ADDITIONAL SUBMISSION TO THE COMMUNITY AFFAIRS COMMITTEE REGARDING THE AGED CARE AMENDMENT (SECURITY AND PROTECTION) BILL 2007

Overview

The purpose of this additional submission is to address issues that were raised by stakeholders or issues that were unable to be explored fully by the Committee given time constraints of the hearings on 1 March 2007.

The Submission addresses the following issues.

Compulsory Reporting

a. What is the definition of unreasonable use of force?

A number of submitters to the Committee sought advice regarding how the term 'unreasonable use of force' should be interpreted.

The term 'unreasonable use of force' has intentionally been chosen (including on the advice of the Office of Parliamentary Counsel) because:

- the term is readily understood; and
- the concept of 'reasonableness' is one that has a long history of use in legislation.

The important point in the context of the proposed provisions in the *Aged Care Act 199*7 is that the term is intended to describe (as simply as possible) the circumstances in which an approved provider should report an allegation or suspicion of the use of unreasonable force on a resident.

The guidelines to the industry will make it clear that if an approved provider is in any doubt as to whether unreasonable force has been used, the approved provider should err on the side of reporting to police and the Department. Approved providers are currently making similar assessments when they decide whether or not to report incidents to the Department or the police under existing voluntary reporting arrangements.

While each case will be judged on its merits, an example of reasonable use of force in the context of compulsory reporting of assaults would be where a staff member is genuinely trying to assist a care recipient, but despite their best intentions the care recipient is accidentally injured.

An example of unreasonable use of force would be where a staff member is violent towards a resident.

b. The legislation requires reporting of incidents that occurred prior to the legislation taking effect – does this make the legislation retrospective?

The legislation does not have any retrospective application. Subject to passage of the Bill through Parliament, the new compulsory reporting requirements will come into effect on 1 April 2007.

A provider will not have to report any allegations or suspicions from before 1 April 2007. However, if an allegation is raised after 1 April 2007 (or the approved provider begins to suspect that a reportable assault has occurred and the suspicion occurs after 1 April 2007) then there will be a requirement to report the allegation or suspicion to the police and the Department, regardless of when the reportable assault may have occurred. It is important that the allegation or suspicion be reported regardless of when the reportable

assault occurred because at the time that the allegation or suspicion arises (at a point after 1 April 2007) it may not be known when the reportable assault actually occurred.

c. Exemptions to the compulsory reporting requirements

i. Residents suffering mental impairment

The Committee expressed concern about the method to assess 'mental impairment' and whether the proposed requirement for medical assessment is practical and reasonable.

The existing proposal is consistent with good practice which suggests that a diagnosis of mental impairment would be made by a health professional and that there should be a care plan and an effective behaviour management plan in place to manage the condition/illness within the home.

This proposed approach was discussed with the aged care sector and the Department had understood that this general approach was recognised as an appropriate means to address this difficult issue.

As noted in the Explanatory Guide to the Bill, the proposed exception to reporting (for assaults carried out by residents with a mental impairment) was developed at the request of the aged care sector which advised that assaults by residents with mental impairments are not uncommon, and in such cases, the focus should be on behaviour management of the resident with the mental impairment and protection of residents, and not police involvement, which can be traumatic for all involved.

Recognising these concerns, provision is made in the Bill for the Principles to prescribe circumstances in which compulsory reporting to the police and the Department will not be required.

The Explanatory Guide also detailed the alternative arrangements that are proposed to be included in the Principles.

ii. Unfounded allegations

In drafting the Bill, careful consideration was given to defining the circumstances in which a report must be made.

On balance it was considered that the police are the most appropriate people to decide the validity of an allegation, not the approved provider. Therefore, the proposed legislation requires all allegations to be reported. This will ensure potentially serious allegations are reported.

It is also intended that both the Department and the police will sensibly respond to the compulsory reports. If it is clear that a report is vexatious or ill-founded then this will emerge in any police investigation.

d. What will be the reporting obligations of health professionals?

