Memo

To: Arthur Moses SC, President, Law Council of Australia

From: Stuart Webb, President, Law Institute of Victoria

Subject: Royal Commission into Aged Care Quality and Safety

Date: 6 September 2019

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1. Introduction:

The Law Institute of Victoria ('**LIV**') welcomes the opportunity to provide the Law Council of Australia ('**LCA**') with the following contribution to the LCA's submission to the Royal Commission into Aged Care Quality and Safety ('**Royal Commission**'). The LIV's submission focuses on the first term of reference:

> "the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of subsidized care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response".

2. Recommendations:

The LIV makes the following recommendations:

Table One:

Recommendations

1.	*Quality of Care Principles:* There should be significant sanctions for an aged care provider that breaches the Principles. These include: public naming and shaming, fines and, with repeated breaches, loss of licence to operate (either for a fixed term or permanently).
2.	*Aged Care Quality and Safety Commission:*

	At present, there are too many opportunities for a provider to delay the regulatory process and avoid any serious sanction. The Aged Care Quality and Safety Commission should be given power to issue an interim suspension order on a provider who delays in responding, fails to respond or provides an unsatisfactory response to a request for an explanation for an apparent breach of the Standards from the Commission.
3.	*Streamlining Care:* The LIV recommends improved information sharing frameworks to streamline care. The number of stakeholders involved in the process of providing medical treatment to residents in facilities (e.g. medical practitioners, health practitioners in state-regulated hospitals and Commonwealth-regulated facilities, ambulance services, and private allied health providers) does not necessarily lead to continuity or clarity of cohesive care and communication. Inevitably, this leads to frustration, confusion and despair for residents and their family members. The components of this fragmented system need to function more seamlessly in order to meet the medical needs of residents.
4.	*Medicare Benefits Schedule:* The LIV recommends that the Commonwealth government should review the Medicare Benefits Schedule relating to medical practitioner visits to residential aged care facilities to incentivise GPs to continue to visit their patients, providing continuity of care and a trusted relationship for residents.
5.	*Prevention of Injury-Related Deaths:* The LIV supports the 104 recommendations of Professor Joseph Ibrahim's report on the causes of premature death and injury in aged care facilities and requests the Royal Commission to note and act upon them.
6.	*Quality of Food:* The LIV recommends that aged care providers should be required to demonstrate that their food and ingredient budget per resident per day is at least $10.00 and that this amount be indexed in accordance with CPI each year.
7.	*Nutrition Standards:*

	The LIV recommends that a more prescriptive provision be drafted and included in the Aged Care Quality Standards, and that the Principles hold aged care providers accountable for the nutrition standards they provide. The provision should also impose minimum standards for hydration.
8.	*Private Funding:* The LIV recommends that the Royal Commission should assess whether the quantum of funding for private providers of RACFs is reflective of community standards and expectations.
9.	*Research Funding:* The Commonwealth government should provide a substantial increase in funding for research into the prevalence and causes of elder abuse in Australia and the extent and causes of maltreatment of residents in aged care facilities.
10.	*Data Collection on Aggression and Assault:* All relevant data on incidents of aggression and assault in RACFs be centrally collected in a national database and reported publicly each year on a de-identified basis to uphold residents' rights to privacy.
11.	*Restrictive Practices*: Although the LIV recognizes the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 as a positive step towards addressing the critical need to regulate restrictive practices in aged care, the Principles could be significantly strengthened by: • better reflecting a human rights framework; • clearly setting out mandatory requirements for controlling the physical and chemical restraint of residents in aged care facilities to minimise restraint, ensure it is used as a last resort and that the resident and their family is fully consulted before restraints are used; • requiring aged care providers to provide meaningful activities for all residents to enhance their quality of life and minimise the risk of behavioural problems arising from boredom and isolation; • restricting the use of psychotropic medications, whether to control behaviour or for a medical purpose, by requiring any such medications only be given with the consent of the resident or, where the resident lacks medical treatment decision-making capacity, consent of the resident's medical treatment decision maker; • requiring the consent of a medical practitioner as nominated by the resident, or where the nominated medical practitioner is unable to

	be contacted or no prior nomination by the resident is provided, an independent medical practitioner not employed by the aged care facility; and • requiring that psychotropic medications can only be prescribed for a maximum period of one month, after which there must be a full medical review of the resident by a registered medical practitioner nominated by the resident (or where the resident lacks medical treatment decision making capacity, nominated by the resident's medical treatment decision maker), including an assessment of any side-effects from the medications. In addition, the States should be required to keep records that relate to exploitation, violence, use of chemical and physical restraint and abuse of elderly and disabled persons within residential care facilities, with providers being required to report all such incidents. In capturing statistical data regarding the use of restrictive practices in aged care, the following should be required to be clearly documented by RACFs (as soon as reasonably practicable after the restraint occurs): • the form of restraint applied, • the reasons for use, the duration of use, • the outcome of the restraint, and • any adverse events that occurred. Additionally, following the use of any restrictive intervention used as a behaviour control mechanism, the resident(s) restrained should have their behavioural support plan reviewed, and where necessary, modified to avoid the use of restrictive practices as a means of controlling behaviour. As soon as reasonably practicable after a restraint is applied, the person(s) affected formally appointed substitute and support decision maker(s), or, if none appointed, the person's primary carer or nearest relative, must be notified of the matters documented (outlined above) and provided with the written report upon request. Where a person has no medical treatment decision maker or no primary carer or relatives, the Public Advocate/Guardian should be informed. Please find **attached** the Office of Public Advocate letter dated 11 July 2019, which expands on the points outlined above.
12.	*Consistent Regulation:* The Council of Australian Governments ('COAG') facilitate the development of a nationally-consistent approach to the regulation of restrictive

	practices. This reflects the Senate Community Affairs References Committee's recommendation that the "Commonwealth develop, in consultation with dementia advocates and service providers, guidelines for the recording and reporting on the use of all forms of restraints in residential facilities". This recommendation mirrors Recommendation 8-2 of the ALRC's report, Equality, Capacity and Disability in Commonwealth Laws, which called for the development of a national approach to the regulation of restrictive practices in sectors other than disability services.
13.	*Challenging Behaviours:* RACFs which report multiple instances of restraint in any given reporting year should be required to provide compulsory training for staff in procedures for managing challenging resident behaviours. Compliance with any such training should be monitored by the Department of Health ('**DHS**') and publicly reported on each year; There should be increased random on-site auditing of RACFs to identify mistreatment of residents, including the use of restrictive practices.
14.	*Reportable assaults:* The term 'reportable assaults' in s 63.1AA be replaced with 'reportable abuse'. Moreover, the definition in s 63.1AA(9) should be amended to include psychological harm and neglect by an aged care provider.
15.	*Serious Incident Response Scheme:* The LIV supports the Australian Law Reform Commission's recommendation that aged care legislation should provide for a new serious incident response scheme. The scheme would require approved providers to notify an independent oversight body of any allegation or suspicion of a serious incident in their facility. In relation to resident-on-resident aggression, these notifications would include incidents of physical abuse causing serious injury, or incidents occurring as part of a pattern of abuse; The LIV also supports the following proposals made by the ALRC: • there should be a national employment screening process for Australian government-funded aged care providers; • a national database should be established to record the outcome and status of employment clearances; • unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers; • Part 7 of the Accountability Principles 2014, which contains an exemption to reporting 'reportable assaults', be repealed.

	All reportable incidents should be reported to the Commissioner, which would create greater clarity for approved providers around reporting obligations and assist in recording and responding to patterns of behaviour; • the reporting exemption in s 23 of the Accountability Principles 2014 should be removed to ensure that all care recipients are safe, and to provide greater transparency and accountability in how approved providers are responding to resident-on-resident incidents and whether such responses are appropriate and effective.
16.	*OPCAT Compliance:* The LIV submits that the broad scope of OPCAT provides the benefit of ensuring that places which are not traditionally seen as detention, but with evidence of mistreatment, can be subject to the same monitoring as would be expected of a prison.
17.	*Staff-to-Patient Ratios:* The LIV recommends a new Division within the Aged Care Act that mandates staffing ratios.
18.	*Aged Care Ombudsman:* The LIV recommends the establishment of an Aged Care Ombudsman with powers to investigate RACFs on its own motion or upon receipt of a complaint. The Ombudsman must be easily contactable and prompt in responding. This role is separate from but will inform the office of the Aged Care Quality and Safety Commissioner.

