

4. Aged Care

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Summary

4.1 Older people receiving 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, family members or friends.

4.2 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 recommendations for reform to aged care laws and legal frameworks to enhance safeguards against abuse of older people receiving aged care. The recommendations are in keeping with the broader direction of reform in aged care, which seeks to provide greater consumer control and a more flexible aged care system

for consumers of aged care, while focusing regulation on ‘ensuring safety and quality [and] protecting the vulnerable’.¹

4.3 In this chapter, the ALRC recommends:

- establishing a serious incident response scheme in aged care legislation;
- reforms relating to the suitability of people working in aged care—enhanced employment screening processes, and ensuring that unregistered staff are subject to the proposed National Code of Conduct for Health Care Workers;
- regulating the use of restrictive practices in aged care; and
- national guidelines for the community visitors scheme regarding abuse and neglect of care recipients.

4.4 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 recommends that aged care agreements cannot require that a person has formally appointed a substitute decision maker.

The aged care system

4.5 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 1997* (Cth). Additionally, entry-level home support services for older people² are provided through the Commonwealth Home Support Programme (CHSP) in all states and territories except Western Australia.³

4.6 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.⁴ These include the right to be treated with dignity and to live without exploitation, abuse or neglect.⁵ In residential care, they also

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 Health (Cth), *Commonwealth Home Support Programme Manual 2017* (2017) ch 5.

3 Entry level home care services for older people in Western Australia will transition to the CHSP from 1 July 2018: Department of Health (Cth), *Commonwealth Home Support Programme* <www.agedcare.gov.au>. There are plans to integrate the two home-based aged care programmes—home care regulated under the *Aged Care Act*, and entry-level care provided under the CHSP—into a single care at home programme: Department of Health (Cth), *Home Care Packages—Reform* <www.agedcare.health.gov.au>. Recipients of grants to provide services under the CHSP must comply with a range of requirements, including in relation to quality and reporting: Department of Health (Cth), above n 2, 86.

4 *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).

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

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.⁶

4.7 The majority of older people live at home without accessing Commonwealth-regulated aged care services.⁷ However, the proportion of people receiving aged care increases with age. For example, in 2014–15, 8.9% of people aged 70 years and over, and 29.7% of people aged 85 years and over, received permanent residential care.⁸

4.8 More people receive some form of aged care at home than in residential aged care. In 2015–16, 234,931 people received permanent residential care, over 920,000 people accessed entry-level home care, and 88,875 people accessed home care packages provided under the *Aged Care Act*.⁹

Regulating quality of care

4.9 Ensuring quality of care is perhaps the best safeguard against abuse and neglect. As Professor Simon Biggs submitted, ‘[i]n addition to adequate monitoring and reporting, residential care work should focus on increasing overall care quality as in these contexts mistreatment is much more likely to be a culture of care than a “bad apple” problem’.¹⁰

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

Department of Health (Cth)

4.11 The Department monitors compliance with the Act and with any agreements or contracts with providers.¹¹ 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.¹²

Australian Aged Care Quality Agency

4.12 The Quality Agency accredits residential aged care providers, and assesses existing providers against quality standards.¹³ Every residential aged care home

6 Ibid sch 1 cl 1(g).

7 Department of Health (Cth), *2014–15 Report on the Operation of the Aged Care Act 1997* (2015) 9.

8 Ibid 4.

9 Department of Health (Cth), *2015–16 Report on the Operation of the Aged Care Act 1997* (2016) xiii. 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.

10 S Biggs, *Submission 235*.

11 Department of Social Services (Cth), *Aged Care Compliance Policy Statement 2015–2017* (2015) 4.

12 *Aged Care Act 1997* (Cth) s 66-1.

13 *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* (Cth).

receives one unannounced assessment against quality standards each year.¹⁴ The Quality Agency may also perform ‘review audits’ when there are concerns about a home’s performance.¹⁵

4.13 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.¹⁶

4.14 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 impose sanctions for non-compliance.¹⁷ Where the Quality Agency identifies a serious risk to care recipients, the service provider and the Department are notified immediately.¹⁸

4.15 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.¹⁹

Aged Care Complaints Commissioner

4.16 The Complaints Commissioner can receive complaints from any source about concerns relating to an aged care²⁰ service provider’s responsibilities under the Act or a provider’s agreement with the Australian Government. The Complaints Commissioner has the power to direct a service provider to demonstrate that it is meeting its responsibilities under the Act or the agreement.²¹ The Commissioner can also refer matters to the Department, the Quality Agency and other relevant agencies.²²

Systemic concerns relating to quality of care

4.17 The Department stated that the existing regulatory framework in aged care ‘has a strong focus on the quality and accountability of aged care services’,²³ and aged care providers argued that the existing regulatory framework was ‘rigorous’.²⁴ Nonetheless,

14 Australian Aged Care Quality Agency, above n 13, 32.

15 A review audit is an assessment of the quality of care provided by a home against all 44 expected outcomes of the Accreditation Standards. They are carried out on-site by an assessment team made up of at least two quality assessors and generally take two to four days: *Ibid*.

16 The Home Care Standards are specified in the *Quality of Care Principles 2014* (Cth). 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.

17 Department of Social Services (Cth), above n 11, 8.

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

19 *Australian Aged Care Quality Agency Act 2013* (Cth) ss 9, 12(e)–(f).

20 Including residential, home or flexible care.

21 *Complaints Principles 2015* s 15.

22 *Ibid* s 19; Aged Care Complaints Commissioner, *Annual Report 2015–16* (2016).

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

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

a number of stakeholders expressed significant concerns about systemic issues relating to the quality of care in aged care, and the processes for monitoring quality.²⁵

4.18 Just before the completion of this Report, the South Australian Chief Psychiatrist led a review of the Oakden Older Persons Mental Health Service—parts of which operated as a Commonwealth-regulated residential aged care facility. The Review found the Oakden facility so deficient in its standard of care as to require closure.²⁶ The Oakden Report observed that the ‘Oakden facility is more like a mental institution from the middle of the last century than a modern Older Person’s Mental Health Facility’.²⁷ The Commonwealth-accredited sections of this facility were nevertheless assessed as meeting 44 of the 44 expected outcomes of the Accreditation Standards in March 2016.²⁸

4.19 The Oakden Report observed that issues with the quality of care at the Commonwealth-regulated parts of the facility were notorious and long-standing:

The Review heard from many sources, including some through the media, that significant problems were known as far back as 2007 at Oakden when it first failed to meet certain Commonwealth Standards. At that time, [an] ... external review ... pointed to some of the reasons for these problems. This Review has confirmed that these problems remain and that ... they have been present throughout the last 10 years.²⁹

4.20 Following the Oakden Report, the Minister for Aged Care, the Hon Ken Wyatt AM, MP, announced an independent review of the Commonwealth’s aged care quality regulatory processes. The independent review is to consider, among other things, what ‘improvements to the Commonwealth aged care regulatory system would increase the likelihood of immediate detection, and swift remediation by providers, of failures of care such as those identified in the Oakden Report’.³⁰ The ALRC considers that the independent review should have regard to the recommendations in this Report, as well as the systemic concerns about quality assurance processes in aged care that have been raised by stakeholders in this Inquiry.

25 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*.

26 A Groves, D Thomson, D McKellar and N Procter, ‘The Oakden Report’ (Department for Health and Ageing (SA) 2017).

27 *Ibid* 57.

28 Australian Aged Care Quality Agency, *Makk and McLeay Nursing Home RACS ID 6010200 Accreditation Report* (2016). A review of the Oakden facility was commissioned in January 2017 by the South Australian Mental Health Minister, in the wake of allegations of mistreatment of a resident. The Quality Agency undertook a full audit of the home in March 2017, and on 17 March 2017, imposed sanctions upon the facility: *Compliance Information* <www.myagedcare.gov.au/compliance-information>. The CEO of the Quality Agency has said that he is ‘taking action to understand’ how the home was found to be compliant with the Accreditation Standards: Australian Aged Care Quality Agency, ‘Makk and McLeay Nursing Home’ (Media Statement, 28 April 2017).

29 A Groves, D Thomson, D McKellar and N Procter, ‘The Oakden Report’ (Department for Health and Ageing (SA) 2017) 77.

30 Ken Wyatt, MP, ‘Federal Aged Care Minister to Commission Review of Aged Care Quality Regulatory Processes’ (Media Release, 1 May 2017). The review is to report by 31 August 2017.

Aged care reforms

4.21 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*.³¹ The Australian Government responded to this report with the ‘Living Longer Living Better’ reform package.³² The goal of reform has been described as an aged care system that is ‘more consumer-driven, market-based and less regulated’.³³ There is an increased emphasis on providing aged care in the home, and a shift to a ‘consumer-directed’ model of home care.³⁴

4.22 The move to marketisation and individualisation in aged care mirrors international trends in the provision of care for older people.³⁵ 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.³⁶

4.23 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’.³⁷

4.24 This may not be the case in aged care. For example, decisions about choosing aged care are frequently made at a time of crisis, and at short notice, which limit the ability to 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.³⁸

4.25 Some stakeholders were concerned by this market-based 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

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

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

33 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* <www.agedcare.health.gov.au>.

34 Department of Health (Cth), *Why Is Aged Care Changing* <www.agedcare.health.gov.au>. Additional changes to home care commenced on 27 February 2017. From that date, funding for a home care package follows the consumer: Department of Health (Cth), *Increasing Choice in Home Care* <www.agedcare.health.gov.au>.

35 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.

36 Brennan et al, above n 35, 379.

37 *Ibid.*

38 *Ibid* 379–80.

operate do not exist'. The result 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'.³⁹

4.26 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'.⁴⁰ 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.⁴¹

4.27 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'.⁴² Other submissions raised concerns about the ability of older people to access and understand meaningful information about care choices.⁴³ 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.⁴⁴

4.28 The Complaints Commissioner emphasised that information provision in consumer-directed care is an important safeguard for older people:

Good information, including how to raise concerns ... helps to correct the power imbalance for the consumer. The provision of information must be done well, and in accordance with the requirements of informed consent in the health sector.⁴⁵

4.29 A legislated review of the reforms made by the Living Longer Living Better package is underway at the time of writing this Report.⁴⁶ 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.⁴⁷ It must report by 1 August 2017.⁴⁸ This review is the appropriate place to consider the broader policy settings for aged care, including in relation to marketisation and individualisation.

39 Aged Care Crisis, *Submission 165*.

40 Department of Health (Cth), *Consumer Directed Care* <www.agedcare.health.gov.au>.

41 ARC Centre of Excellence in Population Ageing Research, *Aged Care in Australia: Part II—Industry and Practice* (Research Brief 2014/02) 18.

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

43 See, eg, Aged Care Complaints Commissioner, *Submission 148*; Australian College of Nursing, *Submission 147*; Queensland Nurses' Union, *Submission 47*.

44 Australian College of Nursing, *Submission 147*.

45 Aged Care Complaints Commissioner, *Submission 148*.

46 *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>.

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

48 Department of Health (Cth), above n 46.

4.30 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. Consultation on draft quality standards closed on 21 April 2017.⁴⁹ 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 2018.⁵⁰

4.31 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.⁵¹ However, submissions to this Inquiry suggested that an emerging issue will be how best to regulate the quality and safety of home care in the further reforms that have been signalled to ‘streamline’ quality accreditation.⁵²

4.32 Improvements to quality assurance processes may prevent or lessen the risk of abuse in aged care. 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.⁵³

4.33 Some stakeholders advocated for increased transparency of quality information.⁵⁴ For example, Alzheimer’s Australia submitted that such information

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- 49 Department of Health (Cth), *Single Set of Aged Care Quality Standards* <www.agedcare.health.gov.au>.
- 50 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>.
- 51 Department of Health (Cth), *Home Care Packages Programme Operational Manual: A Guide for Home Care Providers* (2015) 38.
- 52 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*; Older Women’s Network NSW, *Submission 136*; NSW Nurses and Midwives’ Association, *Submission 29*. Further changes that allow funds to be used to purchase care services other than through brokerage by approved providers will require consideration of how quality and safety of such services might be regulated: whether through aged care legislation or through general consumer protection legislation. For a discussion of the applicability of consumer law in aged care, see, eg: Seniors Rights Service, *Submission to Australian Consumer Law Review Issues Paper* (27 May 2016); R Lewis, *Submission 100*.
- 53 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*.
- 54 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*.

would ‘assist consumers in making informed choices in regard to the services they receive ... [and] drive service competition and quality improvement’.⁵⁵

4.34 However, National Seniors expressed caution about the ability of quality indicators to address elder abuse, arguing that these may increase 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 ... will not actively reduce the risks of abuse in residential care. The same will be true in the home care setting.⁵⁶

4.35 The Aged Care Legislated Review, in its analysis of whether further steps could be taken to move to a consumer-driven demand model of aged care service delivery, provides an opportunity to consider the sufficiency of publicly available information about quality of care.⁵⁷ 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

4.36 Some stakeholders submitted that the majority of elder abuse occurs in the community, rather than in formal aged care.⁵⁸ However, as with prevalence of elder abuse in the community, there is limited research about the rates of abuse of those receiving aged care. One research study has observed that those living in residential aged care are more vulnerable to abuse and neglect because they ‘tend to be frailer and more dependent on others to provide care’.⁵⁹

4.37 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 has noted, this information ‘reflects the number of reports made by providers ... and does not reflect the number of substantiated allegations’.⁶⁰ Reportable assaults also capture a narrower range of conduct than may be described as elder abuse.

4.38 There is also data available relating to complaints made about home and residential aged care to the Complaints Commissioner or its predecessor schemes. There are two difficulties with this data. Not all episodes of concern are captured (due to a reluctance to complain); and not all of the complaints made relate to abuse or neglect. Further, not all complaints of abuse are substantiated.⁶¹ A number of stakeholders reported the results of other projects that capture reports of abuse or

55 Alzheimer’s Australia, *Submission 80*.

56 National Seniors Australia, *Submission 154*.

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

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

59 Lynn McDonald et al, ‘Institutional Abuse of Older Adults: What We Know, What We Need to Know’ (2012) 24(2) *Journal of Elder Abuse & Neglect* 138, 139.