There are existing mechanisms in place which encourage health professionals to report abuse. The Aged Care Act currently requires approved providers to comply with relevant state and territory laws. For example:

- in some jurisdictions (eg NSW) there is a duty to report the commission of a serious offence (in others there is no such duty as in Queensland and Victoria); and

- there are general community expectations that if a health professional is aware or suspicious that abuse may have occurred then they have an ethical obligation to report. A failure to do this may result in a finding of unsatisfactory professional conduct under relevant State and Territory legislation relating to the conduct of health professionals.

Regardless of any legislative requirements to report, it is important to note that:

- any person (including health professionals) may at anytime make a report to the Department and this will be investigated;

- the Department (including through approved providers) encourages any reporting of abuse or other issues of concern regarding the treatment and safety of residents;

- the Department's communications strategy for the new arrangements will target GPs and hospitals; and

- approved providers can also encourage health professionals to report any abuse to the approved provider (who plays a crucial role in relation to the care and safety of residents) or to the police or Department.

e. How can an approved provider be expected to control contractors who may victimise a discloser after they leave the approved provider's facility?

The Bill takes into account that there are limits to the control an approved provider can exercise over the behaviour of others and places a reasonable level of responsibility on the approved provider.

The approved provider is responsible for taking reasonable measures to require each of its staff members (this includes individuals who are employed, hired, retained or contracted by the provider) to report suspicions of assaults (as soon as reasonably practicable) to one or more of a list of people.

The approved provider is not responsible for the actions of individual staff (and whether they actually report or not) but will be responsible for taking reasonable measures to require them to report – this could include for

example, education and training for staff or regular reminders of the need to report any allegations or suspicions of assault.

Similarly the approved provider is expected to take reasonable measures to prevent a discloser from being victimised. But the legislation recognises that the approved provider cannot ultimately control the actions of individuals be they staff, external contractors or anyone else. This is why the legislation does not say that the approved provider must prevent any victimisation against a discloser (something for which the approved provider could not possibly exercise any control) but rather that the approved provider take reasonable measures to prevent victimisation – this could include, for example, limiting the number of people who are told the identity of the discloser and advising such people about responsibilities not to victimise.

The Department believes that it is important for approved providers to create an environment which supports reporting of incidents, including abuse.

f. How will the tension between compulsory reporting requirements and the responsibility to respect resident's wishes not to have the matter reported be resolved?

An approved provider has responsibility under the Aged Care Act to both respect individual residents' rights while balancing those against the rights of other residents to safety and security.

In the context of residential aged care, approved providers (and the Government) have an obligation not only to protect the victims of abuse (and, as far possible, to respect their wishes) but also to protect others in the residential aged care service and ensure the safety of all.

Recognising the broader need to ensure the safety of others, the legislation adopts a cautious approach by requiring reporting of all allegations to police and the Department regardless of whether a resident agrees that such reporting should occur.

While this may sometimes mean that the wishes of a particular resident may not be met, it also ensures that:

- the safety of all residents is paramount; and
- there can be no pressure on a resident to encourage them not to report because the approved provider will be required to report.

The approved provider, the Department, and the police, will however deal with the issue sensitively and the police can, for example, take into account the wishes of the victim in relation to whether charges are pressed.

g. The definition of reportable assault is not limited to the assault taking place at the residential aged care facility – what if the assault occurs off site?

Subsection 63-1AA(9) provides that a reportable assault is one that is inflicted on a person when the person is receiving residential care in respect of which the provider is approved.

"Residential care" is defined in section 41-3 of the *Aged Care Act 1997* as follows.

> (1) ***Residential care*** is personal care or nursing care, or both personal care and nursing care, that:
>
> (a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:
>
> (i) appropriate staffing to meet the nursing and personal care needs of the person; and
>
> (ii) meals and cleaning services; and
>
> (iii) furnishings, furniture and equipment for the provision of that care and accommodation; and
>
> (b) meets any other requirements specified in the Residential Care Subsidy Principles.
>
> (2) However, residential care does not include any of the following:
>
> (a) care provided to a person in the person's private home;
>
> (b) care provided in a hospital or in a psychiatric facility;
>
> (c) care provided in a facility that primarily provides care to people who are not frail and aged.

