

DRG DISCUSSION PAPER #3

Quality and Quality Processes, Including Standards

Anne Cross developed this paper as part of the work of the Disability Reform Group. It combines her input, discussions of the DRG, input from individual members of the DRG and issues raised in the literature.

1. Quality

The use of the term “quality” can be misleading. It is often used in reference to a continuum from poor to excellent, with all stages of the continuum expressing some level of the attainment of quality, even in the inferior ranges. Thus it cannot be assumed that there is a shared sense of what “quality” is, even though the most common sense use of the word generally refers to something done at a very high level of excellence. Thus one part of the struggle for quality would need to include a struggle with what is meant by ‘quality’ in disability services in the ACT. Cultivation of a shared sense of this will be a crucial element of a quality framework in the ACT.

The Disability Reform Group is of the view that the “quality” of service provision is directly related to the extent to which each person is relevantly supported, and whether this occurs at a consistently proficient level. In this sense ***quality ought to be concerned primarily with the outcomes for each and every person that relies on the service for support and whether outcomes are sustained over time.*** Personal outcomes for people then should be used as goals for good service quality. Such descriptors of personal outcomes are increasingly common in the field, and provide a reference point in discussing quality for both individuals and more broadly.

Service monitoring and evaluation will only have a relationship with quality if it is set up in a way that service user experience is the central measure of the quality of the service. If a service is genuinely good then it must be of distinctive benefit to each person being served. Thus quality matters will need to be tackled on a person by person basis, and on a household by household basis or group by group basis (where applicable).

2. Quality Assurance (Accreditation)

Quality Assurance was established to assist consumers to be confident that the needs will be met. There are many accreditation systems. The most widely used system is the ISO 9000 series. It is considered to have many benefits including international acceptance and the support of an established third party

certification process. Many other QA systems either incorporate the ISO 9000 standards or are modeled on them. In the human service areas, there are a number of accreditation bodies operating. Some have been adapted to specifically incorporate the various standards that have developed in particular human service areas.

Some accreditation systems allow choices about how monitoring is done from self-assessment through to various forms of third party audits. Some levels of certification may only include desktop audits and most only include systems audits. Many place more emphasis on policies, systems and records over consumer feedback and measurement of consumer outcomes.

There has ***been little empirical study of the costs and benefits of the systems on consumer outcomes, especially in community and human services arena.*** Anecdotal evidence would include:

- Increased administrative and infrastructure costs to implement systems – it's expensive;
- Increased paperwork and meetings;
- Benefits in 'lifting' standards at the bottom end of the market;
- Disincentives to innovation and pursuit of excellence;
- Benefits if incorporated into a total quality management framework.

3. Quality Management

The term 'quality management' is usually used to mean a continual striving for improvement and best practice. It would generally say quality management is a journey, not a goal. It is about leadership and deployment of clear values, goals, reviews and plans and the pursuit of improved service. It sees quality as deriving from well-designed processes, generally standardised, and continuous improvement. It aims for readiness to accept change and a shared purpose. It usually includes the need for Quality Assurance systems as an integral component of best practice. ***While quality management systems incorporate much of what has been known about 'good management practice', it emphasises systems over people management practices and there is little evidence that the standard application of such quality systems has yielded significant improvement in management practice in community and human services.***

4. Disability Standards

The Commonwealth Government has prescribed a set on ***minimum*** standards for services funded using CSTDA funds. All states and territories are obligated to implement these minimum standards. There are eight prescribed standards.

They are in the areas of:

- Individual need

- Decision making & choice
- Privacy, Dignity and Confidentiality
- Complaints and Disputes
- Service Access
- Participation and Integration
- Valued Status
- Service Management

Most states have undertaken work to delineate and interpret the standards and to develop performance indicators. Most have also developed or are in the process of developing mechanisms for assessing compliance with standards.