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

61 Aged Care Complaints Commissioner, *Submission 148*.

neglect in aged care,⁶² and there is some evidence available relating to deaths in nursing homes.⁶³

4.39 Some taxonomies of abuse also include ‘institutional abuse’ as a form of abuse—described as occurring when the ‘routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of individuals’.⁶⁴ A number of the concerns raised in this Inquiry about aged care might be characterised as about institutional abuse, particularly in relation to adequate levels of staffing.⁶⁵

4.40 Stakeholders reported many instances of abuse of people receiving aged care. These included reports of abuse by paid care workers⁶⁶ and other residents of care homes,⁶⁷ as well as by family members and/or appointed decision makers of care recipients.⁶⁸ 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.⁶⁹

62 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).

63 See further Professor J Ibrahim, *Submission 63*; Georgia Aitken et al, ‘Frequency of Forensic Toxicological Analysis in External Cause Deaths among Nursing Home Residents: An Analysis of Trends’ (2017) 13(1) *Forensic Science, Medicine, and Pathology* 52; Emma Bellenger et al, ‘Physical Restraint Deaths in a 13-Year National Cohort of Nursing Home Residents’ [2017] *Age and Ageing*; Noha Ferrah et al, ‘Death Following Recent Admission Into Nursing Home From Community Living: A Systematic Review Into the Transition Process’ [2017] *Journal of Aging and Health*; Tatiana Hitchen et al, ‘Premature and Preventable Deaths in Frail, Older People: A New Perspective’ [2016] *Ageing and Society* 1; Joseph E Ibrahim et al, ‘Nature and Extent of External-Cause Deaths of Nursing Home Residents in Victoria, Australia’ (2015) 63(5) *Journal of the American Geriatrics Society* 954.

64 Rochdale Borough Safeguarding Adults Board, *Institutional Abuse* <www.rbsab.org>.

65 Concerns related to staffing are discussed below.

66 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*.

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

68 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*.

69 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*; Advocare Inc (WA), *Submission 86*; Elder Care Watch, *Submission 84*.

4.41 The ALRC also received reports of other forms of abuse, including sexual⁷⁰ and financial abuse.⁷¹ Restrictions on movement⁷² and visitation⁷³ were also reported. Many submissions also identified neglect of care recipients.⁷⁴

Responses to serious incidents of abuse and neglect

Recommendation 4–1 Aged care legislation should provide for a new serious incident response scheme for aged care. The scheme should require approved providers to notify to an independent oversight body:

- (a) an allegation or a suspicion on reasonable grounds of a serious incident; and
- (b) the outcome of an investigation into a serious incident, including findings and action taken.

This scheme should replace the current responsibilities in relation to reportable assaults in s 63-1AA of the *Aged Care Act 1997* (Cth).

Recommendation 4–2 The independent oversight body should monitor and oversee the approved provider’s investigation of, and response to, serious incidents, and be empowered to conduct investigations of such incidents.

A new serious incident response scheme

4.42 The ALRC recommends that aged care legislation should include a process for reporting the occurrence of serious incidents of abuse and neglect in aged care, and for oversight of provider responses to such incidents. The recommended serious incident response scheme builds on the existing requirements for reporting allegations of abuse in the *Aged Care Act*, while also drawing on existing and proposed schemes for responding to abuse in the disability sector.

The existing scheme for reporting assaults

4.43 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

70 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).

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

72 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*.

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

74 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 *Accountability Principles* and constituting an offence against a law of the Commonwealth or a State or Territory'.⁷⁵

4.44 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.⁷⁶

4.45 So-called 'resident-on-resident' incidents are exempt from reporting, 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.⁷⁷

4.46 While diverging as to the desired reform approach, most stakeholders were critical of the existing scheme.⁷⁸ Aged and Community Services Australia (ACSA) called for a review of the reportable assaults requirement, arguing that 'there is little evidence that the reporting requirement to the Australian Department of Health has been effective'.⁷⁹ Leading Age Services Australia (LASA) echoed this criticism, submitting that 'it could be contended that those requirements have made little or no difference to the safety of residents ... [They] appear to only support red tape and bureaucratic processes, rather than promote safe quality care'.⁸⁰

4.47 The reportable assault provisions place no responsibility on the provider other than to report an allegation or suspicion of an assault.⁸¹ The *Records Principles 2014* (Cth) require providers to keep records of reportable assaults, containing:

- the date when the approved provider received the allegation, or started to suspect on reasonable grounds, that a reportable assault had occurred;
- a brief description of the allegation or the circumstances that gave rise to the suspicion; and
- information about whether a report has been made to a police officer and the Department; or whether no report has been made because the resident-on-resident exemption applies.⁸²

75 *Aged Care Act 1997* (Cth) s 63-1AA(9).

76 *Ibid* s 63-1AA(2).

77 *Ibid* s 63-1AA(3); *Accountability Principles 2014* (Cth) s 53.

78 See, eg, L Barratt, *Submission 155*; National Seniors Australia, *Submission 154*; Townsville Community Legal Service Inc, *Submission 141*; Leading Age Services Australia, *Submission 104*; Aged and Community Services Australia, *Submission 102*; Office of the Public Advocate (Vic), *Submission 95*; Northern Territory Anti-Discrimination Commission, *Submission 93*; Advocare Inc (WA), *Submission 86*; Hervey Bay Seniors Legal and Support Service, *Submission 75*; Dr C Barrett, *Submission 68*; NSW Nurses and Midwives' Association, *Submission 29*; Quality Aged Care Action Group Incorporated, *Submission 28*. Baptist Care, by contrast, contended that the system was 'working well': Baptist Care Australia, *Submission 288*.

79 Aged and Community Services Association, *Submission 217*.

80 Leading Age Services Australia, *Submission 104*.

81 *Aged Care Act 1997* (Cth) s 63-1AA(2).

82 *Records Principles 2014* (Cth) s 8.

4.48 Significantly, no obligation is placed on the provider to record any actions taken in response to an incident.

4.49 The ALRC heard conflicting reports about any subsequent actions taken by the provider or the Department following the making of a report. The Department of Health's submission to the Inquiry stated that it 'may take regulatory action if an approved provider does not ... have strategies in place to reduce the risk of the situation from occurring again'.⁸³ However, there is no further publicly available information regarding how the Department makes an assessment about the suitability of any strategies implemented by the provider.⁸⁴

4.50 ACSA submitted that there was little value in the existing requirement to report to the Department, 'when no action is taken by the agency you are reporting to'. To illustrate its point, ACSA noted that

on 16 December 2016 in their Information for Aged Care Providers 2016/24, the Department of Health provided the following advice:

'Compulsory reporting of assaults and missing residents over the holiday period. The compulsory reporting phone line will not be staffed from 3 pm Friday 23 December 2016 to 8.30 am Tuesday 3 January 2017. Providers are still required to report within the legislative timeframe. Providers may leave a message but are encouraged to use the online reporting forms during this period'.⁸⁵

4.51 UnitingCare Australia submitted that the 'process of making a report does not in itself trigger any actions. It is up to providers to implement processes to address risks and negotiate solutions'.⁸⁶

4.52 LASA, by contrast, said that the Department did become involved in oversight of provider responses to reportable assaults:

When an investigation occurs at the local level the Departmental Officers often require a full report on what actions are taken, and their outcome. This can lead to involvement by the [Australian Aged Care Quality Agency] and or the Complaints Commissioner and compliance action by the [Department of Health].⁸⁷

4.53 In 2015–2016, there were 2,862 notifications of 'reportable assaults'.⁸⁸ Of these reports, 2,422 were recorded as alleged or suspected unreasonable use of force, 396 as alleged or suspected unlawful sexual contact, and 44 as both.⁸⁹ This represents an incidence of reports of suspected or alleged assaults of 1.2% of people receiving permanent residential care during that period.⁹⁰

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

84 The online form for reporting reportable assaults requires providers to indicate action taken to ensure the safety of care recipients and minimise risk of recurrence. Given the required timeframe for reporting, this can only document actions taken within the first 24 hours: *Compulsory Reporting Forms* <www.agedcare.health.gov.au>.

85 Aged and Community Services Association, *Submission 217*.

86 UnitingCare Australia, *Submission 216*.

87 Leading Age Services Australia, *Submission 377*.

88 Department of Health (Cth), above n 9, 78.

89 *Ibid.*

90 *Ibid.*

4.54 There is little information available beyond these figures—meaning that, as LASA summarised: ‘what we do not know is the outcome of these reports, whether the allegations were found to have had substance, what local actions were put in place, and if any convictions occurred as a result of Police action’.⁹¹

A focus on response to serious incidents

4.55 The ALRC considers that there should be a new approach to serious incidents of abuse and neglect in aged care. The emphasis should change from requiring providers to report the occurrence of an alleged or suspected assault, to requiring an investigation and response to incidents by providers. This investigation and response should be monitored by an independent oversight body. The recommended design of the scheme is informed by the ‘disability reportable incidents scheme’ (DRIS) for disability services in NSW—overseen by the NSW Ombudsman⁹²—and the serious incident reporting scheme planned for the National Disability Insurance Scheme (NDIS).⁹³

4.56 The ALRC agrees with the NSW Ombudsman’s submission that

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 members of the community ... and is fundamental to enabling a genuinely person-centred approach to supports.⁹⁴

4.57 In the context of the NDIS, the Department of Social Services (Cth) has stated that a serious incident should

trigger a response that seeks to address the wellbeing and immediate safety of the people involved, and takes the opportunity to review and improve operational practices as appropriate to reduce the risk of further harm. Both the response and the evaluation should focus on the impact of the incident on the client, and the outcome (in terms of client wellbeing) that was achieved as a result of any remedial action.⁹⁵

4.58 There was significant support for a new scheme.⁹⁶ A number of stakeholders explicitly advocated for an improved focus on responses to serious incidents. For

91 Leading Age Services Australia, *Submission 377*.

92 *Ombudsman Act 1974* (NSW) pt 3C. Part 3C is modelled on Part 3A of the *Ombudsman Act*, which has provided for a reportable conduct scheme since 1999. From 1 July 2017, Victoria and the ACT will implement reportable conduct schemes in relation to children, and COAG has agreed, in principle, to harmonise reportable conduct schemes: Department of Health and Human Services (Vic), *Creating Child Safe Organisations* <www.dhs.vic.gov.au>; ACT Ombudsman, *Reportable Conduct Scheme* <www.ombudsman.act.gov.au/reportable-conduct-scheme>; Council of Australian Governments *Communiqué* (1 April 2016).

93 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 49–53.

94 NSW Ombudsman, *Submission 160*.

95 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 51.

96 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Seniors Rights Victoria, *Submission 383*; National Legal Aid, *Submission 370*; Victorian Multicultural Commission, *Submission 364*; National Older Persons Legal Services Network, *Submission 363*; Office of the Public Advocate (Qld), *Submission 361*; Eastern Community Legal Centre, *Submission 357*; M Berry, *Submission 355*; Legal Aid NSW, *Submission 352*; Law Council of Australia, *Submission 351*; NSW Ombudsman, *Submission 341*; CPA Australia, *Submission 338*; ACT Human Rights Commission, *Submission 337*; Elder Care Watch, *Submission 326*; L Barratt, *Submission 325*; Speech Pathology Australia, *Submission 309*; P Greenwood, *Submission 304*; Seniors Rights Service, *Submission 296*; ADA Australia, *Submission 283*; ACT

example, the National Older Persons Legal Services Network supported a scheme that could provide a response to serious incidents on both a systemic and individual basis:

The scheme needs to balance and address two important interests. Firstly, the interests of the individual user. Secondly the interests of the aged care system. ... Accountability to each through the reporting process is crucial to its success. For example, a reported incident must provide a critical response to those involved (victim and perpetrator), it must translate into accountability outcomes through systemic accountability including service standards, accreditation etc.⁹⁷

4.59 The Australian Research Network on Law and Ageing (ARNLA) made similar observations and noted that the ‘emphasis here should be on a proportionate response, recognising that random and accidental harmful incidents occur in relation to which a regulatory response may be inappropriate’.⁹⁸

4.60 A new scheme would also improve information available about the incidence of abuse and neglect in aged care. A number of stakeholders called for a scheme that could provide more reliable information. For example, Aged Rights Advocacy Service submitted that it

would like to see further information about ‘compulsory reporting’ in addition to the current reports in residential aged care including the result of the outcome of such a report [and] the number of older people interviewed by the relevant police jurisdiction.⁹⁹

Approved providers’ responsibilities

4.61 The ALRC recommends that the provider be required to report both an allegation or suspicion of a serious incident and any findings or actions taken in response to it.¹⁰⁰

4.62 The appropriate response will vary according to the specific incident, but in all cases will require a process of information gathering to enable informed decisions about what further actions should be taken.¹⁰¹ Significantly, the ALRC has not recommended that providers be *required* to report an incident to police.¹⁰² In part, this

Disability Aged and Carer Advocacy Service (ADACAS), *Submission 269*; Churches of Christ Care, *Submission 254*; NSW Nurses and Midwives’ Association, *Submission 248*; Office of the Public Advocate (Vic), *Submission 246*; Lutheran Church of Australia, *Submission 244*; Advocare, *Submission 213*.

97 National Older Persons Legal Services Network, *Submission 363*.

98 Australian Research Network on Law and Ageing, *Submission 262*. See also Combined Pensioners and Superannuants Association, *Submission 281*.

99 Aged Rights Advocacy Service Inc, *Submission 285*. See also, eg, A Wynne, *Submission 322*; Combined Pensioners and Superannuants Association, *Submission 281*.

100 The reporting systems in place for the DRIS provide instructive guides for how a system could be operationalised: NSW Ombudsman, *Disability Reportable Incidents Forms and Guidelines* <www.ombo.nsw.gov.au>.

101 For examples of how these investigations are expected to be carried out under the DRIS and NSW reportable conduct scheme for children, see further NSW Ombudsman, *Planning and Conducting an Investigation—Child Protection Fact Sheet 4*, 2014); NSW Ombudsman, *How We Assess an Investigation—Employee to Client Incidents* (Disability Reportable Incidents Fact Sheet, 2016); NSW Ombudsman, *Risk Management Following an Allegation against an Employee* (Disability Reportable Incidents Fact Sheet, 2016).

102 Nonetheless, some criminal laws may require the reporting of suspicion of serious offences to the police: see, eg, *Crimes Act 1900* (NSW) s 316.

is due to the expanded scope of the definition of serious incident, discussed further under Recommendation 4–3. It also reflects an approach that requires an approved provider to turn its mind to the response required in the circumstances.

