



Submission to

Standing Committee on Health, Aged Care and Sport (House)

*Inquiry into the Quality of Care in Residential Aged Care  
Facilities in Australia*

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*CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 100 branches and affiliated organisations with a combined membership of over 25,000 people living throughout NSW. CPSA's aim is to improve the standard of living and well-being of its members and constituents.*

CPSA is pleased to submit the following comments to assist the Standing Committee on Health, Aged Care and Sport (House) in its Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia. CPSA's comments are grouped under headings that coincide with the Inquiry's terms of reference.

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

## *Mistreatment*

It is unclear what precisely is meant by "mistreatment" in the terms of reference for this inquiry. However, in this submission it is interpreted as any abuse or negligence by nursing home staff or residents resulting, or likely to result in mental or physical injury.

In the table below are listed the number of assaults nursing homes were obligated to report to the Department and to police from 1 July 2008 to 30 June 2017. These data are sourced from the annual *Report in the Operation of the Aged Care Act 1997* for the years listed in the table. These are departmental data published under the signature of the Ministers responsible for aged care in the period covering those years.

This table shows that, since reporting began, the reported rate of reportable assaults has more than doubled.

It should be noted that a reportable assault is a significant physical or sexual assault within a nursing home by a person who is compos mentis. It is therefore very likely that, by and large, assaults by residents on other residents go unreported. A high incidence of this type of assault can be assumed.

It should also be noted that where the same perpetrator assaults the same victim multiple times these multiple assaults are reported as a single assault.

It is therefore fair to say that the published data do not accurately represent the true horror of the incidence of physical and sexual assault in residential aged care in Australia.

<b>Year</b>	<b>Nursing home places</b>	<b>Reportable assaults</b>	<b>Assault ratio</b>	<b>Ratio change</b>
2008 – 2009	228,038	1,411	0.62%	
2009 – 2010	237,164	1,488	0.63%	1.40%
2010 – 2011	247,379	1,815	0.73%	16.94%
2011 – 2012	252,848	1,971	0.78%	6.23%
2012 – 2013	254,848	2,256	0.89%	13.58%
2013 – 2014	263,788	2,353	0.89%	0.76%
2014 – 2015	273,503	2,625	0.96%	7.60%
2015 – 2016	234,931	2,862	1.22%	26.93%
2016 – 2017	209,626	2,853	1.36%	11.72%

While significant physical and sexual assaults clearly fall within the definition of “mistreatment”, neglect and omission in the discharge of care functions by nursing homes are likely to be significant causes of mental and physical injury, including death.

#### *Reporting and response mechanisms*

Despite boasts by Australian Governments, both current and previous, that Australia has a world class aged care system with a compliance system to match, no “mistreatment” data apart from the reportable assaults discussed above are published.

The Australian Aged Care Quality Agency published compliance reports following audits of individual nursing homes. These reports contain, however, no meaningful concrete data. They are useless in themselves and useless for the purpose of compiling data on anything that occurs in nursing homes and that might offer insight into residential aged care practice and performance.

Adding the inadequate reporting on residential aged care performance and the near impossibility to obtain any information relating to aged care performance through Freedom of Information, one is left with the impression that aged care regulation in Australia is framed to enable non-disclosure of provider performance.

CPSA recently applied (under FOI legislation) for information on the aggregated incidence of reportable assaults in nursing homes in the Queensland Gold Coast area. CPSA did this after the Department of Health advised a local journalist it did not have data relating to Gold Coast nursing homes and could not compile those data. This turned out to be incorrect. It is illegal to withhold information applied for under FOI if the information exists and is not exempt from release. The Department initially came back to CPSA with the same answer it had given the journalist. CPSA applied for an internal review under FOI legislation, pointing out that the Department did have the information as it was capable of publishing annually data for all nursing homes in Australia. If it could do that, it could compile data for any subset of nursing homes. Implicitly accepting this argument, the Department then refused CPSA’s application on the basis that the information sought constituted ‘protected information’ and that it would be illegal for that information to be released. A review application by CPSA to the Information Commissioner finally forced the Department to release the information sought, which showed that the reportable assault rate for Gold Coast nursing homes was significantly higher than the national rate during 2015/2016.

