



Associate Professor Merrilyn Walton  
CIS Review Project  
Department of Health and Ageing  
MDP 68  
GPO Box 9848  
CANBERRA ACT 2601

Dear Professor Walton

### **Review of the Complaints Investigation Scheme (CIS)**

Thank you for the opportunity to meet with you on 12 August. I am pleased to make this brief submission to the Review covering the key points that we raised at the meeting.

Our response is relevant to two of the three questions raised in your consultation paper:

- How can the communication between the CIS investigators and involved parties (including: family members, residents and advocacy groups who lodge complaints, aged care service providers and their staff) be improved?
- What can the CIS do to better meet the needs and expectations of residents, their families and aged care service providers?

#### *The place of the CIS within the Aged Care system*

Consumers – and consumer organisations - find it very difficult to understand how the Scheme operates within the aged care system.

The Scheme would be strengthened by articulating it fully within the system in such a way that outcomes of complaints informed and were followed up within the accreditation process. A complaint can be resolved to the satisfaction of the investigator and the facility without improving care outcomes for the resident.

Educating consumers about their rights and the best way to complain and building strong resident involvement and internal complaints arrangements would allow more complaints to be resolved earlier before they reach the CIS.

Consumers are central as the beneficiaries of care and should be engaged in an ongoing way through all aspects of the aged care system including accreditation and complaints.

Any scheme needs quality assurance processes including performance indicators.

*Residents with dementia and family carers*

Residents with dementia and their family carers need to be confident that making a complaint will not jeopardise their continued access to care, particularly given the progressive nature of dementia and the high burden that it places on family carers.

Many may not make a complaint if their perception is that the complaint will be investigated in line with the name of the Scheme, rather than resolved through mediation or otherwise to the benefit of all parties.

If the behaviour of a resident with dementia is the source of a complaint, CIS investigators should ensure that specialist advice is sought from the relevant Dementia Behaviour Management Advisory Service, before full investigation proceeds. As with misuse of an Enduring Power of Attorney, the impact of Behavioural and Psychological Symptoms of Dementia merits specialist input.

All staff need to be aware of the implications of dementia. Most charters of rights are high level and assume that consumers are both healthy and competent.

When a staff member complains about another on behalf of a resident with dementia without a carer, it is important that the complaint is treated on its merits and investigated within the Scheme, rather being resolved in-house as an internal staffing matter.

Natural justice means that a complainant should be advised when an investigation is initiated and given an opportunity to update the material in their original complaint. This means that investigators should always contact the complainant after reviewing the paperwork and initiating the investigation.

*Attached documents*

As promised at our meeting, I have attached the following documents:

- The Alzheimer's Australia WA response to the Review (pages 3-5);
- Our March 2008 submission on a draft National Patient Charter of Rights (pages 6-8);
- Our recent submission to the Review of the Accreditation Process for Residential Aged Care Homes (pages 9-17).

If you need any further information, please do not hesitate to contact me or Anne Eayrs, our National Policy Officer, on 6254 4233 or email [anneeayrs@alzheimers.org.au](mailto:anneeayrs@alzheimers.org.au)

Yours sincerely



Glenn Rees  
CEO Alzheimer's Australia  
27 August 2009

## Response to the Review of the Aged Care Complaints Investigation Scheme



Alzheimer's Australia WA's response falls into five areas:

1. Barriers to use of the CIS
2. Consumer involvement and consultation during CIS processes
3. Outcomes resulting from CIS processes
4. Ensuring that CIS is effective and efficient
5. Getting the balance right

### *1. Barriers to use of CIS*

Alzheimer's Australia WA receives regular feedback from families of people with dementia in residential aged care facilities who identify that the single greatest barrier to engagement with the CIS process is the perception that complaining will result in adverse treatment or a decline in the quality of care provided to their loved one.

Fear of “punishment” of the person with dementia by care staff as retribution for a complaint against them is considered by many a real possibility and appears to be a major consideration in their decision to participate or otherwise in the complaints process. The perception of the possible consequences for making a complaint may be completely baseless, however if it is a significant factor influencing the decision to complain, then it must be addressed in order for the CIS process to be effective.

**Recommendation:** Any review of the CIS scheme should consider ways to overcome this perception, perhaps encouraging users to access it by demonstration and promotion of meaningful outcomes for complainants from the CIS process.