4.63 In some cases an allegation will relate to criminal conduct, and should be reported to police. In such cases, a provider’s key initial responsibility should be to facilitate the police investigation. However, where police do not pursue a matter, this should not be the end of a provider’s responsibilities. As the Office of the Public Advocate (Qld) noted:

aged care providers may misinterpret police taking no action on a reportable incident as meaning they have no further responsibilities in responding to the incident. Police taking no further action in relation to an incident may, however, simply mean that the evidence gathered does not meet the threshold for a criminal prosecution. It may be that, while not strictly criminal in nature, these incidents reflect more subtle forms of elder abuse that are caused by mistakes and poor staffing practice, poorly designed organisational systems and/or insufficient resourcing.¹⁰³

4.64 Where an allegation relates to a staff member, the NSW Ombudsman has reported that, under the DRIS,

even where there may not be a remedy available via the criminal justice system ... there can still be effective and appropriate responses. In this regard, we note that in one-third of all matters involving abuse and/or mistreatment by a staff member towards a client, there has been a finding of unacceptable behaviour on the part of the involved employee, and a range of management action has been taken.¹⁰⁴

4.65 In 91% of matters, the NSW Ombudsman said, ‘action has been taken to improve the support and circumstances of the victim’.¹⁰⁵

4.66 The ALRC considers that the timeframe for reporting a serious incident should be extended from the requirement for notification within 24 hours that exists under the reportable assaults scheme. A requirement to notify the oversight body as soon as possible, and no later than 30 days may be more appropriate to allow a provider to demonstrate a considered response to an allegation or suspicion of a serious incident.

Is compliance with existing quality standards enough?

4.67 Some of those stakeholders opposed to a serious incident response scheme did so on the basis that evidence of compliance with accreditation standards was sufficient to demonstrate that appropriate responses to serious incidents will occur.¹⁰⁶

4.68 For example, ACSA submitted that the ‘Australian Government already has in place a quality and accreditation framework to provide assurance to care recipients of

103 Office of the Public Advocate (Qld), *Submission 361*.

104 This included dismissal of employees or permitting employees to resign: NSW Ombudsman, *Submission 341*.

105 *Ibid.*

106 See, eg, HammondCare, *Submission 307*; Brotherhood of St Laurence, *Submission 232*; Aged and Community Services Association, *Submission 217*.

aged care services that aged care providers achieve a standard of quality and focus on quality improvement'.¹⁰⁷

4.69 Many approved providers will have appropriate systems in place to respond to serious incidents. However, current accreditation may be insufficient to guarantee that all incidents in the intervening period will be responded to appropriately. For example, the review of the Oakden Older Persons Mental Health Service found there to be no established process for determining, escalating and reporting possible incidents of elder abuse.¹⁰⁸

4.70 Even where there are suitable systems in place, the ALRC considers it important to require contemporaneous scrutiny and oversight of the *particular* responses made to each serious incident. Serious incident reporting could be designed to integrate with providers' existing internal processes for responding to serious incidents so as to minimise additional administrative burden.

Oversight body's role and powers

4.71 The oversight body's role should be to monitor and oversee the approved provider's investigation of and response to serious incidents. It should also be empowered to conduct investigations of such incidents. While it is important that the oversight body have powers of investigation, the ALRC anticipates that direct investigations by the oversight body would not be routine. Rather, its focus would be on overseeing providers' own responses to serious incidents, and building the capacity of providers in doing so.

4.72 The oversight body 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.

4.73 The NSW Ombudsman's role in overseeing the DRIS provides an instructive model for the role and powers of the oversight body. The DRIS requires the head of an agency covered by the scheme to notify all reportable incidents to the NSW Ombudsman within 30 days of becoming aware of the allegation. The Ombudsman considers 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.¹⁰⁹

4.74 The NSW Ombudsman has a range of powers to enable it to discharge its oversight and monitoring functions, including the power to: require the production of

107 Aged and Community Services Association, *Submission 217*.

108 A Groves, D Thomson, D McKellar and N Procter, 'The Oakden Report' (Department for Health and Ageing (SA) 2017) 64.

109 NSW Ombudsman, *Submission 160*; NSW Ombudsman, *Disability Reportable Incidents* <www.ombo.nsw.gov.au>.

documents or statements of information; enter and inspect premises; make or hold inquiries; make recommendations; and to report to Parliament and to the public.¹¹⁰

Who should have the oversight function?

4.75 In the Discussion Paper, the ALRC proposed that the Complaints Commissioner be responsible for oversight of the scheme. This proposal received a mixed response from stakeholders. The ALRC remains of the view that the Complaints Commissioner is the most appropriate fit for the scheme in the existing aged care ‘regulatory framework triangle’,¹¹¹ and that there are advantages—both in terms of resources and expertise—in having the functions carried out by an aged care regulatory body rather than an external agency.¹¹²

4.76 However, beyond recommending that the function sit with an independent body, the ALRC does not make a specific recommendation about where the scheme should be located. None of the current ‘regulatory triangle’ agencies are an ideal fit for the proposed scheme. In part, this is the result of the way that reforms to aged care have been implemented.

4.77 The Productivity Commission’s reform package included a recommendation that policy and funding roles be separated from the regulation of aged care. It recommended that the (then) Department of Health and Ageing should be tasked with providing policy advice in aged care, but that a new, independent, regulatory agency—the Australian Aged Care Commission—should be established, with statutory offices for standards and accreditation and complaints handling located within it.¹¹³ This recommendation was not adopted.

4.78 The Department of Health currently receives reports of reportable assaults, but is not an independent body. The ALRC considers that its mix of responsibility for policy, funding and compliance is not best suited to the monitoring and oversight role recommended in this Report.¹¹⁴ However, Departmental officers do have a range of existing monitoring powers that may be amenable to harmonising with the ALRC’s recommendations.¹¹⁵

4.79 The Australian Aged Care Quality Agency accredits and audits aged care providers, but is focused on systemic issues in aged care. A serious incident may not be an indicator of systemic risk, but should still be investigated and responded to by the provider with appropriate oversight.

110 *Ombudsman Act 1974* (NSW) s 25W, pts 3–4.

111 Aged Care Complaints Commissioner, above n 22, 15.

112 ARNLA in contrast suggested that a new body be established with responsibility for oversight of the scheme: Australian Research Network on Law and Ageing, *Submission 262*.

113 Productivity Commission, above n 31, rec 15.1.

114 COTA supported notifying the Department: COTA, *Submission 354*.

115 *Aged Care Act 1997* (Cth) pt 6.4. These powers include, in relation to premises, the power to search the premises; to take photographs; to inspect, examine and take samples of, any substance or thing on or in the premises; to inspect any document or record kept at the premises; to take extracts from, or make copies of, any document or record at the premises: *Ibid* s 90-4.

4.80 The Complaints Commissioner is focused on conciliation and resolution of complaints as well as educating service providers about responding to complaints.¹¹⁶ Some submissions emphasised the importance of distinguishing clearly between complaints and reportable incidents.¹¹⁷ Others suggested that the Complaints Commissioner's focus on local resolution of complaints 'may not be compatible with a role that investigates potentially criminal acts that are currently investigated by appropriate authorities'.¹¹⁸

4.81 The Complaints Commissioner can exercise a range of powers when working to resolve complaints, and may commence own-initiative investigations.¹¹⁹ The Commissioner may also appoint 'authorised complaints officers' who may exercise a range of powers.¹²⁰

4.82 Comparable models have located a complaints handling function and a serious incident or reportable conduct function in the one body—as with the NSW Ombudsman's functions in relation to children and disability. The proposed NDIS Complaints Commissioner under the NDIS Quality and Safeguarding Framework will have responsibility for handling complaints as well as reportable serious incidents.¹²¹ The Australian Health Practitioner Regulation Agency (AHPRA) handles both voluntary complaints and mandatory notifications about health practitioners.¹²²

Definition of serious incident

Recommendation 4-3 In residential care, a 'serious incident' should mean, when committed against a care recipient:

- (a) physical, sexual or financial abuse;
- (b) seriously inappropriate, improper, inhumane or cruel treatment;
- (c) unexplained serious injury;
- (d) neglect;

unless committed by another care recipient, in which case it should mean:

- (e) sexual abuse;
- (f) physical abuse causing serious injury; or

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

117 NSW Ombudsman, *Submission 341*.

118 Baptist Care Australia, *Submission 288*. See also NSW Nurses and Midwives' Association, *Submission 248*. There was some explicit support for locating the function with the Complaints Commissioner: see, eg, ADA Australia, *Submission 283*.

119 Aged Care Complaints Commissioner, *Submission 148*.

120 These include the power to: search premises, take photographs, inspect documents and to ask people questions *Aged Care Act 1997* (Cth) s 94B-2.

121 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 47.

122 State and territory health complaints entities may also be involved in investigating complaints about health practitioners: Australian Health Practitioner Regulation Agency, *Other Health Complaints Organisations* <www.ahpra.gov.au>.

(g) an incident that is part of a pattern of abuse.

Recommendation 4–4 In home care or flexible care, ‘serious incident’ should mean physical, sexual or financial abuse committed by a staff member against a care recipient.

Recommendation 4–5 An act or omission that, in all the circumstances, causes harm that is trivial or negligible should not be considered a ‘serious incident’.

4.83 These recommendations extend the incidents required to be reported under the current regime. The effect of the recommendations is to:

- require home care providers to report and respond to serious incidents, when committed by staff (home care providers are currently exempt from the requirements relating to ‘reportable assaults’);
- extend the types of incidents to be reported to include financial abuse—and, in residential care, seriously inappropriate, improper, inhumane or cruel treatment, as well as unexplained serious injury and neglect;
- require the reporting of instances of resident-on-resident violence in residential aged care, where they reach a higher threshold of seriousness.

4.84 These are serious incidents, and it is appropriate to require reporting and response by providers to them.¹²³ The ALRC also recommends that acts or omissions causing harm that is trivial or negligible not be considered ‘serious incidents’, to respond to concerns that time and resources would be unduly used to respond to and oversee the management of non-serious matters if a reporting regime applied to them.

How broad or narrow should the definition be?

4.85 As the NDIS Quality and Safeguarding Framework noted, while

a broad definition [of serious incident] could enable information about lower-level events to be used as a warning system, employing a narrower definition will ensure that the new system is not overloaded with reports and the most serious incidents can be investigated’.¹²⁴

4.86 The ALRC considers that ‘serious incident’ should not be too broadly defined so that the recommended scheme does not unduly consume time and resources. The

123 The recommendation draws on the definition of ‘reportable incident’ in the DRIS, as well as the proposed scope of serious incident reporting for the NDIS: *Ombudsman Act 1974* (NSW) s 25P; Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 52. See also the requirements for notification of certain incidents in health and social care in the UK to the Care Quality Commission: broadly, incidents including injury, abuse or allegations of abuse (where abuse is defined as sexual abuse, physical or psychological ill-treatment, theft, misuse or misappropriation of money or property, or neglect and acts of omission which cause harm or place at risk of harm): *Care Quality Commission (Registration) Regulations 2009* (UK) reg 18.

124 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 51.

definition of incidents that must be reported should be subject to limited extension, but the ALRC also recommends that it be clear that acts or omissions causing trivial or negligible harm will not fall within the scheme.

4.87 Many stakeholders supported a broad definition of reportable conduct.¹²⁵ A number were concerned to include incidents committed by anyone when in residential aged care, not just staff.¹²⁶

4.88 The ALRC has recommended that some or all of the following incidents be serious incidents, depending on the setting and the person who is alleged to be responsible.

4.89 **Physical, sexual and financial abuse:** the term abuse is intended to capture a broader range of conduct than might constitute a criminal offence. The ALRC recommends that this terminology be used to avoid the need for providers, in determining if particular conduct amounts to a serious incident, to engage in technical legal analysis of whether the relevant conduct amounts to a criminal offence.¹²⁷ It is also intended to emphasise that the onus for responding to these incidents does not solely lie with police.¹²⁸

4.90 **Seriously inappropriate, improper, inhumane or cruel treatment:** this is a flexible category intended to capture a range of serious abuse.¹²⁹ Examples that might fall into this category include a failure to provide an appropriate form of communication for someone who is communication impaired—described as ‘equivalent to “gagging someone”’ by Speech Pathology Australia,¹³⁰ and the practice reported in the Oakden Report of staff leaving ‘the consumer on the floor in considerable distress if they had formed a view that intervening to assist the person was not needed immediately’, described as ‘among the most abhorrent approaches to

125 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Law Council of Australia, *Submission 351*; Elder Care Watch, *Submission 326*; Speech Pathology Australia, *Submission 309*; National Seniors Australia, *Submission 154*; Australian College of Nursing, *Submission 147*; Old Colonists’ Association of Victoria, *Submission 16*.

126 National Older Persons Legal Services Network, *Submission 363*; A Salt, *Submission 278*; UnitingCare Australia, *Submission 216*.

127 Definitions of offences will also vary across state and territory criminal laws.

128 The response required will also vary: for example, an allegation or suspicion of financial abuse of a care recipient by a family member should trigger a different response to that of a staff member. A number of submissions explicitly supported the inclusion of financial abuse: see further Australian Research Network on Law and Ageing, *Submission 262*. Some submissions were opposed on the basis that they should not ‘delve into’ a resident’s financial affairs: Brotherhood of St Laurence, *Submission 232*; Aged and Community Services Association, *Submission 217*.

129 The DRIS requires ‘ill treatment’ to be reported, and what constitutes ill treatment is described as ‘seriously inappropriate, improper, inhumane or cruel treatment’. The ALRC considers that this latter description more effectively communicates the conduct that should be treated as a serious incident than does ‘ill treatment’: NSW Ombudsman, *Guide for Services: Reportable Incidents in Disability Supported Group Accommodation* (2016) 7.

130 Speech Pathology Australia, *Submission 309*.

providing care to severely disturbed consumers that any of the Review had encountered in well over 110 years of collective practice'.¹³¹

4.91 ***Unexplained serious injury***: this is intended to ensure that there is appropriate investigation of the circumstances leading to such an injury, appropriate clinical care provided, and appropriate communication with the injured person and their family members or representatives.

