11. Aged Care

Contents

Summary

11.1 Older people in receipt of aged care—whether in the home or in residential aged care—may experience abuse or neglect. Abuse may be committed by paid staff, other residents in residential care settings, or family members or friends.

11.2 There are a range of existing processes in aged care through which the quality and safety of aged care is monitored. This chapter identifies these, as well as making a number of proposals for reforms to aged care laws and legal frameworks to enhance safeguards against abuse for older people in receipt of aged care. The proposals are in keeping with the broader direction of reform in aged care, which seeks to provide a more flexible aged care system for consumers of aged care, while focusing regulation on 'ensuring safety and quality [and] protecting the vulnerable'.[1]

11.3 In this chapter, the ALRC proposes:

- expanding the scope of the type of incidents required to be reported under the *Aged Care Act 1997* (Cth) (*Aged Care Act*), and establishing a reportable incident scheme;
- 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, and the introduction of an official visitors scheme to provide independent rights monitoring for people in residential aged care.

11.4 This chapter also addresses decision making in aged care. It highlights the recommendation made in the 2014 ALRC Report, *Equality, Capacity and Disability in Commonwealth Laws* (*Equality, Capacity and Disability* Report) that aged care laws should be reformed consistently with the Commonwealth decision-making model, and proposes that aged care agreements cannot require that a person has formally appointed a decision maker.

The aged care system

11.5 The Commonwealth provides funding for aged care and regulates its provision through granting approvals for providers of aged care and prescribing responsibilities for approved providers. Home care, flexible care and residential care are all regulated under the *Aged Care Act*. Additionally, entry-level home support services for older people[2] are provided through the Commonwealth Home Support Programme (CHSP)

1 Productivity Commission, *Caring for Older Australians: Overview* (Report No 53, 2011) xxv.

2 People aged 65 years and over, or 50 years and over for Aboriginal and Torres Strait Islander people: Department of Social Services (Cth), *Commonwealth Home Support Programme Manual 2015* (2015) 13.

in all states and territories except Western Australia.[3] Recipients of grants to provide services under the CHSP must comply with a range of requirements, including in relation to quality and reporting.[4]

11.6 A number of Principles made under the *Aged Care Act* also regulate the provision of aged care. Included among these Principles are Charters of Care Recipients' Rights and Responsibilities.[5] These include the right to be treated with dignity and to live without exploitation, abuse or neglect.[6] In residential care, they also include the right to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction.[7]

11.7 The majority of older people live at home without accessing Australian Government-subsidised aged care services.[8] However, the proportion of people receiving aged care increases with age. For example, while only 7% of people aged 65 years and over receive permanent residential care, this increases to 29.7% of people aged 85 years or over.[9]

11.8 More people receive some form of aged care at home than residential aged care. In 2014–15, 231,255 people received permanent residential care, 812,000 people accessed entry-level home care, and 83,800 people accessed home care packages provided under the *Aged Care Act*.[10]

Regulating quality of care

11.9 Ensuring quality of care is perhaps the best safeguard against abuse and neglect. The Department of Health (Cth) submitted that the existing regulatory framework in aged care 'has a strong focus on the quality and accountability of aged care services'.[11] Aged care providers argued that the existing regulatory framework was 'rigorous'.[12] Other stakeholders expressed significant concerns about systemic issues relating to the quality of care in aged care, and the processes for monitoring quality.[13] However,

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3 Negotiations for transition of entry level home care services for older people in Western Australia to the CHSP are ongoing: Ibid 3. There are plans to integrate the two home-based aged care programs—home care regulated under the *Aged Care Act*, and entry-level care provided under the CHSP—into a single care at home program from July 2018: Department of Health (Cth), *Home Care Packages—Reform* <www.agedcare.health.gov.au>.

4 Department of Social Services (Cth), above n 2, 86.

5 *User Rights Principles 2014* (Cth) schs 1–3. Approved providers have a responsibility not to act in a way that is inconsistent with care recipients' rights and responsibilities: *Aged Care Act 1997* (Cth) ss 56-1(m), 56-2(k), 56-3(l).

6 *User Rights Principles 2014* (Cth) sch 1 cl 1(d), sch 2 cl 1(b), (g), sch 3 cl 2(d).

7 Ibid sch 1 cl 1(g).

8 Department of Health (Cth), *2014–15 Report on the Operation of the Aged Care Act 1997* (2015) 8.

9 Ibid 3.

10 Ibid xii. The number of home care packages under the Act will increase to around 100,000 places nationally by 2017–18: Department of Health (Cth), above n 3.

11 Department of Health (Cth), *Submission 113*.

12 UnitingCare Australia, *Submission 162*; Leading Age Services Australia, *Submission 104*; Aged and Community Services Australia, *Submission 102*.

13 A number of submissions to this Inquiry were critical of the quality assurance systems in aged care: see, eg, Seniors Rights Service, *Submission 169*; Aged Care Crisis, *Submission 165*; Australian Nursing & Midwifery Federation, *Submission 163*; Elder Care Watch, *Submission 84*; NSW Nurses and Midwives' Association, *Submission 29*; Quality Aged Care Action Group Incorporated, *Submission 28*.

addressing such concerns requires considerations of a systemic character that are more suited to a broader review.

11.10 The task of ensuring that approved providers meet their responsibilities in relation to quality of care is shared by the Department of Health, the Australian Aged Care Quality Agency (Quality Agency), and the Aged Care Complaints Commissioner (Complaints Commissioner).

Department of Health

11.11 The Department of Health (the Department) monitors compliance with the Act and with any agreements or contracts with the provider.[14] In the event of non-compliance, the Department may take action, including imposing sanctions on the provider. Sanctions include: revoking or suspending the approved provider's approval as an aged care service provider; restricting such approval; revoking or suspending the allocation of some or all of the places allocated to a provider.[15]

Australian Aged Care Quality Agency

11.12 The Quality Agency accredits residential aged care providers, and assesses existing providers against quality standards.[16] Every residential aged care home receives one unannounced assessment against quality standards each year.[17] The Quality Agency may also perform 'review audits' when there are concerns about a home's performance.

11.13 The Quality Agency also reviews home care providers (provided under both the Act and the CHSP) as well as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program against quality standards.[18]

11.14 Where non-compliance with standards is identified, the Quality Agency will require the provider to address the non-compliance and inform the Department. The Department then makes a decision about whether to take any action in relation to the non-compliance.[19] Where the Quality Agency identifies a serious risk to care recipients, the service provider and Department are notified immediately.[20]

11.15 The Quality Agency also promotes high quality care, innovation in quality management and continuous improvement among approved providers, and provides information, education and training to approved providers.[21]

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14 Department of Social Services (Cth), *Aged Care Compliance Policy Statement 2015–2017* (2015) 4.
15 *Aged Care Act 1997* (Cth) s 66-1.
16 *Australian Aged Care Quality Agency Act 2013* (Cth) s 12. See also Australian Aged Care Quality Agency, *Annual Report 2014–2015* (2015) 30. The Accreditation Standards are set out in the *Quality of Care Principles 2014*.
17 Australian Aged Care Quality Agency, above n 16, 32.
18 The Home Care Standards are specified in the *Quality of Care Principles 2014*. The National Aboriginal and Torres Strait Islander Flexible Aged Care Program has a separate quality framework, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Standards.
19 Department of Social Services (Cth), above n 14, 8.
20 Department of Health (Cth), *Submission 113*.
21 *Australian Aged Care Quality Agency Act 2013* (Cth) ss 9, 12(e)–(f).

Aged Care Complaints Commissioner

11.16 The Complaints Commissioner can receive complaints from any source about concerns relating to an aged care (residential, home or flexible care) service provider's responsibilities under the Act or a provider's agreement with the Australian Government. The Commissioner has the power to direct a service provider to demonstrate that it is meeting its responsibilities under the Act or the agreement. The Commissioner can also refer matters to the Department, the Quality Agency and other relevant agencies.[22]

Aged care reforms

11.17 The aged care system is in a period of reform, the direction of which was broadly set in the 2011 Productivity Commission Report, *Caring for Older Australians*.[23] The Australian Government responded to this report with the 'Living Longer Living Better' reform package.[24] The goal of reform has been described as an aged care system that is 'more consumer-driven, market-based and less regulated'.[25] There is an increased emphasis on providing aged care in the home, and a shift to a 'consumer directed' model of home care.[26]

11.18 The move to marketisation and individualisation in aged care mirrors international trends in the provision of care for older people.[27] Delivering services in this way is said to have a number of benefits:

> First, giving service users (or their agents) purchasing power should empower users by enabling them to exercise consumer sovereignty. Second, this should improve the quality of services and reduce costs to purchasers, by forcing providers to compete for business.[28]

11.19 However, for improved choice, efficiency and quality to be realised, 'certain conditions must be met: information about the price and quality of competing suppliers must be freely available to consumers; the costs of changing suppliers must be low; and suppliers must operate in a competitive market'.[29]

11.20 This may not be the case in aged care. For example, decisions about choosing aged care may be made at a time of crisis, and at short notice, which limit the ability to

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22 Aged Care Complaints Commissioner, *Annual Report 2015–16* (2016).

23 Productivity Commission, *Caring for Older Australians* (Report No 53, 2011).

24 Rebecca de Boer and Peter Yeend, Department of Parliamentary Services (Cth), *Bills Digest*, No 106 of 2012–13 (May 2013).

25 Department of Health (Cth), above n 3. See also Aged Care Sector Committee, *Aged Care Roadmap* (2016); Department of Health (Cth), *What Has Been Achieved so Far* <agedcare.health.gov.au>.

26 Department of Health (Cth), *Why Is Aged Care Changing* <www.agedcare.health.gov.au>. Additional changes to home care will commence on 27 February 2017, and will, among other things, provide that funding for a home care package will follow the consumer, and provide greater portability of home care packages: Department of Health (Cth), *Increasing Choice in Home Care* <www.agedcare.health.gov.au>.

27 See, eg, Deborah Brennan et al, 'The Marketisation of Care: Rationales and Consequences in Nordic and Liberal Care Regimes' (2012) 22(4) *Journal of European Social Policy* 377, 378; Michael D Fine, 'Individualising Care. The Transformation of Personal Support in Old Age' (2013) 33(3) *Ageing & Society* 421.

28 Brennan et al, above n 27, 379.

29 Ibid.

make informed choices. Additionally, where continuity of care is important, the transaction costs of switching providers may limit an aged care consumer's ability to choose other, higher quality, service providers. And finally, consolidation of providers to achieve economies of scale may result in a concentrated market and limit competition over quality and price.[30]

11.21 Some stakeholders were concerned by this approach to the provision of aged care. For example, Aged Care Crisis argued that because aged care recipients are vulnerable, 'the necessary conditions for an unrestricted market to operate do not exist'. The result, it argued, is that 'aged care is a failed market and it has been failing citizens for a long time … The failure to provide basic and empathic care to the vulnerable is a form of elder abuse'.[31]

11.22 Concerns also exist about the move to individualisation through consumer directed care. Consumer directed care is 'both a philosophy and an orientation to service delivery'.[32] It seeks to empower aged care recipients as 'consumers' and provide them with control of the types of care and services they receive, and how they are delivered. It also seeks to utilise market forces to promote improvements in quality.[33]

11.23 However, some have argued that there are risks of abuse in this model. For example, the Office of Public Advocate (Vic) submitted that its main concern was 'how people with cognitive impairment or mental ill-health are assisted to make decisions in these frameworks'.[34] Other submissions raised concerns about the ability of older people to access and understand meaningful information about care choices.[35] The Australian College of Nursing, for example, said that

> A significant risk of [consumer directed care] is an older person's lack of awareness or understanding of the range of services and service alternatives that are available to them. If a care and/or service recipient is not appropriately informed they may select service options that are not in their best interest or of greatest benefit to them.[36]

11.24 The Complaints Commissioner emphasised the importance of good information provision in consumer directed care:

> The provision of good information at times and in a form that takes account of the individual's needs and circumstances is another important safeguard for consumers as they exercise greater choice and control of their aged care and the associated funding. Good information, including how to raise concerns, is vital and helps to correct the

30 Ibid 379–80.
31 Aged Care Crisis, *Submission 165*.
32 Department of Health (Cth), *Consumer Directed Care* <www.agedcare.health.gov.au>.
33 ARC Centre of Excellence in Population Ageing Research, *Aged Care in Australia: Part II—Industry and Practice* (Research Brief 2014/02) 18.
34 Office of the Public Advocate (Vic), *Submission 95*.
35 See, eg, Aged Care Complaints Commissioner, *Submission 148*; Australian College of Nursing, *Submission 147*; Queensland Nurses' Union, *Submission 47*.
36 Australian College of Nursing, *Submission 147*.

> 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.[37]

11.25 A legislated review of the reforms made by the Living Longer Living Better package is underway.[38] The 'Aged Care Legislated Review' must consider, among other things: demand for aged care places; control of the number and mix of aged care places; further movement towards a consumer directed care model; equity of access; and workforce strategies.[39] It must report by 1 August 2017.[40] This review is the appropriate place to consider the broader policy settings for aged care, including in relation to marketisation and individualisation.

11.26 Further reform is also planned for quality assurance processes in aged care. There are plans to consolidate a range of standards applying to approved providers of residential and home care into a single set of aged care quality standards.[41] Other reforms aim to improve transparency about quality of care. For example, a voluntary National Aged Care Quality Indicator Program began on 1 January 2016 for residential aged care. Home care quality indicators are being developed, with implementation planned for 2018.[42]

11.27 Concerns were raised in this Inquiry about how quality and safety will be regulated in an environment in which approved home care providers can sub-contract or broker services to provide consumer directed care to an older person. Where approved providers do sub-contract or broker services, they remain responsible for service quality and meeting all regulatory responsibilities.[43] However, submissions to this Inquiry suggest that an emerging issue will be how best to regulate the quality and safety of home care in the further reforms to 'streamline' quality accreditation that have been signalled.[44]

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37 Aged Care Complaints Commissioner, *Submission 148*.

38 *Aged Care (Living Longer Living Better) Act 2013* (Cth) ss 4(1), (4); Department of Health (Cth), *Aged Care Legislated Review* <www.agedcare.health.gov.au>.

39 *Aged Care (Living Longer Living Better) Act 2013* (Cth) s 4(2).

40 Department of Health (Cth), above n 38.

41 Consultation on draft standards is planned for 2017: Department of Health (Cth), *Single Set of Aged Care Quality Standards* <www.agedcare.health.gov.au>.

42 Department of Health (Cth), *About the National Aged Care Quality Indicator Program* <www.agedcare.health.gov.au>; Department of Health (Cth), *Home Care Quality Indicators* <www.agedcare.health.gov.au>. The Department has also indicated that it is developing options for making additional quality information publicly available to 'help consumers make informed choices' about care: Department of Health (Cth), *Improved Information on Quality of Services* <www.agedcare.health.gov.au>.

43 Department of Health (Cth), *Home Care Packages Programme Operational Manual: A Guide for Home Care Providers* (2015) 38.

44 Department of Health (Cth), *Streamlined Accreditation Arrangements Across Residential and Community Aged Care* <www.agedcare.health.gov.au>. Submissions raising this issue included Australian Nursing & Midwifery Federation, *Submission 163*; NSW Nurses and Midwives' Association, *Submission 29*; Older Women's Network NSW, *Submission 136*.

11.28 Improvements to quality assurance processes may prevent or lessen the risk of elder abuse. For example, in developing the single set of aged care quality standards, consideration could be given to including standards relating to approved providers' provision of safeguards against abuse and neglect of care recipients.[45]

11.29 Some stakeholders advocated for increased transparency of quality information.[46] For example, Alzheimer's Australia submitted that:

> Data on performance and quality of aged care services should be routinely collected, analysed, and made publicly available, to assist consumers in making informed choices in regard to the services they receive. The public availability of such data will also help to drive service competition and quality improvement.[47]

11.30 However, National Seniors expressed caution about the ability of quality indicators to address elder abuse, arguing that

> there is a real threat that these may in fact heighten rather than lessen risk. There have already been concerns expressed, for example, that specific quality indicators create perverse incentives which divert resources at the expense of other areas. … Unless quality indicators are able to focus resources towards the things that residents and their representatives themselves believe make them safe and supported, quality monitoring systems such as the QI Programme will not actively reduce the risks of abuse in residential care. The same will be true in the home care setting.[48]

11.31 The Aged Care Legislated Review, in its analysis of whether further steps could be taken to move to a consumer driven demands model of aged care service delivery, provides an opportunity to consider the sufficiency of publicly available information about quality of care.[49] In particular, it might explore possibilities for making available information relating to a provider's provision of safeguards against abuse and neglect of care recipients.

Abuse and neglect in aged care

11.32 Some stakeholders submitted that the majority of elder abuse occurs in the community, rather than in formal aged care.[50] There is no comprehensive data available on the prevalence of abuse of people receiving aged care. There is data available on numbers of alleged or suspected 'reportable' assaults in residential aged care notified to the Department of Health each year. However, as the Department of Health has noted, this information 'reflects the number of reports made by providers …

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45 For example, safeguarding people from abuse is a fundamental standard for care in the UK: *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* cl 13. See also ADA Australia, *Submission 150*; Townsville Community Legal Service Inc, *Submission 141*; Queensland Nurses' Union, *Submission 47*; Alice's Garage, *Submission 36*.

46 See, eg, Australian Nursing & Midwifery Federation, *Submission 163*; Townsville Community Legal Service Inc, *Submission 141*; Capacity Australia, *Submission 134*; Elder Care Watch, *Submission 84*; Australian and New Zealand Society for Geriatric Medicine, *Submission 51*; Queensland Nurses' Union, *Submission 47*.