### *2. Consumer involvement and consultation during CIS processes*

Alzheimer's Australia WA believes that the shift in focus of the CIS process from resolution to investigation has resulted in a significant marginalization of the complainant during the process. Anecdotal feedback given to our organisation indicates that people making CIS complaints interact only with the scheme at the beginning of the process (when they make the initial complaint) and at the end (when they are advised of the outcome).

The CIS process does not appear to engage all parties equally in the current process. It requires the aged care provider to document their perspective on the issue, however a ruling is usually then made without the opportunity for the complainant to respond to the provider's view. As a result of this abbreviated process, many people feel that the CIS “takes the provider's word for it” and renders them powerless to provide any meaningful further input during the investigation process. They are then, quite understandably, not satisfied with the outcome as they do not perceive the process to be transparent and fair.

**Recommendation:** Alzheimer’s Australia WA is of the view that families of people with dementia accessing aged care services should have an opportunity to be engaged throughout the CIS process, both in the interests of a balanced viewpoint for CIS deliberations, but also to ensure that the complainant accepts that the process has been fair and transparent.

### *3. Outcomes resulting from CIS processes*

The shift in focus from resolution of complaints in the former Aged Care Complaints Resolution Scheme, to investigation in the current CIS, places the emphasis on documenting evidence associated with a complaint and making a determination, rather than seeking to resolve a complaint to the satisfaction of all parties.

This emphasis, combined with the Commission’s perceived inability to enforce any findings that it makes, often leaves complainants feeling that the process has been a waste of time and energy and that the system has not produced a result that satisfies them. This is an unsatisfactory outcome not only for the complainant, but also for the provider who must then continue to deal with the complainant’s issue, and for the CIS which has expended considerable time and effort in investigating and making recommendation in relation to the complaint.

**Recommendation:** If the CIS process is to be seen as an effective means of resolving aged care complaints issues, then it needs to provide the mechanism for resolution as well as investigation of complaints. The capacity for complainants to have input into the process at different points, and opportunities for mediation and an agreed outcome, would greatly increase complainants’ confidence that the issue had been handled appropriately (even if not resolved to their satisfaction).

### *4. Ensuring that CIS is effective and efficient*

Many aged care providers indicate that complaints made against them under CIS are often in relation to relatively minor issues such as lost personal items, or a family member’s impression that their care recipient is not adequately engaged or stimulated by care staff.

Alzheimer’s Australia WA works routinely with families and people with dementia who are transferring from community-based care to residential care facilities. This period of transition in particular places stress on families and the person with dementia, with carers often dealing with guilt, grief and loss issues as a result of having to make this decision. The unfamiliarity of the residential care environment, the fact that the facility care practices may differ from those provided at home, and the distress often experienced by people with dementia entering an unfamiliar environment, can result in families seeking to externalize this guilt onto the aged care provider in the form of a complaint.

**Recommendation:** Alzheimer’s Australia WA believes that the Australian Government could minimize the extent and prevalence of CIS complaints of this type by better resourcing transition to residential care support processes for families and care recipients, particularly in regard to people with dementia and the issues highlighted above.

## *5. Getting the balance right*

Alzheimer's Australia WA believes that the current focus on the complaints scheme as the primary means for care recipients to be able to provide feedback about services presents a very negative view of aged care to the consumer. Our organisation receives regular feedback from families of people with dementia who are complimentary about the quality of services delivered to them by aged care providers; however there is no formal mechanism in place for them to provide this feedback to regulatory authorities.

**Recommendation:** Alzheimer's Australia WA maintains that providing a means for care recipients to recognise best-practice providers and care practices is of equal importance to providing a complaints mechanism. Such a system would also allow care recipients and their families to make more informed choices about aged care placement, as well as recognising the high standard of care provided by the majority of services.

David Gribble  
General Manager: Strategic Initiatives

Wendy Hudson  
Manager: Policy Development & Quality Assurance

10 August 2009

## **Alzheimer's Australia submission on a draft National Patient Charter of Rights**

Note: While our input focuses on issues for people with dementia and their families and carers, we believe that the issues that we highlight also apply to a wide range of other consumers.

Alzheimer's Australia supports the development of this National Charter. The current draft provides an excellent start however, we would like to raise the following concerns.

