Serious Incident Response Scheme for Commonwealth funded residential aged care

Submission to the Australian Department of Health

October 2019

The Public Advocate

Influencing change to empower lives

Introduction

The position of Public Advocate is established under the *Guardianship and Administration Act 2000* (Qld). The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity in all aspects of community life.

More specifically, the Public Advocate has the following functions:

- promoting and protecting the rights of adults with impaired capacity (the adults) for a matter;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach the greatest practicable degree of autonomy;
- promoting the provision of services and facilities for the adults; and
- monitoring and reviewing the delivery of services and facilities to the adults.[1]

As the Public Advocate, I welcome the opportunity to contribute to the consultation process for the development of the Serious Incident Response Scheme (SIRS) for residential aged care.

It is a fundamental human right to live in an environment that is free from abuse and neglect. However, issues relating to the safety and quality of care for Australians living in residential aged care facilities (RACF) remains a critical concern, particularly for those with impaired decision-making capacity. A SIRS provides an opportunity to develop and implement a strong and consistent framework to report and respond to serious incidents within a residential aged care setting.

Context and Purpose

The Public Advocate acknowledges and supports the inquiries and reports that have led to the consideration of an SIRS for RACFs. These include: the 2017 Australian Law Reform Commission's (ALRC) report, *Elder Abuse – A national legal response*[2], the report of the 2018 Carnell and Paterson Inquiry[3] and the Australian Government's National Plan to Respond to the Abuse of Older Australians, which was released in February 2019.[4] The budgetary allocation made in the 2019-20 Australian Government budget to undertake the preparatory work associated with the SIRS is also acknowledged and welcomed.

It is understood that this consultation is one of the first elements of the preparatory work associated with the development of the SIRS, to be followed at a later date with further consultation regarding the Scheme's detailed design elements.

The Proposed Model

The Public Advocate acknowledges and supports the focus of the proposed model on governance measures that encourage continuous improvement and capacity building across the aged care sector.

The two components of the proposed model address incidents of abuse and neglect by staff as well as incidents of abuse and aggression between aged care residents (referred to as consumers in the consultation paper), and expand reporting requirements to include alleged assaults perpetrated by residents with an assessed cognitive or mental impairment, and incidents that involve the same or substantially the same behaviour that have previously been reported to the police and the department. These changes will provide a more comprehensive picture of the type, number, and nature of serious incidents within the aged care sector, creating the opportunity for

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[1] *Guardianship and Administration Act 2000* (Qld) s 209.

[2] Australian Law Reform Commission, *Elder Abuse-A National Legal Response,* Report No 131 (2017).

[3] Carnell, Kate AO and Paterson, Ron ONZM, *Review of National Aged Care Quality Regulatory Processes*, October 2017.

[4] Attorney General's Department (Cth), *National Plan to Respond to the Abuse of Older Australians*, February 2019. Accessed online 6/9/2019 <https://www.ag.gov.au/ElderAbuseNationalPlan>.

trends and issues to be identified and monitored, and providing an evidence base to support systemic change.

The proposal to extend provider responsibilities to identify, manage and resolve serious incidents is welcomed and supported. The ultimate objective of a scheme of this nature is to reduce the number of serious incidents across the sector and protect consumers and staff from harm. This outcome can only be achieved with a greater focus on how providers manage and respond to serious incidents and assume a greater level of responsibility for reducing their incidence.

It is suggested that measures in the serious incident response framework also include a requirement for providers to initiate the development of positive behaviour support plans for residents who display physically aggressive behaviour towards others. A well-developed individualised positive behaviour support plan can provide staff with greater insight into, and understanding of, a person's challenging behaviours as well promoting strategies for staff to use to encourage appropriate behaviours and improve the quality of life of those consumers. An effective positive behaviour support plan to respond to challenging behaviours of aged care consumers will assist not only to manage and resolve particular incidents but should also prevent incidents from occurring again in the future.

The development of positive behaviour support plans should be a regulatory requirement overseen by the Aged Care Quality and Safety Commission in fulfilling its regulatory and compliance functions. The development of positive behaviour support plans in response to the challenging behaviours of residential aged care consumers should be specifically required to be implemented by providers as part of an effective management system and practices for managing high-impact or high prevalence risks associated with the care of consumers. Positive behaviour support plans should also be required as a key response by providers to 'plan the support and assistance to be provided to a consumer affected by an incident (including those subject to allegations) to ensure the consumer's health, safety and well-being'.[5]

Definition of a 'serious incident'

Generally, the proposed definition of a serious incident included in the consultation paper is supported.

