Office of the Public Advocate

Submission to the Commonwealth Department of Health

Single Aged Care Quality Framework: Draft Aged Care Quality Standards and options for assessing performance against Aged Care Quality Standards

April 2017

Introduction

The Public Advocate was established under the *Guardianship and Administration Act 2000* (Qld) to undertake systems advocacy on behalf of adults with impaired decision-making capacity who live in Queensland. 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 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]

Many users of aged care services have, or will develop, impaired decision-making capacity as a result of a range of circumstances and conditions, not the least of which is dementia. In 2011, approximately nine per cent of Australians aged 65 and over had dementia. This proportion increased to 30 per cent among Australians aged 85 years and over.[2] Given that the average age of aged care service users is around the early-to-mid 80s,[3] it is likely that a significant proportion of aged care recipients will have or will experience impaired decision-making capacity at some point during their engagement with the aged care system.

This analysis does not include people with disability who are also recipients of residential aged care, some of whom are under the age of 65 years, and who may have conditions that contribute to impaired capacity such as acquired brain injury or intellectual disability.

Given the functions and interests of the Public Advocate, and the prevalence of conditions that negatively impact on the capacity of users of the aged care system, this submission focuses on the:

- *Single Aged Care Quality Framework: Draft Aged Care Quality Standards consultation paper (2017)* (referred to in this submission as the draft Aged Care Quality Standards paper), and

[1] *Guardianship and Administration Act 2000* (Qld) s 209.
[2] Australian Institute of Health and Welfare 2012, *Dementia in Australia Cat. No. AGE 70*, Canberra, p. 13.
[3] The average age of home care recipients is 82.3 (see Australian Institute of Health and Welfare 2017, *Characteristics of people in aged care*, viewed 27 March 2017, <http://www.aihw.gov.au/aged-care/residential-and-home-care-2013-14/characteristics/>) and the average age of residential aged care recipients is 81.7 for men and 85.9 for women (see Australian Institute of Health and Welfare 2017, *Characteristics of people in aged care*, viewed 27 March 2017, <http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/characteristics/>. Figures are for the period 2014-2015.)

- *Single Aged Care Quality Framework: Options for assessing performance against the Aged Care Quality Standards pap*er (2017) (referred to as the options for assessing performance paper).

The draft Aged Care Quality Standards

I support the Australian government's approach to developing a single set of standards that are sufficiently broad for use within all aged care services. A single set of standards should, in theory, reduce the administrative burden on aged care providers and deliver a more consistent and streamlined approach to quality within the sector.

The numerous references throughout the standards to addressing the abuse, neglect and exploitation of older people in formal care are also supported, as is the inclusion of: 1) the focus on consumer needs, goals and preferences, and 2) articulating expected consumer outcomes, provider requirements, and key features of the draft standards. These features contribute a stronger person-centred approach to the draft standards.

Strengthening the draft standards

Strengthen awareness of vulnerable groups

One of the strengths of the existing aged care quality system (which comprises several sets of standards) is the specific consideration of people from Aboriginal and Torres Strait Islander backgrounds. Under the existing quality system, there are specific standards that must guide quality in the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP). Standard 1.2 (care planning) in particular places a strong emphasis on one of the core service requirements for this group: developing a cultural support plan that outlines how needs will be met in a culturally appropriate way.

Even with the person-centred focus evidenced within the draft standards, the need for culturally appropriate practice in the development and enactment of plans is not sufficiently articulated. Given the ongoing vulnerability of Aboriginal and Torres Strait Islander (ATSI) peoples, it is important that the standards are explicit about the need to maintain high levels of cultural sensitivity when interacting with these individuals and their family and/or community networks.

Additionally, while the draft standards require the identification of individual consumers' needs,[4] they do not make sufficient reference to consumer needs associated with the systemic marginalisation of vulnerable groups. For example, older people with impaired decision-making capacity (which may include people with intellectual disability or acquired brain injury) may be at significant risk of having their autonomy disrespected, and older people from

[4] See draft standard 2 (ongoing assessment and planning with consumers) on page 18 of the draft Aged Care Quality Standards paper.

culturally and linguistically diverse (CALD) backgrounds may have considerable difficulty obtaining the interpreter services that are critical to planning and support.

> There is a need to articulate greater emphasis on establishing internal mechanisms that identify, and enable the service to respond to, older people who bring additional vulnerability to their care as a result of systemic marginalisation, including people from ATSI and CALD backgrounds and older people with cognitive disability.

