Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Submission to the Royal Commission into Aged Care Quality and Safety

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Abbreviations

ACAS	Aged Care Assessment Service
AGAC	Australian Guardianship and Administration Council
ALRC	Australian Law Reform Commission
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
CAG	Council of Attorneys-General
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CoS	Continuity of Supports
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CVP	Community Visitors Program
DSC	Disability Services Commissioner
Department	Commonwealth Department of Health
EPOA	Enduring Power of Attorney
GP	General Practitioner
Joint Committee	Australian Parliamentary Joint Committee on Human Rights
LCA	Law Council of Australia
MTPD Act	*Medical Treatment Planning and Decisions Act 2016* (Vic)
NDIS	National Disability Insurance Scheme

NDIS Commission	NDIS Quality and Safeguards Commission
NPM	National Preventive Mechanism
OPA	Office of the Public Advocate
OPCAT	Optional Protocol to the Convention Against Torture
RACF	Residential Aged Care Facility
SDA	Specialist Disability Accommodation
SIRS	Serious Incident Reporting Scheme
SPT	United Nations Subcommittee on the Prevention of Torture
UN CRPD	United Nations Convention on the Rights of People with Disability
VCAT	Victorian Civil and Administrative Tribunal
VLRC	Victorian Law Reform Commission

Recommendations

Recommendation 1

The Australian Government should immediately implement a comprehensive regulatory framework for the use of restrictive practices in residential aged care, with all the characteristics and protections recommended by the Australian Law Reform Commission in its report *Elder Abuse – A National Legal Response:*

> ALRC 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.
>
> ALRC Recommendation 4–11 The Australian 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.

Recommendation 2

The Australian Government should disallow the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth). Instead, the Australian Government should amend the Aged Care Act 1997 (Cth) to implement recommendations 4-10 and 4-11 of the Australian Law Reform Commission.

Recommendation 3

The Aged Care Quality and Safety Commission should ensure that residential aged care facilities comply with existing state and territory laws concerning medical treatment decision making and advanced care planning laws, for example, the *Medical Treatment Planning and Decisions Act (2016)* (Vic.).

Recommendation 4

The Australian Government should implement OPCAT requirements in respect of all places of detention, including relevant RACFs, from the outset rather than starting the implementation process with a focus on primary places of detention'.

Recommendation 5

The Australian Government should establish a legislated Community Visitors scheme, similar to the one existing in Victoria, in the aged care sector. In order to be effective, a Community Visitors scheme should incorporate the following aspects in legislation:

- clear mandate to monitor abuse, neglect and social inclusion
- clear mandate to monitor the use of restrictive practices in RACFs
- independence
- access to records
- reporting line to a suitable authority.

Recommendation 6

The Australian Government should amend the *Aged Care Act 1997* (Cth) to enable the Aged Care Quality and Safety Commission to launch own motion investigations when it suspects abuse, neglect or exploitation have occurred in a residential aged care facility, without having to wait for a specific complaint or information to be provided to the Commission.

Recommendation 7

The Australian Government should amend the *Aged Care Act 1997* (Cth) to enable the Aged Care Quality and Safety Commission to initiate investigations into systemic issues in the aged care sector. To give effect to these investigatory powers, it may be necessary for the Commission's authorised officers to have the power of entry into residential aged care facilities without the consent of the occupier.

Recommendation 8

The Australian Government should, in collaboration with States and Territories, amend the incident reporting requirements in the *Aged Care Act 1997* (Cth) as recommended by the Australian Law Reform Commission report in its *Elder Abuse – A National Legal Response* report. The incident reporting scheme should replace the current responsibilities in relation to reportable assaults in s63-1AA of the *Aged Care Act 1997* (Cth).

> ALRC Recommendation 4–1 Aged care legislation should provide for a new serious incident response scheme for aged care. The scheme should require approved providers to notify to an independent oversight body:
>
> (a) an allegation or a suspicion on reasonable grounds of a serious incident; and

(b) the outcome of an investigation into a serious incident, including findings and action taken.

ALRC Recommendation 4–2 The independent oversight body should monitor and oversee the approved provider's investigation of, and response to, serious incidents, and be empowered to conduct investigations of such incidents.

ALRC Recommendation 4–3 In residential care, a 'serious incident' should mean, when committed against a care recipient:

(a) physical, sexual or financial abuse;

(b) seriously inappropriate, improper, inhumane or cruel treatment;

(c) unexplained serious injury;

(d) neglect;

unless committed by another care recipient, in which case it should mean:

(e) sexual abuse;

(f) physical abuse causing serious injury; or

(g) an incident that is part of a pattern of abuse.

ALRC Recommendation 4–4 In home care or flexible care, 'serious incident' should mean physical, sexual or financial abuse committed by a staff member against a care recipient.

ALRC Recommendation 4–5 An act or omission that, in all the circumstances, causes harm that is trivial or negligible should not be considered a 'serious incident'.

ALRC Recommendation 4–6 The serious incident response scheme should:

(a) define 'staff member' consistently with the definition in s 63-1AA(9) of the Aged Care Act 1997 (Cth);

(b) require the approved provider to take reasonable measures to require staff members to report serious incidents;

(c) require the approved provider to ensure staff members are not victimised;

(d) protect informants' identities;

(e) not exempt serious incidents committed by a care recipient with a pre-diagnosed cognitive impairment against another care recipient; and

(f) authorise disclosure of personal information to police.

Recommendation 9

The Australian Government should amend the Aged Care Act 1997 to require RACFs to notify the Aged Care Quality and Safety Commission whenever a recipient is transferred to hospital.

