# Chapter 4

# A national concern

> [T]here is evidence to suggest that accreditation may not be adequate in delivering quality care outcomes for consumers.[1]

4.1 As outlined in Chapter 3, many of the submitters and witnesses to this inquiry have raised concerns that the oversight and regulation failures, which allowed the poor conditions at Oakden to continue for so long, are not isolated to the specialised type of service delivery at Oakden, and that the same regulatory failures can be seen more widely across the aged care sector.

4.2 Conversely, aged care sector providers and representative organisations have submitted that Oakden was a special case, and should not be seen as representative of the broader aged care sector or the quality oversight frameworks.[2]

4.3 Notwithstanding the views of aged care providers themselves, a significant body of evidence has been presented to this inquiry which highlights a broad range of problems with the quality oversight and regulation framework. Given the extensive evidence received of this nature and the terms of reference for this inquiry, this chapter will not seek to analyse or make recommendations on those sector-wide regulatory and oversight concerns. Instead, this chapter will highlight the key concerns raised within the scope of this inquiry, which go beyond the regulatory and oversight failures specific to Oakden and impact the aged care sector as a whole.

## Concerns raised in evidence

### *Broad concerns with the accreditation system*

4.4 Submitters and witnesses raised a number of broad criticisms of the current accreditation system.

4.5 Monash University Health Law and Ageing Research Unit submitted that the existing regulatory mechanisms are almost 20 years old, and there has been 'profound changes in the past 20 years about measuring, regulating and investigating quality of care'. The submission from Monash University further stated that the aged care regulatory mechanisms and legal systems are 'complex, fragmented and risk averse with divergent, discordant or contradictory approaches. This contributes to significant gaps in care, especially in [Residential Aged Care Facilities] (RACFs)'.[3]

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1 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report (Carnell Paterson review)*, October 2017, p. 62.

2 This view that care concerns at Oakden were caused by issues specific to the circumstances at Oakden was raised in submissions from Aged and Community Services Australia, Aged Care Industry Association, BUPA, and Leading Age Services Australia.

3 Professor Joseph E Ibrahim and Associate Professor Lyndal Bugeja, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Submission 29*, p. 15.

4.6 The Victorian Government submitted that while the accreditation process has supported improvements in RACFs over the past two decades, the focus on compliance to minimum accreditation standards by individual providers does not support sector-wide capacity building or encourage improvements beyond the minimum benchmarks.[4]

4.7 The Victorian Government submitted it supports amending the Accreditation Standards to ensure they are clear, measurable and specifically applicable to residential aged care.[5] The Victorian Government further submitted that the monitoring approach should not focus only on individual providers, but should also monitor the performance of the aged care sector as a whole.[6]

***Specialised dementia and mental health care***

4.8 The committee heard that there is an increase in the prevalence of dementia and the increased demand for specialist beds is growing faster than supply.[7] Responding to this need, in the 2016–17 Mid-Year Economic and Fiscal Outlook the Australian Government announced the introduction of Specialist Dementia Care Units in residential aged care settings.[8]

4.9 However, there does not appear to be an Australian Aged Care Quality Agency (Quality Agency) accreditation process specific to aged care services with specialist elements of mental health or Behavioural or Psychological Symptoms of Dementia (BPSD) services. The South Australian (SA) Chief Psychiatrist argued the current aged care assessment and accreditation framework is not suitable for care settings for consumers with severe mental illness and dementia care needs.[9]

4.10 The Australian Commission on Safety and Quality in Health Care advised the *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review) that all health services where patients have a severe form of dementia should be assessed against the National Safety and Quality Health Service (NSQHS) Standards. The Makk and McLeay wards were not assessed against the NSQHS Standards as they were rated as aged care facilities, despite the fact that the specialised aged care being delivered incorporated dementia and mental health services.

4 Victorian Government, *Submission 40*, p. 1.

5 Victorian Government, *Submission 40*, pp. 1–2.

6 Victorian Government, *Submission 40*, p. 2.

7 Alzheimer's Australia, *Submission 20*, p. 12. See also *Carnell Paterson review*, pp. 38–39.

8 The Hon Sussan Ley MP, Minister for Health and Aged Care, Media Release 19 December 2019, '*2016-17 MYEFO Drives Health Reform*', http://www.health.gov.au/internet/ministers/publishing.nsf/Content/E757065F44BAF304CA25808E0019AFB5/$File/SL109.pdf, (accessed 29 January 2018).

9 Chief Psychiatrist, Department for Health and Ageing (South Australian (SA) Government), SA Health, *Submission 27*, p. 7.