3. The LIV's position:

The timing of this inquiry is significant.

The aged care industry is worth over $17 billion dollars a year and growing.[1] Today, the marketing of RACFs often focuses on luxury without specific details on how residents with high-care requirements will be looked after. 7 per cent of people aged 65

[1] Deloitte Access Economics, *Australia's Aged Care Sector: Economic Contribution and Future Directions* (June 2016) at 20.

and over are currently residing in a RACF.[2] However, the proportion of older people in Australia's population has increased considerably in recent years, with projections indicating that this trend is set to continue.[3] Further, an increasing number of older Australians are being classified as having a profound or severe disability.[4] The LIV submits that these factors are likely to increase the demands on RACFs, challenging their ability to deliver a high standard of care for residents with wide-ranging needs.

The LIV submits that Australia's provision of RACFs compares favourably with overseas examples. It also aligns with some best practice guidelines.[5] However, preceding the Royal Commission, several media and academic reports uncovered serious failings in the care provided by a number of RACFs.[6] These failings have resulted in financial hardship, injury, unnecessary sickness and the premature death of residents. Further, they have caused trauma for staff and professionals in aged care management, who have lost confidence in their ability to ensure the safety of residents.[7]

Often, it is the quality of an RACF's facilities that is being sold to potential residents and their families; what is not so clear is the quality of training that staff have received, the number of staff employed, or the quality of care they provide. South Australia's Oakden Aged Mental Health Service ('**Oakden**') is one such example. The facility demonstrated a significant failure of care in workplace practice and culture. Consequently, many unwell and vulnerable residents received poor-quality care. As the *Review of National Aged Care Quality Regulatory Processes* stated:

> '…the degree of seriousness of failures to care for residents that were reported at Oakden may be relatively rare, but the types of issues found at Oakden have much in common with the types of

[2] Joseph Ibrahim, 'Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services' (Victorian Institute of Forensic Medicine, 2017) 199, ('Ibrahim Report').
[3] Ibid 196. See also: David Tune, 'Legislated Review of Aged Care' (2017) 23; Victorian Law Reform Commission, 'Chapter Fifteen: Restrictions Upon Liberty in Residential Care' in *Guardianship Final Report* No. 24 (2012) at 15.117.
[4] Australian Institute of Health and Welfare, *Disability and Ageing Australian Population Patterns and Implications* (2000) xviii.
[5] Kate Carnell and Rob Paterson, 'Review of National Aged Care Quality Regulatory Processes' (2017) 73 ('Carnell Review').
[6] David Tune, 'Legislated Review of Aged Care' (2017) 19.
[7] Carnell Review, above n 5, 1.

> issues that arise for aged care consumers whenever there are quality-of-care challenges'.[8]

Oakden is not an isolated case of sub-standard care, although it is at the extreme end of the spectrum. In September 2018, the Australian Broadcasting Corporation's Four Corners program aired its investigation, '*Who Cares*?', into the harrowing neglect and abuse of people in RACFs. Examples of neglect and abuse included residents being left alone for hours, the failure to provide basic needs, such as showering, food and incontinence pads and the overuse of antipsychotic drugs for long-term control of behaviour, often without patient or family consent.

There are also concerns about the use of restraints in this setting. Evidence suggests that physical and chemical restraints are being used to respond to behavioural and psychological symptoms of dementia or intellectual disability in younger residents. This is despite clinical evidence suggesting that psychosocial responses should be the first line approach. Behavioural and psychological symptoms are often an indication of unmet needs, such as untreated pain, hunger or thirst, or boredom.

Together, these examples demonstrate the complex and multifaceted nature of resident mistreatment, which is not currently factored in the Commonwealth's existing regulatory framework.

Over the past few years, the LIV has supported the following policy developments:

- the Single Aged Care Quality Framework;
- unannounced re-accreditation audits of RACFs from 1 July 2018;
- the merging of the Australian Aged Care Quality Agency and Aged Care Complaints Commission into the Aged Care Quality and Safety Commission from 1 January 2019, reducing confusion and overlap;
- the launch of the Aged Care Diversity Framework; and
- the rollout of specialist dementia care units.

However, the LIV submits that there remain significant problems which ought to be considered by the Royal Commission, including:

- an overwhelmed, inadequate complaints system;

[8] Ibid 42.

- restrictive practices still being used to control residents' behaviour;
- poor staff-to-resident ratios leading to insufficient staff to attend promptly to residents' daily requirements;
- inadequate training for staff and a lack of qualified staff,
- the prevalence of resident-on-resident assaults, both physical and sexual;
- inadequate reporting requirements imposed on aged care providers,
- too high a rate of premature deaths of and injuries to residents;
- a lack of access to health practitioners (e.g. doctors, nurses, physiotherapists, psychologists) for Australians living in RACFs;
- the inadequacy of protections available to whistle-blower employees;
- the inconsistency between the entry costs to different RACFs and the ever-increasing high cost of entry placing an RACF beyond the reach of many Australians;
- the lack of a system to require RACFs to lodge their entry deposits for security with the government while still having access to the interest; and
- the outdated Medicare billing framework for health practitioners who see patients in RACFs.

4. Regulatory framework:

Aged care in Australia is regulated by a mix of Commonwealth and state or territory laws. Further, it is difficult to separate the provision and quality of aged care from laws concerning consumer protection, medical treatment, social services, human rights, guardianship and administration, and disability and mental health.

The primary legislative instrument, that being the *Aged Care Act 1997* (Cth) (the '**Aged Care Act**') allows the Commonwealth to make payment of grants for the provision of aged care services, and matters connected with aged care.[9] In relation to the quality of care, Division 54 of the Act sets out the responsibilities of service providers, including those responsibilities contained in the in the *Quality of Care Principles 2018* (Cth) (the '**Quality of Care Principles**'). However, the LIV submits that there remains uncertainty as to what 'quality of care' entails. This is, in part, due to the array of public,

[9] *Aged Care Act 1997* (Cth) s 3-1(1).

private and community-based providers of RACFs, each emphasising different priorities and perspectives on 'quality'. As the Ibrahim Report states, 'the system is complex, fragmented, and risk-averse with divergent or contradictory approaches'.[10]

The LIV submits that the regulatory framework could be improved by the following recommendations:

Recommendation 1: Quality of Care Principles

- There should be significant sanctions for an aged care provider that breaches the Principles. These include: publicly naming the organisation or provider, issuing of fines and, with repeated breaches, loss of licence to operate (either for a fixed term or permanently).

Recommendation 2: Aged Care Quality and Safety Commission*:*

- The Aged Care Quality and Safety Commission should be given power to issue an interim suspension order on a provider who delays in responding, fails to respond or provides an unsatisfactory response to a request for an explanation for an apparent breach of the Standards from the Commission.

5. Meeting the needs of aged care recipients:

> *"Improving quality of care for older people living in residential aged care services in Australia requires a better understanding of how, why, where and when residents die".*[11]

As people age, their need for care changes. Each person's needs are different. Needs are assessed through the Aged Care Funding Instrument, an assessment tool which looks at three different areas of care: activities of daily living, cognition and behaviour, and complex health care. As of 30 June 2017, the Instrument showed that:

- around one-third (31 per cent) of residents had a high care need;

[10] Ibrahim Report, above n 2, 29.
[11] Ibid 27.

- a majority (85 per cent) of residents were diagnosed with at least one mental health or behavioural condition;

- depression was the most commonly diagnosed mental health condition among residents (47 per cent);

- dementia had been diagnosed in just over half of the residents (52 per cent);

- the largest proportion of care needs rated as 'high' (63 per cent) was in the cognition and behaviour assessment area.

The most common perception around the decision for an older person to enter a RACF is a belief that they are no longer safe at home. Although an RACF is considered a safe option, this move may result in greater harm. Examples of short-term harm include new adverse health events (e.g. falls due to a change in environment or assaults by other residents) or a rapid deterioration of pre-existing conditions. Long-term harm comes through institutionalisation that disrupts a person's everyday life that may compromise lifelong routines, and the inherent risks in communal living (e.g. infectious disease outbreaks).

