Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia

House of Representatives Standing Committee on Health, Aged Care and Sport

October 2018
CANBERRA
Chair's Foreword

Providing high quality residential care to older Australians is an obligation we have as a society and a parliament. It is both a debt we must pay to those generations who have done so much to build our prosperous nation and also a fundamental human right.

Australia’s residential aged care facilities provide care to nearly 240,000 Australians. Many are providing aged care which is delivered to a high standard, and provides older Australians with a safe environment to age with dignity and care.

Yet there are also many who have not had a positive experience of their care – in the worst cases care has involved elder abuse or mistreatment. The Aged Care Complaints Commissioner received around 3600 complaints about residential aged care in 2016-2017, and three per cent of these complaints fell under the definition of abuse.

Recently, Australia’s residential aged care facilities have come under increased scrutiny, as high profile reports of mistreatment have come to light and have been investigated. Failures in the provision of care at facilities such as the Oakden Older Persons Mental Health Service have led to major reforms to the delivery and regulation of residential aged care services, and a number of inquiries and reports into how such a failure could occur.

While perhaps the worst example, Oakden cannot be seen as an isolated event. Investigative reporting has highlighted other serious examples of mistreatment and this inquiry has received submissions from residents and family members often outlining what can only be described as harrowing experiences.

This is simply not acceptable in a nation like Australia.
The Committee received evidence which highlighted gaps in the current system for the delivery of care in residential aged care facilities. These included the complexity of the current system, a reluctance or inability to raise concerns or make complaints regarding the quality of care, and an overall lack of consumer focus. The Committee thanks all those who shared their stories and experiences, and understands that the residents, family members and carers who participated in the inquiry did so under difficult circumstances. These experiences helped the Committee understand the challenges of navigating the current system, and the emotional and physical toll of mistreatment.

This parliamentary inquiry has followed a number of government-initiated reviews all of which have made important contributions. More recently, the seriousness of concern about mistreatment in the aged care sector has led the Australian government to establish a Royal Commission.

The Committee has welcomed this announcement and the continued focus on quality and safety in aged care.

At the same time the Australian government has been implementing a number of major reforms flowing from the work of earlier inquiries. This has made the work of this Committee more challenging in what has been a changing regulatory environment. However, in the main the Committee has supported the thrust of those reforms as important positive steps to improving the aged care sector.

For example, from 2019, the regulation of Australian Government-funded aged care will be streamlined, with the formation of the Aged Care Quality and Safety Commission. This will bring together the Australian Aged Care Quality Agency and Aged Care Complaints Commissioner, along with the aged care functions of the Department of Health.

Additionally, a Single Aged Care Quality Framework will replace four separate Accreditation Standards with one, which has a stronger focus on individuals, and the Australian Aged Care Quality Agency has already begun moving to unannounced re-accreditation audits from announced visits.

While it is too early to examine whether these sectoral reforms will be effective, the Committee considers that they are a positive change and will lead to a stronger and more responsive residential aged care sector.

As Australia’s population lives longer, demand for aged care services will inevitably grow. By 2056, it is estimated that 22 per cent of the population will be made up of older Australians. At the same time, nationally, rates of dementia are expected to increase to around one million.
The need for a streamlined, responsive residential aged care system is clear, and recent and upcoming reforms will help the evolving aged care system in Australia. The Committee has considered these reforms but believes there is more that can be done to improve our aged care system. Our 14 recommendations include:

- Improving the Community Visitors Program to ensure volunteers visiting aged care facilities are better able to respond to suspected abuse;
- Reviewing the Aged Care Funding Instrument to ensure it is providing both adequate levels of funding and care for aged care facilities;
- Ensuring that all aged care facilities are required to have at least one registered nurse on site 24 hours a day and that more work be done to monitor staffing mixes and their impacts on reducing complaints and abuse;
- Improving consumer information provided to aged care residents;
- Developing mandatory and more effective quality indicators;
- Cracking down on the use of restrictive practices;
- Developing a consumer rating system for aged care facilities; and
- Providing consumers with greater transparency about complaints lodged against individual aged care centres.

The Committee strongly believes that the efficacy of the existing reforms must be reviewed once they are operational, including by this parliamentary committee.

I want to thank the many organisations and individuals who made submissions to this inquiry. I also thank my fellow committee members who have worked together to deliver a bipartisan report. The Committee is also indebted to the work of the Committee staff who have provided such professional support to our deliberations.

Ensuring Australians are provided with residential aged care they can trust must be a priority for the Australian government and parliament. Our hope is this report will provide additional impetus to reform.

**Mr Trent Zimmerman MP**

Chair
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Australian Aged Care Quality Agency

Charter of Care Recipients’ Rights and Responsibilities

Community Visitors Scheme

Residential Aged Care for Aboriginal and Torres Strait Islander People

Accreditation and Monitoring

Single Aged Care Quality Framework

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Members

Chair

Mr Trent Zimmerman MP

Deputy Chair

Mr Steve Georganas MP

Members

Hon Damian Drum MP (until 19.12.2017 and then from 10.09.2018)

Dr Mike Freelander MP

Mr Andrew Laming MP

Ms Michelle Landry MP (from 6.02.2018 until 26.08.2018)

Mrs Lucy Wicks MP

Mr Tim Wilson MP

Mr Tony Zappia MP
Committee Secretariat

Ms Stephanie Mikac, Secretary
Ms Caitlin Cahill, Inquiry Secretary (from 18.08.2018)
Ms Aleshia Westgate, Inquiry Secretary (until 17.08.2018)
Ms Carissa Skinner, Office Manager
Terms of Reference

The Standing Committee on Health, Aged Care and Sport will inquire into 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.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AASW</td>
<td>Australian Association of Social Workers</td>
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<tr>
<td>ACFI</td>
<td>Aged Care Funding Instrument</td>
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<td>ACSA</td>
<td>Aged and Community Services Australia</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>AH</td>
<td>Allied Health</td>
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<td>AHA</td>
<td>Allied Health Assistant</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AIN</td>
<td>Assistants in Nursing</td>
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<td>ALRC</td>
<td>Australian Law Reform Commission</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<td>ANAO</td>
<td>Australian National Audit Office</td>
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<tr>
<td>ANMF</td>
<td>Australian Nursing and Midwifery Federation</td>
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<td>ANZSGM</td>
<td>Australian and New Zealand Society for Geriatric Medicine</td>
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<tr>
<td>CAAT</td>
<td>Computer Assisted Assessment Tool</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>CER</td>
<td>Consumer Experience Report</td>
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<td>COTA</td>
<td>Council of the Ageing</td>
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<td>CPSA</td>
<td>Combined Pensioners and Superannuants Association</td>
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<td>CPSU</td>
<td>Community and Public Sector Union</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>CVP</td>
<td>Community Visitors Program</td>
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<td>CVS</td>
<td>Community Visitors Scheme</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>FECCA</td>
<td>Federation of Ethnic Communities’ Councils of Australia</td>
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<tr>
<td>GP</td>
<td>General Practitioners</td>
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<tr>
<td>HCCA</td>
<td>Health Care Consumers’ Association</td>
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<td>HLARU</td>
<td>Health Law and Ageing Research Unit</td>
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<td>HSU</td>
<td>Health Services Union</td>
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<td>ICAC</td>
<td>Independent Commissioner Against Corruption</td>
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<td>LASA</td>
<td>Leading Age Services Australia</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>NACAP</td>
<td>National Aged Care Advocacy Program</td>
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<td>NACLC</td>
<td>National Association of Community Legal Centres</td>
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<tr>
<td>NALHN</td>
<td>North Adelaide Local Health Network</td>
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<tr>
<td>NMA</td>
<td>Nurses and Midwives Association</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>OPA</td>
<td>Office of the Public Advocate</td>
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<td>OPAN</td>
<td>Older Person’s Advocacy Network</td>
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<tr>
<td>OPG</td>
<td>Office of the Public Guardian</td>
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<tr>
<td>PCA</td>
<td>Personal Care Attendant</td>
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<tr>
<td>QACAG</td>
<td>Quality Aged Care Action Group</td>
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<tr>
<td>QLD</td>
<td>Queensland</td>
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<tr>
<td>QNMU</td>
<td>Queensland Nurses and Midwives Union</td>
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<tr>
<td>RACF</td>
<td>Residential Aged Care Facility</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RUCS</td>
<td>Resource Utilisation and Classification Study</td>
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<td>SA</td>
<td>South Australia</td>
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</tbody>
</table>
TCLS  Townsville Community Legal Service
UK    United Kingdom of Great Britain
VCOSS Victorian Council of Social Services
Vic   Victoria
WA    Western Australia
WHO   World Health Organization
List of Recommendations

Recommendation 1

2.173 The Committee recommends that the Department of Health develop national guidelines for the Community Visitors Scheme, including policies for volunteer visitors to follow in the event of observed or suspected abuse or neglect.

Recommendation 2

2.174 The Committee recommends the Australian Government review:

- the Aged Care Funding Instrument (ACFI) to ensure that it is providing for adequate levels of care for the individual needs of aged care recipients;

- the adequacy of funding levels to ensure ACFI funding is indexed annually; and

- the range of penalties relating to breaches of ACFI funding standards by aged care providers.

Recommendation 3

2.175 The Committee recommends that the Australian Government review the Medicare Benefits Schedule relating to medical practitioner visits to residential aged care facilities.

Recommendation 4

2.176 The Committee recommends that the Australian Government:
- legislate to ensure that residential aged care facilities provide for a minimum of one Registered Nurse to be on site at all times; and

- specifically monitor and report on the correlation between standards of care (including complaints and findings of elder abuse) and staffing mixes to guide further decisions in relation to staffing requirements.

**Recommendation 5**

2.177 The Committee recommends that the Department of Health ensure consumer information, including the Charter of Rights, for aged care residents and their families is available in a wider range of languages to ensure better access for those from culturally and linguistically diverse backgrounds.

**Recommendation 6**

2.178 The Committee recommends that an independent review and a parliamentary inquiry (by the appropriate Committee) be undertaken into the Aged Care Quality and Safety Commission after two years to determine its effectiveness in ensuring high standards of care, best clinical practice and reducing mistreatment.

**Recommendation 7**

2.179 The Committee reiterates and supports the recommendation from the Carnell-Paterson Review for the current to move to unannounced audits in residential aged care facilities and that any unannounced visits to residential aged care facilities should not be confined to business hours.

**Recommendation 8**

3.178 The Committee recommends that the reportable assault ‘resident-on-resident’ exemption, in which assaults committed by a resident with a cognitive impairment are not required to be reported to the Department of Health, be removed.

**Recommendation 9**

3.179 The Committee recommends that the National Aged Care Quality Indicator Program (the Program):
be made mandatory for providers of Australian Government-funded residential aged care services; and

be expanded to include a broader range of key indicators, to be determined with the involvement of the aged care sector and consumer groups.

Recommendation 10

3.180 The Committee recommends that the Australian Government amend the Aged Care Act 1997 to legislate that:

- the use of restrictive practices in residential aged care facilities be limited to the ‘least restrictive’ and be a measure of last resort only;

- any use of restrictive practices within the legislated meaning be recorded by providers and collected by the Department of Health;

- restrictive practices are only to be used after a medical practitioner has prescribed/recommended such use; and

- the legal guardian and/or family member must be advised immediately.

Recommendation 11

4.115 The Committee recommends that the Department of Health work with the aged care sector to implement a rating system (for example, a star or point rating system) for residential aged care facilities, and develop an action plan for how such a system could be implemented.

Recommendation 12

4.116 The Committee recommends that the public be provided with information through the My Aged Care website regarding the number of complaints and reportable incidents that have been lodged, responded to and resolved, and the number of complainants, at individual aged care facilities.

Recommendation 13

4.117 The Committee recommends that the Australian Government examine ways to ensure all consumers have access to the Older Persons Advocacy Network
(OPAN) advisory services, and include in consumer experience reports the providers that refuse OPAN access to their facilities.

**Recommendation 14**

4.118 The Committee recommends that the Australian Government agencies responsible for the delivery of aged care services commit to a more consumer-oriented focus, with greater, and more transparent, consumer involvement in the delivery of aged care services.
1. Introduction

Background

1.1 Australians are living longer, with estimates that there will be 8.7 million older people living in Australia (22 per cent of the population) by 2056.1 Nearly 240 000 older Australians received permanent residential care in 2016-2017, and with Australia’s population ageing, demand for care is growing. Complexity of care is also increasing, with dementia rates expected to increase to around one million by 2056.2

1.2 Many Australians experience aged care services that are safe and provide quality care.3 Instances of mistreatment of people in aged care, however, have been identified in the recent past, highlighting potential gaps in the existing system and the urgent need for reform.

1.3 Recent high profile failures in the provision of residential aged care in South Australia, Queensland and New South Wales have been reported and investigated, and have led to a number of reviews and reforms to the governance of the sector. At the same time, the number of complaints regarding aged care has grown in recent years, with a 23 per cent increase in

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2 Dementia Australia, Submission 7, p. 7.

3 Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 1.
total complaints made to the Aged Care Complaints Commissioner between 2016-2017 and 2017-2018.4

1.4 On 16 September 2018 the Australian Government announced a Royal Commission into Aged Care Quality and Safety (Royal Commission). The Royal Commission is expected to determine the extent of ‘substandard care’ being provided, and will also consider challenges associated with providing care to people with disabilities living in aged care and older Australians with dementia and complex care needs. In addition, the Royal Commission will consider challenges and opportunities associated with the expected increase in demand for aged care services over the next decade.5

1.5 The mistreatment of older Australians in residential aged care facilities may take many forms, and may be direct (as with assault), or indirect (through neglect).6 Mistreatment in this context is often referred to as ‘elder abuse’, which is defined by the World Health Organization (WHO) as ‘a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person’. Further, this abuse may be ‘financial, physical, psychological and sexual … [and] can also be the result of intentional or unintentional neglect’.7

1.6 For some aged care residents, and their families and carers, making a complaint about real, perceived or alleged mistreatment is a daunting prospect, with many finding the process to be complex and/or ineffective. The true prevalence of mistreatment in residential aged care facilities is not known, as issues may not be identified or complaints not made.

1.7 Communication barriers such as: cognitive or speech impairments, cultural and language barriers, or the lack of a representative or advocate also affect

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6 Mistreatment, or abuse, is defined as the act of treating a person cruelly or unfairly. Aged Care Complaints Commissioner, *Submission 28*, p. 3.

a resident’s ability to raise concerns or make official complaints about their care.

1.8 As the aged care sector expands to provide services to the growing number of older Australians over time, quality care and clear and efficient avenues to raise concerns and make complaints will need to be firmly in place.

About the Inquiry

Objectives and Scope

1.9 On 6 December 2017, the Minister for Health and Sport, the Hon Greg Hunt MP, referred the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (the inquiry) to the Standing Committee on Health, Aged Care and Sport (the Committee).

1.10 As part of the inquiry, the Committee reviewed the current standard of care in residential aged care facilities, and in particular, examined:

- The effectiveness of the Australian Government agencies responsible for the regulation and delivery of aged care services in Australia, including the Department of Health, Australian Aged Care Quality Agency, Aged Care Complaints Commission, and Charter of Care Recipients’ Rights and Responsibilities;
- Allegations of mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms; and
- The adequacy of consumer protection arrangements for aged care residents, particularly those who do not have family, friends or other representatives to help them exercise choice and their rights in care.

1.11 As the Committee is not a reporting body for complaints about residential aged care, it indicated on the inquiry webpage that it was unable to investigate individual cases of abuse or neglect in residential aged care. The Committee, however, provided contact information for the Aged Care Complaints Commissioner, and relevant state and territory reporting bodies, on its webpage.

1.12 In reference to this inquiry, the Committee received personal accounts from residents, family members and carers about allegations of abuse or neglect in residential aged care. Although it was not within the inquiry scope, nor within the power of the Committee, to ascertain the veracity of the claims, the Committee appreciated the information received and understands the courage needed for individuals to speak out. Where appropriate, the
Committee removed identifying and personal information received to both protect the privacy of individuals and ensure that the rights of providers are respected. The personal accounts of aged care received by the Committee provided insight into the lived experience of those in residential aged care, their families and carers, and the staff who support the sector.

**Inquiry Conduct**

1.13 On 7 December 2017, the Committee issued a media release announcing the inquiry, calling for submissions to be received by 8 February 2018. On the request of inquiry participants, the Committee subsequently extended the date for submissions to be received by 1 March 2018.

1.14 The Committee also invited submissions from: government agencies, aged care peak bodies and providers, advocacy groups, medical groups and research organisations.

1.15 The inquiry received 123 submissions and 33 exhibits, which are listed at Appendix A and B respectively.

1.16 The Committee subsequently held seven public hearings as outlined in the table below. A list of witnesses and organisations is at Appendix C.

**Table 1.1 Public Hearings Held**

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<tr>
<td>11 May 2018</td>
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<td>24 May 2018</td>
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<td>15 March 2018</td>
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<tr>
<td>26 April 2018</td>
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Previous and Current Investigations into Aged Care Framework

1.17 The Australian aged care sector has been the subject of a number of major inquiries and reviews in recent years. Each of the reviews focussed on a particular aspect of the aged care sector and contributed to debate on reform.

Australian Law Reform Commission Report

1.18 The Australian Law Reform Commission (ALRC) released its report *Elder Abuse—A National Legal Response* (ALRC Report), in May 2017. The ALRC Report made 43 recommendations, including:

- Establishing a serious incident response scheme in aged care legislation;
- Reforms relating to staffing in aged care;
- Regulating the use of restrictive practices in aged care;
- Reforms relating to decision making in aged care; and
- National guidelines for the community visitors scheme regarding abuse and neglect of care recipients.8

1.19 The ALRC Report’s recommendation for a serious incident response scheme has been adopted by the Australian Government.9

1.20 Limited research on the rates of abuse of those in residential aged care was a noted issue. The ALRC received submissions which included reports of abuse by staff of aged care facilities and family members and decision makers of residents, as well as reports of neglect.10

1.21 Staffing levels were also addressed by the ALRC Report, which stated that a ‘safe, qualified aged care workforce in sufficient numbers is an essential safeguard against elder abuse in aged care’.11 The ALRC observed concerns

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9 The Hon Ken Wyatt AM MP, ‘Minister for Aged Care, Powerful New Reforms to Ensure Safe, Quality Aged Care’, *Media Release*, 18 April 2018. This recommendation was endorsed by Ms Kate Carnell AO and Professor Ron Paterson ONZM in the *Review of National Aged Care Quality Regulatory Processes*.


put to it that current staffing levels were inadequate, and may be leading to neglect.\textsuperscript{12}

1.22 The ALRC Report further recommended that unregistered care workers be made subject to state and territory legislation giving effect to the National Code of Conduct for Health Care Workers, and that people wishing to work or volunteer in an Australian Government-regulated aged care facility be screened.\textsuperscript{13}

Aged Care Legislated Review

1.23 In September 2016, the Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM MP\textsuperscript{14}, appointed Mr David Tune AO PSM to conduct the \textit{Aged Care Legislated Review} (Tune Review) as part of changes to aged care introduced in the \textit{Aged Care (Living Longer Living Better) Act 2013}. The Tune Review was released in September 2017.

1.24 The Tune Review looked at ‘the impact and effectiveness of the changes and … made recommendations for future reform to the aged care system’.\textsuperscript{15} Quality and safety issues relating to aged care lay outside the Tune Review’s scope.\textsuperscript{16}

1.25 The Tune Review received 145 submissions and made 38 recommendations. Recommendations included further steps toward a consumer demand-driven model, increasing transparency around fees, and improving the functionality and performance of the \textit{My Aged Care} website.\textsuperscript{17}

1.26 The Tune Review also suggested changes to increase accessibility for consumers by making the \textit{My Aged Care} website more understandable, recommending that:

\begin{quote}
... the government introduce aged care system navigator and outreach services to assist consumers who have difficulty engaging through the existing
\end{quote}

\textsuperscript{12} Australian Law Reform Commission, \textit{Submission 20}, p. 2.

\textsuperscript{13} Australian Law Reform Commission, \textit{Submission 20}, p. 2.

\textsuperscript{14} Until 28 August 2018 Minister for Aged Care, currently Minister for Senior Australians and Aged Care.


\textsuperscript{16} Mr David Tune AO, PSM, \textit{Aged Care Legislated Review}, September 2017, p. 18.

\textsuperscript{17} Mr David Tune AO, PSM, \textit{Aged Care Legislated Review}, September 2017, pp 13-17.
channels to effectively engage with My Aged Care. The services should be funded by the government and not be delivered by the government or aged care providers.\textsuperscript{18}

**Productivity Commission Report**

1.27 The Productivity Commission’s report *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services* (Productivity Commission Report) inquired into the provision of end-of-life services, social housing, family and community services, services in remote Indigenous communities, patient choice and dental services. The Productivity Commission Report was released in October 2017.

1.28 The Productivity Commission Report focus on end-of-life care found that reforms were needed to ‘improve the standard of end-of-life care in residential aged care facilities’, stating that ‘each year, tens of thousands of people who are approaching end of life are cared for and die in a place that does not fully reflect their choices or meet their needs’.\textsuperscript{19}

1.29 The Productivity Commission Report also found that ‘the quality of end-of-life care in Australia is among the world’s best, but services are not available everywhere and to everyone who would benefit’.\textsuperscript{20} Further, the Productivity Commission Report stated that although four out of five residents of aged care facilities die in them, residents were making potentially unnecessary trips to hospital:

… the lack of palliative care expertise and qualified staff to administer pain relief mean residents often make traumatic (and costly) trips to hospital to receive medical care that could have been provided in surroundings that are familiar to them.\textsuperscript{21}

1.30 Coordination between residential aged care and general practice was found to be poor, and a focus on personal consumer choice was recommended to

\textsuperscript{18} Mr David Tune AO, PSM, *Aged Care Legislated Review*, September 2017, p. 15.


ensure that consumers are able to receive services of their preference for end-of-life care.22

Review of National Aged Care Quality Regulatory Processes

1.31 The Review of National Aged Care Quality Regulatory Processes (known as the Carnell-Paterson Review) was announced by the Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM MP, in May 2017. Minister Wyatt appointed Ms Kate Carnell AO and Professor Ron Paterson ONZM to lead the Review. The Carnell-Paterson Review was released in October 2017.

1.32 The Carnell-Paterson Review was undertaken as a response to the Oakden Report, which detailed the failures in the quality of care provided at Oakden

Box 1.1 Oakden Older Persons Mental Health Service

Oakden opened in 1982, and was a provider of specialised residential care services for older people with complex mental health care needs and people with severe dementia.

Oakden was the responsibility of the North Adelaide Local Health Network (NALHN), however, the Makk and McLeay wards became Australian Government-funded nursing home beds in 1998.23

In February 2016, an Oakden resident was referred to the Royal Adelaide Hospital after ‘significant bruising to his hip’ was identified, ‘for which there was no satisfactory explanation’.24 The resident’s family raised concerns about his care, which were raised with the Chief Executive Officer of the NAHLN, who requested the South Australian Chief Psychiatrist, Dr Aaron Groves, undertake a review of the facility. The Chief Psychiatrist’s review was released in April 2017, and recommended the closure of Oakden due to the poor standard of the facilities,


23 Dr Aaron Groves, Chief Psychiatrist, South Australia, Review of Oakden Older Persons Mental Health Service, April 2017, p. 24.

24 Dr Aaron Groves, Chief Psychiatrist, South Australia, Review of Oakden Older Persons Mental Health Service, April 2017, p. 2.
unsuitability of the design for its residents, poor maintenance, faulty equipment in use, lack of staff training and other failings.\textsuperscript{25}

In June 2017, the Makk and McLeay wards of Oakden were closed, and residents transferred to Northgate House and other providers in South Australia.

The failings at Oakden led to a number of reviews and reforms at the state and federal level.

Older Persons Mental Health Service (Oakden) in South Australia.\textsuperscript{26} The Oakden Report was undertaken by South Australia’s Chief Psychiatrist, Dr Aaron Groves, and recommended, among other things, that the facility close.

1.33 In particular, the Carnell-Paterson Review examined why existing regulatory processes had not identified the ‘systemic and longstanding failures of care at the Makk and McLeay wards documented in the Oakden Report’.\textsuperscript{27}

1.34 Further, the Carnell-Paterson Review sought to identify ‘improvements to the regulatory system that will increase the likelihood of immediate detection, and swift remediation by providers’.\textsuperscript{28}

1.35 The Carnell-Paterson Review received more than 400 submissions and made ten recommendations around centralisation of accreditation and information, a focus on consumer rights, the establishment of a serious

\textsuperscript{25} Dr Aaron Groves, Chief Psychiatrist, South Australia, \textit{Review of Oakden Older Persons Mental Health Service}, April 2017, p. 115, pp 35-50, p. 65.

\textsuperscript{26} Department of Health, \textit{Review of National Aged Care Quality Regulatory Processes},

\textsuperscript{27} Department of Health, \textit{Review of National Aged Care Quality Regulatory Processes},

\textsuperscript{28} Department of Health, \textit{Review of National Aged Care Quality Regulatory Processes},
incident response scheme, enhancements to complaints handling, and the limitation of the use of restrictive practices.\textsuperscript{29}

1.36 The Carnell-Paterson Review found that ‘current regulatory mechanisms do not consistently provide the assurance of quality that the community needs and expects’\textsuperscript{30} Ms Carnell and Professor Paterson also stated that they ‘see the primary role of quality regulation as consumer protection’, requiring a high level of oversight of accredited facilities as well as an effective complaints commissioner.\textsuperscript{31}

1.37 The role of the Australian Aged Care Quality Agency (Quality Agency) in failing to find serious issues at Oakden was highlighted:

Clearly, the accreditation processes that permitted the Makk and McLeay wards at Oakden to pass all 44 outcomes under the Accreditation Standards in February 2016 were inadequate. This was a deeply concerning failure. All too often, the Review heard about accreditation by the Quality Agency that was focused on processes rather than outcomes, and appeared to be a ‘tick-the-box’ exercise.\textsuperscript{32}

1.38 A major recommendation made in the report was the establishment of an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling. The new commission would include a:

- Care Quality Commissioner;
- Complaints Commissioner;
- Consumer Commissioner; and
- Chief Clinical Advisor.\textsuperscript{33}

\textsuperscript{29} Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, pp xi-xiii.

\textsuperscript{30} Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 4.

\textsuperscript{31} Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. vi.

\textsuperscript{32} Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. ix.

\textsuperscript{33} Recommendation 1, Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. xi.
In April 2018, Minister Wyatt announced the establishment of an Aged Care Quality and Safety Commission. This is discussed in Chapter 2.

**ICAC Report on Oakden**

In February 2018, the South Australian Independent Commissioner Against Corruption, the Hon Bruce Lander QC, released the report *Oakden: A Shameful Chapter In South Australia’s History* (ICAC Report).

The ICAC Report highlighted ‘systemic failings in processes and oversight’, stating that:

> The problem was the regime that existed that enabled the Oakden Facility and its operations to deteriorate to such an extraordinarily poor state and to operate in that way for such an extended period of time without any meaningful intervention.⁴

Lessons to be taken from the eventual identification of issues and closure of the Oakden facility were drawn together. The ICAC Report stated that closing the facility without fully understanding the failure to identify the deterioration of service could leave open ‘the very real possibility that similar failures could be perpetuated in the future in other settings’.³⁵

The main issues dealt with in the ICAC Report were around the proper handling of complaints, consequences of attempts to contain issues, the withholding of information, and the ‘extraordinary dangers associated with poor oversight, poor systems, unacceptable work practices and poor workplace culture’.³⁶

The ICAC Report made 13 recommendations, including strengthening the focus on staff training, making expectations of staff responsibilities clearer, increasing the frequency of community visitor inspections, and reviews of clinical governance.³⁷

**Senate Standing Committee on Community Affairs**

On 13 June 2017, the Senate referred an inquiry on the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting

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³⁴ The Hon Bruce Lander, QC, *Oakden: A Shameful Chapter In South Australia’s History*, pp 14-15.
³⁵ The Hon Bruce Lander, QC, *Oakden: A Shameful Chapter In South Australia’s History*, p. 16.
³⁶ The Hon Bruce Lander, QC, *Oakden: A Shameful Chapter In South Australia’s History*, p. 16.
³⁷ The Hon Bruce Lander, QC, *Oakden: A Shameful Chapter In South Australia’s History*, pp 19-21.
residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised to the Senate Standing Committee on Community Affairs (Community Affairs Committee). The Community Affairs Committee was required to report by 18 February 2018, however, the reporting date was extended to 28 November 2018.

1.46 The Community Affairs Committee released an interim report on 13 February 2018, which focussed on ‘the critical care failures in the Makk and McLeay wards of the Oakden Older Persons Mental Health Facility (Oakden) in South Australia’.38

1.47 The interim report found that ‘the Oakden facility failed to provide an appropriate model of care’, and that the Community Affairs Committee was ‘deeply concerned that warning signs in relation to resident health were not heeded, such as unexplained bruising, medication mismanagement and falls, and that complaints from family members and community advocates were ignored’.39

1.48 The Community Affairs Committee extended its inquiry to make it focus on the assessment and accreditation framework, and clinical and medical care standards.

Aged Care Amendment (Staffing Ratio Disclosure) Bill Inquiry

1.49 On 22 August 2018 the Parliament referred the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 to the Committee for inquiry.

1.50 The Committee has called for submissions by 4 October 2018 and is expected to conduct an inquiry which will include issues related to staffing and staffing ratios for aged care.

