Submission from Leading Age Services Australia, Hall & Wilcox and HWL Ebsworth on selected recommendations from Counsel Assisting's final submission to the Royal Commission

We are pleased to provide this submission concerning the legal and regulatory issues raised in the recommendations made by Counsel Assisting (CA) the Royal Commission into Aged Care Quality and Safety in their closing submissions.

In general, we are supportive of legislative change to improve safety and quality in health care and that establishes the rights of the older Australian at the heart of the system based upon a human rights approach.

Having said that, it is important that any legislative change is carefully considered (not rushed) taking into consideration input from stakeholders, including the elderly and their families, the community, Government and approved providers. Sufficient time should be provided to approved providers to be able to prepare to comply with any new regulatory requirements and the regulatory requirements should be fair and equitable and operationally and financially achievable. Guidelines, training and tools, and any other necessary supports should be made available to providers.

While we support stronger standards setting out high level expectations for care we have concerns about the proposed powers of the newly formed regulator without the inclusion of clear procedural fairness requirements, realistic review and appeal processes for providers of aged care.

Recommendation 1: A new Act

Support for the intent

The creation of a new Aged Care Act carries important symbolism. It is impossible to disagree with the intent of the objects, principles and rights that CA has recommended. Many of these ideas are included in the objects of the current Aged Care Act (see e.g. section 2-1(b) and 2(1)(j)), and virtually all of the others apply, through the standards or charter of aged care rights, to the way that providers are required to deliver care.

Application to government institutions

It appears that an important difference under the new act proposed by CA is that the concepts described in the objects, principles and rights would also guide and bind the activities of the entities tasked with the administration of the system under the Act.

Applying the same rules to care delivery and the setting and administration of policy would be a significant step forward for the system – especially given the creation of an ombudsman function to hold the other entities accountable for their responsibilities.

Recommendation should focus on intent rather than statutory construction

Getting the statutory underpinnings of the aged care system right is critical. However, the proposed drafting of the legislation is unknown at this time and therefore the practical implications intended, and how they interact and operate collectively are also unknown.

Much supposition is therefore required to respond and it is difficult to give each idea due consideration in the time and space available given the broader recommendations that must also be addressed. Noting that the

intent is not in dispute we therefore urge Commissioners to merely recommend that the new Act be underpinned by the ideas expressed rather than suggesting a particular statutory construction.

We have noted some specific issues. CA separately proposes a list of objects, principles, rights and 'paramount considerations'. It is unclear how the different levels of ideas are intended to interact. Some ideas overlap with or subsume others and the list could likely be made more parsimonious. Some ideas must clearly be read as aspirational (such as equity of access) while others can be taken more absolutely, such as freedom from neglect and abuse. Some ideas can be read as contrary to other recommendations. For example, one of the proposed rights is the right to be free from restraint. However, CA's subsequent discussion of restraint clearly contemplates that restraint will be necessary in some (highly limited) circumstances. While the right to freedom from restraint could be read down subject to the 'paramount consideration' of ensuring the safety and wellbeing of those in care this is awkward and messy.

We note that the NDIS draws on human rights principles and we suggest that the Government take note of lessons learnt in the implementation of this legislation as well as learnings from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Recommendation 3.1

We welcome the establishment of a new Australian Aged Care Commission (independent of Ministerial direction) with its own legal personality, and able to sue and be sued and therefore is made accountable.

Inherent in any proposed powers to the Commission, there must be review and appeal processes based on the principles of natural justice. To the point that the Commission could be sued, it would be useful to articulate the grounds upon which it is anticipated that the Commission would be sued.

If this recommendation is accepted, we await the articulation of the grounds upon which it is anticipated that the Commission would be held accountable.

Recommendation 22: A general duty to provide high quality and safe care

Whilst there is no doubt that there should be a duty to provide high quality and safe care, there is an existing duty of care imposed under the law of negligence and under the Civil Liability legislation in Australian States and Territories. This is in addition to the regulatory requirements under the Aged Care Act.

Approved providers do not operate in a vacuum and are part of the wider care system, including medical practitioners (such as general practitioners and geriatricians), allied health and hospitals.