The effect of subsection 63-1AA, in conjunction with the definition of residential care, is that approved providers will not be required to compulsorily report assaults which have occurred off the premises. However, approved providers would be encouraged to voluntarily report such assaults if they become aware of them.

Whistleblowing

h. How will the legislation protect staff who have their hours cut as a result of making a disclosure?

The whistleblower protections extend to staff who have their hours cut or otherwise suffer detriment.

The Bill provides that a person must not cause detriment to another person because they have made a protected disclosure.

Responsibility covers not only compliance by the approved provider itself with the provision but extends to the approved provider ensuring as far as reasonably practicable that there is also compliance by others, such as other staff members of the approved provider and other parties with whom the approved provider contracts (for example, an employment agency).

If a staff member has their hours cut or work tasks changed by the approved provider, solely on the basis of making a report, then the approved provider would be in breach of its responsibilities not to cause detriment to a discloser. Compliance action could be taken against the approved provider by the Secretary, under the Aged Care Act.

i. Why does the legislation only protect staff who make a disclosure and not residents, family members, visitors and advocates?

The Bill proposes to give protections (including statutory immunity from suit) to people who are required, by the compulsory reporting requirements, to report reportable assaults.

Family members, residents, visitors and funded advocates are not required by the proposed provisions to report abuse and therefore they do not have statutory protection.

However, such people will be encouraged to report abuse and if they do so, they are able to report to the Department confidentially or anonymously (as they can currently).

If such a person chose to make their disclosure to another person and also chose to disclose their identity and they were sued as a consequence (for example, sued for defamation by the alleged abuser or the approved provider) they would still have all of the common law defences available including the public interest defence.

Investigations

j. How will approved providers be assured of procedural fairness and will this extend to approved providers engaging legal representation?

All relevant parties, including approved providers, will be afforded natural justice and procedural fairness during the course of investigations (and this will be expressly provided for in the Principles).

While the detail of the Investigation Principles is still under development, it is proposed that:

- all relevant parties will be involved throughout the investigation process;
- where a complaint is made about an approved provider, the approved provider will have the opportunity to respond to the issue;
- there will be ample opportunity for all parties to receive feedback;
- approved providers and informants will be given a number of opportunities for their case to be heard including interview by the Department in the course of the investigation, and opportunity to provide relevant evidence
- approved providers and informants will have the opportunity to seek reconsideration by the Department of decisions made by the Department under the Investigation Principles; and
- approved providers and informants will have the opportunity to seek external independent examination by the Aged Care Commissioner of decisions made by the Department under the Investigation Principles.

On the issue of approved providers seeking legal representation, the legislation will not preclude this from occurring and it will be entirely at the discretion of the approved provider regarding whether they wish to seek legal advice on any particular matter or seek legal representation. The Department would, however, hope that the process of investigation will be a co-operative one and that the Department and the approved provider will be able to work productively together to examine issues that arise and ensure any appropriate response. It is important to note that the primary purpose of a Notice of Required Action is to encourage continuous improvement.

k. Will conciliation be able to take place independent of the Department with the result that a successful resolution avoids further investigation?

Yes, where the issues and the parties are amenable to a conciliated outcome. The Department would hope that approved providers take all possible steps to resolve an issue, including before a complaint is made to the Department.

l. Given the distinction between an approved provider and a staff member for the purposes of section 63-1AA, it is not entirely clear when a staff member becomes the approved provider or vice versa.

The approved provider is the corporate, legal entity with responsibilities under the *Aged Care Act 1997*.

