Law Council
OF AUSTRALIA

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced

Senate Community Affairs References Committee

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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.

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- Law Institute of Victoria
- Law Society of New South Wales
- Law Society of South Australia
- Law Society of Tasmania
- Law Society Northern Territory
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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**) 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 Effectiveness of the Aged Care Quality Assessment and Accreditation Framework (**the Framework**).

2. The Australian Law Reform Commission (**ALRC**) recently released its Final Report on the Inquiry into Elder Abuse*, Elder Abuse - A National Legal Response* (**the Report**).[1]

3. The Report made a number of recommendations to improve the quality of care for residential aged care services, including: establishing a serious incident response scheme in aged care legislation; reforms relating to the suitability of people working in aged care – enhanced employment screening processes – and ensuring that unregistered staff are subject to the proposed National Code of Conduct for Health Care Workers; regulating the use of restrictive practices in aged care; and national guidelines for the community visitors scheme regarding abuse and neglect of care recipients.[2]

4. The Law Council supports these recommendations and submits that this independent Inquiry should take account of the Report's recommendations, as detailed below.

5. The Law Council's submission addresses the following issues:

   - the effectiveness of the Framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced;
   - the adequacy and effectiveness of complaints handling processes at a state, territory and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;
   - the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents; and
   - the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and territory and federal governments for reporting on and acting on adverse incidents.

6. Key comments and recommendations of this submission include:

   Ensuring proper standards are maintained

   - Any revision of the legislation should cover medical prescriptions.

   - 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.

   - 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 the use of restrictive practices in aged care.

[1] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131 (2017) 103.
[2] Ibid 102 [4.3].

Injury prevention, monitoring and reporting mechanisms

- If the ALRC's Recommendation of establishing a reportable incidents response scheme is enshrined in legislation, the information reported to the independent oversight body should be made publicly available, subject to protecting the informant and victims' identities.

Responsibility and accountability for reporting incidents

- The establishment of an *independent* oversight body, as recommended by the ALRC, will serve as a critical component of an effective reporting framework.

Ensuring proper standards are maintained

7. This section of the submission addresses the effectiveness of the Framework for protecting residents from abuse and poor practices and ensuring proper clinical and medical care standards are maintained and practiced.

8. The Australian Aged Care Quality Agency (**the Agency**) is the accreditation agency for aged care services in Australia. It assesses the performance of a service against the Accreditation Standards (**the Standards**) in determining whether accreditation is granted. The Standards are found in section 10 of the *Quality of Care Principles 2014* (**Care Principles**) and serve as standards for the quality of care and quality of life to be provided to residents in approved aged care facilities. There are four principle-based standards. There and 44 expected outcomes - across the four Standards and homes must comply with all 44 expected outcomes at all times. Broadly, the Standards cover: management systems; staffing and organisational development; health and personal care; care recipient lifestyle; and physical environment and safe systems.

9. The process of obtaining accreditation is governed by the *Quality Agency Principles* 2013 (**Agency Principles**). The process involves submitting an application to the Agency;[3] self-assessment by the home against the Standards; and assessment by a team of registered aged care quality assessors at a site audit.

10. Within 28 days of receiving an application, the CEO of the Agency must inform the provider of the date of the site audit. The provider, in turn, must inform the care recipients of the date and that they will be given the opportunity to talk to the assessment team. Reasonable steps must be taken to inform each care recipient or their representative. The assessment team must meet with at least ten per cent of the care recipients, or their representatives, to discuss the care and services.

11. The assessment involves an evaluation of the care and services provided against the Standards. This may be facilitated by reviewing documented processes and procedures, observing the practices at the home and looking at documents held by the home, such as staff rosters, incident reports, care plans and complaints registers.[4]

12. Upon the conclusion of the site audit, the assessment team provides a written report. Within 28 days of receiving the report, the CEO of the Agency must decide whether or not to re-accredit the service. The further period of accreditation, as well as any areas of improvement, must be detailed and recorded in writing.