We are not adverse to a non-delegable duty of care in relation to services 'provided by the approved provider', however:

(a) That non-delegable duty of care should not operate for merely 'facilitating' (recommendation 22.2) aged care services. For example, in the past it has been the case that many GPs will simply not visit residential aged care facilities as they are not funded well to do so and it may be difficult to arrange for a patient with complex health needs and/or dementia to physically attend the GP's office. Merely arranging for or facilitating a GP to visit the residential aged care facility to assist access for residents should not mean that the approved provider should be responsible for their negligence. There is no commercial arrangement between approved providers and independent GPs and therefore residential aged care providers have no 'leverage' to require them to do anything.

(b) The non-delegable duty of care should not operate such that the standard of care for approved providers be higher than the wider care system. It would be unfair and inequitable, for example, for a higher standard of care to apply to:

(a) a registered nurse employed by a residential aged care facility who administers medication; and

(b) the independent GP or Hospital who prescribed that medicine,

both of which may be co-defendants in the same case.

The proposal risks an increase in insurance premiums which may be unaffordable to providers under the current funding system.

The case that CA makes for a statutory duty appears to be based on the lack of offence provisions relating to breaches of the standards (p.390) and that having a duty would somehow have averted confusion over responsibilities in response to COVID outbreaks (p.391), prevented cost cutting measures (p.391), send a message to providers about the importance of quality of care (p.392), provide an aspirational duty to encourage providers to go beyond meeting the quality standards, (p395), and augment the standards with a more principles based obligation (p396).

The wording that CA recommends for the statutory duty differs slightly to the common law duty. At times CA appears to suggest it would go beyond what the common law duty requires (see p395 "it will be an aspirational duty", "the focus needs to be to provide the highest quality of care that is reasonable"). However, if the duty is intended to be more expansive there is no explicit discussion of exactly how and why the common law duty is too limited.

The previous standards were described as being the minimum standard required. The previous standards and outcomes were objective rather than the current subjective standards and requirements.

The current Aged Care Quality Standards are principles based. For example, Standard 1 (consumer dignity and choice):

Consumer outcome

(1) I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

Organisation statement

(2) The organisation:

(a) has a culture of inclusion and respect for consumers; and

(b) supports consumers to exercise choice and independence; and

(c) respects consumers' privacy.

Assessment against this Standard

For each of the requirements, organisations need to demonstrate that they:

- understand the requirement
- apply the requirement, and this is clear in the way they provide care and services
- monitor how they are applying the requirement and the outcomes they achieve
- review outcomes and adjust their practices based on these reviews to keep improving.

The current assessment by the Aged Care Quality and Safety Commission is *subjective* to the relevant assessor, rather than objective.

It is vital that duties be well understood if significant penalties and claims for damages may arise. Duties should set objective expectations not subjective aspirations.

As a general principle, there is a good case for having principles based obligations to supplement more prescriptive rules as part of a regulatory regime. However, the current standards already contain many principles based obligations, and Counsel Assisting has not clearly identified the gaps in these principles that necessitate a general duty.

The most compelling issue identified by Counsel Assisting is the lack of offence provisions in the current Act. This links to broader problems with the penalties regime in the Aged Care Act which we discuss later in this

submission. We are not convinced that attaching offence provisions to a general duty is necessarily best practice regulatory design, as it will often be better to allow different offences and penalties for different breaches.

If a statutory duty is created for the purposes of linking this duty to offence provisions it should directly mirror the common law duty and this intention should be clearly stated in the explanatory materials for the legislation.

Part 2 of the recommendation concerns the application of a duty to entities that are not approved providers that facilitate the provision of funded services. We do not comment on that here as it relates to broader policy about the role of self-management rather than the matters of law and regulatory policy that this submission is concerned with. However, an attempt to bind third parties' such as medical practitioners, to the requirements under the Act will be problematic. If third parties are **not** bound by the requirements of the Act, the provider will continue to be responsible for the clinical conduct of other practitioners over whom they have no control.

To 22.1. b The phrase 'the wishes of any person for whom the provider provides' is of concern without a clear definition of the term 'any person'. Providers currently have significant issues with alternative decision makers who demand practices that would not otherwise be in the best interests of the person receiving care. However, to deny the wishes of alternative decision makers would place providers at significant risk.

Recommendation 29: Regulation of restraints

To 29.3 It is important for the process for this independent review to be clear, with opportunity for input by the provider, particularly if regulatory action would then be attached.

To 29.4 The decision to deprive a person of their freedom carries enormous gravity and it is reasonable that doing so recklessly or maliciously should attract a civil penalty. However, it must also be recognised that decisions about restraint are often extremely complex, and sometimes need to be made on the ground in an emergency. The threshold for the application of civil penalties therefore needs to be appropriate. Parties acting in good faith with reasonable care should not be exposed to civil penalties.