Royal Commission

1.51 On 16 September 2018, the Prime Minister, the Hon Scott Morrison MP, announced that he had asked the Governor-General to establish a Royal Commission into Aged Care Quality and Safety (Royal Commission).

1.52 The Prime Minister stated that ‘increased audit work’ commissioned by the Government had led to the closure of ‘almost one aged care service per
month since Oakden, with an increasing number under sanction to improve their care.’

1.53 The Prime Minister also stated that while changes to aged care policy in relation to quality and safety were already taking place, there are still areas of concern in regard to the quality and safety of aged care services. The Prime Minister stated:

Despite the further reforms underway, including the coming establishment of a new Aged Care Quality and Safety Commission, there clearly remains areas of concern with regard to the quality and safety of aged care services. For this reason, our Government has decided to establish a Royal Commission into Australia’s aged care system.40

1.54 The Royal Commission will consider issues of:

- ‘Quality and safety including the extent of substandard care;
- How to best deliver care services to people with disabilities residing in aged care facilities including younger people;
- How to best deliver care to the increasing number of Australians living with dementia;
- The future challenges and opportunities for delivering accessible, affordable and high quality aged care services, including people’s desire to remain living at home as they age, and aged care in rural, regional and remote Australia;
- What the Government, the aged care sector, Australian families and the wider community can do to strengthen care services to ensure quality and safety;
- How to allow people greater choice, control and independence and how to improve engagement with families and carers;
- How to best deliver sustainable aged care services through innovative care and investment in the aged care workforce and infrastructure; [and]
- Any matters that the Commissioners believe is relevant to their inquiry.’

1.55 The Royal Commission is expected to provide an interim report by 31 October 2019 and its final report by 30 April 2020.41

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41 Prime Minister, Minister for Health, Minister for Senior Australians and Aged Care, ‘Appointment of Royal Commissioners and Terms of Reference’, Media Release, 9 October 2018,
Report Structure

1.56 Chapter 2 outlines the current system for the delivery of aged care in Australia, and discusses the changes to the current system which will take effect on 1 January 2019.

1.57 Chapter 3 examines allegations of mistreatment of residents in residential aged care facilities, and the reporting mechanisms in place to respond to these incidences. This chapter also highlights the experience of residents, families and representatives, as well as staff, in making complaints or raising concerns.

1.58 Chapter 4 addresses issues of consumer rights and protection, including for those who do not have family, friends or representatives.

1.59 Chapter 5 discusses the changing nature of Australia’s population, the next generation of residential aged care consumers, and innovation in aged care facilities.
2. Current System for the Delivery of Aged Care

Overview

2.1 In response to an increasingly ageing population, aged care in Australia is evolving towards a more consumer-driven, market-based system.¹

2.2 Aged care regulation and quality is currently delivered by three Australian Government departments and agencies: the Department of Health, the Australian Aged Care Quality Agency (Quality Agency) and the Aged Care Complaints Commissioner (Complaints Commissioner).

2.3 The current system of aged care was viewed by some as not working efficiently or to the benefit of the consumer. Residents, their family members and carers expressed concerns at the complexity of the current residential aged care system. Members of the medical profession were of the view that the funding of aged care services was in need of updating to reflect current best practice.

2.4 Another area of concern was the accreditation system for residential aged care services. A number of inquiry participants stated that the current accreditation system, carried out by the Quality Agency, was too focussed on process and not enough on the consumer or the delivery of high standards of care.

2.5 The regulation of aged care in Australia is undergoing major reform, with the proposed formation of a new and independent Aged Care Quality and Safety Commission (the Commission) and a new set of Accreditation

¹ Department of Health, Submission 72, p. 20.
Standards. The Commission will merge the Quality Agency, Complaints Commissioner and aged care functions of the Department of Health.

Current System

2.6 Responsibility for the quality and safety of residential aged care facilities is currently shared between three Australian Government departments and agencies, with the Department of Health responsible for the funding, regulation and policy oversight of Australian Government-funded aged care services. Accreditation is carried out by the Quality Agency, and the Complaints Commissioner resolves concerns about aged care services.

2.7 The Aged Care Act 1997 (Aged Care Act) is the primary piece of legislation governing aged care services in Australia, and resources are allocated through the Aged Care Funding Instrument (ACFI).

2.8 The services that must be provided by an aged care provider are set out in the Schedule of specified care and services for residential care (the Schedule), in the Quality of Care Principles 2014 (Quality of Care Principles). The Schedule also sets out where fees may apply. Other relevant legislation includes the User Rights Principles 2014 (User Rights Principles) and the Complaints Principles 2015 (Complaints Principles).

2.9 The Australian Government provides the majority of funding to aged care, which was approximately $17.2 billion in 2017-2018.

The Department of Health

2.10 The Department of Health approves aged care providers, allocates and manages aged care places, establishes quality standards, takes enforcement actions against providers and administers the mandatory reporting function for assaults in aged care facilities.

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2 The Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, ‘Powerful New Reforms to Ensure Safe, Quality Aged Care’, Media Release, 18 April 2018.

3 This responsibility is shared between the Department of Health, the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.


5 Department of Health, Submission 72, p. 5.
2.11 Residential aged care services must be operated by an ‘approved’ organisation in order to qualify for Australian Government funding. The Department of Health considers applications against criteria set out in the Aged Care Act. An approved organisation then has the ongoing responsibility to ensure it continues to meet these criteria, and a failure to do so may result in a loss of approval.6

2.12 The Department of Health also manages the allocation of residential aged care places using a competitive process to ensure that places allocated are based on need and match the suitability of the provider of care.7

2.13 The aged care functions of the Department of Health will move to the new Aged Care Quality and Safety Commission from 2020.8

Aged Care Complaints Commissioner

2.14 The Complaints Commissioner was established on 1 July 2016. The Complaints Commissioner is a statutory office holder working under the Aged Care Act and the Complaints Principles.9

2.15 Complaints about the quality of aged care services funded by the Australian Government may be made to the Complaints Commissioner. Anyone can make a complaint.10

2.16 The Complaints Commissioner’s primary functions are to:

- Resolve complaints about aged care services;
- Educate people and aged care providers about the best way to handle a complaint and the issues it raised; and
- On request, provide information to the Minister in relation to any of the Complaints Commissioner’s functions.11

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6 Department of Health, Submission 72, p. 3.
7 Department of Health, Submission 72, p. 3.
8 Ms Maria Jolly, First Assistant Secretary, Aged Care Reform Taskforce, Department of Health, Official Committee Hansard, Canberra, 24 May 2018, p. 2.
9 The Complaints Principles 2015 set out the Complaints Commissioner’s powers and process.
2.17 Established in 2014, the Quality Agency is an independent statutory agency with responsibility for accrediting and reviewing aged care services and home care services.

2.18 The Quality Agency is also responsible for the registration of the assessors who conduct accreditation, and delivers training and education to the aged care sector. The role of the Quality Agency is to hold providers of Australian Government-subsidised aged care services to account against applicable standards.12

2.19 Residential aged care services are reviewed in accordance with the standards and the Quality Agency Principles 2013. Compliance of providers with the standards is monitored by the Quality Agency, which stated that:

Where issues are identified with the performance of a provider, the Quality Agency sets out specific areas for improvement and a clear timetable for making those improvements. The Quality Agency then informs the Department of Health, allowing it to consider what further regulatory action is appropriate in those circumstances.13

Charter of Care Recipients’ Rights and Responsibilities

2.20 The Charter of care recipients’ rights and responsibilities – residential care (the Charter) sets out the rights and responsibilities of care recipients, including the use of personal, civil, legal and consumer rights, the right to quality care, the right to live without discrimination or victimisation and the right to make a complaint.14 The Charter is contained in Schedule 1 of the User Rights Principles. A new single charter of care recipients’ rights and responsibilities is in development.15

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12 Australian Aged Care Quality Agency, Submission 65, p. 4.

13 Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency, Official Committee Hansard, Sydney, 5 March 2018, p. 35.


15 Ms Catherine Rule, First Assistant Secretary, Aged Care Reform Taskforce, Department of Health, Official Committee Hansard, Canberra, 1 March 2018, p. 2.
2.21 Aged care services must be delivered in a ‘manner that is consistent with the rights and responsibilities of care recipients that are specified in the Charter’.\textsuperscript{16}

2.22 The Department of Health advised that the Charter ‘provides the right for care recipients of residential aged care to be treated with dignity and respect, and live without exploitation, abuse, neglect, discrimination or victimisation’.\textsuperscript{17}

2.23 The Charter sets out that a resident has the right to complain, to take action to resolve disputes and ‘to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights’.\textsuperscript{18} If a consumer believes that their rights are not being upheld by a provider, they may make a complaint to the Complaints Commissioner.

2.24 During the accreditation process, the Quality Agency assesses whether consumers understand their rights and responsibilities under the Charter, and whether the provider has systems in place to comply with the Charter. The Complaints Commissioner and Quality Agency may refer matters to the Department of Health, which may take compliance action if the requirements of the Charter are not met.\textsuperscript{19}

2.25 The Charter was described by the Australian Nursing and Midwifery Federation as ‘an essential document’, but which ‘needs to be more rigorously enforced’.\textsuperscript{20}

2.26 The utility of the Charter was questioned by inquiry participants. Mrs Rosaleen Appelhans called the Charter ‘well meaning but in some ways impossible to deliver on’.\textsuperscript{21} The Charter was also described as: having a ‘low/minimal profile within facilities’,\textsuperscript{22} ‘ineffective’,\textsuperscript{23} ‘not adequate’ and in

\textsuperscript{16} Department of Health, \textit{Submission 72}, p. 3.

\textsuperscript{17} Department of Health, \textit{Submission 72}, p. 14.


\textsuperscript{20} Australian Nursing and Midwifery Federation, \textit{Submission 53}, p. 28.

\textsuperscript{21} Mrs Rosaleen Appelhans, \textit{Submission 5}, p. 1.

\textsuperscript{22} Name Withheld, \textit{Submission 58}, p. 1.

\textsuperscript{23} Australian College of Nursing, \textit{Submission 57}, p. 11.
need of review. The language used in the Charter was described as vague or ‘generalised’. The Office of the Public Advocate (Victoria) (OPA Victoria) questioned ‘whether the charter has genuine vitality’.26

2.27 The Older Person’s Advocacy Network (OPAN) uses the Charter when discussing issues with residents, particularly if the resident has expressed a fear of reporting mistreatment. The OPAN also stated that the practical application of the Charter had been questioned, with residents asking who would protect them when the advocate is not there. The OPAN stated that ‘This is a very real concern and a question that can be difficult to answer’. The need for clear supporting guidelines was also highlighted.27

2.28 The OPAN also considered that the interpretation of care recipients’ rights ‘is often a challenge and it can be difficult to ensure that interpretations remain focused on the consumer perspective rather than that of providers’.28

2.29 A low level of understanding and awareness of the Charter by residents and staff was highlighted by inquiry participants.29 The Law Council of Australia recommended ‘an obligation for facilities to regularly provide education or information on rights, support for making complaints and the complaint process’.30

2.30 The Charter’s emphasis on full and effective use of rights was questioned, with one inquiry participant suggesting that consumers may not be aware of their consumer rights. The inquiry participant stated that information relating to consumer guarantees for services ‘should be explained in a way that can be easily understood’.31 Elderlaw described this aspect of the

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24 Name Withheld, Submission 77, p. 4.
25 Elderlaw, Submission 15, p. 6.
26 Office of the Public Advocate (Victoria), Submission 35, p. 7.
27 Older Person’s Advocacy Network, Submission 36, p. 1.
28 Older Person’s Advocacy Network, Submission 36, p. 3.
31 Name Withheld, Submission 77, p. 5.
Charter as a ‘generalised statement which is meaningless unless understood to mean that steps will be taken by the provider’.32

2.31 The Australian Association of Social Workers (AASW) made the point that the Charter may not be accessible or understandable to consumers, and that even though the Charter is available in aged care facilities, it is ‘usually in small print’ which made it difficult to read.33 The AASW also observed that language barriers may present a challenge, as the Charter is:

… only available in certain languages other than English and [is] therefore not an accessible resource to older people and their families from culturally and linguistically diverse (CALD) backgrounds … the Charter should be made more easily accessible to families, those with functional impairments and those from a non-English speaking background.34

2.32 The Australian College of Nursing agreed that there is a need for the Charter to be available in more community languages, and for the Charter to be discussed more frequently.35 The Royal Australian College of General Practitioners also recommended that the Charter be available in more languages, and further, that an Easy English version be created.36

2.33 In contrast, the Aged Care Industry Association expressed the view that the Charter provides ‘a reasonable framework for specifying consumers’ rights and identifying avenues to express dissatisfaction’.37

2.34 Carers NSW recommended ‘mandatory training for all care staff on the practical applications’ of the Charter.38 Carers NSW also recommended a Charter of Family and Carers’ Rights and Responsibilities, with reference to the Commonwealth Carer Recognition Act 2010. Carers NSW envisioned this family and carers’ charter ‘informing carers of their rights as a supporter and guiding staff engagement with residents’ carers, friends and families’.39

32 Elderlaw, Submission 15, p. 6.
33 Australian Association of Social Workers, Submission 51, p. 4.
34 Australian Association of Social Workers, Submission 51, p. 4.
35 Australian College of Nursing, Submission 57, p. 11.
36 Royal Australian College of General Practitioners, Submission 81, p. 2.
37 Aged Care Industry Association, Submission 83, p. 8.
38 Carers NSW, Submission 30, p. 2.
39 Carers NSW, Submission 30, p. 2.
Community Visitors Scheme

2.35 The Australian Government Community Visitors Scheme (CVS) ‘uses volunteers to make regular visits to people who are socially isolated or are at risk of social isolation or loneliness’ in residential aged care.\(^{40}\) The CVS was expanded to include consumers of home care services, and group visits to residential aged care facilities.

2.36 Consumers can be referred to the CVS by their provider, a family member or friend, or can self-identify. Volunteer visitors are matched with aged care recipients in order to improve quality of life, and provide friendship and companionship.\(^ {41}\)

2.37 The CVS services are provided through state and territory organisations, referred to as Auspices, to support the relationships, recruit, train and support volunteer visitors, and also match visitors with volunteers. The Auspices are funded by the Australian Government to recruit and train volunteer visitors, and receive funding for each ‘Active Visitor’, which equals one volunteer attending at least 20 visits per year or equivalent.\(^ {42}\)

2.38 Volunteers who may be concerned about ‘an aspect of a recipient’s care’ are ‘encouraged to seek the advice of their CVS provider’s coordinator’.\(^ {43}\)

2.39 In its report *Elder Abuse—A National Legal Response* (ALRC Report), the Australian Law Reform Commission (ALRC) drew attention to the CVS’s ‘important role in reducing social isolation, which may itself be protective against abuse’.\(^ {44}\)

2.40 The ALRC set out that the CVS does not have detailed national guidelines, with ‘limited guidance about how to respond to concerns about abuse or neglect’. The ALRC Report recommended the development of national CVS


\(^{43}\) Department of Health, *Submission 72*, p. 16.

guidelines which would include policies for volunteer visitors to follow where they become aware of abuse or neglect.45

2.41 The ALRC had canvassed the idea of an Official Visitors Scheme, which would focus on safeguarding aged care consumers by providing independent monitoring of care and to identify abuse or neglect.46 In its report, the ALRC did not to pursue this as a recommendation, instead recommending that focus be put on the development of a serious incident response scheme.

2.42 The Combined Pensioners and Superannuants Association of NSW (CPSA) supported an Official Visitors Scheme, rather than the expansion of the CVS, suggesting that an Official Visitors Scheme provide opportunities for staff and residents to raise concerns to an independent observer.47 Health Care Consumers Australia (HCCA) also supported the introduction of an Official Visitors Scheme, and recommended the model employed in the Australian Capital Territory.48

2.43 Dementia Australia stated that the ‘scope and reach’ of the CVS should be increased to include a role for volunteers in quality monitoring, possibly as part of the accreditation process.49 Similarly, the Council of the Ageing Australia (COTA Australia) supported the ALRC Report’s recommendation to expand the CVS, and suggested that the expansion could include ‘the identification of any issues to the Complaints Commissioner as a third party complaint, or as ‘tip-offs’ about problems with compliance or with accreditation’.50 COTA Australia also stated that it would support an exploration of an Official Visitors Scheme.51

47 Combined Pensioners and Superannuants Association of NSW, Submission 21, p. 8.
48 The ACT has Official Visitors for Children and Young People, Mental Health, Corrections, Disability and Housing (Homelessness). Health Care Consumers Australia, Submission 66, p. 13.
49 Dementia Australia, Submission 7, p. 5.
50 Council of the Ageing Australia, Submission 37, p. 9.
51 Council of the Ageing Australia, Submission 37, pp 9-10.
State Community Visitor Schemes

2.44 Victoria’s Community Visitors Program (CVP) is coordinated by the OPA Victoria, which is a statutory office answerable to the Victorian Parliament. The CVP differs from the Australian Government-funded CVS, in that Victorian community visitors are empowered by law to visit certain facilities, unannounced, to ‘monitor and report on the adequacy of services provided in the interests of residents and patients’.52

2.45 Although the CVP does not visit residential aged care facilities, it monitors the ‘quality of care provided to older people in disability accommodation and mental health in-patient settings’.53 The expansion of the Australian Government CVS to empower visitors to monitor abuse, neglect and social inclusion was proposed by the OPA Victoria.54

2.46 The OPA Victoria contended that the CVP is able to provide ongoing monitoring of facilities, and the identification of issues:

OPA [Victoria] Community Visitors are considered to be the eyes and ears of the community; they represent an important safeguard for all residents, but most importantly for those who do not have family, friends, other representatives or advocates.55

Box 2.1 Case study: Community Visitors Program, Victoria

The OPA Victoria described a situation in which an aged persons’ mental health residential facility had recently passed all 44 accreditation standards.

Members of the CVP and staff at the facility, however, had observed potential failings and prepared complaints on their observations, which included:

- Allegations of patient abuse;
- Poor staff engagement;
- Lack of activities; and

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52 Office of the Public Advocate (Victoria), Submission 35, p. 3.
53 Office of the Public Advocate (Victoria), Submission 35, p. 4.
54 Office of the Public Advocate (Victoria), Submission 35, p. 9.
55 Office of the Public Advocate (Victoria), Submission 35, p. 8.
• Overall low-quality care.

Consequently, the Quality Agency completed a follow-up review and ‘concluded that, contrary to its initial report, eight of the standards were not being met’.\(^{56}\)

Members of the CVP were subsequently involved in two further investigations into the facility, led by the Chief Psychiatrist and Health Network, which resulted in ‘a significant improvement’.\(^ {57}\)

2.47 Queensland also has a CVP in operation for adults with ‘impaired decision-making capacity’, which employs community visitors to make announced and unannounced visits to facilities in order to monitor the quality of service.\(^ {58}\) Community visitors are appointed by the Office of the Public Guardian (Queensland) (OPG Queensland).\(^ {59}\)

2.48 Community visitors under this program may lodge and resolve complaints on behalf of residents, talk with staff and residents, review documentation and programs, and lodge reports with the OPG Queensland.\(^ {60}\)

2.49 The OPG Queensland commented that members of the CVP had raised a number of significant issues which were observed in aged care facilities:

To give you an idea: in any year, my visitors will regularly visit about 1200 sites. Last year, 2016-2017, we made 5224 visits across Queensland and raised 1931 issues. A very large proportion of those related to the personal safety, security, abuse and assault of people in those institutions.\(^ {61}\)

2.50 The expansion of the Australian Government CVS was supported by the Office of the Public Advocate (Queensland).\(^ {62}\)

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\(^ {56}\) Office of the Public Advocate (Victoria), Submission 35, p. 8.

\(^ {57}\) Office of the Public Advocate (Victoria), Submission 35, p. 8.

\(^ {58}\) Office of the Public Guardian, Submission 60, p. 12.


\(^ {60}\) Office of the Public Guardian, Submission 60, p. 12.

\(^ {61}\) Ms Natalie Siegel-Brown, Public Guardian, Office of the Public Guardian Queensland, Official Committee Hansard, Brisbane, 26 April 2018, p. 36.

\(^ {62}\) Office of the Public Advocate (Queensland), Submission 60, p. 12.
Residential Aged Care for Aboriginal and Torres Strait Islander People

2.51 Aged care services (residential and home care services) were delivered to 35,083 Aboriginal and Torres Strait Islander people in 2014–2015, at an estimated cost of $216 million.\(^63\) The Aged Care Act designates Aboriginal and Torres Strait Islander people as a ‘special needs group’, which requires aged care service providers to have regard ‘to the particular physical, physiological, social, spiritual, environmental and other health related care needs of individual recipients’.\(^64\)

2.52 Aboriginal and Torres Strait Islander people make up less than one per cent of people in permanent residential aged care, but access home care and home support in higher numbers.\(^65\)

2.53 Aboriginal and Torres Strait Islander people who are over the age of 50 years are eligible for residential aged care services. Aboriginal and Torres Strait Islander people in aged care are more likely to develop serious medical conditions earlier in life, and Aboriginal and Torres Strait Islander people in residential aged care tend to be younger than non-Indigenous people.\(^66\)

2.54 The Australian Government administers the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program* (Flexible Aged Care Program), which ‘funds organisations to provide culturally appropriate aged care for Aboriginal and Torres Strait Islander people close to their communities’.\(^67\)

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Services delivered under the Flexible Aged Care Program may be residential or home care, and are mainly located in remote and very remote locations.68

2.55 The Flexible Aged Care Program has a set of Quality Standards for service providers, assessed by the Quality Agency. These Quality Standards include ‘two overarching principles’: Continuous Quality Improvement and cultural safety.69

2.56 The Department of Health advised that the Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel provides ‘culturally appropriate local solutions to address the challenges of maintaining and delivering quality aged care services to Aboriginal and Torres Strait Islander communities and people living in remote areas’.70 The Department of Health engages qualified organisations to provide specialist advice and assistance to aged care providers.71

Accreditation and Monitoring

2.57 The Accreditation Standards are set out in Schedule 2 of the Quality of Care Principles. Approved providers have a responsibility to comply with the Accreditation Standards.

2.58 The ongoing assessment of a provider against the Accreditation Standards is conducted by the Quality Agency. Assessment is undertaken on a case management model ‘to ensure targeted contact based on relevant information and compliance history’.72

2.59 Accreditation of a provider includes a self-assessment by the provider, assessment by the Quality Agency, an audit report, a decision on accreditation and the issuing of the certificate as well as publication of the decision.73

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69 Department of Health, Submission 72, p. 26. These Quality Standards will be replaced by the Single Aged Care Quality Framework.

70 Department of Health, Submission 72, p. 19.

71 Department of Health, Submission 72, p. 19.

72 Australian Aged Care Quality Agency, Submission 65, p. 5.

73 Australian Aged Care Quality Agency, Submission 65, p. 6.
2.60 The Quality Agency assesses a provider against the 44 expected outcomes from four categories which make up the Accreditation Standards:

1. Management systems, staffing and organisational development;
2. Health and personal care;
3. Care recipient lifestyle; and
4. Physical environment and safe systems.

**Single Aged Care Quality Framework**

2.61 A Single Aged Care Quality Framework (Single Quality Framework) was introduced in the 2015-2016 Budget, and was developed by the Department of Health and the aged care sector. The Single Quality Framework is expected to take effect from 1 July 2019, with a transition period to enable the sector time to make arrangements already begun.74

2.62 Primarily, the Single Quality Framework will replace four separate sets of Accreditation Standards with one set of aged care standards for aged care services. The Department of Health advised that this will simplify processes for aged care providers who deliver more than one type of care service.75

2.63 The Department of Health advised that the aged care standards will replace the current Accreditation Standards, rather than be a revision, will be ‘far more consumer-outcome focussed’, will be centred on individuals and will begin with ‘I’ statements, such as: ‘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’.76 This will be followed by an organisational statement, on which the aged care provider is tested.

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75 Ms Amy Laffan, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch, Department of Health, *Official Committee Hansard*, Canberra, 24 May 2018, pp 2-3. The four standards currently in operation are: the Accreditation Standards, the Home Care Standards, the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme Quality Framework Standards and the Transition Care Standards. Department of Health, *Submission 72*, p. 22.

Site Audits and Accreditation Decisions

2.64 Site audits are conducted by registered quality assessors with the Quality Agency. During a site audit, an assessment team evaluates the quality of care and services against the 44 total Accreditation Standards. The Accreditation Standards are set out in the Quality of Care Principles.

2.65 Interviews with staff, care recipients, relatives and others are conducted, and observation of the practices of staff and reviews of documents are undertaken. The Quality Agency stated that around 55,000 interviews are conducted each year in residential aged care facilities, which is around ten to 15 per cent of care recipients and family members in assessed facilities.77

2.66 The audit report is compiled by the assessment team, which makes a series of recommendations to a decision-maker. The assessment team does not make the decision on accreditation, and the site visit may be augmented by further documentation provided by the aged care provider, which has:

... an opportunity to provide additional information not available on the day, or perhaps they can inform the decision-maker of additional resources or efforts they might make, and they’re entitled to do that under the principles ... A decision-maker must take that on board.78

2.67 The accreditation audit report is then published to the Quality Agency website, along with accreditation decisions and serious risk decisions.

2.68 The Quality Agency had passed the Makk and McLeay wards of the Oakden aged care facility in South Australia on all 44 Accreditation Standards in March 2016, accrediting it for three years. A second accreditation audit was conducted one year later, which found that the facility passed only 29 of the total 44 Accreditation Standards. The wards were closed in July 2017.

2.69 On 25 October 2017, the Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, stated that announced reaccreditation visits will be replaced with unannounced audits.79 The move to solely unannounced visits follows a recommendation made by the Carnell-Paterson Review.

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77 Mr Nick Ryan, Australian Aged Care Quality Agency, Official Committee Hansard, Sydney, 5 March 2018, p. 36.


Identification of Issues by Agencies

2.70 In the event that an issue is identified during a quality assessment of a residential aged care facility, the Quality Agency sets out ‘specific areas for improvement that are required to ensure that the Standards are complied with, and a timetable for making these improvements’. 80 The Quality Agency then informs the Department of Health, which will undertake ‘a risk-based assessment to determine whether it is appropriate and proportionate to take compliance action in relation to the non-compliance’. 81 The Department of Health advised that:

Where the Quality Agency identifies a failure that has (or may) place the safety, health or well-being of a care recipient of the service at serious risk, the Department is notified as soon as practicable. The Quality Agency liaises closely with the Department when there are concerns about a provider’s performance, including those providers on a Timetable for Improvement. 82

2.71 The Department of Health receives information on non-compliance from the Quality Agency, Complaints Commissioner, prudential compliance statements and members of the public. This information is examined to establish non-compliance and a response, based on the risk to consumers. 83

2.72 The Department of Health can respond with an ‘administrative approach which involves educating the provider’ on responsibilities, and monitoring the provider’s return to compliance, or it may issue a Notice of Non-Compliance, which requires the provider to improve within a set timeframe. 84

2.73 The main objectives of the accreditation system are to ensure the safety of residents, and to ‘help providers get back into compliance’ rather than coming ‘from a position of shutting them down or revoking accreditation’. The Department of Health advised that revoking accreditation is a last step action as it is a ‘bad outcome for the residents involved’. 85

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80 Australian Aged Care Quality Agency, Submission 65, p. 5.
81 Australian Aged Care Quality Agency, Submission 65, p. 5.
82 Department of Health, Submission 72, p. 12.
83 Department of Health, Submission 72, p. 12.
84 Department of Health, Submission 72, p. 13.
85 Ms Catherine Rule, Department of Health, Official Committee Hansard, Canberra, 1 March 2018, p. 3.
2.74 Sanctions may be imposed on a provider that does not return to compliance within the timeframe, such as:

- Ceasing subsidies for new care recipients;
- The appointment of an advisor or administrator to assist the provider to return to compliance; and
- Training of staff and management.86

2.75 Non-compliance with a Notice of Non-Compliance or sanction is recorded on the My Aged Care website and is accessible to the public.