There is currently no single, international definition or consensus, or term, to describe the purpose of residential aged care. The overriding view appears to be that RACFs are a place where older people wait to die. As recommended by the Ibrahim Report, the purpose of RACFs should be defined as 'a place to thrive before we die'.[12]

This section looks at medical treatment, activities, behavioural supports, the safety and levels of nutrition in RACFs.

Medical Treatment:

Although the expression 'nursing home' is a misnomer, it is still commonly used. Even if a member of the community correctly references a 'residential aged care facility' as such, there is a general perception that both nursing and medical care are provided in these residential settings. It may, therefore, be a surprise to residents, and their families, to discover that there is no resident-to-registered nurse staffing ratio for RACFs.

[12] Ibid 39.

They may also be unaware that RACFs do not employ general practitioners ('**GPs**'). Rather, GPs may elect to conduct home visits to patients residing in RACFs.

Most GPs do not conduct home visits to their patients' homes and are unlikely to commence conducting a home visit into a patient's new 'home', that being an RACF. Upon admission, therefore, the resident may be advised by the RACF of those GPs who do conduct home visits and choose to become a new patient of one of the visiting GPs. Like any medical practice electing not to take on new patients due to excessive demand, a visiting GP may elect not to take on a new resident. Potentially, it may be difficult for a resident to source a GP who is prepared to take them on as a new patient.

The GP is providing a service in the patient's home and clearly liaises with the management of the RACF to ensure that patient care plans are informed by relevant medical care. Out of hours, a locum service may be called (which may or may not be connected to the medical clinic at which the relevant GP works), or at times a resident may be transferred to a hospital. Visiting GPs are likely to see multiple residents on a given day. LIV members report that it can be very difficult for family members to try to visit the same time that the GP is present if an appointment cannot be made to facilitate this.

The LIV submits that, at a time in their life when medical needs are likely to be complex, the ramifications for residents are:

- they will need a new GP and may have little choice as to who this will be;
- at time-critical moments, the GP may not necessarily be available, and a locum service may be called. A locum may have difficulty accessing all necessary medical information and may be more inclined to conservative decision-making, such as recommending a transfer to a hospital;
- a transfer to hospital means that the RACF transfers the resident to the care of the ambulance service which, in turn, transfers the resident to the care of the hospital. This process must be confusing to a resident, who is frequently unaccompanied by family members during these transitions; and
- attending specialist appointments in the community may be difficult or impossible if the resident does not have a family member to facilitate this or cannot afford to pay for private case management and additional services over and above those which the RACF is required to provide.

The system described above consists of private medical practitioners, Common-wealth-regulated RACFs, private allied health providers and state-regulated hospitals and ambulance services. Often, a resident will not experience a cohesive system focused on their care. Rather, it is often a clunky exchange between providers with different responsibilities. The LIV submits that the provision of external care in RACFs can be confusing for residents and for their family members, most of whom will have thought that admission to a RACF would ease the difficulties which had presented when the resident previously lived in the community. Rather, they discover a whole new set of difficulties have arisen.

Since 12 March 2018, in Victoria, GPs have been required to obtain consent to medical treatment – including in relation to the administration of prescription medication – from a medical treatment decision-maker when the resident lacks decision-making capacity for medical treatment. This requirement is found within s 58(1) of the *Medical Treatment Planning and Decisions Act 2016* (Vic) ('**MTPDA**'):

> "If a health practitioner proposes to administer medical treatment . . . to a person who does not have decision-making capacity for that medical treatment, a medical treatment decision must be obtained or ascertained in accordance with … Division [2]".

LIV members who work in this space report poor compliance with this requirement. A probable explanation (apart from unfamiliarity of the law) is that some health practitioners, including GPs, who visit RACFs are likely to have formed relationships with the care staff, but not with family members or the resident's medical treatment decision-maker.

Recommendation 3: Streamlining Care

- The LIV recommends improved information sharing frameworks to streamline care.
- The number of stakeholders involved in the process of providing medical treatment to residents in facilities (e.g. medical practitioners, health practitioners in state-regulated hospitals and Common-wealth-regulated facilities, ambulance services, and private allied health providers) does not necessarily lead to continuity or clarity of cohesive care and communication. Inevitably, this leads to frustration, confusion and despair for residents and their family members. The

components of this fragmented system need to function more seamlessly in order to meet the medical needs of residents.

Recommendation 4: Medicare Benefits Schedule

- The Commonwealth government should review the Medicare Benefits Schedule relating to medical practitioner visits to residential aged care facilities to incentivise GPs to continue to visit their patients, providing continuity of care and a trusted relationship for residents.

Safe Environment:

Although the Aged Care Quality Standards makes several references to the provision of "safe personal care", the reality is that preventable injuries, and injury-related deaths, do occur within RACFs. The Ibrahim Report surveyed the cause of death of 56,855 residents in aged care occurring between 2000 and 2012.[13] It identified 1,926 'externally caused' deaths – that is, deaths not caused by illness or disease.[14] The Ibrahim Report records that a significant number of older residents in RACFs are suffering

[13] Ibid.
[14] Ibid.

premature death and preventable injuries.[15] Take the following example in Table Two of the Report.

Table Two:

Inquest into the Death of Paul Joseph Milward [2018]

Mr Milward, aged 53 at the time of his death, suffered Huntington's disease, depression, gastro-oesophageal reflux disease and asthma. He was on numerous medications. He was a resident at Bundaleer Lodge in Queensland. On the morning of 31 August 2015, a staff member brought him breakfast, consisting of two pieces of bread with butter and jam. The staff member then left him. Approximately two hours later, the staff member returned to the room and found Mr Milward deceased, lying on his right side with his left hand raised to his face. There was a piece of bread in his mouth and on the bed underneath his face. An autopsy examination found the cause of death was due to choking.

The Ibrahim Report also identified and classified both intentional and unintentional causes of death. These were (in order of prevalence): falls, choking, suicide, compromise of clinical care, and resident-on-resident aggression. By far the most prevalent causes of death in the cohort were falls and choking. The report made 104 recommendations specifically around quality improvement for those aspects of risk in residential care. The LIV supports these recommendations and submits them for consideration to this inquiry. The prematurity of these reported death raises concerns about the quality of care being provided in RACFs. Any person who dies from an injury does so 'before their time'.[16]

Table Three:

Summary of Key Findings and Recommendations:

Choking:	**Findings:** • 89 choking deaths between 2000 and 2012, with an average of 7.4 preventable deaths per year. • Adults aged over 85 years accounted for the majority of deaths.

[15] Ibid.
[16] Ibid.

	Recommendations: • The policies, procedures and practices of RACFs should reflect the need for specific and detailed care plans of residents who have swallowing difficulties / dysphagia or a prior history of choking. This should be evaluated every 6-months or after any change in the resident's health care.[17] • Residents with swallowing difficulties / dysphagia or a prior history of choking be appropriately supervised by skilled staff when eating.[18] • Residents who are at risk of choking due to impulsive behaviours should be referred to a multidisciplinary team (medical, mental health, nursing, speech pathology, dietetics) for a formal assessment.[19] • RACFs facilitate referrals to provide clinical expertise to assess and manage a resident who has swallowing difficulties.[20]
Medications:	**Findings:** • The likelihood of medication errors resulting in serious effects are greater if the error is repeated, the error occurred during transitions of care or during the prescribing stage, if the wrong medication and resident was chosen, and if there were increasing numbers of high-risk medications administered.[21] **Recommendations:** • A centralised electronic medication management system be accessible to RACF staff and relevant health practitioners to ensure the availability of up-to-date residents' clinical and medical information. Moreover, policy makers should consider the use of such a system as a mandatory requirement for accreditation of RACFs.[22]

[17] Ibid 53, 57.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid 84.
[22] Ibid 86.