Recommendation 10

The Australian Government should amend the principles of the Aged Care Act 1997 (Cth) so as to prevent aged care facilities from requiring prospective residential aged care residents to have an enduring power of attorney or guardianship order in place as condition of entry into a facility.

Recommendation 11

The Australian Government should formally incorporate the four decision-making principles and accompanying guidelines recommended by the Australian Law Reform Commission in its report *Equality, Capacity and Disability in Commonwealth Laws* into the Quality of Care Principles.

Recommendation 12

The Aged Care Quality and Safety Commission should provide education and training for the aged care sector about:

- decision-making support
- the roles and responsibilities of attorneys, guardians and financial administrators
- the rights of people with impaired decision-making capacity to:
    - respect and dignity;
    - have their views and preferences considered and acted upon; and
    - be supported to exercise their autonomy and agency to the greatest extent possible.

The Aged Care Quality and Safety Commission should also collaborate with the Australian Guardianship and Administrators Council (AGAC) when developing the education and training to ensure that it accurately represents the relevant law in each state or territory.[1]

Recommendation 13

State and territory governments should agree to review their laws concerning financial enduring powers of attorney against the options in the Australian Guardianship and Administration Council paper and continue to work on developing options for greater consistency of national arrangements for financial enduring powers of attorney.

[1] OPA has amended recommendation 12 of the Office of the Public Advocate (QLD) in line with its own preferred position.

Recommendation 14

The Australian government should develop guidelines and improved training for residential aged care staff to ensure that they understand and meet their obligations regarding advance care planning and decision making, which includes including meaningful engagement with residents on these topics.

Recommendation 15

The Australian Government should fund an Aged Care Assessment Service/My Aged Care 'shopfront' to provide an accessible option for all clients, including those with cognitive disability, to communicate and engage with the service in person.

Recommendation 16

The Australian Government should increase funding for level 3 and level 4 aged care funding packages to adequately meet demand. An additional amount of funding is required for rural areas to ensure equity of access to packages is maintained regardless of a person's location.

Recommendation 17

The Australian Government should fund a component of case management in home care packages.

Recommendation 18

The Australian Government should fund the cost of travel time for support workers in rural and regional areas.

Recommendation 19

The Australian Government should increase the financial incentives for general practitioners to visit older people in their homes to prevent premature admission to aged care facilities solely for the purpose of accessing health care services.

Recommendation 20

The Australian Government should increase the financial incentives for general practitioners to visit older people in residential aged care facilities in rural areas.

Recommendation 21

The Australian Government should amend the principles of the *Aged Care Act* 1997 (Cth) to require that residents of aged care facilities are able to have a general practitioner of their own choosing visit them in the facility, if the resident wishes for that to occur.

Recommendation 22

The Australian Government should amend the principles of the Aged Care Act 1997 (Cth) and provide financial incentives to enable allied health professionals to visit residents in aged care facilities.

Recommendation 23

The Australian Government should incorporate the *Principles for Palliative and End-of-Life Care in Residential Aged Care* into the Quality of Care Principles for aged care and require that compliance with these standards be a component of the assessment for accreditation of aged care providers.

Recommendation 24

ACAS should be reviewed to ensure that it uses appropriate tools to screen for mental health issues, and that it responds with an appropriate and streamlined referral pathway.

Recommendation 25

The Medical Benefits Schedule should be amended to provide access to specialist mental health services, allied health services, and in-reach specialists to all residents in residential aged care facilities.

Recommendation 26

The Australian Government, the Victorian Chief Psychiatrist and the Victorian Chief Mental Health Nurse and their equivalents in other states and territories should review the clinical governance, referral pathways (including age requirements), and model of care of aged mental health residential care facilities to ensure that care is consistent across all aged mental health facilities.

Recommendation 27

The Australian Government should amend the curriculum for training in the aged care sector to include compulsory training on the behavioural and psychological symptoms of dementia and mental health management strategies. Training should focus on increasing the skills of staff to better manage symptoms so that a reliance on restrictive practices is reduced.

Recommendation 28

The Aged Care Workforce Strategy should include explicit consideration of the workforce's mental health capability requirements and systems for ongoing learning and practice improvement of the aged care workforce. The Australian Government should investigate the mental health skills and experience competency needs required by the aged care workforce.

Recommendation 29

In order to reduce the number of younger people in residential aged care, the National Disability Insurance Agency, in conjunction with the Australian and Victorian Governments, should adjust market levers (including the pricing framework) to stimulate and ensure that the Specialist Disability Accommodation provision is able to meet existing and future demand.[2]

[2] Office of the Public Advocate (Vic), *The Illusion of Choice and Control* (2018) 45.

Recommendation 30

The Australian Government should, as a matter of urgency, seek to clarify and finally settle with State and Territory governments the funding issues associated with the provision of necessary health supports for NDIS participants with complex health and disability needs who are wanting to transition from residential aged care facilities (and other health and disability facilities) to community-based accommodation.[3]

[3] Office of the Public Advocate (QLD) *Submission 17.*

1. About the Office of the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services that works to safeguard the rights and interests of people with disability.[4] The Public Advocate is appointed by the Governor in Council and is answerable to Parliament.

OPA provides a number of services including the provision of guardianship, advocacy, and investigation services to people with cognitive impairment or mental illness. In 2017-18, OPA was involved in 1,806 guardianship matters (963 which were new), 389 investigations and 320 cases requiring advocacy.[5] More than 50 per cent of OPA's guardianship clients were over 65 years of age. This has been the case for many years.