Medical prescriptions

13. The Law Council considers that any revision of the legislation should cover medical prescriptions.

14. There is some uncertainty regarding consent to the use of anti-psychotics in aged care facilities, namely regarding who is consenting to this practice – for example, whether it is the patient, the substitute decision maker, aged care services staff or doctors. Standards should be maintained for oversight and protocols that are to be followed by the aged care facility to ensure that these prescriptions are occurring in compliance with good medical practice, and in consultation with the patient's substitute decision maker (where applicable). This may present an issue between State, Territory and Commonwealth-based schemes, and should be reviewed to ensure that

[3] *Quality Agency Principles 2013* (Cth) ss 2.2-2.3.
[4] The procedure is guided by the Agency's *results and process guide*.

Commonwealth-based regulations do not conflict with State or Territory-based schemes, such as enduring powers of attorney and other guardianship frameworks.

15. In its submission to the Inquiry, the Law Council noted that where a person in aged care has a cognitive impairment, the aged care facility must take all reasonable steps to locate the persons' medical treatment decision maker (and equivalent in other states and territories) to obtain consent to that person's treatment, including the administration of prescription pharmaceuticals. Where a medical treatment decision maker (or equivalent) cannot be located, consent should be sought from the public advocate/guardian.[5]

Lack of agency

16. There is 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.

The importance of documenting processes

17. The Agency's Results and Processes Guide provides that 'processes do not always need to be formalised or documented in order for them to be effective and sustainable'.[6] It is submitted that in aged care services, where employees are often casual, contract or temporary workers, having processes documented in writing is critical to the consistency of care of the residents. It also serves as evidence of the processes followed by the home between assessments and as such, may better indicate compliance with the Standards and gaps that need to be addressed.

Failure to comply with the Standards in cases of serious risk

18. Where is the Agency finds that an accredited service fails to meet one or more expected outcomes in the Standards, and the CEO has determined that the failure has placed or may place the safety, health or wellbeing of a care recipient of the service at serious risk, the CEO must notify the service provider in writing of the specific risk, evidence of the risk and a statement of the expected outcomes the service provider has failed to meet.[7] A written notice must also be provided directing the provider to revise their plan for continuous improvement to demonstrate how they will comply with the Standards.[8] The plan for continuous improvement must be revised within 14 days of receiving the notice.[9]

19. The Agency notes that where there is a failure to meet the Standards, in addition to the potential revocation of accreditation, the Australian Government Department of Human Services (**DHS**) may be notified and may decide to impose sanctions on the

[5] Law Council of Australia, Submission No 351 to Australian Law Reform Commission *Elder Abuse Discussion Paper No 83*, 40 [141].
[6] Australian Aged Care Quality Agency, Results and Processes Guide, 10, URL: https://www.aacqa.gov.au/publications/publications-providers-and-surveyors/Resultsandprocessesguide.pdf.
[7] *Quality Agency Principles 2013* (Cth) s 2.63(2)(b).
[8] Ibid s 2.63(3)(b).
[9] Ibid s 2.63(4).

home. Where the Agency identifies a serious risk, it must notify the service provider and DHS immediately.

20. However, the ALRC Report highlighted that current accreditation may be insufficient to ensure all incidents between reporting periods are responded to appropriately, citing the review of the Oakden Older Persons Mental Health Service, which found there to be no processes for reporting or responding to incidents of abuse.[10] A further shortfall in the current accreditation system is that it focuses on systemic issues in aged care, which may not catch individual serious incidents.

The reliability of self-assessment

21. Self-assessment by service providers involves the providers themselves evaluating the extent to which the required outcomes of the Standards have been met. Providers must give a written assessment to the assessors during the site audit. This may be in any written form and must demonstrate the performance of the provider in meeting the Standards.

22. Self-assessments take place upon a service provider's re-accreditation application. As such, the frequency of self-assessments is dependent upon how frequently a service provider has to apply for re-accreditation.

23. The Law Council queries whether self-assessment without a requirement of strict performance evidence is effective in preventing abuse.

Use of restrictive practices in aged care

24. As it stands the *Aged Care Act 1997* (Cth) does not regulate the use of restrictive practices such as chemical, physical and mechanical restraint. These practices may constitute a breach of human rights and can lead to negative physical and psychological effects on residents in aged care.[11]

25. The Law Council recommends 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, [12] and/or the use of bodily restraints and other restrictive intervention in order to protect the dignity[13] of residents.