47 Alzheimer's Australia, *Submission 80*.

48 National Seniors Australia, *Submission 154*.

49 *Aged Care (Living Longer Living Better) Act 2013* (Cth) s 4(2)(c).

50 See, eg, Resthaven, *Submission 114*; Aged and Community Services Australia, *Submission 102*.

and does not reflect the number of substantiated allegations'.[51] Reportable assaults also capture a more narrow range of conduct than what may be described as elder abuse.

11.33 There is also data available relating to complaints made about home and residential aged care to the Complaints Commissioner or its predecessor schemes. Not all these complaints relate to abuse or neglect. Further, not all complaints of abuse are substantiated.[52] A number of stakeholders also reported the results of projects that capture reports of abuse or neglect in aged care,[53] and there is some evidence available relating to deaths in nursing homes.[54]

11.34 Stakeholders reported many instances of abuse of people receiving aged care. These included reports of abuse by paid care workers[55] and other residents of care homes[56] as well as by family members and/or appointed decision makers of care recipients.[57] For example, Alzheimer's Australia provided the following examples of physical and emotional abuse:

> When working as a PCA [personal care assistant] in 2 high care units, I witnessed multiple, daily examples of residents who were unable to communicate being abused including: PCA telling resident to 'die you f---ing old bitch!' because she resisted being bed bathed. Hoist lifting was always done by one PCA on their own not 2 as per guidelines and time pressures meant PCAs often using considerable physical force to get resistive people into hoists; resident not secured in hoist dropped through and broke arm—died soon after; residents being slapped, forcibly restrained and force-fed or not fed at all; resident with no relatives never moved out of bed, frequently left alone for hours without attention; residents belongings being stolen and food brought in by relatives eaten by PCAs.[58]

11.35 The ALRC also received reports of other forms of abuse, including sexual[59] and financial abuse.[60] Restrictions on movement[61] and visitation[62] were also reported. Many submissions also identified neglect of care recipients.[63]

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51 Department of Health (Cth), *Submission 113*.

52 Aged Care Complaints Commissioner, *Submission 148*.

53 See, eg, Seniors Rights Service, *Submission 169*; ARAS, *Submission 166*; Aged Care Crisis, *Submission 165*; Elder Care Watch, *Submission 84*; NSW Nurses and Midwives' Association, *Submission 29*. See also NSW Nurses and Midwives Association, *Who Will Keep Me Safe? Elder Abuse in Residential Aged Care* (2016).

54 See further Professor J Ibrahim, *Submission 63*.

55 See, eg, ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; TASC National, *Submission 91*; Advocare Inc (WA), *Submission 86*; Elder Care Watch, *Submission 84*; Alzheimer's Australia, *Submission 80*; Name Withheld, *Submission 19*.

56 See, eg, Name Withheld, *Submission 189*; C Jenkinson, *Submission 188*; Alzheimer's Australia, *Submission 80*.

57 See, eg, Seniors Rights Service, *Submission 169*; L Barratt, *Submission 155*; State Trustees Victoria, *Submission 138*; Office of the Public Advocate (Vic), *Submission 95*; Law Council of Australia, *Submission 61*; Legal Aid ACT, *Submission 58*; Older Persons Advocacy Network, *Submission 43*.

58 Alzheimer's Australia, *Submission 80*. For a number of other examples, see, eg, Australian Nursing & Midwifery Federation, *Submission 163*; ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; Elder Care Watch, *Submission 84*; Advocare Inc (WA), *Submission 86*.

59 See, eg, ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; Dr C Barrett, *Submission 68*. See also Rosemary Mann et al, 'Norma's Project: A Research Study into the Sexual Assault of Older Women in Australia' (Monograph Series No 98, Australian Research Centre in Sex, Health and Society, La Trobe University, 2014).

60 See, eg, Older Persons Advocacy Network, *Submission 43*; State Trustees Victoria, *Submission 138*.

Compulsory reporting of abuse and complaint handling

Proposal 11–1 Aged care legislation should establish a reportable incidents scheme. The scheme should require approved providers to notify reportable incidents to the Aged Care Complaints Commissioner, who will oversee the approved provider's investigation of and response to those incidents.

Proposal 11–2 The term 'reportable assault' in the *Aged Care Act 1997* (Cth) should be replaced with 'reportable incident'.

With respect to residential care, 'reportable incident' should mean:

(a) a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or toward a care recipient;

(b) a sexual offence, an incident causing serious injury, an incident involving the use of a weapon, or an incident that is part of a pattern of abuse when committed by a care recipient toward another care recipient; or

(c) an incident resulting in an unexplained serious injury to a care recipient.

With respect to home care or flexible care, 'reportable incident' should mean a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or toward a care recipient.

Proposal 11–3 The exemption to reporting provided by s 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, should be removed.

11.36 The ALRC proposes the introduction of a reportable incident scheme in aged care, modelled on New South Wales' disability reportable incidents scheme, and that this scheme replace the current statutory compulsory reporting scheme. Under the proposed scheme, approved providers would be required to report a broader range of abusive conduct to the Complaints Commissioner. The scheme should sit alongside existing complaint mechanisms, and strengthen the system's responses to complaints (including compulsory reports) of abuse and neglect.

61 See, eg, ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; Capacity Australia, *Submission 134*; Office of the Public Advocate (Vic), *Submission 95*; Law Council of Australia, *Submission 61*; Older Persons Advocacy Network, *Submission 43*.

62 See, eg, Legal Aid ACT, *Submission 58*; Law Council of Australia, *Submission 61*.

63 See, eg, Australian Nursing & Midwifery Federation, *Submission 163*; Capacity Australia, *Submission 134*; Queensland Nurses' Union, *Submission 47*; NSW Nurses and Midwives' Association, *Submission 29*; Aged Care Service, Murrumbidgee Local Health District, *Submission 18*.

The current requirements for reporting allegations of abuse

11.37 Under the current system, approved providers are required to report certain allegations of abuse in respect of residential care recipients. 'Reportable assaults' are defined as

> unlawful sexual contact, unreasonable use of force, or assault specified in the *Accountability Principles* and constituting an offence against a law of the Commonwealth or a State or Territory …
>
> *staff member* of an approved provider means an individual who is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruiting agency) to provide care or other services.[64]

11.38 An approved provider must report an allegation, or a suspicion on reasonable grounds, of a 'reportable assault' on a care recipient to police and the Department of Health within 24 hours.[65]

11.39 The dual reporting requirement has been described as follows:

> The purpose of the police involvement is to assess whether criminal activity has occurred and if charges need to be laid. The police are the best and most appropriate authorities to make that judgment. The purpose of reporting to the Department is for us to consider whether the approved provider has actually met its responsibilities under the aged-care legislation.[66]

11.40 There are exemptions to reporting 'resident–on–resident' incidents, where the resident alleged to have committed the offending conduct has a pre-diagnosed cognitive impairment, provided the approved provider implements arrangements to manage the person's behaviour within 24 hours.[67]

11.41 Approved providers must also take reasonable steps to ensure that staff know their reporting obligations, and take reasonable measures to protect those reporting reportable assaults.[68]

11.42 In 2014–2015, prior to the current complaints scheme being implemented, there were 2,625 notifications of 'reportable assaults'.[69] Of these reports, 2,199 were recorded as alleged or suspected unreasonable use of force, 379 as alleged or suspected unlawful sexual contact, and 47 as both.[70] This represents an incidence of reports of suspected or alleged assaults of 1.1% of people receiving permanent residential care during that period.[71]

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64 *Aged Care Act 1997* (Cth) s 63-1AA(9).
65 Ibid s 63-1AA(2).
66 Senate Standing Committee on Community Affairs, Parliament of Australia, *Aged Care Amendment (Security and Protection) Bill 2007 (Provisions)* (2007) 11.
67 *Accountability Principles 2014* (Cth) s 53.
68 *Aged Care Act 1997* (Cth) s 63-1AA(5)–(8).
69 Department of Health (Cth), above n 8, 107.
70 Ibid.
71 Ibid.

11.43 There is little information beyond these numbers that gives any more detail on these incidents, including who the alleged perpetrator was, what action was taken in response to the report, or the outcome.

The current framework for complaint handling

11.44 The complaint handling process with respect to aged care incorporates two aspects. First, approved providers are required under the *Aged Care Act* to have a 'complaint resolution mechanism', and to use the mechanism to address complaints made by, or on behalf of, a care recipient.[72] Secondly, complaints can be made to the Complaints Commissioner.

11.45 The Complaints Commissioner submitted to the ALRC that, in the first six months of 2016, her office received just 113 complaints identifiable with the keyword 'abuse', representing 2% of all complaints received by her office in that period.[73]

11.46 Reportable assaults are not automatically treated as 'complaints'. The Complaints Commissioner can receive complaints of 'mandatory reports' (or reportable assaults) referred by the Department of Health,[74] however it is unclear how often, if ever, this occurs.

Gaps in the current frameworks

11.47 Both the reportable assault scheme and the complaints scheme enable reports of abuse and neglect in aged care to be brought to light, by providing mechanisms where data relating to complaints of abuse against older people receiving Commonwealth funded aged care is captured. There are, however, gaps in how the two schemes operate together to respond to incidents of abuse, and how they function to safeguard care recipients.

11.48 First, an approved provider is not required to take any 'action' in response to a reportable assault, other than to report it and maintain appropriate records. This means that a provider can satisfy the regulatory compliance obligations without performing any sort of investigation or review into the incident. There are quality standards that providers are required to maintain, but these focus more broadly on quality of care provided, rather than a provider's response to a particular incident.

11.49 Second, reportable assaults are not automatically treated as 'complaints', and therefore the response of approved providers to those incidents is not monitored. Indeed, the Complaints Commissioner would have to rely on a referral of information from either a victim, another concerned party (for example, a family member or care worker) or the Department before that office would know about a reportable assault having occurred.

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72 *Aged Care Act 1997* (Cth) s 56-4, 59-1(1)(g).
73 Aged Care Complaints Commissioner, *Submission 148*.
74 Ibid.

Approved provider response to reportable assaults

11.50 The Department of Health describes its role as 'confirming that reporting is made within the specified timeframe; that there are appropriate systems in place for reporting; and that appropriate action has been taken'.[75] It states that it 'may' take compliance action where approved providers do not meet their obligations under the Act.

11.51 The Department's unequivocal position is that 'investigation of alleged assault is the responsibility of the police who will determine whether the incident is criminal in nature and what further action is required'.[76]

11.52 It is concerning that there is no requirement that an approved provider perform any type of investigation into incidents concerning care recipients in their care. There are likely to be many matters where police determine not to pursue a criminal investigation, yet where there may still be significant concerns and risks arising from the incident that require investigation and analysis to safeguard and protect those in care—both the alleged victim and other care recipients. That an incident is unlikely to result in a criminal investigation or prosecution ought not preclude it from being investigated and examined by the agency responsible for providing care to the alleged victim. There may still be significant risks to the victim or others that could be identified and responded to if an appropriate investigation were performed.

11.53 The ALRC acknowledges the comments of some approved providers that 'responsible' providers will take appropriate action in response to reportable assaults.[77] However, given the serious nature of the incidents captured by the scheme; the approved providers' duty of care owed to, and level of control over the day to day lives of, care recipients; the vulnerability of many of those care recipients; and the potential for conflicts of interest in relation to the management of reportable assaults, there is a strong argument supporting the establishment of a scheme that would function to increase accountability, transparency and organisational responses to serious incidents of abuse of older people.

Treating reportable assaults as complaints

11.54 Proposal 11-1 to 11-3 provide a framework that brings together the aged care complaints function and an oversight function for reportable incidents under the jurisdiction of the Complaints Commissioner.

11.55 The complaints scheme has already had several incarnations. At one time the Act provided for a 'Complaints Investigation Scheme' (CIS). The CIS was a broad complaints scheme and it was not restricted to responding to 'reportable assault' matters. Unlike the current scheme, it was not independent of the Department of Health.

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75 Department of Health (Cth), *Guide for Reporting Reportable Assaults* <www.agedcare.health.gov.au/>.
76 Ibid.
77 See, eg, UnitingCare Australia, *Submission 162*; Resthaven, *Submission 114*.

11.56 The Aged Care Complaints Scheme replaced the CIS in 2011, following a review, that had emphasised the importance of having an investigatory function to resolve complaints, that could operate alongside a resolution or mediation–focused mechanism:

> We would also note that the current complaints scheme embodies significant reforms on the earlier scheme. Many of these reforms are critical to achieving positive outcomes for complainants and for systemic improvements in service delivery in aged care along with identifying and rectifying matters of serious concern. The move away from mediation towards investigation has been a positive step. At the same time, as noted above, we would see benefits in ensuring that the shift away from mediation is not seen as a rejection of individual complaints resolution as a legitimate dimension of the scheme.[78]

11.57 When the legislation establishing the independence of the Complaints Commissioner was passed, part of the rationale was said to be that 'the change will result in a separation of complaints management from the funder and regulator, which reflects best practice in complaints handling'.[79]

11.58 However as noted, 'reportable assaults' are not required to be notified to the Complaints Commissioner. The Commissioner has said that the focus of her role is on 'ensuring service providers have acted appropriately to: ensure any affected residents are safe; find out what happened; ensure it doesn't happen again; and the right people are told'.[80]

11.59 The ALRC considers that such incidents ought to be responded to as 'complaints'. There is a strong argument for incidents of such a serious nature (those that are defined as a 'reportable assault') to be *required* to be reported in a way that triggers an appropriate investigation and response (by the approved provider) that is able to be monitored or overseen by an independent complaints–handling body that can also support and advise the provider to ensure best practice in the management of the incident.

11.60 The ALRC is of the view that there is significant gap in the legislative protection afforded under the current reporting regime, and notes that it was designed to offer 'safeguards to older people' receiving aged care. As observed by the NSW Ombudsman

> a reporting and independent oversight system is an important and necessary component of a comprehensive framework for preventing and effectively responding to, abuse, neglect and exploitation of more vulnerable people members of the community … and is fundamental to enabling a genuinely person-centred approach to supports.[81]

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78 Associate Professor Merrilyn Walton, 'Review of the Aged Care Complaints Investigation Scheme' (Commonwealth Ombudsman, September 2009) 11.

79 Commonwealth *Parliamentary Debates*, House of Representatives, 13 August 2015, 5240 (Mitch Fifield).

80 Aged Care Complaints Commissioner, *Submission 148.*

81 NSW Ombudsman, *Submission 160*.

11.61 To address these gaps, the ALRC proposes that a reportable incident scheme be established in aged care.

Reportable incidents

11.62 The ALRC proposes the establishment of a national reportable incidents scheme designed to respond to concerns raised about the limited scope of the current reporting regime, and the lack of transparency and accountability in responses to reportable assaults. The scheme would replace the existing reporting regime in the *Aged Care Act* and, to be effective, it will be critical that adequate investment and resourcing is allocated to ensure the scheme can function effectively.

11.63 The proposed reportable incident scheme is modelled on the 'disability reportable incidents scheme' (DRIS), established by Part 3C of the *Ombudsman Act 1974* (NSW).[82]

11.64 The ALRC acknowledges the concerns raised by stakeholders regarding the compulsory reporting regime,[83] and has considered the expanded scope of conduct captured by the DRIS, and the distinction between certain categories of incident under that scheme. The benefits of reportable conduct schemes have been acknowledged, including their ability to improve systemic responses across a sector.[84]

11.65 The DRIS provides an instructive model upon which to base a reporting regime for aged care, as it captures people who are closer to the cohort of people the subject of this Inquiry, that is, older people with disability, and draws on 16 years of experience of the employment related child-protection function provided by Part 3A.[85]

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82 Part 3C is modelled on Part 3A of the *Ombudsman Act 1974*, which has provided for a reportable conduct scheme since 1999. There are currently no equivalent schemes in other jurisdictions, however Victoria and the ACT have reported they are developing them, and COAG has welcomed a proposal for 'nationally harmonised reportable conduct schemes to improve oversight of responses to allegations of child abuse and neglect [and has] agreed, in-principle, to harmonise reportable conduct schemes, similar to the current model in operation in NSW and announced in the ACT and Victoria': Department of Justice and Regulation (Vic), *Overview of Child Safe Standards and Reportable Conduct Scheme* <www.justice.vic.gov.au/>; Andrew Barr, MLA, 'New Reportable Conduct Scheme to Better Protect Children' (Media Release, 9 June 2016); Council of Australian Governments *Communiqué* (1 April 2016).

83 Seniors Rights Service, *Submission 169*; People with Disability Australia, *Submission 167*; Aged Care Crisis, *Submission 165*; Australian College of Nursing, *Submission 147*; Townsville Community Legal Service Inc, *Submission 141*; UNSW Law Society, *Submission 117*; National LGBTI Health Alliance, *Submission 116*; Office of the Public Advocate (Vic), *Submission 95*; Northern Territory Anti-Discrimination Commission, *Submission 93*; Law Council of Australia, *Submission 61*.

84 See, eg, Department of Justice and Regulation (Vic), above n 82; NSW Ombudsman, *Strengthening the Oversight of Workplace Child Abuse Allegations. A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2016).

85 'Disability' is defined as 'long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person's full and effective participation in the community on an equal basis with others': *Disability Inclusion Act 2014* (NSW) s 7.

