Submission by the Australian Nursing and Midwifery Federation

ANMF Submission to the Independent Evaluation of Star Ratings for Residential Aged Care

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 326,000 nurses, midwives and care-workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF thanks the Department of Health and Aged Care and Allen + Clarke Consulting for the opportunity to provide a submission on the independent evaluation of star ratings in residential aged care following our videoconference on the 31st of May.

Relevance

1. Do you think Star Ratings accurately reflect the quality of care provided to aged care residents?

7. Based on the limited existing evidence regarding the Australian aged care star rating system, it is premature to establish the degree to which the rating system accurately reflects the quality of care provided to aged care residents. While the star rating system might be a useful tool for consumers in terms of providing information to help investigate and compare nursing homes, any ratings (and the data that underpins them) must be up to date, robust and valid in terms of specifically measuring care quality, and rigorously collected in order to provide an accurate reflection of care.

8. To assert that higher star ratings unproblematically reflect *care quality* could be viewed as misleading as the star ratings are an abstraction of several domains that each relate to, but do not necessarily directly measure, the quality of care. It is important, however, to recognise that the star rating system was not designed to 'accurately reflect the quality of care' but rather the primary objective of the star rating system is to provide consumers with a readily understandable means of comparing nursing homes based on the domains captured by the star rating system. Star ratings are a simplified and abstracted representation of the measures the rating system incorporates and not an accurate depiction of care complexity and quality for aged care residents.

9. The ratings, particularly the staffing component, are not clearly based on evidence in that rather than being built around the care time that residents *should* receive based on their needs and preferences and the aim to provide best practice, high quality, dignified care. The care times and cut offs between star ratings are based instead on the current legislation which itself arose from the Royal Commission's recommended 200 minutes of care per day including 40 minutes of registered nurse care time, which does not appear to have a clear basis in evidence.[1] The ANMF highlights that our 2016 research found that the average 4 hours and 18 minutes of resident and personal care hours per day with a

skills mix requirement of registered nurses (77.4 minutes/30%), enrolled nurses (51.6 minutes/20%) and personal care workers (129 minutes/50%) is the evidence based minimum care requirement and skills mix to ensure safe residential and restorative care. A rating system that suggests that "acceptable care" can be little as 75% of the average 40-minute direct care target for registered nurses with 200 minutes of overall average care time cannot accurately reflect quality care.

10. Unlike the United States' (US) Centers for Medicare & Medicaid Services (CMS) Nursing Home Compare (NHC) star rating system, the Australian version (which was largely transplanted from the US) includes a consumer experience component. Little published evidence is yet available regarding how well the star rating system performs in Australia, however it is important to recognise that research on the US CMS NHC system found that their star rating system does not adequately reflect consumer satisfaction.[2,3]

11. An unpublished discussion paper has reported significant concerns with the utility and accuracy of the star rating system in Australia, with considerable discrepancies between the guidelines and publicly reported data that might skew ratings towards higher star levels than what should be conferred to homes.[4] It is also important to consider consumer perspectives on how well the star rating system represents care quality. Here, do consumers agree that a three star rating for staffing is appropriately defined as "acceptable" when previously, a five star rating has been described as representing "best practice"?[5] All nursing home residents should be able to expect best practice care and staffing, not what has been determined to be minimally acceptable.

12. Further issues can be highlighted in terms of whether the star rating system accurately reflects the care quality provided to aged care residents. For the 'quality measures' rating, points are allotted to homes based on relative performance across five specified quality measures. These measures, while important, aren't the only measures needed to understand the full picture of care quality. Further, as the points and star ratings are given relative to the performance of other homes, while this might provide consumers

with a useful insight into how nursing homes compare on this measure in a broad sense, it might not provide detailed and specific insight into the care quality provided at a particular home especially where the resident profile of a home in terms of acuity is difficult to compare with that of other homes. Here, a home with residents that are generally younger, healthier, and less likely to experience issues such as pressure injuries, restrictive practices, unplanned weight loss, falls and major injury, and medication management issues are more readily able to achieve a higher star rating than homes with a different resident profile not necessarily because care is better quality.