Inquiry Participant Views on Accreditation and Monitoring

2.76 Inquiry participants stated that the current accreditation process is focussed on process, rather than on consumer outcome. The CPSA stated that the Accreditation Standards ‘do not currently consider the care outcomes residents experience. Rather, they consider the organisation’s processes and systems as a proxy for quality care’.87

2.77 Similar sentiments were expressed by the Australian College of Nursing, who agreed that compliance with the Quality Agency’s requirements ‘does not equate to improved resident outcomes’.88 The Australian College of Nursing further stated that ‘compliance requires key staff to be dedicated to documentation and audits to provide evidence of care rather than actually delivering the care’.89 The Health Services Union asserted that the ‘accreditation framework is disadvantageous to the provision of optimal resident care outcomes’, and has an ‘emphasis on self-regulation and reducing regulatory burden’ instead of the promotion of quality care.90

2.78 Dementia Australia outlined the view that the accreditation process does not deliver useful information or insight to consumers, stating that:

> From a consumer perspective, the accreditation process has served to reassure consumers that, over time, there will be consequences for aged care providers offering unacceptable levels of care. However, the [Accreditation] Standards only establish the minimum acceptable level of service for accreditation, rather

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86 Department of Health, Submission 72, p. 13.
87 Combined Pensioners and Superannuants Association of NSW, Submission 21, p. 6.
88 Australian College of Nursing, Submission 57, p. 10.
89 Australian College of Nursing, Submission 57, p. 10.
90 Health Services Union, Submission 92, p. 11.
than providing any insight or guidance into whether a provider is delivering high quality care.91

2.79 The Community and Public Sector Union (CPSU) stated that recent changes at the Quality Agency were ‘impacting on the ability of front line staff to assess compliance in a manner that is strongly focused on resident protection and well-being’.92 The CPSU identified the following areas of concern:

 The failure to monitor the effectiveness of the Computer Assisted Assessment Tool (CAAT) and the Consumer Experience Report (CER);
 Concerns of frontline staff not being addressed or remedied;
 Poor scheduling and planning of assessment visits, increased workloads and stretched capacity to undertake the assessment to the standard needed; and
 A failure to engage with the right staff across the Quality Agency.93

2.80 A stronger focus on the role of the consumer, and hearing consumer voices, in the accreditation process was recommended by the Victorian Council of Social Service (VCOSS), which recommended that the number of audit-related interviews be increased and more widely publicised for residents and their families. The VCOSS also recommended that the Quality Agency undertake audit-related interviews out of business hours, or remotely, and provide alternative interview models for those facing communication barriers, stating that ‘residents and families are often not made aware that accreditation processes are taking place, or provided opportunity to participate’.94

2.81 The accessibility of the information contained in accreditation reports was questioned by Dementia Australia, which asserted that the assessment against the 44 Accreditation Standards:

… does not provide more nuanced information on meaningful, consumer relevant outcomes and this makes it difficult for consumers to ascertain

91 Dementia Australia, Submission 7, p. 12.
92 Community and Public Sector Union, Submission 59, p. 2.
93 Community and Public Sector Union, Submission 59, p. 2.
whether the provider is delivering high quality care or just passing the minimum standards for accreditation.95

2.82 The OPAN stated that there is an opportunity for its network of advocacy services to be involved in the accreditation process, and stated that there is no formal mechanism for the Quality Agency to speak with advocates or advocacy services about their experiences with a facility.96

2.83 The Queensland Nurses and Midwives’ Union (QNMU) compared the aged care quality standards with the standards used in the acute health sector, stating that ‘there seems little comparison between accreditation processes accepted as the norm in other health care sectors and those undertaken by the Quality Agency for the aged care sector’.97

2.84 Ms Fiona Duff put forward the view that the Quality Agency does not have the right approach, and stated that the Quality Agency focuses on a ‘facility’s successes rather than a facility’s deficiencies. But the deficiencies are what are putting our aged at risk’.98

2.85 In contrast, Estia Health expressed the view that the Quality Agency focuses too much on identifying non-compliance:

The focus by the [Quality] Agency on non-conformance tends to move their thinking away from the balance of quality improvement looking at the inherent robustness or weaknesses of the systems that support care and service delivery into a focus on that which has failed.99

2.86 The Aged Care Industry Association also suggested a focus on ‘positive outcomes for residents rather than regulatory responses’.100

Unannounced Visits

2.87 Until recently, residential aged care facilities received one unannounced contact visit per year, with other visits announced in advance. Unannounced visits also occurred on receipt of a high risk referral.101

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95 Dementia Australia, Submission 7, p. 20.
96 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 14.
97 Queensland Nurses and Midwives’ Union, Submission 44, p. 8.
98 Ms Fiona Duff, Submission 34, p. 2.
99 Estia Health, Submission 84, p. 8.
100 Aged Care Industry Association, Submission 83, p. 3.
2.88 Under recent changes, resulting from recommendations from the Carnell-Paterson Review, announced visits have begun to be replaced with unannounced audits. Initial accreditation audits will continue to be conducted in consultation with the aged care provider, with subsequent re-accreditation reviews to be replaced by unannounced audits.102

2.89 The Quality Agency set out that unannounced re-accreditation audits will apply ‘to all applications for re-accreditation from 1 July 2018 and to residential aged care services with an accreditation expiry date on or after 1 January 2019’.103

2.90 A number of inquiry participants asserted that announced visits had been inadequate, with a number stating that providers had prepared facilities in order to pass the accreditation and re-accreditation process.104

2.91 Support for a change to unannounced visits to aged care facilities was expressed by Mrs Rosaleen Appelhans, who stated that it might ‘sharpen up providers’.105 Mrs Yvonne Buters stated that the move to unannounced visits is ‘essential’.106

2.92 Catholic Health Australia supported the introduction of solely unannounced visits, as did the COTA Australia and the Australian Nursing and Midwifery Federation.107 The COTA Australia also requested further information on how this would be implemented.108

101 Australian Aged Care Quality Agency, Submission 65, p. 10.


104 Name Withheld, Submission 58, p. 1; National Council of Women of Australia, Submission 62, p. 3; Vintage Reds of the Canberra Region, Submission 63, p. 21; Health Care Consumers Australia, Submission 66, p. 7; G W Hitchen, Submission 94, p. 17.

105 Mrs Rosaleen Appelhans, Submission 5, p. 1.

106 Mrs Yvonne Buters, Submission 24, p. 6.

107 Catholic Health Australia, Submission 17, p. 4; Council of the Ageing Australia, Submission 37, p. 7; Australian Nursing and Midwifery Federation, Submission 53, p. 24.

108 Council of the Ageing Australia, Submission 37, p. 7.
2.93 On the other hand, the Aged Care Industry Association stated that it had not seen ‘definitive evidence supporting the effectiveness of unannounced visits as a quality assurance tool’. Aged Care Crisis similarly stated that unannounced visits ‘resulted in only minor benefit’, citing Quality Agency data that only ten per cent of Findings of Failure and Serious Risk Decisions over a three year period to 2018 had come from unannounced visits.

2.94 Aged Care Matters called for the publication of reports from unannounced visits, stating that the reports ‘would enable consumers to make informed choices when selecting an aged care home’.

**Staffing of Residential Aged Care Facilities**

2.95 The Department of Health advised that the legislative requirements for staffing of residential aged care facilities are left to the determination of aged care providers:

> Approved providers are required to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met. They also have an obligation to ensure that police certificates, not more than three years old, are held by all staff members who are reasonably likely to have access to care recipients, whether supervised or unsupervised, and volunteers who have unsupervised access to care recipients.

2.96 The Department of Health commissioned the *National Aged Care Workforce Census and Survey* (the Workforce Survey) in 2016, which received responses from more than 15,000 aged care workers from 4,500 facilities. The Workforce Survey found that the ‘overall staffing ratios and the proportion of RNs in the residential sector [has] remained constant since 2012’.

2.97 The number of Registered Nurses (RNs) and Nurse Practitioners (NPs) had increased between 2012 and 2016, but the number of Enrolled Nurses (ENs) had decreased:

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110 Aged Care Crisis, *Submission 90*, p. 27, p. 34.
Table 2.1  Direct Care Employees in the Residential Aged Care Workforce

<table>
<thead>
<tr>
<th>Occupation</th>
<th>2012</th>
<th>2016</th>
<th>Increase/decrease</th>
<th>Percentage increase/decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner (NP)</td>
<td>294</td>
<td>386</td>
<td>+ 92</td>
<td>31.3</td>
</tr>
<tr>
<td>Registered Nurse (RN)</td>
<td>21 916</td>
<td>22 455</td>
<td>+ 539</td>
<td>2.5</td>
</tr>
<tr>
<td>Enrolled Nurse (EN)</td>
<td>16 915</td>
<td>15 697</td>
<td>- 1,218</td>
<td>-7.2</td>
</tr>
<tr>
<td>Personal Care Attendant (PCA)</td>
<td>100 312</td>
<td>108 126</td>
<td>+ 7,814</td>
<td>7.8</td>
</tr>
<tr>
<td>Allied Health Professional (AH)</td>
<td>2648</td>
<td>2210</td>
<td>- 438</td>
<td>-16.5</td>
</tr>
<tr>
<td>Allied Health Assistant (AHA)</td>
<td>5001</td>
<td>4979</td>
<td>- 22</td>
<td>-0.4</td>
</tr>
</tbody>
</table>


2.98 The Workforce Survey also reported, however, that there had been a decrease in the number of RNs, from 24 019 in 2003 to 22 455 in 2016 (6.5 per cent). Inquiry participants drew attention to the longer-term decline in numbers of RNs.

2.99 The average size of residential aged care facilities has remained constant between 2012 and 2016, with an average ratio of direct care workers\(^\text{116}\) to residential aged care places at 0.77 in 2012 and 0.78 in 2016.\(^\text{117}\) The Workforce Survey also stated that negative perceptions of aged care work as having


\(^{116}\) Direct Care workers provide care directly to care recipients as a core component of their work; includes: Nurse Practitioner, Registered Nurse, Enrolled Nurse, Community Care Worker, Allied Health Professional, Allied Health Assistant. Department of Health, *The Aged Care Workforce 2016*, p. xiv.

\(^{117}\) Department of Health, *Submission 72 Supplementary Submission 3*, p. 2.
low pay and status remain, and that ‘given the need for the expansion of the aged care workforce, this issue must be addressed’.

2.100 Productivity Commission reports in 2013 and 2018 outlined that the number of people receiving residential aged care services increased from 269,269 people in 2011-2012 to 298,607 in 2016-2017.

2.101 The care needs of people in residential aged care have also shifted over time. Table 2.2 outlines data on care needs from the Australian Institute of Health and Welfare.

Table 2.2 Care need ratings of people in residential aged care, across all care domains (per cent)

<table>
<thead>
<tr>
<th>Year</th>
<th>Nil</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>14.4</td>
<td>30.9</td>
<td>27.1</td>
<td>27.7</td>
</tr>
<tr>
<td>2012</td>
<td>6.3</td>
<td>22.5</td>
<td>29</td>
<td>42.2</td>
</tr>
<tr>
<td>2016</td>
<td>2.7</td>
<td>12.6</td>
<td>24.8</td>
<td>59.9</td>
</tr>
<tr>
<td>2017</td>
<td>2.2</td>
<td>12.9</td>
<td>26.7</td>
<td>58.1</td>
</tr>
</tbody>
</table>


Inquiry Participant Views on Staffing

2.102 The important role of trained staff in the delivery of high quality care was raised by G W Hitchen, who highlighted the vulnerability of some people receiving care:


120 ‘The ACFI has three funding categories or domains: Activities of Daily Living (ADL), Behaviour (BEH) and Complex Health Care (CHC). Funding in each of these domains is provided at the following levels: High (H), Medium (M), Low (L) and Nil (N),’ assigned based on scores from 12 care need questions.’ Department of Health, ‘Aged Care Funding Instrument (ACFI) Reports, [https://agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports](https://agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports), Accessed 8 October 2018.
Any resident who actually requires high care is in a very risky situation. His or her care depends entirely on who is on a particular shift – as always, it is all about the people. You cannot have good aged care with bad people, just as you cannot have good hospital care without good staff.\textsuperscript{121}

2.103 Dementia Australia observed a ‘trend towards employing less skilled (and [to a] lower cost [to the employer]) staff in residential settings in the delivery of direct care services’, stating that this trend was occurring while the acuity of care required is increasing.\textsuperscript{122} The Australian College of Nursing also stated that ‘increasingly business models are being deployed where nurses are being utilised only for 'legislative requirements', with Assistants in Nursing (AINs) … fulfilling most of the traditional care elements’.\textsuperscript{123}

2.104 The challenging role of RNs in aged care was raised by the Australian Nursing and Midwifery Federation (ANMF), which stated that RNs possess the training and skills to deliver quality care, and that this role is undermined by current staffing conditions and skill levels. The ANMF stated that RNs are:

\begin{quote}
… educationally prepared to assess and instigate or delegate appropriate care, and to monitor for, and identify, where mistreatment might be occurring. However, current staffing conditions, in terms of staffing numbers and levels of qualified staff, are undermining their role as clinical leaders within aged care.\textsuperscript{124}
\end{quote}

2.105 The New South Wales Nurses and Midwives’ Association (NSW NMA) highlighted that professional duties to report issues which apply to RNs do not apply to ‘unlicensed Assistants in Nursing/Care workers’ who ‘provide the most direct care to residents’.\textsuperscript{125}

2.106 A decrease in the employment of RNs, facilities with no nursing staff after hours, and a high turnover of staff were identified as major workforce issues by the Australian Medical Association (AMA).\textsuperscript{126}

\textsuperscript{121} G W Hitchen, \textit{Submission 94}, p. 2.

\textsuperscript{122} Dementia Australia, \textit{Submission 7}, p. 33.

\textsuperscript{123} Australian College of Nursing, \textit{Submission 57}, p. 3.

\textsuperscript{124} Australian Nursing and Midwifery Federation, \textit{Submission 53}, p. 11.

\textsuperscript{125} NSW Nurses and Midwives’ Association, \textit{Submission 6}, p. 12.

\textsuperscript{126} Australian Medical Association, \textit{Submission 23}, p. 8.
2.107 Palliative Care SA stated that staffing shortages lead to higher workloads for remaining staff, who may not have the experience or skills to carry out the work:

   Inadequate worker-resident ratios and the inadequate level of registered nurses employed across all shifts in residential and community aged care means that too many times evidence and best practice are submerged under the sheer volume of work expected of staff who are paid the least and without the skills and ongoing training provided and required.\(^{127}\)

2.108 The QNMU stated its belief that unintentional neglect ‘stems primarily from the continuing and systemic deskilling of the aged care workforce and decreasing levels of care (both in terms of the skill of those providing the care and the hours of care provided)’.\(^{128}\) The QNMU identified the consequences of inadequate quality and quantity of care:

   - Increased fall rates;
   - Increased resident-on-resident harm;
   - Higher rates of pressure injuries;
   - Resident weight loss and nutritional deficits; and
   - Medication errors at higher rates.\(^{129}\)

2.109 Mrs Betty Tuohy described the effect of gaps in available staffing, stating that, in her husband’s facility, staff who are unavailable for work are not replaced.\(^{130}\) Mrs Tuohy stated that her husband, who has dementia, has left the facility three times: ‘The first two times, they didn’t know he was missing. I put all this down to lack of staff, not enough staff to really know what is happening with them.’\(^{131}\)

2.110 An inquiry participant described the effect that low staffing levels can have on the workforce:

   Over decades of visiting family and friends in aged care facilities, it is my observation that poor practices/ inadequate staffing levels contribute to workplace stress and this feeds directly into frustration, fatigue, impatience,

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\(^{127}\) Mrs Tracey Watters, Chief Executive Officer, Palliative Care SA, *Official Committee Hansard*, Adelaide, 15 March 2018, p. 10.

\(^{128}\) Queensland Nurses and Midwives’ Union, *Submission 44*, p. 6.

\(^{129}\) Queensland Nurses and Midwives’ Union, *Submission 44*, pp 6-7.

\(^{130}\) Mrs Betty Tuohy, Consumer Representative, Dementia Australia, *Official Committee Hansard*, Canberra, 11 May 2018, p. 29.

\(^{131}\) Mrs Betty Tuohy, Dementia Australia, *Official Committee Hansard*, Canberra, 11 May 2018, p. 29.
rough physical handling, sometimes to physical mistreatment and abuse that may be mental or physical or both.132

2.111 Another inquiry participant described their experience as an aged care consumer, stating that although many carers ‘do the best they can … the help mostly does not eventuate. This means that you have to continually keep asking, especially if you need the toilet, and your needs can get desperate at times’.133

**Minimum Staffing Levels and Staffing Ratios**

2.112 The ANMF stated that ‘the current level of staffing is inadequate to provide for the needs of Australians living in residential aged care facilities’, with missed care a common result of lower staffing numbers.134 A survey conducted by the NSW NMA and the ANMF in 2016 found that a higher proportion of low skilled staff ‘was a common factor in situations where resident to resident abuse occurred, and, that inadequate staff numbers overall [were] a precursor to elder abuse’.135 A ratio of one RN for 60 to 100 residents, with the potential for the RN to be on call rather than on site, was described as ‘inappropriate’.136

2.113 Minimum staffing levels and/or a mix of staffing skills were recommended by members of the medical profession. The NSW NMA stated that ‘the provision of safe staffing ratios and skills mix in aged care [is] intrinsically linked to safety and protection against abusive practices’.137 The Australian College of Nursing recommended a minimum requirement for an RN to be on site and available at all times,138 and the AMA recommended that the Accreditation Standards ‘should demonstrate a ratio of suitably trained nurses to patients at any one time’.139

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133 Name Withheld, *Submission 18*, p. 5.
135 Australian Nursing and Midwifery Federation, *Submission 53*, p. 6.
137 NSW Nurses and Midwives’ Association, *Submission 6*, p. 4.
138 Australian College of Nursing, *Submission 57*, p. 3.
2.114 The ANMF stated that on average, residents receive 2.84 hours of care per day, and recommended that this be increased to an average 4 hours and 18 minutes per day, with a skills mix of:

- RNs – 30 per cent;
- Enrolled Nurses (ENs) – 20 per cent; and
- Personal Care Workers – 50 per cent.\(^\text{140}\)

2.115 The HCCA recommended an improved ratio of skilled staff to residents, and stated that a reduced staff to resident ratio ‘contributes to a systemic environment conducive to mistreatment of residents’.\(^\text{141}\)

2.116 On the other hand, aged care providers did not agree that mandated minimum staffing levels, or a mandated skills mix, would be appropriate. UnitingCare Queensland stated that although the concept of mandated staff ratios ‘has been discussed for many years, there seems to be no substantive evidence that they achieve better quality outcomes for residents’.\(^\text{142}\)

2.117 UnitingCare Queensland suggested that it is ‘incumbent upon providers … to apply flexible staffing models’ that will be appropriate for each individual facility, given the ‘regularly changing occupancy levels and changing needs of residents’.\(^\text{143}\)

2.118 Leading Age Services Australia (LASA) described staffing ratios as a ‘blunt instrument’ that does not allow the provider staffing flexibility.\(^\text{144}\) Similarly, Aged and Community Services Australia (ACSA) stated that mandated ratios do not take into account different models of care, and may limit the ability of providers to be innovative in their care model.\(^\text{145}\)

2.119 Estia Health stated that the layout of an aged care facility can make a difference to staffing requirements, and that an aged care facility built in

\(^{140}\) Australian Nursing and Midwifery Federation, Submission 53, pp 9-10.

\(^{141}\) Health Care Consumers’ Association, Submission 66, p. 5.

\(^{142}\) Ms Cathy Thomas, Group Executive, Blue Care, South East Queensland, UnitingCare Queensland, Official Committee Hansard, Brisbane, 26 April 2018, p. 25.

\(^{143}\) Ms Cathy Thomas, UnitingCare Queensland, Official Committee Hansard, Brisbane, 26 April 2018, p. 25.

\(^{144}\) Mr Robert Orie, Deputy Chairperson, Leading Age Services Australia, Official Committee Hansard, Canberra, 11 May 2018, p. 22.

\(^{145}\) Ms Patricia Sparrow, Chief Executive Officer, Aged and Community Services Australia, Official Committee Hansard, Canberra, 11 May 2018, p. 56.
wings would require more staff than a facility where all of the residents are on the same floor.\textsuperscript{146}

2.120 Resthaven suggested that the level of staffing in facilities is reflective of available ACFI funding, and stated that an increase in staffing availability would require an increase in funding:

The proposal to lift staff ratios to an average of 4.3 hours/day per resident is of enormous significance in the context of the current and historical resourcing of residential aged care services. A move to 4.3 hours per resident per day as a minimum would suggest increasing government funding through the ACFI in the order of 50 per cent if we move current average ratios levels to this requirement.\textsuperscript{147}

\section*{Efficacy of the Current System}

2.121 Inquiry participants expressed strong concerns at the overall efficacy of the current system, stating frustration at the complexity and utility of the current delivery of aged care.

\section*{Relationship Between Agencies}

2.122 The QNMU characterised the shared regulatory environment for the delivery of aged care as ‘complex, and apparently fragmented’.\textsuperscript{148} Similarly, the Vintage Reds of the Canberra Region stated that the way in which agencies refer complaints to one another has a ‘circular nature’.\textsuperscript{149}

2.123 Aged care providers Estia Health and HammondCare raised concerns over duplication of services between the Quality Agency and the Complaints Commissioner.\textsuperscript{150}

2.124 The Law Council of Australia recommended a ‘comprehensive review of the aged care sector’, and stated that there ‘are often a lack of structures to support coordination and information sharing between these agencies’.\textsuperscript{151}

\textsuperscript{146} Mark Brandon, Chief Policy and Regulatory Officer, Estia Health, \textit{Official Committee Hansard}, Canberra, 11 May 2018, p. 48.

\textsuperscript{147} Resthaven, \textit{Submission 100}, p. 1.

\textsuperscript{148} Queensland Nurses and Midwives’ Union, \textit{Submission 44}, p. 5.

\textsuperscript{149} Vintage Reds of the Canberra Region, \textit{Submission 63}, p. 2.

2.125 Mrs Kate Mannix expressed the view that ‘from the perspective of the family, our interest is rather less in ‘improving the system’ for some time in the future, but in getting real care for our frail aged parent now’.\textsuperscript{152}

2.126 Family members of residents raised concerns over the roles of the agencies involved in the accreditation and complaints process, and confusion at the separation of responsibilities. Ms Fiona Duff expressed frustration at the separate nature of the agencies:

> I initially called the [Quality] Agency to be told they don’t deal with the public and the only recommendations they would accept are ones that are deemed by the [Complaints Commissioner]. They did not want to know about our issue even though it related to a standard they initially failed the home on in the last accreditation.\textsuperscript{153}

2.127 Similar sentiments were expressed by Ms Denise Newton, who described her experience during the interview process which occurs during accreditation audits undertaken by the Quality Agency. Ms Newton stated that documents she had prepared relating to her concerns were not accepted by the assessors. In Ms Newton’s view, her concerns were representative of wider issues within the facility.\textsuperscript{154} Other inquiry participants indicated that they had compiled information to provide during the accreditation process but which was not accepted, being told that the Quality Agency is ‘not a complaints department’.\textsuperscript{155}

2.128 In contrast, the Quality Agency advised that it can receive information from members of the public at any time, independent of the Complaints Commissioner, although this information is used to inform a view of the system. The Quality Agency clarified its role in the complaints process, stating that it is a ‘systems regulator and a systems assessor’, which looks for ‘clear evidence of that system working’, while the Complaints Commissioner assesses individual complaints.\textsuperscript{156}

\textsuperscript{151} Law Council of Australia, \textit{Submission 86}, p. 8.

\textsuperscript{152} Mrs Kate Mannix, \textit{Submission 12}, p. 6.

\textsuperscript{153} Ms Fiona Duff, \textit{Submission 34}, p. 3.

\textsuperscript{154} Ms Denise Newton, \textit{Submission 56}, p. 1.

\textsuperscript{155} Name Withheld, \textit{Submission 69}, p. 3; Mr David Gavin, \textit{Submission 80 Attachment 1}, p. 1.

\textsuperscript{156} Mr Nick Ryan, Australian Aged Care Quality Agency, \textit{Official Committee Hansard}, Sydney, 5 March 2018, p. 36.
Complexity of the Current System

2.129 Estia Health expressed the view that the language used by the Complaints Commissioner ‘tends to be legalistic’, and stated that:

… the current complaints processes tend to be cumbersome, built on the exchange of correspondence and sometimes continue over a long period. We accept the Commissioner’s report that 74 per cent of complaints are resolved in 30 days. It is the other quarter that are problematic.157

2.130 The Law Council of Australia suggested that the Complaints Commissioner ‘is not considered accessible or user-friendly by many residents and their representatives, but rather as protracted and bureaucratic’, and further suggested that existing consumer protections under the aged care legislative framework are ‘confusing and inadequate’.158

2.131 The complexity of the aged care system was also highlighted by Dementia Australia, the QNMU and the Federation of Ethnic Communities’ Councils of Australia.159

2.132 The Department of Health acknowledged that the aged care system is complex, but stated that ‘while complex, Australia’s current regulatory system aligns well with some accepted best-practice regulatory principles’.160 The Department of Health stated that ‘there are areas that can be improved to ensure that the system consistently provides the assurance of quality that the community needs and expects’.161

Aged Care Funding Instrument

2.133 Funding for aged care resources is assessed for individual consumers and delivered, via the ACFI, to the residential aged care facility as the financial entity providing care.162 The ACFI subsidises three ‘domains’ of residential care: activities of daily living, behaviour and complex health care.

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157 Estia Health, Submission 84, p. 8.
159 Dementia Australia, Submission 7, p. 16; Queensland Nurses and Midwives’ Union, Submission 44, p. 15; Federation of Ethnic Communities’ Councils of Australia, Submission 50, p. 2.
160 Department of Health, Submission 72, p. 5.
161 Department of Health, Submission 72, p. 5.
2.134 General Practitioners (GPs) working for New Aged Care described feeling pressured by provider staff into signing ACFI forms which provided no clinical information on how bruises or skin tears were sustained, and which may have had inappropriate diagnoses of dementia.\textsuperscript{163} New Aged Care stated that GPs were told that if they did not sign the form, a replacement GP would be found who would.\textsuperscript{164}

2.135 Inquiry participants stated that the funding provided through the ACFI, and the model itself, was insufficient for the requirements of a modern aged care consumer.\textsuperscript{165} The Australian Physiotherapy Association stated that the ACFI model is not ‘fit for purpose’ and is not able to deliver the best quality care model:

At present, the ACFI funding model is prescriptive and has incentives to practise in ways that are contrary to the best available evidence and quality care. It channels funding to passive treatments to manage pain, rather than to models that include the prevention or slowing of functional decline, and importantly early detection of mistreatment.\textsuperscript{166}

2.136 Similarly, LASA highlighted issues with the ACFI model, stating that the current operation of the ACFI means that consumers with dementia are ‘not being considered for admission to residential care’:

The 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.\textsuperscript{167}

2.137 The QNMU agreed, stating that the ACFI ‘has significantly outlived its usefulness and urgently needs to be replaced by a sustainable alternative’, and instead recommended an ‘activity based funding model’.\textsuperscript{168}

\textsuperscript{163} New Aged Care, \textit{Submission 70}, p. 7.

\textsuperscript{164} New Aged Care, \textit{Submission 70}, pp 7-8.

\textsuperscript{165} Leading Age Services Australia, \textit{Submission 29}, p. 7; Queensland Nurses and Midwives’ Union, \textit{Submission 44}, p. 5.

\textsuperscript{166} Australian Physiotherapy Association, \textit{Submission 45}, p. 12.

\textsuperscript{167} Leading Age Services Australia, \textit{Submission 29}, p. 7.

\textsuperscript{168} Queensland Nurses and Midwives’ Union, \textit{Submission 44}, p. 5.
2.138 The VCOSS stated that there was no incentive to help consumers’ conditions improve, and asserted that consumers requiring a higher level of care would attract more funding for the provider.169

2.139 Aged care providers stated that the ACFI amount allocated per consumer is too low. Catholic Health Australia stated that this limited the capacity of providers to ‘deliver the staffing levels and skills mix often expected by relatives’.170 The Aged Care Industry Association stated that the ACFI amount allocated to each resident had been ‘revised several times in recent years to reduce growth in funding per resident’.171

2.140 A potential link between decreased funding and a lowering of service quality was raised by United Voice, which stated that a ‘decrease in funding to aged care providers can … not be discounted in considerations of quality’.172 Estia Health also stated that the:

... inadequacy of subsidy levels must never be acceptable as an excuse for quality failure. However, we cannot fail to note that the failure to increase subsidies in line with cost growth and increasing resident acuity has created financial tensions for some providers.173

2.141 Resthaven agreed that ACFI funding was too low, stating that ‘in the current financial year there was zero indexation of ACFI and there is proposed continued reduced indexation’ in 2018-2019.174

2.142 The Australian College of Nursing described the ‘laborious’ amount of work required to be undertaken for care plans, which it characterised as ‘not read other than by the [Quality] Agency’:

The staff hours required to generate such detailed assessments are not recouped in the funding, nor does it improve the quality of care provided to the resident. Such care plans and audit documents have little tangible advantage to the staff who are providing direct care to the residents.175


170 Catholic Health Australia, Submission 17, p. 5.

171 Aged Care Industry Association, Submission 83, p. 3.

172 United Voice, Submission 22, p. 5.

173 Estia Health, Submission 84, p. 5.

174 Resthaven, Submission 100, p. 1.

175 Australian College of Nursing, Submission 57, p. 10.
2.143 The Department of Health stated that work on the funding model for aged care services is currently underway, and that ‘moving away from ACFI, given that the business models are all built around ACFI, is a key consideration’.\(^\text{176}\)

2.144 A Resource Utilisation and Classification Study (RUCS) is being undertaken by the Department of Health to examine the ‘clinical and need characteristics’ of aged care consumers which may influence the cost of care and how those costs are spread. The RUCS is ‘a recognition that we need to examine more contemporary ways of looking at the needs of care recipients and how they are funded by government’.\(^\text{177}\)

**Compensation and Civil Accountability**

2.145 Elderlaw stated that the Aged Care Act ‘expressly disallows any legal consequences arising from a breach of the [Aged Care] Act, whether civil or otherwise’, except for the consequences for breach set out in the Aged Care Act.\(^\text{178}\)

2.146 A breach of the Aged Care Act may result in sanctions on the aged care provider.\(^\text{179}\) Elderlaw asserted that ‘an individual case of harm is unlikely to warrant the Secretary [of the Department of Health] to impose sanctions’, and questioned the utility of the complaints format in the event of mistreatment.\(^\text{180}\) Elderlaw stated that:

\[\ldots\] the aged care system offers only advice about complaints. There is no redress for the individual, no improvement of the level of attention to their health needs, no overt recognition of harm and causation.\(^\text{181}\)

2.147 Elderlaw put forward the view that ‘at the moment, under this system, there are no consequences’ for serious harm, and suggested the introduction of

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\(^\text{176}\) Mr Jaye Smith, First Assistant Secretary, Residential and Flexible Aged Care Division, Department of Health, *Official Committee Hansard*, Canberra, 24 May 2018, p. 5.