	• RACF providers should ensure that evidence-based prescribing guidelines are readily available to medical practitioners and aged care staff at the point of care.[23] • RACFs should regularly review their medication administration procedures to identify opportunities for increased support, education and training for staff.[24]
Physical restraint:	**Recommendations:** • A single definition of physical restraint be legislated so it is used universally to ensure a common understanding between aged care, health care professionals and providers about when physical restraint policy and protocols should apply. • The construction of new RACFs adhere to specific building guidelines about structural design to promote a dementia-enabling environment. • The application of physical restraint should only occur in extremely limited circumstances. The process should involve at least two health professionals and requires clearly documenting the reasons for use, duration of use, outcome of restraint and any adverse events that occur. • A national, systematic and coordinated approach be taken to improve the identification, investigation, analysis and reporting of adverse events involving physical restraints among RACF residents.
Respite:	**Findings:** • the demand for respite is high with approximately 80% of older people who require assistance living in the community cared for by informal carers (such as spouses, family members, and friends). **Recommendations:** • that mandatory use of a central electronic system, that stores medical records and information from health and aged care

[23] Ibid.
[24] Ibid.

	providers, is required as part of RACFs accreditation, to reduce adverse handover incidents. • information gathered on respite residents is optimised to identify how and why respite is used, and to provide opportunities to prevent adverse events through enhanced national data collection on respite residents.
Suicide:	**Findings:** • With the ageing population, the number of people with complex physical and mental health conditions requiring aged care services is likely to increase. Adults aged 85 years and older have the highest age-specific suicide rate in Australia. **Recommendations:** • A coordinated and multifaceted approach is taken to align life in RACFs with community living. • A systematic, evidence-based approach is taken to increase support for residents to manage physical health issues. • Residents be consulted in regard to their response to, and preferences for, the physical environment of the RACF. • A greater focus be placed on identifying opportunities for improvements to resident care, safety and quality of life, through the use of technology.

Recommendation 5: Prevention of Injury-Related Deaths

- The LIV supports the 104 recommendations of the Ibrahim Report on the causes of premature death and injury in aged care facilities especially those listed in Table Three and requests the Commissioners to consider them during this review.

Malnutrition:

Malnutrition affects at least one in two residents in RACFs.[25] It is often associated with a cascade of adverse outcomes, including increased risk of falls, pressure injuries, and hospital admissions, leading to poorer resident quality of life and increased healthcare costs. Diminished sensory perception, along with the physiology of ageing, may increase malnutrition risk. However, there is emerging evidence that food insecurity or the limited ability to access adequate, safe, tasty, nutritious and culturally-appropriate food may also be implicated in the malnutrition suffered by so many residents in RACFs. Ever-tightening aged care budgets may be impacting food insecurity and food spends and should be reviewed as part of the problem.

Dietician Dr Cherie Hugo led research on more than 800 aged care facilities in Australia and found, on average, that homes were spending $6.08 a day on food per resident.[26] The team researched 817 RACFs, representing 64,256 residential beds and 23 million bed-days Australia-wide.[27]

It found that the average total spending on catering consumables (including cutlery/crockery, supplements, paper goods) was $8.00 per resident per day ('**prpd**'), and $6.08 prpd when looking at the raw food and ingredients budget alone. Current average food and ingredient budgets in Australian RACFs are trending downwards, with a $0.31 prpd decrease in the last 12-month period. Not only are these figures less than community-dwelling older adults ($17.25 prpd) and less than aged care food budgets internationally, they are also less than the average food spend cost of Australian prisoners per day ($8.25)[28]

Table Four: Comparative PRPD Food Funding

International Example:	**Raw food funding prpd in AUD:**
Ontario, Canada:	$8.63 (2016)
England:	$6.12 (2013)
Norway:	$20.41 (2007) - $22.86 (2013)
United States:	$6.61 (2014)

[25] Christina Bell et al. 'Malnutrition in the Nursing Home' (2015) 18(1) *Current Opinion in Clinical Nutrition and Metabolic Care* 17.
[26] Cherie Hugo, Elizabeth Isenring, David Sinclair and Ekta Agarwal, 'What does it cost to feed aged care residents in Australia?' (2018) 25(1) *Nutrition and Dietics* 6.
[27] Ibid.
[28] Cherie Hugo, 'Why is nursing home food so bad? Some spend just $6.08 per person a day – that's lower than prison', *The Conversation* (Queensland, 19 July 2019).

Comparatively, Australian Corrective Services currently spend 136% more than the RACFs current figures. According to policy, 'the prison system's custodial responsibility requires inmates receive a diet sufficient to maintain them, while its public responsibility means that this must be done on a minimal budget'. Even at its minimal value, the budget exceeds the average budget prpd in Australian RACFs.[29]

Recommendation 6: Quality of Food

- the LIV submits that aged care providers be required to demonstrate that their the food and ingredient budget prpd is at least $10.00 and that this amount be indexed in accordance with CPI each year.

Currently, there are no national nutrition and menu planning standards for RACFs in Australia. Many international regulatory systems are based on a strict system of licensing, with the availability of a license contingent on compliance with input-based standards.

A common criticism of the Accreditation Standards is that they lack specificity and are too open to interpretation. For example:

2.10: 'Nutrition and hydration – care recipients receive adequate nourishment and hydration'.

3.9: 'Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people

4.8: 'Catering, cleaning and laundry services – hospitality services are provided in a way that enhances recipients' quality of life and the staff's working environment.

Table Five: Comparative Nutrition Standards

International Example:	**Standard:**
United Kingdom's National Minimum Standard:	15.2: 'Each service user is offered three full meals each day (at least one of which must be cooked) at intervals of not more than five hours'.

[29] Johns N, Edwards JSA, Hartwell HJ, 'Hungry in Hospital, Well-fed in Prison? A comparative analysis of food service systems', *Appetite* 2013, 68: 45-50.

Scottish Standards:	13.3: 'You have a choice of cooked breakfast and choices in your midday and evening meals'.
US Regulations [483.35 (3f)]	1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. 2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day.
Ontario's *Retirement Homes Act*:	Clause 40: a) If the licensee is the sole provider of the resident's meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal; b) Menus provide adequate nutrients, fibre and energy for the resident, include fresh seasonal foods and are consistent with standards of good nutrition in Canada; c) The menu is varied and changes daily; d) The menu cycle changes at least every 21 days; e) The menu includes alternative entrée choices at each meal; f) An individualised menu is developed for the resident if the resident's needs cannot be met through the home's menu cycle; g) The resident is informed of his or her daily and weekly menu options; h) The resident is given sufficient time to eat his or her own pace; i) Food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences; j) Staff monitor the resident during meals as required;

	k) Staff and volunteers hold and transport perishable hot and cold safely; l) All dishes, utensils and equipment involved in the provision of a meal and provided by the licensee are clean and sanitary before each use and are cleaned and sanitised after each use

While the more detailed, input-based comparative standards are not incorporated into the Australian Accreditation Standards, they are incorporated within other regulatory and associated instruments. For example, Schedule 1 of the Principles (with which approved providers are required to comply, by the application s 54.1 of the Act) provides that all residents who need them must be provided with meals and refreshments compromising:

a) Meals of adequate variety, quality and quantity for each resident, served each day at times generally acceptable to both residents and management

As with other aspects of the Principles, Schedule 1 is vague and therefore provides scope for RACF's to provide bare minimum care standards.

Recommendation 7: Nutrition Standards

- The LIV recommends that a more prescriptive provision be drafted and included in the Accreditation Standards (Schedule 2 of the Principles) that holds aged care providers to account for the nutrition standards they provide. The provision should also impose minimum standards for hydration.

6. The extent of subsidised care:

Australia's aged care sector "is based on a market-driven model".[30] The government's primary role in the aged care system is to regulate and provide funding. However, recently, aged care policy has moved towards encouraging individuals to plan and provide for themselves, rather than relying solely on government support.[31] Since the

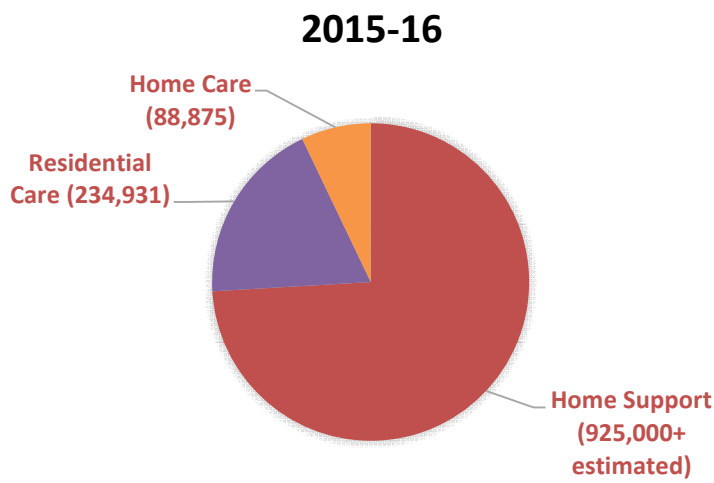
[30] Ibrahim Report, above n 2, 33.
[31] David Tune, 'Legislated Review of Aged Care' (2017) 22.

late 1980s, governments have increasingly sought to incorporate personal responsibility and free choice into social welfare policy. This has been demonstrated in several ways:

- private businesses have been encouraged to deliver human services through the privatisation or 'contracting out' of government responsibilities. Partnerships between the public and private sectors have also been sought;
- the language used by government has become increasingly commercial, with recipients often termed as 'customers' or 'clients'; and
- agencies have cut staff numbers to maximise profit (while compromising their capacity to deliver services).