4.92 ***Neglect***: many of the concerns in this Inquiry related to neglect of aged care residents. The NSW Ombudsman described the level of neglect that warrants treatment as a serious incident as:

- intentional or reckless failure to adequately supervise or support a client that also involves a gross breach of professional standards, and has the potential to result in death or significant harm; or
- grossly inadequate care that involves depriving a client of the basic necessities of life.¹³²

4.93 Examples received by this Inquiry that would meet this threshold include reports of advanced pressure sores said to be caused by failures in wound care.¹³³

4.94 Guidance should be developed to assist providers with understanding what constitutes abuse, with a view to building organisational cultures that do not condone abusive conduct.¹³⁴

Serious incidents in home care

4.95 The ALRC recommends that the serious incident response scheme should extend to home or flexible care, where the alleged perpetrator is a staff member of an approved provider. Given the increasing emphasis on provision of aged care in the home, incidents in home care alleged to be committed by staff should be reportable, and providers should be required to demonstrate that a suitable response has occurred.¹³⁵

4.96 Concerns may exist about the abuse or mistreatment of an older person receiving home or flexible care by someone other than an aged care worker. The ALRC

131 A Groves, D Thomson, D McKellar and N Procter, 'The Oakden Report' (Department for Health and Ageing (SA) 2017) 78.

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

133 See, eg, R Selir, Y Selir and Selir Family, *Submission 13*; David Lewis, 'Man Dies in Hospital after Nursing Home Staff Fail to Properly Treat Wounds' *ABC News*, 27 September 2016 <www.abc.net.au/news>. See also, for discussion of failures in providing nutrition and hydration: Maree Anne Bernoth, Elaine Dietsch and Carmel Davies, "'Two Dead Frankfurts and a Blob of Sauce": The Serendipity of Receiving Nutrition and Hydration in Australian Residential Aged Care' (2014) 21(3) *Collegian* 171.

134 See, eg, NSW Ombudsman, *Guide for Services: Reportable Incidents in Disability Supported Group Accommodation* (2016).

135 As noted above, a number of stakeholders supported the definition proposed in the Discussion Paper. Additionally, some submissions explicitly supported the extension to home care: L Barratt, *Submission 325*; Mecwacare, *Submission 289*.

considers that these should be reported to other relevant authorities—for example, police or to adult safeguarding agencies (as recommended in Chapter 14)—where appropriate.¹³⁶ However, the ALRC does not recommend that these should be reportable within the aged care regulatory framework.

Resident-on-resident incidents in aged care should be serious incidents

4.97 Under the existing reportable assaults scheme, there are exemptions to reporting so-called ‘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.¹³⁷

4.98 The ALRC recommends that incidents of violence between residents in residential aged care should be treated as serious incidents, whether or not the person committing the act is cognitively impaired. This approach better calibrates the level of oversight appropriate to the management of violence between residents, and is consonant with a sector-wide commitment to ensuring that aged care recipients live in an environment free of violence and abuse. Responses to such incidents should be contemporaneously monitored, particularly where such responses may involve the use of restrictive practices.¹³⁸

4.99 Resident-on-resident sexual abuse, and physical abuse causing serious injury should be treated as serious incidents. The ALRC also recommends that an incident committed by a care recipient, that forms part of a pattern of abuse (whether or not committed against the same or different residents), should be considered a serious incident.¹³⁹

4.100 A number of stakeholders supported removing the existing exemption.¹⁴⁰ The Office of the Public Advocate (Vic), for example, asserted that the ‘exception to mandatory reporting of assaults under these conditions is too lenient’.¹⁴¹

4.101 The NSW Nurses and Midwives’ Association supported the removal of the exemption, noting that its members were ‘extremely concerned that the daily resident-on-resident abuse they witness is already unreported. We must consider that people

136 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*.

137 *Aged Care Act 1997* (Cth) s 63-1AA(3); *Accountability Principles 2014* (Cth) s 53.

138 People with Disability Australia, *Submission 167*.

139 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Mecwacare, *Submission 289*; Churches of Christ Care, *Submission 254*; Office of the Public Advocate (Vic), *Submission 246*. See also Name Withheld, *Submission 189*.

140 Office of the Public Guardian (Qld), *Submission 384*; Seniors Rights Victoria, *Submission 383*; National Older Persons Legal Services Network, *Submission 363*; Law Council of Australia, *Submission 351*; CPA Australia, *Submission 338*; Elder Care Watch, *Submission 326*; Seniors Rights Service, *Submission 296*; ADA Australia, *Submission 283*; ACT Disability Aged and Carer Advocacy Service, *Submission 269*; M Sullivan, *Submission 266*; NSW Nurses and Midwives’ Association, *Submission 248*; Office of the Public Advocate (Vic), *Submission 246*; Lutheran Church of Australia, *Submission 244*; W Bonython and B Arnold, *Submission 241*; Advocare, *Submission 213*.

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

living in [residential aged care] are unable to exit that environment and the impact of the abusive act is therefore much higher'.¹⁴²

4.102 Over the course of this Inquiry, a number of fatal assaults on residents by other residents with cognitive impairment have been publicised.¹⁴³ A 2015 systematic review concluded that

resident-to-resident aggression (RRA) is an understudied form of elder abuse in nursing homes ... [W]e must continue to grow our knowledge base on the nature and circumstances of RRA to prevent harm to an increasing vulnerable population of nursing home residents and ensure a safe working environment for staff.¹⁴⁴

4.103 Some stakeholders argued that the current requirements to keep appropriate records of resident-on-resident incidents and of relevant behaviour management plans were sufficient.¹⁴⁵ Particular concern exists in relation to the volume of reports of resident-on-resident incidents that may be required as a result of this reform.¹⁴⁶ Alternatively, that there are high numbers of incidents of resident-to-resident aggression is *itself* an argument for greater oversight of responses by providers to these incidents to ensure the safety of all residents. The higher threshold of seriousness for physical abuse recognises that removing the existing exemption will result in an additional reporting burden.¹⁴⁷

4.104 HammondCare, for example, was opposed to removing the exemption, arguing that education and advice programs were better suited to dealing with resident-on-resident violence. However, it observed that, in practice, it would report resident-on-resident violence of the kind the ALRC specifies in Recommendation 4–3 as serious incidents, notwithstanding that this was not strictly required under existing legislation.¹⁴⁸

4.105 The ALRC agrees that education and advice are important in managing and preventing resident-on-resident violence, but considers that an explicit requirement to respond and report to these incidents can prompt appropriate access to such education and advice. Dementia-specific services, like HammondCare, may be the focus of less intensive oversight of reported incidents where they can consistently evidence robust

142 NSW Nurses and Midwives' Association, *Submission 248*.

143 See, eg, Angeliqne Donnellan and Nicola Gage, 'Oakden Nursing Home Murder Haunts Victim's Family' *ABC News*, 6 April 2017 <www.abc.net.au>; Rebecca Opie, 'Nurse Hid as Elderly Patient Went on Rampage, SA Court Told' *ABC News*, 24 November 2016 <www.abc.net.au/news/>; Megan Gorrey, 'Jindalee Aged Care Nurse Left Bashed Man Unsupervised in the Same Room as Suspect' *Canberra Times*, 25 September 2015 <www.canberratimes.com.au>. See also the personal story recounted in Name withheld, *Submission 189*.

144 Noha Ferrah et al, 'Resident-to-Resident Physical Aggression Leading to Injury in Nursing Homes: A Systematic Review' (2015) 44(3) *Age and Ageing* 356.

145 See, eg, Leading Age Services Australia, *Submission 377*; HammondCare, *Submission 307*; Australian Association of Gerontology (AAG) and the National Ageing Research Institute (NARI), *Submission 291*; Meevacare, *Submission 289*; The Benevolent Society, *Submission 280*.

146 HammondCare, *Submission 307*; Baptist Care Australia, *Submission 288*; The Benevolent Society, *Submission 280*; Aged and Community Services Association, *Submission 217*.

147 Some submissions supported the removal of the exemption, but not the different thresholds for reporting: see, eg Disabled People's Organisations Australia, *Submission 360*; S Henderson, *Submission 275*.

148 HammondCare, *Submission 307*.

systems to assess and respond to such instances of violence, and minimise risk of recurrence.

4.106 The response to resident-on-resident incidents where the person using violence has cognitive impairment may be different from, for example, incidents involving staff members. Reporting to police would generally not be warranted. As the NSW Ombudsman noted in relation to the DRIS, in such cases the emphasis is likely to be 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’.¹⁴⁹ The NSW Nurses and Midwives’ Association similarly observed that the response to these incidents should ‘address underlying causes, seek appropriate solutions and monitor their implementation for effectiveness’.¹⁵⁰

Other elements of the serious incident response scheme

Recommendation 4–6 The serious incident response scheme should:

- (a) define ‘staff member’ consistently with the definition in s 63-1AA(9) of the *Aged Care Act 1997* (Cth);
- (b) require the approved provider to take reasonable measures to require staff members to report serious incidents;
- (c) require the approved provider to ensure staff members are not victimised;
- (d) protect informants’ identities;
- (e) not exempt serious incidents committed by a care recipient with a pre-diagnosed cognitive impairment against another care recipient; and
- (f) authorise disclosure of personal information to police.

4.107 The ALRC recommends that the serious incident response scheme incorporate a number of existing definitions and protections operative in relation to the current provisions for reporting assaults in aged care.

4.108 Staff member is defined in s 63-1AA(9) of the *Aged Care Act* to mean ‘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’. The ALRC recommends that this definition be utilised for the serious incident response scheme.

4.109 The current reportable assault scheme requires the approved provider to take reasonable measures to require staff members to report serious incidents;¹⁵¹ to ensure

149 NSW Ombudsman, *Submission 160*.

150 NSW Nurses and Midwives’ Association, *Submission 248*.

151 *Aged Care Act 1997* (Cth) s 63-1AA(5).

staff members are not victimised;¹⁵² and to protect informants' identities.¹⁵³ These requirements should be a feature of the serious incident response scheme.

4.110 Recommendation 4–6(e) is intended to put beyond doubt that the serious incident response scheme should not retain the current, limited, exemption from reporting serious incidents committed by a care recipient with a pre-diagnosed cognitive impairment on another care recipient, discussed above.

4.111 The ALRC also recommends that it be made clear that disclosure of personal information to police in relation to the response to serious incidents is lawful and appropriate. Given that the ALRC does not recommend that all allegations or suspicions of serious incidents be reported to police, this recommendation is intended to address concerns that such reporting would breach requirements relating to the protection of personal information without being 'required or authorised' by the *Aged Care Act*.¹⁵⁴

The aged care workforce

4.112 A safe, qualified aged care workforce in sufficient numbers is an essential safeguard against elder abuse in aged care. 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'.¹⁵⁵ United Voice emphasised the important role to be played by the aged care workforce in safeguarding older persons from 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'.¹⁵⁶

4.113 Strategies to address elder abuse in aged care must be integrated with broader aged care policy settings in relation to workforce planning and development. The NSW Nurses and Midwives' Association, for example, observed that policy relating to

[c]onsumer 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.¹⁵⁷

4.114 Appropriate planning for a well-supported and qualified aged care workforce is particularly important given projections about the need for 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.¹⁵⁸

152 Ibid ss 63-1AA (6), 96-8.

153 Ibid s 63-1AA(7).

154 See further Ibid s 62.1; Australian Information and Privacy Commissioner, *Submission 233*.

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

156 United Voice, *Submission 145*.

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

158 Productivity Commission, above n 31, 354.

4.115 Additionally, implementing the NDIS may have an impact on the aged care workforce, with workers increasingly likely to work across sectors. This was identified as an emerging issue in the 2016 Aged Care Workforce Survey, which noted that, while

at present there appears to have been very little interaction at the workforce level between the aged care and disability sectors ... [a]s the NDIS rolls out to full implementation and demand for disability supports increase, we can expect that the two sectors will end up sharing some of one another's workforces. ... Given the large numbers involved in the NDIS full roll out over the next two to three years, this could have substantial impacts on the aged care workforce.¹⁵⁹

4.116 Stakeholders raised a range of issues relating to staffing in aged care, including: the quality of training of aged care workers; their pay and conditions; and the challenges presented by an expanding need for care workers.¹⁶⁰

4.117 Many of these issues, while intersecting with the concerns of this Inquiry, extend beyond the issue of elder abuse. As such, they are more suited to being addressed in other reviews of aged care. The Aged Care Legislated Review, referred to above, is required to consider workforce strategies in aged care, and is better positioned to make recommendations relating to these issues.¹⁶¹

4.118 The ALRC has made some specific recommendations involving the aged care workforce that it considers will assist in providing safeguards against elder abuse and neglect, in relation to: staffing numbers and models of care; codes of conduct applicable to the aged care workforce; and pre-employment screening.

Staffing numbers and models of care

Recommendation 4–7 The Department of Health (Cth) should commission an independent evaluation of research on optimal staffing models and levels in aged care. The results of this evaluation should be made public and used to assess the adequacy of staffing in residential aged care against legislative standards.

4.119 The ALRC recommends that there be an independent evaluation of best practice research on staffing models and levels in aged care, to inform quality assessment of aged care. Significant concerns have been raised in this Inquiry that current staffing practices in residential aged care involve staffing levels that are so inadequate as to

159 Kostas Mavromaras et al, 'The Aged Care Workforce 2016' (Department of Health (Cth), March 2017) 165.

160 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*.

161 Department of Health (Cth), above n 46. 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 21 June 2017: *Future of Australia's Aged Care Sector Workforce* <www.aph.gov.au>.

result in neglect of care recipients. An independent evaluation, by a suitably qualified research body with expertise in aged and health care,¹⁶² can provide an evidence-based benchmark for assessing the adequacy of staffing arrangements.

Who works in residential aged care?

4.120 People who provide direct care¹⁶³ in the residential aged care workforce are, in the main, nursing staff—registered nurses and enrolled nurses—and assistants-in-nursing (AINs).¹⁶⁴ Registered and enrolled nurses are more highly qualified than AINs¹⁶⁵ and are regulated by codes and guidelines developed by the Nursing and Midwifery Board of Australia pursuant to the *Health Practitioner Regulation National Law*.¹⁶⁶ The composition of the residential aged care workforce has changed: between 2003 and 2016 the proportion of registered and enrolled nurses has decreased¹⁶⁷ and the proportion of AINs has increased, such that over 70% of direct care workers in residential aged care are AINs.¹⁶⁸

Adequacy of staffing

4.121 Many submissions to this Inquiry raised significant concerns about the adequacy of staffing in residential aged care.¹⁶⁹ For example, an Australian Nursing and Midwifery Federation (ANMF) 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.¹⁷⁰ Emeritus Professor Rhonda Nay has commented that

[w]e 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 extremely vulnerable older people while having no relevant qualification. This should be an outrage.¹⁷¹

162 Such as, eg, a specialist university research centre.

163 Direct Care employees provide care directly to care recipients as a core component of their work: Mavromaras et al, above n 159, xiv.