Recommendation 1

[10] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131 (2017) 117 [4.69], citing A Groves, D Thomson, D McKellar and N Procter, 'The Oakden Report' (Department for Health and Ageing (SA) 2017) 64.

[11] 106 ALR 385 (High Court of Australia, 6 May 1992), 98: 'The inherent dignity of all members of the human family is commonly proclaimed in the preambles to international instruments relating to human rights: see the United Nations Charter, the International Covenant on Civil and Political Rights (which declares "the right to ... security of person": Art.9), the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child'; see also the right to freedom of movement, articles 12 and 13 of the International Covenant on Civil and Political Rights (ICCPR); and article 5 of the Universal Declaration of Human Rights and article 7 of the International Covenant on Civil and Political Rights, both of which provide that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

[12] See for example *Mental Health Act 2014 (Vic)* ss 68-71, and *Disability Services Act 2006 (QLD)* Division 5 s168;

[13] See for example *Mental Health Act 2014 (VIC)* s 16, and *Disability Services Act 2006 (QLD)* Division 5.

Any revision of the legislation should cover medical prescriptions.

Recommendation 2

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.

Recommendation 3

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 the use of restrictive practices in aged care.

Complaints handling processes and complaints mechanisms

26. This part of the submission concerns the adequacy and effectiveness of state and territory and federal complaints handling processes, including consumer awareness and appropriate use of the available complaints mechanisms.

27. The Agency itself does not have an investigatory role, however, information received about the performance of an aged care service may be used in planning future assessment and monitoring compliance with the Standards.

28. The Aged Care Complaints Commissioner (**the Commissioner**) is tasked with the responsibility of handling and investigating complaints made about a Commonwealth-subsidised aged care service. In the six-month period from 1 January 2016 to 30 June 2016, the Commissioner was contacted on 5,223 occasions. Of the 3,588 contacts within the Commissioner's scope, 1,746 pertained to residential age care. The number of enquiries increased by 23% from the corresponding six-month period in 2015. The number of complaints also increased by 11%.[14] While this indicates that awareness of the Commissioner's service is likely growing, the fact that 31% of the total contacts were outside the Commissioner's scope suggests that there is a lack of clarity over what exactly the Commissioner may do.[15] The importance of information among consumers about available processes and options was identified by the Commissioner in its submission to the ALRC Inquiry:

> *Good information, including how to raise concerns… helps to correct the power imbalance for the consumer. The provision of information must be done well, and in accordance with the requirements of informed consent in the health sector.*[16]

29. Upon receiving a concern or complaint, the Commissioner gathers information and seeks to assess the issue that has been raised. This involves contacting the person receiving care or their representative to confirm their desire for the complaint to be investigated, reviewing the service provider's history and liaising with persons relevant to the complaint. Afterwards, the Commissioner may recommend a direct resolution with the service provider in which they can support the complainant or pursue a formal

[14] Aged Care Complaints Commissioner, Australian Government, *Annual Report 2015-16*, 18-19.
[15] The Commissioner's jurisdiction is limited to complaints about service providers' responsibilities under the Act or complaints about funding agreements: *Complaints Principles 2015* (Cth) s 6.
[16] Aged Care Complaints Commissioner, Submission No 148 to Australian Law Reform Commission *Elder Abuse Discussion Paper No 83*, August 2017, 107 [4.28].

resolution process. The latter may entail mediation, conciliation or an investigation. The Commissioner encourages early resolution with the service provider, but notes that this may be impractical in certain circumstances. The focus is on resolving the concern or complaint in the best interests of the care recipient.

30. Out of 2,043 finalised complaints in the six-month period from 1 January 2016 to 30 June 2016, early resolution was used for 1,775 and formal resolution for 268. For those resolved using formal processes, investigation was used on 142 occasions, conciliation on 38 occasions, and service provider resolution on 111 occasions. Once again, the preference for resolving complaints directly with the service provider is apparent.

31. The culmination of an investigation may be a direction issued by the Commissioner to the service provider. This requires the provider to demonstrate how they will address the complaint and meet their responsibilities under the *Aged Care Act 1997* (Cth) (**the Act**). The Commissioner then monitors the service to ensure compliance with issued directions.