11.66 The NSW Ombudsman has said that it has received 'consistent feedback' that providers subject to the DRIS welcome the introduction of the scheme, and have embraced the opportunity to receive feedback and guidance on best practice in preventing and responding to serious incidents.[86]

11.67 The proposed scheme sits in the *Aged Care Act*, however there is a cohort of older people that receive aged care and support from services that are not in receipt of federal funding,[87] and are therefore not cared for by 'approved providers' covered by the *Aged Care Act*. There is an argument that it would be possible for the scheme to apply more broadly, by linking it not to the *Aged Care Act*, but rather establishing a nexus with Australia's international obligations under various instruments and relying on the external affairs power.[88]

11.68 Australia has a number of obligations under various instruments, including the *International Covenant on Economic, Social and Cultural Rights*, the *Convention on the Rights of Persons with Disabilities* and the *International Convention on Civil and Political Rights*. These obligations include, for example, taking 'all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities … from all forms of exploitation, violence and abuse'.[89]

11.69 It would be preferable to cast a wide net to ensure safeguards are extended to all older people receiving aged care, irrespective of whether the provider is regulated under the *Aged Care Act*. However, the ALRC's preliminary view is that it would be more appropriate, and offer more certainty, to establish the scheme under existing Commonwealth legislation, where an existing policy position supporting compulsory reporting already exists specifically to safeguard those receiving care under the Act. After evaluation, consideration could be given to potentially expanding into other areas in the future.

The independent oversight and monitoring role

11.70 A fundamental feature of the scheme is the independence of the oversight and monitoring body. Review mechanisms that are independent ensure greater accountability and transparency: that decision making by the review body is based on relevant information and facts, and free from the influence of extraneous factors which ought not be considered. Such factors might include political or social pressures or, in the context of schemes like the DRIS and in the aged care sector, real or potential conflicts of interest. A typical example might arise where an organisation is

86 NSW Ombudsman, Submission No 29 to Senate Standing Committee on Community Affairs, Parliament of Australia, *Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings* (April 2015) 23.

87 For example, private enterprises including boarding houses and retirement homes and villages.

88 For a discussion of 'potential basis' for the Commonwealth legislating in respect of elder abuse by relying on the external affairs power, see Rae Kaspiew, Rachel Carson and Helen Rhoades, 'Elder Abuse: Understanding Issues, Frameworks and Responses' (Research Report 35, Australian Institute of Family Studies, 2016).

89 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

investigating an allegation in respect of one of its staff members, or the standard of service being provided.

11.71 The DRIS requires the head of an agency covered to notify all reportable incidents to the NSW Ombudsman within 30 days of becoming aware of the allegation. The Ombudsman, on receipt of the notification, will determine whether the agency's investigation into the incident has been properly conducted and whether appropriate action to manage risk has been taken. The Ombudsman may monitor the investigation and, where an incident is the subject of monitoring, the agency is required to report the results of investigation and risk management action taken, to the Ombudsman.

11.72 The Ombudsman reported that the DRIS legislation 'requires and enables' it to

> **receive and assess notifications** concerning reportable allegations or convictions
>
> **scrutinise agency systems** for preventing reportable incidents, and for handling and responding to allegations of reportable incidents
>
> **monitor and oversight** agency investigations of reportable incidents
>
> **respond to complaints** about inappropriate handling of any reportable allegation or conviction
>
> **conduct direct investigations** concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable incident or conviction
>
> **conduct audits and education and training** activities to improve the understanding of, and responses to, reportable incidents, and
>
> **report on trends and issues** in connection with reportable incident matters.[90]

11.73 The DRIS has a number of elements that operate together to form a necessary component of a safeguarding framework. The ALRC proposes that these elements form the foundation of the aged care model. These elements include:

- an independent oversight and monitoring body;
- a definition of 'reportable assault' that captures an appropriate scope of conduct, but distinguishes between assaults perpetrated by those with cognitive impairment, and other incidents;
- powers to enable effective oversight and monitoring, including powers to compel production of documents, to provide information, and to conduct 'own motion' investigations; and
- information sharing provisions.

11.74 The ALRC proposes that the Complaints Commissioner be the independent oversight and monitoring body. The Complaints Commissioner already has jurisdiction to resolve complaints about aged care services, as well as to educate service providers about responding to complaints.[91]

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90 NSW Ombudsman, *Submission 160*.

91 Aged Care Complaints Commissioner, *Submission 148*; *Aged Care Act 1997* (Cth) pt 6.6.

11.75 The Commissioner noted the importance of working cooperatively with complainants and providers to uphold the rights of care recipients, and described the focus of her office as 'resolution rather than sanctions on individuals or aged care services'.[92]

Powers

11.76 The Complaints Commissioner can exercise a range of powers when working to resolve complaints, including the power to commence own-initiative investigations.[93] The Commissioner may also appoint 'authorised complaints officers'. These officers are able to exercise a number of powers, including the power to search premises, take photographs, inspect documents and to ask people questions.[94] However they are unable to enter the premises without the consent of the occupier.[95]

11.77 The NSW Ombudsman has substantial powers conferred upon it under the *Ombudsman Act 1975* (NSW). These include powers to require the production of documents, to require statements of information,[96] to enter and inspect premises,[97] to hold inquiries,[98] to make recommendations,[99] and to report to Parliament and to the public.[100] These powers enable it to effectively oversee and monitor agencies that are subject to the scheme.

11.78 Where the Complaints Commissioner, upon assessing a complaint, forms a view that an approved provider is not meeting their responsibilities under the Act, the Commissioner may issue a direction that the provider make certain changes. Where a provider fails to comply with the direction, the Commissioner may refer the matter to the Department to consider compliance action,[101] or to the Quality Agency to consider any systemic issues identified.[102]

11.79 It is worth noting that the NSW Ombudsman retains a complaints mechanism that relates to disability service providers other than the compulsory reports required under the DRIS. The practical effect is that, while anyone may make a complaint under the complaints function, there is a requirement for service providers to notify certain serious incidents under the DRIS.

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92 Aged Care Complaints Commissioner, *Submission 148.*
93 Ibid.
94 *Aged Care Act 1997* (Cth) s 94B-2.
95 Ibid s 94B-3(3).
96 *Ombudsman Act 1974* (NSW) s 25U(3).
97 Ibid s 20.
98 Ibid s 19.
99 Ibid pt 4.
100 Ibid s 31.
101 Aged Care Complaints Commissioner, *Guidelines for the Aged Care Complaints Commissioner Version 2.0* (2016).
102 Aged Care Complaints Commissioner and Australian Aged Care Quality Agency, *Memorandum of Understanding* (2016); Department of Health (Cth) and Aged Care Complaints Commissioner, *Memorandum of Understanding* (2016).

11.80 The impact on the number of incidents was evident within the first eight months of the DRIS' operation, with the NSW Ombudsman reporting that the DRIS received 437 notifications under the scheme.[103] This represents approximately 50 notifications per month. Deputy Ombudsman, Steve Kinmond, noted the significant increase in reports emanating from the DRIS when compared to those coming through the complaints mechanism that is also managed by the NSW Ombudsman:

> Comparing the data we have in relation to complaints of abuse and neglect, and of course that is one of the functions we perform as compared to the notification of abuse and neglect matters that we have received in relation to the reportable incidents scheme, there is an over 10 times increase in the number of abuse and neglect matters that we receive from this mandatory reporting system than what we receive under the complaints system.[104]

11.81 Mr Kinmond asserted that this provided 'a compelling case for legislative mandatory reporting for certain types of incidents'.[105]

11.82 Combining complaints and compulsory reporting would address a gap identified by some stakeholders, namely that reportable assaults are not necessarily treated as complaints, and responded to appropriately.

11.83 The current complaints system was said to be unable to respond to serious complaints. Mr Rodney Lewis, a solicitor with over 15 years of legal practice in the area of elder law, suggested there is a 'good case' for arguing that the current complaints system is 'inadequate for those whose complaints are serious and not amenable to settlement by mediation or the limited pathways which the system offers'.[106] Quality Aged Care Action Group Inc asserted that there is a 'gap between what 'should' happen and what actually does'.[107]

11.84 The safeguards afforded by the Charter of Residents Rights and Responsibilities were also criticised because the Charter has no 'enforcement or compliance mechanisms and is therefore exhortatory'.[108] Townsville Community Legal Service, in recognising the Charter rights, commented that

> whether this right [to live free from abuse and neglect] truly exists depends on how it translates into the accreditation and quality regime for aged care providers. There is a disconnect here between what the Charter says and the outcomes it produces.[109]

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103 NSW Ombudsman, Submission No 122 to Legislative Council General Purpose Standing Committee 2, Parliament of NSW, *Inquiry into Elder Abuse in NSW* (April 2016). Numbers represent DRIS notifications for the period 3 December 2014 to 25 August 2015.

104 Evidence to the Senate Standing Committee on Community Affairs, Parliament of Australia, Sydney, 27 August 2015, (Steve Kinmond).

105 Ibid.

106 R Lewis, *Submission 100*.

107 Quality Aged Care Action Group Incorporated, *Submission 28*. See also Aged Care Crisis, *Submission 165*.

108 Michael Barnett and Robert Hayes, 'Not Seen and Not Heard: Protecting Elder Human Rights in Aged Care' (2010) 14 *University of Western Sydney Law Review* 45, 57.

109 Townsville Community Legal Service Inc, *Submission 141*.

11.85 Consistent with the DRIS model, the ALRC does not propose that the Complaints Commissioner have any enforcement powers with respect to oversight and monitoring. Instead, the Commissioner should have the power to make recommendations, as well as to publicly report on any of its operations, including in respect of particular incidents or providers.

11.86 The ALRC notes the concern of the Seniors Rights Service that the Complaints Commissioner is a 'toothless tiger',[110] but suggests that there is greater potential for systemic reform through the proposed approach. It has been said that

> a truly remedial institution may not be best served by 'teeth'… an order, grudgingly accepted and implemented can only change one result. A recommendation, if it is persuasive and compelling, can change a mindset.[111]

11.87 The dual functions of complaint resolution and independent oversight and monitoring of internal complaint handling offers many benefits. It builds on the existing expertise of the Complaints Commissioner in relation to aged care; utilises and builds upon the existing complaints function; enables information captured across both functions to be utilised to develop an intelligence profile of approved providers and aged care staff and thus informs more comprehensive risk assessment and management of staff members and providers.

11.88 The proposal also incorporates an education and training element, which builds on the Complaints Commissioner's education function to 'educate people about … best practice in the handling of complaints that relate to responsibilities of approved providers under this Act and the Principles … and matters arising from such complaints'.[112]

11.89 Under the DRIS, the Ombudsman conducts education and training with service providers and key agencies on responding to serious incidents in disability services settings. This component has contributed to providers being better equipped to identify and respond to neglect and abuse; to understand the systems and processes that contribute to a 'client-safe' environment; and to understand the fundamental principles and strategies for conducting investigations.[113]

11.90 Finally, the scheme will contribute to a better understanding of the nature of serious incidents occurring in aged care, and enable data to be captured in a centralised location, thus supporting other safeguarding mechanisms including enhanced employment screening.[114]

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110 Seniors Rights Service, *Submission 169.*

111 Former Chair of the Royal Canadian Mounted Police Commission, Shirley Heafey quoted in Sankar Sen, *Enforcing Police Accountability through Civilian Oversight* (SAGE Publications India, 2010) 77.

112 *Aged Care Act 1997* (Cth) s 95A-1(2)(b).

113 NSW Ombudsman, *Submission 160*.

114 Law Council of Australia, *Submission 61*.

What should be reported?

11.91 Although some stakeholders questioned the merits of the compulsory reporting regime,[115] a strong theme in submissions was that the scope of the current compulsory reporting scheme is too restricted, and focused too heavily on regulatory compliance rather than reporting serious incidents in a way that activates an appropriate investigation and response into the matter.

11.92 Advocates and consumer groups have suggested that the scope of what constitutes a 'reportable assault' under the current scheme is inadequate. In summary, their concerns are that:

- the scope of conduct covered by the scheme was too limited and failed to include other serious forms of abuse;
- the scope was limited to care recipients in residential care;
- the exemption in respect of resident–on–resident assaults, where the offender had a pre-diagnosed cognitive impairment, afforded too broad a discretion to approved providers not to report, and resulted in a lack of understanding of how such incidents were managed, potentially raising broader safety issues in respect of other care recipients, and concealed the number and nature of such incidents.

11.93 If it is accepted that a key rationale for implementing a compulsory reporting regime is to enable visibility of such incidents so that appropriate action can be taken to protect and safeguard victims (and potential victims of abuse), it is important that any compulsory reporting scheme requires notification of an appropriate scope of serious conduct.

11.94 The proposal draws on the definition of 'reportable incident' in the DRIS, which captures a broad *range* of conduct, but draws a distinction between employee-to-client as opposed to client-to-client incidents. The DRIS categories are:

- Employee-to-client incidents—notifications are required in respect of a (relatively) broad range of conduct including any sexual offence, sexual misconduct, assault, Part 4AA offences,[116] ill-treatment and neglect;
- Client-to-client incidents—a higher threshold must be met before a notification is required, including where the incident involves a sexual offence, causes a serious injury, involves use of a weapon or is part of a pattern of abuse;
- incidents involving a contravention of an apprehended violence order (AVO) where the protected person is the person with disability;[117]
- incidents resulting in an unexplained serious injury to a person with disability.[118]

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115 See, eg, Leading Age Services Australia, *Submission 104*.
116 Part 4AA provides for fraud offences, and could capture some forms of financial abuse: *Crimes Act 1900* (NSW).
117 Referred to as intervention orders in some jurisdictions.
118 NSW Ombudsman, *Submission 160*; *Ombudsman Act 1974* (NSW) s 25P.

11.95 It is important to note the distinction, and in particular the different threshold, applicable to incidents where the alleged perpetrator is an employee, as opposed to a resident. In respect of client–to–client matters, the DRIS requires a higher threshold of harm or risk be met before they become 'reportable incidents'.

11.96 These different categories have the capacity to respond to a number of concerns raised by stakeholders.

Scope of conduct captured by 'reportable assault' in aged care

11.97 One of the concerns identified by stakeholders is that the type of conduct defined by the legislation as being a 'reportable assault' is too limited and fails to capture various forms of serious 'abuse' that can result in grave consequences for victims.[119] For example, the UNSW Law Society submitted that the reporting obligation should extend to a 'broader range of serious abuses of a non-sexual or non-physical nature' on the basis that

> globally accepted definitions of elder abuse recognise that it includes a host of practices which are detrimental to recipients of aged care [including] financial abuse, differential treatment, wilful or unintentional neglect, poor practice, bullying and psychological abuse.[120]

11.98 The Australian College of Nursing noted that information relating to 'minor' incidents can assist in assessing risk:

> There should be no provisions allowing aged care services to determine if a complaint should be reported, processed and assessed. In some cases, this information could provide important background information and build evidence in support of future claims or potentially trigger action to mitigate risks. This could be a very important measure in the community context where, for reasons such as social isolation, suspected or 'minor' incidents of elder abuse can easily go undetected and unreported.[121]

11.99 Some stakeholders, including National Seniors and the Old Colonists' Association of Victoria, advocated for a broader scope of conduct to be compulsorily reported, specifically in respect of financial abuse.[122]

11.100 Aged Care Crisis noted the 'narrow' definition of 'reportable assault', and commented they had raised concerns at the commencement of the regime on the basis that the definition failed to address 'poor nutrition, hydration, verbal and emotional abuse [and] financial fraud'.[123] UnitingCare Australia commented that reports of reported assaults 'do not give a full picture'[124] of abuse, because they 'do not extend to all forms of elder abuse'.[125]

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119 Seniors Rights Service, *Submission 169*; National LGBTI Health Alliance, *Submission 116*; Northern Territory Anti-Discrimination Commission, *Submission 93*; Law Council of Australia, *Submission 61*.
120 UNSW Law Society, *Submission 117*.
121 Australian College of Nursing, *Submission 147*.
122 National Seniors Australia, *Submission 154*; Old Colonists' Association of Victoria, *Submission 16*.
123 Aged Care Crisis, *Submission 165*.
124 UnitingCare Australia, *Submission 162*.
125 Ibid.

11.101 Under the DRIS, examples of neglect and ill-treatment include inappropriate use of restrictive practices to manage behaviour, leaving residents unsupervised for an extended period of time, withholding food, locking residents outside for extended periods and depriving them of food and water, and failing to connect or flush enteral nutrition tubes.[126]

11.102 These types of incidents are broadly representative of the types of conduct that stakeholders submitted should be required to be notified, and which the proposed scheme would require to be notified.[127]

11.103 The proposed scheme does not include the DRIS category relating to breaches of intervention orders. In that scheme, such incidents comprised a very small number of notifications (1%),[128] and the ALRC has not heard that it is a significant issue in the aged care context, but invites comment on this issue.

Exemption to reporting resident–on–resident incidents in aged care

11.104 The exemption to reporting resident–on–resident incidents where the perpetrator has cognitive impairment has been an issue of significant interest to stakeholders from the time the notification regime was introduced[129] and continued to elicit responses from stakeholders to this Inquiry.[130]

11.105 The Office of the Public Advocate Victoria asserted that the 'exception to mandatory reporting of assaults under these conditions is too lenient'.[131] It argued that, without visibility of such incidents, and transparency and accountability of the response, it is difficult to evaluate the efficacy and appropriateness, and further develop policy and program responses to those incidents.

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126 NSW Ombudsman, Submission No 122 to Legislative Council General Purpose Standing Committee 2, Parliament of NSW, *Inquiry into Elder Abuse in NSW* (April 2016).

127 See, eg, National LGBTI Health Alliance, *Submission 156*; Older Women's Network NSW, *Submission 136*; Capacity Australia, *Submission 134*; Alzheimer's Australia, *Submission 80*; Quality Aged Care Action Group Incorporated, *Submission 28*.

128 NSW Ombudsman, Submission No 122 to Legislative Council General Purpose Standing Committee 2, Parliament of NSW, *Inquiry into Elder Abuse in NSW* (April 2016).