Staff on consumer incidents

In response to the question whether acts by family and/or visitors should be covered by a SIRS, I would support such an approach. The abuse or neglect of any older person in a RACF is a serious issue, irrespective of who is the perpetrator. It is an artificial distinction to suggest that if the perpetrator is a family member or other visitor to the RACF, that the facility does not have any responsibility to respond or intervene to protect the consumer. If abuse or neglect by family or visitors to the RACF is not included in the SIRS, it is likely that RACFs will not have policies and procedures in place to guide staff about how to respond to these incidents, which may leave consumers exposed to repeated abuse. The SIRS should require providers to record and report any incidents of abuse or neglect that occur in their facilities and come to their attention, irrespective of whether the perpetrator is an employee, visitor or another resident. They should also provide guidance to providers about refusing abusive family members or visitors access to the facility and referrals to police for investigation.

In response to the question whether a SIRS should include an unexplained death, such an approach is strongly supported. All unexplained deaths or serious injury in RACFs should be included in the definition of a serious incident and the subject of appropriate reporting to oversight bodies as well as State Coroners. The reporting of this information may provide the Aged Care Quality and Safeguards Commission with an early 'alert' to potential problems at a specific facility that may require further investigation from an accreditation, standard or incident perspective. If these

[5] Department of Health (Cth), *Serious Incident Response Scheme for Commonwealth funded residential aged care – Finer details of operation – Consultation Paper August 2019*, p 9, accessed online 10/9/2019 <https://consultations.health.gov.au/aged-care-reform-compliance-division/sirs/>

incidents are not recorded and reported, there is a risk that events that could point to serious risks to consumers' health and safety will not be identified and examined.

The proposal to include 'alleged, suspected or actual' abuse, neglect or aggression by staff or consumers is supported. The objective of holding members of staff to higher levels of accountability than consumers is also supported.

The suggestion that the definition of staff should include certain volunteers of a RACF is supported, as is the proposed definition of physical abuse by staff, 'Unlawful contact with, or assault of, an aged care consumer, including the unreasonable use of physical force, injury, or physical coercion of an aged care consumer'.

The proposed definitions of 'sexual abuse', 'financial abuse', 'seriously inappropriate, improper, inhumane or cruel treatment' and 'neglect' contained in the Consultation Paper are also supported.

In terms of 'inappropriate physical and chemical restraint', the proposed definition based on the requirements of the Quality of Care Amendment (Minimising the Use of Restraint) Principals 2019 is not supported. I take this position on the basis that the Quality of Care Amendment is wholly inadequate to protect aged care consumers from the misuse of physical and chemical restraint. I have made a submission to the Parliamentary Joint Committee on Human Rights, raising significant concerns about the amendment and requesting the Committee recommend disallowance of the amendment to the Australian Parliament. I have also attached my submission to the Committee in the hope that it will be used to inform the development of better standards, protections and accountability around the use of restraint in residential aged care.

Until these issues are addressed by the Australian Government, it should be recognised that the use of physical and chemical restraint in residential aged care settings, especially without appropriate consents from the consumers or their legally recognised substitute decision-makers can constitute a form of criminal abuse, which should be reported to the police as well as the regulatory authority. With this in mind, it may be appropriate for the Department to consider including, in the SIRS serious incident definitions, detailed information regarding the relevant authorities (excluding the Commission) to which each type of incident should be reported.

Until the Commonwealth Government introduces an appropriate legal framework around decisions to apply restrictive practices and the need to obtain appropriate consents to their use by properly appointed decision-makers, the SIRS will be compromised.

In relation to the question about whether any definitions require specific thresholds, it was proposed that financial abuse would only be considered a serious incident if it involved a certain dollar value or above. If the incident involves theft or fraud, it is irrelevant how much money is involved. The action still involves criminal conduct that should be acted on and reported and the staff member should be held to account and face consequences. While it may not be appropriate to define lower level matters as serious incidents, all RACFs should have policies and procedures in place for dealing with this type of conduct by staff. If there are no consequences for lower-level misconduct, there is no reason for staff to refrain from or cease this conduct. Ultimately, an absence of accountability may lead to systemic low-level theft and fraud.

Consumer on consumer incidents
The proposed definition of consumer on consumer 'sexual abuse' included in the Consultation Paper is supported. In particular, the inclusion of the term 'consent' in the definition is supported as it constitutes the recognition of aged care consumers' rights to sexual freedom and to give and receive affection, as is contained in the new Charter of Aged Care Rights.

In relation to the definition of 'physical abuse causing serious injury' between aged care consumers, the proposed definition is generally supported. However, the requirement that the abuse causes serious injury and how this would operate in practice is unclear. It is submitted that aged care consumers are entitled to feel safe in their place of residence and be free from the risk

of abuse and assault, including from other residents. Further, any assault on an older person has the potential to cause serious injury because of the person's physical frailty and vulnerability.

In the circumstances, it is submitted that the term 'serious injury' be defined to include bruising or an injury requiring medical assessment or treatment.