Some states have developed additional standards. For instance Queensland has developed several additional standards, including *Protection of human rights and freedom from abuse, Staff support and Development, Leadership, Planning Processes, Service Evaluation, Gathering and Use of Information*. These standards have been developed as a response to a desire to incorporate the standards process into a quality management process. Victoria has also added the standard of *Protection of human rights and freedom from abuse*.

All standards processes include a self-assessment component. Some expect or are working towards an external third party audit process.

Some of the issues that are evident in the standards processes have been:

- The standards are loose and difficult to measure;
- They are tending to measure the easily measurable, rather than matters which require greater discernment and judgment.
- The orientation to *minimum* standards, with no defining or incentives for *optimal* standards.
- Standardisation is driving prescriptive and mandatory practices and working against flexibility and responsiveness to individuals.
- Increasingly oriented to paper compliance, thus focusing on outputs rather than outcomes.
- Have no capacity to recognise quality achievement;

In addition providers have to deal with multiple standards within the one program (e.g. HACCC), as well as many other compliance issues (e.g. OH& S, etc).

5. Some 'Core' Investments in Quality

An overall quality framework for ACT ought to take account of what has been learned over time about predictors of quality in services to people with

disabilities as well as take account of current challenges, including the issues of service re-design, reform and renewal.

What is very evident throughout history is that the prevailing attitudes towards and assumptions about people with disabilities has been the key determinate of how people with disabilities have been treated by society and services. Thus no framework that purports to be about quality could ignore the basic need to invest in **values engagement and the ethics** that are desirable underpinnings of service delivery.

Relatedly, the quality of service, in its most fundamental origins, derives from within **people** more than as a product of abstract systems. Thus whatever shapes our core beliefs and assumptions about the people who provide services (i.e. the workers) and their roles will help predict the ultimate character and quality of what services and service systems ultimately produce. If this premise is given credence, then more weight will be given to workforce investments than to inanimate systems. It will certainly mean the formation of cross sector **workforce planning** mechanisms targeting particular and timely issues. It will require a continuous appraisal of the short and long term trends. It will also mean a commitment to stay with the issue over time, and considerable efforts to maintain and build constituencies of support for quality related human resource issues. The ACT will do better in terms of quality if it invests in people with **passion and commitment** and creates a **favourable employment culture** that fosters competence in service delivery.

Empowerment of service users has also proven to be another key investment in quality. Wherever consumers and their allies have been permitted and supported routinely to be involved in the design and monitoring of services in a routine way, it has born fruit in terms of quality. This is true at the most fundamental levels of personal safeguards around individuals and also at the levels of influencing the nature of supports and services that are provided. Relatedly, the struggle to develop **the 'right relationship'** with service users will be a key determinate of an authentic response to each person.

Relationships and partnerships with 'community' are also an important investment. If one looks at the many things that are now normatively sought as being desirable for the well-being of people with disabilities, one sees immediately that these cannot be intrinsically rendered by services, since their provision is utterly dependent on the cooperation of various elements of the community. Thus investment in 'community' and partnerships with community will be a crucial element of a quality framework. One of the things that is routinely overlooked is the vast contribution to community life that is made by individuals and families and the natural connections that people and families have with ordinary citizens. Thus one sensible investment in quality given the

desirable involvement of community would be to shift some emphasis of our system towards the creation of ethical relationships with the community.

Other investments in quality will be the investment in ***innovation and innovators***. As discussed elsewhere, it is improbable that we will make progress on matters of quality if we don't invest in innovators and exceptional people who might provide leadership to the field in progress on difficult matters. Another element of innovation is the creation of the desirable qualities within the system of ***critical thinking and analysis***. It is certainly painstakingly evident in many organizations that even with the availability of talented people and financial resources; it is quite possible to not succeed if those involved are not operating with high quality thinking. Working "smart" may not be a matter of innate ability so much as whether the person involved is properly schooled in what they are doing. Incompetence may well be present in people, who are otherwise quite favored with natural intelligence, if they are allowed to work with outdated, irrelevant or misguided theories.