It is possible that the management of an approved provider will also be staff members. The important point is that approved providers' internal processes for dealing with compulsory reporting need to take into account the management and reporting structure.

m. Not every complaint will relate to an approved provider's responsibilities under the Act – what strategies will be put in place by the Department to refer such complaints to the approved provider for resolution.

As part of the initial intake and preliminary investigation, the Office will establish whether the issue is one in relation to an approved provider's responsibilities under the Act. If it is not, the Office will advise the complainant and suggest an appropriate body to deal with the complaint – in many cases this may be the approved provider.

n. Will the Department be able to impose financial penalties as part of a Notice of Required Action?

No – Notices of Required Action will require approved providers to address any breaches of their responsibilities under the *Aged Care Act 1997* and to meet their responsibilities under that Act. If an approved provider does not comply with a Notice of Required Action then compliance action may be taken under the Aged Care Act– these are the same actions that can currently be taken by the Secretary for non-compliance with any of the approved provider's responsibilities.

In the event that a breach of the approved provider's responsibilities relates to, for example, failure to repay a resident their full bond or over charging of a resident, then the Notice of Required Action could require the approve provider to repay the resident the appropriate amount – this is not a punitive penalty but rather seeks to restore the resident to the position they should have been in had they not been overcharged.

The role of the Aged Care Commissioner

o. Is there a role for the Aged Care Commissioner in promoting the complaints process to care recipients and the community and reporting publicly on the outcomes?

The Office of Aged Care Quality and Compliance will have responsibility for the investigation of complaints. As part of this responsibility the Office will be undertaking extensive education and communication initiatives to ensure that approved providers, residents and their families are aware of the opportunities to make complaints.

In summary, the primary functions of the Commissioner will be:

- to examine certain decisions made by the Office under the Investigation Principles (on request of, for example the approved provider or a care recipient) and make recommendations to the Office arising from the examination;

- to examine complaints made to the Commissioner about the Office's processes for handling matters under the Investigation Principles, and make recommendations to the Office arising from the examination;

- to examine, on the Commissioner's own initiative, the Office's processes for handling matters under the Investigation Principles, and make recommendations to the Office arising from the examination;

- to examine complaints made to the Commissioner about: the conduct of the Aged Care Standards and Accreditation Agency or the conduct of a person carrying out an audit or support contact and make recommendations to the Agency arising from the examination. The Commissioner may also examine these matters on his or her own initiative.

As part of this role, the Commissioner will have a role in raising awareness about the role of the Commissioner and its place in the quality framework (just as the current Commissioner for Complaints has done in relation to the existing complaints scheme).

Funding

p. What is the full breakdown for the budget allocation for these measures

The Government has committed a total of $100.6 million over four years to measures aimed at providing further protection to recipients of Australian Government subsidised aged care comprising:

- $8.6 m for increased unannounced visits by the Aged Care Standards and Accreditation Agency from 1 July 2007;
- $1.8 m for police checks for Community Visitors Scheme volunteers;
- $90.2 m for the new complaints investigation arrangements, compulsory reporting and protection for those who report.

The $90.2 million is divided over the four years as follows:

	2006-07 ($m)	2007-08 ($m)	2008-09 ($m)	2009-10 ($m)
Departmental	11.066	22.683	23.591	24.792
Administered (offset)	(0.229)	(0.933)	(0.951)	(0.969)
Capital	7.198	2.215	1.805	
Total	18.035	23.965	24.445	23.823

Expected expenditure for 2006-07

Departmental:

- Implementation costs (legislation development, development of staff procedures and industry guidelines, salaries, travel, recruitment and other related expenditure) - $2.475m
- Training - $0.650m
- Communication strategy - $0.550m
- Ongoing salaries and related costs of investigation such as travel, IT etc are $7.162m

Capital:

- office fit out and database development - $7.198m

Expected expenditure for 2007-08 and future years

Departmental:

- salaries - $21.750m includes ongoing salary costs, travel IT and related costs

Capital:

- database - $2.215m

Communication and Education

q. What consultation has there been with police?