129 In 2007 the Bill establishing the reporting regime was the subject of scrutiny by the Senate Standing Committee on Community Affairs, Parliament of Australia, *Aged Care Amendment (Security and Protection) Bill 2007 (Provisions)* (2007), which noted concerns that the 'discretion in relation to assaults by aged residents with mental impairments would detract from approved providers' obligations to provide a safe environment for all aged care residents'. The rationale for the exemption is outlined in the explanatory note to the amending legislation. It refers to the concerns of the aged care sector that 'minor assaults by [residents with mental impairment] are not uncommon and in such cases the focus should be on behaviour management and not police and Departmental involvement which can be traumatic for all involved'. The exemption is described as providing for '… alternative arrangements for these very specific circumstances where the focus should be on effective behaviour management. This approach enables cases involving residents with a mental impairment to be clinically managed by the approved provider where this is the most appropriate response': Explanatory Memorandum, Aged Care Amendment (Security and Protection) Bill 2007 (Cth).

130 Seniors Rights Service, *Submission 169*; Townsville Community Legal Service Inc, *Submission 141*; Office of the Public Advocate (Vic), *Submission 95*; Combined Pensioners & Superannuants Association of NSW Inc, *Submission 76*; NSW Nurses and Midwives' Association, *Submission 29*; Quality Aged Care Action Group Incorporated, *Submission 28*.

131 Office of the Public Advocate (Vic), *Submission 95*.

11.106 Although the legislation requires that approved providers implement a behaviour management plan, a number of stakeholders raised concerns about the appropriateness of plans implemented; and said they were troubled by the lack of oversight in that regard. The NSW Nurses and Midwives' Association, for example, submitted that although providers are required to implement a behaviour management plan, 'our members tell us that there are often inadequate staffing ratios to fulfil the requirements of a robust behaviour management plan and little monitoring of this process by the [Australian Aged Care Quality Agency]'.[132]

11.107 People with Disability Australia (PWDA) argued that the exemption risked creating 'two forms of justice':

> While we acknowledge the issue of criminalisation of people with cognitive impairments, co-residents should have their assaults taken seriously and should be given the opportunity to report to the police. Individuals should be supported to engage in the justice system, as violence is violence, and people with disability are entitled to a justice system response on an equal basis to others. There should not be two forms of justice: one for people without disability, and one for people with disability.[133]

11.108 The Townsville Community Legal Service echoed the position that it did not wish to see residents with cognitive impairments persecuted, but that the exemption brought into question the utility of the reporting system and is 'antithetical to the objects of a protective system'.[134] It submitted the regime ought to be a 'dynamic system that protects all from abuse'.[135]

11.109 PWDA advocated for a 'formal' response to such incidents:

> We have concerns where the aged care provider puts in place arrangements to 'manage' the behaviour or care of this resident, especially as the sole response to a violent incident. Oftentimes, these forms of behaviour management involve the use of restrictive practices, such as limiting the resident's access within or outside of the facility, or medicating the resident to make them more compliant. Instead, the precursors for the assault should be assessed, taking into consideration why the individual acted in the way they did, and a positive behaviour management plan be put in place.[136]

11.110 Advocare Inc (WA) supported removing the exemption, arguing that it concealed what was actually occurring in respect of both the incident and the provider's response:

> An unscrupulous care facility could therefore hide multiple assaults by the same resident. This reporting exemption should be abolished, to allow a clearer picture of the extent of assaults and to ensure appropriate preventative interventions are put in place…[137]

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132 NSW Nurses and Midwives' Association, *Submission 29*.
133 People with Disability Australia, *Submission 167*; NSW Nurses and Midwives' Association, *Submission 29*.
134 Townsville Community Legal Service Inc, *Submission 141*.
135 Ibid.
136 People with Disability Australia, *Submission 167*.
137 Advocare Inc (WA), *Submission 86*.

11.111 Responding to a parliamentary committee, Leading Age Services Australia, enunciated a different view, arguing the current requirements to keep appropriate records of resident–on–resident incidents and the requirements to demonstrate appropriate standards in respect of behaviour management under the *Accountability Principles 2014* were appropriate.[138]

11.112 It was suggested that the consequential impacts, of not requiring such incidents to be reported, included a loss of a right to redress or remedy for the victim, a reinforced substandard response to risks and violence, the family of the victim being unaware of the incident and a lack of sanction, or consideration of sanction, against a perpetrator and/or the service provider.[139] This was the personal experience of one inquiry participant whose mother was assaulted by another care recipient with dementia:

> My late mother was assaulted in an aged care dementia unit in Melbourne. A man punched her in the chest and tried to suffocate her with a pillow—he was pulled off her by staff. The aged care provider deemed it an 'unreportable assault'. There had been at least one previous 'unreportable assault' with a pillow by the same man, and preventative measures were supposed to be in place.
>
> They obviously weren't working …
>
> The new Australian Aged Care Quality Agency is supposed to regulate and monitor aged care compliance (Corporate Plan 2016–2020). It is not possible to do either when assaults are not reported and are not taken into account. Whether or not providers comply with specified actions of non-reportable assaults is not able to be monitored either, since their actions are part of what is not reportable …
>
> I was then required to mediate with the provider, rather than action being taken by the regulatory body. This automatically put me in a conflict situation with the provider, and things got worse …
>
> Section 63-1AA of the *Aged Care Act* enabled the aged care provider to be in control of the entire process, of staff (some lost their jobs) and of my mother. It is my experience—and that of my late mother—that Section 63-1AA(3) of the *Aged Care Act 1997* and the accompanying *Accountability Principles 2014*, Part 7, section 53 equates to legalised abuse within aged care dementia units, and that it further denies institutionalised individuals the fundamental rights of safety, care, empathy, compassion, protection, dignity, health and well-being, and instead enables abuse, violent assault, exploitation and neglect, and as such is a violation of basic human rights.
>
> As the daughter of an 82 year old assault and abuse victim whose rights were not only not addressed but were denied by legislated procedures, it is my opinion that there can be no serious claim of protecting older Australians against abuse without amending the legalised abuse which is Section 63-1AA of the *Aged Care Act*.[140]

11.113 The discretion not to report resident–on–resident incidents effectively 'hides' a potentially significant number of incidents occurring in aged care environments from

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138 Leading Age Services NSW–ACT, *Answers to Supplementary Questions on Notice*, Legislative Council General Purpose Standing Committee 2, Parliament of NSW, Inquiry into Elder Abuse in NSW (March 2016) 2–3.

139 Townsville Community Legal Service Inc, *Submission 141*.

140 Name withheld, *Submission 189*.

view, which affects the ability to develop appropriate policy and operational responses to risk and risk management around vulnerable adults.

11.114 The issue also arises in the disability service context. In NSW, the DRIS responds to it by adopting a nuanced approach. It requires that a higher threshold is met before an incident becomes notifiable. It places the 'main focus' in responding to client–to–client incidents on 'managing and reducing risks, including identifying the cause of the abuse, and the action that needs to be taken (and the support that needs to be provided) to prevent recurrence'.[141]

11.115 The category distinctions in the DRIS model are designed to strike a balance between the 'undesirability' of reporting such incidents and the risk of criminalising people with cognitive impairment, with the need to ensure resident–on–resident incidents are not 'normalised', and are subject to an appropriate response.

11.116 The ALRC likewise proposes that there be a higher threshold of seriousness met before a notification is required to be made in relation to an incident between two care recipients where one has a pre-diagnosed cognitive impairment. Specifically, these should include the types of conduct provided for in the DRIS, namely sexual offences, incidents causing serious injury, incidents involving the use of a weapon, incidents that are part of a pattern of abuse.[142]

11.117 This approach acknowledges the policy rationale behind the existing exemption, but recognises that such serious incidents should be reported, and is designed to ensure that the provider response is appropriate, transparent and accountable. The requirement to report these incidents will also shed light on the nature and extent of such incidents, enabling a better understanding of them and how the system can respond to them.

Limited expansion of the requirement to report beyond the residential care context

11.118 A number of stakeholders noted that older people are increasingly receiving flexible care or home care from approved providers, where no compulsory reporting requirements apply.

11.119 It was suggested that this represented an unacceptable gap in the regime.[143] The University of NSW Law Society said that

> [t]his effectively means that aged care providers in home based or flexible care settings are not subject to the mandatory reporting requirements. This is concerning as it drastically reduces the accountability of an entire subset of staff members, volunteers or key personnel of aged care providers that do not fall within residential care. We submit that there appears to be no principled reason for exempting home-based or flexible care providers from mandatory reporting obligations.[144]

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141 NSW Ombudsman, *Submission 160*.
142 *Ombudsman Act 1974* (NSW) s 25P(2)(b).
143 See, eg, Advocare Inc (WA), *Submission 86*.
144 UNSW Law Society, *Submission 117*.

11.120 The Australian Nursing and Midwifery Federation argued for the compulsory reporting requirements to be amended to 'incorporate approved providers of community-based aged care … services'.[145]

11.121 Leading Age Services Australia also acknowledged that those receiving aged care outside the residential context would 'obviously go unreported'.[146] In its view, 'the reporting requirements imposed on the industry had little positive effect … and only concentrates on a limited area of aged care and does not include other forms of abuse'.[147]

11.122 In the ALRC's view, the current restricted application of the reporting requirement to residential care recipients affords less protection to care recipients receiving aged care outside the residential context. The ALRC therefore proposes that the reportable incident regime apply, in limited circumstances, where a care recipient is receiving home or flexible care. It is proposed to require a notification to be made where the alleged perpetrator is a staff member of an approved provider.

11.123 The proposal attempts to strike an appropriate balance on threshold issues, recognising that where a person is in residential care, an approved provider has a greater duty of care, and controls many aspects of the care recipient's life, including who has access to them. Therefore, reports of abuse ought to be made in all cases, regardless of who the alleged perpetrator is.

11.124 In the home or flexible care context, an approved provider has less control or capacity to act protectively. However, where a staff member is alleged to have acted inappropriately, their employer should report and respond. Where there is alleged abuse of the care recipient by another person, such as a family member, it is not proposed to require mandated reporting of those incidents for the reasons noted by many stakeholders regarding autonomy and choice.[148]

11.125 This does not mean that a person (including a staff member of an approved provider) who has concerns for the welfare of person receiving flexible or home care should not report their concerns to anyone, but merely that they are not required to do so under the compulsory reporting regime. It may be that a report to the police, or to the public advocate (see Chapter 3) is appropriate.[149]

Reporting to other agencies and timeframe for notification

11.126 The DRIS legislation does not impose a requirement on service providers to report reportable incidents to the police or to funding or compliance bodies, although

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145 Australian Nursing & Midwifery Federation, *Submission 163*.
146 Leading Age Services Australia, *Submission 104*.
147 Ibid.
148 Australian Association of Social Workers, *Submission 153*; Townsville Community Legal Service Inc, *Submission 141*; Aged and Community Services Australia, *Submission 102*.
149 For an example of an approved provider responding to such an incident, refer to case study of Mr and Mrs C in Resthaven, *Submission 114*.

providers may have obligations to do so under other laws and frameworks.[150] However, the DRIS notification forms include questions about whether the incident has been reported to the police. This serves an educative function for providers, while also enabling questions to be asked by the oversight body, if necessary, about organisational decisions related to the reporting of incidents, thus allowing a more considered and nuanced approach in respect of matters referred to the police.

11.127 In 2009, the Productivity Commission commented that the 'requirement for the Department to be informed within 24 hours appears to be a necessary pre-condition to protect current and future resident safety'.[151] However, it is not clear that the Department takes an active role in specifically overseeing the provider's response to each notification made.

11.128 It is critical that serious incidents are reported to the police as soon as possible. The ALRC has not formed a firm view on whether it is necessary to impose a legislative requirement to that effect. The DRIS model does not impose such a requirement, but through training and engagement with providers strongly encourages reporting to police for appropriate incidents.

11.129 Similarly, with regard to reporting to the Department of Health, the ALRC considers that there may be sound reasons for such reports to be made, including to enable the Department to assess a provider's compliance with regulatory obligations. Whether such a report is necessary within 24 hours should be considered in light of the purpose of the reporting.

11.130 The ALRC considers that the timeframe applicable for a reportable incident to be notified to the oversight body, that is 'no later than 30 days' from when the provider became aware of the allegation, is appropriate. Such a design enables a provider to consider its plan to investigate and respond to the incident, and to provide a more thorough and considered report outlining its proposed course of action than the current 24 hour window.

Other issues

11.131 A number of other issues have been identified that the ALRC proposes be incorporated into the aged care model. These build on provisions in the DRIS and include enhanced information sharing provisions; whistleblower protections; and data capture capabilities.

Expanded information sharing provisions

11.132 The ALRC proposes that the model include a further information sharing provision that would enable the head of an approved provider to provide to, and receive

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150 For example, some jurisdictions criminal codes may require the reporting of suspicion of serious offences to the police: see *Crimes Act 1900* (NSW). There may also be professional or organisational codes of conduct that require reporting to police. Where a provider is receiving government funding, there may be contractual or regulatory compliance obligations to report such incidents to the funding body.

151 Productivity Commission, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* (Research Report, 2009) 50.

from, other approved providers and public authorities, information that relates to the promotion of safety of people receiving aged care in connection with responding to a reportable incident.

11.133 The DRIS contains provisions that allow disclosure of information by the head of an agency (or the Ombudsman) about reportable incidents with certain people. These people include the person with disability that is the subject of the incident or their nominee.[152] It also includes, in certain circumstances,[153] the person's guardian, attorney,[154] financial manager/administrator, or a close friend or relative of the person.

11.134 However, it is foreseeable that circumstances may arise where a service provider, having information about a reportable incident in relation to a particular person, may develop a concern for the welfare and safety of a care recipient and, in order to protect that person, may need to share information that would otherwise be protected from disclosure.

11.135 Although the DRIS does not have such provisions, they do apply (although much more broadly) in respect of the reportable conduct scheme in respect of children.[155] It is not proposed to expand the provisions to be as broad as those in Ch 16A.

11.136 The NSW Ombudsman has been advocating for amendments to DRIS information sharing provisions that would enable the exchange of information between a range of agencies in circumstances where the exchange of personal information forms part of providing a reasonable response to any safety or significant welfare issue relating to, or arising out of, a reportable incident.[156] The agencies that the Ombudsman proposes be included in the provision encompass a range of disability service providers (including accommodation, employment, community participation, day program and respite services), police, and labour hire agencies, in respect of the DRIS.

11.137 The Ombudsman described a number of examples that demonstrate the problem in the disability context, but which are apposite in the aged care arena:

> **Need to disclose information between disability services relating to risks associated with employees**
>
> A person is working for three different disability services as a casual support worker. in one service, allegations are made that the person committed fraud against a person with disability living in the accommodation service. A police investigation substantiates the allegations, but due to technical reasons no charges are laid. the worker resigns from the service. the service is aware that the worker is employed by two other accommodation services. Neither service is aware of the significant adverse finding that has been made against the worker, or the risks that need to be managed.

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152 *Ombudsman Act 1974* (NSW) ss 25WA(2)(a)–(b).

153 In circumstances where the head of the agency or Ombudsman has a reasonable belief that the person does not have capacity to understand the information or to nominate a person: Ibid s 25WA(2)(c).

154 This is 'a person who holds and enduring power of attorney in respect of the person with a disability': Ibid s 25WA(2)(c)(ii).

155 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ch 16A.

156 NSW Ombudsman, *Submission on the Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework* (May 2016).

Need to disclose information between disability services and labour hire agencies relating to risks associated with employees

A service uses a labour hire agency to access casual staff. Allegations of neglect are made against one of the agency casual workers, including that they failed to seek medical attention for a client who was seriously ill, and left a client unattended in the bath while the worker had a cigarette outside. The service conducts an investigation and substantiates the allegations. the service advises the labour hire agency that they no longer want the worker to cover any shifts, however the labour hire agency requires details of the allegations and sustained findings in order to manage risk to other clients.[157]

11.138 There are sound reasons to include such a provision relating to aged care. Approved providers owe a duty of care to care recipients. The nature of 'reportable incidents' are indicative of potential serious risk to the individual and other care recipients. It is proposed that the provision be restricted to sharing of information in circumstances where doing so will enhance the safety of people receiving aged care.

11.139 It is also critical that information sharing provisions enable the sharing of information comprising adverse findings that have been made against staff members, in circumstances where there are safety or significant welfare issues that would justify the exchange of information, with a national database which would contribute to enhanced employment screening. This is discussed further below.

Whistleblower protection

11.140 The current reporting regime affords protection to whistleblowers when the incident is a 'reportable assault', however the restricted definitional scope may not protect those workers that report matters that fall outside the current definition. A common theme emerging in submissions was the need for whistleblower protections for workers who report incidents.[158]

11.141 Stakeholders, particularly those representing workers in the aged care industry, submitted that the protections afforded to whistleblowers under the reporting regime were inadequate.[159] The basis for this assertion is that the protections only apply in limited circumstances, namely in those circumstances that are able to be defined as a 'reportable assault'. Two consequences were noted as a result of this.

11.142 First, it was argued that, because the protection failed to extend to a broad range of abuse of older people that many workers witnessed in the course of their work, staff reporting abuse that is outside the scope of a 'reportable assault' are left vulnerable to intimidation and harassment from their employer and others.[160]

11.143 The second is that staff members may decide *not* to report such abuse for fear of repercussions, meaning that much abuse remains hidden. The Older Women's

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157 Email from NSW Ombudsman to ALRC, 26 October 2016.

158 National Older Persons Legal Services Network, *Submission 180*; Aged Care Crisis, *Submission 165*; United Voice, *Submission 145*; R Lewis, *Submission 99*; NSW Nurses and Midwives' Association, *Submission 29*.