Under the *Guardianship and Administration Act 1986* (Vic), OPA is also required to arrange, coordinate and promote informed public awareness and understanding about substitute decision making laws and any other legislation dealing with or affecting persons with disability.[6] OPA does this by providing an Advice and Education Service that offers information and advice on a diverse range of topics affecting people with disability. Last financial year, the telephone advice service answered 11,752 calls, one in three of which related to powers of attorney (33 per cent) and almost one in four related to guardianship and administration (24 per cent). OPA also coordinates a Community Education Program where staff address both professional and community audiences across Victoria on a range of topics including the role of OPA, guardianship and administration, enduring powers of attorney, and medical decision making.

OPA's work is supported by more than 600 volunteers across four volunteer programs: the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program (ITP Program) and the Corrections Independent Support Officer Program (CISO).

Community Visitors are empowered by law to visit Victorian accommodation facilities for people with disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients. They ensure that the human rights of residents or patients are being upheld and that residents are not subject to abuse, neglect or exploitation.[7]

There are more than 400 Community Visitors who visit across three streams: disability services, supported residential services, and mental health services. Under the *Mental Health Act 2014* (Vic), Community Visitors visit mental health services, including acute and secure extended care units. Community Visitors conducted 5,261 statutory visits across all three streams in 2017-18, 1,601 of which were to 143 mental health units across Victoria.[8]

[4] *Guardianship and Administration Act 1986* (Vic) pt 3.
[5] Office of the Public Advocate (Vic), *Annual Report* (2017-18) 15.
[6] *Guardianship and Administration Act 1986* (Vic) s15(e).
[7] Office of the Public Advocate (Vic), *Annual Report* (2017-18) 26.
[8] Office of the Public Advocate (Vic), *Community Visitors' Annual Report* (2017-18) 68.

These mental health units included the 32 state-based aged mental health residential care facilities.

2. About this submission

The Public Advocate welcomes the opportunity to make a submission to the Royal Commission into Aged Care Quality and Safety (the Royal Commission). OPA has research and practice expertise in the Victorian context by virtue of its statutory functions that is relevant to the Inquiry's terms of reference. This submission draws on the experiences of our clients to identify relevant systemic issues concerning the quality and safety of aged care in Australia.

2.1. Evidence

OPA has previously provided quantitative information to the Royal Commission in response to a Notice to Give on guardianship clients in aged care facilities and guardianship clients not living in aged care. This information also included the type of cognitive disability of our clients in these groups. The information provided in this submission is qualitative in nature. It draws upon the experience and knowledge of guardians and other staff across OPA, including legal staff and the reports of the Community Visitor Program (CVP).

The case studies provided are from OPA's casework over the past five years. They are de-identified to protect the privacy of the individual concerned. These case studies illustrate the impacts (both positive and negative) of the various issues raised in this submission. This submission also makes use of OPA's previous annual reports, research reports and submissions on topics relevant to this Royal Commission.

2.2. A human rights approach

This submission applies a human rights approach that:

- affirms that all people with disability have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in society
- recognises that the challenges experienced by many people with disability are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- does not deny the reality of impairment or its impact on the individual
- does seek to challenge physical and social environments to accommodate impairment as an expected dimension of human diversity.

In writing this submission, OPA is guided by the following legislative instruments that promote and protect the human rights of people with mental illness and/or disability:

- United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)
- Optional Protocol to the Convention Against Torture (OPCAT)

- Disability Discrimination Act 1992 (Cth)
- National Disability Insurance Scheme Act 2013 (Cth)
- Guardianship and Administration Act 1986 (Vic)
- Charter of Human Rights and Responsibilities Act 2006 (Vic)
- Powers of Attorney Act 2014 (Vic)
- Mental Health Act 2014 (Vic)

3. Context: The role of statutory guardianship in Victoria

Guardianship is the appointment of a person ('a guardian') to make decisions for an adult with a disability (the 'represented person') when they are unable to do so.[9]

Under the *Guardianship and Administration Act 1986* (Vic), the Victorian Civil and Administrative Tribunal (VCAT) has the power to appoint a guardian for a person if it is satisfied that the person:

- has a disability[10]
- is unable 'by reason of the disability to make reasonable judgments' (about matters relating to their personal circumstances)[11] and
- is 'in need of' a guardian.[12]

When deciding whether to appoint a guardian, VCAT must also consider the wishes of any nearest relatives or other family members of the proposed represented person and the desirability of preserving existing family relationships.[13]

The Public Advocate is appointed by VCAT as the guardian when there is no other party either able or willing to act (an appointment of last resort).[14] The Public Advocate is most often appointed as a limited guardian, in that the order of appointment is limited to one or more of the powers and duties that a plenary guardian could be given (being all the powers and duties as if the guardian were a parent of the represented person). In cases where the Public Advocate is appointed guardian for a person over 65 years, the powers most commonly included in the order are those related to accommodation decisions, access to services and health care.

The role of a guardian is to act as a substitute decision maker, acting in the best interests of the represented person, giving effect to their wishes whenever possible in a manner that is

[9] Office of the Public Advocate, *Annual Report 2017-18* (Office of the Public Advocate 2018) 15.
[10] *Guardianship and Administration Act 1986* (Vic) ss 22(1)(a).
[11] Ibid s 22(1)(b).
[12] Ibid ss 22(1)(c).
[13] Ibid ss 22(2)(b)–(c). VCAT is also required to consider the overarching objects in section 4(2) of the Guardianship *and Administration Act* (least restrictive, best interests and the wishes of the proposed represented person are, wherever possible, given effect too).
[14] *Guardianship and Administration Act 1986* (Vic) pt 4.

least restrictive of their freedom and action.[15] A guardian also acts as an advocate for the represented person.

