LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

LASA submission to the Senate Community Affairs Legislation Committee inquiry into the Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Bill 2021

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Submitted via email to community.affairs.sen@aph.gov.au

About LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/seniors housing.

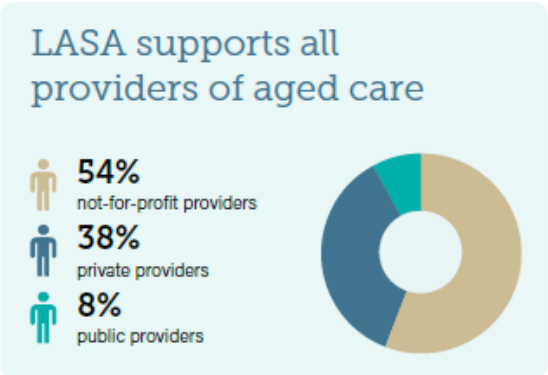
Our Purpose

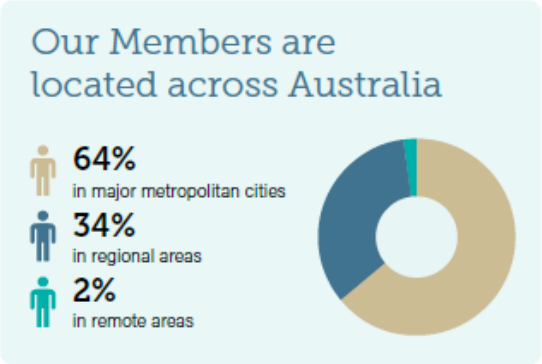
Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing

- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.





Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

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Key points

Restrictive practices

- LASA welcomes in principle the alignment of restrictive practices in residential aged care with requirements under the NDIS if the sector is given appropriate supports. Such supports should include a phasing in period with an implementation timetable, an implementation advisory service, funding for staff training, evidence based clinical guidelines in positive behaviour management etc.
- In some States and Territories this alignment will require State Guardians to appoint substitute decision makers authorised to give informed consent for restrictive practices under State and Territory law. This process will take some time to be undertaken. LASA is concerned that potentially thousands of residents may require a substitute decision maker for restrictive practices.
- LASA proposes that aged care providers and families be given no less than 12 months to undertake the process of having these substitute decision makers appointed. It is crucial to note that failure to provide adequate time to have substitute decision makes appointed appropriately risks reducing the involvement of family members in care.
- Clinical practice change is well known to take much time and effort to implement and enduringly embed in practice. Aged care providers should be given a phasing in period of no less than 12 months in which to implement the shift in definition and requirements from restraint to restrictive practices – notably the deadline that the Royal Commission proposed for implementing changes to regulation of restrictive practices was 1 January 2022.
- Appropriate funding and access to skilled staff for NDIS aligned management of restrictive practices based on cost studies is essential. Funding insufficient to support behaviour management results in risks to quality of care. Providers may choose not to admit people with dementia and difficult behaviours. This would be a tragedy for people with dementia and their families.

Home care accountability audits

- If government is going to review the pricing of home care providers this must be based on clear criteria by people who have an understanding of standard commercial pricing models.
- Any publication of these reports must not publish commercial in confidence information.

Removal of ACFA

- LASA acknowledges that ACFA will be superseded by new institutional arrangements, but it is important for there to be a guarantee that the reports on industry financial circumstances currently prepared by ACFA will continue until those new arrangements are established.

LASA appreciates that the Legislation Committee of the Standing Committee on Community Affairs provides us with the opportunity to raise issues of concern about the Aged Care and Other Legislation Amendment (Royal Commission response No.1) Bill 2021 (the Bill).

Restrictive practices

BILL: Schedule 1 – Amendments relating to restrictive practices

LASA notes that much detail about the operationalisation of restrictive practices will be contained in subordinate legislation. An exposure draft of the proposed amendments to the Quality of Care Principles 2014 was made available on 4 June at 2.40pm. This was too late for LASA to revise our submission prior to the deadline. For this reason LASA is raising issues that become apparent on reading the Bill without being able to reference the subordinate legislation's more detailed requirements.

54-9 Restrictive practice in relation to a care recipient

> 1) *A restrictive practice in relation to a care recipient is any practice or intervention that has the effect of restricting the rights or freedom of movement of the care recipient.*

A residential aged care home is a place of community living where there are private, public and operational spaces. Individual residents' rooms are private spaces where residents enjoy a right to privacy from fellow residents whereas dining rooms are public areas. Residents' private spaces should be respected by other residents[1] but this will curtail residents' freedom of movement.