Enhance the right to autonomous decision-making

The draft standards are not sufficiently supportive of older people's rights to actively participate in the decisions that affect their care.

The draft Aged Care Quality Standards paper indicates that aged care providers may consider family members, carers, representatives or substitute decision-makers to be 'consumers' or 'care recipients' in certain circumstances.[5] I have significant reservations about this suggestion. Family members, carers, representatives and substitute decision-makers may have a genuine interest and concern about the consumer's care, and in some cases it may be necessary and appropriate to consult these individuals in relation to the formal care of the aged care consumer. However, they are not the 'consumers' or 'recipients' of the care services. These supporters, along with aged care providers have obligations under state guardianship legislation to respect the autonomy of the older person and support them to exercise their capacity. To describe them as consumers undermines the rights of older people and may cause confusion. It should also be recognised that while often family members and supporters have the best interests of the older person at heart, they may also have their own agendas in relation to their care.

Aged care providers should not automatically consider that family members are substitute decision-makers in relation to an older person's care unless the older person does not have capacity to make a specific decision and the relevant jurisdiction's legislative requirements in relation to substituted decision-making are met. Further, by merging the concepts of 'consumer' and 'family member/other', the autonomy and agency of the older person is at risk of becoming subsumed in the views of their supporters. It is not appropriate for aged care providers to claim that older people in their care are actively making decisions about their care, when in fact, the decisions are being made by family members.

> The distinction between consumers and their supporters/representatives must be clearly expressed and maintained throughout the standards and all supporting documentation in relation to the proposed aged care quality system. The standards should also refer to the guardianship principles supporting autonomy and support for decision-making to encourage service providers to comply with the spirit of the legislation.

The exclusion of older people from making decisions about their own care is reflected in a similar issue relating to the use of Enduring Power of Attorneys (EPoAs) by aged care services.

[5] See page 12 of the draft Aged Care Quality Standards paper.

My office is aware of an emerging practice in the aged-care sector that involves aged care providers requiring people to have a valid EPoA or a guardianship/administration order before they will have their entry to the facility confirmed. The rationale for this policy is likely to be a financial and legal safeguard for the facility by ensuring that all people seeking placement have a mechanism in place to ensure continuity of decision-making in respect of the person's placement should they cease to have capacity (particularly for financial matters) sometime in the future.[6]

While it is appropriate that all members of our community undertake appropriate planning for the challenges they may face as they aged and lose capacity, it is of significant concern that the concepts of informal and supported decision-making appear to be absent from the way in which some aged care providers operate. In many circumstances, there are family members who are available and willing to assist their ageing family member to make decisions in respect of their aged care placement or make decisions on their behalf, however this no longer appears to be sufficient.

The failure of residential aged care providers and other organisations to accept informal decision-making is a long-standing issue. In 2010, the Queensland Law Reform Commission reported that "the authority of an adult's informal decision-makers is not always recognised by service providers, medical practitioners and others who provide services to the adult".[7]

Further to this, this office has been informed anecdotally, that many aged care providers insist on only dealing with the person holding the enduring power of attorney, even when the aged family member still has legal capacity and the attorney's powers have not been enlivened. These practices breach the human rights of older people, are unlawful, and constitute a form of elder abuse.

The policy of some residential aged care providers to require a person to have a guardianship and/or administration order prior to securing a placement contravenes Queensland's guardianship legislation, the principles that underpin Queensland's guardianship legislation and the United Nations' Convention of the Rights of People with Disability (UNCRPD) .[8] Guardianship and/or administration is a last resort decision-making mechanism that should only be pursued when all other less restrictive alternatives are exhausted. In essence, residential aged care providers, in adopting such policies, are requiring that the older person be stripped of their legal capacity. Providers need to be made aware that the practices outlined above are unlawful, are breaches of the human rights of older people, and constitute a form of elder abuse.

The Australian Law Reform Commission has formally acknowledged our concerns relating to the inappropriate and illegal use of EPoAs in aged care services.[9]

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[6] Office of the Public Advocate (Queensland) 2015, *Position paper: National aged care reforms*, viewed 8 April 2017, <http://www.justice.qld.gov.au/__data/assets/pdf_file/0005/440798/Position-Paper-on-Aged-Care-Reforms-October-2015.pdf>.
[7] Queensland Law Reform Commission 2010, *A review of Queensland's guardianship laws*, report no 67, vol 3(13): 14.38-14.39.
[8] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008).
[9] See Australian Law Reform Commission 2016, *Elder abuse discussion paper,* Discussion Paper 83, viewed 21 April 2017, <https://www.alrc.gov.au/publications/elder-abuse-dp8>.