It has been argued that these market-oriented reforms increase individual choice, as well as a service's overall efficiency. This is due to the profit motive, accountability to shareholders and financiers, and preventing takeovers by competing enterprises. However, it is counter-argued that the introduction of competition in welfare policy does not automatically improve outcomes. There is potential for cost-cutting and low investment by for-profit providers. This may have a damaging impact on accountability, adaptability, innovation, responsiveness, and quality of care. As Professor Ibrahim notes, "reporting of adverse events [is] kept 'in-house' at all levels (facility, organisation, department) to protect reputations".[32]

Most government-funded aged care is one of three kinds: home support, home care packages, or residential care.



[32] Ibrahim Report, above n 2, 33.

Figure One:
Provision of Aged Care Funding[33]

While consumers make contributions to government-funded aged care, government funding covers most of the cost. For home care packages and residential care (the most expensive services), the value of the consumer contribution is determined through means testing. For home care, this is an assessment of income only, while for residential care both income and assets are assessed.

Recommendation 8: RACF Funding

- The Royal Commission should assess whether the quantum of funding for private providers of RACFs is reflective of community standards and expectations.

7. Abuse and mistreatment:

Introduction:

The mistreatment of residents in aged care facilities (including younger residents, often with a disability or terminal illness who have no option but to live in such a facility) falls under broader notions of elder abuse. It has been described as a "serious human rights issue".[34]

The Ibrahim Report found that Australians living in RACFs are at significant risk of experiencing abuse, mistreatment and injury-related harm.[35] This mistreatment often arises due to the residents' physical frailty, cognitive impairment, multiple co-morbidities, and complex drug regimens.[36] It may also be exacerbated by the facility's poor or inadequate care coordination, poor infrastructure and design, lack of training for staff, limited access to specialist services and lack of adequate monitoring of preventable harm and injuries.[37]

Statistics on elder abuse are often confined to those collected by state-based hotlines. There is a lack of substantial research that would provide a reliable indication as to

[33] David Tune, 'Legislated Review of Aged Care' (2017) 23.
[34] Dr Kay Patterson, 'When Sons and Daughters Abuse Our Most Vulnerable' *The Australian*, 2017.
[35] Above n 1, 30.
[36] Ibid.
[37] Ibid 31.

the prevalence of elder abuse, let alone the mistreatment of residents Australia-wide. This is due to several factors, including a lack of dedicated funding to support research, the small number of academics engaged in the field, and, restricted access, as well as high costs in obtaining data.[38] The LIV considers this lack of information to be a significant problem with the current system.

The Office of the Public Advocate's Community Visitors Program report an increase in abuse, neglect and violence since 2014.[39]

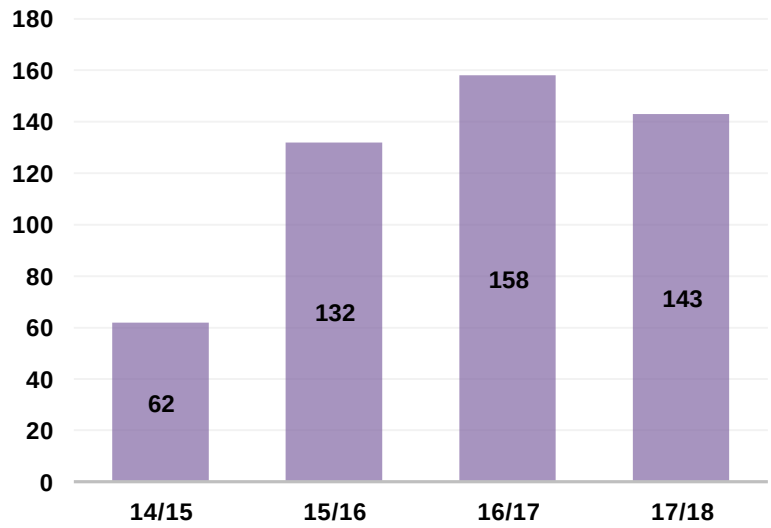


Figure Two:
Abuse, Neglect and Violence in Residential Services[40]

Definitions are important legal tools. They affect how abuse and mistreatment are perceived by victims and perpetrators, whilst also shaping research aims and policy interventions. Further, as the ALRC has stated, definitions are 'significant where data about prevalence of abuse is to be collected'.[41]

It is difficult to define the mistreatment that occurs within RACFs. This is often due to the inability of some residents to communicate their experiences of mistreatment. Fur-

[38] Ibid 32.
[39] Office of the Public Advocate, *Community Visitors Annual Report 2017* at 43; Office of the Public Advocate, *Community Visitors Annual Report 2016* at 17.
[40] Office of the Public Advocate, *Community Visitors Annual Report 2017* at 43; Office of the Public Advocate, *Community Visitors Annual Report 2016* at 17.
[41] Australian Law Reform Commission, *Elder Abuse*, Issue Paper 47 (2016) 13.

ther, as noted by the Rochdale Borough Safeguarding Adult Board, resident mistreatment has its own unique, institutional aspects that differ from other forms of elder abuse:

> '…routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practices which affect the whole setting and denies, restricts and curtails the dignity, privacy, choice, independence or fulfilment of individuals'.[42]

In addition, there is a paucity of empirical research into the regulatory mechanisms and quality of care in RACFs. This is related to a number of factors:

- a lack of dedicated funding to support research into quality of care in RACFs;
- the small number of researchers or academics engaged in the field; and
- restricted access to, as well as high costs in, obtaining data essential to this type of research.

Recommendation 9: Research Funding

- The LIV recommends that the Commonwealth Government provide a substantial increase in funding for research into the prevalence and causes of elder abuse in Australia and the extent and causes of maltreatment of residents in aged care facilities.

The LIV submits that a nationally-consistent approach to defining elder abuse is essential to systematic research. Due to the sector's cross-disciplinary nature, it is important that understandings of elder abuse from different perspectives are incorporated. This should cover forms of abuse prevalent in a residential setting, including: exposure to degrading treatment, poor hygiene, indignity, invasion of privacy, neglect,

[42] Rochdale Borough Safeguarding Adults Board, *Institutional Abuse* www.rbsab.org

resident-on-resident aggression ('**RRA**'), the inappropriate use of restrictive practices and, injury-related harm.

Resident-on-Resident Aggression:

'Resident mistreatment' may be commonly thought of as being perpetrated by staff. However, as the Ibrahim Report notes, RRA may also be as prevalent an issue. It is defined as:

> "Negative, aggressive and intrusive verbal, physical, sexual and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient".[43]

In an additional article by Professor Ibrahim, 28 deaths from RRA were examined over a 14-year study period.[44] Most aggressors were male (85 per cent). Further, the risk of death from RRA was twice as high for male residents as it was for female residents.

[43] Lynn McDonald et al., 'Developing a Research Agenda on Resident-to-Resident Aggression: Recommendations from a Consensus Conference' (2015) 27(2) *J Elder Abuse Neglect*. 146-67

[44] Joseph Ibrahim et al., 'Deaths from Resident-to-Resident Aggression in Australian Nursing Homes' (2017) 65(12) *Journal of the American Geriatrics Society* 2603-2609

Although 25 per cent of RRA deaths had a coronial inquest, criminal charges were rarely filed.[45]

Table Six:

Inquest into the Death of Dorothy Mavis Baum [2018]

Dorothy Baum, aged 93, of St. Basil's Aegean Village in South Australia, died because of blunt trauma with head injury on a background of ischaemic heart disease. The injuries were inflicted by a fellow resident of 85 years old, using a plastic chain with magnets at both ends which was obtained from within the nursing home, such chains being used to discourage residents from entering rooms by placing the chain between the sides of the doorframe. Both residents suffered from dementia. At the time of her death, Mrs Baum was bedridden, while her assailant was mobile.