Because guardianship is a restrictive intervention, a statutory guardian is only involved in a represented person's life for as long as there is a decision to be made and only to the extent of the decision-making authority in the order of appointment. Guardianship orders are usually of limited duration. They are reassessed annually (unless VCAT orders otherwise). Once major decisions are made and implemented and guardianship is no longer needed, the order is usually revoked. For example, if the relevant decision is to place someone in a residential aged care facility (RACF), the person has settled well into the facility and there are no other decisions to be made, it is likely that VCAT will revoke the guardianship order. VCAT may also make a self-executing order that expires after a designated period or event, unless an application is made to extend the order (more common for guardianship than administration orders).

A guardian does not have an ongoing case management or ongoing monitoring role, once a decision has been made and successfully implemented.

The role of a guardian does not equate to that of a family member, a friend, a supporter or an independent advocate. A guardian is a decision maker with legislative authority that is often limited to one or two areas of need and is limited in duration.

While guardianship is a last resort protective but restrictive mechanism, it can also be a rights' enabling mechanism in that it promotes the social wellbeing of the person and gives effect to their wishes whenever possible. Furthermore, it is Australia's position that guardianship, when undertaken with appropriate safeguards, is compliant with the United Nations Convention on the Rights of Persons with Disabilities (2006) (UNCRPD). VCAT regularly reviews guardianship orders to determine if they are still required and, if the order is not required it is revoked. The maximum period of review is three years, but the more usual period is twelve months. OPA guardians are also required to consider the Charter of Human Rights and Responsibilities Act 2006 (Vic) in their decision making, and apply the National Standards of Public Guardianship, introduced by the Australian Guardianship and Administration Council (AGAC).

4. Structure of this submission

4.1. Terms of reference

This submission will address the following terms of reference of the Royal Commission:

> (a) The quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response.
>
> (b) how best to deliver aged care services to:
>
> > (i) people with disabilities residing in aged care facilities, including younger people;

[15] *Guardianship and Administration Act 1986* (Vic) s 22(2).

(d) what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe.

(e) how to ensure that aged care services are person centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care related matters.

(l) the interface with other services accessed by people receiving aged care services, including primary health care services, acute care and disability services, and relevant regulatory systems. This should take into account how people transition from other care environments or between aged care settings.

4.1.1. Issues addressed

The following key issues or themes relating to the terms of reference will be highlighted in this submission:

- safeguarding, including
  - regulation and oversight of the use of restrictive practices in aged care facilities
  - implementation of the Optional Protocol to the Convention Against Torture (OPCAT)
  - consideration of expanding and legislating an aged care Community Visitors scheme to empower visitors to inspect and report on residential aged care, with a clear mandate to monitor abuse, neglect, and social inclusion
  - incident reporting requirements
- decision-making, including
  - amendment to the Aged Care Act 1997 (Cth) to reflect the National Decision-Making Principles and Commonwealth Decision-Making Model
  - supported decision making
  - consistency of laws
  - advance care planning in aged care facilities
- quality of care, including
  - medical model of care as the dominant model of care
  - health and mental health care
  - workforce issues
- young people in nursing homes

5. Safeguarding aged care services

This section of the submission is underpinned by OPA's human rights approach to the provision of safe, quality aged care services. It addresses the regulatory oversight of restrictive practices in aged care services and proposes standards and principles that OPA recommends are incorporated as legislative amendments to the *Aged Care Act 1997* (Cth).

5.1. Restrictive Practices

At common law, the use of any type of restraint, would constitute a criminal office if not properly authorised. There are exceptions, recognised at common law, that restraint can be used lawfully in an emergency or out of necessity until proper, lawful, authorisation is obtained. The use of restraint seriously affects a person's human and legal rights and its use must be justified in each instance.

Despite this, OPA is aware that some people in RACFs are subject to a range of restrictive practices that restrict their freedom of movement and deprive them of their liberty, without appropriate authorisation. Restrictions on liberty may be achieved through one or more of the following mechanisms: environmental, mechanical, physical, or chemical restraints (all of which are defined at section 5.1.1. below).

Existing research indicates that these restrictive practices are often detrimental to the health and quality of life of the person concerned and their use has been linked to preventable injuries and premature deaths.[16] In the absence of an emergency, restrictive practices should not be implemented. Instead, alternative less restrictive interventions should be utilised.[17]

5.1.1. Restraint Minimisation Principles

In *Restrictive Practices in Residential Aged Care in Australia* (Background Paper #4), the Royal Commission describes recent changes in the regulation of aged care services providers, including the introduction of subordinate legislation intended to minimise the use of restraints. While OPA appreciates the intention of the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Restraint Minimisation Principles), it considers they do not sufficiently prioritise the safety and wellbeing of residents.

OPA has raised concerns about the Restraint Minimisation Principles with the Australian Parliamentary Joint Committee on Human Rights (Joint Committee). As a result of those concerns, and concerns raised by Human Rights Watch, the Joint Committee held an

[16] See the discussion and research cited in Queensland Office of the Public Advocate, *Aged Care Quality and Safety in Australia Submission to the Royal Commission on Aged Care Quality and Safety* (Office of the Public Advocate, 2019) 3-4.
[17] See, in relation to the use of physical restraints the position statement in the Australian and New Zealand Society for Geriatric Medicine, *Position Statement No 2 Physical Restraint Use in Older People* (2012) 6.

inquiry into the principles to test their compatibility with human rights[18]. The following concerns were raised by OPA with the Joint Committee.