13. Another issue is that while the experience of residents is undoubtedly important and useful for consumers to understand the perspectives of other older people, it is a surrogate and subjective measure of care quality based on 14 survey questions administered to only 10 percent of a nursing home's residents. Further, questions cover issues that, while important, do not all directly or clearly relate to the quality of care. For example, "do you like the food here?", "is this place well run?", and "how likely are you to recommend this residential aged care home to someone?" do provide important though subjective information about a nursing home that other consumers are likely to want to know for decision making purposes, but do not relate clearly to the quality of care delivery.

14. A large volume of high-quality evidence demonstrates the association between staffing – particularly registered nurses – and higher quality care. A recent study from the United States (US) found that while mandatory public reporting can help to hold nursing homes accountable for quality outcomes, it does not improve staffing ratios based on observations over eight years.[6] In this study, very few significant relationships were found between staffing ratios and the overall star rating a nursing home possessed, which could highlight that mandatory public reporting in this way is ineffective in terms of improving staffing. This study also found that decreasing the number of residents assigned to a registered nurse resulted in an increase in staffing ratings.[6] Here, the authors highlight that resident to nurse ratios were significantly higher at night, which is unsurprising as

many facilities staff fewer nurses overnight partly due to the misconception that most residents sleep continually over night despite knowledge that many residents have issues such as cognitive impairment or dementia that can cause fragmented sleep and greater risk of falls and mortality. This shows how star ratings might obfuscate issues with staffing and quality of care. This is also evident in another study from the US that found that reporting daily variation in staffing might be necessary to improve understanding of the relationship between staffing and quality due to the finding that two facilities with the same average staffing are able to achieve different levels of quality in terms of resident care and survey ratings based on differing day-to-day variations in staffing.[7]

15. Another recent study from the US examined how nursing homes with different star ratings responded to hurricane Irma in terms of estimated direct care nurse staffing.[8] The authors found that overall star rating was positively associated with higher staffing levels for registered nurses, licenced practical nurses, and certified nursing assistants during the hurricane. The change in staffing was largest for five-star facilities and lowest for one-star facilities. Here, it is important to recognise that the star ratings of the facility did not *cause* higher (or lower) staffing during the crisis, and rather highlights that facilities with higher star ratings were better able to respond to the event with more staff while lower rated facilities were not. Importantly, this study noted that lower rated facilities tended to care for people from vulnerable ethnic and racial backgrounds and people from low socioeconomic status groups in comparison to higher rated facilities. The authors concluded that facilities with lower staffing levels during 'business as usual' times (i.e., when a crisis is not unfolding) might be particularly unprepared to response to crises and that increased staffing requirements and resource availability during disasters should be considered.[8]

16. The ANMF highlights that the study above might provide evidence that could be reasonably transferred to the Australian context. We advance, based on this evidence, that nursing homes with lower star ratings (especially for the staffing component) might reasonably be considered at greater risk of worse preparedness for responding to crises

such as infectious disease outbreaks/pandemics, cyclones, bushfires, and floods in comparison to nursing homes with higher star ratings. Combined with the observation that lower rated facilities often tend to care for people from more vulnerable and low socioeconomic backgrounds, this highlights a critical issue in terms of equity where residents of higher rated homes are safer than residents in lower rated homes during an unfolding crisis and could allude to the risk of a widening gap in terms of care quality between low rated and high rated facilities that has been observed in the US.[9,10]

17. This issue of equity must also be reflected upon in terms of where nursing homes are situated and whether or not there is a difference in the vulnerability of homes of different star ratings. Nursing homes in areas with relatively larger populations of vulnerable people of low socioeconomic status (SES) are likely to be more vulnerable to crises that detrimentally impact health and wellbeing including disease outbreaks and natural disasters. Based on evidence from the US, counties with average adjusted overall, nurse staffing, and quality measure star ratings below 3 stars appeared to be clustered in the South where counties associated with lower SES and more vulnerable populations are more likely to live.[11] The authors of this paper highlighted that residents in socioeconomically disadvantaged counties experience disparities in accessing nursing homes with higher star ratings which is likely to persist or even worsen. These areas may lack sufficient resources to adequately staff the facility and deliver care that meets industry quality standards. In this study of 15,090 Medicaid/Medicare-certified nursing homes, based on six county-level SES characteristics (median household income, percentage of high school graduates or above, percentage of population below 100% federal poverty level (FPL), median owner-occupied house value, labour force participation rate, and unemployment rate in the population 16 years and older) nursing homes in counties with the highest SES received 3.84 stars, 4.23 stars, and 3.52 stars, on average, nurse staffing, and quality measure star ratings respectively, which were significantly higher than those in counties with the lowest SES [difference between marginal means (95% CI): overall: 0.18 (0.03, 0.33); nurse staffing: 0.48 (0.27, 0.68); quality measure: 0.23 (0.07, 0.39)]. The authors suggest that lower SES counties receiving