While it is recognised that consumer on consumer assaults may be a consequence of challenging behaviours of residents who may have impaired capacity and may not be criminally responsible for their conduct, they nonetheless potentially involve a criminal act perpetrated on another consumer. While the perpetrator may not be criminally prosecuted, aged care providers have a responsibility to identify and recognise the behaviour as potential criminal acts and take appropriate action to protect other consumers, as well as initiate appropriate supports for the alleged perpetrator. Aged care consumers have the same rights as the general community to be protected from the criminal conduct of others. If these incidents are not appropriately identified, reported and responded to, consumers and staff are exposed to harm and providers should be held accountable.

The proposal to include 'unexplained death or serious injury' in the definition of a serious incident is strongly supported for the reasons outlined in the Consultation Paper. Consistent with our submission above, it is proposed that the threshold for 'serious injury' should include bruising or an injury requiring medical assessment or treatment. While some will suggest that this threshold is too low, the definition must recognise that it is likely that the unexplained injuries may be caused by the criminal conduct of staff, visitors or other aged care consumers. In any event, consumers of aged care services should not be expected to tolerate assaults in their place of residence.

Class and kind exemptions

The new scheme is proposed to include exemptions for certain classes or kinds of serious incidents from mandatory reporting.

While it is understood that there is a need to balance the need to capture incidents against the Government's regulatory resources and targeting efforts to the highest risks, I am of the view that the proposed definitions of serious incidents provided for in the Consultation Paper use language that allows a distinction between a serious and non-serious or trivial incident to be made. I support the proposed definition of actions or incidents that would not be considered to meet the definition of a serious incident.

As the new scheme of regulation and accountability in residential aged care is in its very early stages, it is submitted that at least initially, it should require the reporting of all incidents, so that regulators can get a sense of the issues and problems within the system and providers become accustomed to reporting. Should thresholds or exemptions for certain types of incidents be set in the early stages of the new scheme, it will potentially dilute the regulatory impact of the scheme and its goal to reduce the number and impact of serious incidents across the aged care sector. Applying thresholds or exemptions to certain types of incidents could also potentially contribute to a pattern of behaviour and abuse that escalates over time, particularly when the initial incidents are not investigated because they fall below the threshold for serious incidents.

Proportionate reporting

The application of class and kind exemptions also relates to the concept of proportionate reporting that is noted in the consultation paper. It is noted that the Consultation Paper proposes that, under the new scheme, the Commission will be able to establish proportionate reporting based on a provider's risk profile and performance. This will mean that some aged care providers, who have demonstrated a satisfactory level of competence in relation to serious incident responses, can carry out investigations into exempted matters without having to report to the Commission in the manner set out under the scheme.

It is recognised that the Commission needs to focus its efforts on serious matters and providers who have not displayed a strong level of competence in responding to serious incidents and that

adopting an approach of proportionate reporting may assist with this focus. However, the proposal raises significant concerns.

The introduction of proportionate reporting effectively means that there will not be regular Commission oversight of serious incidents as they occur at certain facilities. Instead, arrangements will be reviewed potentially on an annual, if not longer, basis. It is felt that the risk associated with this practice for residents of aged care facilities may be unacceptable. It will potentially create aged care facility environments where incidents will not be reported or investigated regularly and consistently by an independent oversight body.

Such an approach to serious incidents appears to be inherently dangerous. It also places full responsibility for investigating and responding to such incidents in the hands of the aged care providers who have reporting exemptions. Further, it appears that these arrangements will result in fewer serious incidents in RACFs being publicly reported, or a systemic under-reporting of serious incidents. This will mean that the government and the public will not have accurate information about the rate of serious incidents nor will it be able to monitor the nature, type and scope of serious incidents occurring across RACFs year on year. Such outcomes are completely inappropriate considering the seriousness of the incidents under consideration and the vulnerability and potential isolation of residential aged care consumers. Surely the evidence presented to the Royal Commission into Aged Care Quality and Safety has demonstrated the risks and consequences of an inadequately regulated aged care system that 'trusts' providers to 'do the right thing' in an under-funded sector.

In the unfortunate event that proportionate reporting is implemented in some form under the SIRS it needs to:

- Ensure that at least the number and type of serious incidents occurring at residential aged care facilities are reported to the Commission, along with the strategies employed to address each type of incident and their consequent impact on incident occurrence.
- Incorporate at least an annual review of proportionate reporting agreements with the aged care provider, which includes an audit of record keeping for serious incidents.
- Exclude incident types, such as assaults and sexual assaults that are also required to be reported to other authorities such as police. If incidents occur within an aged care facility that warrant police involvement, the Commission should also be made aware of these incidents within the time frames applicable under the scheme generally.

Timeframes and information provided for reporting

The timeframes for incident notification (24 hours), the provision of an incident status report (five business days) and a final report (60 business days) are considered appropriate and are supported, due to the serious nature of the incidents that are being reported and their potential impact on the health and well-being of aged care consumers.

In terms of the information to be provided at each stage of the reporting process, the details required again appear to be consistent with the serious nature of the incident and not overly onerous for aged care providers to complete, particularly if the form is available online.