The use of restraint and seclusion impacts on a person's fundamental legal and human rights. OPA is surprised that the preferred mechanism of regulation in the aged care system is by a ministerial instrument and not by an Act of Parliament requiring consideration and debate.

By way of comparison, Victoria has the following legislative regimes that specifically regulate the use of restraints:

- The Mental Health Act 2014 (Vic) in relation to patients receiving compulsory treatment for mental illness.
- The Disability Act 2006 (Vic) in relation to people with disability receiving services from disability service providers.

The *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) which has the purpose of protecting and promoting human rights is also applicable. Under the Charter, a public authority must act compatibly with a human right.

Regrettably, there is no equally comprehensive legislative human rights framework for people residing in residential aged care. Consequently, while there is evidence that restraint is often ineffective, possibly dangerous, and should be a last resort, there is no legislative protection for people residing in RACFs, and there are no other safeguards in place.

In this section, OPA considers how the Restraint Minimisation Principles are:

- poorly executed in terms of definitions and the hierarchy of representatives
- of questionable legality given a person's rights at common law and the extraordinary authority they seem to bestow on the representative and medical and nurse practitioners
- lacking safeguards, such as those thought necessary for participants in the NDIS who are subject to regulated restrictive practices
- inconsistent with the human rights of the affected persons.

OPA makes recommendations at the end of this section.

[18] At the time of writing, the Joint Committee 'has not yet finalised its inquiry into the instrument, the committee has resolved to place a protective notice of motion to disallow the instrument, to extend the disallowance period by a further 15 sitting days in order to protect parliamentary control over the instrument pending completion of the committee's inquiry.'
https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment

5.1.2 Definitions

In noting the definitions of the different types of restraints that are used in the Restraint Minimisation Principles, it is helpful to draw a comparison with the definitions used in the *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) (NDIS Rules).

In the NDIS Rules, five categories of restraint are defined as follows:

Physical restraint – the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. (Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.)

Chemical restraint – the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

Mechanical restraint – the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.

Environmental restraint – restrict a person's free access to all parts of their environment, including items or activities. Environmental controls such as locked doors, keypad controls on doors, perimeter fences and other building design features may restrict an individual's freedom to come and go at will. Similarly, being constantly supervised or escorted by staff also severely restricts a person's liberty.

Seclusion – the sole confinement of an individual in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.

In contrast, the Aged Care Restraint Minimisation Principles define only two types of restraints, namely chemical and physical restraints, with the latter defined as 'any restraint other than a chemical restraint'. It could be argued that this broad definition of 'physical restraint' encompasses seclusion, mechanical restraint, and environmental restraint. OPA considers that maintaining the use of these additional categories provides an analytical tool that assists to provide insight into practices in aged care and enables more tailored authorisation procedures.

The *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) provide a far more comprehensive and robust framework for defining, using and reducing the use of restraints, along with stronger safeguards, such as the requirement that the State of Victoria authorise restraints applied to Victorian NDIS participants. OPA is perplexed that an equally rigorous and robust approach was not favoured in aged care legislation.

5.1.3. Substitute decision making regime introduced

Aged care residents are subject to restrictive practices without the free and informed consent of the person themselves or from their authorised legal representative or substitute decision maker. OPA is aware that RACFs rely on the informal consent of family, or on a misconception that the facility's duty of care allows them to impose these restrictions where there is no emergency, or where reliance on the law of necessity is driven by a failure to obtain consent from a proper authority within a reasonable time.

Such practices breach residents' legal and human rights. The Victorian Law Reform Commission (VLRC) has found, in its 2012 Guardianship report,[19] that no common law or statutory power exists to properly authorise these practices.

In response to this identified absence of regulation, the Aged Care Restraint Minimisation Principles introduced two types of substitute decision-making to provide authorisation where a resident in aged care is not able to provide consent to restraint.

OPA notes that the Restraint Minimisation Principles do not reflect Article 12 of the UN CRPD (equal recognition before the law) and the General comment no.1 (2014) on Article 12 or human rights principles more broadly.

It is not clear whether the Restraint Minimisation Principles are intended to empower representatives to consent to physical restraint, or merely to acknowledge that these categories of people may provide consent if they have the power to do so from another source (i.e. guardianship order, power of attorney or the common law). If the Restraint Minimisation Principles are intended to operate to authorise the representative to provide consent to the use of physical restraint, it is not clear how this can be achieved by mere regulation.

If it is intended that the Restraint Minimisation Principles acknowledge that these categories of people may provide consent if they have the power to do so from another source, there is nothing in the common law that permits a person or representative (however well-meaning and/or familial) to consent on another's behalf to physical or chemical restraint.[20]

OPA points to *Victoria's Guardianship and Administration Act 2019* (Vic), *Medical Treatment Planning and Decisions Act 2016* (Vic) (MTPD Act) and *Mental Health Act 2014* (Vic) as examples of legislation that, while maintaining a system of substitute decision-making that permits decisions to be made for other persons about restraint, nonetheless take UN instruments into account.

[19] Victorian Law Reform Commission. *Guardianship: Final Report.* Chapter 15: Restrictions upon liberty in residential care (2012).
[20] Consent may be dispensed with in emergencies or where necessary until proper lawful authority has been obtained.

Physical restraints

The first type of substitute decision-making introduced in the Aged Care Restraint Minimisation Principles relates to authorisation of the use of physical restraints. In the case of physical restraints, the substitute decision-making regime involves obtaining the informed consent of the consumer's 'representative' prior to the administration of the restraint.