What this example shows is that the regulator, let alone the industry itself, prefers to operate in secrecy and to a large extent is successful in doing so. It demonstrates a culture of systemic cover-ups. The victims of this culture are the residents of Australia’s nursing homes. The horror for many of ending their days in a nursing home is shown regularly, if anecdotally, in media stories and coroners’ inquiries with depressing regularity. Data that would enable compilation and collation of neglect and omission in residential aged care exists at the level of individual facilities, where they cannot be accessed through FOI. It is quite obvious that the industry, the regulator and governments of the day prefer them to stay there.

***Recommendation 1.1: That the definition of “protected information” as defined in the Aged Care Act 1997 be reviewed to ensure the current definition can no longer be used to facilitate non-disclosure of information the release of which is in the public interest.***

***Recommendation 1.2: That data collected at the level of individual residential aged care facilities be de-identified and published for analysis.***

#### *Whistle-blowers*

Whistle-blowers are offered protection under the Public Interest Disclosure Act 2013. However, to qualify for public disclosure they must make their disclosure in-house first. This latter provision, which is common to whistle-blower legislation in all Australian jurisdictions, ensures that whistle-blowers will usually leak information anonymously rather than go through the regulated process, which is fraught with risk to their career and sanity.

If the Public Interest Disclosure Act 2013 isn't sufficient discouragement to become a whistle-blower, Part 6.2 of the *Aged Care Act 1997* virtually ensures that no one involved in residential aged care will become a whistle-blower. It stipulates that the unauthorised release of protected information can be penalised with a maximum of two years jail.

The Aged Care Act 1997 very tightly defines protected information, which includes all information that relates to the affairs of an aged care provider, actual or prospective.

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

### *Australian Aged Care Quality Agency*

Audits of individual nursing homes by the Australian Aged Care Quality Agency are based on homes' performances measured against forty-four outcomes tied to four aged care standards. Even a cursory study of these outcomes and standards reveals that they lack rigour and are incapable of assessing actual performance objectively.

A 2005 parliamentary inquiry 'Quality and equity in aged care' made a number of recommendations, including that the Accreditation Standards be reviewed to include a clear definition of the expected outcomes associated with each of the standards<sup>1</sup>. Despite some changes to the Accreditation Standards in 2014, they do not currently consider the care outcomes residents experience. Rather, they consider the organisation's processes and systems as a proxy for quality care.

It is concerning that the Australian Government is committed to introducing an even laxer system of accreditation and regulation (the 'single quality framework') as part of a further move towards a marketised aged care system, where the ultimate goal is for no Government regulation beyond consumer protections<sup>2</sup>.

***Recommendation 2.1: That audit reports of residential aged care facilities by the Australian Aged Care Quality Agency be based on indicators of resident well-being rather than on evidence of the use of process.***

### *Aged Care Complaints Commission*

One of the biggest issues with complaints schemes past and present is that all complaints are referred back to the residential facility as part of the resolution process. This is a significant deterrent for residents and residents' representatives to make a complaint, because of a fear that the facility or certain staff within the facility may exact retribution.

There is a strong perception, particularly among CPSA's membership, that recent moves to increase the independence and effectiveness of the Complaints Scheme and aged care accreditation system have amounted to little more than an exercise in rebranding.

