LASA RESPONSE TO THE INQUIRY INTO THE QUALITY OF CARE IN RESIDENTIAL AGED CARE FACILITIES IN AUSTRALIA

(The Zimmerman Inquiry)

Leading Aged Services Australia

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our purpose is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA's membership base is made up of organisations providing care, support, services and accommodation to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 57% are not-for-profit, 33% are for-profit providers and 10% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

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1. Introduction

LASA's stated purpose is to enable a high performing, respected and sustainable age services industry, delivering accessible, affordable, quality care and services for all older Australians.

In Australia's age services industry quality and safety are not negotiable. Care recipients and their families, alongside providers of age services and the wider Australian community, demand robust, effective, and equitable quality systems and processes. This is fundamental to ensuring confidence in Australia's aged care system.

The Terms of Reference for the Standing Committee on Health, Aged Care and Sport's Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (Zimmerman Inquiry) are to inquire and report on:

1. The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers;

2. The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the *Charter of Care Recipients' Rights and Responsibilities* in ensuring adequate consumer protection in residential aged care; and

3. The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

This new Inquiry duplicates prior work, especially the Carnell Paterson Inquiry and Report.

A Member said:

> *"The latest inquiry is a duplication of several of the previous inquiries and will become another dust collector. The federal government is reminding the industry at every opportunity that there is no more money for the sector. However, they can find money to conduct enquiries, contract high cost consultants and undertake traveling road shows to collect data, but then cry poor when it is time to stump up the funding for the industry".*

LASA has already made submissions to the Carnell Paterson Inquiry including a response to its recommendations which is provided as an attachment. In addition, LASA made a submission to the Senate inquiry into aged care quality assessment and accreditation (Xenophon Inquiry) which has not yet reported. The Australian Law Reform Commission (ALRC) made recommendations in 2016 to combat elder abuse that LASA has reviewed, including to inform its Carnell Paterson Report response.

LASA notes that the Commonwealth Government has said that the Carnell Paterson recommendations will be considered alongside other reform proposals (e.g. the Tune Report), with linkages to the 2018-19 Budget. LASA is unsure of how the outcome of this new Inquiry will be handled by the Government.

LASA notes that workforce reform directions are an essential part of the quality assurance picture and LASA has been closely involved with the work of the new Aged Care Workforce Strategy Taskforce. LASA will be making submissions on options for workforce reform in 2018 and these directions should be part of the overall quality agenda for aged care.

So far, our Members have identified these issues as important for workforce reform, and hence quality outcomes:

- Improvements to workforce training: work with the training sector from VET through to universities to lift standards. Refocus the taught nursing model from clinical to 'ageing well'.
- Improving the image of the aged care sector: a possible marketing campaign, with further support for essential positive cultural features - focusing on meaningful work in aged care, highlighting relationship-based models of care, scope of roles and opportunities available.
- Improved funding to reward workforce skills: avenues for generating additional revenue need to be developed as a priority, including revised consumer contributions, and increasing government funding through a variety of levers.
- Flexible Industrial Relations Instruments: key to delivering Consumer Directed Care.
- Improvements to IT literacy skills: a skills acquisition issue.

2. High level observations

LASA understands the context for the various inquiries into aged care, in particular, the incident, at the Oakden Older Persons Mental Health Facility in South Australia. However, our Members have some high-level observations that further illuminate the context for review.

Providers of age services work diligently to care for and support older Australians and their families, during what can be very difficult times in their lives. This is done with the compassion and professionalism that you would expect in a world class, age services system.

Notwithstanding this, no system is perfect and there are times when things do not go as planned. There are occasions where the care and support provided has fallen short of expectations. However, the number of these instances are isolated. For example, the Aged Care Complaints Commissioner recently reported that of the 1.3 million older Australians who received aged care services last year, there were a total of 4,700 complaints. That is less than half of one percent. And of the 4,700 complaints received – around 3,500 related to residential aged care. This represents less than 2% of the older Australians in residential aged care.