Operational areas such as laundries, kitchens, staff work stations, offices or staff rooms tend not to be accessible to residents, again restricting their right to freedom of movement. However, these restrictions are appropriate in view of other legislation having to be observed, such as protecting the privacy of resident information, food safety, occupational health and safety etc.

Subordinate legislation and/or guidance for providers needs to spell out that community living within a mix of public, private and operational spaces does place some constraints on residents' rights and freedom of movement.

Explanatory Memorandum: bringing practice into line with the disability sector

The Explanatory Memorandum on page 1 states that restrictive practices in aged care are envisaged to align with the NDIS:

> *The Bill defines the term 'restrictive practices' in the Aged Care Act in alignment with the definition applied under the National Disability Insurance Scheme, bringing practice into line with the disability sector. The new definition strengthens protections for care recipients from abuse associated with the unregulated use of restrictive practices.*

NDIS type supports for behaviour management

LASA supports the proposed alignment of restrictive practices in aged care with those under the NDIS provided the aged care sector receives implementation supports such as a phasing in period

[1] And by staff within their role of care givers or providers of other services

with an implementation timetable, an implementation advisory service, funding for staff training, evidence based clinical guidelines in positive behaviour management etc

Further, aged care providers should be receiving the same level of behaviour assessment and management expertise NDIS participants receive, assisting providers and participants in the management of behaviours. For example, NDIS providers are supported by behaviour support practitioners and the individual NDIS behaviour management plans are funded to enable their implementation.

LASA has learned that at times NDIS behaviour support practitioners do not recommend funding for behaviour management plans on the grounds that the participant is living in an aged care home. In LASA's view funding for behaviour management should be determined by a person's need for this highly specialised and skilled service. The care setting (e.g. aged care home) or the age of the person requiring behaviour management supports should not act as a discriminatory factor resulting in the withholding of funding for a service from which the person with difficult behaviours would benefit.

In LASA's view the NDIS type supports for behaviour management in aged care would significantly lift the sector's ability to provide quality behaviour management for residents living with behaviours.

Detailed planning needs to be undertaken as to the roles and responsibilities of the dementia behaviour advisory services in relation to the alignment with NDIS restrictive practices. These should be clearly articulated if not in the legislation, then in associated guidance.

Alignment with NDIS definitions of restrictive practice

Alignment with the NDIS would involve a more detailed definition of restrictive practices than under the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*.

The *Minimising the Use of Restraints Principles* distinguish only chemical and physical restraint[2]. By contrast, regulated restrictive practices under the NDIS include:

- Seclusion
- Chemical restraint
- Physical restraint
- Mechanical restraint
- Environmental restraint[3]

While there may be advantages in a more fine-grained definition of restrictive practices as used by the NDIS, not all of the definitions may apply in aged care. The transferability of the NDIS definitions to the aged care setting should be determined via a research approach first or at least explored in a pilot study.

LASA further believes that more fine-grained definitions will take aged care providers some time to put through a proper implementation process involving:

- Education of senior staff in the new definitions and associated requirements
- Revision of existing policies and procedures and rewrite to meet requirements under new definitions

[2] https://www.legislation.gov.au/Details/F2019L00511
[3] https://www.legislation.gov.au/Details/F2020C01087

- Review of existing expertise of care staff, particularly registered nurses with view to assessing whether they require upskilling.
- Organise training of registered nurses as required
- Review the care environment to identify potential to make it more conducive to behaviour management without resorting to a restrictive practice
- Training of all care staff in updated policies and procedures
- Embed new practice in care setting and maintain overview that updated policy and procedure is consistently practiced.

The introduction of new definitions requires aged care providers to develop further expertise in identifying and avoiding the use of restrictive practices. Clinical practice changes are well known to take much effort and time to implement and embed.[4] LASA is concerned that the clinical practice change envisaged, of which new definitions for restrictive practices are only one component, is impossible for aged care providers to achieve by 1 July 2021 as scheduled in the Bill.
A phased implementation of no less than 12 months for the new requirements for restrictive practices combined with the right implementation supports would be far more realistically achievable for providers. The need to give providers sufficient time to prepare for the changes, then implement and embed them in practice cannot be overstated.