Despite the expectation that RRA will increase as the Australian population continues to age, research on this topic is limited. A recent prevalence study from the United States found that nearly one in five RACFs residents are involved in at least one aggressive encounter with another resident each month.[46]

Recommendation 10: Data Collection on Aggression and Assault

- All relevant data on incidents of aggression and assault in RACFs be centrally collected in a national database and reported publicly each year on a de-identified basis to uphold residents' rights to privacy.

Restrictive Practices:

Restrictive practices involve the use of interventions that limit the freedom of movement of a person with disability.[47] Their objective is to protect the person from harming

[45] Ibid 2603.
[46] Above n 1, 172.
[47] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, at 8.1 (p.244); Royal Commission into Institutional Responses to Child Sexual Abuse, 'Volume 1 – Contemporary Detention Environments' in *Final Report*, 37.

themselves, staff or fellow residents around them. In aged care facilities, they are typically used if the person is exhibiting challenging behaviours,[48] such as those associated with dementia.[49] Examples include detention, seclusion, and chemical, mechanical or environmental restraints.

The *Aged Care Act* enables the development of Accreditation Standards with which a service must comply in order to be eligible for the Residential Care Subsidy. Accreditation Standards prescribe 44 'expected outcomes' across four areas:

- management systems, staffing and organizational development
- health and personal care
- resident lifestyle
- physical environment and safe systems

Many practices which do not result in a continuous or enduring deprivation of liberty may restrict a person's liberty or freedom of movement to a significant degree, such that is borders on a deprivation of liberty. Restrictions on liberty may be achieved through one or more of the following mechanisms:

- *Environmental restraint*: this includes controls, such as locked doors, keypad controls on doors, perimeter fencing, and other building design features may restrict an individual's freedom to come and go at will. Similarly, being constantly supervised or escorted by staff also severely restricts a person's liberty. As noted in s 3(1) of the *Disability Act 2006* (Vic), 'detain' is defined as including 'constantly supervising or escorting a person to prevent the person from exercising freedom of movement'. Such environmental restraints are very common in social care settings.[50]

- *Mechanical restraint*: this is the use of equipment or devices, such as bed rails and strapping applied to wrists, chests or other parts of the body, to restrict movement. Mechanical restraints almost always cause significant harm or risk to the wellbeing of the individual.

[48] *BJ* [2011] QCAT 18; *HRJ* [2011] QCAT 712;
[49] Eleanore Fritze, Office of the Public Advocate (Vic), *Discussion Paper: Designing a Deprivation of Liberty Authorisation and Regulation Framework* (2017).
[50] Ibid.

- *Physical restraint:* it occurs when one person uses their body to restrict another person's freedom to move or act.

- *Seclusion*: refers to confining a person in a room where they are unable to leave or interact with other individuals. This form of restraint is typically used in facilities when a patient receives too much stimulation from other patients or their environment and their behavior becomes agitated, aggressive or erratic. It is also used by some aged care facilities inappropriately as a form of punishment to control the resident's behaviour.

- *Chemical restraint*: the administration of substances to restrict a person's freedom to move or act, rather than to treat a medical condition. The substances used for this purpose include antipsychotic and sedative medications and libido suppressants. There is evidence to suggest that in some cases, these medications are being used inappropriately.[51] The Australian Law Reform Commission ('**ALRC**') has also found that chemical restraint is 'reportedly widely used on people with dementia' and that 'there is a high and inappropriate utilisation of antipsychotics in the elderly'.[52]

These medications are not restricted to aged residents. They are used to control the behaviour of other younger residents living with a disability or suffering a terminal illness. This is usually in cases where the aged care facility is unwilling or unable to provide meaningful activities for these residents which in turn leads to behavioural problems. They are often used as a first option, rather than as a last resort (as required by the Aged Care Quality Standards).

Psychotropic medications can also lead to residents losing mobility, cognition, the ability to engage in meaningful and pleasurable activities and the associated loss of the enjoyment of life. All too often, psychotropic medications are administered without due regard to the risks of dysphagia and falls. Opiates, for example, can adversely affect motor function of the oesophagus. Psychotropic medications, left unchecked, can also lead to premature death.

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[51] Carmelle Peisah and Ellen Skladzien, *The Use of Restraints and Psychotropic Medications in People with Dementia: A report for Alzheimer's Australia*, Paper No 38 (2014) 16.
[52] ALRC, above n 47.

For the person being restrained, the inappropriate use of these practices can often result in physical and psychological harm. Some forms of restrictive practices may also amount to torture.

The *Aged Care Act* has recently been amended to regulate the use of anti-psychotropic drugs and restraint through the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*. The LIV supports these amendments and urges the Commonwealth to enforce these requirements on aged care providers. For example, by auditing the self-assessment tool for recording consumers receiving psychotropic medications.

Moreover, the LIV would like to see a human rights framework built within the Principles. That is:

- **Participation:** residents have the right to participate in decisions that affect them. Participation must be active, free and meaningful, and give attention to accessibility issues, including access to information in a form and language that can be understood;
- **Accountability:** this requires the effective monitoring of compliance with the Principles, as well as human rights standards and the achievement of human rights goals. Moreover, there must be remedies for breaches.
- **Non-discrimination and Equality:** discrimination must be prohibited, and measures taken to address the consequences of discrimination where it occurs, including through the use of restrictive practices.
- **Empowerment:** residents must be empowered to claim and exercise their rights and freedoms. They need to be able to understand their rights and to participate in the development of the Principles, given they affect their lives.
- **Legality:** the Principles on restrictive practices must be consistent with international human rights principles on the freedom of movement.

The LIV also brings the Commission's attention to the following:

- State-based laws limiting restrictive practices do not extend to RACFs. However, in Victoria, the *Medical Treatment Planning and Decisions Act 2016* (Vic), which recently came into force, limits the use of restrictive practices by way of chemical

intervention by defining medical treatment to include prescription medications. A resident of an RACF must consent to the administration of all medications and where the resident lacks decision making capacity in relation to their medical treatment, consent of that person's medical treatment decision maker will be required before medical treatment can be administered. This includes the administration of psychotropic and other prescription medications.

- The right of persons with disabilities to have equal recognition before the law is enshrined within Article 12 of the *Convention on the Rights of Peoples with Disabilities*. In addition, Articles 14 and 15 provide the right to liberty and security of person, and freedom from torture or cruel, inhuman or degrading treatment or punishment. Moreover, Article 16 relays that States must 'enact laws and administrative measures to guarantee freedom from exploitation, violence and abuse'. The LIV submits that 'administrative measures' should include a mandatory requirement for keeping of records that relate to the exploitation, violence, the use of medication as a restraint and abuse of elderly and disabled persons within residential care settings. The data retrieved should be collated so as to inform clear, accessible and enforceable policy on this issue.

- Identifying the prevalence of restrictive practices in RACFs is difficult. One reason for this difficulty is the lack of a single definition of 'restrictive practices'. This absence makes it difficult for aged care workers to know when restraints policy and protocols are applied.

Recommendation 11: **Restrictive Practices**

Although the LIV recognises the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 as a positive step towards addressing the critical need to regulate restrictive practices in aged care, the Principles could be significantly strengthened by:

- better reflecting a human rights framework;
- clearly setting out mandatory requirements for controlling the physical and chemical restraint of residents in aged care facilities to minimise restraint, ensure it is used as a last resort and that the resident and their family is fully consulted before restraints are used;
- requiring aged care providers to provide meaningful activities for all residents to enhance their quality of life and minimise the risk of behavioural problems arising from boredom and isolation.