Older Australians and their families need to feel assured they are receiving quality care and services that meet stringent national standards of quality and safety. Despite the relatively low numbers of complaints it is important to acknowledge issues when they arise, and it is equally important to recognise that adverse incidents are unfortunate and unacceptable. Our Members acknowledge the significant trauma that residents and their families felt and continue to feel because of the failures at Oakden. However, the Oakden situation is not indicative of our industry overall.

There is a shared interest across older Australians and their families, age services providers, and government policy makers and regulators, in ensuring Australia's age services system is safe, fair and sustainable. This provides a platform for the collaboration that will be needed to translate findings

and recommendations into appropriate actions and outcomes that will address any identified shortcomings and contribute to continuous improvement and community confidence.

LASA asks that the Inquiry considers the following perspectives in making recommendations in support of quality residential aged care:

- The Oakden older persons mental health facility was a purpose-built, mental health facility for older people experiencing significant mental health issues. It is not a residential aged care facility. As such, residential aged care accreditation for this facility would appear to be inappropriate.
- The Government has faced poor performance from its own regulatory bodies who all had ability to deal with the issues found at Oakden. Ensuring Government agencies perform their role satisfactorily is a key part of ensuring safety and quality in residential aged care.
- In the Oakden case, many providers in our industry specifically question the role of the Australian Aged Care Quality Agency (AACQA) in the failures and abuses identified. The performance of the AACQA's assessors and internal systems and processes requires further examination. The second part of the Terms of Reference for this Inquiry appears to acknowledge this.
- Similarly, as the owner and operator of the Oakden Facility, the South Australian Government should be held accountable for the abuses revealed, in the same way as any other operators would be held accountable for such issues.

In framing a way forward, LASA proposes that any changes should be:

- carefully designed, consistent with the underpinning principles of the reform agenda and acknowledging both the Aged Care Sector Committee's 'roadmap' and the National Aged Care Alliance (NACA) 'blueprint'
- considered alongside work currently underway with regards to the Single Quality Framework, quality indicators, and consumer reporting initiatives
- rigorously assessed with regards to intent, cost, logistics and regulatory impact for providers/consumers/governments.

3. Term of Reference Part 1

The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers

3.1 Mistreatment of residents

This term of reference appears to be exploring the degree to which mistreatment occurs in residential aged care facilities and how it is reported and acted upon.

Our Members note that the strong regulation of aged care quickly identifies and addresses the mistreatment of residents in residential aged care. While there are instances where systems break down and mistreatment and abuse occurs, this is generally by exception.

Mistreatment is prevented and addressed early through mandatory staff training, having multiple options for people to speak up and make complaints, and ensuring families, residents and staff are not punished for speaking up. Providing this environment is required by legislation and it occurs in practice through strong leadership. When systemic mistreatment in residential aged care facilities happens, it is almost always accompanied by a breakdown in leadership and organisational culture.

An unregulated area where mistreatment can occur is when residents are on leave from facilities and are in the care of their families. Anecdotally, we know of instances where residents have returned from leave with significant bruising or with altered mood states indicating something negative has occurred. Financial abuse of people in residential aged care by family members also occurs, and there is a high risk of this issue escalating in the future.

The frequency and nature of reporting on issues by residents, families and staff rely on the environment in the residential care home, and leadership, as noted above. This is determined by the Board and senior management. Other factors include the health literacy of consumers and their advocates, their appreciation of a communal setting, and the circumstances under which providers are expected to operate.

Members note that some external commentators on residential aged care matters, are not aware of the operating realities of residential care facilities.

One Member notes:

"At our facility, 80% of residents have dementia. Over 50% require assistance with eating. This takes time because residents forget they have already eaten and come back for more, or they cannot eat properly and need close and prolonged attention. Others wander off during meal times and need to be retrieved. It is not unusual for four staff to shower and dress some residents. Staff are subjected to unpredictable bursts of anger and frustration during which they are hit, bitten and scratched. Visitors may seek immediate attention for their resident which cannot be accommodated if staff are already attending to others who cannot be left because, for example, they are being toileted. Challenging behaviours of one resident may set off challenging behaviours in others which takes time to quell".