\(^\text{178}\) Elderlaw, *Submission 15*, p. 4.

\(^\text{179}\) Non-compliance with parts 4.1, 4.2 or 4.3 of the Aged Care Act may result in a sanction. S 64-1, *Aged Care Act 1997*.

\(^\text{180}\) Elderlaw, *Submission 15*, p. 5.

legislation on elder justice which would allow a civil or criminal route to be taken.\textsuperscript{182}

2.148 The National Association of Community Legal Centres (NACLC) stated that the rights of residents who do not own their dwelling, such as tenants, are protected through legislation. The NACLC suggested that similar rights should apply to residents of aged care facilities, which would provide a ‘forum for individual civil enforcement’ of the principles in the Aged Care Act.\textsuperscript{183}

2.149 GW Hitchen observed that, in the United States of America, multimillion dollar damages have been awarded for pain and suffering caused by aged care facilities.\textsuperscript{184}

New Aged Care Quality and Safety Commission

2.150 A new Aged Care Quality and Safety Commission (Commission) will start on 1 January 2019 and bring together the functions of the Quality Agency and Complaints Commissioner, with the aged care functions of the Department of Health to join the Commission from 2020.\textsuperscript{185}

2.151 The Commission has been proposed to respond to the Carnell-Paterson Review into failures at South Australia’s Oakden facility. That report found that the current aged care regulatory framework is fragmented, and not able to provide a level of assurance in line with community expectation.

2.152 The Commission will establish a Chief Clinical Advisor, who will provide advice to the Commission on complex clinical matters.

2.153 Additional quality reforms that have been announced include:

- Developing options for a serious incident response scheme;
- A performance rating against quality standards; and

\textsuperscript{182} Mr Rodney Lewis, Senior Solicitor, Elderlaw, \textit{Official Committee Hansard}, Sydney, 5 March 2018, p. 7, 11.

\textsuperscript{183} National Association of Community Legal Centres, \textit{Submission 91}, p. 5.


\textsuperscript{185} The Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, ‘Powerful New Reforms to Ensure Safe, Quality Aged Care’, \textit{Media Release}, 18 April 2018; Ms Maria Jolly, First Assistant Secretary, Aged Care Reform Taskforce, Department of Health, \textit{Official Committee Hansard}, Canberra, 24 May 2018, p. 1.
A provider comparison tool on the *My Aged Care* website.\textsuperscript{186}

2.154 The Department of Health stated that the Commission will differ from the model put forward by the Carnell-Paterson Review by appointing ‘a single commissioner with a clinical care advisory structure to support that commissioner’ instead of appointing several commissioners, as recommended.\textsuperscript{187}

**Concluding Comment**

**Community Visitors Scheme**

2.155 The Australian Government-funded Community Visitors Scheme (CVS) has provided significant comfort to isolated older Australians in residential aged care. The Committee considers that this is an under-used resource, and could be harnessed to provide a voice for residents who are unsure about raising issues of quality of care.

2.156 There is currently limited guidance for CVS volunteers on how to respond to allegations or suspicions of mistreatment, with volunteer visitors advised to seek the advice of the provider’s coordinator. A consistent, national approach could strengthen the role of the CVS in residential aged care.

**Accreditation and Monitoring**

2.157 A number of inquiry participants described the current accreditation process for residential aged care facilities as being inaccessible, having the wrong approach and being too focussed on the provider.

2.158 The Committee agrees that the current Accreditation Standards, published on the Quality Agency’s website for each aged care facility, do not allow a consumer to know if a provider is delivering high quality care, or passing minimum standards.

2.159 Recent changes to the accreditation and monitoring process, including a move to unannounced visits and a reframing of the Accreditation Standards, may assist the Australian Aged Care Quality Agency (Quality Agency) to determine a more accurate view of the quality of care delivered in a residential aged care facility.

\textsuperscript{186} The Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, ‘Powerful New Reforms to Ensure Safe, Quality Aged Care’, *Media Release*, 18 April 2018.

Efficacy of the Current System

2.160 This Committee, along with the many inquiries before it, has heard evidence which points to significant failings in the effectiveness of the federal government regulatory agencies in preventing the mistreatment or provision of poor care of individuals in residential aged care. This was most dramatically exposed at Oakden, where a facility (now closed because of its failings) passed the accreditation process.

2.161 The Committee is concerned that consumers are facing complex bureaucracy and an onerous administrative system during periods of stress and transition as they care for loved ones in aged care facilities. Many consumers indicated to the Committee their frustration navigating the existing mechanisms for interacting with the bureaucracy, including concerns about the complexity of the My Aged Care website and the responsiveness of information services.

2.162 A number of inquiry participants described frustration and confusion at the separation of the Australian Government agencies responsible for the delivery of aged care.

2.163 There are significant reforms to the aged care system underway, including the new Aged Care Quality and Safety Commission (Commission), consumer-oriented Accreditation Standards for residential aged care facilities, a move to solely unannounced visits to residential aged care facilities and the development of a new Charter of care recipients’ rights and responsibilities – residential care.

2.164 The Committee supports the creation of the Commission as an important reform to reduce the existing complexity and lack of clarity in relation to responsibilities inherent in the current system. The Committee considers that the establishment of the new Commission may ameliorate many of the concerns put forward by those inquiry participants who raised concerns about the separation of the agencies, and the lack of communication between them.

Staffing

2.165 Staffing levels and mixes in residential aged care facilities are not set out in Australian Government legislation, which leaves it to the provider to determine the most effective staffing system. The issue of staffing levels is
complex, and will require a balance between provider flexibility and ensuring minimum safety standards.

2.166 The Committee notes that workforce data indicates an increase in the number of Registered Nurses (RNs) employed in the aged care sector over the last five years. However the Committee also notes that the number of residents in aged care has increased, as has their acuity. The trend has over the past 15 years shown a reduction in the number of RNs.\textsuperscript{188}

2.167 The Committee also received evidence that there are barriers to patients receiving timely access to general practitioners and allied health professionals in aged care facilities, and that this may have led to an increased rate of hospitalisation and a delay in the provision of quality care. The Australian Medical Association stated that it had surveyed its members who visit aged-care facilities, and that one in three respondents intended not to take on new patients, not increase the number of visits, or stop aged care visits entirely in the next two years.\textsuperscript{189}

2.168 Many inquiry participants expressed a desire for minimum staffing levels in aged care facilities, or a mix of skills, to ensure that a consistent standard of care can be delivered at all times.

2.169 A trend towards RNs being expected to provide care for increasingly large numbers of residents as they are replaced with less qualified carers has emerged in recent years. The potential consequences of such changes are missed care, unintentional neglect and a declining quality of care. Appropriate staffing levels and skills mixes need to take into account the significant experience and training of RNs, and ensure that high quality care can be delivered on a continuous basis, in a consistent manner.

2.170 The Committee considers that the continuous presence of a RN in a residential aged care facility is needed in order to meet the complex care needs of residents. As a minimum, a RN should be present at an aged care facility at all times unless it can be demonstrated that the resident mix or size of a facility does not warrant compliance with this minimum standard.

2.171 The Committee notes calls for the publication of staff ratio numbers to allow consumers to make more informed decisions. This specific matter is currently before the Committee as part of the Inquiry into the Aged Care

\textsuperscript{188} Department of Health, The Aged Care Workforce, 2016, p. 13.

\textsuperscript{189} Dr Richard Kidd, Chair, Australian Medical Association Council of General Practice, Australian Medical Association, Official Committee Hansard, Canberra, 11 May 2018, p. 10.
Amendment (Staffing Ratio Disclosure) Bill 2018 and so discussion of this matter will be included in a future report.

Recommendation 1

2.172 The Committee recommends that the Department of Health develop national guidelines for the Community Visitors Scheme, including policies for volunteer visitors to follow in the event of observed or suspected abuse or neglect.

Recommendation 2

2.173 The Committee recommends the Australian Government review:

- the Aged Care Funding Instrument (ACFI) to ensure that it is providing for adequate levels of care for the individual needs of aged care recipients;
- the adequacy of funding levels to ensure ACFI funding is indexed annually; and
- the range of penalties relating to breaches of ACFI funding standards by aged care providers.

Recommendation 3

2.174 The Committee recommends that the Australian Government review the Medicare Benefits Schedule relating to medical practitioner visits to residential aged care facilities.

Recommendation 4

2.175 The Committee recommends that the Australian Government:

- legislate to ensure that residential aged care facilities provide for a minimum of one Registered Nurse to be on site at all times; and
- specifically monitor and report on the correlation between standards of care (including complaints and findings of elder abuse) and
staffing mixes to guide further decisions in relation to staffing requirements.

Recommendation 5

2.176 The Committee recommends that the Department of Health ensure consumer information, including the Charter of Rights, for aged care residents and their families is available in a wider range of languages to ensure better access for those from culturally and linguistically diverse backgrounds.

Recommendation 6

2.177 The Committee recommends that an independent review and a parliamentary inquiry (by the appropriate Committee) be undertaken into the Aged Care Quality and Safety Commission after two years to determine its effectiveness in ensuring high standards of care, best clinical practice and reducing mistreatment.

Recommendation 7

2.178 The Committee reiterates and supports the recommendation from the Carnell-Paterson Review for the current to move to unannounced audits in residential aged care facilities and that any unannounced visits to residential aged care facilities should not be confined to business hours.
3. Mistreatment and Associated Reporting Mechanisms

Overview

3.1 Residents, family members and staff of aged care facilities raised concerns that mistreatment is occurring in residential aged care facilities, and questioned whether the true rate of mistreatment was known. Strong concerns were expressed regarding the handling of medication, wound care, pain management, incontinence management, nutrition and the general standard of care.

3.2 Additionally, concerns were raised that the associated reporting mechanisms for mistreatment in residential aged care are not functioning adequately. Family members and carers of residents of aged care facilities, as well as staff, described their experiences navigating the complaints process, with some citing a fear of reprisal and lengthy process resolution timeframes.

3.3 A number of inquiry participants stated that they had witnessed or suspected mistreatment. As noted on the Committee’s inquiry webpage, the Committee is not able to investigate individual cases. Nevertheless, the information provided a valuable insight into the lived experience of some families, resident representatives and staff of residential aged care facilities.
Instances of Mistreatment

Definition of Mistreatment

3.4 The mistreatment of older persons is often referred to as a form of ‘elder abuse’. The Australian Government’s My Aged Care website sets out that elder abuse can be ‘physical, psychological or emotional, sexual or financial’. Mistreatment ‘can also be the result of intentional or unintentional neglect’.1

3.5 Inquiry participants referred to the definition of elder abuse from the World Health Organization (WHO).2 This definition encompasses:

- A single or repeated act;
- A lack of appropriate action;
- Direct or indirect abuse;
- Financial abuse;
- Physical abuse;
- Psychological abuse; and
- Sexual abuse.3

3.6 The Australian College of Nursing suggested that the definition of mistreatment should include physical, mental and language issues, and stated that ‘that there is a critical difference between deliberate mistreatment and neglect’.4

3.7 Mistreatment was defined by the Australian Physiotherapy Association as ‘not only noteworthy abuse but, equally importantly, neglect and a lack of appropriate action’.5

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4 Australian College of Nursing, Submission 57, pp 5-6.

5 Mr Rik Dawson, Director, Australian Physiotherapy Association, Official Committee Hansard, Melbourne, 6 March 2018, p. 1.
3.8 The Vintage Reds of the Canberra Region described different forms of mistreatment as deliberate, accidental and systemic mistreatment.6

3.9 The Townsville Community Legal Service (TCLS) expressed the view that abuse occurring within a residential aged care facility should be referred to as ‘institutional elder abuse’. Although there is ‘no accepted, authoritative definition of institutional abuse of older persons’, the TCLS stated that institutional abuse ‘is often described as mistreatment or maltreatment or abuse of a person by or from a system of power’.7 The TCLS stated that institutional abuse may occur in three ways:

- Overt abuse, which might include financial, physical, sexual or emotional abuse;
- Program abuse, which may occur when the institution itself operates below acceptable conditions or through improper use of its power; and
- Systems abuse, in which an entire care system might cause mistreatment through inadequate resourcing.8

3.10 The Aged Care Complaints Commissioner (Complaints Commissioner) stated that the WHO definition of elder abuse is ‘a significantly broader definition than the current requirements’ in the Aged Care Act 1997 (Aged Care Act) for mandatory reporting by aged care services. The Complaints Commissioner further stated that the Aged Care Act’s ‘narrow definition’ of abuse for the purposes of mandatory reporting does not include much of what would be considered elder abuse by the WHO.9

How Can Mistreatment Occur?

3.11 Mistreatment of residents in aged care facilities can occur through the actions of staff, other residents, or family members or carers. The Australian College of Nursing stated the ‘overwhelming view [is] that different forms of mistreatment do occur’ in residential aged care facilities.10

3.12 Anglicare Australia stated that although the incidence of mistreatment was low, every incident warranted scrutiny. Anglicare Australia stated that these

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6 Vintage Reds of the Canberra Region, Submission 63, p. 2.
7 Townsville Community Legal Service, Submission 55, p. 3.
8 Townsville Community Legal Service, Submission 55, pp 3-4.
9 Aged Care Complaints Commissioner, Submission 28, p. 3.
10 Australian College of Nursing, Submission 57, p. 5.
incidences ‘could be a result of poor procedures, an unhealthy culture, individual incompetence or a combination of these factors’. 11

### 3.13

Leading Age Services Australia (LASA) asserted that ‘when systemic mistreatment in residential aged care facilities happens, it is almost always accompanied by a breakdown in leadership and organisational culture’. 12 The LASA suggested that instances of mistreatment occur ‘by exception’, and can be managed at the provider level:

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. 13

### 3.14

The Vintage Reds of the Canberra Region stated that accidental mistreatment was ‘highly likely’ to occur when staff numbers or skills were lacking, and that:

It is especially likely to occur when staff are dealing with a high workload, very demanding clientele with competing demands, where staff are working extra shifts, where there is high turnover of staff and where communication between staff or between staff and residents is compromised in some way. 14

### 3.15

A link between insufficient staffing numbers and low-quality care was also raised by the New South Wales Nurses and Midwives’ Association (NSW NMA), which stated that the majority of nurses it surveyed ‘reported that insufficient numbers of staff on duty was a causal factor in the incidence of abuse’. 15

### 3.16

The Australian Medical Association (AMA) stated that low-quality care was occurring due to health issues of residents not being attended to in an efficient manner:

Many of the reports of low-quality care we have seen in the media recently are usually as a result of health issues that could have been rectified by timely medical attention; however, residential aged-care facilities are moving away from employing registered nurses, and medical practitioners are not well

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11 Anglicare Australia, Submission 61, p. 4.
12 Leading Age Services Australia, Submission 29, p. 6.
13 Leading Age Services Australia, Submission 29, p. 6.
14 Vintage Reds of the Canberra Region, Submission 63, p. 12.
15 NSW Nurses and Midwives’ Association, Submission 6, p. 6.
supported to provide the services they want to their older people outside their own practice.\textsuperscript{16}

3.17 New Aged Care stated that a number of its General Practitioners (GPs) had reported observed mistreatment in residential aged care, including:

- Pressure on GPs to prescribe medication inappropriately;
- Residents being transferred to hospitals unnecessarily;
- A witnessed incident in which a carer slapped a resident, and no visible follow up by agencies;
- A rise in the number of errors in the provision of medication;
- The perception of a ‘backlash’ when deaths are reported to a coroner; and
- Alteration of a resident’s notes which documented concerns over care.\textsuperscript{17}

3.18 An example was given by New Aged Care of pressure to prescribe antipsychotic medication to a resident without any clinical needs or indications, because the resident was wandering into rooms, yelling, did not sleep through the night, and was trying to leave the premises while there was inadequate staffing to manage the situation.\textsuperscript{18}

3.19 Estia Health advised that, as a provider of aged care services, it found the role of family members in abuse to be ‘complex’, stating that:

... while many reviews have focussed on staff and fellow residents as the abuser, there has been little study into the role of the family members of the resident, particularly in regard to financial and psychological abuse.\textsuperscript{19}

3.20 The LASA described possible abuse of residents by family members, and stated that residents had returned from leave with family members with signs of mistreatment. The LASA also stated that financial abuse of residents by family members can occur.\textsuperscript{20}

3.21 The Office of the Public Guardian Queensland (OPG Queensland) stated that aged care facilities had contacted the agency to report suspected

\textsuperscript{16} Dr Anthony Bartone, Vice-President, Australian Medical Association, \textit{Official Committee Hansard}, Canberra, 11 May 2018, p. 9.

\textsuperscript{17} New Aged Care, \textit{Submission 70}, pp 5-7.

\textsuperscript{18} New Aged Care, \textit{Submission 70}, p. 5.

\textsuperscript{19} Estia Health, \textit{Submission 84}, p. 2.

\textsuperscript{20} Leading Age Services Australia, \textit{Submission 29}, p. 6.
financial elder abuse when a resident’s residential aged care fees had fallen into arrears. The OPG Queensland further stated that when financial abuse had been investigated, it had found ‘other very frightful forms of abuse as well that are not financial’.21

Data on the Prevalence of Mistreatment

3.22 The Complaints Commissioner stated that ‘on current information it is not possible to say how often residents in aged care facilities are mistreated or abused’.22

3.23 Similarly, Professor Joseph Ibrahim stated that ‘there is no doubt that mistreatment occurs in residential aged care’.23 Professor Ibrahim also stated that ‘mistreatment is easily hidden’ for a number of reasons, such as the misdiagnosis of mistreatment as the ageing process, an inability or reluctance to complain, limited available data on mistreatment, and narrow definitions of mistreatment.24

3.24 Speech Pathology Australia also stated that it can be difficult to differentiate between the effects of neglect and the effect of chronic disease in older people.25

3.25 Catholic Health Australia stated that the number and level of complaints made to the Complaints Commissioner is the ‘primary proxy measure used to gauge the extent of mistreatment’. Catholic Health Australia measured the number of complaints against the number of days of care (67.2 million days of care provided to nearly 240 000 people), describing the incidence of mistreatment as ‘low, but not low enough’.26

3.26 The inability to calculate the true prevalence of mistreatment in aged care facilities was highlighted by a number of inquiry participants.27 The

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22 Aged Care Complaints Commissioner, Submission 28, p. 3.
23 Professor Joseph Ibrahim, Submission 31, p. 8.
24 Professor Joseph Ibrahim, Submission 31, p. 11.
25 Speech Pathology Australia, Submission 41, p. 5.
26 Catholic Health Australia, Submission 17, p. 1.
27 NSW Nurses and Midwives’ Association, Submission 6, p. 5; Mrs Kate Mannix, Submission 12, p. 2; Professor Joseph Ibrahim, Submission 31, pp 8-9; Victorian Council of Social Service,
Combined Pensioners and Superannuants Association of NSW (CPSA) stated that the statistics publicly reported by the Department of Health contain only reportable assaults, and ‘where the same perpetrator assaults the same victim multiple times these multiple assaults are reported as a single assault’. The CPSA stated that ‘it is therefore fair to say that the published data [does] not accurately represent the true horror of the incidence of physical and sexual assault in residential aged care in Australia’.28

3.27 A number of inquiry participants drew attention to the work of the Health Law and Ageing Research Unit (HLARU) at Monash University.29 The HLARU’s research program has focussed on preventable deaths and reducing the risk of fatal injury in residential aged care facilities.30 Professor Ibrahim, a leader of the HLARU team, stated that the team’s work has been limited by the lack of data available:

Our research team’s work into premature deaths is a ‘tip of the iceberg’ phenomenon. Describing the quality of care delivered, let alone any trends, in [residential aged care services] in Australia is hampered by lack of readily available, standardised, objective, national level measures for quality of care that is accessible to researchers.31

3.28 Professor Ibrahim outlined that there was no available data on serious permanent injury, minor temporary injury or abuse of individual rights and choice. Data is collected on the number of unexplained absences of residents,
but Professor Ibrahim questioned the utility of the collection of this data, which is not made available to the public.  

3.29 Mr David Gavin stated that he and a group of family members of residents of a particular aged care facility have recorded observed incidents over a twelve month period, grouped into: clinical, wound care, hygiene, food, communication issues and staff. In total, 55 incidents of mistreatment were observed by the group, for a facility with 120 residents.

3.30 The Department of Health advised that of the ‘239 379 people receiving permanent residential care in 2016-2017, the incidence of reports of suspected or alleged assaults was 1.2 per cent’.

Publication of Key Indicators

3.31 The National Aged Care Quality Indicator Program (the Program) is a voluntary program for aged care services coordinated by the Department of Health. Quality indicators are measured to ‘give consumers transparent, comparable information about quality in aged care to aid decision making’ and for ‘providers to have robust, valid data to measure and monitor their performance’.

3.32 The three clinical indicators measured for the Program are pressure injuries, use of physical restraint and unplanned weight loss. Data from the Program will be published on the My Aged Care website when it has been ‘established as reliable and accurate and following stakeholder consultation’.

3.33 Professor Ibrahim found that 15.2 per cent (3289) of aged care deaths reported to coroners over a 13 year period were ‘from external or

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32 Professor Joseph Ibrahim, Submission 31, pp 9-10.

33 Mr David Gavin, Submission 80, p. 4.

34 Department of Health, Submission 72, p. 8.


36 Department of Health, Submission 72, p. 6.

preventable causes, almost all unintentional’. Of those unintentional deaths, 81 per cent died from falls, 7.9 per cent died from choking and 1.2 per cent died from complications of clinical care. Of those intentional deaths, 4.4 per cent died from suicide and one per cent died from resident-on-resident assault.38

3.34 Professor Ibrahim recommended that these statistics be linked with various indicators of care, for example, the number of choking deaths should lead to an examination of oral and dental care and complications of aspiration pneumonia, malnutrition, and sepsis.39

3.35 The Program was described as ‘clinically focused’ by Dementia Australia, which stated that the information does not ‘capture consumer experience and quality of life within aged care services’.40

3.36 Key indicators for publication were suggested by inquiry participants as being a useful measure of mistreatment, such as:

- Fall rates;41
- Injuries including pressure sores;42
- Infection rates;43
- Staffing and skill mixes;44
- Use of restraints;45
- Medication errors;46
- Transfers and admissions to public hospital from an aged care facility;47 and
- Weight loss.48

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38 Professor Joseph Ibrahim, Submission 31, p. 8.

39 Professor Joseph Ibrahim, Submission 31, p. 10.

40 Dementia Australia, Submission 7, p. 15.

41 Aged Care Matters, Submission 13, p. 1; Australian College of Nursing, Submission 57, pp 3-4.

42 Aged Care Matters, Submission 13, p. 1.

43 Aged Care Matters, Submission 13, p. 1; Australian College of Nursing, Submission 57, pp 3-4.

44 Dementia Australia, Submission 7, p. 6; Mrs Sue Smith, Submission 9, pp 3-4; Aged Care Matters, Submission 13, p. 1; Australian College of Nursing, Submission 57, pp 3-4.

45 Dementia Australia, Submission 7, p. 6; Law Council of Australia, Submission 86, p. 11.

46 Aged Care Matters, Submission 13, p. 1; New Aged Care, Submission 70, p. 6.

47 Aged Care Matters, Submission 13, p. 1.

48 Aged Care Matters, Submission 13, p. 1.
3.37 Aged Care Crisis stated that, in particular, ‘pressure injuries are one of the important markers of good or bad nursing care and should be assessed to determine whether staffing levels and skills are adequate’, as they are preventable and treatable if detected early.49

3.38 The Australian College of Nursing suggested adding nursing hours per resident day.50

3.39 Mrs Sue Smith recommended other metrics be monitored and published, including:

- The budget allocated to meals;
- Performance standards for responding to requests for assistance;
- Resident and family member satisfaction;
- Average life span of residents after admission;
- Fees; and
- Descriptions of the environment.51

Experiences of Mistreatment

3.40 Observed and suspected instances of mistreatment were put forward by inquiry participants, who outlined a range of issues experienced by residents, their families and staff of residential aged care facilities.

3.41 Dementia Australia stated that although it hears ‘many reports of quality service delivery and support in residential aged care settings, [it] also hears from consumers with far less positive experiences’.52 Dementia Australia particularly highlighted the experiences of people with dementia:

These stories paint a disturbing picture of an aged care system under strain and in many cases ill equipped to support residents with dementia, especially in instances where behavioural and psychological symptoms of dementia (BPSD) may be present.53

49 Aged Care Crisis, Submission 90, p. 2.
50 Australian College of Nursing, Submission 57, pp 3-4.
51 Mrs Sue Smith, Submission 9, pp 3-4.
52 Dementia Australia, Submission 7, p. 3.
53 Dementia Australia, Submission 7, p. 3.
3.42 Care Guidance stated that older Australians may be delaying entering residential aged care ‘because they are fearful that they will experience mistreatment’. Older Australians who delay entry to aged care may experience ‘adverse health events that lead to a faster deterioration in health than would perhaps be the case had they accessed residential care earlier’.54

**Restrictive Practices**

3.43 Restrictive practices include the use of physical and chemical restraint. The use of physical restraint in residential aged care facilities is captured under a voluntary Program.55 Accreditation Standard 2.13 ‘Behavioural management’ assesses the restraint policy and authorisation of aged care facilities, and where restraint is used it has been assessed, authorised and is monitored to ensure safe and appropriate use.56

**What Are Restrictive Practices?**

3.44 The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) defined restraints as:

> Any device, material or equipment attached to or near a person’s body and which cannot be controlled or easily removed by the person, and which deliberately prevents or is intended to prevent a person’s free body movement to a position of choice and/or a person’s normal access to their body.57

3.45 The Office of the Public Advocate (Queensland) (OPA Queensland) stated that the use of restrictive practices ‘to manage the challenging behaviours of people in the aged and disability sectors has become a key human rights issue in Australia’.58 OPA Queensland defined restrictive practices as:

- Detention;
- Seclusion;
- Restricted access to objects;
- Physical;

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54 Care Guidance, *Submission 82*, p. 3.

55 *National Aged Care Quality Indicator Program*.

56 Accreditation reports for aged care providers contain the assessment of whether a provider has met or not met this standard, and elaborates on the criteria used.


Chemical; and 
• Mechanical restraint (as well as electronic forms of restraint such as tracking bracelets, camera surveillance, or restrictions on media devices).\(^{59}\)

### 3.46 Use of Restrictive Practices

The Office of the Public Advocate Victoria (OPA Victoria) stated that it was aware of the use of restraints in residential aged care, including:

... physical restraints in beds, on toilets, in chairs, chemical restraints due to challenging behaviours and wandering behaviours in dementia sufferers, and other limitations on freedom of movement—for example, the use of keypads to, effectively, lock dementia wards.\(^{60}\)

### 3.47 Use of Restrictive Practices

The Department of Health produced the *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (Decision-Making Tool), which sets out that in a person-centred, restraint-free approach, ‘the use of any restraint must always be the last resort after exhausting all reasonable alternative management options’.\(^{61}\)

### 3.48 Use of Restrictive Practices

The OPA Queensland stated that there is no reference to the Decision-Making Tool in aged care legislation or the Quality of Care Principles. The OPA Queensland stated that although the document is available online, ‘there is no requirement that residential aged care facilities train their staff in these matters to meet legislative or accreditation requirements’.\(^{62}\)

### 3.49 Use of Restrictive Practices

Similarly, the TCLS stated that the absence of regulatory frameworks for the use of restrictive practices is ‘concerning’, as the Aged Care Act ‘does not prohibit, legislate for, or regulate the use of restrictive practices to manage the challenging behaviours of some aged care residents’.\(^{63}\)

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60 Ms Colleen Pearce, Public Advocate, Office of the Public Advocate (Victoria), *Official Committee Hansard*, Melbourne, 6 March 2018, p. 20.


62 Office of the Public Advocate (Queensland), *Submission 60*, p. 7.

3.50 The Law Council of Australia stated that ‘there are … serious questions in relation to the degree to which some facilities seek consent for use of chemical restraint’, and recommended a review of the use of restrictive practices.\textsuperscript{64} The Law Council of Australia further recommended the collection of data on the use of restrictive practices, including the:

- Form of restraint applied;
- Reasons for use;
- Duration of use;
- Outcome of the restraint; and
- Any adverse events that occurred.\textsuperscript{65}

3.51 The Australian Law Reform Commission (ALRC) recommended the use of restrictive practices be regulated under the Aged Care Act ‘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’.\textsuperscript{66} The ALRC considered that restrictive practices should only be used as a last resort, and only where they would prevent serious physical harm, and their use should be reported to a (new) independent Senior Practitioner for aged care.\textsuperscript{67}

3.52 The Carnell-Paterson Review recommended that restrictive practices be limited to being the ‘least restrictive’ and used only as a last resort. The Carnell-Paterson Review also recommended that providers should record and report the use of restrictive practices, the use of psychotropic agents be assessed by accreditation assessors, and the use of antipsychotic medication to be approved by a Chief Clinical Advisor.\textsuperscript{68}

3.53 The ANZSGM stated that it does not support the use of restraint in acute or long term settings because its use ‘is not supported by evidence of efficacy or safety’. The ANZSGM drew attention to the ‘growing body of evidence

\textsuperscript{64} Law Council of Australia, \textit{Submission 86}, p. 10.

