, quality and quantity for each resident, served each day at times generally acceptable to both residents and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper (b) Special dietary requirements, having regard to either medical need or religious or cultural observance (c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice
1.11	Resident social activities	Programs to encourage residents to take part in social activities that promote and protect their dignity, and to take part in community life outside the residential care service
1.12	Emergency assistance	At least 1 responsible person is continuously on call and in reasonable proximity to render emergency assistance

SCHEDULE 1—continued

PART 2—CARE AND SERVICES—TO BE PROVIDED FOR ALL RESIDENTS WHO NEED THEM

Col. 1 *Item*	*Column 2* *Care or Service*	*Column 3* *Content*
2.1	Daily living activities assistance	Personal assistance, including individual attention, individual supervision, and physical assistance, with: (a) bathing, showering, personal hygiene and grooming (b) maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management (c) eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary) (d) dressing, undressing, and using dressing aids (e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids (f) communication, including to address difficulties arising from impaired hearing, sight or speech, or lack of common language (including fitting sensory communication aids), and checking hearing aid batteries and cleaning spectacles Excludes hairdressing
2.2	Meals and refreshments	Special diet not normally provided
2.3	Emotional support	Emotional support to, and supervision of, residents

SCHEDULE 1—continued

PART 2—CARE AND SERVICES—TO BE PROVIDED FOR ALL RESIDENTS WHO NEED THEM—continued

Col. 1 *Item*	*Column 2* *Care or Service*	*Column 3* *Content*
2.4	Treatments and procedures	Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a resident's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of State or Territory law
2.5	Recreational therapy	Recreational activities suited to residents, participation in the activities, and communal recreational equipment
2.6	Rehabilitation support	Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a resident's ability to perform daily tasks for himself or herself, or assisting residents to obtain access to such programs
2.7	Assistance in obtaining health practitioner services	Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents, or are made direct with a health practitioner
2.8	Assistance in obtaining access to specialised therapy services	Making arrangements for speech therapy, podiatry, occupational or physiotherapy practitioners to visit residents, whether the arrangements are made by residents, relatives or other persons representing the interests of residents

SCHEDULE 1—continued

PART 2—CARE AND SERVICES—TO BE PROVIDED FOR ALL RESIDENTS WHO NEED THEM—continued

Col. 1	*Column 2*	*Column 3*
Item	*Care or Service*	*Content*
2.9	Support for residents with cognitive impairment	Individual attention and support to residents with cognitive impairment (eg dementia, and other behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such residents and ongoing support (including specific encouragement) to motivate or enable such residents to take part in general activities of the residential care service

SCHEDULE 1—continued

PART 3—CARE AND SERVICES—TO BE PROVIDED FOR RESIDENTS RECEIVING A HIGH LEVEL OF RESIDENTIAL CARE

Col. 1 *Item*	*Column 2* *Care or Service*	*Column 3* *Content*
3.1	Furnishings	Over-bed tables
3.2	Bedding materials	Bed rails, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each resident's condition
3.3	Toiletry goods	Sanitary pads, tissues, toothpaste, denture cleaning preparations, shampoo and conditioner, and talcum powder
3.4	Goods to assist residents to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs Excludes motorised wheelchairs and custom made aids
3.5	Goods to assist staff to move residents	Mechanical devices for lifting residents, stretchers, and trolleys
3.6	Goods to assist with toileting and incontinence management	Absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas
3.7	Basic medical and pharmaceutical supplies and equipment	Analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, and urinary alkalising agents Excludes goods prescribed by a health practitioner for a particular resident and used only by the resident

SCHEDULE 1—continued

PART 3—CARE AND SERVICES—TO BE PROVIDED FOR RESIDENTS RECEIVING A HIGH LEVEL OF RESIDENTIAL CARE—continued

Col. 1 *Item*	*Column 2* *Care or Service*	*Column 3* *Content*
3.8	Nursing services	(a) 24-hour on-call access to care by a qualified nurse, or by appropriately trained staff under the supervision of a qualified nurse, if there are 1 to 3 high care residents any of whom are assessed as requiring nursing services (b) 24-hour on-site care by a qualified nurse, or by appropriately trained staff under the supervision of a qualified nurse, if there are 4 to 7 high care residents any of whom are assessed as requiring nursing services (c) 24-hour on-site care by a qualified nurse if there are 8 or more high care residents
3.9	Nursing procedures	Technical and nursing procedures carried out by a qualified nurse, or other appropriately trained staff, under the direct or indirect supervision of a qualified nurse on a sessional or regular basis
3.10	Medications	Medications subject to requirements of State or Territory law
3.11	Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services	(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents' levels of independence in activities of daily living

SCHEDULE 1—continued

PART 3—CARE AND SERVICES—TO BE PROVIDED FOR RESIDENTS RECEIVING A HIGH LEVEL OF RESIDENTIAL CARE—continued

Col. 1 *Item*	*Column 2* *Care or Service*	*Column 3* *Content*
		(b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to reach a level of independence at which maintenance therapy will meet their needs Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma
3.12	Oxygen and oxygen equipment	Oxygen and oxygen equipment needed on a short-term, episodic or emergency basis

APPENDIX 2 – Quality of Care Principles Schedule 2 (Accreditation Standards)

Quality of Care Principles 1997

SCHEDULE 2 Section 18.8

ACCREDITATION STANDARDS

PART 1—MANAGEMENT SYSTEMS, STAFFING AND ORGANISATIONAL DEVELOPMENT

Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Intention of standard:

This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
1.1	Continuous improvement	The organisation actively pursues continuous improvement
1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
1.4	Comments and complaints	Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms
1.5	Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service
1.6	Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives

Source: Aged Care Act (1997)

SCHEDULE 2—continued

PART 1—MANAGEMENT SYSTEMS, STAFFING AND ORGANISATIONAL DEVELOPMENT—continued

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available
1.8	Information systems	Effective management systems are in place
1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals

SCHEDULE 2—continued

PART 2—HEALTH AND PERSONAL CARE

Principle: Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team.