Additional details that would be of benefit include:

- The inclusion of "reasons" associated with responses to particular questions on the form – for example if the family and/or decision maker has not be notified within 24 hours of the serious incident reasons why this has not occurred;
- In the incident status report, there should be provision for the impact and outcome for the consumer/victim to be updated;
- It would also be helpful to providers to specifically require certain information when the incident is between consumers, for instance details of any cognitive impairment identified by an appropriate health professional and the provider's response to that assessment, including the development of a positive behaviour support plan and other actions to minimise risk to other consumers and staff.

- In the final report, there should again be provision for the impact and outcome for the consumer/victim to be updated;
- The final report, should also have a more strategic focus, demonstrating an appreciation of the broader implications of the incident in the context of the aged care facility's operations, resident composition and care needs. It would assist providers to step out a range of actions and responses the provider may have adopted (e.g. new staff training programs, development of behaviour support plans for residents with challenging behaviours) to manage the risks posed by the serious incident and focus on the prevention of incidents of this nature in the future.

Powers of the Commission in relation to reportable incidents

It is noted that the Department of Health's aged care regulatory functions are expected to transfer to the Aged Care Quality and Safeguards Commission in January 2020.

The taking of a risk based approach to regulation by the Commission, including a focus on education and support for providers, is acknowledged and supported. There may be some opportunity, however, for education to include a more strategic and preventative focus for the scheme. This could include the provision of information and resources for residential aged care providers to conduct an internal audit of the scheme as it operates in their facility, to identify key practice and policy improvements that could potentially prevent or reduce the risk of certain types of serious incidents occurring at the facility in the future.

The adequacy or otherwise of the powers provided to the Commission under the serious incident reporting scheme will need to be monitored and evaluated as the scheme progresses through its first 12-24 months of operation. Should this evaluation find that the powers of the Commission in this area do not lead to proactive action by residential aged care providers that reduce the number and nature of serious incidents, change may be necessary. The full range of penalties and sanctions usually available to a regulator should be given to the Commission to respond to serious incidents, including sanctions for poor performance and non-compliance, leading to suspension of accreditation and ultimately de-funding of the provider. The interaction of the powers of the Commission and any further actions that can be taken by the Department should be streamlined to minimise delays in action in responding to serious incidents and risks to consumer safety. Any evaluation should also take into account and assess the actions taken by other responsible authorities, such as police, in response to reported serious incidents.

Public reporting by the Commission on the SIRS

As noted in the Consultation Paper, the Australian Department of Health currently publishes the number of reportable assaults recorded at residential services in the annual Report on the Operation of the Aged Care Act 1997.

The reportable assaults information provided in the 2017-18 report is very brief, including only the total number of assaults required to be reported under the Act (3,773), divided between those recorded as alleged or suspected unreasonable use of force (3,226), those of alleged or suspected unlawful sexual contact (513) or both (34).[6]

This broad level of categorisation and reporting of assaults does not enable government agencies, the general public, or agencies such as the Public Advocate, to determine; what specific types of

[6] Department of Health (Cth), 2017-18 Report on the Operation of the Aged Care Act 1997, accessed online on 11/9/2018 < https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2018/November/2017%E2%80%9318-Report-on-the-Operation-of-the-Aged-Care-A>. November 2018, Canberra, Australia.

assaults are occurring, if the assault is between staff and residents or between residents, whether there are problems in particular areas or regions across Australia, what systemic issues may be present, and if the rate of assaults are increasing or decreasing in real terms year on year.

It is expected that the SIRS will facilitate the public reporting of more detailed information about serious incidents in residential aged care facilities including assaults. More detailed information will encourage greater system transparency and accountability. The community is entitled to this information. Most importantly, older Australians and their family members are entitled to know more about serious incidents that are occurring in residential aged care settings and how the sector is responding to proactively reduce the level of these incidents in the future. We all have the right to live in a safe environment and reporting on the SIRS will assist in monitoring this right.

It is suggested that reporting include (in addition to the number of reports, action taken by the Commission and the provider) the availability of data for analysis by various geographic locations (States, metropolitan, regional and rural) and if the perpetrator or victim has a disability (including cognitive impairment), given that residents with these conditions potentially exhibit the highest degree of vulnerability in this setting.

With the Commission taking an active role in reporting of serious incident figures on an annual basis and being committed to the provision of detailed information that will improve accountability and transparency and allow for the identification of systemic issues, it is not felt necessary for individual providers to publicly report SIRS data. As noted in the consultation report, a requirement of this nature may have negative consequences for residential aged care sector.

Conclusion

Thank you for the opportunity to contribute to the consultation on the SIRS. I look forward to the outcomes associated with this process and to making further contributions regarding the development of the scheme in the future.

Ultimately, the development of schemes of this nature have an important role to play in protecting the fundamental human rights of older Australians living in residential aged care facilities. It is our duty to create safe residential care environments that promote dignity and respect for members of our community as they age.