It is also unreasonable and untenable to apply civil penalties to aged care providers without also applying similar penalties to the medical practitioners responsible for prescribing and seeking consent to prescribe chemical restraints.

It is also important to note that state laws regarding the granting of consent for restraint are highly restrictive in who can grant this permission.

Consideration also need to be given to amendment of the various state laws dealing with this issue (e.g. guardianship laws). Contrary to the general understanding, under these laws, there are few authorised representatives with the clear authority to authorise the use of restraint. In general, only a guardian with plenary, or a very specific authority can lawfully authorise restraint and such appointments are very rare. [1] Without reform of these laws, providers will be exposed to the risk of a civil penalty in addition to the current liability risks if they fail to obtain lawful consent

Further, not all guardians act in the interest of the person they hold guardianship for. However, providers may potentially no longer wish to engage in seeking to have powers revoked where the holder of a power is not acting in the best interests and expressing the values and preferences of a resident for fear of retribution through a complaint process.

We are not adverse to the Royal Commission looking at the current NDIS legislation and practice concerning the use of restraints, although, in disability the issues are also complex.

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[1] See further, Anita Smith from the Tasmanian Guardianship Tribunal, https://www.guardianship.tas.gov.au/__data/assets/pdf_file/0009/203967/Detention_of_people_with_dementia_in_secure_facilities.doc_-_Updated_31.8.17.pdf

Recommendation 52: Legislative amendments to improve provider governance

To 52.1. a. The intent of 52.1 a. appears to be to provide "independent scrutiny of strategic decisions affecting the safety and quality of services." Setting requirements for the boards of private organisations appears unprecedented. We are not convinced that requiring the majority of directors on the board to be independent directors effectively or cost effectively achieves this goal.

The role of independent directors in typical corporate governance is to protect the interests of shareholders or members against the interests of management. They also provide valuable additional expertise to management, but this is not their primary function.

Independent directors are not independent of owners – they expressly serve shareholder interests. If the Commission's concern is that some owners have prioritised profit over care, this cannot be addressed by requiring more directors who will be appointed by owners and obliged to act on behalf of owners. This is true for tightly held private companies, and public companies where independent directors represent shareholder interests.

Additionally, a collaborative and cohesive Board with an appropriate skill mix is valuable and should not be changed for the sake of introducing a majority of independent directors. Rather, each approved provider should have an appropriate corporate and clinical governance framework with access to people with the appropriate skills mix.

Further, we note that not all approved providers have boards, some are sole traders and partnerships etc.

It would be much more effective and cost effective to directly require there to be independent scrutiny of strategic decisions affecting the safety and quality of services. In some circumstances this may be achieved through independent directors. However, access to appropriate skills mix can be obtained in ways other than appointment of directors, for example, the use of Board subcommittees and consultants. We are happy to provide examples of these arrangements to Commission.

To 52.1. b. We are also concerned with the intention of 52.1 b. to prevent directors of wholly owned subsidiaries from taking into account the interests of the holding company. Given those directors are appointed by the holding company, they cannot ignore the holding company's interests. This proposal would create a legal fiction at odds with practical reality that places directors of wholly owned subsidiaries in an impossible position. It would be better to impose the obligation upon the holding company. Moreover, Counsel Assisting has not provided any examples of the situations that have motivated the proposed change.

To 52.1 c. We support a fit and proper person test for key personnel so long as that test is clearly defined and reasonable.

It is reasonable for providers to notify the regulator of changes to key management personnel, but the proposed ten day period seems excessively onerous. It is not clear why such a short notice period is necessary.

To 52.2 There is no reason why such a change should be made to the FOI legislation. To do so is going beyond the intentions of the current FOI legislation and exposes private providers who will increasingly be in receipt of private funds to potentially expose their financials to any application under the proposed changes.

There is sufficient protection for recipients of care to access their own medical records and personal information through health records legislation.

Recommendation 53: New governance standard

To 53.1.i The implications of the attestation by a nominated member of the governing body on (for example) the Chair of a board is unreasonable and exposes not only the board but the individual Chair to retrospective penalty in the event of a non-compliance being identified during the period of the attestation.