lower star ratings may be due resource scarcity in these underprivileged areas, and the low income of facilities, as a result of serving underprivileged communities, are unable to afford adequate resources and staffing to improve their care quality. Placed in the context of the Australian aged care system, this may suggest that as with the US,[12] low rated facilities are unevenly located in low SES areas where recourse scarcities are prevalent, and without government investment may be unable to increase the quality of care they provide

18. In another US study of geographic variations in availability and quality of nursing home care found the correlation of high availability of nursing homes and the presence of 5-star homes was 0.33 (95% CI 0.30–0.36), suggesting that people in regions that have high availability of nursing home care may not receive high-quality care, suggesting that the competition does not drive improvement.[13]

2. To what extent do Star Ratings align with the priorities and needs of different users: including older people and their representatives, care finders, and providers?

19. The ANMF has previously raised concerns that the star rating system could contribute to growing disparities in equity in access to safe, high-quality, dignified residential aged care. Put simply; there is a real risk that nursing homes that are able, due to greater resources – especially funding, and more committed to achieving higher star ratings become inaccessible to people with less means. This observation is supported by research from the US where public reporting in the setting of post-acute care can have mixed effects on areas without public reporting.[9] In this study, improvements in unreported care were particularly large among facilities with high ratings or that significantly improved on reported measures, whereas low-rated facilities experienced no change or worsening of their unreported quality of care. While the benefits of public reporting may theoretically extend beyond areas that are being directly measured, public reporting initiatives may also widen the gap between high-rated and low-rated facilities as consumers may tend to select high-rated providers which increases their market share and revenue. Similar conclusions were also indicated in another study which found that

while when the star rating system was introduced, US 'dual eligibles' (residents dually enrolled in Medicare and Medicaid) chose higher-rated nursing homes initially, over time, the increased likelihood of choosing the highest-rated homes was substantially smaller for dual eligibles than for non–dual eligibles. [12] This indicates that more vulnerable consumers with fewer resources may have been priced-out of higher rated facilities. Furthermore, the benefit of the five-star system to dual eligibles was largely due to providers' improving their ratings, not to consumers' choosing different providers. Evidence appeared to suggest that supply constraints played a role in limiting dual eligibles' responses to quality ratings, as high-quality providers tended to be located closer to relatively affluent areas.

20. There is evidence from the US that shows that there are problems with equity disparities between people in lower starred versus higher starred homes where people from vulnerable and disadvantaged groups including people from ethnic and racial minorities and low socioeconomic status backgrounds tend to be more likely to be living in lower starred homes. This shows that those who often have the greatest need of care are not being equitably provided with that care by nursing homes with lower star ratings. A 2019 study from the US found that vulnerable and disadvantaged groups are more likely than others to be discharged from hospital to nursing homes that are of lower rating.[10] In another US study, people discharged from the lowest quality (one-star) nursing homes spend significantly less time at home than those discharged from higher quality nursing homes.[14]

3. How well do Star Ratings address the specific challenges and requirements of residents from diverse backgrounds (including those with cognitive impairment or dementia, First Nations peoples, people who speak a language other than English, people living in regional, rural, and remote communities, and people who identify as LGBTQI+)?

21. At this stage, there is little to no evidence regarding the extent to which the star rating system is relevant to or addresses the specific challenges and requirements of residents from different backgrounds. Because the rating system does not appear to have been developed with particular attention to meeting the needs and preferences of these

groups or collecting and measuring data that is of particular relevance or sensitivity to them, it would be reasonable to expect that the system does not and would be unlikely to be of particular utility to these groups.