Conversely the Clements ward, which was not receiving Commonwealth aged care funding, was assessed against these higher health care standards.[10]

4.11 The Carnell Patterson review found that despite some stakeholders arguing Oakden does not represent the mainstream aged care sector, the issue of specialist dementia and mental health care in an aged care context is relevant to the broader aged care sector:

> We know from the Aged Care Funding Instrument, for example, that around half of residential care consumers have symptoms of mental illness. This group overlaps with the approximately half who have dementia. We know that frailty is increasing, and that the number of people in care with dementia (and therefore with severe dementia) is increasing. Oakden is not unique, because the characteristics and needs of its residents were not unique.[11]

4.12 The Carnell Paterson review found that regulation must include the capacity to review the full complexity of care being provided to aged care residents and wrote:

> The regulatory system must be designed to respond to the profile of consumers in a service. Had that been the case ten years ago, Oakden—and other facilities with more vulnerable consumers—could have been supported and monitored more closely.[12]

### *Consumer involvement*

4.13 Multiple submitters and witnesses argued that the accreditation and audit processes do not adequately involve consumers and their families.[13] This view was also put forward by the Chief Executive Officer (CEO) of the Northern Adelaide Local Health Network (NALHN) in relation to accreditation audits conducted at Oakden:

> Take Oakden as an example: the residents of Oakden had little or no capacity themselves to speak to people who came for assessments. I don't believe that the carers or the families of the people who lived at Oakden were given an opportunity to share their perceptions with the accreditors. Certainly the past residents' families that I met with subsequent to the report being released, they all, without exception, reported observing the same issues, the same behaviours, the same treatment over many, many years. If they had been involved in the accreditation process, because the residents had no capacity, we would have seen a different outcome.[14]

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10 *Carnell Paterson review*, p. 37.

11 *Carnell Paterson review*, p. 39.

12 *Carnell Paterson review*, pp. 38–39.

13 See for example submissions from: Carers NSW, Council on the Ageing, Federation of Ethnic Communities' Councils of Australia, Mental Health Commission of NSW, Officer of the Public Advocate Queensland and Victorian Government.

14 Ms Jackie Hanson, Chief Executive Officer, Northern Adelaide Local Health Network, SA Health, *Committee Hansard*, 21 November 2017, p. 7.

4.14 The Quality Agency submitted the current audit process has been recently amended to ensure a minimum of 10 per cent of care recipients and their representatives are interviewed using a new structured interview process with standardised questions and that consumers' feedback is published in Consumer Experience Reports as part of a move to greater transparency.[15]

4.15 However Alzheimer's Australia submitted there needs to be greater involvement of consumers at the organisational level of the Quality Agency itself, to drive improvement in the quality assessment processes.[16]

4.16 Submitters also argued the Accreditation Standards only let consumers know which RACFs are failing, but do not let consumers know which facilities are providing high quality care.[17] Older Persons Advocacy Network also submitted that the accreditation process does not require consumers be informed when there are concerns in relation to a facility.[18]

4.17 The Federation of Ethnic Communities' Councils of Australia submitted that processes to accredit and monitor RACFs do not adequately cater for the needs of ageing Australians from a culturally and linguistically diverse background, particularly in the lack of independent translation services provided during accreditation and audit visits.[19]

***Personal care vs medical care and clinical governance***

4.18 Evidence to this committee shows there is a clear schism in how the aged care sector defines different levels of aged care services as personal care as opposed to health or medical care, and therefore the level of clinical governance required for that care.

4.19 HammondCare, which operates more than 1000 residential aged care places, submitted:

> [I]t is not appropriate for the accreditation framework for residential aged care services to monitor the appropriateness of medical care provided to residents, as aged care homes are not medical facilities. While approved providers of residential aged care under the Aged Care Act 1997 are required to provide residents with nursing services and to assist them with daily living activities, their responsibility when it comes to medical care is simply to assist in accessing the services of appropriate medical practitioners as required (Quality of Care Principles 2014, p.6)…
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> As aged care homes are not responsible for the direct provision of medical care, they should not be held accountable for the manner in which it is

15 Australian Aged Care Quality Agency (Quality Agency), *Submission 42*, pp. 6, 13–14; Mr Nick Ryan, Chief Executive Officer, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

16 Alzheimer's Australia, *Submission 20*, p. 14.

17 Alzheimer's Australia, *Submission 20*, p. 7 and Carers Australia NSW, *Submission 21*, p. 2.

18 Older Persons Advocacy Network, *Submission 23*, p. 3.

19 Federation of Ethnic Communities' Councils of Australia, *Submission 32*, p. 2.

> provided. Instead, the adequacy and appropriateness of the medical care provided to aged care residents should be overseen by the appropriate medical colleges.[20]

4.20 Despite arguing that aged care providers are not responsible for medical care, HammondCare also submitted evidence on the specialised health care services it provides, which includes services for people with severe behavioural and psychological symptoms of dementia and palliative care.[21]

4.21 However, the Productivity Commission 2001 report *Caring for Older Australians* defines the 'care' component of aged care as a 'mix of health (or medical care) and personal care services'.[22] Importantly, the Productivity Commission does not make a distinction between medical care and other forms of health care, such as mental health or nursing care.