164 AINs are also referred to as personal care workers or personal care attendants.

165 Generally, registered nurses are degree qualified, enrolled nurses require a Diploma of Nursing: Australian Health Practitioner Regulation Agency, *Approved Programs of Study* <www.ahpra.gov.au>. AINs generally have a vocational education qualification such as a certificate III or IV. See, eg, *CHC33015—Certificate III in Individual Support* <www.training.gov.au>.

166 See, eg, *Health Practitioner Regulation National Law* (NSW) No 86a s 39.

167 In 2003, 21% of the direct care workforce were registered nurses and 13.1% were enrolled nurses; in 2016 this had decreased to 14.6% and 10.2% respectively: Mavromaras et al, above n 159, table 3.2.

168 From 58.5% in 2003 to 70.3% in 2016: *Ibid*.

169 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*.

170 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*.

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

4.122 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’.¹⁷² The Accreditation Standards include an ‘expected outcome’ that there are ‘appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives’.¹⁷³ The draft quality standards include a standard that the ‘organisation has sufficient skilled and qualified workforce to provide safe, respectful and quality care and services’.¹⁷⁴

4.123 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.¹⁷⁵ 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.¹⁷⁶

4.124 The Queensland Nurses Union (QNU) reported that

in one negotiation on behalf of an individual member, QNU officials discovered the RN member was accountable for the care of 136 high care residents during her shift, with the assistance of six AINs. This circumstance is repeated in many residential aged care facilities, where a single RN can be accountable for the care of up to 150 residents.¹⁷⁷

4.125 Stakeholders also cited a number of aged care workers who raised concerns about staffing levels. For example, an AIN said:

Lack of staffing and/or resources can lead to instances of inadvertent abuse of elders. Eg when residents unable to speak up for themselves are left for hours in wet/soiled

172 *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.

173 *Quality of Care Principles 2014* (Cth) sch 2 item 1.6. There are a number of other outcomes that relate to the qualifications and sufficiency of staffing: see further Australian Aged Care Quality Agency, *Results and Processes Guide* (2014) 24–25.

174 Department of Health (Cth), *Single Aged Care Quality Framework: Draft Aged Care Quality Standards Consultation Paper* (2017) standard 7.

175 See, eg, People with Disability Australia, *Submission 167*; Australian Nursing & Midwifery Federation, *Submission 163*; L Barratt, *Submission 155*; Australian College of Nursing, *Submission 147*; Australian National University Elder Abuse Law Student Research Group, *Submission 146*; Capacity Australia, *Submission 134*; Alzheimer’s Australia, *Submission 80*; Queensland Nurses’ Union, *Submission 47*. 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>.

176 NSW Nurses and Midwives’ Association, *Submission 29*.

177 Queensland Nurses’ Union, *Submission 245*. QNU also argued that the staffing ratios were such that registered nurses are unable to comply with professional codes and guidelines regarding delegation of care.

beds or continence aids because staff are busy attending to other, more vocal residents.¹⁷⁸

4.126 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.¹⁷⁹

4.127 In the Inquiry, concerns were raised about the number of staff being insufficient to provide adequate care, as well as the qualifications and skill mix of staff being inappropriate to providing appropriate clinical care.

4.128 These concerns have not been limited to this Inquiry—a number of Coronial Inquiries have also observed that staffing numbers were not appropriate in the circumstances of the death under Inquiry.¹⁸⁰ In a coronial investigation into the death of a resident who suffocated when trapped between her mattress and a bed pole, Coroner McTaggart observed:

the industry benchmarks for adequate staffing did not provide for a realistic workload of the staff nor the ability to fulfil all of their tasks. On a wider scale, the evidence suggests that staffing levels are often inadequate across the aged care industry. The evidence also indicated that staff absenteeism was a significant factor in reducing staffing levels to below what was adequate to provide proper resident care. Again, the evidence gives me no reason to believe such an issue is confined to Vaucluse Gardens.¹⁸¹

4.129 The authors of the 2016 aged care workforce census and survey note as an emerging issue that ‘facilities within the residential sector are growing by opting for a workforce composition with lower use of direct care staff, which may have future implications regarding quality of provision’.¹⁸²

4.130 The Australian College of Nursing (ACN) was ‘concerned by the trend in the makeup of the aged care workforce, which has seen a reduction in the proportion of regulated health professionals working directly at the bedside’. It argued that

direct care with patients at the bedside provides valuable opportunities where an appropriately trained health professional can assess and identify potential problems and respond accordingly. However, increasingly business models are being deployed where nurses are being utilised only for ‘legislative requirements’, with AINs (however titled) fulfilling most of the traditional care elements. This is problematic, as they have limited and varied degree of training and preparation.¹⁸³

178 NSW Nurses and Midwives’ Association, *Submission 29*.

179 *Ibid.*

180 See, eg, *Ambrose, Inquest into the Death of Ambrose, Joan (COR 2009 0711)* [2012] VicCorC 120 (1 August 2012); *Epsimos, Inquest into the death of Savvas Epsimos* (Unreported, NSWCorC, 20 October 2016); *Westcott, Inquest into the death of Barbara Westcott* (Unreported, TASMC, 1 September 2016); *Watson, Inquest into the death of Beryl Joyce Watson* (Unreported, NSWCorC, 23 May 2014).

181 *Westcott, Inquest into the death of Barbara Westcott* (Unreported, TASMC, 1 September 2016).

182 Mavromaras et al, above n 159, 165.

183 Australian College of Nursing, *Submission 379*.

4.131 The ACN argued that

AINs (however titled) work under RN direction and supervision and they do not possess the education, knowledge and skills to substitute for an RN. At a time of increasing aged care service demand, retaining the number of nurses should be a key priority and ... regulation of residential aged care facilities should at a minimum mandate a requirement that a registered nurse be on-site and available at all times to promote safety and well-being for residents.¹⁸⁴

4.132 The ANMF asserted that ‘the ALRC Elder Abuse Inquiry has a duty of care to elderly people to include a specific proposal relating to staffing in aged care, in the final report’.¹⁸⁵

4.133 The Queensland Nurses’ Union was also concerned by changes to the aged care workforce, arguing that ‘changes to the composition of the aged care workforce and their increasing workloads provide the potential for incidents of elder abuse to occur and to go unreported’. It argued that workforce issues are ‘systemic and must not be attributed to individual staff already working to maximum capacity in a notoriously under-resourced sector’.¹⁸⁶

4.134 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.¹⁸⁷ In this Inquiry, the ACN 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’.¹⁸⁸

4.135 One method of measuring adequacy of levels of care provided by staff estimates the hours of direct care received by a resident each day. One estimate suggested that, in 2015, residential aged care residents received 2.86 hours of direct care per day.¹⁸⁹ A 2016 study has argued that the minimum care requirement for care residents should be an average of 4.30 hours per day.¹⁹⁰ This same study argued that the optimal skills mix in residential aged care should be 30% registered nurses, 20% enrolled nurses and 50% assistants-in-nursing.¹⁹¹

4.136 Where staffing numbers are insufficient, or the mix of staffing is inappropriate, there is potential for systemic neglect of residential aged care recipients. The ALRC therefore recommends that a clear evidence-based benchmark for ‘adequacy’ of

184 Ibid.

185 Australian Nursing and Midwifery Federation, *Submission 319*.

186 Queensland Nurses’ Union, *Submission 245*.

187 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.

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

189 E Willis et al, *National Aged Care Staffing and Skills Mix Project Report 2016 Meeting Residents’ Care Needs: A Study of the Requirement for Nursing and Personal Care Staff, 2016* (Australian Nursing and Midwifery Federation, 2016) 15.

190 Ibid 9.

191 Ibid.

staffing in residential aged care should be developed. The Department of Health should commission an independent evaluation by a properly qualified body of available research to provide this benchmark, which can be used to guide practice in aged care and to inform assessment of the adequacy of staffing against legislative standards.

Code of conduct for aged care workers

Recommendation 4–8 Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.

4.137 The ALRC recommends 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.

4.138 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 creates a National Registration and Accreditation Scheme (National Scheme) for registered health practitioners—14 professions, including medical practitioners, nurses and midwives, physiotherapists and psychologists.¹⁹² The professions are regulated by a corresponding National Board. The AHPRA supports the National Boards to implement the National Scheme.¹⁹³

4.139 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’.¹⁹⁴ Measures to ensure public safety include, among other things:

- requiring that National Boards develop registration standards for registered professions;¹⁹⁵
- 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;¹⁹⁶ and
- allowing for complaints to be made about a registered health practitioner.¹⁹⁷

4.140 However, many aged care workers—variously employed as AINs, aged care workers, or personal care workers—are unregistered.¹⁹⁸ The Council of Australian

192 The National Law is enacted through legislation in each state and territory: Australian Health Practitioner Regulation Agency, *Legislation* <www.ahpra.gov.au>.

193 Australian Health Practitioner Regulation Agency, *Who We Are* <www.ahpra.gov.au>.

194 Australian Health Practitioner Regulation Agency, *Home* <www.ahpra.gov.au>.

195 Health Practitioner Regulation National Law s 38.

196 Health Practitioner Regulation National Law pt 8 div 2.

197 Health Practitioner Regulation National Law pt 8 div 3.

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 have moved to those jurisdictions that have less regulatory scrutiny, in order to continue their illegal or unethical conduct.¹⁹⁹

4.141 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).²⁰⁰

4.142 The ALRC recommends that aged care workers providing direct care should be included in the planned National Code of Conduct.²⁰¹ A number of stakeholders supported this recommendation.²⁰²

4.143 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.²⁰³ Any person would be able to make a complaint about a breach of the National Code of Conduct.²⁰⁴

4.144 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.²⁰⁵ However, the Report noted that it can sometimes be unclear whether a service

198 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>.

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

200 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>.

201 COAG Health Council, above n 199.

202 Australian College of Nursing, *Submission 379*; Victorian Multicultural Commission, *Submission 364*; National Older Persons Legal Services Network, *Submission 363*; Office of the Public Advocate (Qld), *Submission 361*; M Berry, *Submission 355*; CPA Australia, *Submission 338*; V Fraser and C Wild, *Submission 327*; Institute of Legal Executives (Vic), *Submission 320*; Darwin Community Legal Service Aged and Disability Advocacy Service, *Submission 316*; Public Guardian (NSW), *Submission 302*; Mecwacare, *Submission 289*; ADA Australia, *Submission 283*; The Benevolent Society, *Submission 280*; Office of the Public Advocate (Vic), *Submission 246*; Lutheran Church of Australia, *Submission 244*; Brotherhood of St Laurence, *Submission 232*; W Millist, *Submission 230*; Aged and Community Services Association, *Submission 217*; Advocare, *Submission 213*.

203 The Code includes requirements such as: health care workers are: to provide services in a safe and ethical manner; not to financially exploit clients; and not to engage in sexual misconduct: COAG Health Council, above n 199, appendix 1.

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

205 Ibid rec 4.

provided by, for example, an assistant in nursing in aged care, is a ‘health service’.²⁰⁶ 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’.

4.145 Some aged care services regulated by the *Aged Care Act* or the CHSP 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 subject to employment screening processes as set out in Recommendation 4–9.

Registration of aged care workers or a specific code of conduct?

4.146 Some stakeholders criticised the inclusion of aged care workers in the planned National Code of Conduct as inadequate, arguing instead that aged care workers should be either registered or subject to an industry-specific code of conduct.²⁰⁷ Further, among those who supported the inclusion of aged care workers in the National Code of Conduct, some saw registration as a preferable longer term goal for regulating the aged care workforce.²⁰⁸

4.147 Professional nursing organisations in particular urged that AINs be subject to the National Scheme.²⁰⁹ Future registration of AINs, or development of an industry-specific code of conduct²¹⁰ is not precluded by Recommendation 4–8. However, a number of issues need to be addressed in considering the viability of registration of AINs, including a detailed examination of the characteristics of the occupation against the criteria for entry to the National Scheme.²¹¹ These issues were not canvassed in this Inquiry, and extend beyond responses to elder abuse.

206 Ibid 24–25.

207 See, eg, Leading Age Services Australia, *Submission 377*; Elder Care Watch, *Submission 326*; Australian Nursing and Midwifery Federation, *Submission 319*; NSW Nurses and Midwives’ Association, *Submission 248*; W Bonython and B Arnold, *Submission 241*; 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.

208 See, eg, Australian College of Nursing, *Submission 379*; Elder Care Watch, *Submission 326*; Office of the Public Advocate (Qld), *Submission 361*.

209 See, eg, Australian Nursing and Midwifery Federation, *Submission 319*; NSW Nurses and Midwives’ Association, *Submission 248*.

210 A Code of Conduct for NDIS providers forms part of the NDIS Quality and Safeguarding Framework: Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 93–96.

211 The COAG Health Council is responsible for agreeing on the inclusion of new professions in the scheme. A health profession must be able to demonstrate that it meets a number of criteria to be considered for registration, including whether: it is appropriate for Health Ministers to exercise responsibility for regulating the occupation; the activities of the occupation pose a significant risk of harm to the health and safety of the public; existing regulatory or other mechanisms fail to address health and safety issues; regulation is possible and practical to implement for the occupation: *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (2008) attachment B. See

Employment screening in aged care

Recommendation 4–9 There should be a national employment screening process for Commonwealth-regulated aged care. The screening process should determine whether a clearance should be granted to a person to work in aged care, based on an assessment of:

- (a) a person’s criminal history;
- (b) relevant incidents under the recommended serious incident response scheme; and
- (c) relevant disciplinary proceedings or complaints.

4.148 An employment screening process would enhance safeguards for older people receiving aged care, by ensuring that people delivering aged care are screened for relevant prior history that may affect their suitability to work with older people.

4.149 The ALRC recommends that people wishing to work or volunteer in Commonwealth-regulated aged care²¹² should be required to undergo employment screening by a screening agency.

4.150 The employment screening process in aged care should assess a person’s criminal history, any adverse findings made about the applicant that resulted from the reporting of a serious incident, as well as any findings from disciplinary or complaint action taken by registration or complaint handling bodies.

4.151 The recommendation will enhance the existing employment screening mechanism—broadly, a police check—to allow non-criminal information to be assessed to determine suitability to work in aged care. Having an independent decision maker will provide greater consistency in decision making about a person’s suitability to work in aged care than the current system.