The Aged Care Funding Instrument (ACFI) prioritises funding towards complex care needs and assistance with activities of daily living (ADL), rather than responding to behaviours. Yet interventions in relation to dementia and its associated behaviours are the most time consuming. This means that funding is inadequate given the resources actually required to care for people with dementia who need minimal assistance with ADLs or complex care. This risks such consumers not being considered for admission to residential care.

Some Members are employing new models of care in support of better quality care e.g. households of 15 residents supported by a stable staff. This example is a social, rather than only medically-focused, model of care in which relationships, companionship and decision making are encouraged between staff and residents and families. Concerns are freely expressed and quickly acted upon. Members also note that the situation is more complex with residents from a non-English speaking background. Culturally appropriate care is essential to the health and social/spiritual wellbeing of the individual. The absence of these factors can lead to challenging behaviors in residents (who may or may not have dementia), misdiagnosis, involuntary isolation and care that is misdirected or superficial because of communication difficulties.

Migrants and refugees coming to Australia from the 1980s are now entering aged care. Many carry trauma from their home countries which will affect their mental health and behaviours in old age. Again, this is an area where ACFI is inadequate, which can lead to service and outcome issues.

Members also observed:

"Every day across Australia there are numerous interactions between aged care employees and residents at residential aged care facilities and the majority of these interactions will present no problems. There will be an issue with a small minority and this is to be expected in any service system."

"The accreditation process is can be loose, leaving too much open for interpretation. Stronger language could be used to describe outcomes e.g. will, must, ensure etc".

"Aged care has far too many agencies governing its operations and it needs to be streamlined. This is starting to happen. Agencies need to be aware of what each is doing and understand each other's roles".

The inquiry needs to look at any specific issues that require attention for the industry generally. As noted, Oakden was a special circumstance and issues there do not translate directly to residential aged care generally.

One reference point is the Australian Law Reform Commission (ALRC) report. It suggests three main areas of reasoning concerning the 'under reporting' of elder abuse by health professionals: (i) lack of education, (ii) subtlety of abuse and (iii) the thought of breaching privacy laws of the older person.

Some issues in aged care will not relate to intended mistreatment but will instead relate to quality of care issues, which may link to limitations in resources, capabilities and/or guidance. This should be recognized by the Inquiry.

Work by **a** research team from Monash University (led by Professor Ibrahim) included 104 recommendations for preventing deaths in residential aged care.[1] For instance, this made the observation regarding the risk of choking, that there is no single standardized approach to screening for dysphagia (swallowing difficulties) in Australia – a reliable assessment tool could be helpful. This work also recommended national standards in support of preventing resident to resident aggression.

The ALRC (page 339 [11.10]) supports a 'National Plan for training', incorporating clinical guidelines i.e. risk factors, signs and symptoms of abuse and guidance of management. Enhanced training is one key approach to ensuring on-going quality of care and this aligns with LASA Member observations on workforce reform contained in Section 1.

An improved national approach to training could make use of updated tool kits (easy to read, easy to implement, and inclusive of safety planning and referrals). The family violence GP toolkit prepared by Women's Legal Service NSW is an illustrative example of how information can be made readily available to service providers.

An improved national approach to training should integrate with Australian Privacy Principles, particularly the sections dealing with "secondary purpose exception", explaining that in some circumstances health professionals are able to discuss or confer regarding an older person's situation to assist in identifying elder abuse. Health professionals are authorised under law" under serious threat exception" to report abuse without the consent of the person. Under the *My Health Records Act 2012* (Commonwealth), a health professional may disclose information in a healthcare recipient's health record if it is 'necessary to lessen or prevent a serious threat to an individual's life, health or safety', and it would be unreasonable or impracticable to gain the health care recipient's consent.