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
2.1	Continuous improvement	The organisation actively pursues continuous improvement
2.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
2.4	Clinical care	Residents receive appropriate clinical care
2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff
2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences
2.7	Medication management	Residents' medication is managed safely and correctly
2.8	Pain management	All residents are as free as possible from pain
2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained
2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration

SCHEDULE 2—continued

PART 2—HEALTH AND PERSONAL CARE—continued

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
2.11	Skin care	Residents' skin integrity is consistent with their general health
2.12	Continence management	Residents' continence is managed effectively
2.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively
2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents
2.15	Oral and dental care	Residents' oral and dental health is maintained
2.16	Sensory loss	Residents' sensory losses are identified and effectively managed
2.17	Sleep	Residents are able to achieve natural sleep patterns

SCHEDULE 2—continued

PART 3—RESIDENT LIFESTYLE

Principle: Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

Col. 1 *Item*	*Column 2* *Matter Indicator*	*Column 3* *Expected Outcome*
3.1	Continuous improvement	The organisation actively pursues continuous improvement
3.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about resident lifestyle
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis
3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service
3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected
3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them
3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered

SCHEDULE 2—continued

PART 3—RESIDENT LIFESTYLE—continued

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
3.9	Choice and decision-making	Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people
3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities

SCHEDULE 2—continued

PART 4—PHYSICAL ENVIRONMENT AND SAFE SYSTEMS

Principle: Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

Col. 1 *Item*	*Column 2* *Matter Indicator*	*Column 3* *Expected Outcome*
4.1	Continuous improvement	The organisation actively pursues continuous improvement
4.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs
4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements
4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks
4.7	Infection control	An effective infection control program
4.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment

APPENDIX 3 – Quality of Care Principles Schedule 3 (Residential Care Standards)

Quality of Care Principles 1997

SCHEDULE 3 Section 18.11

RESIDENTIAL CARE STANDARDS

PART 1—HEALTH AND PERSONAL CARE

Principle: Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team.

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
1.1	Continuous improvement	The organisation actively pursues continuous improvement
1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
1.4	Clinical care	Residents receive appropriate clinical care
1.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff
1.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences
1.7	Medication management	Residents' medication is managed safely and correctly
1.8	Pain management	All residents are as free as possible from pain
1.9	Palliative care	The comfort and dignity of terminally ill residents is maintained
1.10	Nutrition and hydration	Residents receive adequate nourishment and hydration

Source: Aged Care Act (1997)

SCHEDULE 3—continued

PART 1—HEALTH AND PERSONAL CARE—continued

Col. 1 *Item*	*Column 2* *Matter Indicator*	*Column 3* *Expected Outcome*
1.11	Skin care	Residents' skin integrity is consistent with their general health
1.12	Continence management	Residents' continence is managed effectively
1.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively
1.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents
1.15	Oral and dental care	Residents' oral and dental health is maintained
1.16	Sensory loss	Residents' sensory losses are identified and effectively managed
1.17	Sleep	Residents are able to achieve natural sleep patterns

SCHEDULE 3—continued

PART 2—RESIDENT LIFESTYLE

Principle: Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
2.1	Continuous improvement	The organisation actively pursues continuous improvement
2.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about resident lifestyle
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
2.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis
2.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service
2.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected
2.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them
2.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered

SCHEDULE 3—continued

PART 2—RESIDENT LIFESTYLE—continued

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
2.9	Choice and decision-making	Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people
2.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities

SCHEDULE 3—continued

PART 3—PHYSICAL ENVIRONMENT AND SAFE SYSTEMS

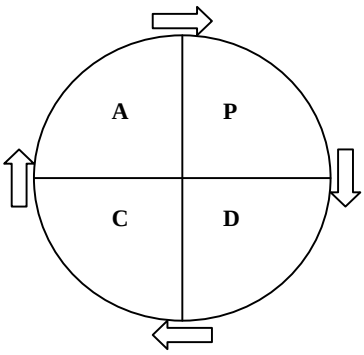
Principle: Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

Col. 1	*Column 2*	*Column 3*
Item	*Matter Indicator*	*Expected Outcome*
3.1	Continuous improvement	The organisation actively pursues continuous improvement
3.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
3.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs
3.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements
3.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks
3.7	Infection control	An effective infection control program
3.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment

APPENDIX 4 – The Fourteen Points, The Deadly Diseases of Quality Management, and Obstacles

