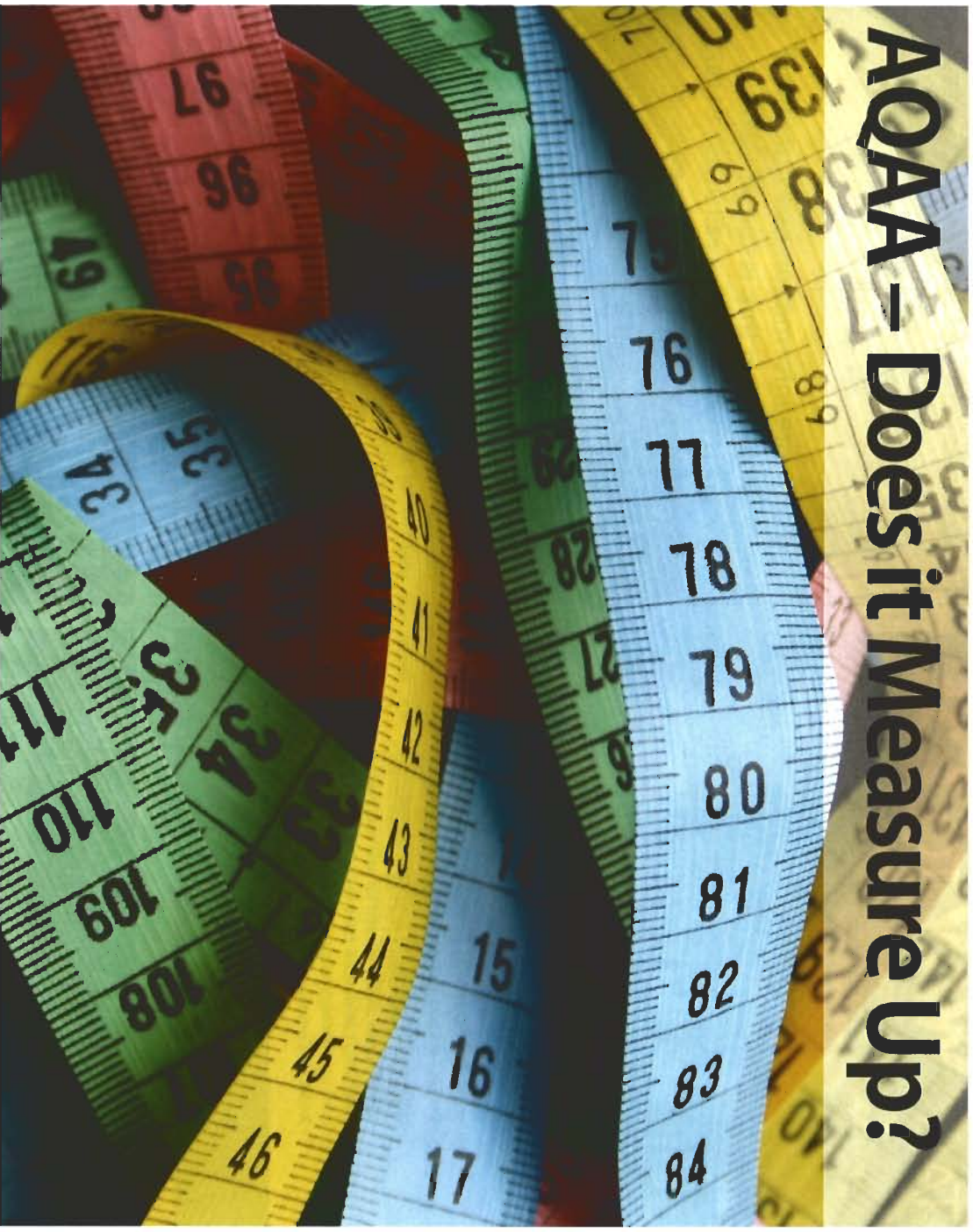


AQAA – Does it Measure Up?



The AQAA has received mixed responses from providers and the industry leading some to question what the CSCI intend to do with the information. Irving Stackpole and Elizabeth Ziemba explore the AQAA, what it aims to achieve and the limitations of its design.

'Disaster off the Scilly Isles: October 1707: Great Britain lost nearly an entire fleet of ships. Admiral Shovell, leading a fleet of warships, smashed his flagship into the rocks of the Scilly Isles in dense fog. One by one, the rest of the fleet, following behind the flagship, also went aground on the rocks. In all, four warships and 2,000 lives were lost. It wasn't that the

admiral was incompetent, but he wasn't able to measure something that he knew to be critical – longitude. Moreover, the command and control model of the time and circumstances almost required the others to follow. Because Admiral Shovell couldn't measure, the fleet was lost.' From Longitude by Dana Sobel.

As the sad story of Admiral Shovell demonstrates, the lack of accurate, reliable measurements or crucial data can have dire consequences. In an attempt to acquire accurate, reliable and crucial data to improve services in care homes, the Care Standards Act 2000 requires all registered care providers to complete the Annual Quality Assurance Assessment (AQAA). The AQAA is a two-part assessment

methodology designed and implemented by the Commission for Social Care Inspection (CSCI), as part of its Inspecting for Better Lives programme.

What are the implications of the AQAA and will the survey instruments and procedures generate the accurate, reliable and crucial data needed to bring about the stated goals of the programme? What results will the survey information

AQAA - DOES IT MEASURE UP?

produce? How can the results be used?

Shift of information gathering

According to the CSCI: 'The completed assessment is the main way that you [care providers] will let us know how well your service is delivering good outcomes for the people using it.' Historically, the CSCI has been responsible for social care inspections including twice-annual inspections of care home providers. These services have been provided at the cost of £122.5 million based on The Commission for Social Care Accounts 2005-6.