The national approach needs to build on existing training, and be focused on providing health professionals with the tools to identify elder abuse, and information on appropriate referral pathways (this is already in the Certificate III Individual Support - Ageing Stream), but there are inconsistencies delivered through various Registered Training Organisations.

LASA is making a number of recommendations on improved aged care sector workforce training, linked to national capability sets, as part of the submission it will make to the Aged Care Workforce Strategy Taskforce.

[1] https://www.australianageingagenda.com.au/2017/12/13/facilities-advised-reduce-residents-risk-preventable-death/

In LASA's 2018-19 pre-Budget submission, Recommendation 15 covers workforce and training issues that are also relevant:

LASA 2018-19 Pre-Budget submission - Recommendation 15

Given that the Commonwealth Government will respond to the Aged Care Workforce Strategy Taskforce later in 2018, it should make a budget provision to provide funding for this response.

A key focus should be ensuring that knowledge and skills acquired are both relevant and applicable to the changing age services environment, providing work-ready staff, whilst also promoting age services as a profession.

As part of this funding provision, the Government should reserve funds for:

i. Review of the barriers to skills development given different State-based approaches and develop and fund a strategy for a more consistent national approach to ensuring the right workforce for the aged care sector - this should include national funds for national aged care provider peak bodies to pilot the best options to nationally consistent training, in line with (ii) and (iii) below.

ii. Development, in partnership with the sector, of an aged care capability framework (with possible common ground with a disability sector capability framework) to underpin role design and skills acquisition in the aged care sector – this should cover nursing, allied health, management, care and other support staff working in aged care.

iii. In line with (i), establishing training subsidies for trial traineeships for aged care workers across a number of key aged care sector roles and skills e.g. dementia care, IT (linked to the capability framework) – these traineeships could be delivered through LASA's RTO.

iv. Sector led work to ensure that the capability framework and traineeships are suitably linked to the Single Aged Care Quality Framework (LASA, including its RTO, could contribute to this).

v. The aged care sector to work with universities to refocus current nursing education to provide specific aged care nursing streams which include a focus on ageing well.

vi. Improving the image of the aged care sector via a possible marketing campaign, with further support for essential positive cultural features - focusing on meaningful work in aged care, highlighting relationship-based models of care, scope of roles and opportunities available.

vii. Improved rewards for quality workforce skills aligned with the capability framework.

viii. Supporting identification and implementation of more effective industrial instruments that include more flexible work practices and provisions to attract future workers to the aged care sector.

LASA supports a multi-disciplined approach to ensure that there are timely and effective responses to elder abuse. This could be supported by exploring the adoption of a health-justice partnership strengthening the bonds between legal, ethical and clinical approaches to elder abuse.

Supporting an integrated care model which incorporates legal perspectives into aged care practice may reduce the number of separate appointments and interactions required to seek assistance.

3.2 Reporting and whistleblowers

Whistleblowing is recognised as a legitimate form of action in a democratic society. However, a difficulty in dealing with protected disclosures involves protecting whistleblowers (or people otherwise associated with their disclosures) against detrimental action. Worldwide experience has clearly shown that being a whistleblower is not easy. Making such disclosures may be seen as disloyalty to, or even an attack on, the employer and colleagues. These realities need to be dealt with in any whistleblower system, but Australia is an advanced democracy in this context.

A Member says:

"We believe there is existing legislation that provides protection for whistle blowers and aged care should easily fit under existing umbrellas. We don't need another system".

Importantly, the role of whistleblowers, should not be overstated in the overall system of quality assurance for aged care. In a well-designed system, adverse incidents are minimized and the handling of any adverse incidents that do occur is effective and efficient, so that the number of situations where a whistleblower may need to take action are very small. While better whistleblowing provisions may have assisted in the case of the Oakden incidents, it is not clear that this is an issue generally for residential aged care.

The Aged Care Amendment (Security & Protection) Act 2007 (Commonwealth)[2] made some important amendments to the *Aged Care Act 1997* providing for compulsory reporting of 'reportable assaults', protection for providers of aged care services and their staff who report such incidents and the establishment of the Aged Care Commissioner.