\textsuperscript{65} Law Council of Australia, \textit{Submission 86}, p. 11.


\textsuperscript{68} Ms Kate Carnell AO and Professor Ron Paterson ONZM, \textit{Review of National Aged Care Quality Regulatory Processes}, October 2017, p. xii.
regarding the negative consequences of restraint use including physical, psychological and ethical problems’.69

3.54 Further, the ANZSGM stated that use of restraints to manage residents ignores the issues causing the behavioural symptoms:

… if we have a patient or a resident who has severe dementia who wanders all the time, the place to look after them is in a place where he or she can wander all the time—not restrain them in any way. That’s where it’s so important to match people’s needs with what they are provided with—whether it is environment, nursing care et cetera.70

3.55 The ANZSGM stated the view that the use of chemical restraints was changing, with education provided on the use of chemical restraints as a last resort only.71 This was demonstrated by UnitingCare Queensland, which stated that its use of antipsychotic medication within its Memory Support Units decreased by 60.8 per cent from 2015 to 2016. This was achieved through the implementation of a new service model.72

Personal Accounts of Restrictive Practices

3.56 Mrs Margaret Daly described witnessing a number of instances of restraints being used in a facility, stating that vulnerable residents who could not communicate ‘were seated with tables over them preventing them from walking or strapped into wheelchairs with no cushioning to prevent pressure sore[s]’, and described seeing:

- A resident ‘strapped into a wheelchair, sometimes in the dark’;
- A resident strapped into a wheelchair who slid down ‘nearly choking herself’;
- A resident whose room entryway was blocked by ‘a large couch across the door’, leading the resident to pace the room;

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70 Dr Peter Gonski, New South Wales Division Committee, Australian and New Zealand Society for Geriatric Medicine, *Official Committee Hansard*, Sydney, 5 March 2018, p. 13.

71 Dr Patricia Reyes, Secretary, New South Wales Division Committee, Australian and New Zealand Society for Geriatric Medicine, *Official Committee Hansard*, Sydney, 5 March 2018, pp 13-14.

72 UnitingCare Queensland, *Submission 74 Supplementary Submission 2*, p. 2. UnitingCare Queensland’s Memory Support Units are designed to support residents with dementia.
A resident being locked in a room containing a chair with a strap ‘ripped to bits’; and
Residents who had previously been seen walking being strapped to chairs after being in the facility for a few weeks.73

3.57 Aged Care Crisis described the use of a physical restraint on a resident with dementia:

She was harnessed into the chair by a piece of cloth tied around her waist to the arms of the chair. One day she wriggled down and was trapped by the cloth around her neck. Had it not been for one of the other residents, she would have choked.74

3.58 One inquiry participant, who did not wish to be named, stated that in one facility, ‘many unfortunate residents are restrained for the entire day and on an ongoing basis. The only time they are unrestrained is for the purpose of using the bathroom’.75 Further, the inquiry participant stated that family members who had consented to the use of restraints for the resident were unaware of the ‘negative effects of using restraints’.76

3.59 G W Hitchen stated that her late mother had been administered a chemical restraint ‘because staff handling my mother failed to take into account she was profoundly deaf and was disturbed by their inappropriate physical handling’, and suggested that staff could have approached her mother using auditory equipment instead.77

3.60 Dementia Australia set out a number of consumer stories about the use of restrictive practices for residents with dementia. These included:

- A family member whose husband was tied to a chair after wandering into other residents’ rooms;
- A family member whose husband was placed onto antipsychotic medication after wandering into other residents’ rooms, and who was given a higher dosage of antipsychotic medication against the family member’s wishes;

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73 Mrs Margaret Daly, Submission 103, pp 1-2.
74 Aged Care Crisis, Submission 90, p. 73.
75 Name Withheld, Submission 43, p. 1.
76 Name Withheld, Submission 43, p. 1.
77 G W Hitchen, Submission 94, p. 12.
- A family member or carer of a resident who was prescribed antipsychotic medication because staff ‘wanted her to be manageable’;
- Sedatives being prescribed without the resident or family member’s knowledge and wishes; and
- Residents with dementia being sedated and left in front of televisions all day.\textsuperscript{78}

### Wound Care and Pain Management

3.61 Clinical care and pain management in aged care facilities are assessed by the Quality Agency under the Accreditation Standards. Wound records and charts are reviewed by the Quality Agency during the assessment process, and education on wound care is assessed.\textsuperscript{79}

3.62 The AMA stated that the Accreditation Standard on clinical care was the second highest outcome not met by aged care facilities in 2016-2017, which ‘shows that aged-care staff are finding it difficult to understand, or are unable to carry out, what is expected of them in terms of clinical care’.\textsuperscript{80}

3.63 Painaustralia stated that ‘up to 80 per cent of people in residential aged care have persistent pain, and evidence suggests [that] pain is often under-treated in the elderly’.\textsuperscript{81} Untreated or mismanaged pain ‘can perpetuate the pain condition’, as well as lowering quality of life and having an impact on mental health.\textsuperscript{82} Painaustralia stated that residents with dementia may be under-treated for pain conditions compared with those without dementia, ‘despite similar levels of potentially painful conditions’. Painaustralia further stated that:

> In one study, pain was detected in just 31.5 per cent of cognitively impaired residents compared to 61 per cent of cognitively intact residents, despite both having similar incidence of potentially painful conditions.\textsuperscript{83}

\textsuperscript{78} Dementia Australia, \textit{Submission 7}, p. 26.

\textsuperscript{79} Accreditation Standard 2.4 Clinical care, Accreditation Standard 2.8 Pain management. Wound care is assessed under Accreditation Standard 2.3 Education and Staff Development.

\textsuperscript{80} Dr Anthony Bartone, Australian Medical Association, \textit{Official Committee Hansard}, Canberra, 11 May 2018, p. 9.

\textsuperscript{81} Painaustralia, \textit{Submission 49}, p. 1.

\textsuperscript{82} Painaustralia, \textit{Submission 49}, p. 3.

\textsuperscript{83} Painaustralia, \textit{Submission 49}, p. 3.
3.64 The Australian Pain Society produced the resource *Pain in Residential Aged Care Facilities: Management Strategies* for use by residential aged care providers, the medical profession and staff of aged care facilities. Painaustralia highlighted the utility of this resource, which provides a guide to ‘what should be happening’ in aged care, but which does not have an implementation or distribution strategy. The guide outlines:

- How to identify and assess pain in aged care residents;
- Alternatives to medication for pain management, including psychological and educational approaches, physical activity and movement, and complementary medicine;
- How pharmacological approaches should be undertaken, and what to consider;
- Special considerations for residents with cognitive impairments and at end of life;
- How to recognise the role of nutrition in pain management, for example, identifying dehydration; and
- How the current aged care regulatory framework assesses pain management.

**Personal Accounts of Wound Care and Pain Management**

3.65 Ms Goya Dmytryshchak described her father’s experience in a facility, in which a bacterial infection was not investigated and led to blood poisoning:

... if dad’s ongoing complaint of pain was properly investigated by the doctor over the last few weeks, perhaps by a urinary test rather than with paracetamol, this infection would have been detected in the early stages where it could have been simply treated, as in the past, with oral antibiotics.

3.66 One inquiry participant, who did not wish to be named, described witnessed mistreatment which included: a resident showered with hot water despite having a large ulcer, and two residents whose wounds were not managed and who later died from sepsis. In each case, the participant stated that it

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84 Ms Carol Bennett, Chief Executive Officer, Painaustralia, *Official Committee Hansard*, Canberra, 11 May 2018, p. 2.


86 Ms Goya Dmytryshchak, *Submission 89*, p. 3.
appeared that the wounds were not reported or managed according to protocol, and that family members may not have been informed.  

3.67 Similarly, G W Hitchen gave an account of a resident with a severe pressure ulcer, and stated that injuries ‘of this sort do not arise overnight – they are markers of sustained neglect, combined with malnutrition, immobility, poor hygiene, rough handling, maceration [and] infection’.  

3.68 An inquiry participant, who did not wish to be named, described an incident in which a resident had experienced a significant amount of pain due to poor handling by facility staff, and had to be put on a pain management program:

… she was dropped onto her bed which resulted broken ribs and … pneumonia. Her care required two staff to assist with a mechanical aid to get her to bed but because another resident required care one staff member decided to operate the mechanical device alone to ‘save time’. It was very distressing to see mum in pain due to an ‘incident’, which resulted in having a pain management program for three weeks.  

3.69 Another inquiry participant stated that they had sought the services of Wounds Australia, after being concerned that the provider was not managing pressure sores appropriately. The participant stated that ‘without these external services I doubt the family member would have received the appropriate and necessary care by [the] facility’.  

Medication Management  

3.70 Medication management in aged care facilities is assessed by the Quality Agency under Accreditation Standard 2.7. The administration and management of medication in residential aged care facilities was the most commonly complained about aspect of care to the Complaints Commissioner in 2017-2018.  

3.71 The Department of Health described the area of medication in residential aged care facilities as ‘complex’, with differences between what can be  

87 Name Withheld, Submission 69, p. 1.  
88 G W Hitchen, Submission 94, p. 3.  
89 Name Withheld, Submission 14, p. 2.  
90 Name Withheld, Submission 77, p. 8.  
dispensed by a nurse and a care worker, and with some aspects of medication management regulated by the states.92

3.72 The Guiding principles for medication management in residential aged care facilities, released by the Department of Health in 2012, set out that enrolled nurses (ENs), assistants in nursing and personal care workers may perform medicine-related tasks in accordance with state and territory legislation.93

3.73 The Carnell-Paterson Review drew attention to failures in medication management at the Oakden Older Persons Mental Health Service (Oakden) in South Australia, and recommended that medication management be more effectively addressed during the accreditation process for aged care providers. The Carnell-Paterson Review also recommended that a Resident Medication Management Review be conducted on a resident’s admission to aged care, following any hospitalisation, on the deterioration of a medical condition or behaviour, or any change in medication.94

3.74 The high number of medications taken by aged care recipients, at an average 9.75 medications per resident, was put forward by the Carnell-Paterson Review as an example of the significance of medication management. The Carnell-Paterson Review stated that staff awareness of adverse effects of medication and medication incident reporting were under the control of the provider.95

3.75 The ANZSGM stated that specialists were required to oversee older Australians who may be taking multiple medications ‘because some of these medications are actually causing some of their problems, and removing them makes them better’.96

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92 Ms Catherine Rule, First Assistant Secretary, Aged Care Reform Taskforce, Department of Health, Official Committee Hansard, Canberra, 1 March 2018, p. 8, and Department of Health, Submission 72 Supplementary Submission 1, p. 2. The Health Practitioner Regulation National Law Act 2009 sets out the requirements for safe administration of prescription medicines.

93 Department of Health, Guiding principles for medication management in residential aged care facilities, 2012, p. 58.

94 Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 142.

95 Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 141.

96 Dr Peter Gonski, Australian and New Zealand Society for Geriatric Medicine, Official Committee Hansard, Sydney, 5 March 2018, p. 16.
3.76 Civil Liberties Australia stated that staff training around the delivery of medication is ‘sometimes inadequate’, and that ‘the quality of life for some residents would be diminished by medications not being given correctly’.97

3.77 Members of the medical profession stated that there was a trend towards medication administration being transferred from Registered Nurses (RNs) to care workers. The Queensland Nurses and Midwives’ Union (QNMU) highlighted the ‘common practice of medication administration by unregulated carers’.98

3.78 The Australian Nursing and Midwifery Federation (SA Branch) (ANMF SA) stated that over the last two years, medication administration had moved to be the work of personal care assistants, but that they are not trained to dispense medication:

The level of training provided to personal care assistants does not provide them with the capacity to properly oversee medication administration, including assessing the need for medication changes, interactions and monitoring unintended reactions.99

3.79 The NSW NMA stated that recent research around medication management found that 83 per cent of those surveyed had ‘witnessed errors in the administration of medication’ and that 63 per cent had noted ‘a delay in people gaining adequate pain relief simply because there was no registered nurse there to administer the level of pain relief that was required’. Further, recent staffing changes at one facility had led medication being delivered according to staff shifts rather than need:

… the registered nurses in the day shift [had] to administer the medication before they left duty rather than at a time that might have been determined by the needs of the people who should have received them. They are good indicators that quality is slipping.100

97 Civil Liberties Australia, Submission 40, p. 6.

98 Ms Sandra Eales, Assistant Secretary, Queensland Nurses and Midwives’ Union, Official Committee Hansard, Brisbane, 26 April 2018, p. 8.

99 Mr Rob Bonner, Director, Operations and Strategy, South Australian Branch, Australian Nursing and Midwifery Federation, Official Committee Hansard, Adelaide, 15 March 2018, p. 41.

100 Mrs Helen Macukewicz, Professional Officer, NSW Nurses and Midwives’ Association, Official Committee Hansard, Canberra, 11 May 2018, p. 53.
3.80 The NSW NMA also stated that RNs have a significantly higher degree of training in medication management than a care worker, as RNs must undertake training in medication management during their three year graduate training whilst ‘an unlicensed care worker may receive two days of in-house training’.101

3.81 Painaustralia set out that an RN must be physically present for the administration of an opioid, which can result in significant delays to the provision of pain relief to a resident. An example was given of a dying resident in ‘excruciating pain’, whose GP was prescribing an increasing amount of pain medication. The dispensing of the pain medication could ‘sometimes take up to five hours’ because the RN was required to attend to 200 residents and was delayed in being present for the resident.102

3.82 The LASA responded to this example, and stated that an RN should be provided if the skills mix for a facility required it, but stated that:

At the end of the day providing care is more than just providing clinical care; it is about providing their social and lifestyle requirements. The best outcome is really to enable the provider to provide the right skills mix necessary to meet the specific care needs of that person.103

3.83 UnitingCare Queensland stated that appropriate training and education for anyone assisting with medication was important, and that although ‘there is always a place for registered staff in administering medications ... there is also a place for personal carers to be able to assist residents with medications’.104

Nutrition

3.84 Catering is assessed by the Quality Agency under Accreditation Standard 4.8 ‘Catering, cleaning and laundry services’, and food safety plans are reviewed during assessments.

101 Mrs Helen Macukewicz, NSW Nurses and Midwives’ Association, Official Committee Hansard, Canberra, 11 May 2018, p. 53.

102 Ms Carol Bennett, Painaustralia, Official Committee Hansard, Canberra, 11 May 2018, p. 7.

103 Mr Robert Orie, Deputy Chairperson, Leading Age Services Australia, Official Committee Hansard, Canberra, 11 May 2018, p. 22.

104 Ms Cathy Thomas, Group Executive, Blue Care, South East Queensland, UnitingCare Queensland, Official Committee Hansard, Brisbane, 26 April 2018, p. 29.
3.85 The OPA Queensland stated that the provision of food is an area of concern for aged care residents’ family members:

We get a lot of people contacting our office concerned about their family members going into care and suddenly losing weight really rapidly. This is because the facilities don’t have the staff to ensure that people can eat their meals. They place it before them and, if they don’t eat it, they come back and take it away.105

3.86 Mrs Sue Smith described a poor quality of food served in a facility, and sought information on the food budget but was told that it was ‘confidential’. Mrs Smith also stated that the facility’s chef expressed frustration at the amount of money available to provide nourishing meals to residents.106

3.87 Mrs Kate Mannix stated that, after a complaint has been made regarding the quality of food in a facility, the assessment of catering is conducted on the ‘paper menu, rather than the food itself’.107

3.88 The inability of some residents to eat unassisted was raised by Ms Debra Aloschi and Ms Lisa Mooney, who stated that residents at a particular facility were considered to have eaten a meal if they ate three to four spoonfuls of food. Ms Aloschi and Ms Mooney further stated that if their mother was asleep when a meal was delivered at the facility, the meal was not kept and offered when the resident was awake. Ms Aloschi and Ms Mooney’s mother would also miss out on water due to communication issues which led to being hospitalised for dehydration:

We were constantly told that mum was ‘offered’ a drink and as she could not show any sign that she wanted the drink, it was not given to her. As mum could not speak or signal to anyone that she was thirsty, she missed out until the next meal.108

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105 Ms Mary Burgess, Public Advocate, Office of the Public Advocate Queensland, Official Committee Hansard, Brisbane, 26 April 2018, p. 35.
106 Mrs Sue Smith, Submission 9, p. 2.
107 Mrs Kate Mannix, Submission 12, p. 8.
108 Ms Debra Aloschi and Ms Lisa Mooney, Submission 68, pp 3-4.
3.89 An inquiry participant, who did not wish to be named, described a resident being provided with pork despite expressed wishes to follow a diet that does not permit the consumption of pork meat products.\textsuperscript{109}

3.90 The Health Care Consumers’ Association (HCCA) stated that residents of aged care facilities were being provided with medically inappropriate food, for example, diabetic residents not provided with diabetic meals. The HCCA also noted the effect of a lack of meal choice for residents, stating that it ‘is distressing for people who cannot eat certain foods for cultural or religious reasons and for people used to eating food they find palatable’.\textsuperscript{110}

3.91 The HCCA also outlined a situation in which a facility had under-catered, which resulted in some residents missing out on a meal.\textsuperscript{111}

3.92 A resident of an aged care facility, who did not wish to be named, described the food served as ‘not fit for dogs’, and stated that many residents do not eat the food because it is inedible and that no fresh fruit is provided.\textsuperscript{112}

3.93 The Federation of Ethnic Communities’ Councils of Australia (FECCA) similarly stated that culturally appropriate food is not always available in residential aged care. The FECCA stated that the Chinese community is ‘not keen to age in a residential aged care facility’, partly due to the food provided.\textsuperscript{113}

**Lack of Assistance**

3.94 Inquiry participants described the lack of assistance experienced by residents of aged care facilities and their family members. One inquiry participant, who did not wish to be named, stated that in one facility, the call bells to alert staff to an issue are not easily reached by residents and that staff do not check on residents who may become stuck in the facility’s garden.\textsuperscript{114}

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\textsuperscript{109} Name Withheld, *Submission 85*, p. 8.

\textsuperscript{110} Health Care Consumers’ Association, *Submission 66*, p. 4.

\textsuperscript{111} Health Care Consumers’ Association, *Submission 66*, p. 5.

\textsuperscript{112} Name Withheld, *Submission 18*, p. 3.

\textsuperscript{113} Federation of Ethnic Communities’ Councils of Australia, *Submission 50*, p. 3. The FECCA further stated that other reasons include a fear of being socially and culturally isolated, and language barriers.

\textsuperscript{114} Name Withheld, *Submission 18*, p. 2.
3.95 The Vintage Reds of the Canberra Region stated that call bells were not answered for issues regarding toileting, pain relief or assistance with meals, and stated that residents had been left alone in bathrooms or in a ‘wet or soiled bed’. Lengthy waiting times for call bell responses were also observed by Mrs Yvonne Buters.

3.96 Ms Robyn Nolan described a lack of assistance for her father, who was a resident of an aged care facility. Ms Nolan stated that her father was:

- Not assisted in attending the dining room, or provided with meals in his room when unable to attend the dining room;
- Left off a list of residents for showering, and did not receive showering assistance;
- Not assisted with cutting up food; and
- Not assisted to access water as the water jug and glasses were placed out of reach, leading to dehydration.

**Current Reporting Mechanisms**

3.97 Residential aged care providers have certain responsibilities regarding complaints resolution. The Aged Care Act sets out that an approved provider must:

- Establish a complaints mechanism;
- Use that mechanism to address complaints;
- Advise the person of other mechanisms for complaint making;
- Allow an authorised complaints office to have access to the service; and
- Must comply with any requirement made under the Complaints Principles.

3.98 Complaints regarding the standard of care in Australian Government-funded residential aged care facilities can be made by anyone to the Complaints Commissioner.

3.99 Major changes to the regulation of aged care services are scheduled to take effect on 1 January 2019, and will see the Quality Agency, Complaints

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115 Vintage Reds of the Canberra Region, Submission 63, pp 11-12.

116 Mrs Yvonne Buters, Submission 24, p. 1.

117 Ms Robyn Nolan, Submission 26, p. 3.

118 S56-4, Aged Care Act 1997.
Commissioner and aged care regulatory functions of the Department of Health form the Aged Care Quality and Safety Commission (Commission).  

3.100 Inquiry participants suggested that various aspects of the reporting process were in need of reform. The TCLS, for example, stated that reporting systems for restrictive practices, serious incidents, assessment of staff suitability and coronial reportability required reform.

3.101 The Australian College of Nursing raised concerns that there was not uniform reporting of complaints across aged care facilities, as some facilities may have a ‘culture of underreporting’ but other staff may ‘over-report incidents due to fearing the consequences of not reporting [them]’. The result of over-reporting may lead to incidents being overlooked due to being ‘outnumbered by minor incidents’, and affecting morale, confidence and relationships with families.

3.102 The National Association of Community Legal Centres (NACLC) expressed the view that there are a ‘number of key issues’ in the reporting of assaults, and characterised the current reporting system as ‘weak’. The NACLC stated that major difficulties with the system included under-reporting due to fear of reprisal, the reportable assaults mechanism being discretionary and the need for staff members to report colleagues.

3.103 The Department of Health advised that in 2015-2016, 71 non-compliance notices were issued to providers, with one provider’s accreditation revoked.

Making a Complaint

3.104 In 2017-2018, 4315 complaints relating to residential aged care were made to the Complaints Commissioner. Of the total complaints (including complaints relating to home care or community care), around 56 per cent were made by family members or representatives of the resident.

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119 The Department of Health will join from 2020.
120 Townsville Community Legal Service, Submission 55, p. 8.
121 Australian College of Nursing, Submission 57, p. 7.
122 National Association of Community Legal Centres, Submission 91, p. 3.
123 Ms Jo Mond, Assistant Secretary, Specialised Programs and Regulation Branch, Department of Health, Official Committee Hansard, Canberra, 1 March 2018, p. 2.
3.105 Of the complaints relating to residential services, the most common were:

- medication administration and management (706);
- personal and oral hygiene (473); and
- personnel numbers/ratio (452).\(^{125}\)

3.106 The Complaints Commissioner stated that a major focus has been to humanise the work of the agency, acknowledging that ‘it is not always an easy thing to raise a complaint’.\(^{126}\)

3.107 The accessibility of the complaints system was questioned by inquiry participants. The Older Person’s Advocacy Network (OPAN) stated that, as the majority of complaints received by the Complaints Commissioner were made by family members or representatives, it considers ‘the mistreatment of residents to be under-reported by residents who are not actively engaged with family/friends/representatives’.\(^{127}\)

3.108 The Australian College of Nursing put forward anecdotal evidence of residents’ families do not always understand how to make a complaint.\(^{128}\) Aged Care Crisis stated that the complaints system was difficult for consumers and family members to use:

> Many simply give up and do not pursue their complaints. There is no one there to support the residents and families when they really need help and support in building confidence, advice when taking action and backing from those with clinical expertise when they confront those who have none.\(^{129}\)

3.109 The Australian Association of Social Workers (AASW) characterised the complaints system as ‘onerous’, and stated that it ‘can be challenging for an older person to initiate and maintain a complaint against a provider in whose residential care they are living’.\(^{130}\)

3.110 Dementia Australia also stated that there may be a ‘power imbalance’ between resident and provider, particularly if the resident has dementia:


\(^{126}\) Ms Rae Lamb, Commissioner, Aged Care Complaints Commissioner, *Official Committee Hansard*, Melbourne, 6 March 2018, p. 22.

\(^{127}\) Older Person’s Advocacy Network, *Submission 36*, p. 2.

\(^{128}\) Australian College of Nursing, *Submission 57*, p. 8.

\(^{129}\) Aged Care Crisis, *Submission 90*, p. 36.

\(^{130}\) Australian Association of Social Workers, *Submission 51*, p. 4.
In the case of people living with dementia, this power imbalance is further exacerbated as these individuals may also face issues such as lack of understanding of complaint mechanisms, limited capacity to engage with such mechanisms, communication difficulties and fear of reprisal.\(^\text{131}\)

3.111 Carers NSW stated that carers may not make a formal complaint because ‘they did not believe it would produce a result’, that they ‘lacked the time or energy required’, or that the resident had changed providers or had passed away.\(^\text{132}\)

3.112 Aged Care Crisis put forward some of the challenges faced by family members who have observed mistreatment and wish to complain:

Families who want to speak out lack power, are looked down on by providers, fear retaliation against their family member in care, face an opaque regulatory system that is not responsive to them and can be threatened with defamation.\(^\text{133}\)

**Timeframes for Complaint Resolution**

3.113 The HCCA stated that the aged care complaints process is burdensome for consumers and family who are experiencing stress during a challenging time:

Making a complaint takes time and energy. There is an emotional cost too. As consumers of aged care services, we are often unwell or struggling with our health and capacity. Many people are too busy dealing with what life presents – such as caring responsibilities, or recovering from illness – to make a complaint they recognise as appropriate to make.\(^\text{134}\)

3.114 Mrs Yvonne Buters characterised the complaints process as ‘difficult and onerous’,\(^\text{135}\) and described the emotional effect of a lengthy complaints resolution timeframe:

Over this period we have had to resend and re-visit disturbing photos, emails and evidence in regards to the case involving both our parents. This has resulted in continuing distress and the lack of ability to move forward.\(^\text{136}\)

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\(^{131}\) Dementia Australia, *Submission 7*, p. 8.

\(^{132}\) Carers NSW, *Submission 30*, p. 2.

\(^{133}\) Aged Care Crisis, *Submission 90*, p. 17.

\(^{134}\) Health Care Consumers’ Association, *Submission 66*, p. 6.

\(^{135}\) Mrs Yvonne Buters, *Submission 24*, p. 6.
The Australian College of Nursing stated that the timeframes involved in resolving complaints may be ineffective, particularly for financial abuse. The Australian College of Nursing stated that ‘current systems are too slow to address indicators of financial abuse as too often funds are already depleted by abusers by the time actions are taken’.\textsuperscript{137}

An inquiry participant, who did not wish to be named, stated that fast timeframes may not be beneficial to the person making the complaint:

I feel that the Aged Care Complaints Commission favours the aged care facility and not the resident and that they rush complainants to resolve disputes and do not provide complainants with adequate information about what changes the aged care facility will make to resolve concerns and prevent them from happening in the future.\textsuperscript{138}

In 2017-2018, 93 per cent of complaints were resolved through ‘early resolution.’\textsuperscript{139} The Complaints Commissioner advised that early resolution involves ‘working directly between the parties, going back and forth, trying to get a result.’\textsuperscript{140} Of the 5738 total finalised complaints received by the Complaints Commissioner in 2017-2018, 4185 complaints were finalised within 30 days and 5330 within 90 days.\textsuperscript{141}

The Complaints Commissioner has key performance indicators at resolving complaints by 30, 60 and 180 days, and stated that difficult cases take longer to resolve.\textsuperscript{142}

\textbf{Communication Barriers}

The OPA Victoria stated that the current complaints process has flaws which are ‘most noticeable for people with cognitive impairment who can be limited in their ability to seek help or remove themselves from abusive
situations’.

The AMA similarly stated that complaints may not be taken seriously ‘if the patient is unable to directly articulate the issue’.

3.120 Speech Pathology Australia expressed the view that residents with communication difficulties are ‘a particularly vulnerable group’ who can experience a power imbalance between themselves and the care provider:

The nature of communication disability exposes individuals to a higher potential for abuse, neglect and ill-treatment and also affects their ability to voice their concerns, to self-advocate, and to disclose/report harm done to them by another.

3.121 Similarly, the Australian College of Nursing stated that residents with a severe degree of dementia ‘usually have no coherent speech and inadequate cognition to be able to report any instances of mistreatment’, which makes them ‘reliant on the culture and ethics of their professional carers for their welfare’.

3.122 The OPA Queensland stated that people with impaired decision-making capacity may experience barriers to making complaints because:

- The resident may not understand their rights;
- The process or the entry points for making complaints are less accessible;
- The resident may not be believed or taken seriously when they do make a complaint;
- The resident is not able to manage and present evidence to support their complaint; and
- A fear of reprisal or withdrawal of a service may lead to a reluctance to make a complaint.

3.123 The OPA Queensland also identified that certain residents may require additional support to use a complaints system, and recommended that:

Complaints schemes for [residents with decision-making impairments] should therefore incorporate mechanisms that maximise accessibility of complaints.

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143 Office of the Public Advocate Victoria, Submission 35, p. 4.
144 Australian Medical Association, Submission 23, p. 6.
145 Speech Pathology Australia, Submission 41, p. 3.
146 Australian College of Nursing, Submission 57, p. 12.
147 Office of the Public Advocate (Queensland), Submission 60, pp 8-9.
management systems for people with impaired decision-making capacity and support to actively engage in the complaint-making process.  

3.124 An inquiry participant, who did not wish to be named, described the creation of a communication sheet for a resident who was not able to communicate, but which was not used by staff of the facility:

The family member was not able to communicate especially due to a medical condition that restricted communication. With my assistance and a speech therapist from an external service, a communication sheet with pictures and words that [they] can point to was composed. Sadly the staff did not use it. They relied on family members to pass on their info.

3.125 The Victorian Multicultural Commission stated that multicultural older people require language support to communicate complaints and complete administration surrounding the complaints process:

The consequence of this support gap is that multicultural older people lose the ability to communicate their views and needs to staff and effectively lose their voice in their care management. This can and has led to many types of mistreatment and harm, including pain and discomfort, misdiagnosis of needs and medical conditions, incorrect medical treatment, mental health issues, withdrawal and isolation.