Bill: 54-10 Matters that Quality of Care Principles must require etc

> *(f) require that informed consent is given to the use of a restrictive practice in relation to a care recipient;*

Alignment with the NDIS will require aged care providers to observe more extensive requirements for obtaining informed consent than is currently usual practice as under the NDIS **authorisation** under State and Territory law is required[5]. This authorisation is part of the informed consent process.

By contrast the Quality of Care Principles 2014[6] *Part 4 A Physical or chemical restraint to be used only as a last resort* in Section *15E State and Territory laws continue to apply* only states:

> *This Part does not affect the operation of any law of a State or Territory in relation to restraint.*

The Aged Care Quality and Safety Commission webpage entitled: *Minimising the use of restraints* [7] only refers to:

[4] Braithwaite, J. 2018 Changing how we think about healthcare improvement. *BMJ* 2018; 361 doi: https://doi.org/10.1136/bmj.k2014 (Published 17 May 2018) https://www.bmj.com/content/361/bmj.k2014
[5] National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 https://www.legislation.gov.au/Details/F2020C01087
[6] https://www.legislation.gov.au/Details/F2021C00292
[7] https://www.agedcarequality.gov.au/providers/assessment-processes/minimising-restraints

State and Territory legislation which regulates the responsibility for prescribers to gain informed consent for chemical restraint;

This lack of an explicit requirement to use restrictive practice in accordance with State and Territory legislation means that most aged care providers may not be operationally prepared for any State and Territory restrictive practice authorisation processes involved in gaining informed consent. This includes:

- Identifying whether a substitute decision maker for a restrictive practice is required in the State or Territory where a residential aged care service is being delivered;[8]
- If a substitute decision maker is required, identifying the type of substitute decision maker who is entitled under State or Territory legislation to make decisions about restrictive practices[9]; and
- undertaking the process of having such a substitute decision maker or guardian appointed by State Public Guardians. This may include the attendance of a resident with dementia at a State or Territory tribunal to identify their decision making capacity in order to determine whether a substitute decision maker for restrictive practices is required.

Obviously, this preparatory effort to operationalise authorisation for restraint under State and Territory laws will take providers some months to undertake. However, we understand that implementation of the Bill is scheduled for 1 July 2021, as shown in the Commencement information included on page 2 of the Bill.

Commencement information		
Column 1	**Column 2**	**Column 3**
Provisions	**Commencement**	**Date/Details**
1. Sections 1 to 3 and anything in this Act not elsewhere covered by this table	The day this Act receives the Royal Assent.	
2. Schedule 1	1 July 2021.	1 July 2021
3. Schedule 2	The day after this Act receives the Royal Assent.	
4. Schedule 3	1 July 2021.	1 July 2021

Below, LASA seeks to estimate of the potential size of the task of having the right substitute decision maker appointed for residents under a restrictive practice in some States and Territories. LASA is not aware of an estimate of the prevalence of restrictive practices of some form in residential care. The National Quality Indicators program identified about 54,000 uses of physical restraint devices in the December Quarter of 2021. There were also 24,000 instances of intent to restrain physically. We are not sure to what extent these relate the same people. Analysis by the Registry of Senior Australians

[8] LASA understands that in Victoria the Senior Practitioner authorises the use of a restrictive practice
[9] LASA understands that Queensland and New South Wales require the appointment of a substitute decision maker authorised to make decisions on restrictive practices.

data suggest prevalence of antipsychotic use alone is around 20 per cent, with 31 per cent given benzodiazepines[10].

These figures indicate the scale of this issue and the importance of the change being proposed. However, they also raise significant practical challenges given the short implementation timeframe. While some of these residents would already have the appropriate guardianship arrangements under their State and Territory law, we could easily have thousands of residents needing guardians appointed. At the very least this issue should be further investigated before such requirements are implemented.

State offices of Public Guardians in those States and Territories requiring the appointment of a substitute decision maker would have to deal with a significant influx of Guardianship applications. The Victorian Senior Practitioner will have to deal with a vastly increased workload.

LASA strongly proposes that the implementation of State and Territory authorisation of restrictive practices be phased in over a period of no less than 12 months to enable aged care providers to (1) discuss the new requirements with residents and their families and (2) undertake the process of having the appropriate substitute decision makers appointed if so required (3) develop policy and procedures to see authorisation from the appropriate State or Territory authority.

