



**Law Council**  
OF AUSTRALIA

# **Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia**

**House of Representatives Standing Committee on Health, Aged Care and Sport**

**1 March 2018**

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# About the Law Council of Australia

The Law Council of Australia exists to represent the legal profession at the national level, to speak on behalf of its Constituent Bodies on national issues, and to promote the administration of justice, access to justice and general improvement of the law.

The Law Council advises governments, courts and federal agencies on ways in which the law and the justice system can be improved for the benefit of the community. The Law Council also represents the Australian legal profession overseas, and maintains close relationships with legal professional bodies throughout the world.

The Law Council was established in 1933, and represents 16 Australian State and Territory law societies and bar associations and the Law Firms Australia, which are known collectively as the Council's Constituent Bodies. The Law Council's Constituent Bodies are:

- Australian Capital Territory Bar Association
- Australian Capital Territory Law Society
- Bar Association of Queensland Inc
- Law Institute of Victoria
- Law Society of New South Wales
- Law Society of South Australia
- Law Society of Tasmania
- Law Society Northern Territory
- Law Society of Western Australia
- New South Wales Bar Association
- Northern Territory Bar Association
- Queensland Law Society
- South Australian Bar Association
- Tasmanian Bar
- Law Firms Australia
- The Victorian Bar Inc
- Western Australian Bar Association

Through this representation, the Law Council effectively acts on behalf of more than 60,000 lawyers across Australia.

The Law Council is governed by a board of 23 Directors – one from each of the constituent bodies and six elected Executive members. The Directors meet quarterly to set objectives, policy and priorities for the Law Council. Between the meetings of Directors, policies and governance responsibility for the Law Council is exercised by the elected Executive members, led by the President who normally serves a 12 month term. The Council's six Executive members are nominated and elected by the board of Directors.

Members of the 2018 Executive as at 1 January 2018 are:

- Mr Morry Bailes, President
- Mr Arthur Moses SC, President-Elect
- Mr Konrad de Kerloy, Treasurer
- Mr Tass Liveris, Executive Member
- Ms Pauline Wright, Executive Member
- Mr Geoff Bowyer, Executive Member

The Secretariat serves the Law Council nationally and is based in Canberra.

## Acknowledgement

The Law Council of Australia is grateful for the assistance of the Law Institute of Victoria (**LIV**), the Queensland Law Society (**QLS**), the Law Society of New South Wales (**LSNSW**) and the Law Council's National Elder Law & Succession Law Committee (**Committee**) in the preparation of this submission.

## Executive Summary

1. The Law Council welcomes the opportunity to comment on the Inquiry into the Quality of Aged Care in Residential Aged Care Facilities in Australia (**the Inquiry**).
2. As an overarching comment, the Law Council is concerned that the Inquiry addresses only some aspects of the failings of Australia's aged care facilities and treatment of older persons. The Law Council considers that much more needs to be done; namely, a review of the entire system with a particular focus on the interaction of State and Commonwealth agencies that regulate and have the ability to impact on each aspect of the aged care quality provided to a consumer. This would require a review from the perspective of the consumer, rather than a 'top down' approach focussing on improving high level policies. The Law Council is concerned that there is a growing separation between different State and Commonwealth agencies and the various policies which are independently developed at different levels to address particular issues, resulting in a program that does not necessarily improve outcomes for residents.
3. The Law Council's submission addresses each of the terms of reference of the Inquiry as follows:
  - incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistleblowers;
  - effectiveness of the Australian Aged Care Quality Agency (**Agency**), the Aged Care Complaints Commission and the *Charter of Care: Recipients' Rights and Responsibilities* in ensuring adequate consumer protection in residential aged care; and
  - adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

4. Key comments and recommendations of this submission include:

### *Mistreatment of residents and report and response mechanisms*

- The Law Council submits that the use of restrictive practices such as chemical, physical and mechanical restraint practices needs to be reviewed, with the objective of installing consistent standards at aged care facilities.
- The Law Council recommends that:
  - (i) aged care legislation should provide for a new serious incident response scheme in line with the Australian Law Reform Commission's (**ALRC**) recommendation;
  - (ii) there should be a national employment screening process for Australian government-funded aged care;
  - (iii) a national database should be established to record the outcome and status of employment clearances; and
  - (iv) unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.