Yours sincerely

Mary Burgess
Public Advocate (Queensland)

ATTACHMENT – SUBMISSION TO THE PARLIAMENTARY JOINT COMMITTEE ON HUMAN RIGHTS – QUALITY OF CARE AMENDMENT (MINIMISING THE USE OF RESTRAINTS) PRINCIPLES 2019

13 August 2019

The Secretary
Parliamentary Joint Committee on Human Rights
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email: human.rights@aph.gov.au

Dear Secretary,

Re: Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019
I am writing in relation to the Quality of Care principles to minimise the use of restraint in aged care, which were made on 2 April 2019 and commenced on 1 July 2019.

I understand that the Committee has responsibility to examine legislation in accordance with the *Human Rights (Parliamentary Scrutiny) Act 2011* for compatibility with human rights. I respectfully request that, when considering the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, the Committee considers the matters outlined below and recommends the disallowance of this instrument.

I have had the benefit of reading the following correspondence sent to the Committee in relation to this instrument:

- Letter from Human Rights Watch, dated 23 May 2019
- Letter from the Public Advocate, Victoria dated 11 July 2019.
- Submission from the Public Guardian, Queensland dated August 2019.

I support all of the concerns raised in those submissions. I would like to re-emphasise for Committee members some particular concerns raised in those submissions.

Use of a legislative instrument to introduce a restrictive practices regime
As noted in Dr Colleen Pearce, Public Advocate, Victoria's letter, at common law, the use of restraint, whether physical or chemical, constitutes a criminal offence unless it is properly authorised. This position has also been supported by the Australian Law Reform Commission (ALRC) in its June 2016 *Elder Abuse Issues Paper,* in which it recognised that some restrictive practices can constitute elder abuse, deprive people of their basic legal and human rights and be classified as assault, false imprisonment and other civil or criminal acts.[7]

Dr Pearce also makes the relevant point:

> Given the legal and human rights affected by the use of restraint and seclusion, it is surprising, that their regulation in aged care is by a ministerial instrument and not by an Act of Parliament after consideration and debate. (p 1 of letter from Public Advocate, Victoria.)

[7] Australian Law Reform Commission, *Elder Abuse Issues Paper* (IP 47) (June 2016) 238.

In my respectful submission, the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 do not formally authorise the use of physical or chemical restraint. Section 15E of the amendments specifically states:

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

It then goes on to state that an approved aged care provider must not use physical or chemical restraint in relation to a consumer unless they have done certain other things listed under sections 15F and 15G of the instrument. However, it falls short of expressly formally authorising the use of physical or chemical restraint in aged care.

The primary object of the *Aged Care Act 1997* is to "provide for funding of aged care" (section 2-1(1)(a)). It lists a range of issues that the legislation is concerned with, including promoting high quality of care and accommodation; protecting health and well-being; facilitating access to aged care services; providing respite care; planning for the delivery of aged care; and promoting ageing in place. There is no mention in the objects of the *Aged Care Act* that it is to also provide for the use of restrictive practices in aged care. Considering the use of restraint is a serious infringement of a person's legal and human rights and must be formally authorised by law and justified in each case, it is reasonable to expect that any legislative amendment intended to formally authorise the use of restrictive practices in residential aged care (actions that would otherwise constitute criminal acts against a person), should be made in the primary legislation and not in a minor amendment to a statutory instrument.

It is also noted that new Aged Care Quality Standards were introduced in the *Quality of Care Amendment (Single Quality Framework) Principles 2018.*[8] The relevant section of the Aged Care Quality Standards is Standard 8 — Organisational Governance which provides for:

Consumer outcome

(1) I am confident the organisation is well run. I can partner in improving the delivery of care and services

Organisation statement

(2) The organisation's governing body is accountable for the delivery of safe and quality care and services

Requirements

(3) The organisation demonstrates the following:

- consumers are engaged in the development, delivery and evaluation of care and services are supported in that engagement;
- the organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery;
- effective organisation wide governance systems relating to the following;
    1. information management;
    2. continuous improvement;
    3. financial governance;
    4. workforce governance, including the assignment of clear responsibilities and accountabilities;
    5. regulatory compliance;
    6. feedback and complaints;
- effective risk management systems and practice, including but not limited to the following;
    (i) managing high impact or high prevalence risks associated with the care of consumers;

[8] *Quality of Care Amendment (Single Quality Framework) Principles 2018* (Cth).

(ii) identifying and responding to abuse and neglect of consumers;
(iii) supporting consumers to live the best life they can;

- where clinical care is provided – a clinical governance framework, including but not limited to the following;
  (i) antimicrobial stewardship;
  (ii) **minimising the use of restraint;** [emphasis added]
  (iii) open disclosure.

7.