3a. What measures can be implemented to enhance the relevance and effectiveness of Star Ratings to meet the diverse needs of different users?

22. The ANMF recommends that the Department engage with members of diverse groups and their representatives in order to determine what their needs and preferences are and how the star rating system might be able to be improved to capture and depict data that is relevant to them and convey it in a way that is understandable, accurate, and useful. It is important to acknowledge that the decision to enter residential aged care or admit a loved one to a nursing home is often done on an emergent and needs basis, rather than following a 'compare the market' approach. Many consumers have limited choice due to geography or means and might need to follow more of a 'take what's available'/'any bed is better than no bed' path. Star ratings are not helpful in this situation and could even be frustrating by emphasising a lack of choice in some situations (e.g., a rural town with only one nursing home).

23. While the star rating system is not intended to be a tool used by workers/staff, future improvements and expansion of the tool could build in measures that incorporate staff perspectives and insight into care quality, staffing, care delivery, and a range of other issues including perceptions regarding their workplace and employer. These might also be helpful measures for consumers to consider in their own decision making.

24. The ANMF also wishes to highlight our view that the overall star rating disproportionately weights staffing relative to other factors, such as the largely self-reported compliance section. Domains of the rating system also appear ill-matched and disconnected. For example, staffing, or the absence of sufficient staffing directly impacts all other categories. This is demonstrated though the sub-category 'Quality Measures'. This uses data inputs such as incidence of pressure injuries, falls and Serious Incidents (SIRs), all of which are directly impacted by the level of staffing, and despite this it is possible to rate

low on staffing and high on quality measures.

25. The Royal Commission into Aged Care Quality and Safety specifically linked substandard care, including lack of access to health care, to inadequate staffing levels, skill mix and training, an issue which it cited as a systemic problem. Furthermore, throughout the Royal Commission lack of transparency was seen as a prevalent issue. This lack of transparency can mask unacceptable and poor practices from the line of sight of consumers. This mask is enhanced, not removed through the current weighting of individual measures used to determine star ratings. An example of how the weighting of star ratings shields quality from consumers is evidenced below.

26. Aged Care Watch provides a medium where people can report understaffing and other quality of care concerns. An outlier in the Newcastle, New South Wales (NSW) region with 42 separate reports is Cameron Park Care Community which details multiple concerns raised regarding understaffing and poor care resulting in people left soiled and distressed for extended periods. On MyAgedCare, this service has an overall star rating of three which is defined as 'acceptable' and a four-star rating ('good') for compliance. Its staffing levels are rated two-stars indicating that improvement is needed. Noting this service is not recorded as having been assessed for compliance since 2022, a member of the public could easily be misled if basing information purely on overall star-ratings as reported on the government website. Dubbo Homestead Care Community in NSW provides a second example, another outlier with 105 individual reports on AgedCareWatch, including understaffing, residents left soiled and distressed, loss of social care and meal disruption, but currently has an overall star rating of three on MyAgedCare. This service has a four-star rating for compliance, including fully meeting clinical, staffing, and care needs, and yet a two-star rating for staffing as determined by the aged care regulator. Two entries made in January 2024, included in the 105 reports made by workers via AgedCareWatch at Dubbo Homestead, are reported below.

    a. *"The model of care isn't working at Dubbo….We have not had full staff since new*

model of care came in on 4th December…we are totally exhausted. On the 9.30 – 19.30 shift today I was made to go into the kitchen as they were short on kitchen staff, correct me if I'm wrong but how can they order a nurse to work in the kitchen and more importantly how is that care minutes?"

b. *"…the residents have gone backwards under Opal's new model of care, there has been NO increase in minutes of resident's care minutes, we are interacting with residents less not more. Opal has…cut out the Lifestyle Staff and are cutting back on kitchen staff and using the Governments increase in residents care minutes by getting care staff to do lifestyle staff duties and getting care staff to do work in the kitchen but putting them on the roster as AIN…Due to lack of care time I have to say "No" to residents multiple times a shift…Lack of care time outcomes: distressed residents, planned residents meals changed, areas not cleaned to expected standard, residents missed out on planned lifestyle activities, workers required to perform tasks outside the scope of their role, stressed staff members, staff experienced abuse, residents not receiving adequate care".*

27. Star ratings, determined without the input or involvement of those delivering direct care cannot provide a source of transparency or truth for the public on quality of care. Star ratings must use a methodology which captures a broader range of inputs, including the voice of direct care workers and mediums such as AgedCareWatch. Star ratings must also be able to rely on the Aged Care Quality and Safety Commission's ability to accurately determine compliance in a more reactive way than currently exists. A simple mapping of AgedCareWatch against MyAgedCare reveals a disconnect between what the regulator and government believes is the status of a facility, against what those accessing the service are reporting.