- The Law Council submits that whistleblower protection should be incorporated into the scheme as follows:
  - (i) facility staff should have the ability to appropriately report issues such as poor care practices, financial abuse of residents by a facility, and suspected 'elder abuse' of residents by family or other visitors; and
  - (ii) the complaints scheme should include independent, appropriately staffed and accessible residential aged care facility inspectors who have statutory ability to visit each facility at random and on at least a quarterly basis; inspect facilities and conduct in person or phone conversations with residents and their next of kin; issue fines and take other appropriate actions in circumstances where a facility is not in compliance; and receive reports from whistleblowers and investigate the allegations, or direct the complaint to the appropriate authorities for investigation and action.

*The Agency, Aged Care Complaints Commission and Charter of Care*

- The powers of the Commissioner should be expanded to include the ability to delegate responsibility to inspectors to investigate residential aged care services (**RACS**) on its own motion as well as upon receipt of a complaint made by residents. This could include the Commissioner and its delegated personnel, support persons, RACS employees, the Public Advocate/Guardian in each State and Territory and official visitors, investigating suspected cases of mistreatment or neglect.

*Consumer protection*

- In order to ensure consistent standards of consumer protection, the regulation of aged care across jurisdictions and models of care, that is, the Commonwealth (Home Care and Residential Aged Care) and State (Retirement Villages and Supported Residential Services) should be harmonised, and fall within the expanded powers of the Commissioner.

## Introduction

5. Seven per cent of people aged 65 and over are currently residing in RACS.<sup>1</sup> However, the proportion of older people in Australia's population has increased considerably in recent years. Projections indicate that this trend is set to continue.<sup>2</sup> Further, older Australians are increasingly being classified as having a profound or severe disability. These factors are likely to increase the demands on RACS, challenging their ability to deliver a high standard of care.
6. Australia's provision of RACS compares favourably, in most regards, with overseas examples. It also aligns with some best practice guidelines.<sup>3</sup> However, preceding this Inquiry, media and scholarly reports uncovered serious failings in the provision of RACS which had resulted in the injury, sickness or death of residents and caused trauma for staff and professionals in regulatory positions, who lost confidence in their ability to ensure the safety of residents.<sup>4</sup>
7. South Australia's Oakden Aged Mental Health Service is one such example. The facility demonstrated a significant failure of care in workplace practice and culture. Consequently, many unwell and vulnerable residents received poor-quality care. The *Review of National Aged Care Quality Regulatory Processes (Review)* stated that:

...the degree of seriousness of failures to care for residents that were reported at Oakden may be relatively rare, but the types of issues found at Oakden have much in common with the types of issues that arise for aged care consumers whenever there are quality-of-care challenges.<sup>5</sup>
8. This point was also emphasised in the ALRC report, *Elder Abuse – A National Legal Response*.<sup>6</sup> The report highlighted that existing regulation failed to respond to the 'many instances of abuse of people receiving aged care'.<sup>7</sup> Similarly, a report released in 2017 by Monash University and the Victorian Institute for Forensic Medicine detailed the extent to which injury-related deaths occur in RACS (**Ibrahim Report**). Together, these reports demonstrate the complex and multifaceted nature of resident mistreatment. This is mistreatment that the Commonwealth's existing regulatory framework has often failed to detect.
9. The Commonwealth's ability to make laws for aged care has been described as 'limited'.<sup>8</sup> The existing framework, being the *Aged Care Act 1997 (Cth) (Act)*, is founded upon the corporations' power<sup>9</sup> and the pensions power<sup>10</sup> of the Australian Constitution. The Act allows the Commonwealth to make payment of grants for the provision of aged care, and matters connected with aged care.<sup>11</sup> In relation to the quality of care, Division 54 of the Act sets out the responsibilities of service providers,

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<sup>1</sup> Joseph Ibrahim, 'Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services' (Victorian Institute of Forensic Medicine, 2017) 199.

<sup>2</sup> Ibid 196.

<sup>3</sup> Kate Carnell and Rob Paterson, 'Review of National Aged Care Quality Regulatory Processes' (2017) 73.

<sup>4</sup> Ibid 1.

<sup>5</sup> Ibid 42.

<sup>6</sup> Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, Report No 131 (2016) 199.

<sup>7</sup> Ibid.

<sup>8</sup> Australian Institute of Family Studies, 'Elder Abuse: Understanding Issues, Frame-works and Responses' (2015) 26.