The standard indicators of standard 1 (consumer dignity, autonomy and choice) or standard 8 (organisational governance) should require aged care providers to respect legal decision-making regimes within relevant jurisdictions.

Include a standard/standard indicator[10] on access

The draft standards do not address another disturbing trend in our treatment of older members of our community: the practice in Australian society of moving older people against their will from their homes and into residential aged care. This enforced relocation to institutional care often occurs at points in older people's lives when they are considered to be failing in health and/or experiencing impaired decision-making capacity.

This is particularly problematic when appropriate and adequate formal or informal care may be provided through other means, such as a home care package. The pressure to enter residential aged care often comes from concerned others, such as family members, who are concerned about their older family members' increasing frailty and the risks associated with living alone, and who may not be aware of less institutionalised care options, aids and technology that may assist them to remain living in the community. Family members and/or health care professionals often provide information that supposedly supports the case for institutionalisation and if the older person challenges this evidence, their disagreement with the plans for their institutionalisation is considered evidence of impaired capacity. This situation clearly violates the spirit of both the *Aged Care Act 1997* (Cth) which reserves residential aged care for the 'frail aged'[11] and the Australian government's historical commitment to supporting older people to live in their preferred community arrangements (ageing in place) for as long as possible.

Decisions about the living arrangements for older people that are made without taking the older persons' views and wishes into account and seeking to implement their desires, breach their human rights.

Article 12 of the UNCRPD (Equal recognition before the law), to which Australia is a signatory, states:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of

[10] This submission uses the term 'standard indicator' to refer to the key features of each standard as outlined in the draft Aged Care Quality Standards paper.
[11] See s 41-3(2)(c).

> conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests. (Emphasis added)

The obligations under the UNCRPD are relevant to the circumstances of older people experiencing conditions that may affect their decision-making capacity, such as dementia and other aged-related conditions that affect cognitive function. The obligations are also reflected in most guardianship legislation in Australian states and territories. In Queensland, the *Guardianship and Administration Act 2000* (Qld) contains numerous provisions supporting the rights of people with impaired capacity to make, and be supported to make, decisions.[12]

The general principles, which are referred to in section 11 of the Act, include strong statements of human rights and respect for dignity and self-determination that are consistent with the UNCRPD. While providing a statement of rights, the general principles also provide some guidance in relation to how to carry out decision-making on behalf of an individual, such as taking into consideration the views and wishes of the adult, as well as highlighting the importance of maintaining the person's autonomy and lifestyle.

Principle 5 of the general principles, emphasises the importance of supporting a person to live life in the general community and to take part in activities. While principle 7, expresses the right of a person to participate as much as practicable in decisions affecting the adult's life and the right to make their own decisions.

Additionally, and irrespective of choice, younger people with physical or cognitive/intellectual disability have historically also been admitted to residential aged care because there is nowhere else for them to live with support once their older parent-carers die; they experience a serious and disabling injury; and/or disability service providers are unable to continue supporting their changing age-related needs. These types of situations often result in the inappropriate placement of people with disability in residential aged care and should be avoided wherever possible. A more appropriate response would be to redirect these individuals into a system such as the National Disability Insurance Scheme (NDIS) that is better equipped to address their disability-related needs.

When the rights of older people and young people with disabilities to make decisions or participate in decisions affecting their lives are disregarded, their human rights are breached. It is our view that people and aged age providers who fail to take account of their views and wishes are breaching the law.

At present, the draft standards do not clarify aged care providers' responsibilities regarding access to their services.[13] Nor do the draft standards require that providers refer people to more appropriate alternative services and systems that are more aligned with consumers'

[12] See ss 5, 6 and 11 of the *Guardianship and Administration Act 2000* (Qld).
[13] Other human service quality systems require organisations to establish policies on access. See, for example, the Queensland Human Services Quality Framework: Queensland Government Department of Communities, Child Safety and Disability Services, *Human Services Quality Framework: Measuring quality, improving services*, version 3.0.

views and wishes. While ACAT does provide a type of 'gatekeeping' in this regard, instigating a standard or standard indicator about access would require aged care providers to clarify who can receive their services and to develop a policy that aligns with the organisations' specialities or limitations as well as ensuring that consumers do not have services imposed on them that are not in accordance with their views and wishes when appropriate alternatives are available. For example, a case in which an aged care provider, with no experience in the provision of care to people with intellectual disability, should refer a 45-year-old person with Down syndrome and dementia to the National Disability Insurance Agency (NDIA) without the risk of a complaint that access was refused on the basis of intellectual disability. A provider of residential aged care services with a robust access policy may also refer an older person to a specialist home care provider where the consumer is expressing this preference and the person's need for residential aged care is not evidenced.