8. In terms of setting standards and an appropriate and accountable regulatory framework for the use of physical or chemical restraint, Quality Standard 8 is wholly inadequate. The standard makes a minimal reference to the use of restraint by merely requiring the clinical governance framework include minimising its use. Because the standard is so vague in its requirements around minimising the use of restraint, it is likely that it would be relatively easy for an aged care provider to satisfy this requirement with very little detail in any clinical governance framework. Consequently, in its current form the Quality Standard is unlikely to achieve much in terms of reducing or eliminating the use of restraint or any other positive outcomes for aged care residents in terms of responding to challenging behaviours.

Taking the above into account and considering section 15E's acknowledgement that Part 4A does not affect the operation of any law of a State or Territory in relation to restraint, the question must be asked, whether the Commonwealth Government actually has a legislative head of power to authorise restrictive practices in aged care.

The NDIS restrictive practices regime as a model

In their submissions, the Victorian Public Advocate and the Queensland Public Guardian both refer to the restrictive practices regimes for disability operating in their respective jurisdictions,[9] which support the operation of the National Disability Insurance Scheme while relying on decision-making under the respective State guardianship schemes. It is interesting to note, that under the NDIS, the Commonwealth has not legislated to authorise the use of restrictive practices, but has relied on the state and territory disability restrictive practices regimes, with complementary arrangements under state, territory and Commonwealth legislation to achieve this outcome.

I note and support the suggestion by the Queensland Public Guardian that consideration should be given by the Commonwealth to adopting a model equivalent to the Queensland disability restrictive practices statutory regime. In her submission, the Public Guardian stated:

> This regime has proven strength in safeguarding an adult's rights and interests through comprehensive regulation of the assessment, approval, monitoring and review of the use of restrictive practices by disability service providers that includes the establishment of a positive behaviour support plan which is designed to reduce and eliminate the use of restrictive practices. Queensland is considered world-leading in its regulation of restrictive practices in the disability sphere. (at p 11 of Public Guardian, Queensland submission.)

I also respectfully support the Queensland Public Guardian's recommendation to the Committee that it recommend the Commonwealth Government undertake public consultation and work collaboratively with states and territories to develop a human rights-compliant statutory regime to govern the use of restrictive practices in aged care facilities.

Key characteristics of a human rights-compliant restrictive practices regime

I thought it would be of assistance to the Committee to also refer members to the recommendations of the ALRC in its final report for the Elder Abuse Inquiry, *Elder Abuse: A National Legal Response*. In that report, the ALRC recommended that aged care legislation should regulate the use of restrictive practices in residential aged care and outlined some key characteristics of such a regime:

[9] Under the *Disability Act 2006* (Vic) and the *Guardianship and Administration Act 2000* (Qld) and the *Disability Services Act 2006* (Qld).

Recommendation 4–10 Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:

(a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
(b) to the extent necessary and proportionate to the risk of harm;
(c) with the approval of a person authorised by statute to make this decision;
(d) as prescribed by a person's behaviour support plan; and
(e) when subject to regular review.

Recommendation 4–11 The Commonwealth Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:

(a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
(b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
(c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.[10]

The 2017 independent review of the national aged care quality regulatory processes, conducted by Ms Kate Carnell and Professor Ron Paterson[11] also recognised this gap in the legislation, making a recommendation to government to legislate to regulate the use of restrictive practices as follows:

7. Aged care standards will limit the use of restrictive practices in residential aged care
    i. Any restrictive practice should be the least restrictive and used only:
        a. as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
        b. to the extent necessary and proportionate to the risk of harm;
        c. with the approval of a person authorised by statute to make this decision;
        d. as prescribed by a person's behaviour support plan; and
        e. when subject to regular review.
    ii. Approved providers must record and report the use of restrictive practices in residential aged care to the Aged Care Commission
    iii. Accreditation reviews will review the use of psychotropic agents
    iv. Chief Clinical Advisor must approve the use of antipsychotic medications for aged care residents.[12]

More recently (October 2018), the Standing Committee on Health, Aged Care and Sport released its *Report on the inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*[13] which also recommended the Australian Government amend the *Aged Care Act* 1997 to legislate for the use of restrictive practices in residential aged care facilities.

[10] Australian Law Reform Commission, *Elder Abuse-A National Legal Response,* Report No 131 (2017) 11.
[11] Carnell, Kate AO and Paterson, Ron ONZM, *Review of National Aged Care Quality Regulatory Processes*, October 2017.
[12] *Ibid*, Recommendation 7, p xii.
[13] Standing Committee on Health, *Aged Care and Sport, Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia* (October 2018), Canberra Australia.

How the Quality of Care standards fall short of the ALRC recommended model
While any tightening of the standards of care around the use of physical and chemical restraint in residential aged care is supported, the amendment does not adopt many of the fundamental features of an accountable and transparent restrictive practices regulatory framework as recommended by the ALRC.