159 See, eg, United Voice, *Submission 145*; NSW Nurses and Midwives' Association, *Submission 29*.

160 National Older Persons Legal Services Network, *Submission 180*; Aged Care Crisis, *Submission 165*.

Network NSW submitted, for example, that the inadequate protections meant that staff lacked confidence to report abuse, and therefore 'reported assaults are the tip of the iceberg'.[161]

11.144 It is critical for appropriate protection to be afforded to those who report incidents in good faith. The ALRC proposes that such protections be incorporated into the reportable incidents scheme.

11.145 The proposed expanded scope of the definition of what is required to be notified should also expand whistleblower protections to those who report any incident that falls within that definition, provided the report is made in good faith.

Data capture

11.146 There is currently only limited data about reportable assaults. If a broader range of abusive conduct were required to be reported, as the ALRC proposes, then this information could be used to inform policy and system responses.

11.147 The narrow definition of the term 'reportable assault' effectively conceals incidents that may have serious consequences for the victim but, because they are not captured, are not required to be reported. Examples of types of abuse that the current scheme does not capture includes, for example, neglect and financial abuse. While there may be some anecdotal data about abuse that falls outside the current scope captured by, for example, elder abuse hotlines and by the Complaints Commissioner, all rely on a person choosing to report, as there is no compulsory requirement to report such incidents.

11.148 A number of stakeholders, advocated for better data about abuse of older people.[162] PWDA noted the issues with the current regime and the closed nature of aged care facilities:

> Far too often, older people with disability experience elder violence at the hands of home care workers, support workers, staff in residential facilities and co-residents in residential institutions…we know that closed institutions bring with them higher levels of violence. Data on violence in closed aged care settings is limited, as approved providers are only mandated to report certain types of assaults…However, data from the NSW Bureau of Crime Statistics and Research…and the NSW Ombudsman's Disability Reportable Incidents Scheme illustrates that there is a significant amount of violence occurring in closed settings such as boarding houses, supported group accommodation, nursing homes and aged care facilities.[163]

11.149 The data resulting from the DRIS indicate that, in the disability space, there are concerns about the conduct of staff and volunteers toward clients. The NSW Ombudsman reported that over half of the 437 notifications in the first eight months of the scheme's operation were employee-to-client matters (240 incidents or 55%).

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161 Australian Nursing & Midwifery Federation, *Submission 163*; Older Women's Network NSW, *Submission 136*.

162 National Seniors Australia, *Submission 154*; Office of the Public Advocate (Vic), *Submission 95*; Law Council of Australia, *Submission 61*.

163 People with Disability Australia, *Submission 167*.

Physical assaults comprised the largest proportion of reports (38%), followed by neglect (20%).

11.150 About a third of notifications were client-to-client matters (148 incidents or 34%), most of which were notifications of a pattern of abuse (34%). About a quarter of notifications of client-on-client incidents were for assault causing serious injury, and sexual offences and assault involving the use of a weapon comprised 20% of notifications respectively. Notifications for unexplained serious injuries comprised 10% of notifications, while AVO breaches made up only 1%.

11.151 While there is a lack of data about abuse in aged care, by requiring notification of a broader range of abuse the proposal would contribute to enhanced understandings of the nature and scope of abuse occurring in the aged care context, which in turn will enable the development of better policy and program responses.[164]

Employment screening in aged care

Proposal 11–4 There should be a national employment screening process for Australian Government funded aged care. The screening process should determine whether a clearance should be granted to work in aged care, based on an assessment of:

(a) a person's national criminal history;

(b) relevant reportable incidents under the proposed reportable incidents scheme; and

(c) relevant disciplinary proceedings or complaints.

Proposal 11–5 A national database should be established to record the outcome and status of employment clearances.

11.152 It is critical that potential aged care workers are subjected to proper screening processes to ensure that, as far as possible, only those who are appropriately qualified and do not pose an unreasonable risk are placed in those roles.

11.153 The ALRC proposes that the safeguards to care recipients be improved by enhancing the employment screening of people working in aged care. The proposal builds on the proposed reportable incident scheme (Proposals 11-1 to 11-3) by requiring that information about adverse findings made against employees working in aged care be shared with a centralised screening agency.

11.154 The ALRC proposes that people wishing to work or volunteer in Commonwealth-funded aged care should be required to apply for a clearance with the screening agency. That process would screen a person's national criminal history, any

164 See also the proposals for a National Plan to Address Elder Abuse, and a national prevalence study in ch 2.

adverse findings or notifications made about the applicant that resulted from a reportable incident, as well as any findings from disciplinary or complaint action taken by registration or complaint handling bodies. The identification of potential risk enables the screening agency to conduct a risk assessment of the applicant.

11.155 The *Aged Care Act* contains a number of provisions that set out suitability requirements for employment in aged care, including:

- Any person who is 'key personnel'[165] of an approved provider must not have been convicted of an indictable offence, be insolvent, or be of 'unsound mind'.[166] Penalties may apply where an approved provider has a 'disqualified person' in a key personnel role.[167]
- Staff[168] of approved providers must be issued with a police certificate. Police certificates are current for three years. Where a person has been convicted of murder or sexual assault, or has been convicted of any other form of assault where the sentence included a term of imprisonment, the person is unable to be employed or to volunteer in aged care.[169]
- Where a police certificate discloses something that is not an outright bar to employment, police certificate guidelines published by the Aged Care Quality and Compliance Group (Guidelines) provide direction to approved providers on assessing the information, noting that '[a]n approved provider's decision regarding the employment of a person with any recorded convictions must be rigorous, defensible and transparent'.[170]

11.156 Other employment safeguards that may operate include reference checks conducted as part of recruitment processes,[171] and registration requirements for certain professions involved in aged care. For some groups of employees, for example nurses and doctors, there are registration or accreditation requirements, usually overseen by a regulatory agency.[172] Codes of conduct usually apply to individuals who are subject to accreditation processes, with the possibility of disciplinary action where an individual has breached the relevant Code.

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165 Key personnel include members of the group of persons who are responsible for the executive decisions of the entity; and any other person with authority or responsibility (or significant influence over) planning, directing or controlling the activities of the entity at that time: *Aged Care Act 1997* (Cth) s 8-3A.

166 Ibid s 10A-1.

167 Ibid s 10A-2.

168 'Staff member' is defined as being a person that is at least 16 years old; and is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the approved provider; and has, or is reasonably likely to have, access to care recipients: *Accountability Principles 2014* (Cth) s 4.

169 Ibid s 48.

170 Department of Social Services, *Aged Care Quality and Compliance Group—Police Certificate Guidelines* (2014) 11.

171 Leading Age Services Australia, *Submission 104*; Alzheimer's Australia, *Submission 80*.

172 See, for example, Australian Health Practitioner Regulation Agency.

Gaps in the current framework

11.157 The concept of conducting screening of potential employees is based on the notion that past behaviour is a potential indicator of future behaviour, and can assist in identifying and assessing risk. The importance of staff screening has been recognised in respect of vulnerable or at-risk groups.[173] The NSW Ombudsman urged that 'it is of vital importance to ensure that, wherever practical, those individuals in the community who engage in inappropriate behaviour or take advantage of vulnerable people are prevented from working in care-focussed support roles'.[174]

11.158 This is the rationale underpinning the existing requirements. While no system of background checking will be 'fail-safe', police checks are an important component that can assist in determining whether an applicant is appropriate in the circumstances.

11.159 Police checks have some limitations in enabling a thorough assessment of the risk posed by an individual. A police clearance does not provide other relevant information that may assist in assessing the risk posed by the applicant to the people they would be providing care to. Examples of the type of information that might be relevant include:

- relevant employment proceedings, including information about disciplinary action taken against the person;
- spent convictions or convictions arising when a person was a juvenile;
- allegations or police investigations involving the person; and
- apprehended violence, intervention and prohibition orders.[175]

11.160 Additionally, the conduct must meet a very high evidentiary threshold before it will be recorded on a police check. It has been argued that it is important to capture conduct that meets a lower (balance of probabilities) threshold, for the purposes of assessing risk.[176]

11.161 Police check information may not be current. Although police clearances are required to be obtained and/or renewed every three years, and providers must take 'reasonable steps' to ensure staff notify them of any convictions, there is no capacity for continuous monitoring of national criminal records.[177]

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173 See, eg, Joint Family and Community Development Committee, Parliament of Victoria, *Betrayal of Trust: Inquiry into Handling of Abuse by Religious and Other Non-Government Organisations Vol 2* (2013) 229.

174 NSW Ombudsman, *Submission 160*.

175 Australian Institute of Family Studies, *Pre-Employment Screening: Working With Children Checks and Police Checks* (2016).

176 National Disability Services, *Improving Safety Screening for Support Workers* (2014) 9.

177 While there are variations across jurisdictions, current screening systems with regard to working with children checks do monitor criminal records from the jurisdiction in which the check is being conducted. The Royal Commission into Institutional Responses to Child Sexual Abuse has recommended that the Commonwealth Government enhance the capacity for national criminal history to be accessed and assessed to prevent an individual from committing an offence in another jurisdiction that could remain

11.162 The mobililty of individuals across different community support sectors (children, disability and aged care), and across borders is also an identified gap.[178]

11.163 Reference checking may not always be reliable. For example, it is unlikely that applicants will list a former employer as a referee if there had been issues with their performance or conduct while under the employer's management.

Enhanced employment screening in other community service sectors

11.164 In the ALRC's view, there is capacity for enhanced employment screening in aged care that could offer better protection to care recipients. The key components of the proposal would be the establishment of a screening mechanism that would draw on a person's national criminal history, reportable incidents under the proposed reportable incidents scheme for aged care and relevant disciplinary proceedings in assessing their suitability to work in aged care.

11.165 This scheme would be similar to working with children and working with vulnerable person checks. All Australian jurisdictions require persons working with children to hold a working with children check.[179] Two Australian jurisdictions, the ACT and Tasmania, have moved to broaden their employment screening to people working with other vulnerable groups.[180]

11.166 The value of utilising relevant employment proceedings in determining a person's suitability for work with vulnerable groups has been recognised.[181]

11.167 Working with children checks generally capture a broader range of information than what is reported in a national police check. Working with children checks may include: convictions (including spent or juvenile convictions; intervention orders; charges (for example, where a conviction has not been recorded because a proceeding has not been heard or finalised by a court, or where charges have been dismissed or withdrawn); relevant allegations or police investigations involving the individual; and relevant employment proceedings and disciplinary information from professional organisations (for example, organisations associated with teachers, childcare service providers, foster carers, and health practitioners).[182]

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undetected until the check was due for renewal: Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks Report* (2015) 19, 108.

178 ARTD Consultants, *National Disability Insurance Scheme Quality and Safeguarding Framework Department of Social Services Consultation Report* (2015) 43; National Disability Services, above n 176, 7.

179 *Working with Vulnerable People (Background Checking) Act 2011* (ACT); *Working with Children (Criminal Record Checking) Act 2004* (WA); *Working With Children Act 2005* (Vic); *Working with Children (Risk Management and Screening) Act 2000* (Qld); *Care and Protection of Children Act 2007* (NT); *Child Protection (Working with Children) Act 2012* (NSW); *Registration to Work with Vulnerable People Act 2013* (Tas); *Children's Protection Act 1993* (SA).

180 *Working with Vulnerable People (Background Checking) Act 2011* (ACT); *Registration to Work with Vulnerable People Act 2013* (Tas); *Safeguarding Vulnerable Groups Act 2006* (UK).

181 NSW Auditor-General, *Working with Children Check: NSW Commission for Children and Young People* (2010) 15; Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177, 5.

182 Australian Institute of Family Studies, above n 175. The information captured across jurisdictions can vary.

11.168 In New South Wales, the working with children check also includes consideration of reportable conduct matters.[183] Reportable conduct schemes do not exist in other jurisdictions. Most jurisdictions that consider employment history as part of the check take into account any disciplinary proceedings conducted by professional bodies.[184]

11.169 While professional bodies are involved in responding to complaints about those people who are subject to regulation by them, there are some people who are not subject to regulation in the aged care context. This is considered further below when discussing the proposed National Code of Conduct for Health Care Workers.

11.170 The Australian Health Practitioner Regulation Agency (APHRA) requires certain categories of people[185] to report 'notifiable conduct', although the threshold to make a mandatory complaint is high. A notifier must have a 'reasonable belief that a practitioner has behaved in a way that constitutes notifiable conduct and that their belief is based on reasonable grounds'.[186]

11.171 In contrast, the reportable conduct scheme for people working with children is allegation based. This means that an organisation must notify when they receive an allegation, as opposed to when, or if, they form a 'reasonable belief'. This lower threshold for notification responds to concerns about the 'hidden' nature of child abuse and neglect, and recognises that, for various reasons, including the alleged victim's (in)capacity, the higher 'reasonable belief' threshold might not be met but nonetheless a risk may still be present.

11.172 The ACT and Victorian employment screening mechanisms apply more widely than to people working with children, extending to 'vulnerable persons'. Both schemes are in the early implementation phase and focus primarily on employment screening of people applying to work with children.

11.173 Under the ACT and Victorian schemes, a person must apply for registration to engage in a regulated activity with a vulnerable person. 'Vulnerable persons' are defined as people accessing a regulated activity.[187]

11.174 'Regulated activities' are broadly defined in the ACT, and encompass activities or services for vulnerable people, including mental health and addiction services; services delivered to migrants … and 'people who cannot communicate or who have difficulty communicating in English'; services delivered to homeless people; housing and accommodation services delivered to people suffering social or financial

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183 Findings and notifications resulting from reportable conduct incidents feed into the information used to assess the suitability of a person to work with children. See also *Ombudsman Act 1976* (Cth) pt 3A.

184 For example, registration or accreditation bodies that regulate nurses, teachers, foster carers and certain health practitioners.

185 Registered health practitioners, employers and education providers.

186 Defined to include: practising while intoxicated by alcohol or drugs; sexual misconduct in the practice of the profession placing the public at risk of substantial harm because of an impairment (health issue), or placing the public at risk because of a significant departure from accepted professional standards: Australian Health Practitioner Regulation Agency, *Mandatory Reporting* <www.ahpra.gov.au/>.

187 *Working with Vulnerable People (Background Checking) Act 2011* (ACT) s 7; *Registration to Work with Vulnerable People Act 2013* (Tas) s 4.

hardship; victims of crime; community, disability and respite services.[188] However, the ACT's vulnerable person check does not apply to staff members under the *Aged Care Act*.[189]

11.175 The proposed reportable incident scheme would, if implemented as suggested, enable adverse findings that result from a reportable incident to be captured and disclosed in circumstances where the individual subsequently applies to work in Commonwealth funded aged care.

11.176 A number of stakeholders submitted that a more robust screening system of people working or volunteering in aged care would better safeguard older people receiving care.[190] The Australian Association of Social Workers said that such checks were 'necessary'.[191]

11.177 Alzheimer's Australia stated:

> To help prevent and address physical, psychological and sexual abuse of residents of aged care facilities, all direct care workers in both residential and community aged care should be required to undertake more extensive background checks analogous to Working with Children Checks.[192]

11.178 Other stakeholders also referred to working with children checks and working vulnerable person checks.[193] However not all supported further screening. There were concerns about privacy and the administrative burden and cost of further screening processes. The national peak body for aged and community care workers, Aged and Community Services Australia (ACSA), suggested that while it understood the intent behind such schemes, it was

> cautious about introducing another administrative process unless there is clear evidence from an ageing/aged care sector perspective that demonstrates such a check provides additional protection for older people and employers without infringing on the rights of employees.[194]

11.179 Similar concerns have been raised in regard to the working with children check schemes, namely that there is limited evidence of their efficacy and that they come with a significant operational cost. Notwithstanding those concerns, in its review of the various schemes across Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse indicated that it shared 'the view held by the majority of government and non-government stakeholders … consulted about [working

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188 *Working with Vulnerable People (Background Checking) Act 2011* (ACT) sch 1 pt 1.2. The Tasmanian legislation is modelled on the ACT's, however Tasmania has yet to define 'regulated activities' in respect of vulnerable adults.

189 Ibid s 12(2)(i)(v).

190 See, eg, NSW Ombudsman, *Submission 160*; Australian Association of Social Workers, *Submission 153*; Alzheimer's Australia, *Submission 80*; Law Council of Australia, *Submission 61*.

191 Australian Association of Social Workers, *Submission 153*.

192 Alzheimer's Australia, *Submission 80*.

193 National LGBTI Health Alliance, *Submission 156*; Aged and Community Services Australia, *Submission 102*; Law Council of Australia, *Submission 61*.

194 Aged and Community Services Australia, *Submission 102*.

with children checks]: that they deliver unquestionable benefits to the safeguarding of children'.[195]

A national aged care workforce screening process

11.180 The key features of Proposal 11-4 are that relevant staff members[196] of approved providers should be subject to employment screening by an independent Commonwealth agency. The agency will assess the person's suitability to work in aged care by taking into account the person's criminal history through a national police check, any findings or notifications resulting from the proposed reportable incident scheme, and any disciplinary proceedings that the person has been subject to.

11.181 The outcomes and status of clearances should be maintained on a register that is able to be checked by approved providers when employing staff.

Criminal history and national police checks

11.182 As discussed above, police checks are already required to be performed in respect of people seeking to work in Commonwealth funded aged care. The proposal builds on this requirement.

11.183 The ALRC agrees that it is critical to retain a check of an individual's criminal history, and notes the scope of the current police checks conducted for those applying to work in aged care: convictions; guilty, but no conviction recorded; and pending criminal charges.

11.184 Although other information could be extracted from national criminal history checks (discussed previously in this chapter), there has been no research that the ALRC is aware of that suggests such information is as relevant to assessing risk posed to older people as there is in respect of children. For example, in respect of children, it is widely understood that there will be people against whom allegations of abuse have been made, and who may have been the subject of investigation or even charges, but where no conviction has followed.[197] In those instances, there are strong arguments for capturing such information in working with children checks.