> The draft quality standards should require aged care providers to develop a policy on access. This policy should require providers to articulate any service specialties (such as service delivery to older people with intellectual disability) or limitations as appropriate, and require them – where relevant – to refer older people to providers or systems better able to meet their needs, goals and preferences.

Address the use of restrictive practices

Unregulated restrictive practices such as chemical, physical and mechanical restraint and restricting access to places and things are reported to be in widespread use with older people in both formal and informal care settings[14] yet the draft standards make little or no reference to the quality of care older people can expect in relation to such practices. This may be because currently, there are no legal frameworks regulating the use of restrictive practices in Australian Government-funded aged care services.[15] Conversely, service standard indicator 5.3 states that "Consumers can move freely within the service environment, including both indoor and outdoor areas."[16] This statement implies that one indicator of quality in aged care services is that restrictive practices will not be used. It is clearly misleading given that restrictive practices are routinely used in many residential aged care facilities.

The use of restrictive practices outside of a formal legal framework is a breach of human rights and in many cases may constitute a criminal offence. Those persons and facilities that engage in restrictive practices outside of a formal, legislative regime expose themselves to law suits and criminal prosecutions and are participating in a form of institutionalised elder abuse.

[14] See, for example, Borbasi S et al. A nurse practitioner model of service delivery in caring for people with dementia. Contemporary nurse: A journal for the Australian nursing profession (Supplementary advances in contemporary nursing: Workforce and workplaces) 2010; 36(1-2): 49-60. See also Davison T, Bird M, McCabe M, Mellor D. Non-pharmacological approaches to managing challenging behaviors associated with dementia in aged care. InPsych 2010; 32(5), viewed 20 April 2017, <https://www.psychology.org.au/publications/inpsych/2010/october/davison/>. Moore K, Ozanne E, Ames D, Dow B. How do family carers respond to behavioral and psychological symptoms of dementia? International Psychogeriatrics 2013; 25(5): 743-753.

[15] Office of the Public Advocate 2017, *Submission to the Australian Law Reform Commission: Elder abuse discussion paper (DP83)*, accessed on 7 April 2017, <http://www.justice.qld.gov.au/public-advocate/submissions>, p. 14.

[16] See page 26 of the draft Aged Care Quality Standards paper.

The Aged Care Quality Framework should expressly prohibit the use of restrictive practices by aged care providers, except in accordance with a formal, legal regime similar to that used in Queensland for dealing with challenging behaviours of people with disability under the *Disability Services Act 2006*. The Commonwealth government should act as a matter of urgency to establish an appropriate restrictive practice regime to provide for the appropriate regulation of these practices in the aged care sector. Once this has occurred, the quality framework should reflect these arrangements and establish appropriate standards to support the operation of the restrictive practices regime.

Integrate the consumer outcomes, organisation statements and requirements

While consumer outcomes, organisation statements and requirements are important inclusions in the standards, they are not currently well-articulated in the draft Aged Care Quality Standards. The consumer outcomes and organisation statements should, for example, effectively summarise the key themes/indicators of the standard in ways that reflect best practice. Examples include the following:

- Standard 1 (Consumer outcome: *I am treated with dignity and respect, and can maintain my identity. I can make choices about my care and services and how they support me to live the life I choose.*)

  The second sentence is unclear: This outcome does not include the elements of privacy and confidentiality (which are key themes/standard indicators of this standard). These elements should be specifically included in a consumer outcome.

- Standard 6 (Consumer outcome: *When I give feedback or make complaints, I see appropriate action taken. I feel safe and comfortable making complaints.*)

  Standard indicator 6.1 outlines the key themes of complaints resolution systems and reflects the content of the *Better practice guide to complaint handling in aged care services*. However the key principles (fairness, accessibility, responsiveness, open disclosure, resolution and learning) omit the theme of 'efficiency'[17] which is incorporated into the international standard for complaints handling in organisations[18] and the Guidelines for the Aged Care Complaints Commissioner.[19] This standard indicator seems incomplete and should be reviewed to incorporate efficiency into the consumer outcome.