<sup>9</sup> *Aged Care Act 1997 (Cth)* s 51(xx).

<sup>10</sup> Ibid s 51(xxiii).

<sup>11</sup> Ibid s 3-1(1).

including those responsibilities contained in the *Quality of Care Principles 2014* (Cth) (**Principles**).

10. Despite the *Principles*, the Law Institute of Victoria has advised that there remains uncertainty as to what 'quality of care' entails. This is, in part, due to the array of public, private and community-based providers of RACS, each emphasising different priorities and perspectives on 'quality'. As the Ibrahim Report states, 'the system is complex, fragmented, and risk averse with divergent or contradictory approaches'.<sup>12</sup> It is also due to ageist attitudes and assumptions about 'old age' and 'aged care'.<sup>13</sup> Rather than viewing RACS as a place for older persons to thrive, the atmosphere and culture in many RACS are akin to hospital settings. Many are regimented with set times each day for the various activities of daily living. Spontaneity is seen as risky by many RACS providers. Personal privacy is often compromised and is more closely aligned to what a hospital patient can expect, rather than a resident in a 'home' environment.<sup>14</sup>
11. The United Nations' (**UN**) *Principles of Older Persons* (**UN Principles**) provide a strong basis for conceptions of 'quality'. Enshrined within the UN Principles is the need for consumer protection. Specifically, that older persons 'should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility'.<sup>15</sup> In ensuring these rights and freedoms are upheld, the regulation should ensure that aged care workers are well-trained, with an emphasis on care and compassion. They should also be supported by an effective organisational structure with mandated minimum staff-to-resident ratios to ensure high-quality care and clear policies and procedures to meet expected standards of care.
12. Although many of these features are already included within the current Act, its effectiveness at protecting care recipients' rights is questionable following its implementation some twenty-one years ago. There have been substantial changes over this period to the measuring, regulating and investigating of care, but the complex legislative framework for consumer protection and complaints mechanisms has fallen short of meeting its aims of protecting residents from mistreatment and neglect.
13. As the Review noted, the aged care system gives the impression of resulting from multiple incremental changes, rather than 'system-based design to achieve the most efficient and effective regulation of quality in aged care'.<sup>16</sup>
14. The need for a comprehensive review of the aged care sector is best demonstrated by the complex arrangement of agencies that oversee the sector. Agencies that may be involved with mandatory reporting and responding to complaints include the Aged Care Complaints Commissioner, the Agency, the Australian Competition and Consumer Commission, the Australian Health Practitioner Regulation Agency, police services and the Coroner. There are often a lack of structures to support coordination and information sharing between these agencies.
15. In addition to the Ibrahim Report, the Australian Institute of Family Studies has noted that there is an increasing recognition for the need of systematic research in this area.

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<sup>12</sup> Joseph Ibrahim, 'Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services' (Victorian Institute of Forensic Medicine, 2017) 29.

<sup>13</sup> Ibid 30.

<sup>14</sup> The preceding section is based directly on input from the Law Institute of Victoria.

<sup>15</sup> *United Nations' Principles for Older Persons*, adopted by General Assembly resolution 46/91, 16 December 1991, 14.

<sup>16</sup> Kate Carnell and Rob Paterson, 'Review of National Aged Care Quality Regulatory Processes' (2017) 28.