### **Partnership**

We believe that consumers should be supported as full partners in the provision of health care. However, the Charter as written appears to be predicated on the assumption that individuals are physically and cognitively well enough to participate fully in this way. Health diversity is not recognised, eg disability is not acknowledged under the 'Respect' principle.

In addition, the role of family carers is not covered in the draft Charter and only in a peripheral manner in the Principles. Family carers provide much-needed and wide-ranging support to people with dementia within health settings. This is noted in the introduction to the Principles and under 'Information'.

Cognitive disability and ill health will impact on an individual's ability to 'meet the expectations' set out under the draft Principles. The very vital role that family and others commonly play should be appreciated and fully acknowledged.

These issues might be addressed by including:

- an additional right to 'support' in the Charter;
- a preamble which points to the partnership principle while acknowledging the limitations imposed by cognitive and other health issues. Such a preamble could also acknowledge the very real role that family members and carers play as support people and substitute decision makers;
- additional points related to these issues under the Principles, where appropriate.

### **Recognition of dementia**

Alzheimer's Australia has just completed research for the Department of Health and Ageing into the viability and potential impact of developing a National (and International) dementia symbol within the Acute, Community, Residential and Transitional care settings; emergency services and the broader community.

The concept of a symbol for people with dementia was an outcome of the October 2005 National Consumer Summit on Dementia. Participants suggested that people with dementia and their family carers required a National symbol in order to encourage appropriate treatment of people with dementia, particularly in relation to the delivery of care services. They also called for action to 'Improve the responsiveness of acute care so it better meets the needs of people with dementia'.<sup>1</sup>

In order to exercise their rights under this type of patient charter, consumers need health staff to:

- be able to recognise possible or probable dementia or other forms of cognitive impairment where this has not been diagnosed;
- understand the implications of dementia, delirium, etc on care delivery and their professional practice;
- provide best practice support to the people with cognitive impairment who use their services.

This implies that:

- consumer records, including information about diagnosis and cognitive deficits, are available to staff;
- every member of the care staff has the necessary knowledge and understanding of dementia to communicate appropriately, manage pain, etc;
- management takes into account the impact of cognitive deficits in how health facilities are run and services delivered

Without leadership and training to underpin rights and principles, people with dementia will not receive the care that they should, and safety will inevitably be compromised. More information is available on Quality Dementia Care at <http://www.alzheimers.org.au/content.cfm?topicid=351>

### **Advance planning**

There should be recognition under 'Respect' that consumers have views about the health care that they want and do not want. Respecting advance planning arrangements supports people with dementia and their family carers in achieving the health outcomes that the individual may have planned and respects his or her wishes.

### **Implementation**

While the Charter generally provides a useful tool to 'support safe and high quality care', the approach to implementation will be very critical.

Alzheimer's Australia is well-positioned and willing to provide further information or other assistance to help the Commission to address implementation issues around dementia or cognition more generally.

---

<sup>1</sup> <http://www.alzheimers.org.au/upload/Communique2.pdf>

**Further comment**

Studies have indicated that:

- the number of people with dementia is projected to increase from about 227,000 in 2008 to 731,000 in 2050;
- the prevalence of dementia doubles with each 5 year increase in age after 65, until about 1 in 4 have dementia at ages over 85;
- life expectancy is shortened after a diagnosis of dementia, although it is not known the differential impact of disease progression, reduction in ability to manage co-morbidities or decreased access to the range of health options;
- People with dementia who are unable to request pain relief for conditions such as hip fracture, receive less pain medication than those without a diagnosis.



## **REVIEW OF THE ACCREDITATION PROCESS FOR RESIDENTIAL AGED CARE HOMES**

### **Response from Alzheimer's Australia**

#### **Executive summary**

Alzheimer's Australia (AA) believes that from a consumer perspective the main benefit of the current accreditation process is protecting consumers against under-performing residential care services. This process does not provide an indication of outcomes being achieved and as a consequence consumers have little information about how services are operating beyond minimum service levels. Nor does the process necessarily address the issues of most concern to residents and their family carers or representatives.

AA recognises the value of engaging the consumer in the accreditation process but questions whether the existing process is sufficiently rigorous or independent to get a real understanding of the perspectives of consumers. In summary Alzheimer's Australia envisages an approach that;

- Strengthens the existing accreditation process by having a more structured approach to consumer consultation; engaging the residents and their family carers more actively with the staff and the service provider.
- Establishes an additional and independent process through the Agency or some other means that would survey at intervals a proportion of residents and their families with a view to protecting confidentiality of respondents.