[17] Efficiency incorporates such elements as resolving complaints in a timely, efficient and professional manner, and implementing comprehensive best-practice complaints management policy and procedure. See Office of the Public Advocate 2015*, Strengthening voice: A scoping paper about complaints management systems for adults with impaired capacity*', <http://www.justice.qld.gov.au/__data/assets/pdf_file/0020/362342/strengthening-voice-scoping.PDF>, p. 12.
[18] The International Standard is intended to establish consistency across complaints management globally. See Standards Australia and Standards New Zealand, *Guidelines for complaint management in organizations* (AS/NZS 10002:2014) for the standard applicable to Australia.
[19] Australian Government Aged Care Complaints Commissioner 2016, *Guidelines for the Aged Care Complaints Commissioner*, version 2.0, viewed 20 April 2017, <https://www.agedcarecomplaints.gov.au/raising-a-complaint/aged-care-complaints-guidelines/>, p. 15.

Additionally, some consumer outcomes appear weak which is reflected in what seem to be low expectations on aged care providers. For example:

- Standard 6 (Consumer outcome: *When I give feedback or make complaints, I see appropriate action taken. I feel safe and comfortable making complaints.*)

  Best practice in complaints management practice requires that organisations attempt to resolve complaints to the complainants' satisfaction.[20] The term "appropriate action" effectively replaces the concept of 'consumer satisfaction' and allows the service provider to offer a solution that meets some internally devised minimum standard but does not necessarily result in satisfactory resolution of the concern or complaint from the consumer standpoint. In which case, this standard misses the mark in terms of excellence in complaints handling practice. We would suggest adoption of an alternative consumer outcome: *When I give feedback or make complaints, I am satisfied with the action taken. I feel safe and comfortable making complaints*.

- Standard 8 (Consumer outcome: *I am confident the organisation is well run and that the consumer voice and experience is sought and heard.*)

  Seeking and hearing the consumer voice is a vital component of organisational continuous improvement. Seeking and hearing are not sufficient, however, to align practice with consumer need – the consumer voice must be sought, heard *and acted upon* if aged care providers are to demonstrate authentically person-centred approaches to the provision of care in line with the Australian Government's commitment to afford aged care consumers "more choice and control".[21]

Overall, there is a need for clear, accessible statements that clearly express consumer expectations and provider requirements so that consumers and their supporters are empowered to engage proactively with aged care providers about the quality of their care and are encouraged to participate in organisational quality improvement processes.

I therefore recommend that the consumer outcomes, provider statements, and statements (or standard indicators) of each standard be reviewed and rewritten so that they: comprehensively reflect key themes of the standards and/or best (or authoritative) practice; afford greater clarity with respect to what consumers can expect from providers of aged care service providers; ensure consistency with the major thrust of the Australian government's aged care reforms (consumer-centred care) and the movement towards greater choice and control for consumers; and ensure that consumer expectations and outcomes are not sacrificed for the sake of provider expediency.

Options for assessing performance against the Aged Care Quality Standards

The current processes for quality accreditation/certification of aged care providers are both confusing and onerous. There is evidently a need for a single set of standards that guide quality among all government-funded aged care providers as well as a single, straightforward

[20] Cook S 2012, *Complaint management excellence: Creating customer loyalty through service recovery*, Kogan Page.
[21] Australian Government Department of Human Services, *Aged Care reforms,* updated 10 March 2017, viewed 7 April 2017, <https://www.humanservices.gov.au/health-professionals/subjects/aged-care-reforms>.

system of quality accreditation/certification that both reduces the administrative burden on providers and is easily understood by consumers and their supporters.

However, some of the proposals outlined in the options for assessing performance paper raise concerns which are outlined below.

A key priority: The aged care quality system as a safeguard for vulnerable older people

Older people are often some of the most vulnerable people in Australian society. Even under the current system of certification and accreditation in aged care, it is widely recognised that older people remain at significant risk of abuse, neglect and exploitation.[22] Consequently, while I support the development of a streamlined approach to quality in aged care, a primary objective for reform of the aged care quality system must be preserving its function as a critical safeguard for vulnerable older people. Processes for achieving and maintaining quality certification/accreditation should therefore be directed towards keeping older people safe and maintaining quality of life, rather than enabling aged care providers to obtain and sustain certification with the minimum administrative effort.

I therefore support an aged care quality accreditation/certification process that, at the very least, aspires to maintaining the highest possible standard of aged care provision in Australia.

> If a standardised approach to quality accreditation/certification applies to all types of government-funded aged care providers, then I strongly encourage adoption of the more stringent system of quality accreditation to demonstrate compliance with the (proposed) quality standards.