4.22 Leading Age Services Australia, a national peak body representing aged care service providers, submitted that many providers have recommended that in order to properly assess the quality of clinical care being provided in individual RACFs, all Quality Agency auditors should have a background in clinical care.[23] BUPA similarly submitted that allied health service provision should be considered in the Quality Agency assessment process.[24]

4.23 However, Aged and Community Services Australia, another provider representative body, argued that individual clinical care was not an area that the Quality Agency should be assessing at all, and submitted that:

> Concerns about the standard of care provided by doctors and other health practitioners should be considered by the appropriate health practitioner body and is not something that an assessor from the Australian Aged Care Quality Agency would or should be able to make a decision about.[25]

4.24 The Quality Agency submitted that clinical issues, such as governance and practices, are currently incorporated into the Quality Agency's Accreditation Standards.[26]

4.25 However, Professor Craig Whitehead of Flinders University noted that clinical care oversight in the aged care sector was significantly less developed than in health care, and told the committee:

> One of the things that struck us is that the idea of quality or clinical governance in an aged care institution is very much in its infancy. Some

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20 HammondCare, *Submission 11*, pp. 4–5.

21 HammondCare, *Submission 11*, p. 2.

22 Productivity Commission, *Caring for Older Australians*, 8 August 2011, Volume 2, p. 12.

23 Leading Age Services, *Submission 4*, p. 4.

24 BUPA, *Submission 18*, p. 14.

25 Aged and Community Services, *Submission 12*, p. 5.

26 Quality Agency, *Submission 42*, pp. 12–13.

> aged care organisations are starting to look at risk and quality and managing adverse events, but, by and large, it is not mandated.[27]

4.26 The Victorian Government submitted it supported the development of a clinical governance framework for aged care providers, arguing 'the clinical needs of people living in residential aged care are increasing' and that clearly defining clinical care standards will facilitate workforce development.[28] The Victorian Government further submitted that this framework should include a definition of clinical risk as 'where action or inaction on the part of the organisation results in potential or actual adverse health impact' and goes on to list a number of personal care services such as hydration and nutrition, skin integrity and oral hygiene which, if done poorly or neglected, can result in adverse health outcomes for elderly people.[29]

4.27 The Law Council of Australia submitted that any changes to the oversight of clinical governance should include oversight of prescription medications, in particular the use of antipsychotic medications, which is linked to the practice of chemical restraint.[30]

***Committee view***

4.28 The lack of a defined model of care, coupled with appropriate clinical governance to deliver that model of care, was raised in Chapter 2 as a significant contributor to the substandard service delivery at Oakden.

4.29 The committee notes the evidence shows this issue is not isolated to Oakden. The evidence presented to this inquiry shows there is significant conflict within the aged care sector as to the definition of the care being provided, who is responsible for providing appropriate clinical care in RACFs, and which agencies should have quality oversight responsibility of that care.

4.30 The current impasse cannot continue and needs to be resolved.

### *Abuse and Restrictive practices*

4.31 Investigations of care and practices at Oakden revealed an over-reliance on restrictive practice. The chair of the Oakden Oversight Committee stated it was one of the worst aspects of the abusive treatment found at Oakden.[31] The SA Chief Psychiatrist report found that:

> There has been ongoing, repeated use of restrictive practices at Oakden that has contravened legislation, national standards, state policy and local

27 Professor Craig Whitehead, Clinical Director, Rehabilitation, Aged Care and Palliative Care, Flinders University, *Committee Hansard,* 21 November 2017, p. 31.

28 Victorian Government, *Submission 40*, pp. 2–3.

29 Victorian Government, *Submission 40*, p. 5.

30 Law Council of Australia, *Submission 24*, p. 7.

31 Dr Tom Stubbs, Chair, Oakden Response Oversight Committee, *Committee Hansard*, 21 November 2017, p. 3.

> procedures and likely implemented for staff convenience and or used as punishment.[32]

4.32 Beyond Oakden, the unregulated use of restrictive practice across the broader aged care sector was raised by a number of submitters and witnesses as being a key concern. Alzheimer's Australia noted the use of chemical restraint, in the form of over-prescribing antipsychotic medication, was a continuing problem in the aged care sector.[33]

4.33 The Law Council of Australia also raised concerns with restrictive practice, and pointed to the Australian Law Reform Commission (ALRC) June 2017 report, *Elder Abuse – A National Legal response* (Elder abuse report), discussed in greater detail later in this chapter, which recommended regulating the use of restrictive practice in the aged care sector.[34]

### *Aged care workforce*

4.34 A number of different workforce related issues were raised as matters of concern by submitters and witnesses, including training, staffing levels and regulation.[35]