The present process does not do justice to the complexity and importance of the factors that contribute to resident satisfaction and to the concerns of the family carer. Alzheimer's Australia proposes that a new approach is needed to accreditation that;

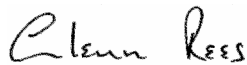
- Results in staff and consumer engagement and provides the consumers with the opportunity to input confidentially at intervals if they choose through an independent process;
- Is sensitive to the needs of people with dementia and their family carers;
- Results in consistent outcomes that can be reported to consumers in an accessible form;
- Achieves and highlights continuous quality improvement; and
- Achieves better quality of life outcomes for the residents and their family carers.

Such a system needs to be underpinned by quality of care and quality of life indicators. AA understands that the Department is committed to exploring the development of a set of quality indicators for residential aged care homes. Alzheimer's Australia requests the opportunity to be involved in the process of developing the quality indicators.

Until there is greater transparency in the outcomes being achieved unannounced spot checks will remain an essential part of gaining public confidence in residential care services.

Not every resident or their family carer may choose to be involved in the decision-making process. But, where residents or their family carers are interested they should be encouraged and assisted to participate in all aspects of decision making in the care home.<sup>2</sup>

Alzheimer's Australia starts from the position that good care creates positive outcomes for all concerned, including staff. Studies have indicated that the experiences of residents, staff and to some extent family members are interrelated. The accreditation process needs to be designed to ensure the full involvement of all the parties and the complexity of their inter-relationships and that information from the accreditation process is easily accessible to prospective residents.<sup>3</sup>



Glenn Rees  
CEO Alzheimer's Australia  
24 July 2009

---

<sup>2</sup> *My Home Life – Quality of life in care homes*, A review of the literature, prepared for Help the Aged by the National Care Homes Research and Development Forum, 2007

<sup>3</sup> Boldy D, Davies S & Grenade L, *Quality of Life, quality of care and resident satisfaction in care homes*, *Journal of Care Services Management*, Vol. 1 No1, pp1-13.

## RESPONSE TO QUESTIONS

### 1. Self assessment

*Should approved providers have to apply for re-accreditation or should the accreditation body conduct a rolling program of accreditation audits, which ensures that each home is reassessed prior to their current period of accreditation running out (without the need for the approved provider to put in an application)? What are the advantages/disadvantages of the two approaches?*

*Should the provision of detailed self-assessment data continue to be a requirement of any application process? If so, why?*

*Would the removal of the requirement to provide self-assessment data on application create a more stressful accreditation site audit? If so, how might this be avoided?*

Accreditation should be a rolling program, including self assessment, accreditation audits and support visits as this supports the service provider to;

- Focus on a continuous improvement mechanism, ensuring ongoing maintenance of reporting systems and functions and providing consistent quality of care provision to the resident.
- Minimise peak / high resource utilisation timeframes that occur in the current system of re-accreditation.

The emphasis should be on continuous improvement in a service rather than stop and start assessment at different points. A rolling program will also minimise the impact for both residents and staff. There is a degree of cynicism among consumers about the cleaning, painting etc done when re-accreditation is about to occur.

### 2. Use of electronic information

*What problems, if any, have approved providers /services experienced in respect of accreditation audits and electronic records?*

*What are the current barriers to assessment teams utilising electronic records and how might these be overcome?*

No comment

### 3. Nomination of a member of the assessment team

*Should approved providers continue to be able to nominate a quality assessor as a member of the assessment team that will be conducting the site audit on their aged care home?*

*If yes:*

- *Why? How does this improve the assessment process?*
- *How can issues of perceived conflict of interest be managed?*

Service nomination of a member of the assessment team assists in supporting the team in familiarising itself with the service provider and also enhances consistency in approach.

However, nominated assessors who may have been the service provider's staff in the past would have a possible conflict of interest that needs to be managed by the Agency.

Additionally a service provider should be able to appeal an Agency appointed assessor that they do not wish to have as part of the audit team in the event they can provide evidence of previous issues of professional conduct or conflict.