Avoiding a risk-based approach to quality management in aged care

I have strong reservations about the adoption of risk-based approaches to determining the quality of aged care. The focus on 'risk' shifts the orientation of quality in aged care away from meeting people's needs, goals and preferences and the objectives articulated in authoritative ageing frameworks such as 'healthy ageing'. A quality system that is based on risk management prioritises the identification and management of decline and harm, and is fundamentally paternalistic in nature, denying individual autonomy and agency in order to protect institutional interests. Managing risk should always be an important consideration in human service provision: it should not be the focus, however, in a service framework that is being promoted to the Australian public as person-centred and as one that enhances choice and control.

> The Australian government should not prioritise risk-based approaches to determining quality management in aged care.

[22] See, for example, the Australian Law Reform Commission's recent work on elder abuse at <https://www.alrc.gov.au/inquiries/elder-abuse>.

Maintaining a minimum level of on-the-ground scrutiny during audits

In line with the above, the proposed hierarchy of quality audits based on determination of risk is also of concern.

It should not be presumed that because an aged care provider has achieved a high standard of quality accreditation/certification in the past that this level of performance will continue into the future. Nor should it be presumed that low levels of complaints indicate high levels of provider performance and consumer satisfaction. On the contrary, low levels of complaint-making can indicate cultures of retribution where staff intimidate consumers who provide negative feedback about their care and/or reflect a management strategy that discourages formal reporting of complaints to keep complaint numbers low and avoid targeted scrutiny by organisational administrators and quality auditors. Further, if aged care providers can reduce their administrative burden because they have fewer complaints (contributing to a 'low-risk' rating and less stringent audits), it encourages non-reporting of complaints and rewards them for hiding evidence of consumer dissatisfaction. It may also promote the growth of aged care cultures that victimise consumers for making complaints. Such an approach is irresponsible at best and dangerous at worst, potentially creating a culture of cover-ups that undermines consumer wellbeing and the transparency necessary to accurately assess quality in aged care services.

It should also not be presumed that aged care delivered in people's homes or services subcontracted to assist older people are fundamentally lower risk than those delivered in residential aged care. There is generally little-to-no direct supervision of worker performance when services are delivered in people's homes. In those circumstances, it must be assumed that some older people may be subject to poor worker performance or, worse, abuse, neglect and exploitation by those involved with their care. Also workers who are familiar with organisational policy and procedure and who are meticulous administrators may easily convince an auditor of superior practice when the opposite may be true. The social exclusion experienced by many older people who live in the community and lack of professional external scrutiny in home-care based services constitute considerable risk to government as the funder of these services and should not be discounted in a paper-based assessment of risk in home-based aged care service provision.

Finally, the introduction of desk audits is also contrary to the intent of the options for assessing performance paper which explicitly states that one of the objectives of the quality system reform is to include the voices of consumers so that "the consumer voice is more strongly heard as part of the quality assessment and monitoring process."[23] Decreased scrutiny of providers and the implementation of desk audits are in direct contrast to this objective. Additionally, a quality management system that does not involve observing actual worker performance or seeking input from consumers is little more than tokenism and fails to recognise the importance of life experiences of people in the human service sector.

[23] See page 12 of the draft Aged Care Quality Standards paper.

I therefore do not support a plan to reduce the requirements on aged care providers to demonstrate that the care and services they offer keep consumers safe and meet their needs, goals and preferences. Successful quality audit histories, sound organisational reputations, and paper-based risk assessments are not sufficient justifications for compromising the key aims of a quality management system: supporting people's wellbeing and keeping them safe.

> Baseline audit requirements should be established for quality certification processes and on-the-ground audits of services of services (that incorporate the voices of consumers and their supporters) should be conducted as a matter of routine in all services providing care to older people.

Concluding comment

I strongly urge the Australian government to maintain the focus on quality systems as a means to improve older people's experiences of aged care services and to safeguard vulnerable consumers. Reducing the administrative burden on aged care providers is an important consideration but should not become the driving force behind quality reform. Essentially in any human service enterprise the primary consideration should be to provide for a quality experience for consumers that respects their rights and interests.

I thank the Australian government for the opportunity to provide feedback about proposed changes to the aged care quality system in Australia. Should the opportunity arise, I would be pleased to be part of further discussions in relation to these reforms or any of the matters raised in this submission.

Yours sincerely

Mary Burgess
Public Advocate (Queensland)