Section 5 of the *Aged Care Principles 2014* states that a consumer representative may be a person who is nominated by the consumer but can also be a person who nominates themselves as 'a person to be told about matters affecting a consumer'. The restraint minimisation principles indicate (but do not determine) that this could be a partner, a close relative or another relative of the consumer. A representative could also be a person who holds an enduring power of attorney or an appointed guardian with power to make relevant decisions on behalf of the consumer. It could be the person who 'represents the consumer in dealings with the organisation'.

OPA makes the following observations about the list of people who can fulfil the substitute decision maker role under the Restraint Minimisation Principles:

- There is no hierarchy of persons should there be a dispute as to who fulfils the role. It is OPA's experience that these matters are regularly contested.
- The restraint minimisation principles permit individuals other than the consumer to nominate themselves, but do not provide the consumer with any right to veto the person so nominating.
- Terms like 'partner' and 'close relation' are defined in the Aged Care Act 1997 (Cth) but solely in the division concerning the amount of residential care subsidy. This is a very different context from determining the use of restraint. Definitions for these two terms are not written into the Restraint Minimisation Principles, and nor is there a definition of 'relative'.
- The Restraint Minimisation Principles do not distinguish between different types of powers of attorney. For example, in Victoria, a person can be an attorney for financial matters, but this would not seem a relevant qualification for consenting to the use of restraint. In Victoria, a person could appoint a medical treatment decision maker, but restraint would not qualify as medical treatment under the MTDP Act. In Victoria, a person can also appoint an attorney for personal matters who may have sufficient authority to consent to restraint, but that is not apparent from the list of examples contained in the definition of 'personal matters'[21].
- The Restraint Minimisation Principles do not differentiate between guardianship appointments. In Victoria, the Public Advocate may be appointed as a guardian to make decisions about a represented person's accommodation, but that power does not authorise the guardian to make decisions about a person being physically restrained. Unless a guardian has specific powers to agree to the use of physical restraint under Victorian law, OPA does not think that that the guardian would be authorised to be the resident's representative to provide informed consent to

[21] Potter v Minahan (1908) 7 CLR 277 – there is a presumption that fundamental rights are not altered unless there is clear language of an intention by Parliament to do so.

physical restraint. Subsection 3 of the definition of 'representative' does not make this limitation apparent.

- The Restraint Minimisation Principles permit the representative to be a person 'who represents the consumer in dealings with the organisation'. An advocate may represent a person in dealings with an organisation but have no formal authority to make decisions for that person.

By way of comparison, OPA draws attention to the definitions in the MTPD Act, and specifically to section 55 of this Act for a hierarchy of persons in Victoria who are authorised by that legislation to make medical treatment decisions for a person who lacks decision making capacity. These people are called medical treatment decision makers in the Act.

Chemical restraints

The second type of substitute decision making introduced by the Restraint Minimisation Principles relates to the authorisation of the use of chemical restraint.

In the case of chemical restraint, the Restraint Minimisation Principles provide that the decision to consent to the use of the restraint can be made by medical or nurse practitioners, without the requirement to obtain consent from a representative. Rather, the Restraint Minimisation Principles only require that the person's representative is informed before the restraint is used.

Psychotropic medications tend to be prescribed by medical practitioners attached to, or who have a relationship with, the RACF. In these cases, visiting medical practitioners may have a divided loyalty between the facility and their patient. Practitioners may have significant experience in the use of such medications, but irrespective of experience, tend to be reliant upon staff at the facility to provide information on the presentation of the person to inform the prescription.

It is regrettable that the Australian Government has introduced a system where the decision to use chemical restraint is made in this way. Prior to the commencement of the MTPD Act on 12 March 2018, Victoria had a system under the *Guardianship and Administration Act 1986* (Vic) whereby a medical practitioner could consent to the administration of a pharmaceutical drug for the purpose, and in accordance with the dosage level, recommended by the registered practitioner, or as recommended in the manufacturer's instruction. This previous system was akin to that under the Restraint Minimisation Principles, in that restraints could be provided on the authorisation of a medical practitioner.

The VLRC rejected this approach in its 2012 report *Guardianship: Final Report*, which in part led to the introduction of the MTPD Act. While the MTPD Act is more aligned with the VLRC's recommended approach, it does not regulate the use of a chemical restraint where a person is unable to consent to it.

Sometimes OPA guardians are asked to consent to the use of chemical restraints.[22] This is problematic. Where chemical restraint is proposed solely for behaviour management, a

[22] Appendices A and B contains two examples of forms that RACFs may require a GP or an Advocate Guardian to complete to authorise the administration of psychotropic medication.

legal authority specific to that issue would need to be granted by VCAT. Without that authority, a guardian cannot legally consent to the administration of restraint medication.

When the Public Advocate has powers to make decisions regarding health care, her delegated guardians could not (and would not) consent to the administration of medication for restraint as it is beyond their authority. When OPA is appointed as guardian, for instance in the case of a person exhibiting behavioural and psychological symptoms of dementia, the OPA guardian would recommend referral to aged psychiatry assessment teams for suggestions as to how best to manage behaviour. A referral to a gerontologist may also be appropriate. In most instances, the recommended course of action would first be through a behaviour plan.

The sole independent safeguard in the restraint minimisation principles lies in the role of the 'representative' who is merely informed about (and not consenting to) the use of chemical restraint. There is no legislated mechanism for objection, challenge, or refusal of the use of chemical restraints.

Where the administration of psychotropic drugs is purported to be for therapeutic purposes, the process outlined in the MTPD Act in Victoria requires that, where a medical practitioner proposes to administer significant medical treatment to a person who does not have decision-making capacity in respect of that treatment and there is no appointed decision maker, the health practitioner may only administer the treatment if authorised by OPA.