Current pre-employment checks in aged care

4.152 A number of provisions in the *Aged Care Act* and associated Principles set out suitability requirements for employment in aged care. These include:

- Any person who is ‘key personnel’²¹³ of an approved provider must not have been convicted of an indictable offence, be insolvent, or be of ‘unsound mind’.²¹⁴

further Kim Snowball, ‘Independent Review of the National Registration and Accreditation Scheme for Health Professions’ (Final Report, Australian Health Ministers’ Advisory Council, 2014) 24–27.

212 That is, regulated by the *Aged Care Act* or the Commonwealth Home Support Programme.

213 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.

214 *Ibid* s 10A-1. Penalties may apply where an approved provider has a ‘disqualified person’ in a key personnel role: *Ibid* s 10A-2.

- Staff²¹⁵ of approved providers must be issued with a police certificate.²¹⁶ 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.²¹⁷
- Where a police certificate discloses something that is not an outright bar to employment, guidance has been developed to assist providers to assess the information.²¹⁸ These note that an ‘approved provider’s decision regarding the employment of a person with any recorded convictions must be rigorous, defensible and transparent’.²¹⁹

4.153 Aged care providers are also likely to undertake reference checks.²²⁰ These may operate as an additional safeguard against employing unsuitable applicants.

4.154 Members of some health professions working in aged care are subject to the National Registration and Accreditation Scheme. A registered health professional must meet registration requirements, which include an assessment of criminal history.²²¹

Pre-employment checks in other sectors

4.155 All Australian jurisdictions require people who work with children to hold a ‘working with children’ check.²²² Two Australian jurisdictions, the ACT and Tasmania, have moved to broaden their employment screening to people working with other vulnerable groups.²²³

4.156 The NDIS Quality and Safeguarding Framework has signalled that a nationally consistent employment screening process will be developed for workers who have significant contact with people with disability as part of their work. The screening process will take into account:

215 ‘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.

216 A police certificate discloses whether a person has been convicted of an offence; has been charged with and found guilty of an offence but discharged without conviction; or is the subject of any criminal charge still pending before a Court: Department of Social Services, *Aged Care Quality and Compliance Group—Police Certificate Guidelines* (2014) 10.

217 *Accountability Principles 2014* (Cth) s 48.

218 Department of Social Services, above n 216, 11.

219 *Ibid.*

220 Leading Age Services Australia, *Submission 104*; Alzheimer’s Australia, *Submission 80*.

221 Australian Health Practitioner Registration Agency, *Registration Standard: Criminal History* (1 July 2015). The standard is made under the *Health Practitioner Regulation National Law* s 38.

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

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

information such as convictions, including spent and quashed convictions; other police/court information, such as current or pending charges; Apprehended Violence Orders, Child Protection Orders and child protection information; international police checks for those who have worked overseas, when feasible; and workplace misconduct, which comes to light through complaints and serious incident reporting.²²⁴

4.157 Working with children checks generally capture a broader range of information than that reported in a national police check. Working with children checks may include assessment of convictions, charges, relevant allegations or police investigations and relevant employment proceedings and disciplinary information from professional organisations.²²⁵ In NSW, the working with children check also considers adverse findings made in relation to reportable conduct.²²⁶

4.158 The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) has recommended that there be a national model for working with children checks, with consistent standards and a centralised database to facilitate cross-border information sharing.²²⁷

What information should be assessed?

4.159 The ALRC recommends that both criminal history and some forms of non-criminal information be assessed as part of pre-employment screening for aged care. Most submissions responding to this issue supported an employment screening process.²²⁸ The ALRC agrees with stakeholders that, as far as practicable, the process for screening workers in the aged care, disability and child sectors should be compatible.²²⁹ For example, the NSW Ombudsman suggested that there was ‘strong merit in developing a consistent national approach to screening in relation to people seeking to work with vulnerable people more broadly ... In the absence of a national

224 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 62.

225 Australian Institute of Family Studies, *Pre-Employment Screening: Working With Children Checks and Police Checks* (2016). The information captured across jurisdictions can vary.

226 *Child Protection (Working with Children) Act 2012* (NSW) s 35; sch 1. The NSW Ombudsman may disclose information to the Office of the Children’s Guardian, including information about reports of investigations into reportable conduct by the Ombudsman or a designated government or non-government agency: *Ombudsman Act 1974* (NSW) s 25DA.

227 Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks Report* (2015) 5.

228 See, eg, Office of the Public Guardian (Qld), *Submission 384*; National LGBTI Health Alliance, *Submission 373*; National Legal Aid, *Submission 370*; Victorian Multicultural Commission, *Submission 364*; National Older Persons Legal Services Network, *Submission 363*; Office of the Public Advocate (Qld), *Submission 361*; Eastern Community Legal Centre, *Submission 357*; Legal Aid NSW, *Submission 352*; Law Council of Australia, *Submission 351*; NSW Ombudsman, *Submission 341*; AnglicareSA, *Submission 299*; Holman Webb Lawyers, *Submission 297*; Mecwacare, *Submission 289*; ACT Disability Aged and Carer Advocacy Service (ADACAS), *Submission 269*; Office of the Public Advocate (Vic), *Submission 246*; Aged and Community Services Association, *Submission 217*; UnitingCare Australia, *Submission 216*; Advocare, *Submission 213*.

229 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Victorian Multicultural Commission, *Submission 364*; Disabled People’s Organisations Australia, *Submission 360*; Office of the Public Advocate (Qld), *Submission 361*; COTA, *Submission 354*; Law Council of Australia, *Submission 351*; NSW Ombudsman, *Submission 341*; AnglicareSA, *Submission 299*; Mecwacare, *Submission 289*. Some stakeholders suggested that information from past conduct in all three sectors should be used to screen aged care workers: see, eg *Ibid*.

screening system for vulnerable people, we are keen to see alignment between the screening systems'.²³⁰

4.160 Not all supported further screening. 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.²³¹

4.161 Similar limitations in evidence exist for working with children screening processes. Background checking is premised on the concept that prior behaviour can be an indicator of future behaviour, and can serve to inform risk assessment. There is some contention about this—for example, research in the context of child abuse suggests that the majority of perpetrators have not been convicted of child abuse in the past.²³²

4.162 Nonetheless, in a 2015 report evaluating working with children check schemes, the Royal Commission concluded that it shared 'the view held by the majority of government and non-government stakeholders whom we consulted ... they deliver unquestionable benefits to the safeguarding of children'.²³³

4.163 **Criminal conduct:** A person's criminal history should be screened before a clearance to work in aged care is granted. The ALRC does not make specific recommendations about the kind of criminal conduct that should be assessed, and when such conduct should be disqualifying or evaluated as part of an overall risk assessment. A discussion of stakeholder views is provided to inform the further detailed policy work that is required on these questions.

4.164 Stakeholders in this Inquiry strongly supported an assessment of a person's criminal history as part of pre-employment screening. Some considered that the existing list of offences disqualifying a person from working in aged care should be maintained.²³⁴ Many suggested that the relevant criminal history should align with pre-employment checks in other sectors. However, there was also significant support for including fraud offences or offences relating to financial abuse as disqualifying a

230 NSW Ombudsman, *Submission 341*.

231 Aged and Community Services Australia, *Submission 102*. See also Leading Age Services Australia, *Submission 377*; Carroll & O'Dea, *Submission 335*; Australian Association of Gerontology (AAG) and the National Ageing Research Institute (NARI), *Submission 291*; Brotherhood of St Laurence, *Submission 232*.

232 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 227, 29. See also Clare Tilbury, 'Working with Children Checks—Time to Step Back?' (2014) 49(1) *Australian Journal of Social Issues* 87.

233 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 227, 4.

234 Legal Aid NSW, *Submission 352*.

person from working in aged care.²³⁵ Some considered that drug offences should be disqualifying.²³⁶

4.165 A number of stakeholders argued that international criminal history should also be assessed for workers who had lived overseas.²³⁷ This was considered particularly important given the large, and increasing, numbers of migrant workers in aged care. The ANMF noted that, given ‘around one-third of unregulated health workers who are employed in direct care work within the aged care sector (both residential and community) were born outside Australia ... the criminal history declaration for this group must also encompass national and international convictions’.²³⁸

4.166 Some submissions argued that having been a respondent to intervention orders should be considered as part of the employment screening process, although evidence of this did not necessarily require an outright bar.²³⁹

4.167 Stakeholders also warned that an overzealous approach to preventing people from working in aged care as a result of prior criminal history can be unfair. For example, Legal Aid NSW warned that a system that prohibits services from employing people who have been convicted of certain offences, with no discretion or procedure for review, can ‘lead to the unfair and perhaps unintended outcome of prohibiting people who do not pose a risk’.²⁴⁰

4.168 Registered health professionals are already required to have an annual criminal record check as part of the conditions of their registration. Consideration might be given to whether registration should provide sufficient screening of criminal history so as not to require an additional criminal history check.

4.169 **Non-criminal information:** Information about adverse findings arising out of the serious incident response scheme should be considered in the employment screening process, as well as information relating to a person’s professional registration.

4.170 Only screening criminal history has limitations in terms of assessing someone’s suitability to work in aged care. Conduct must meet a very high evidentiary threshold before it will be recorded on a police check. Capturing conduct that meets a lower threshold would allow a more comprehensive risk assessment of a person’s prior history.²⁴¹ As the ACT Disability Aged and Carer Advocacy Service noted, ‘Criminal charges are rarely progressed in elder abuse cases, therefore the employment screening process would also need access to the reportable incident register so that past

235 See, eg, Law Council of Australia, *Submission 351*; AnglicareSA, *Submission 299*; Mecwacare, *Submission 289*; Office of the Public Advocate (Vic), *Submission 246*.

236 Law Council of Australia, *Submission 351*; Lutheran Church of Australia, *Submission 244*.

237 Australian Nursing and Midwifery Federation, *Submission 319*; Name Withheld, *Submission 266*; NSW Nurses and Midwives’ Association, *Submission 248*.

238 Australian Nursing and Midwifery Federation, *Submission 319*.

239 See, eg, National LGBTI Health Alliance, *Submission 373*; Churches of Christ Care, *Submission 254*.

240 Legal Aid NSW, *Submission 352*. See also, eg, Leading Age Services Australia, *Submission 377*; National LGBTI Health Alliance, *Submission 373*.

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

allegations of abuse or neglect can be considered in determining whether a person is fit to work in the sector'.²⁴²

4.171 Submissions were supportive of including non-criminal information in the pre-employment screening process. A number suggested that any adverse finding from the serious incident scheme should disqualify a person from working in aged care.²⁴³ Others considered that such information should not automatically disqualify a person, but should be assessed as part of an evaluation of a person's suitability.²⁴⁴

4.172 In NSW the pre-employment process for working with children requires prescribed organisations to report findings that a worker has engaged in sexual misconduct committed against, with, or in the presence of a child; or any serious physical assault of a child to the employment screening body.²⁴⁵ This is a narrower class of conduct than is required to be reported to the Ombudsman under the reportable conduct scheme in relation to children in NSW.²⁴⁶

4.173 The NSW Ombudsman has noted that its oversight of the reportable conduct scheme provides 'confidence in the integrity of the findings of misconduct reported to the screening agency'. It further observed that its oversight role allows it to assess

the quality of the agency investigation and the validity of the related findings. Both of these elements need to be properly addressed so that they can be relied on by the [Office of the Children's Guardian] for the purposes of informing the ... screening process.²⁴⁷

4.174 The ALRC considers that similar benefits would accrue from the integration of the serious incident response scheme with pre-employment screening in aged care. Adverse findings should be assessed as part of the screening process. However, it considers that such information should be assessed as part of an overall consideration of risk rather than acting to automatically exclude a person from aged care work.

4.175 Information from professional registration bodies should also be assessed in the pre-employment screening process. For example, information relating to a health practitioner's registration should be considered (such as previous cancellation of registration, suspension, conditions on registration). The planned National Code of

242 ACT Disability Aged and Carer Advocacy Service (ADACAS), *Submission 269*.

243 Office of the Public Advocate (Qld), *Submission 361*; Law Council of Australia, *Submission 351*; AnglicareSA, *Submission 299*; Holman Webb Lawyers, *Submission 297*; Mecwacare, *Submission 289*; ADA Australia, *Submission 283*; Churches of Christ Care, *Submission 254*.

244 Legal Aid NSW, *Submission 352*; Institute of Legal Executives (Vic), *Submission 320*; Seniors Rights Service, *Submission 296*; Lutheran Church of Australia, *Submission 244*.

245 *Child Protection (Working with Children) Act 2012* (NSW) s 35, sch 1. The NSW Ombudsman may disclose information to the Office of the Children's Guardian, including information about reports of investigations into reportable conduct by the Ombudsman or a designated government or non-government agency: *Ombudsman Act 1974* (NSW) s 25DA. The NSW Ombudsman has stated that, in 'determining whether an investigation into a reportable allegation has been properly conducted, and whether appropriate action has been taken in response, we check to see whether, as required under the Working with Children Act, relevant misconduct findings have been notified to the Office of the Children's Guardian': NSW Ombudsman, *Strengthening the Oversight of Workplace Child Abuse Allegations. A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2016) 9.

246 *Ombudsman Act 1974* (NSW) pt 3A.

247 NSW Ombudsman, above n 245, 9.

Conduct for Health Care Workers will allow for complaints to be made against unregistered practitioners, and any relevant information relating to such complaints should also form part of the information that is assessed.

How long should clearances last?

4.176 Police certificate 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.²⁴⁸

4.177 Most stakeholders in this Inquiry suggested three years would be an appropriate timeframe for clearances. A number of submissions considered that appropriate timeframes for clearances would depend on whether there was capacity for continuous monitoring of criminal history.²⁴⁹

Who should screen?

4.178 An appropriate independent organisation should be responsible for employment screening, and for making a determination about whether a person should be granted a clearance to work in aged care.

4.179 Having an independent decision maker will provide greater consistency in decision making about a person’s suitability to work in aged care than the current system, which, where information is available that might suggest risk, but does not disqualify a person from working in aged care, leaves individual providers to make a final decision on suitability.

4.180 Approved providers should still take other steps to establish a person’s suitability, including by conducting reference checks with a person’s previous employers.

Who should be screened?