4.35 Monash University submitted that the lack of gerontology-specific nursing training directly impacted the ability of nurses to monitor standards of care in aged care:

> [T]here is not a single tertiary nursing course on gerontology, let alone specific training for care of persons in [RACFs]. With such a large gap in the nursing workforce knowledge and training it is unreasonable to expect nurses to be able to monitor standards of care, advocate and challenge the status quo. This is very unlike the situation of health care in public hospitals.[36]

4.36 Staffing levels were raised in a number of submissions, with the majority being in favour of minimum nurse to patient ratios 'to ensure that skilled care can be provided to residents in a timely way'.[37] The Victorian Government pointed to the

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32 Dr Aaron Groves, Chief Psychiatrist, SA Health, *Oakden Report – Report of the Oakden Review*, p. 113.

33 Alzheimer's Australia, *Submission 20*, p. 20.

34 Law Council of Australia, *Submission 24*, pp. 9–10.

35 Workforce concerns, such as levels of staff and training, were raised in submissions from Australian Law Reform Commission, Bupa, Australian Nursing and Midwifery Federation, Law Council of Australia, Office of the Public Advocate Queensland, Mental Health Council of NSW, Monash University, NSW Nurses and Midwives Association and Victorian Government, among others.

36 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16.

37 Victorian Government, *Submission 40*, p. 3. Staffing levels was also raised in submissions from Aged Care Crisis Inc., Australian Nursing and Midwifery Federation, NSW Nurses and Midwives Association, Occupational Therapy Australia, Office of the Public Advocate Queensland, Queensland Nurses and Midwives' Union and Victorian Government, among others.

ALRC Elder abuse report, which expressed concern that low staffing levels could lead to restrictive practises being used to manage patients, as well as lead to abuse or neglect.[38]

4.37 The heavy reliance of personal care attendants in the aged care workforce was also raised as a significant concern for quality care, given it is an unregulated workforce.[39] Submitters pointed to the recommendations of the ALRC Elder abuse report to increase the regulation of this section of the aged care workforce.[40] This recommendation was also made by the recent Senate inquiry into the *Future of Australia's Aged Care Workforce*.[41]

***Data***

4.38 The lack of data on quality of care was raised by multiple submitters as being a significant barrier to ensuring an appropriate quality framework for aged care services. Monash University discussed this at great length, and pointed to a recent study of coronial data which indicates there are a disturbing number of preventable deaths occurring in RACFs.[42]

4.39 Following on from the above study, Monash University have produced a report *Recommendations for prevention of injury-related deaths in residential aged care services,* which makes 104 recommendations on strategies to prevent similar deaths from choking, medication events, physical restraint, an unexplained absence 'while in respite care', suicide and, resident–resident aggression.[43]

4.40 Monash University further submitted there is a lack of empirical research into RACFs, regulatory mechanisms and quality of care, largely due to the lack of dedicated funding to support research, and that research is made all the more difficult by the lack of readily available, standardised national measures for quality of care.[44]

4.41 In relation to medication management data, the Department of Health have indicated that the government does not currently collect specific data on prescription rates or patterns of usage in aged care as many people who live within RACFs may not receive all of their medications through that facility. However national residential medication charts, where they are in use, offer an opportunity for data collection about

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38 Victorian Government, *Submission 40*, p. 4.

39 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16. This issue was also raised by Alzheimer's Australia.

40 See submissions from Council on the Ageing, Law Council of Australia and Victorian Government, among others.

41 Senate Community Affairs References Committee, *Future of Australia's aged care sector workforce*, April 2017.

42 Department of Forensic Medicine, Monash University, *Submission 29*, pp. 13–14.

43 Department of Forensic Medicine, Monash University, *Submission 29*, p. 14.

44 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16. The lack of appropriate data and the impact on quality of care was also raised in submissions from: Aged Care Crisis Inc., Aged Care Industry Association and Victorian Government, among others.

medications prescribed in particular facilities, and data under the PBS can be narrowed to the population aged over 65 years, so these could be areas for improvement in data research in the future.[45]

### *Critical, serious or reportable incidents*

4.42 The Quality Agency told the committee 'no accreditation or compliance monitoring system can fully safeguard against individual instances of abuse or neglect'.[46] The Law Council of Australia similarly submitted that the accreditation looks at systemic issues, not individual serious incidents[47] and recommended a serious incidents response scheme.[48]

4.43 Monash University discussed the need for a 'national register which is comprehensive, coordinated and requires mandatory reporting of a suite of significant adverse events that include but are not limited to: physical restraint, elder abuse, resident–resident aggression, suicide, choking, unexplained absences that are occurring in [RACFs]'.[49]

4.44 The Victorian Government similarly raised the need for a reportable incident register and pointed to the ALRC Elder Abuse report recommendation for an independent body to oversee the investigating and monitoring of serious incidents.[50]

### *Complaints handling*

4.45 In addition to the need for a serious incident reporting framework, submitters and witnesses discussed the need to improve the complaints handling systems, both within individual RACFs and systemically.[51]

4.46 Mr Stewart Johnston, a family member of a resident at Oakden, told the committee there is a range of serious problems with the complaints handling systems, both internal and external:

> Overwhelmingly, the consistent theme for all people who have come forward to me in the conversations I've had is the confusion experienced about where to lodge a complaint, how to lodge a complaint and whether it's safe to lodge a complaint. And after lodging a complaint via the many

45 Ms Catherine Rule and Mrs Lisa La Rance, Department of Health, *Committee Hansard*, 5 February 2018, pp. 22–23.

46 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 11.