28. It is unclear if compliance with mandatory care minute obligations is one of the types of compliance factored into the Compliance sub-category, leading to a perverse outcome in which it appears to be possible for a facility to routinely be failing to meet direct care

minutes and registered care minutes under the staffing sub-category, but nonetheless be reported as being excellent in compliance. For example, Bupa Baulkam Hills, in metropolitan Sydney has consistently failed to comply with mandatory care minutes and been given two stars – needs improvement, for more than 12 months. The provider reported being 52 minutes below mandatory care minute obligations in the last reporting period, and yet has in the previous quarter been rated as 'excellent' in Compliance. One ANMF NSW member at the facility expressed it this way: "*Our residents should be receiving a higher level of care with more staff to attend to their needs. They are not getting the care they deserve, which they and the government have paid for*".

Awareness and Decision-Making

4. What is the level of awareness about Star Ratings among individuals making decisions about aged care for themselves or someone else?

29. At this stage, there is little to no evidence regarding how aware these decision makers are about the star ratings.

4a. What can be done to increase awareness of Star Ratings particularly among hard-to-reach consumers (including those with cognitive impairment or dementia, First Nations peoples, people who speak a language other than English, people living in regional, rural, and remote communities, and people who identify as LGBTQI+)?

30. The ANMF recommends that the Department of Health and Aged Care consult with members and representatives from these groups to determine the most effective and appropriate ways to increase awareness of the star rating system and draw on past research and evaluations of strategies/interventions that have been used previously to inform future efforts to raise awareness. It is important to recognise that it might be likely that there are groups of consumers who simply will not access or be aware of star ratings and that there might be need for multiple modes of communication for diverse audiences.

5.To what extent do Star Ratings influence the decision-making processes of older people and their representatives when choosing a residential aged care home?

31. At this stage, the extent to which the star rating system influences older people and their representatives when choosing a nursing home appears to be unclear based on little to no evidence.

6. Have Star Ratings contributed to increased consumer confidence in choosing a residential aged care home?

32. The extent to which increased consumer confidence has risen from the adoption of the star rating system cannot be measured as there appears to be little to no evidence pertaining to this. Based on available media reports on the star rating system, it appears that issues with currency, inconsistency, and accuracy might be likely to have concerned some consumers which might negatively influence their confidence basing decision making on the star rating system.

Continuous Improvement

7. Have Star Ratings driven improvements in care quality and care outcomes? If so, what changes have you observed and what influenced this change?

33. There is little to no evidence to date based on Australian data that we are aware of to enable us to observe whether or not the star rating system has driven improvements in care quality and care outcomes. As above, it is important to recognise that as an approach intended to assist with informing consumers, the star rating system cannot be expected to directly improve care quality and care outcomes. It is also important to acknowledge that from a regulatory perspective, some aged care providers do not always do the right thing, even with the threat of sanctions. Some providers are known to ignore their obligations under industrial agreement requirements, fail accreditation requirements, and some performed very badly throughout the COVID-19 pandemic despite intense scrutiny. Expecting that a star ratings system will do much to drive safety and quality improvements could be overly hopeful.

34. In a study from the US, improvements in nursing home star ratings after the release of the 5-star rating system were not accompanied by improvements in a broader measure of outcomes for post-acute care patients in terms of hospitalisations.[15] While the authors highlighted that it was unclear if this was due to better matching of sicker patients to higher-quality nursing homes or superficial improvements by nursing homes to increase their ratings without substantial investments in quality improvement, the 5-star ratings became less meaningful as an indicator of nursing home quality for post-acute care patients.