Some of the key features missing from the Australian Government's proposed new scheme include:

- the proposed scheme does not provide for the appointment of a formal independent decision-maker who is at arms-length from the provision of care to the person subject to the restrictive practice;
- there is no appeal process;
- there is no requirement that there should be regular reviews of the use of restrictive practices;
- there is no requirement that providers develop a behaviour support plan for the person which would guide the care provided to the person and decision-making and ensure the focus is on reducing and eliminating the use of restrictive practices;
- in the case of the use of chemical restraint, there is no requirement that the restrictive practices be applied for the least time necessary;
- there is no requirement that the restrictive practices used be proportionate to the risk of harm; and
- the proposed regime only requires that the consumer pose 'a risk of harm' which is a much lower threshold than the ALRC's recommendation that restrictive practices only be used to 'prevent serious physical harm'.

It is extremely concerning that the proposed regime provides for a doctor (most often a general practitioner), nurse practitioner or registered nurse to make decisions in relation to the use of restrictive practices, when most of these health practitioners will not have any formal training or recognised specialty in relation to the provision of clinical care in aged care or positive behaviour management.

This concern is further compounded by the fact that the health practitioners making the decisions also have an interest in the outcome of the decision, in terms of the management of the resident, the workloads of staff and the operation of the facility (because they also work there or provide services to the residents through an arrangement with the service provider). Decisions to prescribe medication to 'manage' residents who are displaying challenging behaviours will necessarily be influenced by considerations other than the rights of the residents and the immediate risk of harm to them or others. Those other considerations may include the views of management, the availability/numbers of staff and their skills in dealing with challenging residents, as well as convenience.

When decisions are being made to use chemical or other restraints on aged care residents by people who are not sufficiently independent of the provision of services, or trained in this type of decision-making, there is a risk that the decisions to use the restrictive practices may give too much weight to certain considerations or may take other, irrelevant, considerations into account, which will ultimately affect the quality and appropriateness of the decision.

Consent to the use of restrictive practices
Another key legal issue that arises from the proposed new Quality of Care Principles is that they make provision for the provider to obtain 'the informed consent of the consumer or the consumer's representative' to the use of restraint. (This consent is not required by the Principles in relation to the use of chemical restraint, apparently because it is a 'clinical' decision. Concerns relating to this approach are discussed further below.)

Across Australia, it is generally accepted that the law is unclear about whether a person's guardian or formal decision-maker can consent to the use of restrictive practices on a person for whom they are appointed to make decisions:

> … absent specific legislative authorisation either through restrictive practices or coercive powers provisions in the legislation, questions remain about authorising restrictive practices through the

guardianship system. This is despite the apparent widespread reliance on it, including with some apparent endorsement of this position by guardianship bodies.[14]

While guardians and formally appointed decision-makers, such as enduring attorneys for personal matters, are generally recognised as having the authority to consent to medical treatments for the person for whom they can make decisions, the law distinguishes between consent to medical treatment and consent to a restrictive practice. As noted above, this issue has been addressed in the disability space under the NDIS. However, it is particularly concerning that the Australian Government is proposing an approach to correct the current inadequacies of the law around the use of restrictive practices in residential aged care that relies on the consent of guardians and other substitute decision-makers when the law is uncertain about whether guardians can lawfully consent to these practices in each jurisdiction, and without any consultation with guardians/advocates and state and territory governments. Instead of providing legal clarity to protect the rights and interests of aged care consumers and those who would be giving consent to restrictive practices, the Minister's recent changes to provide for chemical and physical restraint only raise further legal questions and leave residents, substitute decision-makers and residential aged care staff in a legal limbo.

The problems associated with representatives' consent to the use of restrictive practices is compounded by the very informal 'representation' arrangements that are provided for under the Aged Care Act 1997. Under section 5 of the Quality of Care Principles 2014, other than under an enduring power of attorney or guardianship appointment, the following representative arrangements can be made:

- the consumer can nominate 'a person to be told about matters affecting the consumer';
- a person can nominate themselves to be 'a person to be told about matters affecting a consumer' and the approved provider 'is satisfied the person has a connection with the consumer' and is concerned for that person's safety, health and well-being;
- the person can be 'a partner, close relation or other relative of the consumer'; or
- it can be as relaxed as 'the person represents the consumer in dealings with the approved provider.'

It is unclear who can make the determination that the person can be regarded as the consumers' representative. However, again it seems wholly inappropriate that a person accepted as a 'representative' in most of the circumstances outlined under section 5 of the Principles, should also be authorising providers to physically restrain a person in aged care or be the person to be notified about the use of chemical restraint. It is difficult to envisage how most ordinary people trying to fulfil such a role could provide 'informed consent' to the use of restraint on the aged care consumer they are trying to support. Most members of the public confronted with such a decision would not know what questions to ask and would have great difficulty challenging the proposed use of the restrictive practice. Quite rightly, they would feel they did not have enough knowledge or authority to question or challenge the aged care provider or its medical or nursing staff.