## Mistreatment of residents and report and response mechanisms

16. This section of the submission addresses the incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistleblowers.
17. The aged care sector should ensure that a rigorous accreditation process occurs, and that RACS providers (that receive a Commonwealth licence) meet high standards of safety.
18. Despite being signatory to these international frameworks, the Ibrahim Report found that older Australians living in RACS are at significant risk of experiencing abuse, mistreatment and injury-related harm.<sup>17</sup> This mistreatment often arises due to the residents' physical frailty, cognitive impairment, multiple co-morbidities and complex drug regimens,<sup>18</sup> and may also be exacerbated by the facility's poor or inadequate care coordination, infrastructure and design, lack of training for staff, limited access to specialist services, and lack of adequate monitoring of preventable harm and injuries.<sup>19</sup>
19. There is a lack of substantial research providing a reliable indication of the prevalence of elder abuse. The Ibrahim Report and the Australian Institute of Family Studies note that there is an increasing recognition for the need of systematic research in this area. As recommended by the ALRC, systematic research would involve a national prevalence study into elder abuse.<sup>20</sup> If conducted, a study like this would help reveal the extent of mistreatment within RACS and the data collected could enable the Commonwealth to develop an effective response.
20. The ALRC has also stated that definitions are 'significant where data about prevalence of abuse is to be collected'.<sup>21</sup> Definitions affect how abuse and mistreatment are perceived by victims and perpetrators, whilst also shaping research aims and policy interventions.
21. It can be difficult to define the mistreatment that occurs within RACS, often due to the fact that some residents are unable to communicate their experiences of mistreatment.
22. A nationally consistent approach to defining elder abuse is vital for systematic research. Due to the sector's cross-disciplinary nature, it is essential to incorporate understandings of elder abuse from different perspectives. This should cover forms of abuse that are common in a residential setting, including: exposure to degrading treatment; poor hygiene; indignity; invasion of privacy; neglect; resident-on-resident aggression (**RRA**); the inappropriate use of restrictive practices; and injury-related harm.

### Restrictive practices

23. Safety standards can also be improved by requiring the reporting of all serious incidents, and mandating compliance with guidelines that limit the use of restrictive

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<sup>17</sup>Joseph Ibrahim, 'Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services' (Victorian Institute of Forensic Medicine, 2017) 30.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid 31.

<sup>20</sup> Kate Carnell and Rob Paterson, 'Review of National Aged Care Quality Regulatory Processes' (2017) 93.

<sup>21</sup> Australian Law Reform Commission, *Elder Abuse*, Issue Paper No 47 (2016) 13.

practices. Restrictive practices include: the use of medication to control behaviour, physically, chemically or mechanically restricting the free movement of one's body, limiting access to a particular object, and seclusion.<sup>22</sup> These practices can lead to negative physical and psychological effects on residents in aged care, and there are also serious questions in relation to the degree to which some facilities seek consent for use of chemical restraint.

24. The Law Council recommends that these practices be reviewed, with the objective of implementing consistent standards at aged care facilities.
25. The Law Council suggests a more comprehensive regulatory framework should be considered as a potential model for Commonwealth reform regarding the use of restrictive practices in aged care to provide greater transparency, consistency, professionalism and oversight of these practices in addressing the capacity of residents in aged care to provide informed consent for the purposes of treatment or medical treatment,<sup>23</sup> and/or the use of bodily restraints and other restrictive intervention in order to protect the dignity<sup>24</sup> of residents.
26. In its current form the Act does not regulate the use of restrictive practices such as chemical, physical and mechanical restraint. Rather, their regulation falls under state and territory laws, particularly those relating to disability, mental health and guardianship, as well as voluntary codes of conduct. State-based laws limiting restrictive practices do not extend to RACS, which are governed by Commonwealth legislation.
27. The *Principles* outline some standards that may be used at the Commonwealth level to protect residents who are vulnerable to restrictive practices. These standards involve requirements to manage challenging behaviours effectively, provide a safe living environment and ensure respect for residents' independence, dignity, choice and decision-making.
28. By way of example, the Law Council notes that the inclusion of restrictive practice provisions in the *Disability Services Act 2006* (Qld) has resulted in greater transparency, consistency, professionalism and oversight of these practices. This regulatory framework could be considered in the context of guiding Commonwealth reform. In Victoria, the *Medical Treatment Planning and Decisions Act 2016* (Vic), which is yet to come into force, may limit the use of restrictive practices by way of chemical intervention by defining medical treatment to include prescription medication.
29. The Law Council submits that the Council of Australian Governments (**COAG**) facilitates the development of a nationally-consistent approach to the regulation of restrictive practices. This reflects the Senate Community Affairs References Committee's recommendation that the 'Commonwealth develop, in consultation with dementia advocates and service providers, guidelines for the recording and reporting on the use of all forms of restraints in residential facilities'. This recommendation mirrors Recommendation 8-2 of the ALRC's report, *Equality, Capacity and Disability in Commonwealth Laws*, which called for the development of a national approach to the regulation of restrictive practices in sectors other than disability services.<sup>25</sup>

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<sup>22</sup> Office of the Public Advocate (Qld), 'Legal Frameworks for the Use of Restrictive Practices in Residential Aged Care: An Analysis of Australian and International Jurisdictions' (2017) i.