32. It is also important to note the Commissioner's ability to make referrals to other organisations. Referrals may be made to state at territory departments of health and human services, state and territory governments, public health units or the police. A total of 231 referrals were made in the abovementioned six-month period. This allows for a cohesive and broader complaints handling process. For example, referrals to DHS may result in compliance action against the provider if they fail to meet their responsibilities under the Act.

Injury prevention, monitoring and reporting mechanisms

33. This part of the submission addresses the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents.

34. Under the current complaints framework, complaints registers may not contain details of the outcome of a complaint or the merits of an allegation. This was identified by DHS in the ALRC Report as a gap in accurate and comprehensive data about 'reportable assaults' in aged care.

35. A further impediment to reporting and responding to serious injury and mortality incidents in aged care services is the legislative definition of 'reportable assaults'.

36. In its recent submission to the ALRC, the LIV and the Law Council supported the establishment of a 'serious incidents response scheme'. Specifically, the Law Council submitted in favour of expanding the scope of the type of incidents to be reported under the Act by replacing the term 'reportable assault' with 'reportable incident', recognising that one of the gaps in the current framework is that no investigation is required by an approved provider – reporting the incident and maintaining records is sufficient for providers to meet their legislative obligations.[17]

37. In its submission to the ALRC, the Law Council also recommend that the exemption to reporting provided by section 53 of the *Accountability Principles 2014* (Cth), regarding alleged or suspected assaults committed by a care recipient with a pre-diagnosed cognitive impairment on another care recipient, be removed. In its Report, the ALRC recommended that the serious incident response scheme should not exempt serious

[17] Australian Law Reform Commission, *Elder Abuse*, Discussion Paper No 83 (2016) 202 [11.48].

incidents committed by a care recipient with a pre-diagnosed cognitive impairment against another care recipient.[18]

38. In its submission to the ALRC, the Law Council also recommended Part 7 of the *Accountability Principles 2014* (Cth), which contains an exemption to reporting 'reportable assaults' be repealed. All reportable incidents should be reported to the Commissioner, which would create greater clarity for approved providers around reporting obligations and assist in recording, and responding to, patterns of behaviour.

39. In its Report, the ALRC adopted this recommendation and further recommended the establishment of a reportable incidents response scheme for aged care, requiring approved providers to notify an independent oversight body of an allegation or suspicion on reasonable grounds of a serious incident, and the outcome of an investigation into a serious incident, including the findings made and actions taken.[19]

40. However, the ALRC noted that apart from recommending the scheme sit with an independent body, it would not make a recommendation about where the scheme should be located within the aged care framework.[20]

41. There is currently a lack of publicly accessible data around reportable assaults in aged care. If the ALRC's Recommendation of establishing a reportable incidents response scheme is enshrined in legislation, the information reported to the independent oversight body should be made publicly available, subject to protecting the informant and victims' identities. The public availability of data around serious incidents in aged care would increase the accountability of approved providers, which would encourage the adoption of best clinical practices in responding to allegations of abuse.

Recommendation 4

If the ALRC's Recommendation of establishing a reportable incidents response scheme is enshrined in legislation, the information reported to the independent oversight body should be made publicly available, subject to protecting the informant and victims' identities**.**

Responsibility and accountability for reporting incidents

42. This part of the submission concerns the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and federal governments for reporting on and acting on adverse incidents.

Comments with respect to *staff*

43. It was widely reported by stakeholders to the ALRC Inquiry that staff in aged care services are reluctant to make complaints against their employer for fear of victimisation or harassment.[21] The Law Council, in its submission to the Inquiry, also

[18] Australian Law Reform Commission, Australian Government, above n 1, Recommendation 4-6 [125].
[19] Australian Law Reform Commission, Australian Government, above n 1, Recommendation 4-1 [111].
[20] Ibid 4.76.
[21] Australian Law Reform Commission, Australian Government, above n 11, 220 [11.142].

cited the reasons of fear of contravening state, territory or Commonwealth privacy laws and fear of dismissal or adverse treatment by an employer.[22]

44. The ALRC has recommended that the requirements of the current reportable assaults scheme, which obliges the approved provider to take reasonable measures to require staff members to report serious incidents;[23] to ensure staff members are not victimised;[24] and to protect informants' identities,[25] be a feature of the serious incident response scheme. Given the failings of the current system it remains to be seen how incorporating these existing elements into the new scheme will mitigate abuse. However, the establishment of an *independent* oversight body, as recommended by the ALRC, will serve as a critical component of an effective reporting framework.