The Fourteen Points

1. Create constancy of purpose for improvement of product and service	Managers should be dedicated to the organisation's constancy of purpose instead of quick profits, which means acceptance and obligation of: • Innovation; by allocating resources for long-term planning. • Putting resources into research and education. • Constantly improving the design of products and services; an obligation that never ceases given that the customer is the most important part of the production line.
2. Adopt the new philosophy	The new philosophy is that we can no longer live with the levels of quality that we were able to tolerate in the past; therefore transformation is required. Consumers are becoming more demanding and to keep in business the company of tomorrow must meet these demands. Management must awaken to challenges, learn their responsibilities, and take on leadership for change.
3. Cease dependence on mass inspection	Inspection to improve quality is too late, ineffectively and costly. Quality comes not from inspection, but from improvement of the production process.
4. End the practice of awarding business on the basis of price tag alone	Price has no meaning without a measure of the quality being purchased. Purchasing departments customarily operate on the lowest cost of purchase supplier and ignore cost of use, which often leads to suppliers of low quality. Instead, they should seek the best quality and work to achieve it with a single supplier for any one item in a long-term relationship.
5. Improve constantly and forever the system of production and service	Quality must be built in at the design stage. Manager's intent must be translated into plans, specifications and tests in an attempt to deliver customer's requirements. Additionally, improvement is not a one-time effort. Management is obligated to continually look for ways to reduce waste and improve quality.
6. Institute training	Training must be totally reconstructed. Money and time spent for training will be ineffective unless inhibitors to good work are removed. Additionally, people have different ways of learning; some learn from written words, others by hearing, others by demonstration, through pictures, and so on. In companies, workers usually learn their job from another worker, who sometimes has never been trained appropriately. As a result, they are forced to follow unintelligible instructions and due to that, they cannot really do their job because no one tells them how to do it properly.
7. Adopt and institute leadership	The job of management is not supervision, but leadership; through guiding and leading people to do a better job.
8. Drive out fear	No one can provide their best performance unless they feel secure. Insecurity and fear can result in many losses for the organisation, as for example staff's inability to serve the company's best interest due to specific rules.
9. Break down barriers between staff areas	To improve the processes it is important that departments work as teams so that they can solve or foresee problems instead of competing against each other.
10. Eliminate slogans, exhortations, and targets for the work force	Exhortations and posters that urge the workforce to increase productivity can generate frustration and resentment, given that most of the problems come from the system (management responsibility).
11. **a) Eliminate numerical quotas for the work force** **b) Eliminate numerical quotas for people in management**	 Usually the quotas set in a company take account only of numbers, not quality or methods. For example, should the quota of someone whose job it is to answer the phone be to take twenty-five calls per hour or to be courteous with clients? Usually, it is impossible to do both things at the same time, resulting in inefficiency and high costs. In order to hold a job, a person, meets a quota at any cost, without regard to damage to the company. The job of management is to replace work standards by knowledgeable and intelligent leadership; which results in increased quality and productivity. To manage, one must lead. To lead, one must understand the work he and his people are responsible for.
12. Remove barriers	Barriers and handicaps rob the hourly worker of his birthright; the right to be proud of

that rob people of pride of workmanship	his work, the right to do a good job. Most employees are eager to do a good job, and become unhappy when they cannot do so. However, misguided supervisors, faulty equipment and defective materials are obstacles and can be the reason why employees are not able to produce their best. To ensure that a job is correctly performed, these barriers must be removed.
13. Encourage education and self-improvement for everyone	What an organisation needs is not just good people, but people that are improving with education.
14. Take action to accomplish the transformation	Everybody in the company must work to accomplish the transformation, and enough people in the company must understand the Fourteen Points, the Seven Deadly Diseases, and the Obstacles. Every activity, every job is part of a process, and the final stage will send the product or service to the ultimate customer. Every stage involves production and continual improvement of methods and procedures; the Shewhart cycle is helpful as a procedure to follow for improvement of any stage. 

Source: (Adapted from Deming, 1986)

The Deadly Diseases of Quality Management

1. Lack of constancy of purpose	Lack of constancy of purpose to plan product and service that will have a market and keep the company in business, and provide jobs.
2. Emphasis on short-term profits	Short-term profit thinking defeats constancy of purpose. The heavy pressure faced by companies for short-term gains undermines quality and productivity.
3. Evaluation by performance, merit rating, or annual review	Performance appraisal or merit rating focuses on the end product, at the end of the stream, not on leadership to help people. The effects of annual performances checking, where supervisors rate subordinates on predetermined criteria, can have devastating results as it starts to build fear.
4. Mobility of management	Job-hopping managers never understand the companies that they work for and are never there long enough to follow through on long-term changes that are necessary for quality and productivity. They destroy teamwork, which is vital for the continued success and existence of the company.
5. Running a company on visible figures alone	Visible figures are important, although no management can be successful by analysing visible figures alone. The most important figures are unknown and unknowable – as, for example, the multiplier effect of a happy customer.

Source: (Adapted from Deming, 1986)

Obstacles

1. Hope for instant pudding	The supposition that improvement of quality and productivity is accomplished suddenly by affirmation of faith.
2. The supposition that solving problems, automation gadgets, and new machinery will transform industry	Every net contribution to efficiency is important, however small. Having a group of workers to come up with changes that will save the company with whatever amount result in staff taking pride in the improvement. This results in better quality, productivity, and staff morale.
3. Search for examples	Improvement of quality is a method, transferable to different problems and circumstances. It does not consist of cookbook procedures on file ready for specific application to this or that kind of product. Instead, the company's success depends on their knowledge as to map their own route to quality.
4. Our problems are different	This is the pretext of most managers as to avoid dealing with quality issues. Problems are different, but the principles that will help to improve quality of product and of services are universal in nature.
5. Obsolescence in schools	Studying management does not mean that people are ready to step into jobs, given that most of them have no experience in production or in sales.
6. Poor teaching of statistical methods in industry	No one should teach the theory and use of control charts without knowledge of statistical theory.
7. Use of military standard 105D and other tables for acceptance	The use of such plans can only increase costs. If used for quality audit or final product as it goes out the door, they guarantee that some customers will get defective product.
8. Our quality control department takes care of all our problems of quality	Managers are those who can contribute the most to quality, along with supervisors and production workers.
9. Our troubles lie entirely in the work-force	Workers are handicapped by the system, and the system belongs to management.
10. False starts	False starts are deceptive. They give satisfaction, something to show for effort, but they lead to frustration, despair, disappointment, and delay. For example, a quality control circle can only thrive if management takes action on the recommendations from the circle.
11. We installed quality control	Quality control cannot be installed. To be successful, improvement of quality and productivity must be a learning process, year by year, with top management leading the whole company.
12. The unmanned computer	Data means nothing if they only sit on the computer and management does not interpret them, learning causes for variations that should be investigated.
13. The supposition that it is only necessary to meet specifications	The ultimate customer does not care about the specifications, he only cares if the product works.
14. The fallacy of zero defects	There is obviously something wrong when a measured characteristic barely inside a specification is declared to be conforming, outside it is declared to be nonconforming. It will not suffice to have customers merely satisfied; an unhappy customer will switch.
15. Inadequate testing of prototypes	The test of putting together a prototype may go off well, but when assembly goes into production all characteristics will vary.
16. Anyone that comes to try to help us must understand all about our business	Help may come from outside the company, combined with knowledge already possessed by people within the company but not being utilised.