In recommendation 11-6 the ALRC proposes that, to provide a further safeguard relating to the suitability of people working in aged care, unregistered aged care workers who provide personal care should be subject to state and territory legislation giving effect to the National Code of Conduct for Health Care Workers. A National Code of Conduct for Health Care Workers was developed in 2015 by COAG[3] and was planned to take effect at State level by the end of 2017 (Western Australia is consulting on this now[4]). New South Wales, South Australia and Queensland already had statutory codes of conduct or similar in place, which were used as the basis for developing the national code.

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[2] https://www.legislation.gov.au/Details/C2007A00051

[3] https://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers https://www.australianageingagenda.com.au/2016/06/08/new-code-of-conduct-covering-aged-care-workers-what-you-need-to-know/

[4] https://www.hadsco.wa.gov.au/codeofconduct/

These states agreed to consider adjusting their codes and arrangements to achieve national consistency.

Existing legislation, COAG work on a national Code of Conduct, existing industry codes of conduct,[5] guidance (e.g. provided by the NSW Midwives and Nurses Association) and professional obligations for staff, including regulated nurses should provide an effective framework for quality residential aged care services, including whistleblowing, where this is appropriate.

Empowering staff to speak up regarding quality and safety issues was raised with LASA Members in seeking input for the Carnell Paterson response. Members did not see that there were current barriers to staff speaking out, including in the whistleblower context. But vexatious raising of issues, under the guise of whistleblowing, can have a negative impact of the effective running of a facility.

It is important to note that providers are required to have systems and processes in place to manage and report serious incidents as defined by the Aged Care Act (Compulsory Reporting Guidelines). The Department of Health provides extensive guidance on reporting including a guide on compulsory reporting and a guide on reportable assaults[6]. This is a critical requirement and reinforces that whistleblowing should be a second order protective provision.

The focus should be on strengthening and streamlining existing systems and processes for managing serious incidents and supporting providers to 'raise the bar' in terms of risk management and incident management. Approaches need to work with the systems that providers currently use to manage their operations.

A Member said:

"Most facilities already take risk seriously and take action to remove or reduce risk related to serious incidents. This is via mandatory reporting legislation and also via our own internal systems to ensure resident safety".

Where whistleblowing does occur, it should be noted that whistleblowers have the right to protection from discrimination and victimisation. Ensuring effective protection is an obligation for aged care providers. The protections that are or may be available to whistleblowers can be divided into two categories: (a) statutory protections, and (b) administrative protections.

Aged care managers who receive complaints or reports of misconduct, corrupt conduct or criminal conduct must manage the complaint in accordance with relevant legislation and the organisation's policies and procedures.

Employees should use internal procedures wherever possible to make a complaint or report to their employer of suspected or actual misconduct, corrupt conduct or criminal conduct. All such complaints or reports should initially, be investigated internally.

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[5] https://bettercaring.com.au/help/code_of_conduct/

[6] https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/compulsory-reporting-forapproved-providers/guide-for-aged-care-staff-compulsory-reporting
https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportableassaults

The investigation should commence as soon as practicable and be conducted in accordance with procedural fairness, including ensuring the investigation is undertaken by a suitably qualified and independent person.

Investigation by an external independent person may also be appropriate in some circumstances. In making a complaint or report, registered health practitioners must also comply with the reporting requirements of the Australian Health Practitioner Regulation Agency. Nurses, midwives or assistants in nursing who make a complaint or report or who are the subject of a complaint or report are able to seek legal support and advice from their Union.

4. Term of Reference Part 2

The effectiveness of the Australian Aged Care Quality Agency (AACQA), the Aged Care Complaints Commission (ACCC), and the Charter of Care Recipients' Rights and Responsibilities *in ensuring adequate consumer protection in residential aged care; and*

4.1 Accreditation

The aged care system in Australia aims to make sure that all older people can receive care and services when they need them. Residential Aged Care providers are accredited by the Commonwealth Government and must comply with an Aged Care Standard including 44 outcomes[7].