- restricting the use of psychotropic medications, whether to control behaviour or for a medical purpose, by requiring any such medications only be given with the consent of the resident or, where the resident lacks medical treatment decision-making capacity, consent of the resident's medical treatment decision maker;
- requiring the consent of a medical practitioner as nominated by the resident, or where the nominated medical practitioner is unable to be contacted or no prior nomination by the resident is provided, an independent medical practitioner not employed by the aged care facility;

- requiring that psychotropic medications can only be prescribed for a maximum period of one month, after which there must be a full medical review of the resident by a registered medical practitioner nominated by the resident (or where the resident lacks medical treatment decision making capacity, nominated by the resident's medical treatment decision maker), including an assessment of any side-effects from the medications.
- The States should be required to keep records that relate to exploitation, violence, use of chemical and physical restraint and abuse of elderly and disabled persons within residential care facilities, with providers being required to report all such incidents;
- In capturing statistical data regarding the use of restrictive practices in aged care, the following information should be clearly documented by RACFs (as soon as reasonably practicable after the restraint occurs):
  - the form of restraint applied;
  - the reasons for use;
  - the duration of use;
  - the outcome of the restraint; and
  - any adverse events that occurred.

Additionally, following the use of any restrictive intervention used as a behaviour control mechanism, the resident(s) restrained should have their behavioural support plan reviewed, and where necessary, modified to avoid the use of restrictive practices as a means of controlling behaviour. As soon as reasonably practicable after a restraint is applied, the person(s) affected formally appointed substitute and support decision maker(s), or, if none appointed, the person's primary carer or nearest relative, must be notified of the matters documented (outlined above) and pro-

vided with the written report upon request. Where a person has no medical treatment decision maker or no primary carer or relatives, the Public Advocate/Guardian should be informed.

Human-right based approach - Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

The use of restraints seriously affects a person's human and legal rights and its use must be justified in each instance. As such, the use of restrictive practices to manage challenging behaviours in the aged care and disability sectors is primarily a human rights issue. The LIV is concerned that the Quality of Care Amendment Principles were passed as a ministerial instrument rather than as an Act of Parliament, and without due consideration of the human rights of the people it effects. The Principles are at odds with the regulation of restraints in the disability sector.

> Under the *Disability Act 2006* (Vic) the purpose of the restrictive practices provisions of disability service providers is to "protect the rights of persons to whom this Part applies[53]" and the overarching principles expressly acknowledge that persons with a disability have the same rights and responsibilities as other members of the community[54]. In contrast, the Principles do not explicitly acknowledge the rights of resident choice and decision making. It is recommended that the Principles make reference to the right of equal recognition before the law under article 16 of the *International Covenant on Civil and Political Rights* and section 8 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic), and the right to autonomy, dignity, choice and control under article 12 of the *Convention on the Rights of Persons with Disabilities*.

Recommendation 12: Consistent Regulation

- The LIV recommends that the Council of Australian Governments ('COAG') facilitate the development of a nationally-consistent approach to the regulation of restrictive practices. This reflects the Senate Community Affairs References Committee's recommendation that the "Commonwealth develop, in consultation with dementia advocates and service providers, guidelines for the recording and reporting on the use of all forms of restraints in residential facilities". This recommendation mirrors Recommendation 8-2 of the ALRC's report, *Equality, Capacity and Disability in Commonwealth Laws*, which called for the development of a national approach to the regulation of restrictive practices in sectors other than disability services.

Recommendation 13: Challenging Behaviours

[53] *Disability Act 2006* (Vic) s133.
[54] *Disability Act 2006* (Vic) s5(1).

The LIV recommends that:

- RACFs which report multiple instances of restraint in any given reporting year should be required to undertake training in procedures for managing challenging resident behaviours. Compliance with any such training should be monitored by the Department of Health ('DHS') and publicly reported on each year;
- there should be an increase in random on-site auditing of RACFs to identify mistreatment of residents, including the use of restrictive practices.

8. Causes of systemic failures:

The LIV submits that there are a number of underlying reasons as to why RACFs fail to provide a high quality of care. Not all of these reasons relate to the inner workings and senior management of particular RACFs. Rather, they extend to the regulatory environment in which RACFs operate and wider societal views on older people. The causes of systemic failures which LIV members wish to bring to the Commission's attention to are:

- ageist views informing policy-making;
- narrow reporting mechanisms;
- irregular and inadequate monitoring of RACFs;
- ineffective complaints handling;
- secrecy and concealment;
- gaps in research on residents' lived experiences and, subsequently, a lack of knowledge within the sector;
- inadequate levels of funding;
- poor facility design;
- limited access to specialist services;
- a lack of staff training;

- staff ratios;
- complexity in federal and state laws and, subsequently, a lack of knowledge of them.

Ageist Attitudes and Policy Making:

The Ibrahim Report noted that changing the values and attitudes of professionals towards aged care requires: addressing ageist attitudes; and a better understanding of the processes of ageing. The Ibrahim Report criticised the social meanings behind the concept of 'old age' as they influence decisions on the resources and priorities attributed to the lives of residents. Furthermore, over time, these meanings may become thought of as 'fact'. Quality of care, therefore, is not shaped by sound research, but by socially-informed attitudes and perceptions.[55]

Rather than viewing RACFs as a place for older persons to thrive, the atmosphere and culture in many RACFs are akin to hospital settings. Many are regimented with set times each day for the various activities of daily living. Spontaneity is seen as risky by many providers. Personal privacy is often compromised and is more closely aligned to what a hospital patient can expect, rather than a resident in a 'home' environment.

Narrow Reporting Mechanisms:

The LIV submits that the statutory mechanism to report the mistreatment of residents is outdated and in need of reform.

Division 63 of Part 4.3 of the *Aged Care Act* relates to accountability. It outlines the responsibilities of approved providers. It outlines, in particular, the requirement that providers report allegations or suspicions based on reasonable grounds of 'reportable assaults' to the police and the Secretary of the Department of Health: s 63.1AA(2).

As per s 63.1AA(9), the definition of reportable assault is:

[55] Ibrahim Report, above n 2, 28-29.

"unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory, that is inflicted on a person when:

a) the person is receiving residential care in respect of which the provider is approved; and
b) either:
    i) subsidy is payable for the provision of the care to the person; or
    ii) the person is approved under Part 2.3 as the recipient of that type of residential care"

The LIV submits that this section is problematic for several reasons:

- first, it limits reporting to physical assaults. This contrasts with the Australian Law Reform Commission's finding that elder abuse includes emotional harm and neglect.[56] As the Australian Law Reform Commission noted, "reportable assaults also capture a more narrow range of conduct than what may be described as elder abuse".[57] The ALRC received submissions which provided examples of emotional abuse by paid care workers and other residents, as well as family members and appointed decision makers of residents.[58] Behavioural and psychological effects of emotional abuse also include insomnia; weight loss and malnutrition; refusal to eat, drink or take medication; and low energy, physical activity and responsiveness.[59]

- second, the term 'assault' is too narrow. Changing this word, or broadening its definition, would better reflect the *Aged Care Act's* objective to protect the health and well-being of the recipients of aged care services: s 2.1(c).

- third, although sexual assaults form part of mandatory annual reporting requirements, LIV members have relayed that data on the incidence of

[56] Australian Law Reform Commission, *Elder Abuse – A National Legal Response* (2017), Report 131, 37.
[57] Ibid 199.
[58] Ibid.
[59] Ibid.

these types of assaults is difficult to obtain. This may be due to misinterpretation as to what classifies as 'sexual assault'.

Recommendation 14: Reportable Assaults

The LIV recommends that:

- the term 'reportable assaults' in s 63.1AA be replaced with 'reportable abuse'; and
- the definition in s 63.1AA(9) should be amended to include psychological harm and neglect by an aged care provider.

Further, the LIV contends that it is unlikely that an aged care provider would report itself. As a result, there is little oversight of assaults and neglect inflicted on residents of aged care facilities.

Lack of a Serious Incidents Response Scheme:

The *Aged Care Act* also includes a discretion for providers not to report incidents of resident-on-resident aggression if: 1) the alleged offender has a previously assessed cognitive impairment, and 2) a behaviour management plan has been put in place for the care recipient within 24 hours of receipt of the allegation or suspicion of assault. The consequence of this is that the most common types of RRA incidents – those involving cognitively impaired residents – are never identified and publicly reported.

The LIV acknowledges that there are complex dynamics that surround the reporting of resident mistreatment. Factors that are influential in this context include the difficulties in identifying mistreatment, and the conditions within which it occurs. Cognitive impairment may also prevent reporting, as residents may not be believed. Shame, embarrassment, and fear of reprisal from RACFs staff and management is also relevant. This is compounded by the dependency (to varying degrees) of the resident on the provider to meet their care needs. An older person may be reluctant to disclose mistreatment if it was perpetrated by someone on whom they depend for care. This reluctance comes from fear of further neglect or mistreatment.