As stated in relation to 52.1 a. we do not believe that requiring all organisations to have majority independent board members is the most effective way to ensure oversight.

To 53.1 a&b. even when organisations have independent boards, recruiting board members with specialised expertise such as care governance is likely to be difficult for many smaller providers, but particularly for small providers in regional, rural and remote Australia. Some of the recruitment issues may be overcome by board members with special expertise attending board meetings remotely, but in regional, rural and remote Australia the necessary IT infrastructure may not always be available.

Currently the majority of boards are not remunerated and the level of skill and expertise expected in the future and the exposure of those directions is untenable. The funding model certainly does not provide for a skills based board to be remunerated.

We recommend further education on governance. We welcome the involvement of the Australian Commission on Safety and Quality in Health and Aged Care and hope that some of the clinical resources that are available to the health system can be customised and made available for approved providers and that evidence based work on service improvement can be done to improve the interface between aged care and the health and hospital systems from both sides of the equation, not only the aged care approved providers.

Any accreditation system should be fair and reasonable.

Recommendation 101: Establishment of prudential standards

To 101.2.b We agree that the affairs of approved providers should be conducted with integrity and professional skill. However, the inclusion of the word 'prudence' creates issues with its interpretation. Would it go so far as to determine the way in which the subsidies and fees and charges were spent by providers?

Recommendation 105: Continuous disclosure requirements in relation to prudential reporting

This is an enormously broad obligation that could capture a very wide range of events and cause confusion. Continuous disclosure requirements are also inherently burdensome and difficult to comply with. We note that it is proposed that this obligation apply not just to providers holding refundable accommodation deposits (RADs), but to all approved providers.

It would be much more appropriate to apply a clearer obligation of continuous disclosure to advise of specifically defined events. We also draw your attention to ASX Listing Rules 3.1 and 3.1A where the concepts of 'reasonable person' 'becomes aware' and 'material effect' are used.

Recommendation 109: Civil penalty for certain contraventions of the general duty

We agree that there is a role for civil penalties as part of the penalties regime for breaches of aged care regulations given the potential risks to personal safety. Similarly, we agree that there may be a role for personal liability.

On the other hand, as Counsel Assisting highlights elsewhere, caring for vulnerable older people with complex health needs and cognitive impairments is a challenging endeavour, which requires great care and skill. The delivery of appropriate care and support is made doubly challenging by the restrictions on funding, which prevents the directors and management of organisations from ensuring that they have the resources that they need to deliver care to the standard that they believe is appropriate in their particular circumstances. The problem is further compounded by security of tenure rules that make it almost impossible for providers to simply say that there are people they cannot care for appropriately with the resources that they have available.[2]

[2] The only power a provider currently holds is who to admit to their service. This is generally done on the basis of being able to meet the expectations of the resident and their representatives. Security of Tenure in fact exposes residents who can no longer be cared for by a particular provider to remaining within an environment that may expose them to risk for whatever reason, be it geographical or access to experts. Consideration must be given to more realistic security of tenure provisions.

Any penalty regime must acknowledge the complexity of the challenge and the constraints facing providers. There are likely a relatively small number of cases where it could be reasonably argued that providers deliberately or recklessly breached their obligations because the penalties were insufficiently severe.

In any penalty regime, civil penalties and personal liability should be reserved for particularly egregious breaches that are reckless or intentional and which cause serious harm. Civil penalties and personal liability must also be part of a suite of appropriately graduated enforcement powers, with appropriate checks and due process.[3]

As a practical matter, the imposition of civil penalties with personal liability for poorly understood obligations may do more harm than good for the management and governance of aged care services. This sort of broad, poorly understood liability is likely to be uninsurable for many years. Experienced leaders with options to work in other sectors where such liabilities do not apply may leave. Skilled directors, particularly those who volunteer, may resign their directorships.

There is already a pervasive culture of fear among providers that the regulator would be able to find a reason to find any provider non-compliant at any time. This is compounded by the regulator's failure to publicly articulate its interpretations in most areas, and demonstrable inconsistency even in the most obviously identical circumstances. For example, the same home care or resident agreement can be judged compliant by one assessor and non-compliant by another. Providers are also fearful that if they seek to challenge any regulatory action they will be punished by the regulator in its future enforcement activities.

Services will also expend significant funds on legal advice to guard against and then defend themselves from such actions, diverting funds and attention from improving care to regulatory compliance. The likely result will be the opposite of CA's stated aim of focusing services on delivering the best possible care rather than simply complying with the rules.