Source: (Adapted from Deming, 1986)

APPENDIX 5 – The 14 Steps of the Quality Improvement Program and Quality Measurement Maturity Grid

The 14 Steps of the Quality Improvement Program

Step 1: Management Commitment	It is necessarily to help management understanding that being personally committed to the program raises the level of visibility for quality and ensures everyone's cooperation so long as there is some progress.
Step 2: Quality Improvement Team	This team must coordinate the quality improvement program. It will be composed of representatives from all departments who will assist in the implementation of improvement activities.
Step 3: Quality Measurement	It is necessary to establish quality measurements for each area of activity where they do not exist and reviewing where they do exist. Quality status is recorded to show where improvement is possible, where corrective action is necessary, and to later document actual improvement.
Step 4: Cost of Quality Evaluation	The cost of quality is not an absolute performance measurement; it is an indication of where corrective action will be profitable for the company.
Step 5: Quality Awareness	Management must share with employees the measurement of what non quality is costing. The real benefit of communication is that it gets supervisors and employees in the habit of talking positively about quality. It aids the process of changing and/or clarifying attitudes toward quality.
Step 6: Corrective Action	As people are encouraged to talk about their problems, opportunities for correction come to light. The real purpose of corrective action is to identify and eliminate problems forever, through determining and acting on their causes.
Step 7: Establish an Ad Hoc Committee for the Zero Defects Program	At this stage, members of the team are selected to investigate the Zero Defects concept and to implement the program. The purpose is to communicate to all employees what zero defects means and that everyone should do things right at the first time.
Step 8: Supervisor Training	All managers must understand each step well enough to be able to explain it to their people. For that, training is necessary for all levels of management prior to implementation of all steps.
Step 9: Zero Defects Day	It is important to create a one day event that establishes zero defects as the new standard performance of the company. This will emphasise the program and ensure that everyone understands it in the same way.
Step 10: Goal Setting	Encourage people to establish improvement goals for themselves and their teams. All goals should be specific and capable of being measured.
Step 11: Error Cause Removal	Encourage employees to communicate to management the obstacles to attaining improvement goals. Once employees start trusting the communication methodology, the program can continue forever.
Step 12: Recognition	To motivate and recognize those people who meet their goals or perform outstanding acts. The prizes or awards should not be financial, recognition is what is important.
Step 13: Quality Councils	Bring together regularly all quality professionals and team chairpersons to communicate with each other and to determine actions necessary to upgrade and improve the quality program being installed.
Step 14: Do it over again	A new team of representatives must be set up. The new team will develop many new ways of doing things, causing even more improvement than the first time. A quality improvement program never ends; repetition makes the program perpetual. As quality improvement becomes more and more an enduring way of life, as it becomes the culture of the company, the process gains speed and permanence. If quality is not ingrained in the organisation, it will never happen.

Source: Adapted from (Crosby, 1979, 1984)

Quality Measurement Maturity Grid

Measurement Categories	Stage I: Uncertainty	Stage II: Awakening	Stage III: Enlightenment	Stage IV: Wisdom	Stage V: Certainty
Management understanding and attitude	No comprehension of quality as a management tool. Tend to blame quality department for "quality problems".	Recognising that quality management may be of value but not willing to provide money or time to make it happen.	While going through quality improvement program learn more about quality management; becoming supportive and helpful.	Participating. Understand absolutes of quality management. Recognise their personal role in continuing emphasis.	Consider quality management an essential part of company system.
Quality organisation status	Quality is hidden in manufacturing or engineering departments. Inspection probably not part of organisation. Emphasis on appraisal and sorting.	A stronger quality leader is appointed but main emphasis is still on appraisal and moving the product. Still part of manufacturing or other.	Quality Department reports to top management, all appraisal is incorporated and manager has role in management of company.	Quality manager is an officer of company; effective status reporting and preventative action. Involved with consumer affairs and special assignments.	Quality manager on board of directors. Prevention is main concern. Quality is a thought leader.
Problem handling	Problems are fought as they occur; no resolution; inadequate definition; lots of yelling and accusations.	Teams are set up to attack major problems. Long-range solutions are not solicited.	Corrective action communication established. Problems are faced openly and resolved in an orderly way.	Problems are identified early in their development. All functions are open to suggestion and improvement.	Except in the most unusual cases, problems are prevented.
Cost of quality as % of sales	Reported: unknown Actual: 20%	Reported: 3% Actual: 18%	Reported: 8% Actual: 12%	Reported: 6.5% Actual: 8%	Reported: 2.5% Actual: 2.5%
Quality improvement actions	No organised activities. No understanding of such activities.	Trying obvious "motivational" short-range efforts.	Implementation of the 14-step program with thorough understanding and establishment of each step.	Continuing the 14-step program and starting Make Certain.	Quality improvement is a normal and continued activity.
Summation of company quality posture	"We don't know why we have problems with quality".	"Is it absolutely necessary to always have problems with quality?"	"Through management commitment and quality improvement we are identifying and resolving our problems".	"Defect prevention is a routine part of our operation".	"We know why we do not have problems with quality".

Source: (Crosby, 1979, p. 38)

APPENDIX 6 – Ishikawa's Quality Tools

Cause & Effect Diagram	The cause and effect diagram (also known as the fishbone diagram) is used to explore all the potential or real causes (inputs) that result in a single effect (output). Causes are arranged according to their level of importance or detail, resulting in a depiction of relationships and hierarchy of events. This can help searching for root causes, identifying areas where there may be problems, and comparing the relative importance of different causes. Causes in a cause & effect diagram are frequently arranged into five major categories; manpower, methods, materials, and machinery, and measurements.
Control Charts	Every process varies. Control charts expose the existence of an abnormality, yet they do not indicate the causes.
Histograms	A histogram is a specialized type of bar chart. Individual data points are grouped together in classes, so that the reader can have an idea of how frequently data in each class occur in the data set. High bars indicate more points in a class, and low bars indicate less points. The strength of a histogram is that it provides an easy-to-read picture of the location and variation in a data set.
Scatter Diagrams	Scatter diagrams are used to investigate the possible relationship between two variables that both relate to the same "event."
Pareto Charts	The Pareto effect operates in diverse areas, including quality, where 80% of problems usually stem from 20% of the causes. Pareto charts arrange data so that the few vital factors that are causing most of the problems reveal themselves.