<sup>23</sup> *Mental Health Act 2014* (Vic) ss 68-71; *Disability Services Act 2006* (Qld) s 168.

<sup>24</sup> *Mental Health Act 2014* (Vic) s 16; *Disability Services Act 2006* (Qld) Div 5.

<sup>25</sup> Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 251.

30. With regards to capturing statistical data on the use of restrictive practices in aged care, the following should be required to be clearly documented by RACS (as soon as reasonably practicable after the restraint occurs):
- (a) the form of restraint applied;
  - (b) the reasons for use;
  - (c) the duration of use;
  - (d) the outcome of the restraint; and
  - (e) any adverse events that occurred.
31. Additionally, following the use of any restrictive intervention used in order to control behaviour, the resident(s) restrained should have their behavioural support plan reviewed, and modified where necessary to avoid the use of restrictive practices as a means of controlling behaviour. As soon as reasonably practicable after a restraint is applied, a formally appointed substitute and support decision maker(s) of the person(s) affected or, if none appointed, the person's primary carer or nearest relative, must be notified of the matters documented (as outlined above) and provided with the written report upon request. Where a person has no medical treatment decision maker or no primary carer or relatives, the Public Advocate/Guardian should be informed.<sup>26</sup>
32. Where the Public Advocate suspects abuse or mistreatment has occurred, the Law Council considers it should be able to enter the RACS to investigate the allegations and observe the older person whether or not an application for guardianship is sought or on foot. Increasing the powers of the Public Advocate may require increased funding to support its functions.
33. The Law Council considers that RACS which report multiple instances of the use of restraints in any given reporting year should be required to undertake training in procedures for managing challenging resident behaviours. Compliance with any such training should be monitored by the Department of Health (**DHS**) and publicly reported on each year.
34. In addition, the Law Council supports random on-site auditing of RACS to identify mistreatment of residents, including the use of restrictive practices.

## Injury-related harm

35. The Ibrahim Report surveyed the cause of death of 56,855 deaths of residents in aged care occurring between 2000 and 2012 and identified 1,926 'externally caused' deaths – that is, deaths not caused by illness or disease. The report also identified and classified intentional and unintentional causes of death (in order of prevalence): falls, choking, suicide, compromise of clinical care, and RRA. The report made 104 recommendations regarding quality improvement for those aspects of risk in residential care, which the Law Council supports and notes for consideration to this Inquiry.<sup>27</sup>

## Reporting and response mechanisms

36. Division 63 of Part 4.3 of the Act relates to accountability, and outlines the responsibilities of approved providers, including the requirement that providers report

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<sup>26</sup> Paragraphs 30-31 based directly on input from the Law Institute of Victoria.

<sup>27</sup> Paragraphs 33-35 based directly on input from the Law Institute of Victoria.

allegations or suspicions based on reasonable grounds of 'reportable assaults' to the police and to DHS. This reporting provision is limited, however, to physical assaults.

37. Sexual assaults form a part of mandatory annual reporting requirements, though data on the incidence of these types of assaults is difficult to obtain. This may often be due to interpretation as to what classifies as 'sexual assault'.
38. The Act also includes a discretion for providers not to report incidents of RRA if the alleged offender has a previously assessed cognitive impairment and a behaviour management plan has been put in place for the care recipient within 24 hours of receipt of the allegation or suspicion of assault. Consequently, the most common types of RRA incidents – those involving cognitively impaired residents – are not identified and publicly reported.
39. The reporting of resident mistreatment is a complex area given the difficulties in identifying mistreatment, and the conditions within which it occurs. Cognitive impairment can prevent reporting as residents may not be believed, and shame, embarrassment, and fear of punishment from RACS staff and management are also factors. This can be compounded by the dependency of the resident on the provider's care for them. An older person may be prevented from disclosing mistreatment if it was perpetrated by someone on whom they depend for care, fearing further neglect or mistreatment.
40. The Law Council supports the ALRC's recommendation that aged care legislation should provide for a new serious incident response scheme.<sup>28</sup> The scheme would require approved providers to notify an independent oversight body of any allegation or suspicion of a serious incident in their facility. In relation to RRA, these notifications would include incidents of physical abuse causing serious injury, or incidents occurring as part of a pattern of abuse.
41. Further, the Law Council supports the following proposals made by the ALRC:
42. there should be a national employment screening process for Australian government-funded aged care;<sup>29</sup>
43. a national database should be established to record the outcome and status of employment clearances;<sup>30</sup> and
44. unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.<sup>31</sup>

## Whistleblowers

45. The Law Council is concerned that whistleblowers are inadequately protected under Commonwealth legislation, and that clear procedures to enable anonymous reporting should be implemented.
46. The Law Council believes that whistleblowers should be given statutory protection through qualified privilege (excluding reporting that is motivated by malice).
47. The Law Council submits that whistleblower protection be incorporated into the scheme to ensure that facility staff can appropriately report issues such as poor care

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<sup>28</sup> Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, Report 131 (2016) 10.