6. Differentiating Strategies and Investments in Response to the Needs of the various Stakeholders

It is apparent to the Disability Reform Group, that there exists different needs within the system and that different responses may be needed to satisfy these different perspectives and responsibilities. These different perspectives could be simply delineated as:

- ***Shared / Mutual Interests and Needs***
- ***Needs of Government (funding bodies)***
- ***Provider Needs***
- ***Service User Needs***

Of course, these interests overlap to some degree.

6.1 Shared /Mutual Interests and Needs

At the level of shared interests, it is important that there exists some broad agreement about what we mean by quality and what investments need to be made in quality. (Points 1 and 5 above). Thus there will need to be foundational work done to seek agreement across the field that ***quality ought to be concerned primarily with the outcomes for each and every person that relies on the service for support and whether outcomes are sustained over time***. Underpinning this, of course, is the work that is being done around the vision and values that will guide and underpin actions and strategies. With respect to quality the vision and values will need to inform a set of descriptors of the kinds of personal outcomes for people that should be used as goals for good service quality. There are various examples of these available in the field and they offer some reference points for the discussion of quality for individuals and

more broadly. One example of these would be *Personal Outcome Measures* developed by the US based Council on Leadership and Quality. Such outcomes provide a useful starting point, particularly as they require a person – by person assessment, which at least is consistent with the proposed definition of quality. However the use of these would be meaningless if the threshold for their achievement is set too low. The audit of personal outcomes relies on a meet / do not meet criteria. Even developing them so that there was graded levels of achievement from “do not meet” through to “minimal achievement” through to “optimal achievement” would demand more discernment about what is actually being achieved and help guard against complacency about meeting a minimum standard.

Others matters of mutual concern that pertain to quality relate to the nature and capacity of the service system to provide relevant and potent supports. The Disability Reform Group and the Office of Disability will substantially take up these matters in its work on workforce planning, service reform matters, the nurturing of innovation and funding reform matters.

6.2 Needs of Government (funding bodies)

Disability ACT will be seen by the public and the field as having responsibility for ensuring the proper use of public monies and as the guarantor of ***provider capacity and capability to do the job responsibly***. Thus governments do need to be able judge providers. Furthermore it is conceivable that government should only fund providers who can demonstrate their capacity and capability to:

- Provide responsible care;
- Relate appropriately to service users and their families and understand how service users and their families prefer to be treated;
- Familiarity with the generally recommended practices and principles regarding the design of services that support people in the community routinely rather than occasionally;
- Assure people the “common sense” necessities of home life, etc – those matters that pertain to specific service types;
- Provide feasible safeguards for health, safety, & physical security;
- Manage administrative, financial and legal obligations;
- Protect people from abuse, mistreatment and neglect.

Thus government will need to be able to judge whether providers and staff provide responsible support and supervision of people's interests and well being.

One level of government responsibility should be in the realm of processes that would assist government to judge whether a provider should be entrusted with the job of supporting vulnerable people. This would be similar to establishing the

credentials of providers to do the job. In some systems this would be a form of licensing of providers or establishment of an approved register of providers. The formulation of guidelines and a mechanism to do this (which could include the national standards requirements) should be developed with considerable consultation with providers, service users, families and advocates. Such guidelines should be developed with a view to determining whether a provider can do the job responsibly. In some jurisdictions providers would need to pre-qualify in order to receive funding. Thus failure to meet guidelines would result in the loss of contracts automatically. In general this pre-qualification of review of the status of providers should be in the form of a rigorous ***third party audit or review***. It is stressed that such a process should incorporate more than the national standards and should seek to review the capability and capacity of providers.

A ***second level*** of monitoring of providers should be part of the ongoing service agreement / contracting environment and relates to the monitoring of the quality of service person by person, and home by home, where people share a house and support. Here a level of review of arrangements for each person (and household) should be developed as discussed above. Providers should demonstrate that such review is being undertaken and this should be taken up in a routine way as part of the negotiations around service agreements and contracts.