Notifications or findings from reportable incident scheme

Question 11–1 Where a person is the subject of an adverse finding in respect of a reportable incident, what sort of incident should automatically exclude the person from working in aged care?

195 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177, p 5.

196 As defined: *Aged Care Act 1997* (Cth) s 63-1AA(9).

197 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study 6: The Response of a Primary School and the Toowoomba Catholic Education Office to the Conduct of Gerard Byrnes* (2015); Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study 2: YMCA NSW's Response to the Conduct of Jonathan Lord* (2014); Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177.

11.185 The proposed reportable incident scheme would provide information resulting from notifications and findings made in respect of a person employed or volunteering in aged care.

11.186 The ALRC proposes that any adverse findings/determinations should be assessed as representing a higher risk than notifications made in respect of a person where the conduct is similar. For example, where the reportable incident involves financial abuse, an adverse finding made in respect of a person should be considered more serious than a notification in respect of the same conduct but where no adverse finding resulted.

11.187 However, both determinations and notifications should be considered as 'red flags' in respect of a person, and trigger an assessment of their suitability.

11.188 The ALRC's preliminary view is that there may be incidents captured under the proposed reportable incident scheme that ought to automatically exclude a person in the event an adverse finding is made. This approach recognises and responds to risks posed by individuals whose conduct, while perhaps not satisfying a criminal threshold, is found to have breached standards and as such ought to be subject to either a prohibition or further risk assessment (depending on the nature of the incident).

11.189 The ALRC considers that such information—information specifically relevant to a person's conduct in the aged care workforce—is of significance in assessing a person's suitability to work with vulnerable people.\

11.190 The ALRC invites comment on the type of reportable incidents that should, in the event an adverse finding is made against a staff member, result in the staff member being refused a clearance to work in aged care.

Disciplinary proceedings and complaints

11.191 Disciplinary action may be taken against members of certain professions by registration or accreditation bodies. There are also complaint bodies that can receive complaints about people working in those professions.

11.192 In some cases, these organisations are national,[198] while others are state or territory based.[199] Registration or accreditation agencies and complaint handling bodies may also hold information relevant to assessing the potential risk posed by individuals seeking to work in aged care.

11.193 Consideration could be given to incorporating information held by such agencies, noting that significant work would need to be conducted to identify relevant organisations and establish appropriate information sharing networks. Such an approach could be implemented at a later stage.

198 For example, the Australian Health Practitioner Regulation Agency.

199 For example, NSW Health Care Complaints Commission; Office of the Health Care Complaints Commissioner, Victoria.

Continuous monitoring of people working in aged care

11.194 The police check offers a clearance that represents a point in time. There is no capacity for ongoing monitoring of police records, without applying for a new clearance. The practical effect of this is that a person could have a police clearance, but be subject of criminal proceedings that would not be identified by the checking system.[200]

11.195 Several organisations have supported or recommended national employment screening in respect of children that utilises a continuous monitoring process.[201] The Australian Human Rights Commission has suggested that

> A continuous feed of all state and commonwealth criminal databases should be readily available to the checking body, which should engage in daily monitoring of such records. Such a system has now been implemented in several states, noting that this is for state based offences only. Point-in-time screening only at recruitment or application phase is inadequate to ensure ongoing protection, and may be counterproductive insofar as it induces complacency.[202]

11.196 Continuous monitoring of people who have clearances is an important safeguard that should be embedded in the architecture of the screening mechanism. The screening agency should have the capacity to monitor national criminal history (subject to recommendations for ongoing national police database monitoring being progressed) as well as notifications made under the proposed reportable incidents scheme.

Mechanics

Persons to whom the scheme should apply

11.197 The existing requirement to obtain a police clearance for those people working in Commonwealth subsidised aged care offers a definable group of persons to whom the proposal should apply, at least in the first instance.

How long should a clearance last before renewal is required?

Question 11–2 How long should an employment clearance remain valid?

11.198 The current police clearance must be renewed every three years. The duration of working with children and vulnerable person checks in Australian jurisdictions varies across jurisdictions.[203]

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200 Australian Human Rights Commission, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper 1: Working with Children Checks* (August 2013) 5–6.

201 Ibid 8; Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177, 45.

202 Australian Human Rights Commission, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper 1: Working with Children Checks* (August 2013) 8.

203 South Australia has a 'point in time' check, while a clearance lasts for two years in the Northern Territory, three years in the ACT, Queensland, Tasmania, and Western Australia, and five years in Victoria and New South Wales: Australian Institute of Family Studies, above n 175.

11.199 The Royal Commission into Institutional Responses to Child Sexual Abuse recommended that, subject to continuous monitoring of criminal history records, working with children checks should remain valid for five years before a person must apply for renewal.[204] This included recognition of the impost, including cost, on organisations to conduct checks among other factors.[205]

11.200 The ALRC invites comment on how long a clearance under the proposed national employment screening scheme should last.

How should risk be assessed and checks determined?

> **Question 11–3** Are there further offences which should preclude a person from employment in aged care?

11.201 Currently, there are a number of criminal offences (see above at 11.155)[206] which bar a person from being employed in aged care.

11.202 The ALRC invites comment on whether there are further criminal offences that should exclude a person from working in aged care.

11.203 Where a police certificate returns convictions for offences that are not an outright bar, the ALRC suggests that the decision about whether a person should be given a clearance should lie with the screening agency, who would be responsible for conducting a risk assessment and determining an outcome. This represents a shift away from the current process, whereby an approved provider can determine whether to employ a person whose police check returns a conviction for an offence that is not an automatic bar to employment. Approved providers would still take other steps to establish a person's suitability, including by conducting reference checks with a person's previous employers.

11.204 The ALRC suggests that it is appropriate that a single, independent organisation be responsible for assessing risk in such instances, and that that agency have appropriately trained staff to perform such assessments. This approach reflects the approach taken in respect of working with children and vulnerable person checks.

11.205 The screening agency will also need to conduct risk assessments of individuals whose check returns certain information that, while not meeting the 'outright bar' threshold, nonetheless may present a risk to older people.

11.206 At this stage, the issue of which organisation or agency should be responsible for conducting the check is not an issue about which the ALRC has a view.

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204 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177, rec 31.
205 Ibid 108.
206 *Accountability Principles 2014* (Cth) s 48.

11.207 The ALRC acknowledges that there will be implementation issues to be resolved, including who will be responsible for the scheme and the architecture that will establish it and, importantly, mechanisms for information sharing across jurisdictions.

11.208 There are a number of substantive issues that will require significantly more work before the scheme could become operational. These include where a disclosure does not automatically bar a person but signifies the need to conduct a risk assessment, how should risk be assessed and determined.

11.209 There is some guidance on these issues in respect of working with children checks,[207] however there has not been sufficient examination of the evidence base in regards to aged care.

11.210 In part, this issue is likely to be impacted by the question of having nationally consistent screening that would apply across community sectors including children, disability and aged care, noting that some of these are already conducted at state and territory level. This is discussed further below.

National approach across sectors

11.211 It has been suggested that a nationally consistent workforce screening process be established across service delivery to children, people with disability and older persons.[208]

11.212 Such an approach would better address the mobility issues referred to above, as well as offer enhanced safeguards and deliver cost savings in the future. The Department of Social Services reported that, in response to the proposed National Disability Insurance Scheme Quality and Safeguarding Framework,

> [t]here was also strong support for establishing a consistent approach across relevant sectors because the same type of information would be important for deciding who is safe to work in these sectors. Most references were to the need for consistency with aged care and children's services because staff often work in positions that have contact with these groups at the same time or move between these sectors. But there was also reference to the benefit of consistency across the broader community services sector.[209]

11.213 The ALRC acknowledges that several stakeholders, including the NSW Ombudsman, indicated support for enhanced staff screening as a safeguarding mechanism. It said 'there would be merit in exploring the introduction of a nationally consistent screening system for vulnerable people more broadly (including child-related, aged care, and disability support)'.[210]

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207 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 177.

208 Ibid; ARTD Consultants, above n 178, 40.

209 ARTD Consultants, above n 178, p 43; NSW Ombudsman, *Submission 160*; National Disability Services, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper 1: Working with Children Checks* (August 2013) 2.

210 NSW Ombudsman, *Submission 160*; Australian Association of Social Workers, *Submission 153*; Alzheimer's Australia, *Submission 80*; Law Council of Australia, *Submission 61*.

11.214 Although beyond the scope of this Inquiry, the ALRC considers that there may be merit in incorporating the proposed national check designed to cover those working in aged care, with other national clearances that have been either recommended or proposed in respect of children and people with disability. This would require significant investment, but could foreseeably result in savings in the mid-to-long term, while also providing more comprehensive safeguards for children, people with disability and people receiving aged care by restricting individuals refused a clearance from working in one sector from moving across to another sector.

Code of conduct for aged care workers

Proposal 11–6 Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.

11.215 The ALRC proposes that, to provide a further safeguard relating to the suitability of people working in aged care, unregistered aged care workers who provide personal care should be subject to state and territory legislation giving effect to the National Code of Conduct for Health Care Workers.

11.216 Some people who work in aged care—such as registered and enrolled nurses—are members of a registered profession. The Health Practitioner Regulation National Law[211] creates a National Registration and Accreditation Scheme (National Scheme) for registered health practitioners—14 professions, including medical practitioners, nurses and midwives, physiotherapists and psychologists. The professions are regulated by a corresponding National Board. The Australian Health Practitioner Regulation Agency (AHPRA) supports the National Boards to implement the National Scheme.[212]

11.217 The National Scheme has, as one of its objectives, keeping the public safe by 'ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered'.[213] Measures to ensure public safety include, among other things:

- requiring that National Boards develop registration standards for registered professions;[214]

211 The National Law is enacted through legislation in each state and territory: Australian Health Practitioner Regulation Agency, *Legislation* <www.ahpra.gov.au>.
212 Australian Health Practitioner Regulation Agency, *Who We Are* <www.ahpra.gov.au>.
213 Australian Health Practitioner Regulation Agency, *Home* <www.ahpra.gov.au>.
214 Health Practitioner Regulation National Law s 38.

- requiring that certain conduct of a health practitioner (including engaging in sexual misconduct and placing the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards) be notified to AHPRA;[215] and
- allowing for complaints to be made about a registered health practitioner.[216]

11.218 However, many aged care workers—variously employed as assistants in nursing, aged care workers, or personal care workers—are unregistered.[217] The Council of Australian Governments (COAG) Health Council has noted that this may present risks to persons receiving care:

> There is no nationally uniform or consistent mechanism for prohibiting or limiting practice when an unregistered health practitioner's impairment, incompetence or professional misconduct presents a serious risk to the public. There is evidence that practitioners will move to those jurisdictions that have less regulatory scrutiny, in order to continue their illegal or unethical conduct.[218]

11.219 To address these concerns about unregistered health practitioners, state and territory Ministers have agreed, in principle, to implement a National Code of Conduct for Health Care Workers (National Code of Conduct).[219] Some stakeholders argued that a specific licensing body or registration scheme should be established for aged care workers.[220] However, given that there is agreement in relation to enacting a National Code of Conduct, the ALRC proposes instead that aged care workers providing direct care should be included in the planned National Code of Conduct.[221]

11.220 The National Code of Conduct is to be implemented by state and territory legislation. The National Code of Conduct is a 'negative licensing' scheme. It does not restrict entry into health care work, but will set national standards against which disciplinary action can be taken and, if necessary, a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety.[222] Any person would be able to make a complaint about a breach of the National Code of Conduct.[223]

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215 Health Practitioner Regulation National Law pt 8 div 2.

216 Health Practitioner Regulation National Law pt 8 div 3.

217 Many of these will have obtained a vocational qualification such as a Certificate III in Individual Support: *CHC33015—Certificate III in Individual Support* <www.training.gov.au>.

218 COAG Health Council, *Final Report: A National Code of Conduct for Health Care Workers* (2015) 14.

219 Ibid 8, 11. NSW and South Australia have previously implemented a Code of Conduct for unregistered health practitioners: Ibid 12. Queensland has implemented the National Code of Conduct, effective from 1 October 2015: Office of the Health Ombudsman (Qld), *Unregistered Health Practitioner Notifications* <www.oho.qld.gov.au>.

220 See, eg, Australian Nursing & Midwifery Federation, *Submission 163*; National Seniors Australia, *Submission 154*; United Voice, *Submission 145*. See also Legislative Council General Purpose Standing Committee No 3, Parliament of NSW, *Registered Nurses in New South Wales Nursing Homes* (27 October 2015) rec 6: the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish a licensing body for aged care workers.

221 COAG Health Council, above n 219.

222 The Code includes requirements such as: health care workers are to provide services in a safe and ethical manner; are not to financially exploit clients; engage in sexual misconduct: Ibid appendix 1.

223 Ibid rec 5. The Complaint would be made to the relevant state or territory health complaints entity.

11.221 In its Final Report containing recommendations about the Code, the COAG Health Council defines 'health care worker' as a natural person who provides a health service. The COAG Health Council Report also provides a recommended definition of 'health service'. Relevantly, a health service includes 'health-related disability, palliative care or aged care service', as well as support services necessary to implement these.[224] However, the Report noted that it can sometimes be unclear whether a service provided by, for example, an assistant in nursing in aged care, is a 'health service'.[225] The ALRC considers that all aged care workers who provide direct care services should be covered by the National Code of Conduct and proposes that legislation enacting the Code should ensure that these workers are covered by the definition of 'health care worker'.

11.222 Some Australian Government-funded aged care services may provide services that do not involve direct care, such as transport, home maintenance or domestic assistance services. The ALRC does not consider that workers providing these services should be subject to the Code, but should, in appropriate cases, be required to be subject to employment screening processes as set out in Proposals 11-4 and 11-5.

Other staffing issues

11.223 Stakeholders raised a range of other issues relating to staffing in aged care, including: the adequacy of numbers and mix of staff; appropriate qualifications for performing aged care work; the quality of training of aged care workers; pay and conditions; and the challenges presented by an expanding need for care workers.[226] The Aged Care Legislated Review is required to consider workforce strategies in aged care, and is better positioned to make recommendations relating to these issues.[227]

11.224 As the Older Women's Network pointed out, aged care work is 'important work, carrying high levels of responsibility, requiring well trained, compassionate care workers and care managers'.[228] United Voice also emphasised the important role to be played by the aged care workforce in safeguarding older persons form abuse, arguing that '[q]uality support that respects and advances the rights of older Australians to live free from harm and exercise choice and control in their own lives requires a stable, professionally trained, qualified and dedicated workforce'.[229]

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224 Ibid rec 4.

225 Ibid 24–25.

226 See, eg, Seniors Rights Service, *Submission 169*; Australian Nursing & Midwifery Federation, *Submission 163*; L Barratt, *Submission 155*; Australian College of Nursing, *Submission 147*; Older Women's Network NSW, *Submission 136*; Capacity Australia, *Submission 134*; Advocare Inc (WA), *Submission 86*; Alzheimer's Australia, *Submission 80*; Queensland Nurses' Union, *Submission 47*.

227 Department of Health (Cth), above n 38. The Senate Standing Committee on Community Affairs is also conducting an Inquiry into the future of Australia's aged care sector workforce, to report on 28 April 2017: *Future of Australia's Aged Care Sector Workforce* <www.aph.gov.au>. See also Debra King et al, 'The Aged Care Workforce, 2012—Final Report' (Department of Health and Ageing, 2013).

228 Older Women's Network NSW, *Submission 136*.

229 United Voice, *Submission 145*.

11.225 As stakeholders argued, strategies to address elder abuse in aged care must be integrated with broader aged care policy settings. The NSW Nurses and Midwives Association, for example, observed that

> There will be increasing reliance on registered nurses, enrolled nurses and assistants in nursing to meet the needs of the ageing population. This means that strategies to reduce the incidence of elder abuse must be aligned with wider government reform within the aged care sector as a whole. Consumer directed care; increasing use of community based care services and workforce planning within the aged care sector will all impact on the ability of frontline staff and the wider community to ensure adequate protections are in place for the most vulnerable elderly.[230]

11.226 Appropriate planning for a well-supported and qualified aged care workforce is particularly important given projections about the expansion of the aged care workforce as the population ages. Some estimates suggest that, by 2050, the number of employees engaged in the provision of aged care will account for 4.9% of all employees in Australia.[231]

11.227 A 2011 systematic review concluded that research on the staffing models for residential aged care that provide the best outcomes for residents and staff is limited, and further research is required.[232] In this Inquiry, the Australian College of Nursing also called for further research to 'identify the right skill-mix of staff to prevent decreases in quality of care in aged care settings including the neglect of care recipients'.[233]

11.228 A number of submissions to the Inquiry raised significant concerns about the adequacy of staffing in residential aged care.[234] For example, an Australian Nursing and Midwifery Federation survey about aged care reported that 80% of participants who worked in residential aged care considered that staffing levels were insufficient to provide an adequate level of care to residents.[235] Emeritus Professor Rhonda Nay has commented that

> We tolerate a level of staffing and staff mix in aged care that would close wards in the acute system. Despite years of discussion and criticism it is still possible to work with

230 NSW Nurses and Midwives' Association, *Submission 29*.

231 Productivity Commission, above n 23, 354.

232 Brent Hodgkinson et al, 'Effectiveness of Staffing Models in Residential, Subacute, Extended Aged Care Settings on Patient and Staff Outcomes' [2011] (6) *Cochrane Database of Systematic Reviews*. The review used the term 'staffing models' to mean how staffing was organised to meet resident/patient needs and included the mix, and the level of skills, as well as interventions such as staffing ratios, skill mixes, continuity of care and primary nursing: Ibid 3.