**Fear of Reprisal**

3.126 Inquiry participants, including family members of residents and staff of aged care facilities, expressed a sense of fear at making a formal complaint regarding the quality of service in an aged care facility. Ms Fiona Duff stated that a person who has made a complaint may experience intimidation or harassment:

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148 Office of the Public Advocate (Queensland), *Submission 60*, p. 9.

149 Name Withheld, *Submission 77*, p. 9.


Whether you are a family member or staff member who is being the informer, your life will be turned upside down and soon filled with intimidation and harassment, threats of legal action and more. I have seen and experienced firsthand, both as a daughter, and through advocating aged care, supporting whistle blowers on their plight to come forward.\textsuperscript{152}

3.127 Fear of reprisal by the provider was expressed by the Quality Aged Care Action Group (QACAG), which stated that ‘residents and relatives are stifled from making complaints because of the inherent fear of reprisals against either themselves, or their loved ones’. The QACAG described instances of residents and family members ‘being issued with warning letters by aged care providers when we have raised our concerns about poor quality of care’.\textsuperscript{153}

3.128 Similarly, the Association of Independent Retirees - Fleurieu Peninsula Branch stated that residents of aged care facilities can ‘live in a stressful environment often in a state of fear through reprisals for those comments or complaints made’, and may feel vulnerable. A resident could ask someone to complain on their behalf, but when the advocate has left the facility, the resident ‘will be alone with staff central to the complaint’.\textsuperscript{154}

3.129 An inquiry participant, who did not wish to be named, described the process of making a complaint as ‘very daunting’, and stated that they had ‘been a victim of retribution several times as well as experienced a threat for the intention to cause fear and cease a care concern matter going further’.\textsuperscript{155}

3.130 The Western Australian Department of Health (WA Department of Health) stated that family members of residents are ‘anxious about being perceived as the “difficult family” and have concerns about the potential impact to the resident’s ongoing treatment if they raise concerns’. The WA Department of Health further stated that having a ‘positive reporting culture’ would move away from the need for someone to act as a whistleblower.\textsuperscript{156}

3.131 The ability for staff of aged care facilities to make a complaint regarding the quality of service was raised by representative bodies. The Health Services

\textsuperscript{152} Ms Fiona Duff, \textit{Submission 34}, p. 1.

\textsuperscript{153} Quality Aged Care Action Group, \textit{Submission 8}, p. 5.

\textsuperscript{154} Association of Independent Retirees - Fleurieu Peninsula Branch, \textit{Submission 19}, p. 2.

\textsuperscript{155} Name Withheld, \textit{Submission 77}, p. 1.

\textsuperscript{156} Western Australian Department of Health, \textit{Submission 88}, p. 2.
Union (HSU) stated that a survey of aged care workers in NSW had found that there was ‘significant pressure and fear of reprisal experienced by individuals who report incidents of resident mistreatment’:

More than half of those surveyed indicated that they had witnessed mistreatment of residents by family members, facility visitors, other residents, or staff. And yet, despite this, nearly a third of all anonymous survey participants reported feeling pressured by managers to not report critical incidents as they would reflect negatively on the [residential aged care facility].

3.132 The QNMU called for ‘greater protection of employees in the aged care sector who wish to raise issues in relation to the quality of care provided to residents of aged care facilities’. The QNMU stated that a fear of reprisal from the provider may have led to a reluctance for aged care workers to make a complaint:

... many aged care employees are reluctant to make complaints related to the quality of care, poor facilities, resident neglect or the misappropriation of public funds because the potential for making such complaints may result in the termination of their employment, a reduction in the number of shifts or hours or other less favourable treatment.

3.133 Greater protection of staff of aged care facilities was also recommended by Civil Liberties Australia, which stated that staff in these facilities are often vulnerable:

Staff of residential facilities need greater whistle blower protection than do average Australians: they are usually poorly paid, very job dependent, and relatively powerless in society. They fear sacking, which would in practice lead to virtually no chance to get a job in a similar facility.

**Fear of Restricted Access**

3.134 Elderlaw commented that, when there is conflict between a provider and a resident’s family members in relation to the standard of care, ‘these cases can escalate to the stage of exclusion of the person who is accused of

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157 Health Services Union, Submission 92, p. 7.

158 Queensland Nurses and Midwives’ Union, Submission 44, p. 12.

159 Civil Liberties Australia, Submission 40, p. 2.
continual complaints about explicable incidents’. Elderlaw stated that there is no recourse for a family member who has been excluded, or whose access to the resident is restricted.

3.135 Elderlaw gave an example of a family member raising a number of concerns about the quality of care her mother was receiving, and who was then banned from accessing the facility, and therefore from her mother. Elderlaw stated that ‘during that term of ban her mother died’.

3.136 The OPAN stated that the exclusion of family members from aged care facilities happens ‘frequently’, which creates a culture of under-reporting:

... we certainly frequently hear ... that family members, when they start to raise concerns around issues, are excluded from facilities. So, again, there’s a culture of: 'Don’t raise it. I can no longer have my son or daughter visit because they’ve complained about the service.' Retribution is real.

3.137 An inquiry participant, who did not wish to be named, stated that they had been banned from visiting a resident after raising concerns over the quality of care received by the resident. The inquiry participant moved the resident to another facility, as the resident was distressed by the family member’s absence.

3.138 The QACAG also stated that people had been threatened with being banned from the aged care facility.

3.139 The User Rights Principles 2014 provides that access must be granted to a person who has been asked to act for a residential aged care recipient. That person must be allowed access to the residential aged care service at any time.

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160 Elderlaw, Submission 15, p. 9.
161 Mr Rodney Lewis, Senior Solicitor, Elderlaw, Official Committee Hansard, Sydney, 5 March 2018, p. 9.
162 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 15.
163 Name Withheld, Submission 85, p. 10.
164 Mrs Margaret Zanghi, Quality Aged Care Action Group, Official Committee Hansard, Sydney, 5 March 2018, p. 21.
165 8(1) User Rights Principles 2014.
Protections for Reporting Mistreatment

3.140 The Department of Health advised that a range of protections exist for staff of approved providers of residential aged care under the Aged Care Act and the Australian Aged Care Quality Agency Act 2013 (Quality Agency Act). The Department of Health stated that:

A disclosure of information by a person qualifies for protection if the approved provider or a staff member discloses information to a police officer, the Department, the Complaints Commissioner, the Quality Agency, the approved provider or one of the approved provider’s key personnel or a person authorised by the approved provider.166

3.141 These protections will apply if the person making the disclosure: identifies themselves, has reasonable grounds to suspect that a reportable assault has occurred, and is acting in good faith in making the disclosure.167 Approved providers and staff who make a disclosure are protected from civil or criminal liability, and in proceedings for defamation relating to the disclosure. The Department of Health stated that a person’s contract may not be terminated on the basis of a disclosure, and that a disclosure made under the Aged Care Act would override an employment contract which prohibited discussion of issues arising in the aged care home.168

3.142 The Department of Health further advised that protections under the acts ‘do not extend to care recipients, their families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors. Nor do they extend to disclosures of general failings in care’.169

3.143 Catholic Health Australia stated that staff are able to contact the Complaints Commissioner anonymously to report concerns over mistreatment, which may alleviate concerns ‘about how they might be treated both emotionally and psychologically by colleagues and management of the service, or that they might suffer financially’.170

166 Department of Health, Submission 72, p. 8.
167 Department of Health, Submission 72, p. 8.
168 Department of Health, Submission 72, p. 8.
169 Department of Health, Submission 72, p. 8.
170 Catholic Health Australia, Submission 17, p. 2.
3.144 The LASA stated that although whistleblowing is ‘recognised as a legitimate form of action in a democratic society’, it played a small role in the aged care 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.\textsuperscript{171}

3.145 The LASA further stated that ‘better whistleblowing provisions may have assisted in the case of the Oakden incidents’, but that it was ‘not clear that this is an issue generally for residential aged care’.\textsuperscript{172}

3.146 In contrast, the CPSA stated that the provisions of the Aged Care Act which relate to disclosure of information ‘virtually ensures that no one involved in residential aged care will become a whistle blower’. Further, the CPSA stated that the Aged Care Act’s definition of protected information includes ‘all information that relates to the affairs of an aged care provider, actual or prospective’.\textsuperscript{173}

3.147 Volunteering Australia recommended that whistle blower provisions be extended to apply to the volunteer workforce in residential aged care.\textsuperscript{174} The QACAG called for more protection for residents, relatives and others to raise concerns regarding the quality of care.\textsuperscript{175} Civil Liberties Australia suggested an annual, national award for courage be administered for staff who raise issues over quality of care.\textsuperscript{176}

3.148 The QNMU recommended that whistle blowers be permitted to make a disclosure to a third party in order to seek advice prior to making the disclosure. The QNMU stated that it advises nurses and midwives ‘who make a complaint or report or who are the subject of a complaint or report to seek support and advice from the QNMU in the first instance’. Further, the QNMU stated that, in its experience, ‘nurses and midwives seeking to

\textsuperscript{171} Leading Age Services Australia, \textit{Submission 29}, p. 10.
\textsuperscript{172} Leading Age Services Australia, \textit{Submission 29}, p. 10.
\textsuperscript{173} Combined Pensioners and Superannuants Association of NSW, \textit{Submission 21}, p. 5.
\textsuperscript{174} Volunteering Australia, \textit{Submission 39}, p. 2.
\textsuperscript{175} Quality Aged Care Action Group, \textit{Submission 8}, p. 6.
\textsuperscript{176} Civil Liberties Australia, \textit{Submission 40}, p. 3.
disclose information may be unfamiliar with the reporting process for the relevant agency’, and that an error made during the disclosure process may potentially exclude a person from protection.\textsuperscript{177}

\section*{Reportable Assaults}

3.149 Approved providers must report allegations or suspicions of ‘reportable assaults’ to the police and to the Department of Health within 24 hours of becoming aware of the incident. Reportable assaults are ‘unlawful sexual contact or assault … or unreasonable use of force on a resident of an aged care home’.\textsuperscript{178} Such incidents may additionally be reported to the Complaints Commissioner.

3.150 If an assault is committed by a resident with a diagnosed cognitive or mental impairment, it is not required to be reported.\textsuperscript{179} In these instances, the provider must demonstrate to the Department of Health that the provider has ‘taken action within 24 hours, in an administrative way, to deal with that situation’.\textsuperscript{180}

3.151 The Department of Health then assesses whether the provider has taken appropriate action and there is a safe environment for the resident. The Department of Health may take compliance action or refer the incident to the Quality Agency.\textsuperscript{181}

3.152 In 2016-2017, 2853 notifications of reportable assaults were made to the Department of Health. Of those:

- 2463 were recorded as alleged or suspected unreasonable use of force;
- 348 as alleged or suspected unlawful sexual contact;
- 42 as both; and
- 130 incidents were referred to the Quality Agency.\textsuperscript{182}

3.153 The Complaints Commissioner stated that data on the number of mandatory reportable assaults ‘is not a reliable measure of the extent of abuse in aged care facilities in Australia’\textsuperscript{177}.

\vspace{1em}\footnotesize{\textsuperscript{177} Queensland Nurses and Midwives’ Union, \textit{Submission 44}, pp 11-12.}\footnotesize{\textsuperscript{178} Department of Health, \textit{Submission 72}, p. 6.}\footnotesize{\textsuperscript{179} Department of Health, \textit{Submission 72}, p. 7.}\footnotesize{\textsuperscript{180} Ms Jo Mond, Department of Health, \textit{Official Committee Hansard}, Canberra, 1 March 2018, p. 3.}\footnotesize{\textsuperscript{181} Department of Health, \textit{Submission 72}, p. 7.}\footnotesize{\textsuperscript{182} Department of Health, \textit{Submission 72}, p. 8.}
MISTREATMENT AND ASSOCIATED REPORTING MECHANISMS

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care’, as only some incidents are reportable assaults, assaults committed by someone with a cognitive impairment are not captured, and allegations or suspicions are captured which may not be substantiated.183

3.154 The ALRC stated that providers are required to keep records on reportable assaults, including the date the provider received the allegation, a brief description of the allegation, and whether a report has been made to the police and the Department of Health, or whether exemptions apply.184 There is no obligation for a provider to record any action taken as a response to the allegation.185

3.155 Estia Health stated that the current mandatory reporting of assaults ‘is no proxy for measuring mistreatment’, and that ‘it is unclear how the collection of this limited range of information is value adding’.186 Estia Health questioned the focus of the requirements:

These mandatory reporting arrangements are not a relevant response to dealing with abuse. The legislation seems to place more importance on reporting the allegation to police and the Department within 24 hours than it does to investigating the allegation and taking action.187

3.156 Estia Health recommended that unsubstantiated allegations of mistreatment should not be made to the Department of Health, that the definition of serious incidents be expanded, and that a provider should be able to report abuse by a person other than a staff member or resident.188

3.157 The OPAN also considered the current reportable assaults requirements as ‘inadequate in capturing the scope and prevalence of mistreatment within residential aged care’, and supported an expanded scope, which would offer ‘providers and consumers a more consistent understanding of what constitutes mistreatment’.189

183 Aged Care Complaints Commissioner, Submission 28, p. 3.
186 Estia Health, Submission 84, p. 4.
187 Estia Health, Submission 84, p. 5.
188 Estia Health, Submission 84, p. 5.
189 Older Person’s Advocacy Network, Submission 36, p. 2.
The ‘Resident-on-Resident’ Exemption

3.158 The ALRC recommended the removal of the exemption relating to residents with cognitive impairments (known as the ‘resident-on-resident exemption’), and stated that these should be treated as serious incidents.190

3.159 The Carnell-Paterson Review agreed that assaults committed by a resident with a cognitive impairment should be reported.191

3.160 Dementia Australia acknowledged concerns that people with dementia can behave aggressively towards other residents and staff, and stated that the behaviour of those with dementia relates to broad issues around appropriate care and support.192

3.161 Dementia Australia stated that aggression by residents with dementia towards other residents and staff is ‘common, and poses a serious dilemma’, but was not of the view that aggression by people with dementia should be criminal abuse. Dementia Australia recommended the expansion of reportable assaults to include those perpetrated by residents with a cognitive impairment.193

Serious Incident Response Scheme

3.162 The ALRC recommended a serious incident response scheme replace the current responsibilities in relation to reportable assaults, and that it should require approved providers to notify ‘an independent oversight body’ of:

- An allegation or a suspicion on reasonable grounds of a serious incident; and
- The outcome of an investigation into a serious incident, including findings and action taken.194

3.163 The ALRC also recommended that the definition of a serious incident when committed against a recipient of residential care should include:

- Physical, sexual or financial abuse;

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192 Dementia Australia, *Submission 7*, p. 11.

193 Dementia Australia, *Submission 7*, p. 11.

• Seriously inappropriate, improper, inhumane or cruel treatment;
• Unexplained serious injury; and
• Neglect.195

3.164 If committed by another recipient of residential care, the ALRC stated that the definition should mean sexual abuse, physical abuse causing serious injury, or an incident that is part of a pattern of abuse.196

3.165 The establishment of a serious incident response scheme was supported by the OPA Victoria, OPAN, and the Victorian Council of Social Service (VCOSS).197 VCOSS also stated that the scheme should ‘require providers to report on the outcome of the investigation into the incident and what action was taken’.198

3.166 The Aged Care Guild expressed support for the ‘intent’ of the serious incident response scheme, but stated that these practices are ‘largely followed by providers as a matter of best practice’. The Aged Care Guild also stated that it had concerns over an increased administrative burden:

... there is no evidence that a new [Serious Incident Response] Scheme would improve safety or quality. Instead, it would likely create a significant administrative burden, thereby directing time and resources away from caregiving duties. Any amendments to existing arrangements should be evidence-based and not introduce more compliance with no clear evidence or affect.199

3.167 The Council of the Ageing Australia (COTA Australia) stated that it did not wholly endorse a serious incident response scheme. Notwithstanding, COTA Australia agreed that providers should have appropriate systems in place to investigate incidents.200

3.168 The Department of Health advised that the ALRC recommendation for a serious incident response scheme is being considered.201

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197 Office of the Public Advocate (Victoria), Submission 35, p. 5; Older Person’s Advocacy Network, Submission 36, p. 2; Victorian Council of Social Service, Submission 47, p. 3.
199 Aged Care Guild, Submission 33, p. 14
200 Council of the Ageing Australia, Submission 37, p. 9.
201 Department of Health, Submission 72 Supplementary Submission 1, p. 10.
Concluding Comment

Measuring the Prevalence of Mistreatment

3.169 During the conduct of this inquiry, the Committee received evidence and heard personal accounts from a large number of individuals who made claims of mistreatment relating to family and friends in the aged care sector. Many of these individuals presented harrowing accounts of substandard care and treatment.

3.170 The true prevalence of mistreatment in residential aged care is not known, as only a limited range of data is regularly collected and published by the Department of Health. A strong desire for more comprehensive data to be published on a range of key indicators was expressed by inquiry participants, as well as a wish for the expansion of the reportable assaults mechanism.

3.171 The Committee considers that incidents of mistreatment should be measured more fully, and draw on a range of practical indicators, as the collection of data relating to mistreatment is an important function of the regulatory system and would provide consumer confidence in the aged care system moving forward.

Experiences of Mistreatment

3.172 Issues with the quality of care received by aged care residents around wounds and pain management were raised. Inquiry participants gave personal accounts of low standards of care for these matters, and detailed the effect this had on residents and their family members.

3.173 Personal accounts by residents, family members and staff of mistreatment in residential aged care detailed failings of care in the management of wounds and pain, the provision of medication, nutrition and lack of assistance for residents. Family members described the distress felt at seeing loved ones experience unnecessary pain, and frustration at their powerlessness to navigate the aged care complaints system.

3.174 Family members expressed fears of being excluded from visiting residents of aged care facilities as a means of reprisal for making any type of complaint. The Committee also received anecdotal evidence that complaints may be met with aged care providers stating that they would involve their lawyers. Inquiry participants raised issues around the imbalance of power between
residents and aged care providers, as residents are reliant on the provider for their care and quality of life and may not be able to exercise their consumer rights and move to another facility or communicate issues.

**Current Reporting Mechanisms**

3.175 Various barriers to engaging fully with the current reporting mechanisms for mistreatment in residential aged care were put forward by inquiry participants. These barriers included communication difficulties as a result of dementia or language loss, the complexity of the complaints system for consumers and family members or advocates, and a fear of reprisal which would be felt by the resident or family member for raising issues.

3.176 Inquiry participants’ experiences of complaints process painted a picture of a system which is not accessible or user-friendly, and which may not result in noticeable outcomes for the resident. The system was characterised as bureaucratic and focussed on recording instances of alleged mistreatment, rather than on achieving an improvement to a resident’s quality of life.

3.177 The removal of the so-called ‘resident-on-resident’ exemption for reportable assaults, in which assaults committed by a resident with a cognitive impairment are not reported to the Department of Health, was recommended by inquiry participants. The reporting of these assaults would enable a truer measurement of mistreatment in residential aged care facilities. The Committee considers that there are sensitivities in requiring the reporting of these currently exempted assaults, due to the perpetrator’s impairment, but agrees that the exemption leads to a distortion of the incidence of mistreatment currently known.

**Recommendation 8**

3.178 The Committee recommends that the reportable assault ‘resident-on-resident’ exemption, in which assaults committed by a resident with a cognitive impairment are not required to be reported to the Department of Health, be removed.

**Recommendation 9**

3.179 The Committee recommends that the National Aged Care Quality Indicator Program (the Program):
be made mandatory for providers of Australian Government-funded residential aged care services; and

be expanded to include a broader range of key indicators, to be determined with the involvement of the aged care sector and consumer groups.

Recommendation 10

3.180 The Committee recommends that the Australian Government amend the Aged Care Act 1997 to legislate that:

the use of restrictive practices in residential aged care facilities be limited to the ‘least restrictive’ and be a measure of last resort only;

any use of restrictive practices within the legislated meaning be recorded by providers and collected by the Department of Health;

restrictive practices are only to be used after a medical practitioner has prescribed/recommended such use; and

the legal guardian and/or family member must be advised immediately.
4. Consumer Protection

Overview

4.1 As the aged care system evolves towards a more consumer-driven market, consumers are demanding a stronger focus on consumer protection, rights, access to information and a high quality of service. Although the aged care system has changed over the last few decades to operate more like a consumer-driven market, issues with the model still exist.¹

4.2 Increasing demand for residential aged care has led to an under-supply of residential aged care places, which is set to continue as an increasing number of Australia’s population ages.

4.3 The important role of consumers within the aged care system was highlighted by a number of inquiry participants, who drew attention to the significant cost of residential aged care and, at the same time, the dearth of information available to consumers to enable informed decision making.

4.4 The ability of consumers to make choices regarding their care was raised by inquiry participants, as entry to residential aged care usually happens suddenly and may be due to medical reasons. Consumers’ choice of facility and care type, ability to move to another facility and to provide open feedback are significant issues for the sector to address.

4.5 Another area of concern was the accessibility of the current system for prospective and current consumers, and their family members. The challenges faced by those with communication barriers, including consumers requiring language support, were also raised.

Increased competition within the aged care sector and the utility of consumer ratings in a ‘star’ or similar rating system were identified as ideas for reform.

**Aged Care Market**

In September 2017, the *Aged Care Legislated Review* (known as the Tune Review) described the current aged care system as a ‘supply-constrained system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages’. The Tune Review contrasted this with a consumer demand-driven system, which is ‘one in which the quantity and types of consumer demands for care drive the size and shape of the aged care system’.

In a consumer demand-driven aged care system, the Tune Review set out that a consumer would be assessed as needing care, receive appropriate funding, and would then choose their provider along with how, where and what services would be delivered.

In 2015, the Aged Care Sector Committee, appointed by the Australian Government to create a roadmap for aged care in Australia, stated that the aged care system had undergone changes in recent years to become more consumer focussed:

> Increased consumer choice will be a major change into the future. A fiscally sustainable aged care system that requires consumers to contribute to their care costs where they can afford to do so means that there will be increased consumer expectations for greater choice and control.

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2 The Aged Care Legislated Review (Tune Review) was conducted as part of changes to aged care introduced in the *Aged Care (Living Longer Living Better) Act 2013*. Mr David Tune AO PSM was appointed by the Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM MP, to conduct the review, which was released in September 2017. Mr David Tune AO PSM, *Aged Care Legislated Review*, September 2017, p. 34.

3 Mr David Tune AO PSM, *Aged Care Legislated Review*, September 2017, p. 34.


Box 4.1 Roadmap to a More Competitive Market

The Aged Care Sector Committee set out that creating a more competitive and innovative market would involve consumers being able to choose between aged care providers. Aged care providers would, in turn, ‘respond to the increasing diversity of consumers’ care needs, preferences and financial circumstances’ to contribute to a sustainable aged care system.⁶

Major features of a consumer-driven aged care system are:

- Consumers, their families and carers proactively preparing for their future care needs;
- A single process to assess a person’s care needs, operated by government and independent of providers;
- Consumer access to care and support regardless of cultural or linguistic background, sexuality, life circumstance or location;
- Dementia care as a core business of the aged care system;
- Increased consumer choice for care setting, type of care and support, with government no longer regulating the number or distribution of services;
- A single provider registration scheme;
- Market-determined price in a sustainable aged care sector, with government acting as a safety net when there is insufficient market response;
- A well-led and well-trained aged care workforce; and
- Greater quality and innovation driven by consumer choice.⁷

4.10 Catholic Health Australia stated that ‘unlike most other service industries, [the aged care system] is almost exclusively reliant on regulations to ensure the delivery of quality services and to protect consumers’. Catholic Health Australia set out the role of competition in the aged care market:

The contribution that competition in service provision and greater consumer choice and control can make to supporting higher quality services that are more responsive to consumer needs and preferences is diluted in the aged care

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⁶ Aged Care Sector Committee, Aged Care Roadmap, 2015, p. 2.
⁷ Aged Care Sector Committee, Aged Care Roadmap, 2015, p. 3.
sector by the rationing of services and the regulated balance of supply of home care and residential care services.  

4.11 Hall and Prior supported a focus on consumers rather than ‘recipients of care’, and characterised it as a ‘small, but important, shift in the language used in aged care to describe and define itself’. Hall and Prior recommended that aged care providers embrace a customer service orientation to deliver services that residents want:

An important part of a consumer orientation is transparency, open disclosure, and with greater input from consumers into the accreditation process and this move within the revised aged care quality standards is welcomed.  

**Consumer Rights**

4.12 Residents’ rights do not vary between aged care provider, and are protected by the *Aged Care Act 1997* (Aged Care Act). The *My Aged Care* website contains information on quality of care and consumer rights, and sets out: that rights are protected in resident agreements, the *Charter of care recipients’ rights and responsibilities – residential care* (the Charter), the Accreditation Standards for service providers and that residents have access to a complaints process.  

4.13 The Charter sets out that care recipients maintain the full and effective use of their consumer rights, along with personal, civil and legal rights, the right to quality care, the right to live without discrimination or victimisation and the right to make a complaint.  

4.14 Complaints regarding consumer rights in residential aged care can be made to the Aged Care Complaints Commissioner (Complaints Commissioner). The Complaints Commissioner can refer matters to the Australian  

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8 Catholic Health Australia, *Submission 17*, p. 5.  
Competition and Consumer Commission ‘where questions arise as to a service’s compliance with the Australian Consumer Law’.  

4.15 Civil Liberties Australia stated that a greater focus should be placed on maintaining the rights of older Australians:

Australians don’t lose rights and liberties when they pass an age milestone, say 70 years. If anything, they should gain greater rights, more respect, increased consideration and extra care. That is not how the system works now.  

Resident Agreements

4.16 Resident agreements are legal agreements between residents and providers and set out the care and services available, fees (including for additional services), how the complaints process will operate in the facility, and residents’ rights and responsibilities. A resident agreement may include other matters negotiated between the resident and the provider. The requirements for resident agreements are set out in the Aged Care Act and the User Rights Principles 2014 (User Rights Principles).  

4.17 The Aged Care Act further sets out that a resident agreement ‘must not contain any provision that would have the effect of the care recipient being treated less favourably in relation to any matter than the care recipient would otherwise be treated’. The Complaints Commissioner stated that resident agreements ‘cannot waive protections afforded under consumer law’.  

4.18 Elderlaw stated that individual resident agreements can vary, with two major forms. The first form of resident agreement ‘makes it clear’ that the standard of care required under the Quality of Care Principles 2014 (Quality of

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12 Aged Care Complaints Commissioner, Submission 28, p. 10.
13 Civil Liberties Australia, Submission 40, p. 1.
17 59(3) Aged Care Act 1997.
18 Aged Care Complaints Commissioner, Submission 28, p. 9.
Care Principles) must be adhered to, and is part of the obligation of the Provider. The second form of resident agreement ‘merely refers’ to the Quality of Care Principles, which ‘leaves the resident with recourse to the complaints system, and without an enforceable claim for breach’.  

4.19 Elderlaw was of the view of that the second form of resident agreement was more common, but could be ‘misleading and deceptive’ by allowing the resident to believe that the standard of care they will receive is clear and enforceable when it is not.

4.20 Elderlaw suggested reform which would see a resident agreement ensure that an aged care provider arrange and submit to arbitration if requested by a resident or representative.

4.21 Mr David Gavin stated that, in his experience, resident agreements were not always adhered to. Mr Gavin described personal accounts of family members of residents of a facility, in which personal hygiene products and mobility assistance were not provided as set out in resident agreements.

**Education and Awareness of Consumer Rights**

4.22 Education on consumer rights for residents of aged care is provided by the Older Person’s Advocacy Network (OPAN), a national network of organisations which delivers advocacy, information and education services to residents and workers in Australian Government-funded residential aged care. The OPAN delivers the National Aged Care Advocacy Program (NACAP), which is funded by the Australian Government.

4.23 The NACAP provides ‘free, independent and confidential advocacy support and information to older people (and their representatives)’ who receive Australian Government-funded residential aged care.

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19 Elderlaw, Submission 15, p. 13.

20 Elderlaw, Submission 15, p. 13.


22 Mr David Gavin, Submission 80, p. 33, 38.

23 Older Person’s Advocacy Network, Submission 36, p. 1.

On 8 August 2018, the Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, announced extra funding to OPAN to expand its delivery of services. The OPAN will use the $2 million in funding to develop key projects, including: national elder abuse advocacy response protocols, a national decision making system to support older people, a national elder abuse minimum dataset, elder abuse referral and support pathways, and researching the needs of rural and remote populations.25

The OPAN currently delivers education sessions on advocacy and rights to more than 40 000 aged care residents each year, but stated that a ‘large number’ of residential care facilities choose to decline OPAN’s offer to conduct free consumer education lessons.26 The OPAN is currently funded to provide 1400 education sessions per year across Australia, which it stated is ‘only a fraction of the number of aged care facilities that exist across the country’.27

The National Association of Community Legal Centres (NACLC) stated that private individuals have access to enforceable housing rights, including consumer claims. The NACLC stated that, unlike private individuals, residents of aged care may not have the same rights as tenants of other housing types, as ‘rights under consumer law are patchy and not well known, and would not cover the full range of rights referred to in the Principles accompanying the Aged Care Act’.28

Consumers’ awareness of their rights was questioned by inquiry participants. Anglicare Australia stated that consumer information is not always accessible:

Access to information about rights and responsibilities that is easy to understand is essential to empower residents and drive provider performance and accountability. This is not always available … There is a role here for providers, but equally there is a responsibility for those agencies and

25 The Hon Ken Wyatt AM MP, Minister for Senior Australians and Aged Care, ‘$2 Million in Extra Support to Tackle Elder Abuse’, Media Release, 8 August 2018.