Source: (Ishikawa, 1990)

APPENDIX 7 – Quality Management Programmes for the Aged Care Sector in Other Countries

Country	Quality Assurance	Inspections Overseen By	Standards	Details of Standards	Sanctions
Australia	Accreditation evaluation performed by the Aged Care Standards and Accreditation Agency (body recognised by the Department of Health and Ageing)	Aged Care Standards and Accreditation Agency (ACSAA)	There are 44 expected outcomes across four different standards that residential aged care homes must conform to.	• Management systems, staffing and organisational development • Health and personal care • Resident lifestyle • Physical environment and safe systems	ACSAA may recommend to the Secretary of the Department of Health and Ageing that sanctions be imposed.
Canada	Based on licensing and inspection	Ministry of Health and Long-Term Care undertakes regular reviews and inspections against service agreements, the relevant legislation and regulations, and the standards outlined in the program manual for long-term care homes.	Minimum expectations relating to care and services for residents.	37 standards and 426 supporting criteria	When a home fails to address identified problems or other issues of non-compliance, the government can impose sanctions on that home.
England	A licensing and inspection approach applies. There is no accreditation requirement.	The Department of Health has published England's National Minimum Standards for Care Homes for Older People (the National Minimum Standards)	Compliance with national minimum standards is not itself enforceable, but compliance with regulations is enforceable subject to national standards being taken into account.		
United States of America	Based on an inspection model	Shared federal–state responsibility	The Centers for Medicare and Medicaid Services (CMS) defines standards which aged care homes must meet. CMS contracts with states, for annual surveys and complaints investigations, to assess whether services meet these standards.	Each aged care home payment must undergo a standard survey not less than once every 15 months. Separate teams conduct a comprehensive assessment of federal quality of care and fire safety requirements, while during a complaints investigation the focus generally is on a specific allegation regarding quality of care.	CMS imposes sanctions on homes with Medicare or dual Medicare/Medicaid certification on the basis of state referrals, while the states are responsible for enforcing standards in homes with Medicaid-only certification.
New Zealand	Certification system, with compliance with standards audited by approved independent auditors.	• Accreditation Agency: Quality Health New Zealand (QHNZ). • Health and Disability Services (Safety) Act 2001: audit agencies, which are approved by the Ministry of Health. • QHNZ accreditation and certification audits can occur at the same time, but certification depends entirely on compliance with all the standards approved under the Act.	Providers are audited against the standards and receive certification when they meet the level of service required.	The standards establish requirements for safe practice and continuous quality improvement systems.	The Director-General of Health has statutory authority to close a service if there are serious concerns for patient safety.

Source: Adapted from (CR&C, 2007)

APPENDIX 8 – Application Fees for Re-accreditation and Commencing Homes
(on or After 1 July 2012)

No. of allocated places	Existing home	Commencing home
1 to 19	No fee payable by Approved Provider	
20	$ 1,906.00	$ 380.00
21	$ 2,541.00	$ 508.20
22	$ 3,176.00	$ 635.20
23	$ 3,811.00	$ 762.20
24	$ 4,446.00	$ 889.20
25	$ 5,081.00	$ 1,016.20
26	$ 6,994.00	$ 1,398.80
27	$ 7,114.00	$ 1,422.80
28	$ 7,234.00	$ 1,446.80
29	$ 7,354.00	$ 1,470.80
30	$ 7,474.00	$ 1,494.80
31	$ 7,594.00	$ 1,518.80
32	$ 7,714.00	$ 1,542.80
33	$ 7,834.00	$ 1,566.80
34	$ 7,954.00	$ 1,590.80
35	$ 8,074.00	$ 1,614.80
36	$ 8,194.00	$ 1,638.80
37	$ 8,314.00	$ 1,662.80
38	$ 8,434.00	$ 1,686.80
39	$ 8,554.00	$ 1,710.80
40	$ 8,674.00	$ 1,734.80
41	$ 8,794.00	$ 1,758.80
42	$ 8,914.00	$ 1,782.80
43	$ 9,034.00	$ 1,806.80
44	$ 9,154.00	$ 1,830.80
45	$ 9,274.00	$ 1,854.80
46	$ 9,394.00	$ 1,878.80
47	$ 9,514.00	$ 1,902.80
48	$ 9,634.00	$ 1,926.80
49	$ 9,754.00	$ 1,950.80
50	$ 9,874.00	$ 1,974.80
51	$ 9,994.00	$ 1,998.80
52	$ 10,114.00	$ 2,022.80
53	$ 10,234.00	$ 2,046.80
54	$ 10,354.00	$ 2,070.80
55	$ 10,474.00	$ 2,094.80
56	$ 10,594.00	$ 2,118.80
57	$ 10,714.00	$ 2,142.80
58	$ 10,834.00	$ 2,166.80
59	$ 10,954.00	$ 2,190.80