47 Law Council of Australia, *Submission 24*, p. 9.

48 Law Council of Australia, *Submission 24*, pp. 11–12.

49 Department of Forensic Medicine, Monash University, *Submission 29*, p. 19. The need for improvements to individual and systemic responses to critical, serious or reportable incidents was also raised in submissions from Australian Law Reform Commission, Council on the Aging, Office of the Pubic Advocate Queensland, Queensland Nurses and Midwives Union and Victorian Government.

50 Victorian Government, *Submission 40*, p. 4.

51 Attendant Care Industry Association, *Submission 19*, p. 7; Older Persons Advocacy Network, *Submission 23*, p. 3; Law Council of Australia, *Submission 24*, p. 11.

> channels, there are no clear avenues of independence and responsibility to follow up communication.[52]

4.47 The SA Principal Community Visitor told the committee of his concerns that complaints raised within facilities are investigated by a member of staff, raising conflict of interest issues as well as concerns regarding the complaints investigation skills of the person reviewing the complaint:

> The way that complaints are raised at facilities—say at NALHN at the moment—are investigated is by a consumer liaison officer, which is a member of staff who sits among staff that they're investigating. So it puts them in a very difficult situation. Again, I think it's really important to have a level of independence of anyone investigating any of these complaints and it's important that they have the skill sets—the investigative interviewing skills—and a background in enquiry and in making objective independent assessments.[53]

4.48 The CEO of NALHN told the committee that many complaints to relevant external agencies are never made, due to fears of repercussions or other intimidation:

> I asked them why they [family members of Oakden residents] didn't complain. They complained internally, to the management team. I'm not speculating when I say they were intimidated, in relation to using any of the external agencies to make further complaints…It is my view that people who could have complained were intimidated.[54]

4.49 The Aged Care Complaints Commissioner (Complaints Commissioner) agreed that there was work to be done around encouraging consumers to engage with complaints processes, particularly where they are conducted by a Commonwealth entity:

> …I do think there is some evidence that more people know about us and more people are coming to us, but I would be the first to admit that there's a lot more we have to do and particularly to help those people who are frightened to come to us or who are worried that there'll be repercussions.… If you're sitting in an aged-care facility and you're worried about involving the Commonwealth Aged Care Complaints Commissioner because that might lead to repercussions, a local advocate can be equally as effective with some complaints and seem a lot less scary. The provider's certainly likely to be perhaps a little less intimidated than if it's escalated to us. There's that opportunity.[55]

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52 Mr Stewart Johnston, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 58.

53 Mr Maurice Corcoran, SA Principal Community Visitor, *Committee Hansard*, 21 November 2017, p. 28.

54 Ms Jackie Hanson, Northern Adelaide Local Health Network, SA Health, *Committee Hansard*, 21 November 2017, p. 9.

55 Ms Rae Lamb, Aged Care Complaints Commissioner, *Committee Hansard*, 5 February 2018, p. 15.

4.50 The Complaints Commissioner echoed the evidence provided by other witnesses and submitters that consumers have problems with engaging with the complaints process as it stands for a number of reasons and described the work being done to change this, including:

- actively encouraging industry to be more open about complaints, with increased transparency in complaints processes;
- working with providers to improve complaints handling 'at the front door', as many complaints are made to the provider first;
- working with advocacy networks to help families and consumers through complaint processes either with a provider, a state or territory entity, or with the Complaints Commissioner; and
- raising the public profile of the Complaints Commissioner to ensure that consumers know this is an avenue for complaints.[56]

4.51 The Complaints Commissioner also provided evidence that the complaints resolution process in aged care does not have the same strength as similar processes for health care, submitting that all Australian hospitals are required to openly disclose adverse events to patients and their families and respond appropriately, but no such requirement exists in aged care. The Complaints Commissioner further submitted that '[r]equiring proactive and appropriate open disclosure of adverse events is one of the key steps to ensuring failures of care are acknowledged and appropriately and promptly remediated'.[57]

## Broader actions

4.52 In addition to the Oakden-specific responses outlined in Chapter 3, the Australian Government is undertaking two key reforms of the aged care sector. These are discussed below.