There is the further concern under the current arrangements, also raised by the Queensland Public Guardian, of a risk that aged care providers will require a person's formal and other decision-makers (under the Aged Care Act) to provide a blanket consent to the use of restrictive practices before accepting a prospective resident into care. This could potentially occur even when there has not yet been an identified need for the use of restrictive practices for the resident. Considering the history of some aged care providers requiring enduring powers of attorney or guardianship appointments before accepting a resident into care, this response by aged care providers is a real possibility. Commonwealth legislation should prohibit such practices as a breach of residents' human rights.

[14] Kim Chandler, Ben White and Lindy Willmott, 'What role for adult guardianship in authorising restrictive practices?' (2017), *Monash University Law Review,* (Vol 43, No 2) p 496.

Consent and the use of chemical restraint

The 'use of chemical restraint' provisions under the Quality of Care Principles also raises significant concerns. The definition of 'chemical restraint' under the provisions is deficient because it does not require that the behaviour that the chemical restraint is administered to influence or control, is causing harm to the person or others,

These problems are further compounded by the approach to consent in relation to chemical restraint. Section 15G(1)(c) of the recent amendment to the Quality of Care Principles proposes that the consumer's representative be informed 'before the restraint is used if it is practicable to do so' [emphasis added]. Such an approach is not consistent with usual medical practice about obtaining consent to treatment. It is unlawful to administer any medical treatment to a person without their consent (or the consent of their substitute decision-maker), except in an emergency.

I draw Committee members' attention to documents that have been filed with the Royal Commission into Aged Care Quality and Safety by the Australian Government and are posted on the Royal Commission website. In particular, I refer the Committee to a document by the Minister's Aged Care Clinical Advisory Committee titled, Reducing the inappropriate use of chemical restraints in residential aged care: Options Paper (Cth.1007.1007.03). In that document the Advisory Committee states:

> The Committee agreed that there was clearly a problem with the overuse of antipsychotic medications and benzodiazepines in RAC [residential aged care], noting that a small proportion (estimated at about 10%) of the current use was clearly justified in the treatment of (often pre-existing) mental illness and some rare, acutely psychotic, manifestations of dementia. Most of the inappropriate prescribing was in the context of behavioural and psychological symptoms of dementia (BPSD) … They expressed the strong view that any prescription of these drugs for BPSD should be limited, closely monitored by a multidisciplinary team and decreased or discontinued whenever possible. (p 1.)

The Advisory Committee Options Paper also noted that 'formal or implied consent is currently not commonly obtained by prescribing practitioners'.15 Again, as noted above, the provision of medical treatment without the informed consent of the patient or the patient's decision-maker is unlawful unless in an emergency.

The approach to consent to the use of chemical restraint in aged care is inconsistent with the usual definition of informed consent used in the health sector and contained in the National Safety and Quality Health Service Standards:

> Informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[16]

Clearly, aged care residents have not been receiving medical care and treatment, including the administration of medication as chemical restraint, in accordance with this definition of medical treatment. Not only is it clear that medical practitioners prescribing these medications to chemically restrain people in residential aged care have not been having these types of conversations with the resident/patient or their decision-makers, it would appear on the advice of the Aged Care Minister's Clinical Advisory Committee and the evidence before the Royal Commission, that medical practitioners are routinely prescribing antipsychotics and benzodiazepines without obtaining any consent, formal or implied.

The concern with the proposed new chemical restraint provisions under section 15G of the Quality of Care Principles, is that they appear to be suggesting to medical practitioners that they can prescribe and administer medications without informed consent and transfer all responsibility for the notification of the residents' representatives, as well as documenting the basis for the treatment

[15] Options Paper, at p 5.
[16] National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care.

and monitoring the effects of the treatment on the residents, to the aged care provider. This approach is dangerous and inappropriate and does not hold medical practitioners properly and professionally accountable for their prescribing practices and the treatment of their elderly patients in residential aged care.

Considering what we now know about the problem of physical and chemical restraint in aged care, it is reasonable to anticipate that the recent amendments to the Aged Care Quality Principles in relation to chemical restraint are unlikely to achieve the stated objective of reducing chemical restraint and may actually result in an increase in inappropriate prescribing practices.

It is difficult to understand the basis on which this treatment of older members of the Australian community can be justified. These restrictive practice provisions amount to clear breaches of the human rights of people in residential aged care, including their rights to dignity and respect and quality health care.

We all have the fundamental right to be free from physical restrictions and to bodily integrity. These rights do not diminish with age or infirmity. The Australian community should rightly be extremely concerned about the poor treatment and practices that we have allowed to proliferate in parts of the aged care sector. These recent amendments are likely to exacerbate these problems.

I respectfully request the Committee recommend disallowance of the Quality of Care Amendment (Minimising the Use of Restraints) Principle 2019.

Yours sincerely

Mary Burgess
Public Advocate (Queensland)