Explanatory Memorandum: Overview of the Bill

> *The Bill will also enhance compliance of approved providers by including civil penalties for those providers who fail to comply with compliance notices produced by the Aged Care Quality and Safety Commissioner (Commissioner) in relation to a breach of restrictive practice responsibilities under the Aged Care Act.*

The Explanatory Memorandum on page 3 notes the inclusion of civil penalties for providers who fail to comply with a compliance notice issued by the Aged care Quality and Safety Commission. Key concerns here for LASA are (1) that the restrictive practice requirements for aged care providers must be supported by funding so as to be actually achievable and (2) the size of the civil penalty.

Essential here is that providers' efforts and activities to achieve the increased requirements for safeguarding residential care residents from unlawful and inappropriate restrictive practices undergo a cost study. Information gained from the cost study should inform the funding for restrictive practices and positive behaviour management for residents living with dementia and difficult behaviours.

If improved restrictive practices are insufficiently supported by funding, then the admission of people with dementia poses a serious financial risk for providers. The possibility of a civil penalty being imposed adds to the financial risk. Providers may choose to no longer admit residents with behavioural issues as the care of these residents is not financially viable. This outcome would be a real tragedy for people with dementia and for their families.

[10] https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.50501

Home care accountability audits

BILL: Schedule 2 – Amendments relating to home care assurance reviews

LASA notes that much detail about the operationalisation of assurance reviews will be dependent on reviewer interpretation of home care administration with regard to measures of effectiveness and efficiency. The detail for how the Department will determine effectiveness and efficiency has not yet been specified.

95BA- 1 Home care assurance reviews

*The Secretary may from time to time conduct reviews (*assurance 19 reviews*) for the purposes of:*

(a) assuring that arrangements for the delivery and 21 administration of home care are effective and efficient;

It is unprecedented to our knowledge, that officials would be making administrative decisions about the appropriateness of the pricing of private organisations, without reference to any methodology or criteria.

In his review of academic freedom of speech Former High Court Justice Robert French discusses the challenges of laws that make use of broad subjective terminology.

> Terminology of that kind, when used in statutes or in the common law, fits into what Professor Julius Stone described as 'legal categories of indeterminate reference'. They allow 'a wide range for variable judgment in interpretation and application approaching compulsion only at the limits of the range'.583 Courts, in applying such language generally, operate within parameters established by long-standing practice and precedent coupled with a degree of visibility in relation to their decision-making. Even then their decisions can involve contestable and not always visible normative choices. Administrative application may be informed by more variable and less visible perspectives[11]

We would argue that these same issues apply to the broad terminology of efficiency and effectiveness included within this Bill.

At the very least, the criteria and considerations to be accounted for in determining effectiveness and efficiency need to be specified. They need to account for the influence of funding, policy, workforce and regulatory inputs relative to the home care program outputs being sought after as defined by consumer experiences and outcomes. They also need to give regard to market based costing for the delivery of in-home care services to support the upholding of quality in care provision.

The recent approach taken by the Department of Health to home care pricing issues gives us particular concern about the methodological principles and rigour that will be applied to these reviews.

[11] https://www.dese.gov.au/higher-education-publications/resources/report-independent-review-freedom-speech-australian-higher-education-providers-march-2019

In the wider economy, consent to price change to an ongoing service can be gained by providing reasonable notice of the price change and an opportunity to disagree. This is the arrangement for banking services, electricity, gym members, newspaper subscriptions and many other sectors.

The Department of Health and quality regulator have advised the sector that in the context of home care, they expect providers to gain active and positive consent from consumers to initiate price changes. This, ironically, adds an additional administrative cost that all consumers must pay for.

We do not see any legislative basis for this interpretation, nevertheless the vast majority of home care providers have complied because the cost and risk of disputing this interpretation is greater than the cost of implementing it.

Another example is advice that Department of Health representatives circulated among home care provider networks in April 2020, indicating that it is unreasonable to charge percentage-based processing fees for commissioned services from third parties. This interpretation appears to have been introduced after an extended period without direction and despite percentage-based processing fees for commissioned services from third parties being in place with the commencement of consumer-directed home care in July 2015. In most industries, such as construction, percentage-based charges for commissioned services are standard practice. This is because tracking and charging based on actual time spent creates its own administrative costs. It is also because charging the actual cost of commissioning for low value services would often deter older Australians from accessing these services.

Regulatory drivers of home care costs

Future home care reforms, as proposed in Government's response to the Royal Commission recommendations, highlight a number of reform measures that will impose substantial administrative cost increases for provider service delivery.