4.181 The ALRC considers that potential ‘staff members’, as currently defined in the *Aged Care Act*, should be required to undergo employment screening as a pre-condition to employment, that is, a person ‘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’.²⁵⁰

248 The duration of working with children and vulnerable person checks in Australian jurisdictions varies across jurisdictions. 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 New South Wales and Victoria: Australian Institute of Family Studies, above n 225. Most working with children checks have capacity for continuous monitoring: see Royal Commission into Institutional Responses to Child Sexual Abuse, above n 227.

249 See, eg, ADA Australia, OPA Vic, Churches of Christ Care. The Royal Commission into Institutional Responses to Child Sexual Abuse recommended that, if criminal history was continuously monitored, working with children checks should remain valid for five years: Royal Commission into Institutional Responses to Child Sexual Abuse, above n 227, rec 31.

250 *Aged Care Act 1997* (Cth) s 63-1AA(9).

4.182 There should be a process for review and appeals of decisions made about whether a person be excluded from working in aged care that affords procedural fairness for those who are subject to the screening. In the NSW screening process for working with children, for example, this process includes:

- notifying a person of a proposal to bar them from working with children and inviting them to submit information which may affect the decision, which is taken into account in the final decision;
- informing a person of a decision not to grant a clearance; and
- the opportunity to appeal a decision in the NSW Civil and Administrative Tribunal.²⁵¹

Restrictive practices

Recommendation 4–10 Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:

- (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
- (b) to the extent necessary and proportionate to the risk of harm;
- (c) with the approval of a person authorised by statute to make this decision;
- (d) as prescribed by a person’s behaviour support plan; and
- (e) when subject to regular review.

Recommendation 4–11 The Australian Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:

- (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
- (b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
- (c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.

4.183 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

251 *Office of the Children’s Guardian, Bars and Appeals (Fact Sheet 12, 2014)* 12. See also, eg, Department of Justice and Regulation (Vic), *Failing the Check* <www.workingwithchildren.vic.gov.au>.

imprisonment and other civil and criminal wrongs. The ALRC recommends that the use of these practices in residential aged care facilities be regulated in the *Aged Care Act*. This would mean that restrictive practices are used less frequently and only when appropriate, reducing one type of elder abuse and serving to protect older people's legal and human rights.

4.184 The key elements of regulation set out in Recommendation 4–10 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.

4.185 The ALRC also recommends that the Australian Government consider a number of additional oversight measures for the use of restrictive practices, as well as the merits of consistently regulating the use of restrictive practices in aged care and the NDIS.

What are restrictive practices?

4.186 Restrictive practices have 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’.²⁵²

4.187 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, claspings 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).²⁵³ The Australian and New Zealand Society for Geriatric Medicine submitted that restrictive practices are ‘still pervasive’ in residential aged care facilities, ‘particularly in relation to chemical sedation and inappropriate use of drugs’.²⁵⁴

4.188 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’.²⁵⁵

4.189 In practice, restrictive practices are most often used on people with an intellectual disability or cognitive impairment (including dementia) 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.

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

253 Admitting a person to a residential care facility against their wishes or without their consent (perhaps when they do not have the legal 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 Law Commission inquiry: Law Commission (UK), *Mental Capacity and Deprivation of Liberty* <www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>.

254 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*.

255 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).

4.190 However, some question whether restrictive practices are ever truly necessary. People with Disability Australia said these practices should be stopped, and that there should instead be a focus on the ‘environmental or service factors’ that cause problematic behaviour.²⁵⁶ 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’.²⁵⁷ Others submitted that, although they should be a last resort, restrictive practices are sometimes necessary ‘to protect other care recipients and staff’.²⁵⁸

4.191 Recommendations 4–10 and 4–11 are not intended to imply that restrictive practices are sometimes necessary, much less condone their use. Rather, they are intended to limit and carefully regulate their use.

Regulating restrictive practices in aged care

4.192 A national framework exists for reducing and eliminating the use of restrictive practices in the disability service sector.²⁵⁹ In aged care, the use of restrictive practices is not explicitly regulated, although guidance has been provided.²⁶⁰

4.193 In the *Equality, Capacity and Disability* Report, the ALRC discussed the use of restrictive practices in Australia, highlighted the ‘patchwork’ of federal, state and territory laws and policies governing restrictive practices, and set out stakeholder calls for reform.²⁶¹ 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.²⁶² Calls for reform, including for nationally consistent legislated regulation, were repeated in submissions to this Inquiry.²⁶³

256 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*. See also Disabled People’s Organisations Australia, *Submission 360*; FECCA, *Submission 292*.

257 Older Women’s Network, *Submission 136*. See also ARNLA, who submitted that restrictive practices in response to challenging behaviours are ‘indicative of environments that have not achieved a sense of wellbeing for the older person with dementia’: Australian Research Network on Law and Ageing, *Submission 262*.

258 National Seniors Australia, *Submission 154*.

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

260 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*.

261 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.

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

263 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*.

4.194 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 recommends that aged care legislation regulate the use of restrictive practices in residential care facilities. The scheme in the *Disability Act 2006* (Vic) pt 7 (*Disability Act*) may be a suitable model.²⁶⁴ Some of the key elements of the Victorian law are contained in Recommendation 4–10, including the requirement that the restraint only be used when necessary to prevent harm.

4.195 Submissions on this issue shared a view that the use of restrictive practices should be reduced or eliminated, but diverged about how this should be done. A number supported legislative regulation of restrictive practices.²⁶⁵ Those that opposed legislative regulation of restrictive practices argued either that restrictive practices should not be used,²⁶⁶ or that non-legislative means were a better approach to achieving a reduction or elimination of their use.²⁶⁷

4.196 The recommendation adds some additional elements to regulate restrictive practices than made in the Discussion Paper—principally, to further emphasise that the use of restrictive practices should be a last resort and that their use should be subject to regular review.²⁶⁸ With respect to Recommendation 4–11 that the use of restrictive practices be approved by a person authorised by statute, the ALRC envisages a similar process to that in the Victorian legislation. The *Disability Act 2006* (Vic) requires that disability services that use restrictive interventions appoint an ‘authorised program officer’, who must approve the inclusion of restrictive practices in a person’s behaviour support plan *before* they can be used on a person.²⁶⁹

264 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*.

265 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Australian College of Nursing, *Submission 379*; Victorian Multicultural Commission, *Submission 364*; National Older Persons Legal Services Network, *Submission 363*; Justice Connect Seniors Law, *Submission 362*; Office of the Public Advocate (Qld), *Submission 361*; Eastern Community Legal Centre, *Submission 357*; M Berry, *Submission 355*; COTA, *Submission 354*; Legal Aid NSW, *Submission 352*; Law Council of Australia, *Submission 351*; CPA Australia, *Submission 338*; Carroll & O’Dea, *Submission 335*; V Fraser and C Wild, *Submission 327*; Elder Care Watch, *Submission 326*; L Barratt, *Submission 325*; Institute of Legal Executives (Vic), *Submission 320*; Darwin Community Legal Service Aged and Disability Advocacy Service, *Submission 316*; Speech Pathology Australia, *Submission 309*; M Daly, *Submission 308*; Public Guardian (NSW), *Submission 302*; Seniors Rights Service, *Submission 296*; Aged Rights Advocacy Service Inc, *Submission 285*; Office of the Public Advocate (Vic), *Submission 246*; Lutheran Church of Australia, *Submission 244*; Brotherhood of St Laurence, *Submission 232*; Aged and Community Services Association, *Submission 217*.

266 See, eg, Disabled People’s Organisations Australia, *Submission 360*; FECCA, *Submission 292*.

267 See, eg, HammondCare, *Submission 307*. LASA highlighted work within the sector to reduce the use of sedation in aged care: Leading Age Services Australia, *Submission 377*.

268 The Office of the Public Advocate (Vic) pointed out that review was a key element of the regulation of restrictive practices in the *Disability Act*: Office of the Public Advocate (Vic), *Submission 246*. Other stakeholders supported regular review as a feature of any regulation: see, eg, Speech Pathology Australia, *Submission 309*; Australian Research Network on Law and Ageing, *Submission 262*; Aged and Community Services Association, *Submission 217*.

269 *Disability Act 2006* (Vic) ss 139, 145.

4.197 That restrictive practices should only be used when necessary was stressed in many submissions to this Inquiry. For example, the ACN urged that ‘restrictive practices in all circumstances must be practices of last resort’.²⁷⁰ 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.²⁷¹

4.198 Similarly, the Office of the Public Advocate (Qld) argued that the legal framework should ensure that restrictive practices 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’.²⁷²

4.199 In addition to explicitly recommending that restrictive practices only be used as a last resort, the ALRC also recommends that they be used only to prevent *serious* physical harm, to further raise the threshold for justification for their use.²⁷³

Regulating restrictive practices—additional considerations

4.200 A Senior Practitioner and required reporting on the use of restrictive practices are features of the regulation of restrictive practices in the disability sector, including in the planned Quality and Safeguarding Framework for the NDIS.²⁷⁴ The ALRC recommends that these additional oversight mechanisms should be considered as part of any regulation of such practices in aged care.

4.201 A Senior Practitioner role has resource implications. However, there is widespread concern—shared by providers and aged care consumer advocates—that restrictive practices, and especially chemical restraint, are inappropriately used in aged care. These additional measures may assist in providing leadership and expertise in reducing and eliminating the use of restraint.²⁷⁵

270 Australian College of Nursing, *Submission 147*.

271 National Seniors Australia, *Submission 154*.

272 Office of the Public Advocate (Qld), *Submission 149*. See also, eg, Law Council of Australia, *Submission 351*; Speech Pathology Australia, *Submission 309*; Australian Research Network on Law and Ageing, *Submission 262*.

273 See Law Council of Australia, *Submission 351*; HammondCare, *Submission 307*. A failure to comply with the recommended requirements in relation to the use of restrictive practices would likely amount to a reportable ‘serious incident’ as discussed above.

274 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 71–72. See also *Disability Act 2006* (Vic) s 148.

275 A number of stakeholders supported the establishment of a Senior Practitioner role in aged care: see, eg, Disabled People’s Organisations Australia, *Submission 360*; Mecwacare, *Submission 289*; Office of the Public Advocate (Vic), *Submission 246*.

4.202 The ALRC considers that a consistent approach to regulation of restrictive practices in aged care and disability services is desirable, both as a matter of principle and pragmatism. Similar human rights considerations apply across both sectors to decisions to interfere with a person's rights and freedoms, and a consistent approach also provides the opportunity for aged care to adopt best practice approaches to regulation developed in other sectors.²⁷⁶

4.203 The ALRC's recommendations relating to restrictive practices are limited to residential aged care. However, people who would have previously moved into residential aged care will increasingly receive aged care at home. The use of chemical restraint in particular will be an emerging issue, and extension of the regulation or restrictive practices to home care settings should be considered in the longer term.

Decision making

Recommendation 4–12 The Australian Government should further consider Recommendation 6–2 of ALRC Report No 124 *Equality, Capacity and Disability in Commonwealth Laws*, that aged care laws and legal frameworks should be amended consistently with the National Decision-Making Principles set out in that Report.

4.204 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;²⁷⁷
- abuse by informal and appointed decision makers, including misuse of powers of attorney, and abusive or prohibitive lifestyle decisions;²⁷⁸
- a lack of understanding of the powers and duties of appointed decision makers, by both the decision maker and aged care workers;²⁷⁹ and

276 See, eg, Office of the Public Guardian (Qld), *Submission 384*; Disabled People's Organisations Australia, *Submission 360*; Australian Association of Gerontology (AAG) and the National Ageing Research Institute (NARI), *Submission 291*; Office of the Public Advocate (Vic), *Submission 246*. CPSA recommended mandatory reporting on the use of physical restraints: Combined Pensioners and Superannuants Association, *Submission 281*.

277 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*.

278 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*.

- 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.²⁸⁰

4.205 In the *Equality, Capacity and Disability* Report, the ALRC recommended that aged care laws and legal frameworks should be amended consistently with the National Decision-Making Principles.²⁸¹ 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.²⁸² The ALRC also developed a Commonwealth Decision-Making Model that, among other things, makes provision for the appointment of a ‘supporter’ or a ‘representative’ for a person who requires decision-making support, and recommended that aged care legislation be amended consistently with this model.²⁸³

4.206 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.

4.207 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.²⁸⁴ 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.²⁸⁵

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

280 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 51, 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.

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

282 *Ibid* rec 3–1. The National Decision-Making Principles, and the ALRC’s approach to supported decision making, are discussed further in ch 2.

283 *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.

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

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

4.208 The *Quality of Care Principles* define ‘representative’ in a way that is ‘similar to both supporters and representatives in the Commonwealth decision-making model’.²⁸⁶

4.209 The Law Society of South Australia was concerned about the potential for abuse that arises from the ‘vague and uncertain’ definitions relating to decision makers in the *Aged Care Act* and associated Principles:

An example of potential abuse (often seen in practice) ... is the entitlement of a care recipient within the Charter of Care Recipients’ Rights in relation to home care to have his or her representative participate in decisions, etc. There is no definition of ‘representative’ for the purposes of the Charter, or more generally in the User Rights Principles. If one were to apply the broad and uncertain definition appearing in the Records Principles, any person who had some dealings (whether authorised or otherwise and of whatever level of significance or duration) would be entitled to put themselves forward as a representative of the care recipient and therefore entitled to participate in the choice of services.²⁸⁷

4.210 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.²⁸⁸

4.211 This is particularly important when considering major decisions, such as the decision to enter residential aged care. The Law Council of Australia argued that there should be a ‘more robust approvals process around entry to aged care, such as determining the wishes and preferences of older person and considering these wishes and preferences, irrespective of the person’s capacity’.²⁸⁹ Justice Connect Seniors Law was similarly concerned about safeguards relating to a person’s entry to aged care. It argued that the decision to enter residential aged care is a key decision, and that ‘regulation is required to clarify the person responsible for making the decision and safeguards and oversight of those decisions’.²⁹⁰

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

287 Law Society of South Australia, *Submission 381*. The *Records Principles 2014* (Cth) defines ‘representative’ as a person nominated by the care recipient as a person to be told about matters affecting the care recipient; or a person who nominates themselves to be told about matters affecting a care recipient; and who the provider is satisfied has a connection with the care recipient, and is concerned for the safety, health and wellbeing of the care recipient: s 5(1). A person who has a connection with the care recipient is non-exhaustively defined to include a person who ‘represents the care recipient in dealings with the approved provider’: s 5(2)(d).

