The Public Advocate
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The Australian Department of Health and Aged Care
GPO Box 9848
CANBERRA ACT 2601

Via email: sah.implementation@health.gov.au

Feedback in response to 'A New Program for In-Home Aged Care' Discussion Paper

Thank you for the opportunity to comment on this consultation draft in relation to the development of a new program for In-Home Aged Care, aligned with the recommendations of the Royal Commission into Aged Care Quality and Safety.

As the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability.[1]

People with impaired decision-making ability are a broad and diverse group due to the range of conditions that may affect a person's decision-making ability. These include intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or alcohol and drug misuse. While not all people with these conditions will experience impaired decision-making capacity, many of them will at some point in their lives. For some, impaired decision-making capacity may be episodic or temporary, requiring intensive supports at specific times, while others may require lifelong support with decision-making and communicating their wishes and preferences.

Any type of cognitive decline can make it extremely difficult for older people to receive a package that will allow them to remain at home and 'age in place' when they wish to do so. This leaves them, in the current system, with few options other than residential aged care. It is hoped that the new in-home aged care program recognises this factor and is able to provide the services and supports required to assist in allowing members of this cohort to remain at home for as long as this is their preference.

In relation to the discussion paper, I would like to put forward the following for consideration.

Assessments for in-home care while in hospital

The infographic used to summarise the proposed model for in-home care in the discussion paper indicates that assessments will be undertaken in different locations, including at home and in hospitals. The inclusion of hospitals as an assessment site is welcomed, as it provides for improved flexibility in the process and will allow more people to be assessed for this type of care.

However, there will be a need for assessments undertaken in hospital to be expedited, as a decline in a person's health in these circumstances can be rapid, due to them being in a hospital bed for extended periods of time.

This is particularly relevant for patients who have a degree of cognitive impairment, as they are often unable to access in hospital (for a variety of reasons) allied health services like physiotherapy and other forms of rehabilitation. In these circumstances, a stay in hospital of a week or more, once immediate medical concerns have been addressed, can potentially result in a rapid physical decline that could exclude the person from being assessed as suitable for an in-home aged care package and able to return home.

[1] *Guardianship and Administration Act 2000* (Qld) s209.

The development of an appropriate safeguarding framework for vulnerable people receiving in-home aged care

No discussion regarding future models of in-home aged care can be considered without giving attention to the provision of an appropriate safeguarding framework surrounding service provision.

The Aged Care Quality and Safety Commission operates to 'protect and improve the safety, health, wellbeing and quality of life of people receiving Australian funded aged care'[2] and has a formal process for those in receipt of aged care to make and resolve complaints. It also performs a variety of other functions, including the approval of organisations to deliver aged care services, administering the Serious Incident Response Scheme and working to reduce the use of restrictive practices.[3]

The Commission does not, however, provide a monitor to ensure that particularly vulnerable people (including those with cognitive decline or impairment) or those who have a single service provider (which might involve just one person) coming to their home to provide services, are not being abused, neglected or exploited.

We have seen circumstances in which the single provider arrangement can have tragic outcomes. While in receipt of NDIS services from a single provider, Ms Ann Marie Smith, from South Australia, died in a situation of extreme neglect and abuse, perpetrated by her sole care provider.

Ms Smith's tragic death led to a series of recommendations related to the operation of the NDIS and the NDIS Quality and Safeguards Commission, including that vulnerable NDIS participants are required to have multiple care providers, and that 'face to face' check-ins (ideally by different people at different times) are implemented.[4]

While it is understood that most in-home aged care package participants do not require this level of support, particularly vulnerable people, and especially those experiencing cognitive decline, mobility issues, or difficulty communicating, do. Participants may also be classified as vulnerable if they live alone (without a partner, carer or other family member) or do not have a support network of family and friends living nearby.

Any safeguarding framework developed will need to include a provision for there to be 'eyes on the person' as opposed to other types of contact. It will also be critical to monitor key physical and mental changes that could potentially indicate that the person is subject to abuse, exploitation or neglect.

There are several options that could be explored to implement a safeguarding framework similar to the one described above. This could include the requirement for the care partners proposed in the new model (provided they are independent of service providers) to conduct personal visits to vulnerable participants or the development of a more formal safeguarding team, either on a state or territory or national basis. Again, it would be a principal requirement that members of the safeguarding team conduct face-to-face visits with vulnerable participants on a reasonably regular basis (potentially once a quarter), liaise with service providers and care finders as required and escalate any particular issues through to the Aged Care Quality and Safety Commission for action if required.

Supported decision-making

The proposed model incorporates additional communication and consultation between an older person and assessor to develop support plans (short term and ongoing), where there is agreement regarding the older person's goals and support needs.

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[2] Australian Government, Aged Care Quality and Safety Commission, *About Us* https://www.agedcarequality.gov.au/about-us>, 26 November 2021.
[3] Ibid.
[4] Stacey Pestrine and Daniel Keane, *What has changed since the tragic death of Ann Marie Smith*, ABC News online <https://www.abc.net.au/news/2021-08-01/ann-marie-smith-what-changes-have-been-made/100335540> , 1 August 2021.

For older people with cognitive decline or impairments, this type of communication and consultation may require assessors to develop more specialised skills in the area of supported decision-making. This will assist them to appropriately include the person in the planning phase and afford them the same opportunities to determine their goals and care requirements as those offered to other older persons.

Supported decision-making principles should also be applied in situations where an older person has a substitute decision maker, like an attorney or a guardian (public or private). While a substitute decision-maker may need to be involved in the assessment process this should not be at the exclusion of the older person and plans should not be agreed unless the process has included the older person to the greatest extent possible.

The use of policies and practices that involve supported decision making will contribute to the meeting of obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to which Australia is a signatory. Jurisdictions also now have specific provisions within guardianship and administration legislation that necessitate this type of approach. In Queensland, the *Guardianship and Administration Act 2000* includes a number of general principles that must be applied by guardians and attorneys during decision making processes, which include, in general principle 8, maximizing an adult's participation in decision making.

Other considerations

While potentially not an immediate priority in relation to the development of the new model, consideration will need to be given as to how the new model will integrate with the old, particularly in relation to the transfer of existing packages and the waiting lists that currently exist within the system.

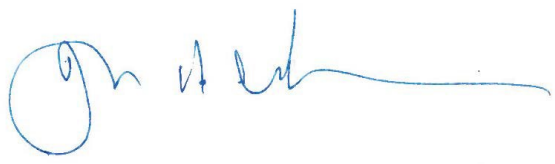
Given that older people are vocal about wanting to remain in their own home and 'age in place' the demand for home care services will only increase in the future. Respecting a person's wishes and preferences to remain at home will mean that the continued availability, in greater numbers, of home care packages will be essential.

With this growth, the demand placed on existing aged care services providing in-home care will also increase, which does raise questions regarding whether initiatives and incentives are required in the short term to increase the number of services and workers available to meet this demand once the new model is introduced.

Other issues include the need to reduce existing waiting lists prior to the new program being introduced, so that it has the capacity to be used by new entrants as opposed to exclusively catering for those people who have been waiting for an extended period for a package to be provided.

Thank you for the opportunity to provide feedback regarding the proposed new program for in-home aged care. If you require clarification of any of the issues raised in this correspondence, please contact my office on 07 3738 9513.

Yours sincerely



John Chesterman (Dr)
Public Advocate