Victoria's Department of Health and Human Services published guidance to health professionals as to what constitutes routine and significant treatment.[23] In that guideline, antidepressants and antipsychotics are regarded as significant treatment. These are the usual medications used as chemical restraint. Accordingly, the administration of psychotropic medication is significant medical treatment under the MTPD Act.

The Australian Newspaper reported in October 2017 that 40 per cent of people in aged care facilities have no visitors.[24] It is likely therefore that many people who reside in RACFs do not have anyone to consent to their significant medical treatment. OPA would therefore expect to receive a large number of inquiries from medical practitioners seeking OPA's consent to administer psychotropic drugs to these residents for therapeutic purposes.

However, since the commencement of the operation of the MTPD Act, OPA has received less than 20 requests from a health practitioner seeking consent to provide medical treatment to a resident in a RACF.

It seems that medical practitioners and RACFs are not complying with Victorian law in this area. Effective safeguarding measures are urgently required to address this non-compliance with the law. The restraint minimisation principles as currently conceived and written will not address what OPA suspects is an extraordinary degree of non-compliance with the provisions of the MTPD Act. OPA will continue to monitor this issue and will raise

[23] Department of Health and Human Services, *Significant treatment clinical guidelines for the Medical Treatment Planning and Decisions Act 2016*, 2017, 9. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/significant-treatment-clinical-guidelines-for-mtpd-act-2016

[24] The Australian (25 October 2017)

instances where consent to administer medical treatment has not been sought with the appropriate regulator.

Furthermore, a recent study on the use of psychotropic medications in RACFs and its impact on the quality of life of older people concluded that while older people report a wish to experience the best quality of life possible, psychotropic medications were associated with a lower quality of life for older people. The study suggested that

> health care practitioners and consumers should consider this association and the existing evidence of harm vs benefit of psychotropic medications, when treating older people living in residential aged care facilities.[25]

Julia's story- psychotropic medications used as chemical restraint

OPA was an accommodation and health care guardian for a woman with dementia who did not have a diagnosed psychiatric illness. The RACF became concerned about Julia's agitated and aggressive behaviour and requested the guardian complete the RACF's form— developed to conform to the Restraint Minimisation Principles—to authorise the administration of psychotropic medication. The GP provided no information on the form as to why chemical restraint was needed (Appendix B).

The RACF's GP then contacted the guardian to request consent to reduce the daily dosage of the medication from three times to twice a day. The GP thought that Julia has recently been presenting as drowsy which may be due to current dose. Furthermore, he advised that there is no significant evidence that the prescribed anti-psychotic improves agitation and may in fact increase agitation. This medication can also increase risk of stroke and is not recommended to be used in the long term.

The guardian asked why the dosage had not already been reduced in these circumstances. The GP advised that this was not possible due to 'family interference'.

The GP had no plans to review the cessation of the administration of the medication altogether but agreed after discussion with OPA to review the dosage in a few weeks.

Environmental restraints

OPA is aware of the use of environmental restraints and other limitations on freedom of movement in aged care settings. Environmental restraint practices are common in aged care settings, particularly where some residents have a cognitive impairment such as dementia and are often intended to protect residents from harm. For example, dementia units may be using locked key pads to prevent residents from leaving the facility unsupervised and wandering. In OPA's experience, restrictive practices like these impact people who are not at risk of such harm but who reside with residents who do. In one

[25] S.L. Harrison et al. "Psychotropic medications in older people in residential care facilities and associations with quality of life: a cross-sectional study", *BMC Geriatrics* 18:60 (2018) 6. https://doi.org/10.1186/s12877.-018-0752-0.

instance, OPA observed a RACF that used a keypad to restrict the movement of some residents, which prevented another resident who was permitted to move freely and safely from leaving because they could not remember the code.[26]

OPA has seen an increase in requests for guardians to consent to or waive legal liability for (though an indemnity clause), a resident leaving an aged care facility to attend activities and/or visit friends and family. Guardians have not been signing these consent forms as to do so would usually be beyond the guardian's authority. This requirement for consent, or seeking a waiver of legal responsibility, has the potential to negatively impact on the quality of that person's life if the consent or waiver is not provided. This might be overcome through advocacy and negotiation. Nonetheless, it raises concerns for residents who do not have anybody to provide consent and who consequently may not be allowed to leave the facility. This is alarming when we know that forty per cent of residential aged care residents have no visitors.[27]

The use of environmental restraints by RACFs for the purpose of protecting residents is often a result of the need to manage risks to residents, or to shift that risk to others. For example, some facilities have justified the requirement of a signed consent form to ensure protection from liability if something happens to a person once they are outside the facility. Risk management policies and procedures can indiscriminately deprive persons of their right to freedom of movement. A human rights approach would instead consider alternatives to environmental restraints that strike a more appropriate balance between safety and risk.

Jasmine's story- Prevented from leaving the RACF

OPA was guardian for Jasmine with accommodation and access to services decision-making powers. The guardian placed Jasmine in a facility that required the guardian to sign a legal liability waiver (indemnity clause), protecting the RACF from being sued if the resident left the facility to attend activities and/or visit friends or family.

The guardian decided not to sign the form as it was beyond the scope of the guardian's authority being related to the person's legal right to sue. As a result, Jasmine was prevented from leaving the facility for several months, despite strong advocacy from the guardian, who also made a complaint to the Aged Care and Quality Safety Commission (the Commission) and to its predecessor body (Aged Care Complaints Commission) about this practice. The RACFs refusal to let Jasmine leave breached her right to freedom of movement.