If there were more time remaining in the Royal Commission's deliberations we would recommend a dedicated consultation paper and set of hearings or workshops on enforcement powers. Given the limited remaining time, we instead suggest that the Royal Commission recommend that the Government commission an urgent independent review specifically focused on investigation and enforcement powers, including the role of civil penalties and director liability.

To 109.1.ii We observe the subjective nature of the current standards. Applying these proposals to the current standards appears unreasonable.

To 109.1.iii. We observe that this seeks to bind third parties.

Recommendation 110: Private right of compensation for certain contraventions of the general duty

If the concerns above regarding the design of the civil penalties provisions are addressed it is reasonable for the regulator to also have the power to seek damages on behalf of those harmed by a contravention involving a deliberately or reckless breach.

Noting that individuals may already sue for breaches of the common law duty to deliver reasonable care and for breaches of the Australian Consumer Law guarantees, we are of the opinion that an additional right of private action is unnecessary.

If such a right of action is granted, it should be linked to the successful application of a civil penalty, and ensure that damages are capped to a reasonable level.

[3] The problem is that the regulator who determines the standards, reviews and monitors those standards, determines the outcomes for the provider, reviews the appeals by the provider, issues sanctions and penalties and determines whether a person is suitable to be in aged care. This does not reflect due process particularly where these determinations can be made without setting foot in the service or meeting with the provider.

As with the broader issue of civil penalties, this needs to be considered alongside a broader analysis of penalties and enforcement powers, including the due process and rights to review in the application of these penalties.

Recommendation 111: A wider range of enforcement powers

We agree that standards must be maintained and adequately regulated. The best remedy for non-compliance for care recipients and providers is getting the service back to compliance (with the exception of repeat offenders).

We also agree in principle, that the regulator requires a wider range of enforcement powers. In some respects, the existing enforcement powers are insufficient, but more broadly they are too inflexible. For example, the effect of sanctions such as the ability to no longer receive subsidies for new clients depend heavily on the circumstances of the provider. Penalties also need to be commensurate with the size of organisations. Providers report that on average the cost of a sanction on a residential aged care service exceeds $1 million in lost revenue and in the consultancy fees that providers are forced to expend in this process. This is an enormous penalty for a smaller provider with a turnover of $5 million. However, it is much less severe for a provider with a turnover of more than $100 million.

The various powers proposed by CA are worthy of consideration, but their suitability will depend on the circumstances in which they can be applied, including the arrangements to ensure appropriate opportunity for review and procedural fairness.

We understand the reasons for CA proposing the power to appoint an external manager. The regulator is already able to require providers to appoint an external adviser. However, the power to appoint a manager amounts to the power to take control of a service and its assets. This is a very significant power – and may perhaps even be unconstitutional. If it is granted it must:

- be in very limited circumstances (such as where there is serious and immediate risk to safety where an external manager is necessary to facilitate the revocation of accreditation while protecting the safety of clients);
- require the regulator to establish these circumstances to the satisfaction of a court or tribunal; and
- be for a limited time, with strict limits on the scope of decisions that can be made by the external manager.

More generally, the power to remove the management of an organisation should be subject to the application to court or tribunal.

As with recommendation 109 and 110 we urge the Royal Commission to recommend a broader review of enforcement powers that allows for holistic consideration of all relevant matters.

Recommendation 112: Strengthened powers for the quality regulator to undertake investigations and inquiries

The Aged Care Act already affords very limited procedural fairness to providers in investigations undertaken by the regulator, with the failure to provide information to demonstrate compliance with the standards already grounds for the regulator to find non-compliance and issue sanctions. The power to undertake searches without warrants and compel witnesses goes well beyond the scope of the powers generally available to regulators, including other health regulators. Moreover, CA does not contemplate what protections would be in place to prevent the abuse of these powers by the regulator. Law firms advising providers tell us that they are already seeing evidence of such an abuse of power with providers reluctant to pursue action.

Furthermore, providers should still be able to maintain rights, including for legal professional privilege.

As mentioned above there is already pervasive fear among providers regarding the ability of the regulator to punish them if they seek to challenge the regulator's decisions. This is not a healthy regulatory environment, and providing further unfettered powers is only likely to worsen this situation.

A review of investigatory powers and the checks and balances that apply to them should be undertaken alongside the review of enforcement powers recommended above.