Additionally both providers and service users (and their families or advocates) should be able to register concerns and issues directly with the funder. In most instances it is expected that agreements about how to resolve such matters will be reached voluntarily. Such agreements could become either variations or specific items to be attached to a service agreement or contract. Formal complaint mechanisms would be a further level of safeguard on these matters.

6.3 Service Providers

Service Providers need a whole range of developmental, preventative and corrective safeguards in place to deliver high quality service. Providers will need to ensure robust safeguards around individuals and safeguards at the program and organisational level.

At the individual level, this will require deep clarification of the vulnerabilities of service users, identification and recognition of the person's most fundamental needs and priorities, and negotiation with the person being served and their family and /or advocates. Clarity about the role of service in the person's life will be a crucial.

At the program and organisational level, many of the points that have been made about the qualities of staff are most crucial. Safeguards should include

extensive preparation of staff in regards the values that guide the service, selection of staff who are right for the job, ongoing training and role clarification with staff, educational experiences, reliable supervision and management of staff, etc.

Providers will also benefit from development and probing of their 'model of service' through consultation with consumers, educational experiences for the Boards, staff and consumers on what is possible, and the use of external consultants to probe areas of service where satisfactory progress is not being made. The submission of plans and proposals to internal and external comment and critique, and visits and exchanges with exemplary services are also useful safeguards.

Corrective safeguards include staff supervision, engagement with service users, families and advocates about noted shortcomings, consumer complaint mechanisms, access to external advocates for services users, and external evaluation amongst others.

Thus providers need to create a reliable, but dynamic program, which embraces critical thinking and analysis, and sees the quest for high quality as an on-going issue and matter.

The introduction of quality management systems and accreditation systems should be at the discretion of the provider. It is accepted that the value of these systems applied in a standardised way has not been established. What cannot be discretionary is the responsibility for service quality and the presence of robust mechanisms for review and evaluation within a service.

6.4 Service Users

One key element of quality service provision as referenced above is the ***delegation of sufficient personal authority to service users*** (and their families and advocates as appropriate) to influence service and to determine the quality of it. This implies a conscious strategy to offset the substantial powers of funders, providers, professionals and staff. This is crucial in developing a shift in culture of how service is provided. Some of the authorities that should be delegated to service users and their families is the authority to imagine "better", the ability to accept or refuse services as offered and to propose alternatives, and to have considerable say over how supports and resources are implemented.

It follows that providers need to develop an internal culture that would support such relationships with service users and that service users should have the option to raise issues with the funder or without side bodies if they have been unable to do this with their provider to their satisfaction.

It also follows that service users and their families or advocates as appropriate should be key informants to the person-by person, and household by household reviews discussed above. (Point 6.1 above) Likewise they should be empowered to be part of conducting the reviews and evaluations of services discussed above. (6.1 above)

7. Summary of DRG Recommendations

In summary of the above, the Disability Reform Group makes the following recommendations. See Appendix 1.

- 7.1. Disability ACT in partnership with service users, families and providers should develop a quality framework for disability services in the ACT.
- 7.2. The ***definition of quality*** in such a framework ought to be concerned primarily with the outcomes for each and every person that relies on any service for support and whether these outcomes are sustained over time.
- 7.3. The quality framework should recognise and provide for strategies that incorporate the following as key determinants of quality.
 - Investment in values engagement and ethics
 - Investment in people in provide services, service users and their families and advocates
 - Workforce planning and the creation of an employment culture that fosters competence in service delivery
 - Empowerment of service users and their families and advocates
 - Relationships and partnerships with the community
 - Investment in innovation and innovators
 - Investment in critical thinking and analysis
- 7.4. A process should be developed that engages service users, families, advocates and service providers in seeking broad agreement to the above definition of quality and key investments.
- 7.5. Consistent with the proposed definition of quality, a set of descriptors of personal outcomes for service users should be adopted, modified or adapted. These should reflect the draft vision and values statement, and become a reference point for assessing quality service as it pertains to each individual.