### *Independent Aged Care Legislated Review*

4.53 A critical input to future reform is the Independent Aged Care Legislated Review, undertaken by Mr David Tune AO PSM. This review assessed the impact of aged care reforms announced in 2012, how the system has changed and adapted, and where the Government could make further changes. The final report was provided to the Minister for Aged Care on 31 July 2017 and a response by the Australian Government has not yet been released.[58]

### *Single Aged Care Quality Framework*

4.54 The Australian Government announced in the 2015–16 Budget it would work with the aged care sector to make changes to the Aged Care Accreditation Standards

56 Ms Rae Lamb, Aged Care Complaints Commissioner, *Committee Hansard*, 5 February 2018, pp. 11, 12, 15.

57 Aged Care Complaints Commission, *Submission 7*, p. 6.

58 Department of Health, *Submission 37*, pp. 23–24.

used by the Quality Agency, and proposed to establish a Single Aged Care Quality Framework (single quality framework) for all aged care services.[59]

4.55 The single quality framework has undergone a public consultation process on the two proposed components: a single set of quality standards and options for a streamlined approach for assessing provider performance against those quality standards.[60] It is important to note that while the single quality framework was announced in May 2015, the public consultation process was opened in March 2017, at a time when the Oakden complaints were public knowledge and the SA Chief Psychiatrist's investigation was underway.[61]

*Single standards*

4.56 The single set of standards, which is proposed to apply to all aged care services including residential care, home care and flexible care, were released in draft form on 30 January 2018 with a view to start the transition to these standards by mid-year.[62] These standards:

> …focus on quality outcomes for consumers rather than provider processes. This will make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. It will also make regulation simpler for providers working across multiple aged care services, and encourage innovation, excellence and continuous improvement.[63]

4.57 The draft standards also include a draft explanatory document detailing the application of the standards, noting that they 'have been structured so that aged care providers will only have to meet those standards that are relevant to the type of care and services they provide and the environment in which services are delivered'.[64]

4.58 The consultation report on the single quality framework noted '[p]rior to implementation, the draft standards will be tested and piloted. This will provide

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59 Department of Social Services, *Aged Care Quality Agency: 2015 Budget*, available at https://www.dss.gov.au/sites/default/files/documents/05_2015/2015_budget_fact_sheet_-_aged_care_quality_agency.docx, (accessed 10 January 2018).

60 Department of Health, *Single quality framework: focus on consumers*, available at https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers, (accessed 10 January 2018).

61 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 3.

62 Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, p. 17.

63 Department of Health, *Single set of aged care quality standards*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards, (accessed 7 February 2018).

64 Department of Health, *Draft Aged Care Quality Standards and Draft Application of Draft Aged Care Quality Standards by service type*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards/draft-aged-care-quality-standards-and-draft-application-of-draft-aged-care-quality-standards-by-service-type (accessed 7 February 2018).

valuable insight into the application and assessment of the standards and guidelines to support their refinement'.[65] The Department of Health also described publishing the draft standards at this point as 'an important step in strengthening the standards and ensuring we're setting contemporary best practice benchmarks for providers to meet'.[66] The pilot phase will be undertaken from late January to April 2018 by the Quality Agency and will involve a number of service providers and consumers from around Australia.[67]

4.59 The Department of Health further noted the development of the single quality framework as part of an overall shift to 'a more market-based system where the consumer drives quality'.[68]

4.60 The Carnell Paterson review also made comments on the need for overhaul of the current regulatory system, writing that the 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'.[69]

*Streamlined provider assessment*

4.61 The 2015–16 Budget also proposed privatising aged care accreditation services:

> The Government will also work with the sector to deliver private market provision of accreditation services as part of a single aged care quality regime across both community and residential care. Currently, the Government's Aged Care Quality Agency is the sole provider of aged care accreditation services.[70]

4.62 However, the March 2017 public consultation process on the single quality framework did not include privatisation of accreditation services in the three options for assessing performance it presented for comment. The consultation report found the majority of stakeholders supported the adoption of a single, risk-based assessment process for all aged care settings, combined with the use of a safety and quality declaration by organisations providing low-risk services.[71]

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65 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 9.

66 Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, p. 17.

67 Department of Health, *Single set of aged care quality standards*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards, (accessed 7 February 2018).

68 Department of Health, *Submission 37*, p. 24.

69 *Carnell Paterson review*, p. 28.

70 Department of Social Services, *Aged Care Quality Agency: 2015 Budget*, available at https://www.dss.gov.au/sites/default/files/documents/05_2015/2015_budget_fact_sheet_-_aged_care_quality_agency.docx, (accessed 10 January 2018).

71 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 10.