The current iteration of the aged care complaints scheme provides for an Aged Care Commissioner appointed by the Minister responsible for aged care. The Commissioner is

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<sup>1</sup>Senate Standing Committee on Community Affairs (2005) 'Quality and Equity in Aged Care: Recommendation 14' *Commonwealth of Australia* available at: [http://www.apph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/aged\\_care04/report/index](http://www.apph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/aged_care04/report/index)

<sup>2</sup> See: pp13 Aged Care Sector Committee (2016) 'Aged Care Road Map' available at: [https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04\\_2016/strategic\\_roadmap\\_for\\_aged\\_care\\_web.pdf](https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2016/strategic_roadmap_for_aged_care_web.pdf)

therefore independent from the Department. However, the people who investigate complaints are authorised complaints officers. Such an officer “is an officer of the Department appointed by the Aged Care Complaints Commissioner”<sup>3</sup>. In other words, complaints investigations are carried out by departmental employees, not by independent investigators appointed by the Aged Care Commissioner

Currently, complaints investigators have an obligation imposed through legislation to make the provider subject to a complaint part of the resolution process. Arguably, the current complaints resolution mechanism, like its predecessors, has been set up to make life not too difficult for the industry. As a consequence, consumers and their representatives having gone through a complaints resolution process often express the view that they have been duded.

***Recommendation 2.2: That the Aged Care Complaints Scheme be administered and operated by officers who have no ties with the regulator or the aged care industry.***

***Recommendation 2.3: That the role of the aged care provider in the complaints resolution process be limited to responding to a proposed resolution negotiated between the Aged Care Commissioner and the resident.***

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<sup>3</sup> Section 94B1, Aged Care Act 1997.

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

The assumption at the basis of this term of reference appears to be that aged care residents with family, friends or other representatives have access to adequate consumer protection arrangements, i.e. it is the access rather than the arrangements which might be a problem. In CPSA's view, both the access and the arrangements are problematic.

While CPSA is very concerned for the wellbeing of residents who have no one to represent their interests as an aged care resident, CPSA believes that the position of aged care residents supported by family, friends or representatives is in many cases also dire. Bad things happen whether or not a resident has family or friends who are able to speak up for them, but obviously residents with no one are in an even worse position.

Consumer protection arrangements in residential aged care are such that any complainant very quickly gets into a situation where they are bounced between the Aged Care Complaints Scheme and the aged care provider whose services are the subject of the complaint. The inadequacies of consumer protection arrangements are discussed in detail in section 2 of this submission.

CPSA supports the implementation of an Official Visitors Scheme. CPSA views an Official Visitors Scheme as a more appropriate and effective way of dealing with elder abuse than extending the responsibilities of CVS volunteers as proposed by the Australian Law Reform Commission<sup>4</sup>.

It is critical that the proposed Official Visitors Scheme operates to provide staff and residents of residential aged care facilities with an opportunity to raise their concerns with an independent and impartial observer, without fear of retribution from the facility. One of the biggest issues with the current complaints scheme, administered by the Aged Care Complaints Commissioner, is that all issues are referred back to the facility as part of the resolution process. This is a significant deterrent for residents experiencing abuse. The Official Visitors Scheme must avoid falling into this same trap by ensuring that the privacy, autonomy and agency of both residents and staff are a priority. It is critical that the response of the Official Visitors Scheme to cases of elder abuse does not result in the 'outing' of any residents.

In order for the Official Visitors Scheme to function as intended, it must be independent, adequately funded and sufficiently staffed. It is CPSA's view that the Scheme should operate autonomously from the existing complaints and accreditation schemes as well as the Department of Health.

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<sup>4</sup> Elder Abuse—A National Legal Response (ALRC Report 131).



An expansion of the National Aged Care Advocacy Program could accommodate the Official Visitors Scheme. This would require a substantial increase in funding, but this expansion would provide assistance, including legal assistance, to all residents and/or their representatives.

***Recommendation 3.1:*** *That an Official Visitors Scheme should be introduced in residential aged care and function independently and separately from the Aged Care Complaints Commission, the Australian Aged Care Quality Agency and the Department of Health.*

***Recommendation 3.2:*** *That the National aged Care Advocacy Program be expanded to include an adequately funded Official Visitors Scheme for residential aged care.*