<sup>29</sup> Australian Law Reform Commission, *Elder Abuse*, Discussion Paper No 83 (2016) 13.

<sup>30</sup> *Ibid* 200.

<sup>31</sup> This section is based on input from the Law Institute of Victoria.

practices, financial abuse of residents by a facility, and suspected 'elder abuse' of residents by family or other visitors.

48. The Law Council recommends that the complaints scheme should include independent, appropriately staffed and notionally available residential aged care facility inspectors who have statutory ability to:

- (a) visit each facility on at least a quarterly basis;
- (b) make unscheduled visits to facilities on an 'as-required' basis;
- (c) inspect facilities and conduct in person or phone conversations with residents and their next of kin; and
- (d) issue fines and take other appropriate actions in circumstances where a facility is not in compliance.<sup>32</sup>

49. Furthermore, the Law Council submits that the complaints scheme should include receiving reports from whistleblowers and investigating the allegations, or directing the complaint to the appropriate authorities for investigation and action.

### **Recommendation 1**

**The use of restrictive practices such as chemical, physical and mechanical restraint practices should be reviewed, with the objective of installing consistent standards at aged care facilities.**

### **Recommendation 2**

**In line with the ALRC's recommendation, aged care legislation should provide for a new serious incident response scheme. The Law Council also supports the following proposals made by the ALRC:**

- **there should be a national employment screening process for Australian government-funded aged care;**
- **a national database should be established to record the outcome and status of employment clearances; and**
- **unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.**

### **Recommendation 3**

**Whistleblower protection should be incorporated into the scheme as follows:**

- **facility staff should have the ability to appropriately report issues such as poor care practices, financial abuse of residents by a facility, and suspected 'elder abuse' of residents by family or other visitors;**
- **the complaints scheme should include independent, appropriately staffed and accessible residential aged care facility inspectors who have statutory ability to visit each facility on at least a quarterly basis; make unscheduled visits to facilities on an 'as-required' basis; inspect facilities and conduct in person or phone conversations with residents**

<sup>32</sup> This recommendation is based directly on input from the Law Society of New South Wales.

**and their next of kin; and issue fines and take other appropriate actions in circumstances where a facility is not in compliance; and receive reports from whistleblowers and investigate the allegations, or direct the complaint to the appropriate authorities for investigation and action.**

## The Agency, Aged Care Complaints Commission and Charter of Care

50. This part of the submission concerns the effectiveness of the Agency, the Aged Care Complaints Commission and the *Charter of Care: Recipients' Rights and Responsibilities* in ensuring adequate consumer protection in residential aged care.
51. The Act establishes the Aged Care Complaints Scheme<sup>33</sup> and the office of the Aged Care Commissioner.<sup>34</sup> The Commissioner is tasked with the responsibility of handling and investigating complaints made against Commonwealth-subsidised RACS. The complaints process works to protect consumers who make a complaint, as well as ensure existing standards of care are being met. The Commissioner can give early warnings of deficiencies in quality of care, and identify the likelihood for system failures. Although this education function exists, the Commissioner's role is primarily reactive (when complaints and concerns are put forward).
52. Some complaints against the Commissioner concern a lack of timeliness, clarity and fairness. The Commissioner is not considered accessible or user-friendly by many residents and their representatives, but rather as protracted and bureaucratic.<sup>35</sup>
53. While funding is not a solution on its own, the Law Council also queries whether these entities are sufficiently resourced to undertake their objectives. This may in fact be compounding the problem, as:
- (a) increased funding might allow for more robust and meaningful review capabilities, leading to greater compliance and consumer confidence in the accreditation system; and
  - (b) less financial strain on these agencies may allow a more tailored approach to dealing with facilities where there is a failing. It may be more appropriate to assist those facilities which are genuinely striving to be compliant by taking a more collaborative and education-based response to issues affecting accreditation.
54. There is little evidence to suggest that the expansion of the Charter will result in any meaningful change for residents. Staff in some facilities do not seem to be aware of the Charter's existence. Including an obligation for facilities to regularly provide education or information on rights, support for making complaints and the complaint process would assist to ensure that residents and their families are better informed about their rights.
55. Residents should have access to an advocate that investigates their, or their representatives', complaints. The effectiveness of such an authority would lie in its

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<sup>33</sup> *Aged Care Act 1997 (Cth)* s 94A-1.