4.63 The Carnell Paterson review also made comment on external regulation, and wrote:

> In our view, the rationale for regulation of residential aged care quality is that the market is an inadequate mechanism to ensure the safety and well-being of highly vulnerable residents. Elderly citizens living in care facilities, many of whom suffer from disabilities and dementia associated with ageing, are especially in need of protection.[72]

***Committee view***

4.64 The committee notes the fundamental change to the aged care quality assessment framework and processes being brought about under the draft single quality framework. As this new framework has only just been published in a draft form, but is directly relevant to the terms of reference for this inquiry, it will be difficult for the committee to form a final view and set of recommendations for this inquiry.

4.65 Furthermore, the committee notes the Department of Health comments that the provision of aged care is moving to a more 'market-based system', which is similar to the change to disability services which resulted in the National Disability Insurance Scheme. While this move in disability services has been positive overall, there have also been significant unintended negative consequences for some service users as well as implementation difficulties, which should be studied and used to inform any such market-based reform of aged care services.

## Recent inquiries

4.66 Perhaps the most compelling argument pointing to a regulatory system that is failing to provide adequate oversight of the aged care sector is the number of recent reviews and inquiries into various aspects of aged care service delivery. Many of the recommendations made in these inquiries remain unimplemented.

### *Productivity Commission*

4.67 The Productivity Commission recommended an overhaul of the aged care regulatory system in its 2011 report *Caring for Older Australians*, finding 'the current regulatory framework is unsatisfactory and there is scope to improve its efficiency and effectiveness while ensuring an acceptable approved standard of care'.[73] Relevant to concerns raised in this inquiry, the Productivity Commission recommended the establishment of an Australian Aged Care Commission, with Commissioners for Care Quality and for Complaints and Reviews and to implement a national independent statutory Community Visitors Program and improvements to data collecting and sharing.[74]

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72 *Carnell Paterson review*, p. v.

73 Productivity Commission, *Caring for Older Australians*, 8 August 2011, Volume 2, p. 387.

74 Productivity Commission, *Summary of Proposals Caring for Older Australians Productivity Commission Inquiry Report*, 8 August 2011, pp. 8–10.

### *Australian Law Reform Commission*

4.68 The ALRC June 2017 Elder abuse report looked at, among other things, the issue of abuse and neglect in residential aged care facilities. The Elder abuse report recommended the development of a National Plan to combat elder abuse, and specifically in the aged care context recommended establishing a serious incident response scheme, reforms relating to the regulation of care workers, regulating restrictive practices and developing national guidelines for community visitor schemes.[75] To date these recommendations have not been implemented, or agreed to by the Australian Government.[76]

### *Senate inquiry into Aged Care workforce*

4.69 The Senate inquiry report *Future of Australia's aged care sector workforce*, released on 28 April 2017, made a series of recommendations regarding the regulation of residential aged care workforce, including a national employment screening or worker registration scheme.[77] The Minister for Aged Care, the Hon. Ken Wyatt AM, MP, responded to the report on 21 June 2017, announcing the Australian Government's intention to establish a taskforce to support an industry led workforce strategy.[78] The Minister for Aged Care subsequently announced the establishment of the taskforce on 1 November 2017, to be led by Professor John Pollaers to 'explore short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce'.[79]

## Concluding committee view

> Aged care is the only institution where the person who goes in dies—that is almost guaranteed—so there are no repercussions for society about how they've been treated. If you have a bad education system, a bad prison system or a bad hospital system, there are repercussions for society when those people leave those institutions. That's not the case in aged care.[80]

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75 Australian Law Reform Commission, *Elder Abuse - A National Legal Response*, 14 June 2017, pp. 8-12.

76 Attorney-General's Department, *Corporate Plan 2017-21*, p. 14, https://www.ag.gov.au/About/Documents/Attorney-Generals-Department-Corporate-Plan-2017-21.PDF.

77 Senate Community References Committee, *Future of Australia's aged care sector workforce*, April 2017.

78 The Hon Ken Wyatt AM, MP, Minister for Aged Care, *Media release* 'Report welcomed as Government works to strengthen aged care sector', http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt052.htm, (accessed 29 January 2018).

79 The Hon Ken Wyatt AM, MP, Minister for Aged Care, *Media release* ' New aged care workforce taskforce to focus on safety and quality, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt109.htm?OpenDocument&yr=2017&mth=11, (accessed 29 January 2018).

80 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Monash University, *Committee Hansard*, 21 November 2017, p. 30.

4.70 The evidence presented to this inquiry, which includes the reports of two in-depth inquiries into the services provided at Oakden, shows that Oakden had a toxic culture of wilful negligence, cover-up and avoiding management and regulatory responsibilities, which resulted in a 'care' service which shocked the two external reviews tasked with making an in-depth investigation into Oakden.

4.71 Services at Oakden included appallingly sub-standard clinical and personal care, as well as abusive practices, some of which have been reported as criminal acts. Evidence of this sub-standard care was noticeable to anyone who cared to pay attention, but it seems that no-one in a position to effect change wanted to pay the required attention.