- 7.6. Such descriptors should reflected graded levels of achievement from non-achievement, through to achievement of a minimum level through to optimal levels.
- 7.7. Providers should develop internal mechanisms that would enable them to review person by person (and household by household, if appropriate) their achievement of the personal outcomes for each individual.
- 7.8. In order to receive funding, it is proposed that Service Providers must demonstrate that their capacity and capability to:
- Provide responsible care;
 - Relate appropriately to service users and their families and understand how service users and their families prefer to be treated;
 - Familiarity with the generally recommended practices and principles regarding the design of services that support people in the community routinely rather than occasionally;
 - Assure people the “common sense” necessities of home life, etc – those matters that pertain to specific service types;
 - Provide feasible safeguards for health, safety, & physical security;
 - Manage administrative, financial and legal obligations;
 - Protect people from abuse, mistreatment and neglect.

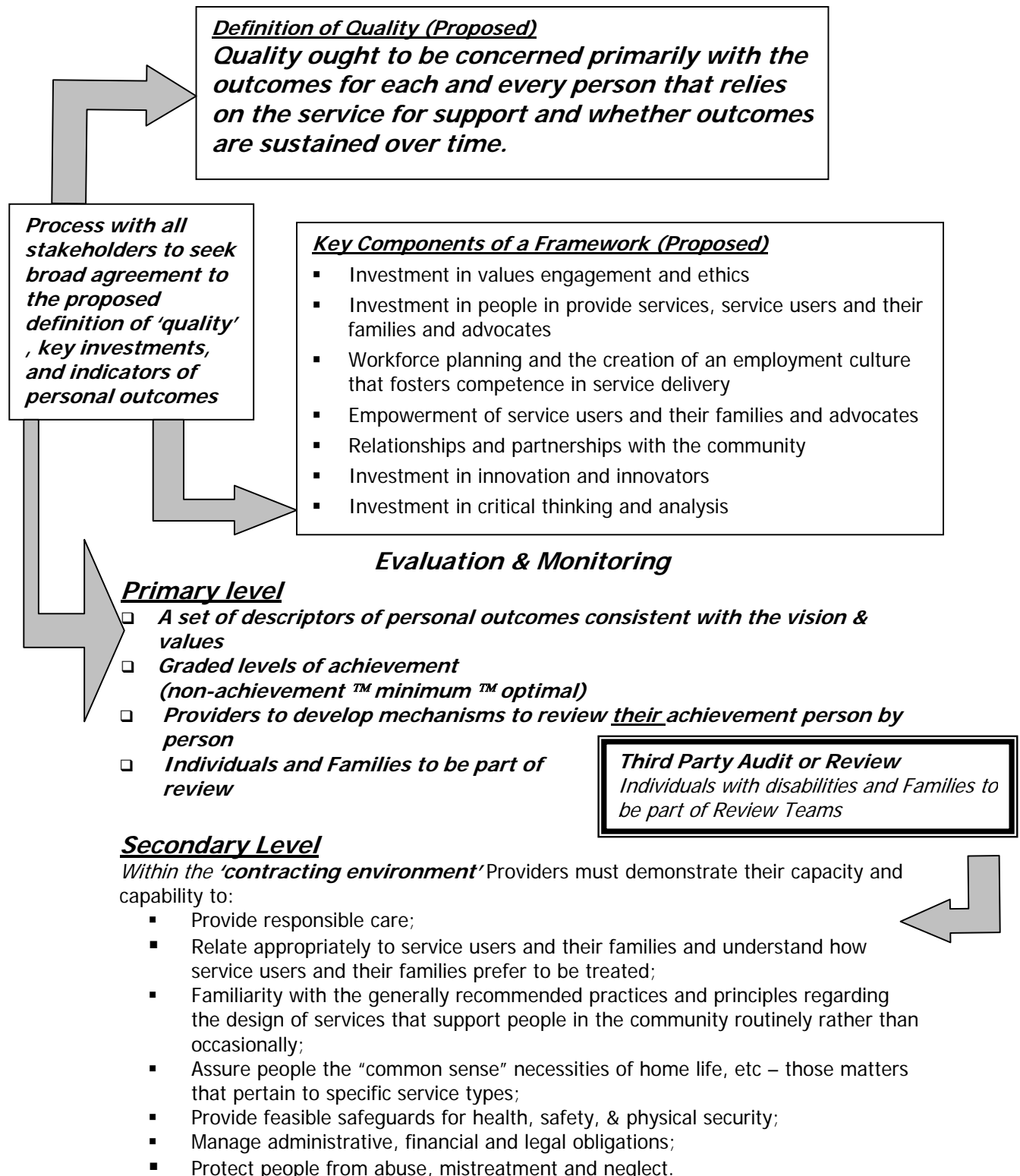
Failure to demonstrate such capacity would result in loss of contracts.