Under the AQAA, the CSCI is shifting the burden of inspections and monitoring onto the care providers themselves with a considerable cost savings to the regulator. According to one source:

“ The AQAA is a two-part assessment methodology designed and implemented by the Commission for Social Care Inspection as part of its Inspecting for Better Lives programme. **”**

'Despite the inevitable politicians' platitudes about "raising standards" by making providers "take responsibility" for the quality of their services, in reality this process involves shifting most of the burden of assessing whether a care home meets the National Minimum Standards onto the provider. This will save the CSCI millions and liberate inspectors from the traditional grind of twice-yearly inspections of all care homes so they can lock their radar on "poor" providers.'

The AQAA may result in time savings as well as a reduction in direct and indirect costs for care providers as the process shifts from twice annual pre-inspection surveys and the CSCI inspections to a once per year survey.

According to the English Community Care Association, the time to complete the AQAA varies between 5.5 to 12 hours - a considerable time and money savings for care home providers. Time to complete the survey may be reduced as providers become familiar with the survey instruments.

Some keen observers believe that the AQAA will focus providers' attention on the quality of care and the measures of good care, such as staff levels and training as well as understanding and complying with sound policies and procedures.

'Care providers are fully responsible for the care they provide and this process focuses them on that responsibility,' stated Des Kelly, Executive Director of the National Care Forum. ▶



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“ Questions that produce the best data are typically based on a rating scale.

” determine if they truly are ‘delivering good outcomes’? Outcomes measurement in health and human services is a set of disciplines that have been developed, honed and practiced for decades. By applying the principles established by those disciplines, it is unlikely that the AOQA, as its current format is designed, accomplishes the goal of measuring ‘good outcomes’ due to numerous methodological problems. To quote Professor Malcolm Morrison, University of Bristol,

Sheila Scott, Chief Executive of the National Care Association concurred: ‘This process is a very good internal quality audit requiring providers to look carefully at what they are doing well and those areas needing improvement. And over time, these self-assessments will be an excellent record for care providers as evidence that they are offering a good service.’

Examination of survey methodology
With this shift in burden for data collection from the CSCI to care providers, the question then becomes ‘Will the survey tools generate accurate, reliable and crucial data to identify care providers whose services require closer scrutiny?’ Will the assessment methodology allow care providers to

‘Methodologically, it is such a pickle!’
For a better understanding of the underlying flaws of the AOQA assessment tools, certain concepts behind good outcomes measurement require definition such as ‘objective’, ‘reliable’ and ‘lacking bias’.

Solid data collection is built on carefully crafted questions that produce objective and reliable answers that lack bias. Questions that produce the best data are typically based on a rating scale. Subjective questions are open-ended and the responses are more likely to change from day to day. ‘Reliable’ data is based on survey design that generates consistent responses over time

Example of an objective question with rated scales

Each service user’s plan is as drawn up based on a comprehensive assessment.

Each plan sets out in detail the actions staff need to take to meet the service user’s health, personal and social care needs.

	Completely Disagree					Completely Agree				
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	



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and between and among respondents. 'Lacking bias' refers to the neutrality of the format and content of the question being asked. When these basic survey design concepts are implemented, the survey results produce information that can be used to measure outcomes that, in turn, can be used confidently to make management and operations decisions.

The design of the AQAA Self Assessment portion consists of open-ended questions resulting in responses in the form of words or anecdote. By relying on anecdote for information, the risk of biased responses is high because such responses may be incomplete, ill informed or highly subjective. Data collected in this manner can result in lopsided, misleading results that can have unintended consequences for the care home. Let us look at an example.

The Health and Personal Care questions in the 'Self Assessment: Care Homes for Older People' are linked to the National Minimum Standards 7, 8, 9, 10 and 11 dealing with care planning; services; medication management; privacy and dignity and death and dying. The survey asks for a response to the statement 'What we do well'.

The range of possible responses to that statement is so broad, subjective and likely to be influenced by the bias of the respondent that it is difficult to generate information that can be used to assess the quality of service.

A far more effective method to gather objective and reliable information that is lacking in bias would be to draft specific questions with rated scales. For example, to evaluate the National Minimum Standard relating to service users' plans (Standard 7), a specific, objective, reliable question could be asked.



“ Care providers are well advised to be cautious about their responses. ”

Thinking about the service users' plans the example in the panel can be used.

The benefits of questions formatted with this type of rating scale are that they are easier to answer, provide responses that can be compared over time and from various respondents and are subject to substantially less bias. A response in the form of a number rather than words is easier to interpret and compare

could read all that and keep it sorted and then do anything with the insights? Computer based database engines are available that incorporate sophisticated text analyst software, but is that what's planned? The answers will be revealed over time but care providers are well advised to be cautious about their responses. Since the design of the AQAA does little to safeguard against biased responses, quality of care may be assessed as being much better or worse than it actually is resulting in misleading assessments. Martin Green, Chief Executive of the English Community Care Association warned: 'We advise our members to respond to the Self Assessment with an eye on the future.'

As with any new process, wrinkles will need to be ironed out and changes made as problems arise, inviting the active participation of care providers directly and through associations. Opportunity exists for enhancement of the assessment tools themselves to generate data that is accurate, reliable and lacking bias. While the focus on internal self-assessment may result in cost and time savings for the CSCI and care providers, the value of the data gathered and how it will be used remains to be seen.

How the process evolves and how care providers utilise the opportunity for internal self-auditing will determine if the AQAA will become a successful method whereby the CSCI, the politicians, families and the public can '... know how well your service is delivering good outcomes...'

The CSCI were asked to comment on what they intend to do with the AQAA results. Their response had not been received at time of going to **CMM**

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