In principle, the current Framework that includes the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the *Charter of Care Recipients' Rights and Responsibilities* should work well. As outlined in Section 2, the main issue is whether AACQA and ACCC performed their roles appropriately. This appears not to have been the case for the Oakden incidents. Ensuring that the current accreditation provisions are fairly and properly applied needs to be the focus for the Government.

Critical is the provision that if the Department of Health is aware that an aged care home does not meet their requirements under the Act, it may issue a Notice of Non-Compliance or impose sanctions on that home. Consumers may search for a home using the aged care homes finder, and this will show if a home has a sanction in place.

Changes to reaccreditation visits are being looked at by the Government and LASA and its Members are engaging with the Government on this. More risk-based approaches to assessments provide scope to provide incentives for quality care, and focus effort on any providers who are having problems. Other refinements, such as reducing the degree of paper-based evidence required in favour of giving auditors greater time to engage with residents, families and staff, should be considered. In doing this, auditors would be able to immerse themselves in organisations and get a stronger sense of quality of care and the day-to-day experience of residents. This approach would support regulators to clearly identify any organisations where leadership may be breaking down.

[7] https://www.aacqa.gov.au/providers/accreditation-standards

Members note that the AACQA can only be as good as the funding it receives, its staff and its operating guidelines. Given the scope of the Agency's responsibilities it is therefore important to ensure that it has highly competent staff that are supported by effective systems and processes. On behalf our Members, LASA has raised issues with the AACQA regarding reported incidents of inconsistent interpretations of the quality standards and/or inappropriate behaviour displayed by assessors in the conduct of their activities.

One Member says:

"Our experience is that Agency staff are subjective in their assessments and that those assessments are inconsistent between teams. For example, a recommendation made by one team was acted on but was condemned by another team. This has happened more than once. AACQA assessors tend to be biased in respect of their expertise. Someone with an OH&S background will zero in on standard 4 relating to environment. A dietician will focus on food and nutrition. The result is an unbalanced report".

4.2 Complaints

The ACCC is also a critical part of the protections for the aged care system. The legislative basis for the Complaints Resolution Scheme, Complaints Resolution Committees and Review Panels is contained in the *Aged Care Act 1997* and the *Aged Care Principles 1997*. The processes outlined in the legislation that supports the Scheme are based on resolution through negotiation, mediation or determination. If the mediator advises the matter is not amenable to mediation, or mediation is ultimately unsuccessful, the matter is referred to a Complaints Resolution Committee for Determination. Hearings are conducted by Complaints Resolution Committees, which are made up of three independent members with expertise and experience in aged care and complaints resolution. Committees are appointed to hear a matter by the Commissioner for Complaints. Determinations set out a course of action for and are legally binding on the service provider. Again, when applied well, this system should provide sound protections for residents and their families.

Providers ensure that they establish effective internal reporting systems to facilitate the making of complaints or disclosures by their staff and the protection of those who have made such complaints.

Sound internal reporting systems should: (a) promote a culture that encourages and enables staff to report the problem internally (b) outline the processes available to employees in situations when immediate supervisors are implicated in the misconduct or corrupt conduct, including identifying a senior person within the organisation responsible for responding in this case.

In relation to the Aged Care Complaints Commission, one Member noted:

"The effectiveness of the Aged Care Complaints Commission has been growing. The Commission's approach is collaborative, aiming to work with providers to achieve outcomes that improve care for the person involved and all other residents. As the Commission takes a reconciliation approach, difficulties arise when families making complaints are seeking retribution, such as the sacking of a manager or the closure of service. This is an ongoing tension that must be managed by the Commission.