26 Older Person’s Advocacy Network, Submission 36, p. 4.

27 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 14.

28 National Association of Community Legal Centres, Submission 91, pp 4-5.
associated advocacy bodies to provide the support, advance notice and visibility that residents might need.\textsuperscript{29}

4.28 The Council of the Ageing Australia (COTA Australia) recommended that providers ensure their staff undertake regular OPAN education on consumer rights.\textsuperscript{30}

4.29 The OPAN stated that consumers have regularly approached OPAN staff after education sessions in residential aged care facilities to raise issues, and have provided feedback that they were unaware of the service.\textsuperscript{31}

4.30 An inquiry participant, who did not wish to be named, stated that information on the application of Australian consumer law in a residential aged care setting was ‘seriously lacking’. The inquiry participant suggested that information should be provided in multiple formats which sets out example scenarios on acceptable quality, due care and skill, supply of service within a reasonable time and compensation.\textsuperscript{32}

4.31 The Quality Aged Care Action Group (QACAG) recommended that all residents and advocates should be provided with consumer advocacy service information on admission, and that ‘independent consumer advocates should be appointed to undertake regular visits to residents and represent them’.\textsuperscript{33}

4.32 Mrs Kate Mannix expressed the view that the current aged care system denies consumer rights, and ‘prevents the consumer from achieving financial remedies or service redress’.\textsuperscript{34} Mrs Mannix stated that ‘aged care recipients are also consumers and should have the same consumer rights as they did when they were not aged care recipients, guaranteed by the standard aged care contract’.\textsuperscript{35}

\textsuperscript{29} Anglicare Australia, \textit{Submission 61}, p. 6.


\textsuperscript{31} Mr Geoff Rowe, Olders Persons Advocacy Network, \textit{Official Committee Hansard}, Brisbane, 26 April 2018, p. 15.

\textsuperscript{32} Name Withheld, \textit{Submission 77}, p. 5.

\textsuperscript{33} Quality Aged Care Action Group, \textit{Submission 8}, p. 8.

\textsuperscript{34} Mrs Kate Mannix, \textit{Submission 12}, p. 5.

\textsuperscript{35} Mrs Kate Mannix, \textit{Submission 12}, p. 7.
Residents’ reliance on others for information on rights, and how they may apply, was put forward by Mrs Rosaleen Appelhans. Mrs Appelhans stated that residents rely on others for the rights set out in the charter, as ‘these rights almost always need to be enabled for the elderly through mechanisms provided by others’.  

Elderlaw drew attention to the lack of redress available to consumers of aged care, stating that the focus of the aged care system is on offering advice about complaints, and stated that, in aged care, ‘there is no redress for the individual, no improvement of the level of attention to their health needs, no overt recognition of harm and causation’. 

**Human Rights**

Some inquiry participants stated that human rights should be focussed on, rather than consumer rights. Anglicare Australia stated that the current focus of the aged care framework ‘forces providers to be naturally risk averse’ which can limit a resident’s right to make informed choices and take risks. 

Estia Health stated that ‘an approach that focuses on the protection of rights (consumer protection) does not go far enough’ and does not ‘acknowledge that residential aged care is not a transaction whose quality can be easily measured nor one from which one can withdraw, receive a refund and find another seller’. Estia Health suggested that a human rights-based approach will underpin aged care services in future.

Inquiry participants drew attention to the United Nations’ Principles of Older Persons, which enshrine the need for consumer protection.

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36 Mrs Rosaleen Appelhans, Submission 5, p. 1.
37 Elderlaw, Submission 15, p. 12.
38 National Association of Community Legal Centres, Submission 91, p. 5.
39 Anglicare Australia, Submission 61, p. 5
40 Estia Health, Submission 84, p. 3.
41 Office of the Public Advocate (Victoria), Submission 35, p. 6; Federation of Ethnic Communities’ Councils of Australia, Submission 50, p. 4; Law Council of Australia, Submission 86, p. 8; Corrimal Dementia Carers Support Group, Submission 95, p. 2.
Consumer Choice

4.38 The Aged Care Sector Committee stated that older Australians may be reluctant to discuss future aged care needs, and that ‘too often the first point of contact with the aged care system and decisions regarding aged care needs are made during a time of crisis’. The OPAN similarly stated that ‘we are seeing more and more that people enter aged care at a time of crisis’.

4.39 Inquiry participants highlighted the challenging circumstances under which families may need to find residential aged care for a family member, particularly if a person requires residential aged care after an injury or hospital stay. The Health Care Consumers’ Association (HCCA) gave a personal account of a consumer trying to find aged care for her mother following a fall:

The family was under significant pressure from hospital nursing staff to find a place and accept an offer. But the family were reluctant to take the first offer as they wanted to know things like: What is the general health of other residents? How long do people generally live at each facility? Is the quality of life good? Do they have access to health care? … The Audit Reports provide some but far from all of this information.

4.40 The OPAN also stated that older Australians face pressure from the health system to enter residential aged care:

A lot of people are being pushed out of hospital beds and into residential aged care who may have been able to return home with more planning and support, but it’s about freeing up the bed, and that’s deeply concerning at both ends.

4.41 The reality of consumers’ ability to make informed choices regarding residential aged care was also questioned by Dementia Australia, which stated that ‘market-based incentives do not work in a system that is

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42 Aged Care Sector Committee, Aged Care Roadmap, 2015, p. 5.
43 Mr Geoff Rowe, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 16.
44 Health Care Consumers’ Association, Submission 66, p. 9.
45 Mr Geoff Rowe, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 16.
operating at capacity or under supply. Many residents have no choice but to accept any facility that is available’.46

4.42 Dementia Australia further stated that those with dementia may find it particularly difficult to obtain an aged care place, as demand is greater than supply:

It seems inevitable that vulnerable, ‘resource-intensive’ consumers, including people with dementia and especially those with more complex care needs, will lose out if we rely solely on market forces to drive access and quality.47

4.43 The Vintage Reds of the Canberra Region stated that consumer choice related more to consumers considering entering retirement villages than entering residential aged care. The Vintage Reds of the Canberra Region set out that prospective residential aged care consumers’ choice is ‘limited by what they can afford, what is available at any given time, geographical constraints and their particular reasons for needing residential aged care’.48

4.44 Limited consumer choice was highlighted by Aged Care Matters, which stated that it is ‘extremely difficult’ for residents to exercise choice in aged care homes, as seen in the ‘low rates of changing providers in the event of dissatisfaction’.49

4.45 G W Hitchen stated that ‘families do not stand a chance of assessing what a nursing home will really be like for their family member’.50

4.46 Carers NSW suggested that Australian Aged Care Quality Agency (Quality Agency) audit reports ‘could be better utilised to aid consumers and carers in making informed choices in an increasingly consumer driven environment’.51

4.47 Care Guidance suggested attaching the funding entitlement for residential aged care to the consumer, rather than the provider. Care Guidance stated that this would ‘empower consumers with greater choice and control’, and make it harder for poor performing providers to continue:

46 Dementia Australia, Submission 7, pp 13-14.
47 Dementia Australia, Submission 7, p. 37.
48 Vintage Reds of the Canberra Region, Submission 63, pp 4-5.
49 Aged Care Matters, Submission 13, p. 2.
50 G W Hitchen, Submission 94, p. 17.
51 Carers NSW, Submission 30, p. 3.
This would make it easier for high quality providers to grow their presence with new homes and beds in line with demand for their services, while at the same time making it harder for poorer performing providers to rely on an allocation of bed licenses [approved places] to keep them in the market.\textsuperscript{52}

### Consumer Feedback

4.48 The role of the consumer in providing open, public feedback on aged care was raised by inquiry participants. Care Opinion Australia stated that consumers could drive an improvement in aged care quality:

> When consumer feedback systems are public, transparent, and independent of the provider, so that all interested stakeholders can see what consumers are saying and how providers are ‘listening and responding’, then there is a greater likelihood that the quality of care will be improved.\textsuperscript{53}

4.49 Care Opinion Australia highlighted its web-based platform for residents of aged care, and their family members, to ‘provide direct feedback regarding their experiences’ on a ‘public and transparent’ website.\textsuperscript{54} The website is moderated and de-identified, and a closed loop established between the feedback author and the staff in the named service in which providers are able to respond to the feedback.

4.50 Carers NSW stated that although the Quality Agency publishes Consumer Experience Reports, these should include a ‘user-friendly interface’ for comparing residential aged care facilities. Further, Carers NSW stated that the current accreditation system for aged care providers, which uses ‘met/not met’ in accreditation audit reports, provided ‘no point of comparison, giving little insight for consumers into the actual quality of a provider’.\textsuperscript{55}

4.51 Proposed Standard 6 of the Aged Care Quality Standards, which will replace the Quality Agency’s Accreditation Standards from 1 July 2019, sets out the

\textsuperscript{52} Care Guidance, \textit{Submission 82}, p. 5.

\textsuperscript{53} Care Opinion Australia, \textit{Submission 2}, p. 1.

\textsuperscript{54} Mrs Sue Palmer, Client Liaison Officer, Care Opinion Australia, \textit{Official Committee Hansard}, Brisbane, 26 April 2018, p. 30.

\textsuperscript{55} Carers NSW, \textit{Submission 30}, p. 3.
standards around feedback and complaints.\textsuperscript{56} The consumer outcome statement for Standard 6 states:

I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.\textsuperscript{57}

4.52 The corresponding organisation statement in Standard 6 requires the aged care provider to seek ‘regular input and feedback from consumers, carers, the workforce and others’, which will then be used to inform organisation-wide improvements. The provider must demonstrate that consumers and their representatives are encouraged to provide feedback and make complaints, that consumers are aware of advocates and language services and have access to these, that action is taken to respond to complaints, and that feedback and complaints are reviewed.\textsuperscript{58}

4.53 Care Guidance recommended that assessment against the new Standard 6 of the Aged Care Quality Standards include the content of the resident feedback.\textsuperscript{59}

**Consumer Experience Reports**

4.54 The Quality Agency stated that it is moving to provide more consumer-friendly information, and acknowledged that the current provision of information is not always accessible to the consumer:

As of next year, we’ll have much richer information around the compliance history of a home, in a much more consumer-friendly form. Our current findings are long text, and we are very aware that consumers don’t always


\textsuperscript{59} Care Guidance, *Submission 82*, p. 4.
find that accessible; we know that there’s room for improvement in accessibility of information.60

4.55 The Quality Agency publishes Consumer Experience Reports for aged care facilities, which may be found alongside the audit reports for a particular facility. Consumer Experience Reports ‘are aimed at promoting consumer choice by capturing the consumer experience of the quality of care and services in aged care’. Assessors from the Quality Agency ask aged care residents a set of interview questions during the accreditation or audit process. The answers are de-identified and collated for publication.61 Between May and December 2017, 460 Consumer Experience Reports were published to the Quality Agency’s website.62

4.56 Questions asked of residents include: ‘Do staff treat you with respect? Do you feel safe here? Do staff follow up when you raise things with them?’ Residents are also asked to express their level of agreement with statements such as: ‘The staff know what they are doing. This place is well run.’ A colour-coded bar chart displays consumers’ responses as a percentage against the criteria ‘Never, Some of the time, Most of the time, Always’.63

4.57 The OPAN supported the publication of Consumer Experience Reports, but stated that the processes in compiling the information were important and must avoid provider involvement in choosing residents to be interviewed:

In some cases we hear of cherry-picking people to be involved—the ones that aren’t going to raise too many issues when talking to the accreditation agency. A lot more work needs to be done around those sorts of things, ensuring the consumers inform that type of information.64

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60 Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency, *Official Committee Hansard*, Sydney, 5 March 2018, p. 41.


64 Mr Geoff Rowe, Older Persons Advocacy Network, *Official Committee Hansard*, Brisbane, 26 April 2018, p. 17.
4.58 The Quality Agency advised that it uses a ‘structured process for random sampling consumers for interviews’ to ‘mitigate the risk that selected care recipients are nominated by the home to be interviewed or that others are excluded’.\textsuperscript{65} The Quality Agency is working with public guardian agencies across Australia to raise awareness of the Consumer Experience Reports.\textsuperscript{66}

4.59 Inquiry participants were supportive of the Consumer Experience Reports, and the Aged Care Guild stated that the introduction of this measure had increased transparency in the quality of care.\textsuperscript{67}

4.60 The COTA Australia stated that it was supportive of an increased focus on the consumer through the Consumer Experience Reports and the consumer outcome statements in the new Aged Care Quality Standards. The COTA Australia recommended that the number of residents interviewed for the Consumer Experience Reports be increased from a minimum of 10 per cent to a minimum of 20 per cent, and the collection of this information on an annual basis.\textsuperscript{68}

4.61 In contrast, the Community and Public Sector Union (CPSU) stated that the Quality Agency had failed ‘to monitor and evaluate the effectiveness of new tools and processes, in particular, the Consumer Experience Report’.\textsuperscript{69} The CPSU also stated that interviewing residents for the Consumer Experience Report had added to the existing workload of Quality Agency assessors, and making the completion of audit and accreditation tasks ‘increasingly difficult to achieve’.\textsuperscript{70} The CPSU further stated that the time spent on conducting the Consumer Experience Reports ‘has meant far less time for in-depth interviews with residents’.\textsuperscript{71}

**Consumer Rating System**

4.62 The *Review of National Aged Care Quality Regulatory Processes* (known as the Carnell-Paterson Review) stated that consumer choice of aged care provider relies on information on provider performance being accessible, and that ‘at

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\textsuperscript{65} Australian Aged Care Quality Agency, *Submission 65*, p. 17.

\textsuperscript{66} Australian Aged Care Quality Agency, *Submission 65*, p. 18.

\textsuperscript{67} Aged Care Guild, *Submission 33*, p. 16.

\textsuperscript{68} Council of the Ageing Australia, *Submission 37*, p. 8.

\textsuperscript{69} Community and Public Sector Union, *Submission 59*, p. 2.

\textsuperscript{70} Community and Public Sector Union, *Submission 59*, p. 4.

\textsuperscript{71} Community and Public Sector Union, *Submission 59*, p. 7.
present, information on the quality of care in aged care homes does not achieve this objective’.  

4.63 The Carnell-Paterson Review stated that the ‘segregation and complexity of information makes it difficult for people to compare residential aged care homes’. Further, the Carnell-Paterson Review stated that the performance reporting system could make better use of accreditation audits conducted by the Quality Agency and consumer feedback.

4.64 The Carnell-Paterson Review recommended a star-rating performance system which would incorporate information from accreditation audits and Consumer Experience Reports into an overall score for each facility.

4.65 Care Guidance stated that consumer feedback is ‘key to differentiating between acceptable and excellent levels of care’, and stated that there were a number of possible models of consumer platforms. Nevertheless, Care Guidance stated that there were some limitations to consumer ratings platforms including fraudulent entries, and stated that any accreditation system would need to be ‘robust’.

4.66 Carers NSW recommended a rating out of five be given to a provider, and stated that such a system ‘not only aids consumers to make informed decisions, but also provides an incentive for providers to exceed the minimum quality standard in order to be more competitive’.

4.67 The COTA Australia, however, suggested that a comparative rating information website should be developed by the sector and funded by the Australian Government.

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72 The Review of National Aged Care Quality Regulatory Processes was announced by the Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM MP, in May 2017. Minister Wyatt appointed Ms Kate Carnell AO and Professor Ron Paterson ONZM to lead the Carnell-Paterson Review. The Carnell-Paterson Review was released in October 2017. Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 101.

73 Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 103.

74 Ms Kate Carnell AO and Professor Ron Paterson ONZM, Review of National Aged Care Quality Regulatory Processes, October 2017, p. 103.

75 Care Guidance, Submission 82, p. 6.

76 Carers NSW, Submission 30, p. 3.

77 Council of the Ageing Australia, Submission 37, p. 7.
A star-rating system was supported by some inquiry participants. In contrast, UnitingCare NSW/ACT stated that a star-rating system used in the United Kingdom of Great Britain’s (UK) aged care sector had not had a positive impact on the sector:

If we look at what has happened in the UK with regards to some of the star rating systems that they’ve put in place, they’ve not increased or enhanced the quality of care at all. It could cause a perversity within the system.

Star-rating systems used in the United States of America’s and the UK’s aged care sectors were highlighted by inquiry participants. The HCCA stated that the UK’s star-rating system allows consumers to view an assessment of a provider and requires the provider to display the rating on site and on its website. An online, interactive map is also published which allows consumers to compare providers on a geographic basis.

The Department of Health stated that a ‘star-rating system’ for aged care providers will not be implemented on the My Aged Care website as a star rating system ‘often has the feeling of a consumer rated system’ as opposed to one which evaluates against standards. The Department of Health further stated that a star-rating system may be better suited to being run by industry rather than the Government.

Experiences of Aged Care Consumers

Access to Information

Consumers stated that the information available for prospective residents, and their family members and carers, was difficult to access and could be confusing. Dementia Australia expressed the view that the amount of available information involved in the aged care system, including forms,
pamphlets and brochures, was ‘overwhelming’, and ‘had resulted in some consumers resorting to hiring a broker at a cost of $500-800 to assist in finding suitable residential care’.\(^{84}\)

4.72 Civil Liberties Australia set out the challenges faced by family members trying to navigate the aged care system, and the vulnerabilities that exist for those without assistance. Civil Liberties Australia stated that:

… a single person would find it extremely difficult to navigate the system to find a place in residential care. Being alone and in poor health, lacking computer skills and access to transport would be virtually insurmountable obstacles. Financial problems including the sale of a house to fund the accommodation deposit could expose older people to unscrupulous 'service' providers.\(^{85}\)

4.73 The OPAN stated that access to information offered benefits to prospective residents and their families:

Information is power, so the more information you give people, the more opportunities they have. A lot of families are involved when that decision comes. Will my parents use a website when they’re looking at residential aged care? Absolutely not: they’ll talk to me or my sisters.\(^{86}\)

4.74 The Victorian Council of Social Service (VCOSS) stated that consumers may find it difficult to access information:

Often the only information available to prospective residents is marketing material provided by the facility themselves, whether or not the service has ‘complied’ with accreditation requirements and any sanctions for previous non-compliance.\(^{87}\)

4.75 The COTA Australia stated that consumers find it difficult to access basic information about aged care services, including information on fees and charges, and services available. Conflicting information on bed availability was described by COTA Australia:

\(^{84}\) Dementia Australia, Submission 7, p. 15.  
\(^{85}\) Civil Liberties Australia, Submission 40, p. 6.  
\(^{86}\) Mr Geoff Rowe, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 17.  
\(^{87}\) Victorian Council of Social Service, Submission 47, p. 11.
Many reported that most residential services identify as having beds available on *My Aged Care*, for example, yet on enquiry to a specific provider they learned that the only bed available is beyond their price-range.88

4.76 Further, COTA Australia stated that a consumer had been told by a provider that ‘they weren’t allowed to give information about fees to consumers over the phone or on the website’, and recommended that consumers have greater clarity over unit prices of services.89

**Using the *My Aged Care* Website**

4.77 The *My Aged Care* website is the entry point for consumers into the aged care system, and provides information for prospective residents and their family members and carers on aged care services, contacts and support. The website is operated by the Department of Health, and also sets out whether a provider has been issued a notice of non-compliance and sanctions.90

4.78 The Tune Review stated that although the *My Aged Care* website had been a ‘major reform to Australia’s aged care system’, there were several areas where improvements could occur, such as information sharing between the website and other government agencies and care providers.91

4.79 The Australian Medical Association (AMA) suggested that the *My Aged Care* website link with My Health Record to ‘achieve better communication between the care team, faster access to hospital discharge summaries, fewer medication errors, and better access to Advance Care Directives’.92

4.80 Aged Care Crisis criticised the *My Aged Care* website, stating that it is a ‘product of the bureaucratic mind’, and questioned its place within the aged care system:

> It is part of the centrally controlled, structured, complex, process driven aged care system that has been created. It is rigid, impersonal and difficult to understand and navigate. It is inflexible and unable to respond flexibility to needs. People readily fall through the cracks.93

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90 Department of Health, *Submission 72*, p. 4.
93 Aged Care Crisis, *Submission 90 Attachment 1*, p. 44.
4.81 The HCCA stated that ‘many people do not have ready access to the My Aged Care website’, and suggested that additional information sharing be explored, such as support for advocacy services to advise individuals about residential care entry issues.94

4.82 Inquiry participants expressed the view that more information should be included on the My Aged Care website. The VCOSS suggested a ‘Trip Advisor’ style review function be incorporated.95

4.83 Dementia Australia stated that important consumer information, including price and quality, should be available on the My Aged Care website. Dementia Australia further stated that the reliance on the My Aged Care website as an information access point posed challenges for people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islanders, and the homeless.96

4.84 The COTA Australia suggested that information on the accreditation process and how residents and family members can participate in it be included on the My Aged Care website.97

4.85 The Department of Health stated that consumers without access to the My Aged Care website may obtain information through the contact centre, the Translating and Interpreting Service, or National Relay Service, and ‘printed information resources available from My Aged Care assessors and some service providers’.98

Consumers With No Family or Advocate

4.86 Inquiry participants expressed the view that there were limited protections for consumers with no family or advocate.99 Mrs Rosaleen Appelhans stated that ‘there is virtually no protection for the elderly who are without friends

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95 Victorian Council of Social Service, Submission 47, p. 3.
96 Dementia Australia, Submission 7, p. 16.
97 Council of the Ageing Australia, Submission 37, p. 8.
98 Department of Health, Submission 72, p. 15.
99 Name Withheld, Submission 18, pp 4-5.
and family capable of supporting them to exercise their rights. It is hard enough for those who do have such support’.100

4.87 Similarly, the Combined Pensioners and Superannuants Association of NSW (CPSA) stated that ‘bad things happen whether or not a resident has family or friends who are able to speak up for them, but obviously residents with no one are in an even worse position’. The CPSA supported an Official Visitors Scheme in which independent, impartial observers would be able to raise concerns.101

4.88 The QACAG stated that some residents of aged care may have family members who live too far away to visit frequently, and recommended that independent consumer advocates be appointed to visit and represent residents.102

4.89 Mrs Kate Mannix recommended that ‘there should be much more effort to determine whether there is, or is not, a family member or friend or other representative to assist the care recipient’. In the event that no family or friend can be identified, Mrs Mannix recommended that adult protection agencies should be subject to scrutiny and subject to prosecution if quality care is not delivered to the resident.103

4.90 The OPAN stated that access to advocacy through the NACAP is ‘particularly important for aged care residents who do not have family, friends or representatives to support them in voicing their concerns’. The OPAN suggested that, to address this, aged care providers should be required to provide residents with access to advocacy and consumer education on an annual basis, and that the relationship between the NACAP and the Community Visitors’ Scheme (CVS) be enhanced. The OPAN stated that the CVS should be used more, and could report concerns about mistreatment.104

4.91 Anglicare Australia advised that some residential aged care services are designed for residents who may not have family or advocate support, and stated that the Brotherhood of St Laurence, Anglicare SA at Brompton and

100 Mrs Rosaleen Appelhans, Submission 5, p. 2.
101 Combined Pensioners and Superannuants Association of NSW, Submission 21, p. 8.
102 Quality Aged Care Action Group, Submission 8, p. 7.
103 Mrs Kate Mannix, Submission 12, p. 8.
104 Older Person’s Advocacy Network, Submission 36, pp 4-5.
St Bartholomew’s House in Perth ‘provide dedicated services that are so often the closest thing to a home and a community that their residents have ever known’.  

4.92 Aged and Community Services Australia highlighted the avenues available for consumers with no family or advocate, including the regulatory agencies, state administrative tribunals, consumer advocacy bodies including OPAN and the CVS.

4.93 Catholic Health Australia also highlighted the work of OPAN and the CVS, but stated that ‘there is a case for strengthening protection and support arrangements for older people who do not have family, friends or other dependents to help them exercise choice and with their rights in care’. Catholic Health Australia suggested that providers be funded to provide pastoral care and support, which could ‘provide consumer assistance and advocacy independently from day-to-day personal and clinical care’.

4.94 The Office of the Public Guardian (Queensland) (OPG Queensland) described the framework for guardianship for adults with impaired decision-making capacity. The OPG Queensland stated that it is a guardianship of last resort:

My guardianship clients in the aged care system are the most likely to have nobody else in their lives. That’s why I’ve been appointed. They tend to have the most complex needs. Some of them have come directly from prison or mental health facilities and go straight into aged care, and they are very vulnerable to abuse and need somebody to represent their rights and interests and speak out on their behalf.

4.95 Further, the OPG Queensland stated that the guardianship clients ‘are heavily dependent on daily personal support. They often have limited ability to speak out against ill-treatment, abuse or poor practice’. The Queensland Community Visitor Program (CVP), which operates under the OPG Queensland, is not able to enter Australian Government-funded

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105 Anglicare Australia, Submission 61, p. 6.

106 Aged and Community Services Australia, Submission 16, pp 7-8.

107 Catholic Health Australia, Submission 17, p. 6.

residential aged care, which limits the ability to act on a vulnerable person’s behalf.\(^{109}\)

**Consumers from Culturally and Linguistically Diverse Backgrounds**

4.96 The challenges faced by consumers from culturally and linguistically diverse (CALD) backgrounds were highlighted by inquiry participants, and particularly for CALD aged care residents with dementia.

4.97 The AMA stated that in 2021, 30 per cent of the older population of Australia will have been born in a country other than Australia.\(^{110}\) The AMA stated that this presents providers with a ‘major challenge’ to incorporate different cultures, and communicate with consumers who may have low levels of English literacy. The AMA also recommended that aged care providers be culturally aware and informed of Aboriginal and Torres Strait Islander populations.\(^{111}\)

4.98 The Federation of Ethnic Communities’ Councils of Australia (FECCA) stated that people from a CALD background are ‘less likely to utilise residential aged care services’ due to the barriers faced in accessing and engaging with services. The FECCA stated that barriers include: lack of awareness or knowledge of the services offered, complexity of the system, language barriers, and lack of CALD aged care providers.\(^{112}\)

4.99 The FECCA stated that ‘effective communication and an understanding of cultural values are essential to the carer and resident relationship’, and recommended that staff make use of symbols or pictures to convey information if necessary.\(^{113}\)

4.100 The Victorian Multicultural Commission (VMC) stated that there is a support gap for people from CALD backgrounds, particularly when:

- Care needs discussion, and the development of care plans occurs without the involvement of an interpreter or bilingual staff member;

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\(^{110}\) Australian Medical Association, *Submission 23*, p. 11.

\(^{111}\) Australian Medical Association, *Submission 23*, p. 11.

\(^{112}\) Federation of Ethnic Communities’ Councils of Australia, *Submission 50*, p. 2.

\(^{113}\) Federation of Ethnic Communities’ Councils of Australia, *Submission 50*, p. 3.
Residents and their family members face difficulties in communicating problems and making complaints; and

Forms and paperwork are only provided in English, with no translation or assistance.\textsuperscript{114}

4.101 The VMC stated that many older people ‘revert to their first language as they age’, making language support particularly important for residents of aged care from a CALD background. Further, the VMC stated that unqualified interpreters or family members have been used to provide interpreter assistance, which ‘jeopardises confidentiality and residents’ independence’.\textsuperscript{115}

4.102 The VMC recommended that aged care staff be provided with training on ‘how to care for residents from multicultural backgrounds who present additional and different challenges in comparison to mainstream older people’.\textsuperscript{116}

4.103 The National Council of Women of Australia suggested that providers should ensure that there is an ‘allocated support person who is familiar with client’s culture and religious background’. Further, anyone responding to allegations of mistreatment of a person from a CALD background or who is Aboriginal and Torres Strait Islander should have ‘specific training in cultural sensitivity or competence’.\textsuperscript{117}

4.104 An inquiry participant, who did not wish to be named, recommended the provision of brochures in different languages to be visible in residential aged care.\textsuperscript{118}

**LGBTI Consumers**

4.105 The experience of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) consumers was highlighted by the National LGBTI Health Alliance (the Alliance). The Alliance operates the Silver Rainbow program, which provides policy and program advice to the Department of Health and aged

\textsuperscript{114} Victorian Multicultural Commission, \textit{Submission 67}, p. 6.


\textsuperscript{117} National Council of Women of Australia, \textit{Submission 62}, p. 3.