As noted by departmental officers appearing before the Committee, members of the Australian Federal Police attended meetings of the ACAC during 2006 when the issue of compulsory reporting was being explored. The departmental officers also noted that consultation was ongoing and that the Department's state and territory offices have been meeting with relevant police forces and offered to provide further details of such consultation.

It should be noted that the Department has in place Memoranda of Understanding (MOUs) in most states and territories which formalise the exchange of information. Under these existing arrangements, the Department refers matters such as alleged abuse to the police.

On 9 January 2007 the Department wrote to all State/Territory Police Deputy Commissioners suggesting meetings between the Department and each of the State and Territory Police Commissioners to discuss the implementation of police checks and compulsory reporting. The Minister for Ageing, Senator the Hon Santo Santoro, has also written to State and Territory Ministers for Police concerning the proposed arrangements.

To date, meetings have been held in Qld, ACT and Victoria. Meetings are scheduled or being arranged in NSW, Tasmania, SA, WA and NT during March 2007.

These meetings are discussing the police check requirements as well as the issue of compulsory reporting.

In Queensland, meetings have been held on 15 December 2006 and 2 and 9 February 2007. At each of these the proposed legislation and the compulsory reporting requirements was discussed. Police representatives highlighted the need for reporting of all assaults and did not express concerns about the compulsory reporting of assault. The police representatives advised that they had appropriate systems in place to identify those assaults that warranted further attention.

In Victoria, there has been ongoing liaison between the Department and police about referral of abuse cases and progress of investigations. Formal meetings about the proposed arrangements were held on 23 January and 19 February 2007. The Victorian Police confirmed that it was appropriate for allegations of assault to be referred to the police for action.

The issues that have and will be discussed are:

- ongoing communication between the two organisations;
- the strategies that could be adopted to ensure the 'smooth' implementation of proposed changes;

- the review of existing MOUs to take into account the new legislation, once passed.

The Department will continue to consult on these issues with the police.

r. Outline of the education/information campaign planned by the Department – both funding allocated and detail of campaign

The Department is developing a Communications Strategy to raise awareness of the proposed measures.

The budget allocation for the Communications Strategy is $550,000

The target audience is aged care providers; aged care residents, their families and carers; community aged care recipients, their families and carers; aged care workers; Aged Care Assessment Teams; peak aged care industry representative groups/organisations. Other stakeholders targeted are the general public; federal Members of Parliament; state and territory governments; GPs/medical profession; State/Territory Elder Abuse organisations; carer groups; police; private and public hospitals and advocates.

Industry and stakeholders will receive advance Fact Sheets about the proposed arrangements prior to 1 April 2007.

Subject to passage of the legislation, a copy of the detailed Guidelines will be sent to Providers as well as brochures, posters etc.

In terms of provision of information to the target audience after 1 April 2007, an Information Kit (to aged care providers, Aged Care Assessment Teams, Peak Aged Care Representative Organisations, Advocacy, Carer and 'Elder Abuse' support organisations, public and private hospitals) is considered the most direct way of getting information about the reforms to this core target group. The kit will include:

- brochures for care recipients and their families;
- brochures for care workers;
- fact sheets; and
- promotional posters for display throughout aged care services.

Officers of the Office of Aged Care Quality and Compliance intend to speak at relevant industry and other forums and editorial pieces will be placed in relevant aged care industry publications, nursing and GP magazines.

In addition to the specific campaign for the new arrangements, there are existing mechanisms in place to inform the aged care industry of their responsibilities as well as consumers about their rights and the care they can expected to receive. Such mechanisms include:

- the Department of Health and Ageing website, including the recently launched Aged Care Australia website (www.agedcareaustralia.gov.au);
- the Aged Care Information Line in the Department which provides information on the range of Australian Government subsidised aged care services;
- Payment Essentials and Care Essentials publications regularly distributed by the Department to aged care providers; and
- Regular newsletters from the Minister for Ageing distributed to all aged care services.