No. of allocated places	Existing home	Commencing home
60	$ 11,074.00	$ 2,214.80
61	$ 11,194.00	$ 2,238.80
62	$ 11,314.00	$ 2,262.80
63	$ 11,434.00	$ 2,286.80
64	$ 11,554.00	$ 2,310.80
65	$ 11,674.00	$ 2,334.80
66	$ 11,794.00	$ 2,358.80
67	$ 11,914.00	$ 2,382.80
68	$ 12,034.00	$ 2,406.80
69	$ 12,154.00	$ 2,430.80
70	$ 12,274.00	$ 2,454.80
71	$ 12,394.00	$ 2,478.80
72	$ 12,514.00	$ 2,502.80
73	$ 12,634.00	$ 2,526.80
74	$ 12,754.00	$ 2,550.80
75	$ 12,874.00	$ 2,574.80
76	$ 12,994.00	$ 2,598.80
77	$ 13,114.00	$ 2,622.80
78	$ 13,234.00	$ 2,646.80
79	$ 13,354.00	$ 2,670.80
80	$ 13,474.00	$ 2,694.80
81	$ 13,594.00	$ 2,718.80
82	$ 13,714.00	$ 2,742.80
83	$ 13,834.00	$ 2,766.80
84	$ 13,954.00	$ 2,790.80
85	$ 14,074.00	$ 2,814.80
86	$ 14,194.00	$ 2,838.80
87	$ 14,314.00	$ 2,862.80
88	$ 14,434.00	$ 2,886.80
89	$ 14,554.00	$ 2,910.80
90	$ 14,674.00	$ 2,934.80
91	$ 14,794.00	$ 2,958.80
92	$ 14,914.00	$ 2,982.80
93	$ 15,034.00	$ 3,006.80
94	$ 15,154.00	$ 3,030.80
95	$ 15,274.00	$ 3,054.80
96	$ 15,394.00	$ 3,078.80
97	$ 15,514.00	$ 3,102.80
98	$ 15,634.00	$ 3,126.80
99	$ 15,754.00	$ 3,150.80
100	$ 15,874.00	$ 3,174.80
101 or more	$ 15,945.00	$ 3,189.00

Source: (ACSAA, 2012e)

APPENDIX 9 – Accreditation Course

In July 2010, a three-day "Understanding Accreditation" course was undertaken by the researcher. This course was provided by the Aged Care Standards and Accreditation Agency, and it aimed to provide a better understanding of the accreditation process from an RACH's perspective. The course was really valuable in terms of the following:

- gaining a better knowledge of the accreditation process,
- gaining insights into the accreditation process from both ACSAA's and RACHs' perspectives,
- learning more about RACHs and how they operate,
- getting to know people from RACHs and making possible contacts in order to find prospective RACHs to participate in the main study.

Additionally, some key learning points captured from the course include:

- accreditation standards represent minimum standards of quality;
- RACHs must meet the standards in any way they can. Because every home is different, as long as the standards are fulfilled assessors have to accept the home's results. Hence, assessors must be open to understand how the standards apply to the different circumstances of each RACH;
- one standard is linked to the other; thus if you are not compliant with one standard, chances are that you will not be compliant with some others;
- to be accredited an RACH does not have to satisfy all accreditation requirements. It can still receive accreditation while having some standards to follow up. ACSAA will keep a closer eye to see how it is performing and follow up on the weaknesses.

In the first day of the course the instructor asked whether RACH managers believed the accreditation process had improved the level of quality of their facilities. Everyone had a positive answer and agreed that it did improve the level of quality. However, some key observations were made by RACH managers regarding the accreditation course:

- "They leave the accreditation requirements too open for interpretation";
- "Why don't they provide us with a check list of what they want in each standard, it would make our lives so much easier";

- “It would be much easier if they gave us examples and told us what to do”;
- “They told me I had too much stuff, because I document every single thing”;
- “The requirements and things they pick on during the visit changes so much from one assessor to the other”;
- “Some assessors are really helpful and come with a positive attitude of ‘what can I do to help and let’s see what can be improved’, while others come with an attitude of ‘what can I find here that is wrong’ ”;
- “By law we can ask assessors to go away when they come on an unannounced visit, but we will end up in big trouble if we do so”;
- “This course is being really helpful specially in getting to know people; not having a good network OR not having good networking makes us very lonely with regard to the accreditation process. I’m in a very small city and the other facility that exists there is not a good benchmark.”
- “There are so many different departments (DoHA, Occupational Health and Safety (OH&S), ACFI, Food Authority, ACSAA) with different requirements that we need to fulfil. It would be much easier if they had standard requirements across the board for these different bodies.”
- “It’s easy for them (assessors) because, as the instructor said, they have their preferred standards and they always look at the same things. So when they come to visit us they know what they are looking for, but we don’t know what exactly they are looking for.”
- “Some assessors are very understanding when they realise you are just new at the job, and some will go away when they come for an unannounced visit and see that you are just new. Others are not that understanding at all.”

The main aspect learnt with regard to the standards managed by ACSAA was that each of the standards have their own “key words”, which form the basis of that standard. In case the assessors have a disagreement regarding the compliance or noncompliance of a standard, they will call the office and consult with their managers.

Some other contributions of the course included:

- The undertaking of this course allowed for significant networking, and allowed the researcher to obtain contacts with different RACH managers who said they would

be happy to participate in the main study. People from the Department of Health and Ageing were also in the course and contacts were exchanged.

- At the same time that this course was being undertaken, the ethics application for the pilot study was being completed and questionnaires were being finalised. As a result, the information acquired in this course along with comments made by RACH managers were used for the development of new questions that were included in the questionnaires.
- With regard to the interview process, information received from an RACH manager was that in a 50-bed facility, there are usually 3 people involved with the accreditation process (being the Director of Care, General Manager and an extra person). Additionally, it was advised by an RACH manager that the interviews should not be longer than two hours, as "RACH's staff are busy people and do not have much time".

The documentation provided in the course, included:

- A handbook (with key information and exercises to be done during the course)
- A copy of the Aged Care Act
- Three handbooks:
    - Audit Handbook
    - Results and Processes Guide
    - Assessment Modules

Whilst the course was being undertaken, the instructor mentioned that the standards were currently being reviewed and were "sitting in Canberra", and that at that stage they had no idea how long it would take for the new standards to be put into practice.

Attendance at this course was extremely valuable. It was valuable in terms of having a better understanding of the accreditation program and how it works; it was valuable in terms of networking with people and acquiring possible participants to this research; and it was valuable for the opportunity it gave to improve the interview questions.