233 Australian College of Nursing, *Submission 147*. See also United Voice, *Submission 145*.

234 See, eg, Seniors Rights Service, *Submission 169*; Australian Nursing & Midwifery Federation, *Submission 163*; L Barratt, *Submission 155*; Australian College of Nursing, *Submission 147*; Elder Care Watch, *Submission 84*; Alzheimer's Australia, *Submission 80*; Queensland Nurses' Union, *Submission 47*; NSW Nurses and Midwives' Association, *Submission 29*; Quality Aged Care Action Group Incorporated, *Submission 28*.

235 Australian Nursing & Midwifery Federation, *ANMF National Aged Care Survey Final Report* (2016) 13. The survey was referred to in Australian Nursing & Midwifery Federation, *Submission 163*.

> extremely vulnerable older people while having no relevant qualification. This should be an outrage.[236]

11.229 The *Aged Care Act* requires that residential aged care providers 'maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met'.[237] However, there have been consistent calls, repeated in this Inquiry, for a legislated mandated minimum of staff and/or registered nurses in residential aged care. [238] Concerns were raised that an adequate number and mix of staff are not being maintained in residential aged care. The NSW Nurses and Midwives Association provided this account from a care recipient's relative:

> On a public holiday there was one qualified nurse for 85 people. The catheter had fallen out [and] the nurse was unable to replace it. The hospital phoned for an ambulance to take dad to hospital. It was 8 hours before an ambulance arrived.[239]

11.230 They also cited a number of aged care workers who raised concerns about staffing levels. For example, an assistant in nursing said that

> Lack of staffing and /or resources can lead to instances of inadvertent abuse of elders. E.g. when residents unable to speak up for themselves are left for hours in wet/ soiled beds or continence aids because staff are busy attending to other, more vocal residents.[240]

11.231 A registered nurse reported:

> Where I work NEGLECT would be without a doubt the main form of Elder Abuse in residential aged care. The cause is time constraints, inadequate training and lack of resources (registered nurses and assistants in nursing) I have seen people who may have difficulty walking soon become wheelchair bound because the nursing and care staff do not have time to walk the resident often enough.[241]

11.232 Another concern raised by submissions related to the qualifications of workers who may provide home-based aged care. The Queensland Nurses Union noted, for example, that people with complex health needs are increasingly receiving aged care in the home, and argued that such care should be 'provided or supervised and evaluated by a registered nurse'.[242]

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236 Rhonda Nay, 'The Good, the Bad and the Downright Ugly: Reflections on 10 Years' (2016) 11(4) *Residential Aged Care Communiqué* 6.

237 *Aged Care Act 1997* (Cth) s 54-1(b). The Quality Agency, when assessing a residential aged care service, should assess the adequacy of staffing numbers and types: Australian Aged Care Quality Agency, *Pocket Guide to the Accreditation Standards* (2014) 12.

238 See, eg, People with Disability Australia, *Submission 167*; Australian Nursing & Midwifery Federation, *Submission 163*; L Barratt, *Submission 155*; Australian College of Nursing, *Submission 147*; Capacity Australia, *Submission 134*; Alzheimer's Australia, *Submission 80*; Queensland Nurses' Union, *Submission 47*; Australian National University Elder Abuse Law Student Research Group, *Submission 146*. For previous calls for mandated minimum staffing levels, see, eg, Legislative Council General Purpose Standing Committee No 3, Parliament of NSW, *Registered Nurses in New South Wales Nursing Homes* (27 October 2015) 30–1; NSW Nurses and Midwives' Association, *Let's Have RNs 24/7 in Aged Care Across Australia!* <www.nswnma.asn.au>.

239 NSW Nurses and Midwives' Association, *Submission 29.*

240 Ibid.

241 Ibid.

242 Queensland Nurses' Union, *Submission 47*.

Restrictive Practices

Proposal 11–7 The *Aged Care Act 1997* (Cth) should regulate the use of restrictive practices in residential aged care. The Act should provide that restrictive practices only be used:

(a) when necessary to prevent physical harm;

(b) to the extent necessary to prevent the harm;

(c) with the approval of an independent decision maker, such as a senior clinician, with statutory authority to make this decision; and

(d) as prescribed in a person's behaviour management plan.

11.233 The use of restrictive practices will, in some circumstances, be elder abuse. Restrictive practices can deprive people of their liberty and dignity—basic legal and human rights. The practices might also sometimes amount to assault, false imprisonment and other civil and criminal wrongs. The ALRC proposes that the use of these practices in residential aged care facilities be regulated in the *Aged Care Act*. If regulated, restrictive practices may be used less often and only when appropriate. This will reduce one type of elder abuse and serve to protect older people's legal and human rights.

11.234 The key elements of regulation set out in the proposal are intended to discourage the use of restrictive practices and set a clear and high standard, so that the practices are subject to proper safeguards and only used when strictly necessary.

What are restrictive practices?

11.235 Restrictive practice has been defined as 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm'.[243]

11.236 Common forms of restrictive practice include: detention (eg, locking a person in a room or ward indefinitely); seclusion (eg, locking a person in a room or ward for a limited period of time); physical restraint (eg, clasping a person's hands or feet to stop them from moving); mechanical restraint (eg, tying a person to a chair or bed); and chemical restraint (eg, giving a person sedatives).[244] The Australian and New Zealand Society for Geriatric Medicine submitted that restrictive practices are 'still

243 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 4.

244 Admitting a person to a residential care facility against their wishes or without their consent (perhaps when they do not have the capacity to consent) may also be considered a type of restrictive practice. In the UK, this is governed by 'deprivation of liberty safeguards', which have been the subject of criticism and a current Law Commission inquiry: Law Commission (UK), *Mental Capacity and Deprivation of Liberty* <www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>.

pervasive' in residential aged care facilities, 'particularly in relation to chemical sedation and inappropriate use of drugs'.[245]

11.237 Although not commonly included in discussions of elder abuse, the use of restrictive practices can amount to abuse. Concerns have been expressed about the use of restrictions as a 'means of coercion, discipline, convenience or retaliation by staff or others providing support, when aged care facilities are understaffed'.[246]

11.238 In practice, restrictive practices are most often used on people with an intellectual disability or cognitive impairment who exhibit 'challenging behaviours', such as striking themselves or other people or 'wandering'. They are therefore intended to be used to protect the restrained person or others from harm.

11.239 However, some question whether restrictive practices are ever truly necessary, often stressing the importance of instead using 'Positive Behaviour Support'. Instead of using restraints, care workers and informal carers 'need to be supported and given adequate time to provide responsive and flexible and individualized care'.[247] PWDA also said these practices should be stopped, and that there should instead be a focus on the 'environmental or service factors' that cause problematic behaviour.[248] Others submitted that, although they should be a last resort, restrictive practices are sometimes necessary 'to protect other care recipients and staff'.[249]

11.240 The proposal in this section is not intended to imply that restrictive practices are sometimes necessary, much less condone their use. Rather, it is intended to limit and carefully regulate the use of restrictive practices. If it is never necessary to use these practices, the proposed law would serve to prohibit the use of restrictive practices.

Regulating restrictive practices in aged care

11.241 A national framework exists for reducing and eliminating the use of restrictive practices in the disability service sector.[250] In aged care, the use of restrictive practices is not explicitly regulated, although guidance has been provided.[251]

11.242 In the *Equality, Capacity and Disability* Report, the ALRC discussed the use of restrictive practices in Australia, highlighted the 'patchwork' of federal, state and

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245 Australian and New Zealand Society for Geriatric Medicine, *Submission 51*. 'Much of this practice is driven my lack of skills and knowledge as well as staffing numbers': Ibid.

246 Older Women's Network NSW, *Submission 136* quoting Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Elder Abuse in New South Wales* (2016).

247 Older Women's Network, *Submission 136*.

248 They also suggested that government guidance on the use of restrictive practices may amount to 'tacit approval of these practices': People with Disability Australia, *Submission 167*.

249 National Seniors Australia, *Submission 154*.

250 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

251 The Department of Health submitted that it had 'produced tool kits to assist staff and management working in both residential and community aged care settings to make informed decisions in relation to the use of restraints': Department of Health, *Submission 113*.

territory laws and policies governing restrictive practices, and set out stakeholder calls for reform.[252] The report recommended that Commonwealth, state and territory governments 'develop a national approach to the regulation of restrictive practices', including in the aged care sector.[253] Calls for reform, including for nationally consistent legislated regulation, were repeated in submissions to this Inquiry into elder abuse.[254]

11.243 That the use of restrictive practices may sometimes amount to elder abuse provides further support for the need for additional regulation. In this Inquiry, the ALRC proposes that the *Aged Care Act* be amended to regulate the use of restrictive practices in residential care facilities. The scheme in the *Disability Act 2006* (Vic) pt 7 may be a suitable model.[255] Some of the key elements of the Victorian law are contained in the above proposal, including the requirement that the restraint only be used when necessary to prevent harm.

11.244 That restrictive practices should only be used when necessary was stressed in many submissions to this Inquiry. For example, the Australian College of Nursing urged that 'restrictive practices in all circumstances must be practices of last resort'.[256] National Seniors Australia also said they should only be used when necessary, and outlined some safeguards:

> Restrictive practices should only be used following assessment by a qualified medical practitioner, preferably a psychogeriatrician, geriatrician or geropsychologist or after advice from a Dementia Behavioural Management Advisory Service or Older Persons Mental Health Service. Restrictive practices should also only be used after the consent of a guardian or representative has been obtained. Restrictive practices should only be used when all behavioural prevention strategies have been systematically attempted or considered.[257]

11.245 Similarly, the Office of the Public Advocate (Qld) argued that the legal framework should ensure that restrictive practices should are 'only ever used in aged care environments as a last resort, that they are complemented by appropriate safeguards and that there is appropriate monitoring and oversight of their use'.[258]

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252 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) ch 8. See also Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014) ch 6; Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) ch 15.

253 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) rec 8-2.

254 See, eg, Office of the Public Guardian (Qld), *Submission 173*; Seniors Rights Victoria, *Submission 171*; Australian Nursing & Midwifery Federation, *Submission 163*; National LGBTI Health Alliance, *Submission 156*; Office of the Public Advocate (Qld), *Submission 149*; Leading Age Services Australia, *Submission 104*; Queensland Nurses' Union, *Submission 47*.

255 See Michael Williams, John Chesterman and Richard Laufer, 'Consent vs Scrutiny: Restrictive Liberties in Post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 1. See also Office of the Public Advocate (Vic), *Submission 95*.

256 Australian College of Nursing, *Submission 147*.

257 National Seniors Australia, *Submission 154*.

258 Office of the Public Advocate (Qld), *Submission 149*.

11.246 Staff shortages or convenience should not justify the use of a restrictive practice. If only used when strictly necessary, restrictive practices are more likely to be a proportionate and justified limitation on the rights of people who are restrained.

Decision making

11.247 Abuse of formal and informal decision-making powers was identified in submissions as a form of elder abuse in aged care. Stakeholders raised concerns about:

- failures to respect or acknowledge the decision-making ability of an older person;[259]
- abuse by informal and appointed decision makers, including misuse of powers of attorney, and abusive or prohibitive lifestyle decisions;[260]
- a lack of understanding of the powers and duties of appointed decision makers, by both the decision maker and aged care workers;[261] and
- in relation to consumer directed care, concern about family members inappropriately influencing the decisions made by older people about the design of a care package.[262]

11.248 In the *Equality, Capacity and Disability* Report, the ALRC recommended that aged care laws and legal frameworks should be amended consistently with its National Decision-Making Principles.[263] These Principles emphasise the equal rights of all adults to make decisions that affect their lives, and prescribe that the will, preferences and rights of a person who may require decision-making support must direct these decisions.[264] The ALRC also developed a 'Commonwealth decision-making model' that, among other things, makes provision for the appointment of a

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259 A number of submissions raised concerns about decision making in relation to admission to residential aged care: Justice Connect, *Submission 182*; Office of the Public Advocate (Qld), *Submission 149*; Townsville Community Legal Service Inc, *Submission 141*; Office of the Public Advocate (Vic), *Submission 95*. See also the example of June, in a case study provided in ADA Australia, *Submission 150*.

260 For example, the NSW Nurses and Midwives Association submitted that one third of members responding to a survey about elder abuse had either witnessed, or were unsure about witnessing financial abuse of a person by relatives who held Power of Attorney: NSW Nurses and Midwives' Association, *Submission 29*. See also Justice Connect, *Submission 182*; ADA Australia, *Submission 150*; Townsville Community Legal Service Inc, *Submission 141*; GLBTI Rights in Ageing Institute, *Submission 132*; Leading Age Services Australia, *Submission 104*; Office of the Public Advocate (Vic), *Submission 95*; Alice's Garage, *Submission 36*.

261 ADA Australia, *Submission 150*; Advocare Inc (WA), *Submission 86*.

262 Office of the Public Advocate (SA), *Submission 170*; UnitingCare Australia, *Submission 162*; National Seniors Australia, *Submission 154*; Australian College of Nursing, *Submission 147*; Aged and Community Services Australia, *Submission 102*; Advocare Inc (WA), *Submission 86*. There are existing safeguards against inappropriate care packages being developed through a CDC model. These include providers' responsibilities in relation to providing ongoing review of a person's home care package: *Aged Care Act 1997* (Cth) s 56-2(k); *User Rights Principles 2014* (Cth) sch 2 cl 3(d); Department of Health (Cth), above n 43, 36. There are also limits on what home care package funds can be spent on: *Quality of Care Principles 2014* (Cth) sch 3 pt 2.

263 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) rec 6-2.

264 Ibid rec 3-1. The National Decision-Making Principles, and the ALRC's approach to supported decision making, are discussed further in Chapter 1.

'supporter' or a 'representative' for a person who requires decision-making support, and recommended that aged care legislation be amended consistently with this model.[265]

11.249 The ALRC considers that the implementation of these recommendations will assist in ensuring that decisions in aged care are made in accordance with an older person's will, preferences and rights.

11.250 The *Aged Care Act* and associated Principles contain a number of provisions relating to decision making. For example, the Charters of Care Recipients' Rights and Responsibilities include rights in relation to decision making in residential and home care.[266] There are also provisions in aged care legislation that allow for supported or representative decision making. However, the use of terminology across the legislation, and the powers and duties attached to persons who may act in these roles, are not consistent. As the *Equality, Capacity and Disability* Report noted, the

> current legal framework provides for some elements of supported and representative decision-making in aged care. Section 96-5 of the Aged Care Act provides for a person, other than an approved provider, to represent an aged care recipient who, because of any 'physical incapacity or mental impairment' is unable to enter into agreements relating to residential care, home care, extra services, accommodation bonds and accommodation charges. Section 96-6 states that in making an application or giving information under the Act, a 'person authorised to act on the care recipient's behalf' can do so.[267]

11.251 The *Quality of Care Principles* define 'representative' in a way that is 'similar to both supporters and representatives in the Commonwealth decision-making model'.[268]

11.252 Implementation of the ALRC's recommendation to amend aged care legislation in line with the Commonwealth decision-making model would provide a consistent approach to supported decision making, and offer an important safeguard against abuse for older people receiving aged care. It would provide clear statutory guidance for decision making, with the starting point that the older person's will, preferences and rights should guide decisions made regarding their care.

11.253 Implementation of the ALRC's recommendation would also require:

- consideration of interaction with state and territory appointed decision makers;[269]

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265 Ibid rec 6-2. For a discussion of how the ALRC's recommended terminology of 'representative' maps on to the existing use of 'representative' in the *Aged Care Act*, see Ibid 168–73.

266 *User Rights Principles 2014* (Cth) sch 1 cl 1(n), sch2 cls 2(c)–(d), 5(d).

267 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 168.

268 Ibid 169; *Quality of Care Principles 2014* (Cth) s 5.

269 The ALRC considered this in the context of decision making in the NDIS in Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) ch 5.

- revision of guidelines and operational manuals across the aged care system, including for aged care assessment teams, approved providers, and advocacy services to ensure consistent guidance about decision making; and
- training and education for aged care workers in principles for decision making for care recipients, including powers and duties of appointed decision makers, and avenues for reporting concerns about abuse of decision-making powers.[270]

11.254 The Office of the Public Advocate (Vic) supported the recommendations relating to aged care made in the *Equality, Capacity and Disability* Report, arguing that these will help 'ensure older people with cognitive impairment are adequately supported to make and enact decisions according to their will and preferences, thereby protecting them from people making decisions for them that contravene their rights'.[271] The GLBTI Rights in Ageing Institute argued that an 'individual's rights and autonomy would be better protected by legal frameworks which emphasised the benefits of supported decision-making processes'.[272] The Australian College of Nursing noted that a person's ability to make decisions may change, and that following a period of dependence, 'processes must facilitate and protect an older person's right to resume control in directing their care planning and resume independence in decision-making'.[273]

11.255 A revision of the decision-making provisions in aged care laws and legal frameworks is particularly timely given the move towards consumer directed care. As a number of submissions to this Inquiry noted, many recipients of aged care may need support to make decisions about care planning.[274] For example, Speech Pathology Australia noted that communication difficulties 'are one of the greatest barriers to the execution of choice and active participation in decision making and care planning, including development of a support or care plan under a consumer directed care model'.[275] The importance of funded advocacy programs in providing decision-making support was also highlighted by stakeholders.[276]

11.256 Reforms proposed elsewhere in this Discussion Paper will also assist in providing safeguards against abuse of a person's decision-making rights. These include proposals for reform of laws relating to enduring powers of attorney and guardianship (Chapter 5); guardianship and financial administration (Chapter 6) as well as the proposal to provide oversight of the use of restrictive practices in aged care (Proposal 11-7).

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270 This was supported by Justice Connect, *Submission 182*; ADA Australia, *Submission 150*; NSW Nurses and Midwives' Association, *Submission 29*.