There should be notification providing reasonable detail and reasonable timeframes and appeal rights in relation to strong powers granted to the Australian Aged Care Commission.

Recommendation 114: Improved complaints management

There are significant gaps in procedural fairness regarding the existing complaints process, whereby the regulator is able to issue directions to providers without any opportunity for the provider to seek administrative review of these decisions until the complaint is finalised, which the regulator often refuses to do until the provider has complied with, or agrees to comply with those directions. Where a provider disagrees with the directions or believes they are unlawful, they are left with the following choices:

- Comply with the directions even those directions are harmful to their interests.
- Fail to comply with the directions, automatically placing the provider at risk of compliance action including sanctions; or
- Where available, apply for judicial review at the Federal Court, an option which is cost prohibitive to the vast majority of providers.

The right to appeal applies once sanction is imposed, at which point it is too late.

Any decision to apply a direction or make a finding of non-compliance needs to be subject to appropriate mechanisms for review. Providers, as well as complainants, should have the right to refer to the matter to the Inspector-General. Reporting should include the satisfaction of both providers and complainants with the outcomes and process.

Recommendation 115: Protection for whistle-blowers

We support protections for whistleblowers. However, there should be situations where the whistle blowing protection is not available for example, when reports are not made via appropriate channels. Further, there should be reasonable grounds for the whistleblower to suspect misconduct, similar to the whistleblower rights and protections under the Corporations Act 2001 (Cth). The process should be fair and equitable.

Whistleblower provisions applying to aged care must be in accordance with existing requirements under the current legislation.

Recommendation 118: Serious incident reporting

LASA supports a Serious Incident Response Scheme that focusses on the prevention of truly serious incidents through sector-wide learning for providers.

The reality of the definitions currently being proposed for the scheme by Government is that they do not distinguish between incidents and serious incidents and will in effect require providers and their staff to report all incidents to avoid the risk of failing to comply with their obligations. This deluge of formal incident reporting is likely to detract resources from care and make it more difficult to identify serious incidents among the large number of other incidents reported.

Applying broad reporting of incidents in a home based setting is also problematic when this might relate to incidents between the older person receiving care and family member or friend. While it is reasonable to require reporting where potential criminality is observed, it is unreasonable and likely unhelpful to require provider staff to report on any suspicion of an incident between a person in care and a family member.

The reporting of a suspicion of an incident caused by a family member or other informal carer, if not confirmed, will seriously damage the relationship of trust between care provider, care recipient and their family. LASA suggests that detailed guidance be provided as to the type of incidents and the level of suspicion and evidence required for reporting. Further, an advisory service should be made available for providers where they can seek advice as to the potential requirement for reporting of an incident involving family or other

informal carers. In some cases a mandatory reporting scheme similar to child abuse may enable approved providers to make reports where otherwise they may not be able to due to privacy obligations.

If providers are to devote significant resources to reporting these incidents there must also be a commitment from the regulator and police to act on the information that is reported. It is common for aged care providers to report incidents such as assaults to police and not have these matters followed up. More generally, the information reported must actually be analysed and used to inform risk management and improve care.

When linking the name of a person involved to the incident, provisions need to be included to ensure procedural fairness for the person alleged to have caused the incident(s). This is important for staff and for care recipients against whom such allegations are put. For this reason, names of individuals alleged of being involved in an incident should be linked to the incident only after a thorough investigation confirmed that their involvement has in fact occurred.

Reporting of serious incidents should have clearly specified reporting requirements. Approved Providers should not be 'punished' for being good reporters and having a higher number of incidents reported. Often it is those that do not report which are the higher risk.

Further, the reporting requirement should apply when the provider has formed a 'reasonable belief' that the conduct which is reportable has occurred similar to the mandatory reporting requirements of registered practitioners under the Health Practitioner Regulation National Law.

The aged care sector quality assurance committees should have similar qualified privilege protections which are provided for Quality Assurance Committees for Hospitals.

Recommendation 121: Requirement of continuing suitability for approval

We agree that the Commission should monitor a provider's compliance with their obligations – including the obligation for key management personnel – on an ongoing basis. However, this recommendation could be read to imply that the Commission have a broad discretion to revoke approved provider status based simply on a general belief that the provider is no longer suitable.

Where the regulator cannot provide evidence that a provider is breaching their regulatory obligations this sort of plenipotentiary power to revoke accreditation is unfair and difficult to justify.