35. There is evidence based on the rating system used in the US which shows that higher rated homes have performed better across a number of metrics such as where nursing home quality ratings have been found to be associated with COVID-19 incidence, mortality, and persistence.[16,17]

36. Evidence from the US also shows that star rating systems could improve, better help users find nursing homes of higher quality, and stimulate homes to improve quality in ways that benefit residents by incorporating outcomes measures such as preventable hospitalisations and emergency department visits.[18]

Expansion to National Aboriginal Torres Strait Islander Flexible Aged Care (NATSIFAC) and Multi-Purpose Services (MPS)

8. Should Star Ratings be expanded to NATSIFAC services and MPS?

37. The ANMF suggests that the current star rating system could be adapted and expanded to NATSIFAC and MPS, but better evidence is needed regarding the current system's performance and appropriateness before rolling it out further.

8a. What are the potential benefits of publishing Star Ratings for MPS and NATSIFAC services?

38. The potential benefits of publishing star ratings for MPS and NATSIFAC services could be anticipated to be similar to those associated with the mainstream star rating system and likewise are dependent on the system's effectiveness, accuracy, and fitness for purpose.

8b. What potential challenges and barriers would need to be considered when implementing Star Ratings for MPS and NATSIFAC service types?

39. Both NATSIFAC and MPS services are distinct from 'mainstream' nursing homes and are more likely to be in rural/regional/remote areas which might also have larger populations of people from lower SES backgrounds. Any roll out to these settings must be done carefully and based on a thorough assessment of potential barriers and challenges including evaluation of local and international evidence. Implementing star ratings in these contexts will need to be underpinned by diligent engagement and consultation with stakeholders including the ANMF.

Refinement

9. Star Ratings is made up of four sub-categories: Residents' Experience, Compliance, Staffing, and Quality Measures

9a. Do you think the way Star Ratings are weighted is appropriate? If not, what weightings should each sub-category contribute to the Overall Star Rating?

40. The ANMF submits that based on the extensive, high-quality evidence that staffing, particularly registered nurses, plays a fundamental and significant role in the quality of nursing home care, the weighting apportioned to staffing should be increased.

41. The ANMF is concerned that providers can attain an overall four- or five-star rating despite non-compliance with mandated care minutes and a low (1- or 2-star rating) for staffing. The latest Quarterly Financial Snapshot for Quarter 1 2023-24, noting there is a significant lag in publication of the data, shows that the sector average is 196 minutes per resident per day with 38 minutes of that delivered by a registered nurse. This represents an average shortfall of 4 minutes across the sector. It is unacceptable to the ANMF that a 5-star rating can be achieved without care minute compliance. Care minutes and registered nurse requirements are not subject to strong regulatory monitoring and enforcement. Despite the sector failing to meet the current mandated care minute requirements, and with it highly unlikely care minutes will increase rapidly enough to meet the new requirements taking effect in October 2024, the Aged Care Quality and

Safety Commission is not effectively regulating staffing practices. This is why the ANMF advocates for care minutes to be a core and explicit inclusion in the new Aged Care Act, as opposed to being held only in subordinate legislation where it is exposed to the risk of disallowance. Not only would this signal to the sector the importance of safe staffing and skills mix, it would also ensure that a provider's failure to comply with care minute requirements is subject to a suite of strengthened regulatory mechanisms set out in the new Aged Care Act. The ANMF recommends these measures include a worker advisory committee empowered to report on staffing non-compliance, as the higher weighting for staffing under star ratings.

9b. Are there any changes to these sub-categories or additional information that you would like incorporated into Star Ratings?

42. The ANMF recommends that the star rating system be updated to specifically incorporate reporting of enrolled nurse minutes. Further, care in nursing homes, while largely provided by nurses and care workers, is also delivered by a range of other staff including doctors, specialists, and allied healthcare professionals. There should be consideration of how care provided by these groups contributes and could be reported in a more comprehensive rating system.

43. Further work must be done to ensure that the rating system more accurately, meaningful, and effectively reports on care quality. Other data that could be included could be in relation to interfaces with the wider healthcare sector such as hospital and emergency department transfers (unwarranted and warranted),[19] palliative and end of life care,[20] use of agency and temporary staff,[21] and a range of other nurse-sensitive outcome indicators.[22] The ANMF refers the Department to our recent submission to the consultation for the expansion of the national aged care mandatory quality indicator program which contains important considerations regarding quality indicators that might be usefully incorporated into a robust star rating system.[23]

10. Does the Star Ratings reporting process facilitate data accuracy, ensure the timeliness of published data, and reduce the reporting burden on service providers?