APPENDIX 10 – Interview Questionnaire

The Adoption of the Accreditation Process

A - Residential Aged Care Home Processes

1. Before adopting the Agency accreditation standards, did this facility have any established operational standards or quality management systems in place?

2. How has the adoption of accreditation improved the processes of the running of this organisation?

3. How has the adoption of accreditation standards provided more guidance for staff in undertaking their tasks?

4. Can you comment on whether the volume of administrative work has increased in this facility as a result of the adoption of accreditation?

B - Residents

5. In what way has the adoption of accreditation standards:
    a. enhanced the level of quality of care provided to the residents of this facility?
    b. enhanced the level of quality of life of residents of this facility?

6. In what way does the adoption of accreditation standards:
    c. result in this facility conforming to residents' expectations?
    d. result in this facility conforming to residents' needs?
    e. influenced residents' level of satisfaction?

C - Quality

7. In what way do you believe that accreditation standards are reflective of minimum levels of quality?

8. In your opinion, does the Accreditation Agency make it clear to you how evidence should be provided for each of the standards?

9. How do you measure the degree of quality improvement for each of the standards? How do you provide evidence for each of the standards?

10. Apart from the Agency, there are other bodies that have standards with which your organisation must also be compliant with (e.g. DoHA, Occupational Health and Safety (OH&S), Food Authority). Are their standards based on or similar to the standards managed by the Accreditation Agency?

D - Financial Aspects

11. Is there a high cost involved to support the preparation for accreditation? And if so, do you think there would be a more efficient use for this money? (e.g. facilities' improvements, fulfilment of specific needs residents may have, etc). In what way?

12. If it wasn't compulsory to achieve accreditation in order to receive funding from the government, do you believe this organisation would still go through the process? Why?

E - Benchmarking

13. In seeking to satisfy the accreditation outcomes, do you observe or have you observed the processes implemented in:
    a. Other residential aged care homes that have achieved accreditation?
    b. Other residential aged care homes that you have worked at, if any?

14. What other types of benchmarking do you utilise/have utilised?

F - The Accreditation Process

15. Did you take part in more than one accreditation round? Was the assessment you received different from one team of assessors to the other? In what way?

16. In what ways, if any, do you believe the accreditation process could be simplified and improved?

17. Are there any other comments/suggestions you would like to make about the accreditation program managed by the Accreditation Agency?

APPENDIX 11 – Pre-Interview Questionnaire

1. Why has this residential aged care home decided to adopt the accreditation program managed by the Aged Care Standards and Accreditation Agency?

Please indicate with an "x" which option(s) best describe your opinion.

- ☐ To improve the level of quality of services provided to residents
- ☐ To improve the standing in the eyes of the following stakeholders:
  - ☐ a) Residents
  - ☐ b) Government
  - ☐ c) Staff
  - ☐ d) Other Residential Aged Care Homes
  - ☐ e) Other, please specify_____
- ☐ To receive funds from the government
- ☐ To indicate minimum levels of quality to residents
- ☐ To improve residents' general level of satisfaction of the services provided by us
- ☐ None of the above
- ☐ Other, please specify_____

Are there any other important additional details you would like to make on the reasons why this residential aged care home has decided to adopt the accreditation program?

_____
_____
_____

2. Does this organisation seek any external assistance (e.g. hiring of additional staff, hiring of specialised staff, etc) in order to fulfil the accreditation requirements? If yes, what sort of assistance?

_____
_____
_____

3. Does this organisation belong to any professional association which requires that accreditation and/or other type of quality program be adopted? If so, please list which professional association(s) and the quality program required by them.

_____
_____
_____

4. From the accreditation outcomes listed below, please indicate with an "x" (*on the checkbox provided on the left hand side of each outcome*) those outcomes that you consider not applicable to your organisation.

Checkboxes

	Item	Matter Indicator	Expected Outcome
	1. Management systems, staffing and organisational development		
	Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates. **Intention of standard:** This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.		
	1.1	Continuous improvement	The organisation actively pursues continuous improvement.
	1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
	1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
	1.4	Comments and complaints	Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.
	1.5	Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.
	1.6	Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.
	1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available.
	1.8	Information systems	Effective information management systems are in place.
	1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.
	2. Health and personal care		
	Principle: Residents' physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team.		
	2.1	Continuous improvement	The organisation actively pursues continuous Improvement.
	2.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care.
	2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
	2.4	Clinical care	Residents receive appropriate clinical care.
	2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
	2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences.
	2.7	Medication management	Residents' medication is managed safely and correctly.
	2.8	Pain management	All residents are as free as possible from pain.
	2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained.
	2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration.
	2.11	Skin care	Residents' skin integrity is consistent with their general health.
	2.12	Continence management	Residents' continence is managed effectively.

	2.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively.
	2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents.
	2.15	Oral and dental care	Residents' oral and dental health is maintained.
	2.16	Sensory loss	Residents' sensory losses are identified and managed effectively.
	2.17	Sleep	Residents are able to achieve natural sleep patterns.
	3. Resident lifestyle		
	Principle: Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.		
	3.1	Continuous improvement	The organisation actively pursues continuous improvement.
	3.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about resident lifestyle.
	3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
	3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis
	3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
	3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected.
	3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.
	3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
	3.9	Choice and decision making	Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.
	3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities.
	4. Physical environment and safe systems		
	Principle: Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.		
	4.1	Continuous improvement	The organisation actively pursues continuous improvement.
	4.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about physical environment and safe systems.
	4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
	4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
	4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements.
	4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
	4.7	Infection control	An effective infection control program.
	4.8	Catering, cleaning and laundry Services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

APPENDIX 12 – Staff Survey

You are invited to participate in a study being conducted by Mrs Gabriela Damiani to meet the requirements of her PhD, under the supervision of Dr Vicki Baard (vicki.baard@mq.edu.au; Tel. No. 9850 9192) in the Department of Accounting and Corporate Governance of Macquarie University. The project is entitled "The Accreditation Process for Australian Residential Aged Care Homes (RACHs)", and your participation is voluntary. Please note that this is an anonymous survey, and data will be collated and analysed summatively. Your consent to have your responses and comments used anonymously is implied by your completion of this questionnaire.