### 4. Skills of quality assessors

*Should the accreditation body have the flexibility to contract 'expert members', who are not quality assessors, to participate on an assessment team? If not, why not?*

*If yes, what sort of 'expert members' might be used and what safeguards, if any, would need to be put in place to maintain the integrity of the assessment process?*

*Should it be a legislative requirement for assessment teams conducting visits to high care facilities, or to low care facilities with a significant number of high care residents, to include a quality assessor who is a registered nurse?*

The skills required and the need for experts depends on the task to be performed. If there is to be greater consumer input and quality indicators around quality of life the skills required will be different. Contracted experts might add value if there was a particular focus on dementia care.

'Expert members', in addition to those from a nursing background who would be able to make significant contributions in identifying quality of life information for the residents could include; psychologists, diversional and occupational therapists, nutritionists, palliative care and pain management experts, DBMAS representatives, consumer advocates, and experts from an indigenous and CALD background.

Requirements of assessors around privacy and intellectual property should also be the same for an expert members used during the process.

## 5. Announced site audits

*Should accreditation site audits be unannounced?*

*If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a home's general performance be addressed?*

*If yes, what strategies need to be put in place to minimise disruption to staff and residents?*

*What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?*

*Should a home be able to nominate some 'black-out' days, during which the accreditation body will try to avoid scheduling a site audit? If not, why not?*

Announced site audits assist in ensuring that residents and their family carers are available 'on site' to participate in the audit mechanism.

Greater emphasis needs to be placed on meeting with residents and their family carers or representatives. This should be a significant part of the assessment process, not a secondary role to the process of examining documented evidence of policy and process. It is essential that assessors spend time being part of the organisations daily activities – that is observing the care and support of the resident.

Unannounced support contacts should continue only on a risk assessed basis as they offer the opportunity for observation and clarification of audit findings when a service is not 'performing'. They also respond to consumer concern that announced visits give the opportunity for cover up.

## 6. Consumer focus

*Does the current accreditation process allow for appropriate levels of consumer input? If not, why not? How might this be improved?*

*Should there be a minimum target set for consultations with residents and/or their representatives during visits to a home by the accreditation body? If so, what would be an appropriate number or percentage?*

*Should assessment teams seek to attend homes out of normal business hours? Would this increase opportunities for consultation with relatives/representatives?*

*Are there other strategies that may increase engagement with residents and/or their representatives?*

The current process allows for limited consumer input. Consumer input should be increased. The issue is how to achieve this increase in consumer input, given the nervousness that consumers exhibit in raising their concerns and the possible fear of retribution.

First AA suggests that the current process of engaging with the residents and their family carers or representatives be strengthened thus, maintaining the link between the resident and the staff and service provider. For the purposes of the onsite process 10per cent of residents or their representative if properly selected should be adequate.

The consultation process with the resident and their family carer or representative could be strengthened by;

- Increased time dedicated to resident or their family carers involvement during the audit process to better assess resident staff interaction
- Appointing consumer assessors who can relate with the residents or their family carers, ensure privacy and confidentiality and provide some independence in the selection of residents consulted;
- Actively encouraging residents and family representatives to have direct access to the Agency through:
  - Feedback on the comments they have made so they know the effort was worthwhile.
  - Making it possible for them to make contact with assessors if they cannot be available on site during an audit or have concerns about confidentiality.
  - Enabling them to talk to the Agency at any time.

Second, the onsite accreditation process is unlikely to capture all the issues of relevance to residents and their families. There is the need for an additional and independent process to gather consumer input and develop a profile of satisfaction from the perspective of the residents and their family carers.

AA suggests that an independent organisation or the Agency conduct a survey of all the residents and family carers of care homes. A regular structured survey questionnaire based on quality of life performance indicators should be developed. This survey questionnaire will provide the residents and their family carers with an opportunity to provide their feedback /comments and raise their concerns about the quality of care and quality of life issues which are important to them. This survey should be independent of the onsite accreditation process but information gathered from the survey should feed into the overall accreditation process.

Feedback received from the survey should be confidential to the Agency. In the event of serious concerns being identified the Agency should take these up with the provider as part of the assessment process and include those residents or their advocates who are willing to take part.

The survey should be designed to address the resident's overall well-being, including levels of social activity, physical activity and health status that meet their personal need and expectation and should allow improvements of care to be measured and reported in feedback to consumers.