44. While the ANMF cannot speak on behalf of providers and will continue to advocate for increased transparency and reporting, because many measures that contribute to the star rating system are derived from preexisting data collection mechanisms, the reporting burden placed on service providers would appear to be minor. As providers are only required to enter readily available data regarding staffing and quality measures, there should be no issues in ensuring the timeliness of data provision. Punitive action for delayed provision of this data (such as receiving a 1-star rating for that category) must be maintained to ensure the continued commitment by providers to deliver this information in a timely manner. Further action must also come into effect for providers who continue to fail to meet this requirement including sanctions. It is also concerning that some providers are being creative in their reporting of care minute data (e.g., who they include, changes to hotel and food services etc.). Here, the regulator must have processes that are robust and frequent enough to reduce gaming so that users can be confident in the validity and reliability of data submitted by providers.

45. In a recent discussion paper, Aged Care Consulting & Advisory Services Australasia suggests that the accuracy of public Star Ratings data has not been achieved, and that star ratings may not be reflective of the reality experienced in aged care facilities.[4] The report estimates that between 1 July 2023 – 12 December 2023 of the 152 services identified on the Non-Compliance Register at least 65 facilities were incorrectly reported. Further a significant proportion of non-compliant homes were self-rated between three to five stars for quality measures despite non-compliance with minimum basic standards. While this may be representative of rating errors in the weighting and calculation of the star ratings (which in of itself warrants an audit of star rating system), it also highlights concerns with the accuracy of data that is made publicly available for consumers to make informed decisions. Inaccuracies in data undercuts consumers trust in the star rating system.

46. Here, the ANMF requests that the transparency in the compliance measure is improved to ensure that consumers may make informed decisions. As stated by Peter Edwards (Executive Director of the Compliance Management Group) "*finding of non-compliance in itself does not impact a service's star rating; rather it is only where the Commission then uses its formal powers to require a service to take corrective action that a service's star rating will be impacted*."[24] This is of major concern to the ANMF, as this description of compliance does not align with consumer expectations, and there is potential for this to warp consumer decisions and make uninformed decisions towards non-compliant facilities. Here, the ANMF stresses that as the main goal of the star ratings is to provide understandable information to consumers, the ratings must be reflective of actual practice and indicative of the quality of care that consumers can expect to be provided within that facility. Additionally, the Aged Care Quality and Safety Commission (ACQSC) must be adequately resourced to identify provider gaming of the reporting process. Any identified pattern of gaming behaviour must be reflected in a reduced star rating and must initiate a formal response by the ACQSC.

47. As aged care providers self-report data that is used to inform that the quality measures and staffing sub-categories of the star ratings there is potential for data inaccuracies and for providers to game reporting responsibilities to achieve a higher rating and appear more compliant. Here, the ANMF highlights the need for frequent randomised audits and strategic auditing of discrepancies and questionable patterns of provided data to ensure accuracy. Further, this auditing should apply to the ratings provided by the department, through an independent party, to ensure that rating accuracy is upheld to a high standard and issues such as the one listed above do not occur.

11. Are there any adverse or unintended consequences that have arisen as a result of the introduction of Star Ratings?

48. At this early stage of implementation of the Australian star rating system, there is little evidence of specific adverse, unintended, or even intended consequences beyond what has already been explained above. The ANMF highlights that evidence from the US

(explained above) does include several adverse and unintended consequences that can arise following introduction of a similar rating system particularly in terms of equity of access and care quality.

12. What strategies can be employed to enhance coordination and coherence between Star Ratings and broader reforms aimed at improving aged care services?

49. The ANMF highlights that as the broader reforms in aged care progress, the star rating system will need to evolve and mature in tandem with regular reviews and audits to ensure that it is fit for purpose and not resulting in adverse or unintended consequences. It will be vital to ensure that as the care needs of residents increase, care times will in turn lengthen and this will have knock on impacts on the star rating system.

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