We have recently experienced a high turnover of staff at the Commission while dealing with complaints. This is not ideal as it means individuals and families may need to repeat their stories and particular aspects of complaints may get lost or change as time moves forward. This adds to the complexity of dealing with complaints in an aged care setting. For example, around three quarters of the residents in our care have a cognitive impairment. This means that when complaints are made, people's recall of events and names of those involved can be difficult to determine, which is why all issues must be thoroughly investigated. In our experience, these investigations can be very stressful for staff members named in complaints and allegations are often unsubstantiated. However, we always take claims of mistreatment seriously and investigate them accordingly".

Another said:

"We have not had a problem with its approach or officers. It has been non-judgemental and fair".

4.3 Charter of care recipient rights and responsibilities

This Charter is readily available on the Department of Health website.[8]

Providers will generally ensure that their staff know about the charter and are able to apply it in practice on the job. It is important that staff and care recipients and their representatives understand the legislative and binding nature of the Charter of Rights and Responsibilities. The Charter affirms social justice principles of dignity, equity, free of prejudice, just and humane.

In practice, there may be some barriers and complications in residents and their families and representatives understanding and applying the charter. It may be useful to investigate how the charter is used in practice and whether residents and their families find it useful.

One Member says that:

"The Charter of Residents' Rights and Responsibilities has been around for a long time and is included in residents' information packs and on the walls of aged care homes. Incoming residents and their families are taken through its provisions on entry to the home, however, not much attention is given to it thereafter. A re-reading of the document indicates that its principles are contained in the assumptions underlying the standards".

An important aspect that needs to be well understood by all parties is that the Charter recognises that residents of nursing homes or hostels have the responsibility to ensure that the exercising of their individual rights does not affect others' individual rights, including those providing care. The Charter recognises that residents have specific rights and responsibilities which balance the needs of the individual against the needs of the nursing home and hostel community as a whole.

[8] https://agedcare.health.gov.au/publications-and-articles/guides-advice-and-policies/charter-of-care-recipients-rights-and-responsibilities-residential-care

Part 2 b) of the Charter says that care recipient responsibilities include to respect the rights of staff to work in an environment free from harassment. Our Members note that the Charter is not enough to ensure this. One study[9] notes that there has been little research done on aggression directed at nursing home staff by residents and families.

Members observed:

"There is nothing intrinsically wrong with the charter as a document, however it could be emphasised that this is a two way street – providers need just as much protection as consumers when it comes to rights and responsibilities – very little consideration is given to this very important issue, sadly it is not covered in the Terms of Reference".

"What is often overlooked is that part of the document which relates to care recipients' responsibilities. It is a cause of complaints and requires a great deal of compromise to settle".

In a survey[10] by the New South Wales Nurses and Midwives' Association more than 90 per cent of aged care staff reported that they had been subject to some form of aggression from residents, such as hitting, kicking, pushing or verbal abuse. Our Members report that aggression and inappropriate behaviour by residents' families can also be an issue.

In any approach to looking at the effectiveness of the Charter, both the rights and responsibilities of residents, their families and their representatives need to be examined. Improved options to ensure practical respect for the rights and responsibilities of residents, their families and representatives could be examined and should include a focus on the well-being of aged care staff. There may be an option for improved respect for rights and responsibilities to be included in the contracts and service agreements for residential aged care. There should be clear responses if a resident creates a problem and clear sanctions for unacceptable behaviour by a resident's family. Reportable assaults relate to assaults on residents and there may need to be better reporting and responses if staff are subject to abuse etc. Unions and other stakeholders could be consulted on this issue and any common law and Police remedies could be examined for their adequacy.

The Charter also informs the care recipient to accept personal responsibility for his or her own actions and choices, even though these may involve an element of risk. The resident has the right to accept the risk and not to have the risk used as a ground for preventing or restricting his or her actions and choices.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3631060/

[10] https://www.australianageingagenda.com.au/2016/02/19/staff-experience-high-rates-of-aggression-in-aged-care-union-survey/

5. Term of Reference Part 3

The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

Members agree that consumer protection for vulnerable residents who do not have family or who have extremely complex and challenging needs is vital.