\textsuperscript{118} Name Withheld, \textit{Submission 43}, p. 3.
care sector to achieve ‘the best possible health outcomes for LGBTI elders by ensuring aged care services are inclusive and accessible’.119

4.106 The Alliance stated that older LGBTI Australians may suffer from discrimination in residential aged care, such as:

- Being threatened with eviction or refused admission to residential aged care facilities;
- Visitors, personal care services and partners prevented from visiting or participating in medical decision making;
- Refusing to allow LGBTI elders to display public affection, to display cultural tokens, artefacts, pictures or memorabilia, or couples to share rooms;
- Refusing to allow a transgender or gender diverse elder to be placed in a ward that corresponds with their gender identity, or being prevented from dressing or presenting according to one’s identified gender;
- Physical or psychological abuse, neglect and/or abandonment, including medications being withheld; and
- Being involuntarily ‘outed’ or threatening to out somebody’s gender or sexuality.120

4.107 The Alliance stated that older LGBTI Australians may rely on family members to advocate for them, which can, in some cases, lead to vulnerability:

In some instances, some family members may be not be aware of and/or hostile to their relatives being LGBTI. As a result, LGBTI elders may be vulnerable to having their wishes disregarded by relatives or carers when making financial, property and medical decisions.121

4.108 Hall and Prior described the efforts of the staff of one of its facilities in providing care and advocacy to a resident who wished to transition to a transgender identity, but whose family was unaware of the resident’s wishes. The resident expressed a desire to wear a dress and then to identify as transgender, but was concerned at the reaction of other residents and family members. The facility staff arranged care conferences with family

119 National LGBTI Health Alliance, Submission 48, pp 1-2.
120 National LGBTI Health Alliance, Submission 48, p. 2.
121 National LGBTI Health Alliance, Submission 48, p. 3.
members, focussing on mediation and education, leading to a positive outcome.\textsuperscript{122}

**Concluding Comment**

4.109 The aged care market experiences a high level of demand for services, which has led to a loss of competition in the market. Consumers are not able to exercise full choice of aged care facility due to: urgent need to enter residential aged care, geographic or economic constraints, and complexity of care required.

4.110 Inquiry participants stated that there was a low level of awareness of consumer rights and advocacy services among residents and family members. It was suggested that the My Aged Care website should hold a greater range of consumer-oriented information, including information on how to participate in the accreditation process for residential aged care services and consumer ratings. The accessibility of the My Aged Care website was questioned, particularly for those with language barriers or who find it difficult to use the Internet.

4.111 The Older Persons Advocacy Network (OPAN) delivers the National Aged Care Advocacy Program (NACAP), which is funded by the Australian Government. The NACAP provides an important service for consumers, by delivering free, independent and confidential advocacy. The OPAN is able to deliver education sessions on advocacy and consumer rights to around 40 000 aged care residents per year, and recently announced extra funding will enable it to expand its reach.

4.112 The Committee believes that consumer choice and awareness would be enhanced by consumer experience reporting including data on the number of complaints and reportable incidents that have been lodged, responded to and resolved at individual aged care facilities. Such reporting would increase public transparency and allow members of the public to access more detail.

4.113 A consumer rating system for residential aged care facilities was suggested by inquiry participants. This system could potentially resemble ‘Trip Advisor’, with a combination of star-ratings and consumer feedback. It was

\textsuperscript{122} Hall and Prior, *Submission 105*, p. 9.
suggested that such a system may be more appropriately maintained by the aged care sector, rather than the Australian Government.

4.114 Consumers with no family or advocate are reliant on aged care providers for their care and quality of life, and may not be able to communicate issues regarding care or experience for various reasons. The important work of advocates was highlighted by inquiry participants.

**Recommendation 11**

4.115 The Committee recommends that the Department of Health work with the aged care sector to implement a rating system (for example, a star or point rating system) for residential aged care facilities, and develop an action plan for how such a system could be implemented.

**Recommendation 12**

4.116 The Committee recommends that the public be provided with information through the *My Aged Care* website regarding the number of complaints and reportable incidents that have been lodged, responded to and resolved, and the number of complainants, at individual aged care facilities.

**Recommendation 13**

4.117 The Committee recommends that the Australian Government examine ways to ensure all consumers have access to the Older Persons Advocacy Network (OPAN) advisory services, and include in consumer experience reports the providers that refuse OPAN access to their facilities.

**Recommendation 14**

4.118 The Committee recommends that the Australian Government agencies responsible for the delivery of aged care services commit to a more consumer-oriented focus, with greater, and more transparent, consumer involvement in the delivery of aged care services.
5. Where To From Here?

Overview

5.1 The evolution of Australia’s aged care system towards a consumer-driven, market-based model was highlighted by a number of inquiry participants. The current aged care market has an under supply of residential aged care places, particularly for those with dementia, which restricts choice for consumers and innovation for aged care providers.

5.2 Australia’s ageing population presents challenges to the aged care system as it currently operates. By 2056, older Australians will make up 22 per cent of the population, an increase from today’s figure of 15 per cent.\(^1\) This will lead to significant pressure on the aged care system, particularly as dementia rates also increase to more than one million dementia sufferers by 2056, which is more than double today’s figures.\(^2\)

5.3 Although the aged care system is evolving, careful planning will need to be undertaken to ensure that the quality and type of care delivered matches the expectations of current and future residential aged care consumers.

Changing Expectations, Changing Culture

5.4 Australia’s ageing population will see a larger percentage of Australians over the age of 65 by 2056, but it will also lead to a changing age profile. The

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\(^2\) Dementia Australia, *Submission 7*, p. 7.
Australian Institute of Health and Welfare (AIHW) projects the proportion of Australians between the ages of 65 to 74 years to decrease from representing 57 per cent of Australia’s older people to representing 45 per cent in 2046. The next age bracket, between 74 to 84 years is set to increase from 30 per cent to 35 per cent, and the 85 years and over age bracket will increase from 13 per cent to 19 per cent in the same time period.3

5.5 The Australian Medical Association (AMA) stated that the aged care system currently ‘does not have the capacity, capability or systems integration to adequately deal with this growing, ageing population’.4 The Queensland Nurses and Midwives’ Union (QNMU) similarly stated that there may not be enough Registered and Enrolled Nurses (RNs, ENs) to be able to meet minimum targets for nursing staff in residential aged care. The QNMU stated that the targets could not be met today, but the workforce could be grown to reverse the ‘long-term decline’ in the number of RNs and ENs.5

5.6 The Department of Health stated that it is currently examining the longer term needs of the aged care workforce:

There is a view that the aged-care workforce will grow to almost one million people over the next decade. It will become a really significant part of the economy. So we need to make sure we get the right kind of people who are skilled in the right way and paid in the right kind of framework.6

5.7 The Department of Health’s Aged Care Workforce Strategy Taskforce (Taskforce) has been established to develop a ‘strategy for growing and sustaining the workforce providing aged care services and support for older people, [and] to meet their care needs in a variety of settings’.7 The Taskforce

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4 Australian Medical Association, Submission 23, p. 2.

5 Ms Sandra Eales, Assistant Secretary, Queensland Nurses and Midwives’ Union, Official Committee Hansard, Brisbane, 26 April 2018, p. 12.

6 Ms Catherine Rule, First Assistant Secretary, Aged Care Reform Taskforce, Department of Health, Official Committee Hansard, Canberra, 1 May 2018, p. 1.

has focussed on five strategic imperatives for the future of the aged care workforce:

- Recognising consumer demand, and ‘acknowledging it is essential to have people that want to belong to this industry’;
- Industry leadership, mindset and accountability;
- Transitioning the industry operating model to a future state;
- Industry attraction and retention; and
- Using research and technology for new models of care and practice.8

Next Generation of Aged Care Consumers

5.8 Aged care providers, advocates and family members of aged care residents described the changing demographics of aged care consumers as the Australian population ages and the generation of ‘baby boomers’ begins to enter residential aged care.9

5.9 The ‘changing face’ of aged care users was put forward by the Older Persons Advocacy Network (OPAN). The OPAN stated that the current generation of aged care consumers have a different set of expectations to the next generation:

When I started in my current role, about four years ago, and talked to the advocates who have been working for many years about the current users of aged care they described them as, 'The grateful generation'. They are a cohort of people who are grateful for what they get, they’re reluctant to complain and they accept things that others wouldn’t necessarily.10

5.10 Mrs Yvonne Buters similarly stated that the current generation of aged care residents are ‘a generation who have typically not complained, especially to authority figures and government’.11

5.11 The OPAN stated that the effects of the changing face of aged care consumers had started to be seen in home care based services, and that

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9 The ‘baby boomer’ generation is generally considered to include those born in the post Second World War years of 1946 to 1965.

10 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, Older Persons Advocacy Network, Official Committee Hansard, Brisbane, 26 April 2018, p. 14.

11 Mrs Yvonne Buters, Submission 24, p. 2.
'residential aged care absolutely needs reform'. The New South Wales Nurses and Midwives’ Association (NSW NMA) also stated that the standard of care currently being delivered ‘won’t meet the expectations of [the next] generation when we face it’.

5.12 Estia Health agreed that the next generation of residential aged care users will have different expectations around quality of care:

Contemporary consumers and our interactions with the next generation of aged care residents provide strong indicators that there is an expectation of more than the baseline Government requirements reflected in the legislation.

5.13 The Aged Care Industry Association stated that more funding for residential aged care would be needed to meet the needs of older Australians in the future, and stated that: ‘If you put today’s consumers in a 1950s hospital, I think you’d have an awful lot of complaints going on. As our expectations and our requirements expand, they do get more expensive’.

5.14 The Federation of Ethnic Communities’ Councils of Australia (FECCA) drew attention to the increasing numbers of older Australians from culturally and linguistically diverse (CALD) backgrounds who will require culturally appropriate care. The FECCA recommended that aged care providers have CALD strategies and training for staff in cultural competency.

5.15 The Aged Care Complaints Commissioner (Complaints Commissioner) advised that it had begun to use new channels to disseminate information, including producing videos on YouTube and using social media in order to reach out to the ‘next-generation cohort’.

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13 Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, *Official Committee Hansard*, Canberra, 11 May 2018, p. 50.
14 Estia Health, *Submission 84*, p. 3.
16 Federation of Ethnic Communities’ Councils of Australia, *Submission 50*, p. 4.
Change in Culture

5.16 Anglicare Australia suggested that a change in culture in residential aged care is needed, and recommended a focus on the ‘purpose of care’, which it defined as ‘not only about avoiding harm, but … the wellbeing and the quality of life enjoyed by people in care’. Anglicare Australia acknowledged that achieving cultural change is difficult, ‘especially across large organisations and industries’. Further, Anglicare Australia stated that a ‘robust complaints and disclosure regime needs to sit alongside this sense of the purpose of care’.18

5.17 Civil Liberties Australia put forward the view of an older Australian, who called for a change in culture around aged care:

… aged care in Australia is primarily regarded as in need of better management … but not needing an entirely different value given to old age. Nowhere is it seen as a priority to listen to and speak with elderly people themselves, as the main people that Aged Care should be for.19

5.18 New Aged Care recommended a change in culture which focusses on the resident: ‘We need to go back to basics, with resident centred care the priority, where policies and procedures support rather than oppose the model’.20 Further, New Aged Care stated that the current aged care system does not see collaboration:

Our current situation where care providers work in silos with little or no collaboration between RACFs, accreditation bodies & medical services, results in dysfunctional, costly and at times inappropriate care for residents.21

5.19 Professor Joseph Ibrahim suggested that international examples from Holland and Sweden offer good models, and stated that Holland and Sweden ‘care about the population and want to integrate them and have them as part of society’. Professor Ibrahim contrasted this with his view of

18 Anglicare Australia, Submission 61, p. 4.
19 Civil Liberties Australia, Submission 40, p. 6.
20 New Aged Care, Submission 70, p. 11.
21 New Aged Care, Submission 70, p. 11.
the Australian aged care system, which was characterised as being driven by avoiding hospitalisation of older Australians.22

### Innovation in Residential Aged Care Facilities

5.20 Aged care providers described innovative models developed in response to consumer needs, and the positive effect these models had on residents. Innovative policies around dementia care were highlighted by Dementia Australia, who described the policies of the Grafton Aged Care Home for residents with dementia and others. After collaborating with Dementia Australia on staff education around the needs and wants of those with dementia, the Grafton Aged Care Home developed an ‘open doors’ policy in its secure dementia unit.23

5.21 Following the open doors policy at Grafton Aged Care Home, Dementia Australia stated that the facility had developed an afternoon café and friendship morning, which allows residents to participate in meaningful activities while assisting staff workloads. Dementia Australia stated that as a result of this innovation, ‘staff members have witnessed a reduction in wandering and an increased appetite in residents when involved in the preparation of food’. The ‘Friendship Morning’ initiative provides one-on-one meaningful activities for residents to participate in, run by recreational activities officers and assistants in nursing with a sound knowledge of dementia care.24

5.22 The Aged Care Guild highlighted the model of care used in Bupa’s residential aged care facilities. This model aims to deliver person-centred care through a multi-disciplinary team to achieve ‘better health outcomes for residents through access to medical services and choice in how and where they receive care’.25

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22 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University Victorian Institute of Forensic Medicine, *Official Committee Hansard*, Melbourne, 6 March 2018, p. 13.


24 Dementia Australia, *Submission 7*, pp 30-31. Other innovations include moving from using plastic cups and plates to china crockery for tea, coffee, and meals, and a ‘Resident of the Day’ initiative designed to allow staff to understand a resident’s history and engage more fully with them.

25 Aged Care Guild, *Submission 33*, p. 16.
Box 5.1 Case study: Flying Squads

The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) stated that ‘flying squads’ are used in some regions to assess and (if possible) treat people in aged care facilities whose health is rapidly deteriorating, and potentially reduce the rate of hospitalisation. The ANZSGM described the process and stated:

We ... have flying squads that go out urgently to see people who are deteriorating, so, instead of a resident in an aged-care facility deteriorating and being put in an ambulance and going to an emergency department, we now have a lot of teams that can urgently go out and see these people and assess them, and, through this mechanism, we’ve been able to reduce their hospitalisation by 90 per cent.\(^\text{26}\)

The ANZSGM stated that the flying squad: assesses the resident; talks to staff and family members; consults general practitioners; constructs a management plan; and provides treatment. This process takes place within two to four hours.\(^\text{27}\)

Box 5.2 Case study: Dementia Villages

Innovative approaches to residential aged care have emerged internationally and are being trialled in Australia, such as the ‘dementia village’ model of residential aged care facility.

In the Netherlands, the Hogewey Care Centre contains a specially designed village, known as Hogeweyk, with 23 houses for 152 older people with dementia. In this village, residents are grouped together based on their ‘lifestyle’ and characteristics and manage the household together, with the assistance of staff.\(^\text{28}\)

Washing and cooking are done each day in the houses, groceries are sourced from the village’s supermarket, and residents are able to move

\(^{26}\) Dr Peter Neil Gonski, New South Wales Division Committee, Australian and New Zealand Society for Geriatric Medicine, *Official Committee Hansard*, Sydney, 5 March 2018, p. 12.

\(^{27}\) Dr Peter Neil Gonski, Australian and New Zealand Society for Geriatric Medicine, *Official Committee Hansard*, Sydney, 5 March 2018, p. 15.

around the village’s gardens, park and square. The village has been designed to allow a continuation of the resident’s lifestyle and promotes autonomy and independence, while providing assistance.\(^{29}\)

A Tasmanian dementia village is currently being developed by Glenview Community Services and HESTA, with Australian Government funding. The ‘Korongee’ facility will be based on the Hogeweyk model and will see 15 homes set in a village setting which includes streets, a supermarket, cinema, café, beauty salon and gardens.\(^{30}\)

### Intergenerational Living

5.23 The Victorian Council of Social Service (VCOSS) highlighted a Homeshare program, which is based in Melbourne. The Homeshare program ‘matches older people living in their own home with people willing to provide some care and household maintenance in return for accommodation’. The VCOSS also drew attention to an intergenerational living trial in the Netherlands, which offers free accommodation within an aged care facility to students, in exchange for 30 hours per month of socialising with residents.\(^{31}\)

5.24 The VCOSS described trials of including childcare centres within aged care facilities, and stated that Playgroups Victoria had run playgroups in Victorian residential aged care facilities with positive effects:

> Workers report people with dementia become more lucid and engaged chatting with toddlers, and children can learn a lot from engaging with older people. Intergenerational activities show older people that they are valued as individuals that still possess lifelong skills, rather than just being passive recipients of care.\(^{32}\)

### Concluding Comment

5.25 Australia’s ageing population poses a significant challenge to the Australian aged care system as it currently operates. Although change has been


observed, and a focus on the consumer has emerged, there remains a need for reform.

5.26 The model for operation and funding of aged care was designed at a time when the profile of the aged care sector was different. Consumer needs and expectations have changed as people enter aged care at a later stage in life, often with higher medical needs, and the aged care model has not adequately responded.

5.27 This report, along with so many other inquiries and it is assumed the Royal Commission, has or will find major deficiencies within the aged care sector. It is vital that Australians of all generations can have confidence that Australia will provide high quality aged care that allows people to live in dignity and with appropriate medical care.

5.28 The next generation of older Australians, the ‘baby boomers’, will place different demands on the standard and type of care provided in residential aged care facilities. Inquiry participants stated that the next generation will be more likely to demand a higher standard of care. This will require government to evaluate the adequacy of existing funding and how we fund aged care into the future.

5.29 Increasing numbers of Australians with dementia will also place significant strain on the aged care system. Alternative models of residential aged care have emerged overseas, and a ‘dementia village’ model of care will be trialled in Tasmania. Currently, 52 per cent of residents of aged care facilities have dementia. As dementia rates are expected to increase, the Committee is pleased that innovative new models of care are being explored.

5.30 Aged care providers have begun to respond to consumer pressure and have implemented new, person-centred policies, and have observed positive effects from these policies. The Committee encourages providers to continue thinking of innovations and responding to consumers as their needs and wishes change.

5.31 Strategies to grow the aged care workforce will require collaboration between the aged care sector and Australian Government, in order to ensure that the changing needs and increasing numbers of Australians in aged care receive the quality and type of care they require.

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Mr Trent Zimmerman MP
Chair

12 October 2018
A. Submissions

1  Greysafe Inc
2  Care Opinion Australia
3  Confidential
4  Ms Lyndall Kay
5  Mrs Rosaleen Appelhans
6  NSW Nurses and Midwives' Association
7  Dementia Australia
8  Quality Aged Care Action Group Inc.
9  Mrs Sue Smith
10 Name Withheld
11 Confidential
12 Mrs Kate Mannix
13 Aged Care Matters
14 Name Withheld
15 Elderlaw
16 Aged & Community Services Australia
   ▪ 16.1 Supplementary to submission 16
17 Catholic Health Australia
18 Name Withheld
19 Association of Independent Retirees Ltd - Fleurieu Peninsula Branch
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<th>No.</th>
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<td>Australian Law Reform Commission</td>
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<td>Combined Pensioners &amp; Superannuants Association of NSW Inc.</td>
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<td>United Voice</td>
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<td>Mrs Yvonne Buters</td>
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<td>Ms Robyn Nolan</td>
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<td>Aged Care Complaints Commissioner</td>
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<td>Professor Joseph Ibrahim</td>
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<td>Ms Fiona Duff</td>
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<td>Office of the Public Advocate (Vic)</td>
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<td>National Association of People With HIV Australia</td>
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<td>Speech Pathology Australia</td>
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Queensland Nurses and Midwives' Union
  44.1 Supplementary to submission 44
Australian Physiotherapy Association
  45.1 Supplementary to submission 45
Confidential
Victorian Council of Social Service
National LGBTI Health Organisation
Painaustralia
Federation of Ethnic Communities' Councils of Australia
Australian Association of Social Workers
HammondCare
Australian Nursing and Midwifery Federation
Confidential
Townsville Community Legal Service Inc
Ms Denise Newton
Australian College of Nursing
  57.1 Supplementary to submission 57
  57.2 Supplementary to submission 57
Name Withheld
Community and Public Sector Union
Office of the Public Advocate
Anglicare Australia
National Council of Women of Australia
Vintage Reds of the Canberra Region Inc.
Name Withheld
Australian Aged Care Quality Agency
Health Care Consumers’ Association Inc.
Victorian Multicultural Commission
Debra Aloschi and Lisa Mooney
Name Withheld

New Aged Care

Care Leavers Australasia Network

Department of Health
  - 72.1 Supplementary to submission 72
  - 72.2 Supplementary to submission 72
  - 72.3 Supplementary to submission 72

Business Council of Co-operatives and Mutuals

UnitingCare Australia
  - 74.1 Supplementary to submission 74
  - 74.2 Supplementary to submission 74

Name Withheld

Name Withheld

Name Withheld

Name Withheld

ACT Government

Mr David Gavin

The Royal Australian College of General Practitioners

Care Guidance

Aged Care Industry Association
  - 83.1 Supplementary to submission 83

Estia Health
  - 84.1 Supplementary to submission 84

Name Withheld

Law Council of Australia

Ms Sofia Mercer

Western Australian Department of Health

Ms Goya Dmytryshchak

Aged Care Crisis Inc
91 National Association of Community Legal Centres
92 Health Services Union
93 Confidential
94 G W Hitchen
95 Corrimal Dementia Carers support Group
96 Queensland Government
  • 96.1 Supplementary to submission 96
97 Mrs Judith Nicholas
98 Mr Robert C Anderson
99 Confidential
100 Resthaven Incorporated
101 Aged Rights Advocacy Service Inc.
102 Mrs Joy Rock
103 Mrs Margaret Daly
104 Confidential
105 Hall & Prior Health and Aged Care Group
106 Name Withheld
B. Exhibits

1. Confidential

2. Confidential

3. Professor Joseph E Ibrahim
   Residential Aged Care Communiqué Issue: October 2016
   a) Premature deaths of nursing home residents: an epidemiological analysis, Medical Journal of Australia, 2017
   b) Recommendations for prevention of injury-related deaths in Residential aged care services, Health Law & Ageing Research Unit, Department of Forensic Medicine, Monash University

4. United Voice
   United Voice Submission to the Senate Community Affairs References Committee, The future of Australia’s aged care workforce, March 2016

5. Care Leavers Australasia Network
   Presentation: Third National Elder Abuse Conference 2014

6. Professor Joseph E Ibrahim
   Professor Joseph E Ibrahim, 2017, Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services: Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, Melbourne
   a) Murphy BJ, Bugeja LC, Pilgrim JL, Ibrahim JE, December 2017, Suicide among nursing home residents in Australia: A national population-based retrospective analysis of medico-legal death investigation information, International Journal of Geriatric Psychiatry
7 Office of the Public Advocate (Vic)

Client incident management summary guide, Health and Human Services, State Government of Victoria

a) Client incident management guide: Client incident management system, November 2017, Government of Victoria

8 Victorian Multicultural Commission

Submission template: Discussion Paper: Future reform – an integrated care at home program to support older Australians

9 Palliative Care South Australia

A Day in the Life of a Personal Carer: Two Perspectives

10 Confidential

11 Helping Hand

The Helping Hand Way – An Overview

a) The Helping Hand Way Program: Evaluation Overview and Matrix

b) The Helping Hand Way Mobile Phone App Screenshots

c) The Organisation of Risk: How do dementia care providers adapt to regulation? The Cognitive Decline Partnership Centre, 2018

12 Aged Rights Advocacy Service Inc.

A decade on: Shedding light on compulsory reporting, July August 2016 - Linda Belardi, Australian Ageing Agenda

a) How do we protect the rights of people in aged care? Carolanne Barkla, INDAILY Opinion

b) Draft Position Statement: Cameras in Aged Care, September 2016, Aged Rights Advocacy Service

c) The ethics of using cameras in care homes, Fisk M, Florez-Revuelta F, 2016, Nursing Times

13 Mrs Margaret Daly

Article: Dementia Nursing homes lack resources: Drugs, straps used to control residents

14 Office of the Public Advocate Queensland
Paper: Legal frameworks for the use of restrictive practices in residential aged care: An analysis of Australian and international jurisdictions

15 Office of the Public Guardian
The Office of the Public Guardian, Community Visitor Program (Adult)
a) The Office of the Public Guardian, Submission to the Senate Community Affairs References Committee, August 2017

16 Painaustralia
Australian Pain Society, Pain in residential aged care facilities, 2nd edition

17 New South Wales Nurses and Midwives’ Association
Ratios save lives

18 Mr Bill Mitchell, Townsville Community Legal Service Inc
C. Hearings and Witnesses

Thursday, 1 March 2018 - Canberra

Department of Health
- Ms Catherine Rule, First Assistant Secretary, Aged Care Reform Taskforce
- Ms Amy Laffin, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch
- Ms Jo Mond, Assistant Secretary, Specialised Programs and Regulations Branch

Monday, 5 March 2018 - Sydney

Australian Law Reform Commission
- Dr Julie McKenzie, Senior Legal Officer
- Mr Matthew Corrigan, Principal Legal Officer

Elderlaw
- Mr Rodney Lewis, Senior Solicitor

Australian and New Zealand Society of Geriatric Medicine
- Dr Peter Gonski, NSW Division Committee
- Dr Patricia Reyes, NSW Division Committee

Quality Aged Care Action Group
- Mrs Margaret Zanghi, President

Australian College of Nursing
- Adjunct Professor Kylie Ward, Chief Executive Officer
Ms Marina Buchanan-Grey, Executive Director, Professional Combined Pensioners & Superannuants Association of NSW

Mr Paul Versteeg

Australian Aged Care Quality Agency

Mr Nick Ryan, Chief Executive Officer
Ms Christina Bolger, Executive Director, Regulator Policy and Performance
Ms Pamela Christie, Executive Director, Industry Engagement and Communications

Tuesday, 6 March 2018 - Melbourne

Australian Physiotherapy Association

Mr Rik Dawson, Director
Ms Christine Leach, Policy Advisor

Professor Joseph Ibrahim, Private capacity

Office of the Public Advocate (Vic)

Ms Colleen Pearce, Public Advocate (Vic)
Ms Sophia Spada-Rinaldis, Policy and Research Officer

Aged Care Complaints Commissioner

Ms Rae Lamb, Aged Care Complaints Commissioner

Speech Pathology Australia

Ms Gail Mulcay, Chief Executive Officer
Ms Patricia Johnson, Senior Advisor, Ethics and Professional Issues

Victorian Multicultural Commission

Mr Tsebin Tchen, Commissioner
Mr Tony O’Hea, Manager, Research and Policy
Mr Walter Rapopart, Commissioner

Thursday, 15 March 2018 - Adelaide

Aged Care Industry Association

Mr Luke Westenberg, Chief Executive Officer
Palliative Care South Australia
- Mrs Tracey Watters, Chief Executive Officer

Helping Hand
- Ms Megan Corlis, Director, Research and Development
- Mrs Vicki York, Director, Care Governance

Aged Rights Advocacy Service
- Ms Carolanne Barkla, Chief Executive

Association of Independent Retirees (Fleurieu Peninsula Branch)
- Mrs Helen Withers, President

Resthaven
- Mr Richard Hearn, Chief Executive Officer
- Ms Christina (Tina) Cooper, Executive Manager, Residential Services

Australian Nursing and Midwifery Federation (SA Branch)
- Mr Robert (Rob) Bonner, Director, Operations and Strategy
- Ms Patricia Currie, Professional officer – Aged Care

Thursday, 26 April 2018 - Brisbane

Queensland Department of Communities, Disability Services and Seniors
- Ms Clare O’Connor, A/g Director General
- Ms Helen Ferguson, Assistant Director General, policy

Queensland Nurses and Midwives’ Union
- Ms Sandra Eales, Assistant Secretary
- Mr Daniel Prentice, Research Officer

Older Persons Advocacy Network and Aged and Disability Advocacy Australia
- Mr Geoff Rowe, Chief Executive Officer
- Ms Anna Harrington, Policy Officer

Townsville Community Legal Service
- Mr Bill Mitchell, Principal Solicitor
UnitingCare Queensland

- Ms Cathy Thomas, Group Executive, Integrated Services
- Ms Glenys Webby, Program Director, Service Reform and Innovation

Care Opinion Australia

- Ms Sue Palmer, Assistant Secretary
- Mr Anthony Bishop, Project Officer

Office of the Public Advocate Queensland

- Ms Mary Burgess, Public Advocate

Office of the Public Guardian Queensland

- Ms Natalie Siegel-Brown, Public Guardian

Friday, 11 May 2018 - Canberra

Painaustralia

- Ms Carol Bennett, Chief Executive Officer
- Ms Louise Moes, Director of Policy

Australian Medical Association

- Dr Richard Kidd, Chair, AMA Council of General Practice
- Dr Tony Bartone, Vice President
- Mr Luke Toy, Director, Medical Practice Section, AMA Federal Secretariat

COTA Australia

- Mr Ian Yates, Chief Executive

Leading Aged Services Australia

- Mr Robert Orie, Deputy Chairperson
- Ms Kate Lawrence-Haynes, General Manager Policy and Advocacy

Dementia Australia

- Ms Priyanka Rai, National Policy and Strategy Advisor
- Mrs Betty Touhy, Consumer Representative

Catholic Health Australia

- Mr Nick Mersiades, Director Aged Care
- Mr Richard Gray, Senior Aged Care Advisor

**UnitingCare Australia**

- Ms Claerwen Little, National Director
- Ms Linda Justin, Director, Practice and Quality, Director, Practice and Quality, UnitingCare NSW/ACT
- Mr Saviour Buhagiar, Director, Residential Aged and Health Care, UnitingCare NSW/ACT

**Estia Health**

- Adjunct Professor Mark Brandon OAM, Chief Policy and Regulatory Officer

**New South Wales Nurses and Midwives' Association**

- Mr Brett Holmes, General Secretary
- Mrs Helen Macukewicz, Professional Officer

**Aged and Community Services Australia**

- Ms Patricia Sparrow, Chief Executive Officer

**Thursday, 24 May 2018 - Canberra**

**Department of Health**

- Dr Lisa Studdert, Deputy Secretary, Aged Care Sport and Population Health Group
- Mr Jaye Smith, First Assistant Secretary, Residential and Flexible Aged Care Division
- Ms Maria Jolly, First Assistant Secretary, Aged Care Reform Taskforce
- Ms Amy Laffan, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch
- Ms Jo Mond, Assistant Secretary, Specialised Programs and Regulation Branch