4.72 The committee commends the SA Government for the extensive actions taken to remediate the services at Oakden. However, the committee must also strongly condemn the length of time it took for the relevant SA authorities to take action after receiving serious complaints and clear warnings relating to Oakden. Some of the instances of abuse or neglect occurred well after the date of the Spriggs family complaint, and most likely would not have been possible had appropriate action been taken at the time of the complaint.

4.73 The committee is deeply concerned that the Quality Agency visited Oakden and had no concerns with the service as late as November 2016. This a mere month before the CEO of NALHN formed a serious view about the quality of service at Oakden, a view that was based on complaints made five months earlier. The Committee is not convinced by the Agency's explanation as to how this came about.

4.74 The committee believes that if a situation like that at Oakden can occur for many years under the eyes of the regulators, then there are serious concerns about the quality of oversight for the broader aged care sector, and the quality of care being provided to vulnerable aged Australians.

4.75 The committee cannot be confident that there are not other aged care facilities where abuse and neglect are occurring elsewhere in Australia.

4.76 The committee notes that while the two key inquiries into the standards of care at Oakden have concluded, investigations into individual instances at Oakden are ongoing. These investigations are by the Australian Health Practitioner Regulation Agency into the standards of professional care being given by individual registered health practitioners, by SA Police into assaults on residents under the guise of restrictive practice, and by SA Independent Commission Against Corruption into the appropriate actions of individual local, state and federal management personnel. This last investigation, when concluded, will be crucial in providing an assessment of any oversight failures, and whether those are systemic failures or the actions of individuals acting outside their mandated area of responsibility.

4.77 The committee strongly agrees with the views expressed by the majority of submitters that while Oakden is at the extreme end of sub-standard aged care services, it exemplifies broader concerns with the quality and oversight frameworks for the overall aged care sector.

4.78 Of particular concern to the committee is the body of evidence relating to model of care issues, definitions of personal versus medical care, and clinical governance within aged care facilities. The aged care sector appears divided in how it defines the provision of allied health or medical services, and who takes ultimate responsibility for the quality of service provision or the oversight and regulation of that health service.

4.79 The committee is concerned about the ongoing use of restrictive practice. We are aware that there are residential aged care facilities that have virtually eliminated use of chemical and physical restraints. The reform process needs to address this issue.

4.80 Additionally, aged care is experiencing an explosion of demand for dementia and mental health specialist services. Providers of those services are themselves divided as to whether these are health (or medical) services, and whether there needs to be specialist internal governance and external oversight mechanisms. It is clear the aged care sector needs better links to broader mental health and cognitive impairment service providers, to implement best practice of those specialisations within an aged care context.

4.81 The committee notes the views expressed above by aged care sector expert Professor Ibrahim. The committee firmly states that vulnerable aged Australians deserve the same level of personal and clinical care, the same level of oversight, regulation and protection from abuse that any other Australian deserves, regardless of their time of life.

## Recommendations

4.82 The evidence presented to this inquiry clearly showed that many of the circumstances that led to the substandard level of care given to residents of Oakden were not unique to that facility. Not only are there similar models of care in other facilities, many of the failures in the quality oversight frameworks are universal, in that they could occur again in relation to any aged care facility, in any location, providing any kind of general or specialised aged care service.

4.83 The committee intends to extend this inquiry to further investigate aged care quality frameworks, with amended terms of reference to remove reference to Oakden, to ensure the inquiry can review the same issues without any restriction on location.

4.84 The committee anticipates that the Australian Government response to the recommendations of the Carnell Paterson review, due to be announced in the context of the Budget in May 2018, and the new Single Aged Care Quality Framework, due to be introduced in July 2018, will play major roles in the ongoing examination of the Aged Care Quality Assessment and accreditation framework. Continued inquiry by the committee will be directed by the outcomes of those external bodies of work.

### Recommendation 1

**4.85 The committee recommends the extension of this inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.**

4.86 A primary cause of the failures at Oakden was due to the specialist mental health services being delivered in the context of being classified as an aged care service as opposed to a health service. This incorrect classification directly led to lower levels of service planning, workforce specialisation, oversight and regulation.

4.87 The committee strongly agrees with the views put forward to the Carnell Paterson review by the expert organisation in health safety, the Australian Commission on Safety and Quality in Health Care, which recommended that all services for severe dementia should be accredited under the Australian Health Service Safety and Quality Accreditation Scheme and must meet the National Safety and Quality Health Service Standards.

**Recommendation 2**

**4.88 The committee recommends that in the current aged care oversight reforms being undertaken, all dementia-related and other mental health services being delivered in an aged care context must be correctly classified as health services not aged care services, and must therefore be regulated by the appropriate health quality standards and accreditation processes.**

**Senator Rachel Siewert**

**Chair**