PART A: General Information

1. What is your current role within this RACH? *(Please indicate with an "x" one option that best describes your current role)*

☐ Supervisor
☐ Registered Nurse
☐ Care Staff
☐ Other

2. To what extent are you involved in the accreditation process relating to this organisation?
(Please indicate with an "x" one option only.)

☐ A great deal
☐ Quite a lot
☐ A moderate amount
☐ Some
☐ Little or none

PART B: The Accreditation Process

3. In my opinion, this Residential Aged Care Home (RACH) has decided to adopt the accreditation program managed by the Aged Care Standards and Accreditation Agency to: *(Please indicate with an "x" which option(s) best describe your opinion.)*

☐ Improve the level of quality of services provided to residents
☐ Improve the prestige of this RACH in the eyes of the following stakeholders:
  ☐ a) Residents
  ☐ b) Government
  ☐ c) Staff
  ☐ d) Other Residential Aged Care Homes
  ☐ e) Other, please specify_____
☐ Receive funds from the government
☐ Indicate minimum levels of quality to residents
☐ Improve residents' general level of satisfaction of the services provided by us
☐ None of the above
☐ Other, please specify_____

Please indicate the extent to which you agree with the statements provided below, by placing an "x" in the space provided.

Statement	Strongly Agree	Agree	Slightly Agree	Unsure	Slightly Disagree	Disagree	Strongly Disagree
The adoption of accreditation standards…							
4. …positively influences the way I do my job.	☐	☐	☐	☐	☐	☐	☐
5. …has not influenced the level of quality of care provided to residents.	☐	☐	☐	☐	☐	☐	☐
6. …has increased the level of training received by staff in this RACH.	☐	☐	☐	☐	☐	☐	☐
7. …has enhanced the information system of this RACH.	☐	☐	☐	☐	☐	☐	☐
8. …has improved the professional standards, guidelines, and policies of this RACH.	☐	☐	☐	☐	☐	☐	☐
9. …has improved the management of medications provided to patients.	☐	☐	☐	☐	☐	☐	☐
10. …has provided additional guidance to staff when undertaking their tasks.	☐	☐	☐	☐	☐	☐	☐
11. …has resulted in additional staff being recruited for this RACH.	☐	☐	☐	☐	☐	☐	☐
12. …has influenced the residents' quality of life.	☐	☐	☐	☐	☐	☐	☐
13. …has not influenced in the physical structure available for residents of this RACH.	☐	☐	☐	☐	☐	☐	☐
14. …has enhanced residents' general level of satisfaction with this RACH.	☐	☐	☐	☐	☐	☐	☐
15. …has improved the outcomes of procedures undertaken by staff.	☐	☐	☐	☐	☐	☐	☐
16. …has resulted in this RACH being better able to conform to residents' expectations.	☐	☐	☐	☐	☐	☐	☐

17. …has enhanced most processes in this RACH.	☐	☐	☐	☐	☐	☐	☐
18. …has resulted in staff working longer hours.	☐	☐	☐	☐	☐	☐	☐
19. …has not influenced how this RACH conforms to residents' needs.	☐	☐	☐	☐	☐	☐	☐
20. …has improved the equipments available in this RACH.	☐	☐	☐	☐	☐	☐	☐
21. …has assisted in reducing the amount of complaints received from residents.	☐	☐	☐	☐	☐	☐	☐
22. …has helped to ensure that appropriate goods are available for service delivery.	☐	☐	☐	☐	☐	☐	☐
23. …has made me learn more about the vision, values, philosophy and objectives of this organisation.	☐	☐	☐	☐	☐	☐	☐

24. Why do you think residential aged care homes (RACHs) adopt accreditation standards?
25. If it wasn't compulsory to achieve accreditation in order to receive funding from the government, do you believe this organisation would still go through the process? Why?
26. What influence do you believe the adoption of accreditation standards has on the quality of RACHs?
27. Are there any other comments that you would like to make about the influence that you think the adoption of accreditation standards has/has not had on the way you do your job?

Thank you for your contribution! ☺

Dr Vicki Baard and Mrs Gabriela Damiani
Macquarie University

APPENDIX 13 – Final Ethics Approval

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20 September 2010

Dr Vicki Baard
Macquarie University
Department of Accounting and Finance
North Ryde NSW 2109

Reference: 5201000897(D)

Dear **Dr Baard**

FINAL APPROVAL

Title of project: ***Factors Influencing the Accreditation Process for Australian Residential Aged Care Homes: An Institutional Theory and Quality Perspective***

Thank you for your recent correspondence. Your response has addressed the issues raised by the Human Research Ethics Committee and you may now commence your research. The following personnel are authorised to conduct this research:

Dr Vicki Baard - Chief Investigator/Supervisor
Mrs Gabriela Lopes Damiani - Co-Investigator

Please note the following standard requirements of approval:

1. The approval of this project is **conditional** upon your continuing compliance with the *National Statement on Ethical Conduct in Human Research (2007)*.

2. Approval will be for a period of five (5 years) subject to the provision of annual reports. **Your first progress report is due on 20 September 2011.**

   If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report on the project.

   Progress Reports and Final Reports are available at the following website:
   http://www.research.mq.edu.au/researchers/ethics/human_ethics/forms

3. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. Please notify the Committee of any amendment to the project.

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that might affect continued ethical acceptability of the project.

6. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University. This information is available at: http://www.research.mq.edu.au/policy

If you will be applying for or have applied for internal or external funding for the above project it is your responsibility to provide Macquarie University's Research Grants Officer with a copy of this letter as soon as possible. The Research Grants Officer will not inform external funding agencies that you have final approval for your project and funds will not be released until the Research Grants Officer has received a copy of this final approval letter.

Yours sincerely

Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

10 REFERENCES

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