Quality of life and quality of care assessment in aged care residential facilities must focus on resident satisfaction as a key indicator. Resident input should be independent and complement the accreditation process. The resident and their care giver or representatives must be involved to identify what is important to residents.<sup>4</sup>

A significant proportion of residents in the aged care homes may not be physically or mentally capable of responding meaningfully to interviewers or completing questionnaires. Special considerations are essential in assessing quality of care for people with dementia. A solution may be to engage the main carer or a close family member in assisting/supporting the resident in this process.

## 7. Communication with residents about serious non-compliance

*Should approved providers be required to organise a meeting with residents and their representatives to discuss incidences of non-compliance?*

*If so, should this be a general requirement for any non-compliance, or should it only apply where there is major non-compliance, for example, non-compliance with four or more expected outcomes, or non-compliance against specified outcomes?*

Providers should be required to convene meetings with residents and their family carers or representatives as part of the assessment process. This is an opportunity for consumer education, open communication and the ability for a service provider to demonstrate to the resident what issues have been identified and actions that have been or will be taken to rectify issues.

The information should also be disseminated via newsletters or email to enhance communication and engagement activity.

Communication is vital to support the continuing engagement of the resident and their family carer or representatives about changes in their 'home environment' and demonstrates a commitment to continuous improvement to the residents.

## 8. Confidentiality of sources

*Does the lack of confidentiality for staff act as a barrier to them providing frank information to the accreditation body?*

*Should the confidentiality protections provided in the Aged Care Principles for residents or their representatives be extended to all persons who provide information to the accreditation body?*

We think the answer to this is yes. Staff may well become aware of less than ideal practice but feel powerless to do anything about it.

---

<sup>4</sup> My Home Life – Quality of life in care homes

## 9. Monitoring failures

*Is the current accreditation and monitoring regime for residential aged care homes effective in identifying deficiencies in care, safety and quality? If not, why not?*

*If the accreditation and monitoring regime was to be enhanced, what approaches should be adopted?*

*Should homes be required to collect and report against a minimum data set?*

It has been a change for the better in identifying underperforming homes.

We support the introduction of quality indicators as argued elsewhere in this submission.

## 10. Reconsideration, review rights and offences

*Should decisions only be appealable to the Administrative Appeals Tribunal if they have already been subject to reconsideration by the accreditation body?*

*Should the accreditation body be able to undertake 'own motion' reconsideration of decisions in certain circumstances?*

No comment

## 11. Reporting of accreditation decisions

*Is the current way in which audit reports and decisions are published adequate? If not, why not?*

*Should audit reports and decisions of the accreditation body that are subject to reconsideration or review be made publicly available prior to the finalisation of the review process? If not, why not?*

*Should approved providers be required to provide residents and carers with access to reports and decisions of the accreditation body?*

Assessment outcomes should not be black and white, but more of a sliding scale so that residents and their family carers have a clearer idea of the standing of the facility relative to other facilities and to its previous assessment. In this way there would be a greater element of comparative reporting.

Service providers should be required to provide and support access to the reports and decisions of the accreditation body – this information should be publicly accessible in hard copy in the facility to residents and their family carers or representatives and other interested parties such as prospective residents.



## 12. Distinction between various types of visits

*Are the current distinctions between different types of visits conducted by the accreditation body appropriate? If so, why? If not, why not?*

No comment

## 13. Provision of industry education by the accreditation body

*Is it problematic for the accreditation body to provide education to industry?*

*If not, why not? What are the benefits of the current approach?*

*If yes, what are some alternate models for providing education to industry?*

*Does there need to be another source of advice for industry, besides the accreditation body, about issues in respect of accreditation and improving performance? If so, what would be an appropriate source for such advice?*

We have no objection in principle provided that it is clear that the education is focussed on accreditation and not specialist care skills and that it is clear to all that undertaking such education with the Agency does not give a provider inside running in the accreditation process. There are other agencies including peak service providers, Dementia Training Study centres and Alzheimer's Australia who provide quality education and training.

## 14. Period of accreditation

*Should there be a maximum period of accreditation specified in the legislation?*

*Should homes that have sustained compliance with the Accreditation Standards over a number of years be rewarded with a longer period of accreditation?*

*Are there other means of rewarding good performance?*

Accreditation should not be longer than 5 years even for consistently high performers as changes in management can lead to quite rapid changes in performance.