The role of the aged care workforce as a protective factor in preventing abuse must be acknowledged. The vast majority of people working in residential aged care have a strong interest and passion in caring for and advancing the wellbeing of older people. Often, staff play a key role in advocating on behalf of residents and linking them to the care and social support they need. However, external advocates should also regularly access organisations to provide an additional safeguard. This is particularly important in organisations where there are leadership issues, if auditors have identified a range of problems, or where there is a high proportion of vulnerable residents with complex needs.

There is an assumption in this term of reference that family, friends and relatives help aged care residents to exercise choice and rights in care. This is usually the case but reports on abuse against older people suggest this is not always the case.

LASA Members comply with provisions e.g. guardianship provisions, to ensure that the rights of residents in this situation are protected. It is important to note that our Members provide compassionate and individualized care suited to the different circumstances of their residents, including those who do not have family, friends or representatives.

One option may be refined checks and balances for all residents. For example, the expanded list of risk indicators for Agency visits (as recommended in the Carnell Paterson Report) might include residents who have infrequent visitors and no appointed local guardians.

Members noted that overall, the system of consumer protection seems to work reasonably well. The government might consider what it can learn from the numbers of complaints in each category and any trends in complaints. Would there be any way of ascertaining any gaps for residents who do not have a representative capable of making a complaint in their behalf?

Broadly though, this Term of Reference is largely a matter for review by Governments e.g. guardianship provisions.

Members observed that:

"In terms of consumers who do not have a representative, a service providing good quality care does not differentiate between consumers who have representatives or not. This is a very tired comment that is often made by people who put complaints forward – it usually goes something like "I am not just making the complaint for my mother/father/insert relationship, I am concerned about all those who do not (?) have anyone to advocate for them".

"Consumer law applies to all. For residents with families, all is not necessarily OK. Facilities sometimes have to protect residents from their own family members. There is a system

through VCAT, in Victoria, that can be used to assist with the management of residents with or without family members. State Trustees are another agency that can be used".

LASA is aware of some anecdotal evidence on issues with public guardianship for residents. For instance, processes to obtain small supports for residents e.g. new clothing, can be administratively complex and slow. Public guardians tend to never see the residents they represent and the allocated guardian will change regularly, so there is no relationship or continuity. Decision making on key issues such as end-of-life care can be taken out of the hands of the public guardian and assigned to legal departments, rather than focusing on compassionate, consumer-led decision making. Consumer advice and aged care planning could better highlight planning for people without a representative and give them information to examine options other than public guardianship.

LASA notes that there are a number of programs to help support residents that do not receive visitors e.g. the Commonwealth community visitors scheme[11] and Community Visitors under the Office of the Public Advocate in Victoria. While this is about social support, it is possible that these visitors may be able to help residents raise and resolve concerns of a more minor nature. There might be scope to make formal refinements to these visitor roles, with input from providers, consumer representatives and the AACQA.

The ALRC Report on Elder Abuse is one source of information and analysis regarding the protections for residents without family, friends or representatives. For instance, recommendation 5–1 safeguards against the misuse of an enduring document in State and Territory legislation. LASA agrees that there could be a review of the terminology, testing and functionality of the assessment process for an elder person with declining cognitive abilities to help ensure Enduring Appointment law and guidelines are consistent and effective across Australia.

LASA supports the ALRC recommendation for a national decision making functional tool for application of legal "incapacitation" or "cognitive decline" ([5.14] p.163)

The ALRC in Recommendation 5-3 proposes a national online register of enduring documents, and court and tribunal appointments of guardians and financial administrators. This could allow for more efficient verification of documents.

ALRC Recommendation 10-2 is that the Australian Guardianship and Administration Council should develop best practice guidelines on how State and Territory tribunals can support a person who is the subject of an application for guardianship or financial administration to participate in the determination process as far as possible. Again, this would appear to be sensible.

[11] https://agedcare.health.gov.au/older-people-their-families-and-carers/community-visitors-scheme