<sup>34</sup> *Ibid* div 95A.

<sup>35</sup> Paragraphs 48-49 based on input from the Law Institute of Victoria.

ability to: provide redress for mistreated residents; make findings that can be used for quality improvement; and identify patterns of concern within complaints.

56. The Law Council suggests that the powers of the Commissioner should be expanded to include the ability to delegate responsibility to inspectors to investigate RACS on its own motion or upon receipt of a complaint made by residents. This could include the Commissioner and its delegated personnel investigating suspected cases of mistreatment or neglect, their support persons, RACS employees, the Public Advocate/Guardian in each State and Territory and official visitors.

#### **Recommendation 4**

**The powers of the Commissioner should be expanded to include the ability to delegate responsibility to inspectors to investigate RACS on its own motion or upon receipt of a complaint made by residents. Delegated personnel could promptly investigate suspected cases of mistreatment or neglect, their support persons, RACS employees, the Public Advocate/Guardian in each State and Territory and official visitors.**

## Consumer protection

57. This part of the submission concerns the adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.
58. The Law Society of New South Wales advises that consumer protections currently available to residents and their carers and families (**the consumers**) under the existing aged care legislative framework are confusing and inadequate. There are multiple points of contact for consumers to seek recourse in the event of a dispute with the aged care provider.
59. Recourse for mistreatment is even harder for residents without representatives or support persons. Difficulties faced include that the person may not be aware of their rights; the person may not have the resources to make a complaint; the person may not have sufficient capacity to make a complaint; the person's physical and emotional health is not being monitored independently of the RACS and any deterioration in the person's wellbeing can be justified as the effects of 'institutionalisation'; and the person may fear retribution or victimisation by management or staff of the RACS.<sup>36</sup>
60. There is also some concern about the lack of agency for residents in aged care facilities. A resident who moves into an aged care facility often has a new and unknown doctor. This can be unnerving and distressing for an elderly patient who may struggle with the imposition of a new doctor, after potentially spending many years building a relationship of trust with one general practitioner. The Law Council considers that revision of the legislation should include greater consideration of the mechanisms whereby general practitioners can continue to visit their patients at the aged care facility, once they have become a resident.
61. Harmonisation of the regulation of aged care across jurisdictions and modes of care, that is, the Commonwealth (Home Care and Residential Aged Care) and State

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<sup>36</sup> This paragraphs is based directly on input from the Law Institute of Victoria.

(Retirement Villages) would be desirable. This harmonisation should lead to a rationalisation of the handling of consumer protection issues in aged care.

62. A revised and harmonised framework should have clear and efficient pathways to address all matters which cause consumers of aged care services concern – from quality of care, fees and charges, and disputes with the operator of the aged care services. The framework should distinguish between those consumer complaints that are a consequence of a medical condition, such as dementia, and those which are genuine complaints about the aged care services they are receiving.
63. The current framework requires consumers to apply to different regulators for particular issues, for example, quality or fees. Further, those regulators hear the complaints on a single issue (such as quality or fees) when the ability to hear a full complaint would give a more accurate picture of the consumer’s complaint and the aged care operator’s practices. In addition, those regulators can only give orders for limited remedies. The Inquiry should consider whether there are opportunities for complaints raising multiple issues to be dealt with as part of the same proceedings.<sup>37</sup>

#### **Recommendation 5**

**In order to ensure constituent standards of consumer protection, the regulation of aged care across jurisdictions and modes of care, that is, the Commonwealth (Home Care and Residential Aged Care) and State (Retirement Villages) should be harmonised, and fall within the expanded powers of the Commissioner.**

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<sup>37</sup> Paragraphs 62-63 are based directly on input from the Law Society of New South Wales.