For example, the improved home care package payment administration arrangements to commence September 2021 will see providers receive Government payments in arrears for services delivered but with increased administrative costs relative to current arrangements.

While LASA supports the in-principle changes to payment administration, the process for transition of providers to these alternate administrative arrangements will come at considerable cost without financial support being offered in the context of pricing controls.

Providers have only just been provided the detailed required to map their change of administrative operations. They have a short window of four months to implement a substantial administrative change management program, whose concept has been with Government since mid 2019. Administrative provider costs to implement this reform measure will include software upgrades, newly introduced client budget administration arrangements, revised consumer budget statements, staff training and consumer education.

These administrative demands will require an adjustment of market-based pricing relative to the cost-of-service delivery, particularly if no adjustments are made to the current timetable.

LASA notes that there are a number of other pending home care reform measures that will also have further impacts on market-based pricing and costs for the delivery of home care package services that quality assurance reviews will interact with. They include, but are not limited to:

- The introduction of a serious incident response scheme for home care services to commence 2022.
- Demands for increased workforce attraction, recruitment, retention and skill development activities in response to increasing numbers of home care packages being released through to July 2023.
- Demands for higher levels of care to be provided by a more highly skilled workforce than is currently available.

Providers cannot cease services if consumers do not agree to price changes

If consumers do not agree to price changes, providers are prevented by security of tenure arrangements from ceasing to provide services – in effect this makes a home care agreement an indefinite term fixed price contract. Costs not covered as a result of refusal to agree to price changes must then be covered by fees to other consumers.

Intersection of assurance reviews with the functions of the Aged Care Quality and Safety Commission

LASA notes that the subject matter to be a focus of assurance reviews has a number of remits and may be broad in focus.

95BA-2 Scope of assurance reviews

(2) The subject matter of the review may be any or all of the following 7 matters, so far as they relate to home care services undertaken by 8 approved providers and the home care provided through those 9 services:

*(a) how approved providers are using *home care subsidy and charging for home care, including justifications for amounts charged to care recipients;*
(b) how approved providers are structuring their financial 14 accounting for home care services; 15
(c) the nature and type of home care provided by approved 16 providers; 17
(d) the nature and type of approved providers' dealings with care 18 recipients to whom home care is provided; 19
(e) any other matters the Secretary considers relate to the 20 purposes set out in section 95BA-1; 21
(f) approved providers' procedures and documentation in 22 relation to matters mentioned in any of the above paragraphs.

Clarity needs to be provided concerning the intersection of review processes across the Department of Health's quality assurance review program and the Aged Care Quality and Safety Commission's quality review and accreditation programs. This clarity needs to be communicated to both home care providers and consumers with clear and transparency mechanisms established to ensure consistency of review processes without duplication and onerous provider administration across programs.

LASA recommends a schedule of reporting on the intersection of review processes across the Department of Health's quality assurance review program and the Aged Care Quality and Safety Commission's quality review and accreditation programs to facilitate consistency of review processes without duplication and onerous provider administration across programs.

Notice periods for giving information and answering questions

LASA notes that the notice period to be issued to providers for the provision of information (95BA-5(3)) or answer questions (95BA-6(3)) is set as being no less than 14 days after the notice has been issued with the approved provider having to comply with the notice.

Absent in the draft Bill is the provision for providers to have a right for response to an issued notice, in negotiating a reasonable timeframe for the provision of information and answer questions relative to the operational context in which they operate. While quality assurance reviews are an important regulatory control to support the effective and efficient administration of home care services, it should not take priority over the delivery of home care services to care recipients where unreasonable demands will require the reallocation of administrative and management resources away from home care service delivery. The reallocation of limited resources in a period of substantial reform demands will be more apparent in the operations of smaller home care providers.

LASA recommends provision be made in the draft legislation for providers to have a right for response to an issued notice, in negotiating a reasonable timeframe for the provision of information and answer questions relative to the operational context in which they operate.

Publication of assurance review reports

If reports are to be published, there is a serious risk that commercial in confidence information will be released. The legislation should explicitly provide that commercial in confidence information will not be published.

Removal of ACFA

LASA acknowledges that the role of ACFA will be superseded under the new institutional arrangements outlined by the Government's response to the Royal Commission. However, it is important that the sector and broader public be assured that the annual reports on sector financial performance , and enquiries into other important matters will continue to occur.

A Strong voice and a helping hand

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