In addition, employees in the aged care sector may not report abuse for a number of further reasons, such as fear of contravening Commonwealth, state or territory privacy laws; fear of dismissal or adverse action by employers; fear of breaching their clients' trust; and a lack of education around what constitutes abuse.

Recommendation 15: Serious Incident Response Scheme

- The LIV supports the ALRC's recommendation that aged care legislation should provide for a new serious incident response scheme. The scheme would require approved providers to notify an independent oversight body of any allegation or suspicion of a serious incident in their facility. In relation to RRA, these notifications would include incidents of physical abuse causing serious injury, or incidents occurring as part of a pattern of abuse.
- The LIV also supports the following proposals made by the ALRC:
    - i) there should be a national employment screening process for Australian government-funded aged care providers;
    - ii) a national database should be established to record the outcome and status of employment clearances;
    - iii) unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers;
    - iv) Part 7 of the Accountability Principles 2014, which contains an exemption to reporting 'reportable assaults', be repealed. All reportable incidents should be reported to the Commissioner, which would create greater clarity for approved providers around reporting obligations and assist in recording and responding to patterns of behavior;
    - v) the reporting exemption in s 23 of the Accountability Principles 2014 should be removed to ensure that all care recipients are safe, and to provide greater transparency and accountability in how approved providers are responding to resident-on-resident incents and whether such responses are appropriate and effective.

Lack of Adequate Monitoring of RACFs:

In 2002, the United Nations adopted the *Optional Protocol to the Convention Against Torture* ('**OPCAT**'). It aims to prevent the abuse of people in detention by opening

places where people are deprived of liberty to regular inspections visits by local inspection bodies, known as National Preventive Mechanisms ('**NPM**'). In February 2017, it was announced that Australia would ratify OPCAT by the end of 2017. The Federal government will be responsible for implementing OPCAT inspections in areas of its responsibility. The states and territories are responsible for implementing visits in places of detention they administer.

According to the Victorian Ombudsman, the definition of 'detention', under OPCAT, 'requires inspections of any place under the jurisdiction or control of the state where persons are, or may be, deprived of liberty'.[60] The Australian government has indicated that the National Preventive Mechanism will be limited, focusing on prisons, youth justice centres, immigration detention, military detention, police custody and closed psychiatric facilities. Whilst aged care facilities may not be seen as a primary place of detention, they may fall within the definition of 'deprivation of liberty' for OPCAT purposes., According to the United Nations:

> "…the preventative approach underpinning the Optional Protocol means that as extensive an interpretation as possible should be made in order to maximise the preventive impact of the work of the [NPM]".[61]

Table Six: Comparative NPMs

Austria	Austria, having ratified OPCAT in 2012, designated the Austrian Ombudsman Board as its NPM. It inspects all places envisioned in the wide definition of detention, including aged care facilities. In 2017, the Austrian Ombudsman Board made 100 unannounced visits to aged care facilities.
Germany	Germany ratified OPCAT in 2008, establishing the National Agency for the Prevention of Torture as its NPM. Aged care facilities are among the places the agency can visit.
New Zealand	New Zealand ratified OPCAT in 2007 and designated multiple agencies as its NPM. These include the Office of the Ombudsman, the Inspector of Service Penal Establishments, and the

[60] Victorian Ombudsman, 'Implementing OPCAT in Victoria: Report and Inspection of the Dame Phyllis Frost Centre, 6.
[61] United Nations, Office of the High Commissioner, *Preventing Torture: The Role of National Preventive Mechanisms*: *A Practical Guide* (2018) 22.

	New Zealand Human Rights Commission, the Office of the Children's Commissioner, and the Independent Police Conduct Authority. The NPM inspects all places as envisioned by the broad definition of 'detention', including aged care facilities.
United Kingdom	The United Kingdom ratified OPCAT in 2003 and, similar to New Zealand, designated 21 different organisations as NPM. Among these include the Care Quality Commission of England, which inspects, monitors and regulates health and social care services throughout England. The organisation rates nursing and residential homes against five key questions: *is it safe, is it effective, is it responsive, is it caring*, and *is it well-led?*

Recommendation 16: OPCAT Compliance

The LIV submits that the broad scope of OPCAT provides the benefit of ensuring that places which are not traditionally seen as detention, but with evidence of mistreatment, can be subject to the same monitoring as would be expected of a prison.

Staff Ratios:

Section 53.1(1)(b) of the Aged Care Act states that it is the responsibility of an approved aged care provider "to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met". There is no statutory definition, Ministerial regulation, or elaboration in the Quality of Care Principles or Aged Care Standards as to what an adequate number would be. This is problematic. Take the following example from Katrina Legzdins who spoke to Four Corners:

> "I'm an enrolled nurse. I'm speaking out because I became frustrated with the poor conditions working in aged care. There was just the sheer number of people that you have to look after. So, there was myself and a registered nurse in charge of 72 residents. There's no ratio, I guess, for number of staff to residents, so they can just get away with bare bones, bare minimum".

Before the previous parliament there was the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 which, if it had passed, would require approved providers to publicise staffing ratios in facilities. The LIV submits that this should go further.

As a point of comparison, the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic) enshrines minimum numbers of nurses and midwives to care for patients. An objective of the legislation is "to provide for safe patient care in hospitals by establishing requirements for a minimum number of nurses or midwives per number of patients in specified wards or beds, recognising that nursing workloads impact on the quality of patient care".

The ratios are set out in Part 2 of this Victorian Act. They provide a minimum requirement only and are not intended to prevent the operator of a hospital from staffing a ward with additional nurses or midwives beyond the number required by the ratio.[62]

Recommendation 17: Staffing Ratios

- The LIV recommends a new Division within the Aged Care Act that mandates staffing ratios that relate to, but are not necessarily identical to, ratios that exist in public hospitals.

Conclusion:

The mistreatment of residents is a significant issue. In ensuring the rights and freedoms of residents are upheld, the LIV submits that the Commonwealth's regulation of the aged care sector should feature the following:

- providers of RACFs that receive a Commonwealth licence must meet high standards of safety. In ensuring that standards are met, a rigorous accreditation process must occur. Standards can also be improved by requiring the reporting of all serious incidents, and mandating compliance with guidelines that limit the use of restrictive practices.

- residents should have access to an independent advocate that investigates theirs, or their representatives', complaints. The effectiveness of such an authority would lie in its ability to: provide redress for mistreated residents; make

[62] *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* s 9(1)(c).

findings that can be used for quality improvement; and identify patterns of concern within complaints.

- regulation should ensure that aged care workers are well-trained, with an emphasis on care and compassion. They should also be supported by an effective organisational structure with mandated minimum staff-to-resident ratios to ensure high-quality care and clear policies and procedures to meet expected standards of care.

Many of these features are already included within the current legislative framework. However, twenty-one years have passed since its implementation. Its effectiveness at protecting care recipients' rights in today's current climate is due for review. Over this period, there has been substantial changes to the measuring, regulating and investigating of care, but the complex legislative framework for consumer protection and complaints mechanisms has not been effective at meeting its aims in terms of protecting residents from mistreatment and neglect. Although the Aged Care Act has been amended several times, the LIV submits that further changes are required to better reflect current societal expectations. As the *Review of National Aged Care Quality Regulatory Processes* noted:

> 'The [aged care] system gives the impression of being the result of multiple incremental changes, rather than system-based design to achieve the most efficient and effective regulation of quality in aged care'.[63]

Recommendation 18: Aged Care Ombudsman

- To achieve these ends, the LIV recommends the establishment of an Aged Care Ombudsman with powers to investigate RACFs on its own motion or upon receipt of a complaint. The Ombudsman must be easily contactable and prompt in responding. This role is separate from but will inform the office of the Aged Care Quality and Safety Commissioner.

[63] Above n 3, 28.

9. Conclusion:

Should you have any queries about this memo, please contact Alexander Laurence, Paralegal to the Elder Law Section (03 9607 9565 or ALaurence@liv.asn.au).

Kind regards,

Stuart Webb
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