Comments with respect to *family*

45. As stated above, residents and their families are able to make complaints about service providers' responsibilities under the Act. In practice, however, there appears to be limited community awareness of the options available. The complaints process can be very lengthy and onerous for a complainant, especially in a time that is often fraught with emotion. Another issue in family-reporting is a lack of understanding within the aged care sector of the roles of family and friends, particularly where a person lacks capacity to make certain decisions for themselves.[26]

46. People experiencing abuse in aged care that do not have family or friends may not be able to communicate a complaint against a service provider. These people are therefore reliant on staff and community visitors to report abuse.

47. In its submission to the Inquiry, the Law Council noted that the Act should provide for an 'official visitors' scheme for residential aged care, which empowers official visitors to enter and inspect a residential aged care service, confer with residents and staff and make complaints or reports about suspected elder abuse to the appropriate person or organisation.[27]

48. In its Report, the ALRC decided not to establish an official visitors' scheme, but recommended that DHS should develop national guidelines for the existing community visitors' scheme. The guidelines should include policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients. This was supported by the Law Council and the LIV. These guidelines alone may not be effective to mitigate abuse of those vulnerable by isolation.

49. Reporting and responding to allegations of abuse is ultimately the responsibility of aged care service providers.

Comments with respect to *providers*

50. As identified by the ALRC Report, providers are likely to have increased clarity around their reporting obligations if the reportable assaults scheme is replaced by the

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[22] Law Council of Australia, Submission No 351 to Australian Law Reform Commission *Elder Abuse Discussion Paper No 83*, 13 [22].
[23] *Aged Care Act 1997* (Cth) s 63-1AA(5).
[24] Ibid ss 63-1AA (6), 96-8.
[25] Ibid s 63-1AA(7).
[26] Please note, these provisions will be repealed next year with the enactment of the *Medical Treatment Planning and Decisions Act 2016* (Vic), but will be replaced by a similar hierarchy in relation to medical treatment decisions.
[27] Law Council of Australia, above n 15, 41 [151].

reportable incidents scheme. The latter is set to change from the requirement on approved providers to merely report incidents, to requiring details of investigations into and responses to reported incidents.[28]

51. The Law Council strongly supports the ALRC's recommendation requiring providers to notify an independent oversight body of a serious incident and develop an appropriate response. However, the ALRC has recommended amending the time-frame within which a provider must respond to a serious incident from 24 hours to no more than 30 days, in order to allow the provider sufficient time to provide a response to an allegation or report of a serious incident.[29] The Law Council submits that the time frame for reporting a serious incident to the oversight body should be within 24 hours of the allegation being raised with the provider or of the incident occurring. Depending on the seriousness of the allegation or incident, the oversight body could then provide a time-frame within which the provider must respond. The time allowed should be reasonable in all the circumstances, taking into account the risk of harm that may be caused to the care recipient if the response is delayed.

Comments with respect to the *State*

52. The Law Council queries whether, in circumstances where a person concerned about a care recipient in an approved aged care service is unaware of processes and jurisdiction, and for instance makes a complaint to the state or territory departments of health and human services instead of the Commonwealth DHS, this service should be obliged to re-direct the complaint to the Commissioner or DHS, or at least notify the complainant that they do not have jurisdiction to deal with the matter to enable the complainant to redirect their concerns. The Law Council queries whether this duty should be higher where the allegations involve serious abuse that poses a risk to the care recipient's life.

Recommendation 5

The establishment of an *independent* oversight body, as recommended by the ALRC, will serve as a critical component of an effective reporting framework.

[28] Australian Law Reform Commission, Australian Government, above n 1, 114 [4.55].
[29] Ibid 116 [4.66].