271 Office of the Public Advocate (Vic), *Submission 95*.

272 GLBTI Rights in Ageing Institute, *Submission 132*. See also Speech Pathology Australia, *Submission 168*; Australian College of Nursing, *Submission 147*; TASC National, *Submission 91*; Law Council of Australia, *Submission 61*.

273 Australian College of Nursing, *Submission 147*.

274 See, eg, Speech Pathology Australia, *Submission 168*; Australian Association of Social Workers, *Submission 153*; Office of the Public Advocate (Vic), *Submission 95*.

275 Speech Pathology Australia, *Submission 168*.

276 See, eg, Australian Nursing & Midwifery Federation, *Submission 163*; Advocare Inc (WA), *Submission 86*.

Requiring appointed decision makers

Proposal 11–8 Aged care legislation should provide that agreements entered into between an approved provider and a care recipient cannot require that the care recipient has appointed a decision maker for lifestyle, personal or financial matters.

11.257 Some submissions observed that it was the practice of some approved residential aged care providers to require, as part of an agreement with the provider, that a person has appointed a financial and/or a lifestyle decision maker as a condition of entry into residential aged care.[277]

11.258 The Office of the Public Advocate (Qld) observed that the 'rationale for this policy is likely to be a financial and legal safeguard for the facility by ensuring that all people seeking placement have a mechanism in place to ensure continuity of decision-making in respect of the person's placement should they cease to have capacity'.[278]

11.259 Other submissions outlined the complexities that aged care providers can face in relation to decision making. The Australian College of Nursing noted that 'aged care providers can be significantly challenged by situations when an older person does not have advance care directives about the appointment of guardians and there is no suitable substitute decision maker to work with'.[279] Resthaven stated that providers 'face a real challenge for the older person who has not made any Advance Directives about the appointment of guardians prior to their loss of competency and where it is not evident there is a suitable substitute decision maker to work with'.[280]

11.260 While recognising these challenges, the ALRC considers that appointing a representative decision maker should not be required as a condition of receipt of aged care. Advance planning for decision-making support in aged care should be encouraged.[281] However, requiring that a person has appointed a decision maker before entry into aged care is an inappropriate encroachment on the decision-making rights of older people.

11.261 In keeping with an emphasis on respecting a person's decision-making ability, the ALRC proposes that aged care legislation should provide that agreements entered into between an approved provider and a care recipient cannot require that the

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277 See, eg, Seniors Rights Service, *Submission 169*; Office of the Public Advocate (Qld), *Submission 149*; Townsville Community Legal Service Inc, *Submission 141*. Agreements entered into between an approved provider and a residential care recipient include accommodation agreements and resident agreements. The Act specifies a number of requirements for those agreements: *Aged Care Act 1997* (Cth) ss 52F-3, 59-1, 61-1.

278 Office of the Public Advocate (Qld), *Submission 149*.

279 Australian College of Nursing, *Submission 147*.

280 Resthaven, *Submission 114*.

281 Information and education about the utility for older people of putting in place arrangements for a person to make financial and/or lifestyle decisions on their behalf would form part of the proposed National Plan to reduce elder abuse (see prop 2-1). National Seniors Australia supported an 'ongoing public campaign' in relation to this: National Seniors Australia, *Submission 154*.

care recipient has appointed a decision maker for lifestyle, personal or financial matters.

11.262 As Seniors Rights Service argued, 'a resident should have the right to choose whether or not they will appoint a substitute decision maker. The provider may wish to take steps to ensure that their fees are paid but this should not encroach on the fundamental rights of the resident to make their own decisions'.[282]

Community visitors

Proposal 11–9 The Department of Health (Cth) should develop national guidelines for the community visitors scheme that:

(a) provide policies and procedures for community visitors to follow if they have concerns about abuse or neglect of care recipients;

(b) provide policies and procedures for community visitors to refer care recipients to advocacy services or complaints mechanisms where this may assist them; and

(c) require training of community visitors in these policies and procedures.

11.263 The 'community visitors scheme' (CVS) is a scheme in which recipients of both residential and home care, who are socially isolated or at risk of social isolation, are matched with volunteer visitors. Volunteers are coordinated by organisations funded by the Australian Government (auspices).[283] Community visitors are not advocates, and are directed to report any concerns they have about care to their auspicing organisation.[284]

11.264 The CVS provides an important role in reducing social isolation, which may itself be protective against abuse.[285] In 2014–15, community visitors made more than 148,000 visits to residents in aged care homes.[286] The ALRC does not propose any change to the community visitors' primary function—providing companionship. Nor does it propose that community visitors take on a pro-active role in identifying elder abuse. Instead, in Proposal 11-10, it proposes that an official visitors scheme be established.

11.265 However, the ALRC considers it essential that community visitors have an understanding of the avenues available to care recipients to protect and enforce their rights, as well as procedures for reporting concerns about abuse or neglect. At present, the CVS lacks detailed national guidelines. Auspices are required to develop internal

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282 Seniors Rights Service, *Submission 169*.. See also Office of the Public Advocate (Qld), *Submission 149*.

283 *Aged Care Act 1997* (Cth) pt 5.6; Department of Social Services (Cth), *Community Visitors Scheme (CVS) Policy Guide 2013–2016* (2013).

284 Department of Social Services (Cth), *Community Visitors Scheme (CVS) Frequently Asked Questions—Auspices*.

285 See further Kaspiew, Carson and Rhoades, above n 88, 8–9.

286 Department of Health (Cth), above n 8, 24.

policies relating to the CVS. However, there is limited guidance on what these should contain, including limited guidance about how to respond to concerns about abuse or neglect.[287] The ALRC proposes that national guidelines applying to the CVS should be developed, in place of the current approach that directs auspices to develop their own internal policies for the scheme. The guidelines should set consistent policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients; provide policies and procedures for visitors to refer care recipients to advocacy services or complaints mechanisms where this may assist them; and require training of community visitors in these policies and procedures.

Official visitors

Proposal 11–10 The *Aged Care Act 1997* (Cth) should provide for an 'official visitors' scheme for residential aged care. Official visitors' functions should be to inquire into and report on:

(a) whether the rights of care recipients are being upheld;

(b) the adequacy of information provided to care recipients about their rights, including the availability of advocacy services and complaints mechanisms; and

(c) concerns relating to abuse and neglect of care recipients.

Proposal 11–11 Official visitors should be empowered to:

(a) enter and inspect a residential aged care service;

(b) confer alone with residents and staff of a residential aged care service; and

(c) make complaints or reports about suspected abuse or neglect of care recipients to appropriate persons or entities.

11.266 The ALRC proposes that there should be an 'official visitors' scheme established for residential aged care. Such a program would offer an additional safeguarding mechanism for older people in residential aged care, providing independent monitoring of residential aged care to ensure that residents' rights are being upheld, and to identify issues of abuse and neglect.

11.267 Such a scheme would complement existing (independent complaints and advocacy services) and proposed (reportable conduct, employment screening and oversight of restrictive practices) safeguards in aged care to provide an enhanced safeguarding strategy against abuse and neglect in aged care. Official visitors should be limited to residential aged care. While provision of aged care in the home is increasing, the ALRC considers that the powers of entry and inspection proposed for official

287 Department of Social Services (Cth), above n 285, 4–5.

visitors are not appropriate to private residential settings. The reportable incident scheme (Proposals 11-1 to 11-3) and the expanded powers proposed for public advocates or public guardians (Chapter 3) will assist in addressing concerns about abuse of recipients of home-based aged care.

11.268 Official visitors would perform a different function to advocacy services, who are reliant on being contacted by the care recipient or a representative. They would complement complaints and reportable incident schemes, by providing an additional opportunity to identify issues of concern, especially on behalf of those with cognitive or communication disabilities, and those with fewer social supports.

11.269 The ALRC has heard reports that some residential aged care staff, residents and family members felt inhibited to raise concerns about care through existing complaints and quality oversight processes. For example, the Australian Nursing and Midwifery Federation reported that:

> Our members working in [residential aged care facilities] feel unable to be open with [Quality Agency] assessors about perceived care failures due to fear of reprisal from their employers. Few systems exist for reporting on the operation of the home between inspections, which are often over a year apart.[288]

11.270 The ACT Disability, Aged and Carer Advocacy Service described its experience of aged care residents who 'report that some staff are abusive in the manner in which they go about their work … yet are fearful of making a complaint due to anxiety about retribution'.[289] Official visitors, operating as independent monitors, and empowered to speak to staff and residents, may enable the concerns of such residents and staff to be heard and appropriately responded to.

11.271 A number of submissions were supportive of a visitors program with a rights-monitoring focus in aged care.[290] The Productivity Commission also recommended that there be a similar program introduced into aged care as part of its recommended reforms to aged care in *Caring for Older Australians*.[291]

11.272 Similar visitors schemes operate in a number of states and the Northern Territory for people receiving mental health or disability services.[292] In Victoria, for example, it is a function of a community visitor to inquire into any case of suspected abuse or neglect of a resident in a range of accommodation settings, and can make

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288 Australian Nursing & Midwifery Federation, *Submission 163*.

289 ACT Disability, Aged and Carer Advocacy Service, *Submission 139*. See also Office of the Public Guardian (Qld), *Submission 173*; National Seniors Australia, *Submission 154*; Australian Research Network on Law and Ageing, *Submission 90*; Advocare Inc (WA), *Submission 86*; Queensland Nurses' Union, *Submission 47*; NSW Nurses and Midwives' Association, *Submission 29*; Quality Aged Care Action Group Incorporated, *Submission 28*.

290 See, eg, Office of the Public Advocate (Qld), *Submission 149*; United Voice, *Submission 145*; Australian College of Nursing, *Submission 147*; State Trustees Victoria, *Submission 138*; Office of the Public Advocate (Vic), *Submission 95*; Law Council of Australia, *Submission 61*.

291 Productivity Commission, above n 23, rec 15.3.

292 See, eg, *Public Guardian Act 2014* (Qld) pt 6; *Mental Health Act 2013* (Tas) pt 2; *Disability Services Act 2012* (NT) pt 6.

reports directly to the Department of Health and Human Services and the Victorian Parliament.[293]

11.273 In NSW, the Ombudsman coordinates an 'Official Community Visitor' scheme. The Ombudsman reported that this scheme performed 'a critical role in independent monitoring, resolution of complaints and emerging issues, and advocacy support'.[294] The Ombudsman submitted that the close link between the Official Visitors and its own complaints function has

> achieved substantial change and improved outcomes for people with disability … particularly in relation to matters concerning violence, abuse and neglect in residential care. These matters have benefitted from the separate but complementary functions we perform: notably, the ability of visitors to identify incidents of abuse and neglect … and to act to raise and resolve the issues as independent persons; and the powers and ability of our office to progress these matters on an individual and/or systemic basis.[295]

11.274 The ALRC considers that integrating its proposed expanded reportable incident scheme with an official visitors scheme could achieve similar improvements in the safeguarding of older people in residential aged care. The proposed powers of official visitors build on existing powers of community visitors and advocates under aged care legislation, and are similar to many of the state and territory schemes.[296]

11.275 An official visitors scheme adds an additional layer to the regulation and oversight of aged care that some stakeholders may consider unduly burdensome.[297] However, the ALRC considers it is important to embed independent oversight mechanisms into aged care in concert with plans for increasing deregulation of aged care.[298]

11.276 Some stakeholders suggested that the existing community visitors scheme could be reformed to take on a more active rights-monitoring role.[299] However, existing visitors and their auspicing organisations may not be well suited to this role, given the primary focus of the CVS is on providing companionship for aged care recipients. The CVS is important in reducing social isolation for aged care recipients,

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293 Office of the Public Advocate (Vic), *Submission 95*.

294 NSW Ombudsman, *Submission 160*.

295 Ibid.

296 Aged care legislation currently makes provision for access to a residential care service at any time for a person acting for a care recipient, including a community visitor and advocate where the care recipient has asked for their assistance: *User Rights Principles 2014* (Cth) ss 8(1), (2)(b). It also provides for access for advocates and community visitors during business hours in other circumstances: Ibid ss 8(2)(a), (3). For state and territory schemes, see, eg, *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 8; *Public Guardian Act 2014* (Qld) s 44; *Disability Services (Community Visitor Scheme) Regulations 2013* (SA) s 4(2).

297 A number of submissions suggested, in relation to monitoring of quality, that standards are rigorous and independently assessed: UnitingCare Australia, *Submission 162*; Resthaven, *Submission 114*; Aged and Community Services Australia, *Submission 102*.

298 The Aged Care Roadmap suggests that the destination of reform in aged care is co-regulation and 'earned autonomy' for approved providers: Aged Care Sector Committee, above n 25.

299 See, eg, Australian College of Nursing, *Submission 147*; Office of the Public Advocate (Vic), *Submission 95*.

and should be retained with clear guidance about how to deal with concerns about abuse or neglect.

Advocacy services

11.277 The National Aged Care Advocacy Programme (NACAP) provides assistance to people receiving Australian Government-funded residential care and home care.[300] The NACAP was reviewed in 2015, and there are plans to redesign the aged care advocacy system.[301] Consultation on a draft National Aged Care Advocacy Framework closed on 7 October 2016.[302]

11.278 The ALRC does not propose any changes to aged care advocacy services. However, submissions to the Inquiry highlighted the importance of an effective system of funded advocacy in providing safeguards for older people. For example, the Office of the Public Advocate (Vic) argued that advocacy services were 'essential to protecting the rights of older people in care. This is particularly important when moving to a consumer directed model of care to enable consumers to get the full benefit of such a system'.[303]

11.279 Stakeholders also pointed out that the effectiveness of advocacy services relied on their independence and accessibility. Accessibility for those with cognitive impairment as well as those who may be isolated or physically frail are key challenges that must be addressed to ensure that advocacy operates as a safeguard for older people. A number of submissions also emphasised the importance of ensuring that advocacy services should be inclusive to all older people receiving aged care, including Aboriginal and Torres Strait Islander; culturally and linguistically diverse; and lesbian, gay, bisexual, transgender and intersex people.[304]

Other issues

Aged care assessments

11.280 Before being approved as a care recipient, a person must have their care needs assessed.[305] For care regulated under the *Aged Care Act*, the assessment is conducted by an Aged Care Assessment Team (ACAT).[306] For the CHSP, the assessment is performed by a Regional Assessment Service (RAS).

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300 *Aged Care Act 1997* (Cth) div 81. Advocacy is also available for those receiving aged care through the CHSP: Australian Healthcare Associates, *Department of Social Services Review of Commonwealth Aged Care Advocacy Services Final Report* (2015) 15.

301 Australian Healthcare Associates, above n 301, 17.

302 Department of Health (Cth), *Consultation on the Draft National Aged Care Advocacy Framework* <www.consultations.health.gov.au>.

303 Office of the Public Advocate (Vic), *Submission 95*. See also ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; Australian College of Nursing, *Submission 147*; Office of the Public Advocate (Qld), *Submission 149*.

304 See, eg GLBTI Rights in Ageing Institute, *Submission 132*; Older Persons Advocacy Network, *Submission 43*; Alice's Garage, *Submission 36*.

305 *Aged Care Act 1997* (Cth) s 22-4; Department of Social Services (Cth), above n 2, 76–82.

306 In Victoria, the assessment is provided by an Aged Care Assessment Service. The abbreviation ACAT is used in this chapter to refer to all assessment services for the purposes of the *Aged Care Act*.

11.281 The ALRC does not propose any changes to aged care assessments. As identified in the proposed National Plan,[307] it is important that all people working with older people receive appropriate training regarding elder abuse, and this is applicable also to personnel working in aged care assessment programs.

11.282 A number of submissions commended the value of ACATs, and their potential to play a role in identifying abuse.[308] Notwithstanding this, some noted that their role is a specific one—to assess a person's need for aged care—and argued that they were not appropriately placed to take on a broader case management role in cases of suspected elder abuse.[309]

11.283 The ACAT and RAS use the National Screening and Assessment Form (NSAF) when assessing the aged care needs of clients.[310] The NSAF includes items relating to risks, hazards, or concerns to a person in their home,[311] and concerns relating to living arrangements. It also includes a question asking if a person is 'afraid of someone who hurts, insults, controls or threatens you, or who prevents you from doing what you want.[312] A number of supplementary assessment tools may also be used in the assessment process, including tools relating to pain, alcohol use, and activities of daily living.[313] Consideration might be given to including a validated tool for assessment of risks of elder abuse where concerns have been identified.[314] Additionally, ensuring that ACATs and the RAS have a clear understanding of the referral pathways for elder abuse will be an important component of broader elder abuse response strategies.[315]

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307 See further prop 2-1.

308 See, eg, Office of the Public Advocate (SA), *Submission 170*; Justice Connect, *Submission 182*; ADA Australia, *Submission 150*; Townsville Community Legal Service Inc, *Submission 141*; Macarthur Legal Centre, *Submission 110*; GLBTI Rights in Ageing Institute, *Submission 132*; Aged and Community Services Australia, *Submission 102*.

309 UnitingCare Australia, *Submission 162*; Aged and Community Services Australia, *Submission 102*; Australian and New Zealand Society for Geriatric Medicine, *Submission 51*.

310 Department of Social Services (Cth) and My Aged Care, *National Screening and Assessment Form Fact Sheet* (2015).

311 Department of Social Services (Cth) and My Aged Care, *National Screening and Assessment Form User Guide* (2015) 137.

312 Ibid 144–45.

313 Ibid 189.

314 See, eg, in the context of family violence, the Common Risk Assessment Framework: Domestic Violence Resource Centre Victoria, *CRAF* <www.dvrcv.org.au/training/family-violence-risk-assessment-craf>.

315 Office of the Public Advocate (SA), *Submission 170*; Australian Nursing & Midwifery Federation, *Submission 163*; GLBTI Rights in Ageing Institute, *Submission 132*; Law Council of Australia, *Submission 61*.