- 7.9. Disability ACT should, in consultation with service providers, service users and their families and allies, formulate guidelines and a mechanism for determining Service Provider capacity and capability to provide services responsibility. Such guidelines should incorporate the national standards and other significant matters in Recommendation 7.7 that pertain to provider capacity.
- 7.10. The mechanism for determining provider capacity should include a rigorous third party audit or review at least every three years.
- 7.11. As part contract negotiations and management, providers should provide evidence of person by person reviews that reflect at least the personal outcomes that are developed and agreed as per recommendation 7.5.
- 7.12. Disability ACT should undertake negotiations with the HACC programme and other funding bodies to see if agreement can be reached about the

use of one approach to standards and reviews in agencies that receive funding from multiple sources.

- 7.13. Service users, (families and advocates) and service providers should be able to register concerns and issues that pertain to the quality of service directly with the funder.
- 7.14. Voluntary agreements about how to resolve such matters should become variations or specific items in contracts between the funder and providers.
- 7.15. Matters that are not resolved satisfactorily and voluntarily should be referred to the appropriate external complaint mechanism.
- 7.16. Contracts and prices should reflect the wide range of internal safeguards that providers should have in place in order to provider quality services.
- 7.16. Service users should be empowered with sufficient authority to influence the services they receive. Such authority should include the authority to imagine better, to accept or refuse proposed services, to propose alternatives and to have considerable say over how resources and supports are deployed.
- 7.17. Service providers must be able to demonstrate what practical steps they have taken to delegate such authority and support service users to exercise such authority.
- 7.18. Service users (and their families and advocates) should be empowered to participate in reviews of their arrangements.
- 7.19. Service users (and their families and advocates) should be supported to participate as team members in reviews and audits.

Quality Framework



References

- Australian Government
Disability Services Standards
- Australian Quality Council (1999)
Australian Business Excellence Framework
- Capie, Angus, Stands and Monitoring Services Trust (SAMS) (1997)
Quality Assurance and Service Monitoring – A Consumer/ Family Based Approach,
Directions and Reforms in Queensland Forum, Brisbane.
- Community Resource Unit (1998 and various)
Thoughts about Quality and Service Monitoring, CRUcial Times.
- Disability Reform Group
Minutes of meetings, 9th July 2002
- Kendrick, Michael, (2000)
An Evaluation of the Nova Scotia Community Based Options Community Residential Service System
- Richardson, Bev, (1998)
Quality Management for the Community Sector, Institute for Healthy Communities.
- Quality Improvement Council (1999)
The CHASP Continuous Quality Improvement Cycle
- The Accreditation Council on Services for People with Disabilities (1995)
Putting Outcomes Into Action, Maryland USA
- The Accreditation Council on Services for People with Disabilities
A Guide to Accreditation through the Independent Quality Review
Maryland, USA
- The Council on Quality and Leadership in Supports for People with Disabilities (1997)
Personal Outcome Measures, Maryland USA
- Disability Services Queensland (2002)
Queensland Disability Standards Framework – DRAFT

Disability Services Queensland (undated)
Quality framework for the Disability Sector in Queensland

Queensland Chamber of Commerce (1995)
Quality Assurance Information Paper, Quality Development Unit.