288 See also Deirdre Fetherstonhaugh, Laura Tarzia and Rhonda Nay, ‘Being Central to Decision Making Means I Am Still Here! The Essence of Decision Making for People with Dementia’ (2013) 27(2) *Journal of Aging Studies* 143.

289 Law Council of Australia, *Submission 351*.

290 Justice Connect Seniors Law, *Submission 362*.

4.212 Implementation of the ALRC’s recommendation would also require:

- consideration of the interaction with state and territory appointed decision makers;²⁹¹
- 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.²⁹²

4.213 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’.²⁹³ 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’.²⁹⁴ The ACN 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’.²⁹⁵

4.214 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.²⁹⁶ 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

291 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. In the context of aged care, the Law Society of SA observed that the ‘extent to which rights under the Act are only exercisable by a care recipient’s formal appointee has been, and continues to be an area of considerable uncertainty’: Law Society of South Australia, *Submission 381*.

292 This was supported by Justice Connect, *Submission 182*; ADA Australia, *Submission 150*; NSW Nurses and Midwives’ Association, *Submission 29*. See also Laura Tarzia et al, ‘“We Have to Work Within the System!”: Staff Perceptions of Organizational Barriers to Decision Making for Older Adults With Dementia in Australian Aged Care Facilities’ (2015) 8(6) *Research in Gerontological Nursing* 286. Measures might include, eg, guidance about when ACAT teams should speak to the older person alone.

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

294 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*.

295 Australian College of Nursing, *Submission 147*.

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

model'.²⁹⁷ Stakeholders also highlighted the importance of funded advocacy programs in providing decision-making support.²⁹⁸

4.215 Reforms recommended elsewhere in this Report will also assist in providing safeguards against abuse of a person's decision-making rights. These include recommendations for reform of laws relating to enduring powers of attorney and guardianship (Chapter 5); guardianship and financial administration (Chapter 10) as well as the recommendations to provide oversight of the use of restrictive practices in aged care (Recommendations 4–10 and 4–11).

Appointed decision makers—a matter of choice

Recommendation 4–13 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.

4.216 A number of submissions to this Inquiry 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.²⁹⁹ ARNLA, who supported the recommendation against such a requirement, referred to this as an 'ingrained' practice of providers.³⁰⁰

4.217 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.³⁰¹

4.218 Other submissions outlined the complexities that aged care providers can face in relation to decision making. The ACN 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'.³⁰² Resthaven stated that providers 'face a real challenge

297 Speech Pathology Australia, *Submission 168*.

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

299 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.

300 Australian Research Network on Law and Ageing, *Submission 262*. ADA Australia noted that it had been involved in a number of cases of this type: ADA Australia, *Submission 283*.

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

302 Australian College of Nursing, *Submission 147*. See also Leading Age Services Australia, *Submission 377*.

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'.³⁰³

4.219 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.³⁰⁴ Advance planning for decision-making support in aged care should, however, be encouraged.³⁰⁵ Speech Pathology Australia argued that there is a

need for ongoing training and education for all aged care workers and health professionals regarding the importance of advance care planning and having those difficult conversations with clients as early as possible and across all levels of contact with the health and aged care systems. This must be seen as core business and addressed as a central element of aged care.³⁰⁶

4.220 COTA was similarly concerned that any choice not to appoint a decision maker be an informed one, and suggested that providers be required to 'inform care recipients of what the consequences may be if there is no one appointed and they become incapacitated in regard to decision making'.³⁰⁷

4.221 ACSA opposed such a recommendation, arguing that it would be inconsistent with a market-based approach, 'as it seeks to override contractual arrangements between an aged care provider and a care recipient'.³⁰⁸ However, the ALRC considers that 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. Further, it may have harmful effects on the older person. Seniors Legal and Support Service Hervey Bay argued that such a requirement meant that

too often older people appoint 'risky' attorneys or spend unnecessary time in hospital waiting for the tribunal to appoint a substitute decision maker because aged care

303 Resthaven, *Submission 114*.

304 Many submissions supported the Discussion Paper proposal: Leading Age Services Australia, *Submission 377*; Victorian Multicultural Commission, *Submission 364*; National Older Persons Legal Services Network, *Submission 363*; Justice Connect Seniors Law, *Submission 362*; Office of the Public Advocate (Qld), *Submission 361*; Disabled People's Organisations Australia, *Submission 360*; Eastern Community Legal Centre, *Submission 357*; M Berry, *Submission 355*; COTA, *Submission 354*; Law Council of Australia, *Submission 351*; CPA Australia, *Submission 338*; Carroll & O'Dea, *Submission 335*; Institute of Legal Executives (Vic), *Submission 320*; Darwin Community Legal Service Aged and Disability Advocacy Service, *Submission 316*; Seniors Legal and Support Service Hervey Bay, *Submission 310*; Speech Pathology Australia, *Submission 309*; Public Guardian (NSW), *Submission 302*; Seniors Rights Service, *Submission 296*; ADA Australia, *Submission 283*; Australian Research Network on Law and Ageing, *Submission 262*; Office of the Public Advocate (Vic), *Submission 246*; Lutheran Church of Australia, *Submission 244*; Brotherhood of St Laurence, *Submission 232*; Advocare, *Submission 213*.

305 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 rec 3–1). National Seniors Australia supported an 'ongoing public campaign' in relation to this: National Seniors Australia, *Submission 154*.

306 Speech Pathology Australia, *Submission 309*.

307 COTA, *Submission 354*. See also W Bonython and B Arnold, *Submission 241*.

308 Aged and Community Services Association, *Submission 217*.

facilities will not offer accommodation to prospective residents who do not have a substituted decision maker appointed.³⁰⁹

4.222 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.³¹⁰

4.223 In keeping with an emphasis on respecting a person's decision-making ability, the ALRC recommends that 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.

Other issues relating to aged care agreements

4.224 Seniors Rights Service raised broader concerns with aged care agreements, arguing that some provisions included in agreements were 'oppressive' and that further protections for older people against unfair provisions were required. It advocated for a mandated uniform aged care agreement, or failing this, a requirement that the Department of Health produce an information booklet, together with a schedule of rates and costs, relating to aged care agreements on an annual basis, together with a prescription that any aged care agreement which seeks to avoid or restrict the operation of the information contained in the booklet be void and of no effect.³¹¹

Community visitors

Recommendation 4–14 The Department of Health (Cth) should develop national guidelines for the community visitors scheme. The guidelines should include policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients.

4.225 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).³¹² Community visitors are not advocates, and are directed to report any concerns they have about care to their auspicing organisation.³¹³

309 Seniors Legal and Support Service Hervey Bay, *Submission 310*.

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

311 See further Seniors Rights Service, *Submission 296*; Seniors Rights Service, *Submission 169*.

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

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

4.226 The CVS provides an important role in reducing social isolation, which may itself be protective against abuse.³¹⁴ In 2015–16, the Department of Health (Cth) funded over 220,000 visits by community to people receiving residential and home care.³¹⁵ 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, but does envisage a more limited role should they become aware of it.³¹⁶

4.227 At present, the CVS lacks detailed national guidelines. Auspices are required to develop internal policies, but there is limited guidance on what these should contain, including limited guidance about how to respond to concerns about abuse or neglect.³¹⁷

4.228 The ALRC recommends that national guidelines applying to the CVS should be developed, with standardised policies and procedures for visitors to follow where they become aware of abuse or neglect. That national guidelines for the CVS should be introduced received widespread support from stakeholders.³¹⁸ For example, Elder Care Watch argued that 'the present reliance on auspicings organisations is not satisfactory and invites inconsistency'.³¹⁹ The Queensland AIDS Council (QuAC) reported that volunteers with 'concerns about abuse or neglect of Community Visitor Scheme care recipients can experience distress and concern in the event of witnessing or learning of a situation of elder abuse impacting the person they visit'.³²⁰

4.229 Some submissions emphasised that any guidelines about dealing with abuse and neglect observed by community visitors should be carefully designed so as not to compromise a visitor's relationship with a care recipient or care provider. QuAC noted:

volunteers are not trained advocates and should not act in that position. Advocating for people is a complex matter and it should be done by trained professionals. Volunteers are not trained to take more complex actions, and a good reporting system along with a strong working relationship between the volunteer, client and auspice should prevent any negligence.³²¹

314 See further Rae Kaspiew, Rachel Carson and Helen Rhoades, 'Elder Abuse: Understanding Issues, Frameworks and Responses' (Research Report 35, Australian Institute of Family Studies, 2016) 8–9.

315 Department of Health (Cth), above n 9, 20.

316 CPSA was opposed to national guidelines because of a perception that the role of community visitors was to be changed, however this is not the intent of this recommendation: Combined Pensioners and Superannuants Association, *Submission 281*.

317 Department of Social Services (Cth), above n 313, 4–5.

318 See, eg, State Trustees (Vic), *Submission 367*; National Older Persons Legal Services Network, *Submission 363*; Eastern Community Legal Centre, *Submission 357*; COTA, *Submission 354*; Law Council of Australia, *Submission 351*; Queensland AIDS Council (on Behalf of the National LGBTI Community Visitor Scheme Auspices' Network), *Submission 331*; Elder Care Watch, *Submission 326*; Seniors Legal and Support Service Hervey Bay, *Submission 310*; ADA Australia, *Submission 283*; Lutheran Church of Australia, *Submission 244*; Brotherhood of St Laurence, *Submission 232*; Aged and Community Services Association, *Submission 217*.

319 Elder Care Watch, *Submission 326*.

320 Queensland AIDS Council (on Behalf of the National LGBTI Community Visitor Scheme Auspices' Network), *Submission 331*.

321 *Ibid.*

4.230 QuAC and the Eastern Community Legal Centre recommended that visitors should report any concerns that they have regarding abuse or neglect to their CVS coordinator, who would be in a more appropriate position to take further action.³²² ADA Australia suggested that relationships between advocacy services and the CVS could be strengthened, such that National Aged Care Advocacy (NACAP) services could deliver regular education sessions to CVS program coordinators and volunteers on the role of advocacy services and the rights of aged care recipients.³²³

4.231 In 2016, the Department of Health reviewed the CVS.³²⁴ The ALRC suggests that Recommendation 4–14 be considered as part of the Department’s response to the CVS review.³²⁵

Official visitors

4.232 In the Discussion Paper, the ALRC proposed that there be an ‘official visitors’ scheme established for residential aged care. It was suggested that 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. A number of submissions were supportive of a visitors program with a rights-monitoring focus in aged care.³²⁶

4.233 However, the ALRC has decided not to make a specific recommendation that an official visitors scheme be established. At this stage, the ALRC considers that reform efforts are better focused on establishing a robust serious incidents response scheme. It also considers that support for the existing body of highly trained aged care advocates should be continued. The NDIS Quality and Safeguarding Framework intends to undertake an independent evaluation of state and territory visitors schemes to consider how such schemes might integrate with other oversight mechanisms.³²⁷ Results of this evaluation should inform future consideration of the utility of an official visitors scheme in aged care.

4.234 The Australian Government has signalled its intention to ratify the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) by December 2017.³²⁸ OPCAT’s objective is to

322 Ibid; Eastern Community Legal Centre, *Submission 357*.

323 ADA Australia, *Submission 283*.

324 Department of Health (Cth), *Community Visitors Scheme* <agedcare.health.gov.au>.

325 HammondCare and ACSA argued that national guidelines should be developed after consultation with the aged care sector and exiting auspices: HammondCare, *Submission 307*; Aged and Community Services Association, *Submission 217*.

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

327 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 53–54.

328 Julie Bishop MP and Senator George Brandis, ‘Improving Oversight and Conditions in Detention’ (Media Release, 9 February 2017); *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006.

establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty.³²⁹ Compliance with OPCAT will require the establishment of a ‘National Preventive Mechanism’ to conduct inspections of all places of detention.³³⁰ As the ACT Human Rights Commission noted in its submission, any place where people may not be free to leave, that is subject to the regulation or oversight of the state, could fall within the scope of a ‘place of detention’—including residential aged care facilities.³³¹ Ensuring that residential aged care facilities are compliant with OPCAT will provide important additional oversight of human rights standards in aged care.

Advocacy services

4.235 The National Aged Care Advocacy Programme (NACAP) provides assistance to people receiving Commonwealth-regulated residential care and home care.³³² The NACAP was reviewed in 2015, and there are plans to redesign the aged care advocacy system.³³³ Consultation on a draft National Aged Care Advocacy Framework closed on 7 October 2016.³³⁴

4.236 The ALRC therefore does not propose any changes to aged care advocacy services. However, submissions to this 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’.³³⁵

4.237 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

329 *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006 art 1.

330 *Ibid* art 3.

331 ACT Human Rights Commission, *Submission 337; Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006 art 4(2).

332 *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.

333 Australian Healthcare Associates, above n 332, 17.

334 Department of Health (Cth), *Consultation on the Draft National Aged Care Advocacy Framework* <www.consultations.health.gov.au>. A revised draft Framework was released in December 2016, updated with feedback from this consultation period. The Framework is to be finalised in mid-2017: Department of Health (Cth), *(Draft) National Aged Care Advocacy Framework (Version 2.0)* (2016).

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

that advocacy services should be inclusive of all older people receiving aged care, including Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse people; and lesbian, gay, bisexual, transgender and intersex people.³³⁶

Other issues

Aged care assessments

4.238 Before being approved as a care recipient, a person must have their care needs assessed.³³⁷ For care regulated under the *Aged Care Act*, the assessment is conducted by an Aged Care Assessment Team (ACAT).³³⁸ For the CHSP, the assessment is performed by a Regional Assessment Service (RAS).

4.239 The ALRC does not propose any changes to aged care assessments. As identified in the recommended National Plan,³³⁹ 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.

4.240 A number of submissions commended the value of ACATs, and their potential to play a role in identifying abuse.³⁴⁰ 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.³⁴¹

4.241 The ACAT and RAS use the National Screening and Assessment Form (NSAF) when assessing the aged care needs of clients.³⁴² The NSAF includes items relating to risks, hazards, or concerns to a person in their home,³⁴³ 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’.³⁴⁴ 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.³⁴⁵ Consideration might be given to including a validated tool for assessment of

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

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

338 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*.

339 See further rec 3–1.

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

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

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

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

344 *Ibid* 144–45.

345 *Ibid* 189.

risks of elder abuse where concerns have been identified.³⁴⁶ 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.³⁴⁷

346 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>.

347 For the ALRC recommendations regarding adult safeguarding agencies, which would form a significant element of elder abuse referral pathways, see ch 14. 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*.