Eventually as a last resort, the administrator, who was responsible for Jasmine's legal affairs, unlike the guardian, signed the form to enable Jasmine to leave the facility. The RACF made some minor changes to the form after further advocacy from the guardian and the Commission but did not change its policy. The Commission did not sanction the RACF.

[26] Office of the Public Advocate (Vic). Submission to the Standing Committee on Health, Aged Care and Sport Inquiry into the quality of care in residential aged care facilities in Australia (2018) 5.
[27] *The Australian* (25 October 2017).

Consent to restraint by the resident / patient

Notwithstanding the introduction of the Restraint Minimisation Principles, the Australian Government states that 'Consent to the use of physical or chemical restraint should be given by the person themselves unless they lack the capacity to do so'.[28] The prescribing health practitioner is expected to

> make a clinical judgement about the person's capacity to provide informed consent to the medication, and seek informed consent, either from the person, or their representative if they do not have capacity to consent.[29]

It is implied that this consent, or substituted consent is sufficient authorisation of the use of the restraint by the provider. However, it is the provider who is at risk of committing an assault or trespass to the person through the implementation of the restraint, not the doctor or nurse practitioner.

There is nothing in the Restraint Minimisation Principles to guide providers about their reliance on the communication by the doctor or nurse practitioner of the resident's consent. Where the provider is aware that the resident is unable to provide informed consent, there should be guidance that any consent so given and recorded would not be valid and could not be relied upon by the provider to avoid civil or criminal penalties.

5.1.4. Safeguards

In comparison with the regulations of the disability and mental health sectors, the aged care Restraint Minimisation Principles do not include safeguards that align with a human rights person-centred approach. In the disability sector, the *National Framework for Reducing and Eliminating the Use of restrictive Practices in the Disability Service Sector* sets out guiding principles to make explicit Australia's obligation under the UN CRPD.

OPA considers mechanisms that embed accountability provide an essential safeguard to ensure the minimisation of the use of restraints. These could include monitoring the use of restrictive practices, along with independent clinical leadership to support providers to implement less restrictive / more therapeutic behaviour management strategies.

The *Disability Act 2006* (Vic) sets out the statutory role of the Senior Practitioner which sits within the Office of Professional Practice in the Department of Health and Human Services. The Senior Practitioner has powers and functions under the Act for ensuring that the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with. The Senior Practitioner authorises the use of restrictive practices as well as oversees behaviour support plans where positive and restrictive strategies are documented.

For NDIS participants, an additional layer of safeguarding lies with the statutory role of the NDIS Quality and Safeguards Commission (NDIS Commission). Under the NDIS system, a behaviour support plan can only be developed by a specialist behaviour support provider.

[28] Parliamentary Joint Committee on Human Rights, *Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, Ref No: No 1, Answers to Questions on Notice, Health Portfolio* (2019)
[29] Ibid 2.

Before a regulated restrictive practice in a plan can be implemented, it must be authorised by Victoria's Senior Practitioner. A person must be informed of the proposed use of restrictive practices in their behaviour support plan and there is scope to apply to VCAT for review.

It is expected that the NDIS Commission and the Victorian Senior Practitioner will work with providers to address the challenges they face that may lead to the use of restrictive practices on individual consumers. The NDIS Commission keeps a register of all behaviour support plans, receives incident reports on the authorised and unauthorised use of restrictive practices, and collates data for quality improvement purposes.

In comparison, the governance and oversight arrangements in the aged care sector are virtually non-existent. In their current format, the Restraint Minimisation Principles include an obligation to document the use of restraints, but no obligation to report such practices, thus lacking the additional layers of oversight and monitoring.

In the aged care sector, there is no role equivalent to that of the Senior Practitioner to provide the clinical leadership and support. Section 35 of the *Aged Care Quality and Safety Commission Act 2018* (Cth) does provide for a 'Chief Clinical Advisor' to 'assist the Commissioner in the performance of the Commissioner's functions' but is silent on their specific functions and responsibilities. OPA considers the role of Chief Clinical Advisor should be further defined in legislation to include functions similar to the Senior Practitioner in the disability sector.

To give the Chief Clinical Advisor a role for clinical leadership implies that the Aged Care Quality and Safety Commission will take on a mandate to oversee and monitor the use of restrictive practices in the sector. OPA further recommends that aged care providers should be obligated through legislation to report on the development of behaviour support plans, the use of restrictive practices and steps taken to reduce the need for use of restraint, to the Aged Care Quality and Safety Commission.

5.1.5. Human rights focus

For reasons explained above, the Restraint Minimisation Principles are inconsistent with a human rights approach. Without this overarching guidance, it is unlikely that their implementation will result in the protection and promotion of resident rights and wellbeing.

A human rights framework for the use of restrictive practices fully recognises a person's decision-making capacity and ability to consent. An appropriate human-rights focussed regulatory system would ensure that restrictive practices are:

- only used as a last resort with other less restrictive means being explored first
- only used to the extent necessary and are proportionate to the level of risk/harm
- only used upon the recommendation of a suitably qualified professional
- documented (including the rationale for the intervention) and reportable
- subject to independent monitoring and oversight
- subject to review

- occurring in the context of a behavioural support plan.

The ALRC has made recommendations on these points in their report *Elder Abuse – A National Legal Response*.[30] In their submission to this Royal Commission, the Queensland OPA (Qld OPA) recommended that the ALRC recommendations be immediately implemented. OPA endorses and repeats that recommendation:

Recommendation 1

The Australian Government should immediately implement a comprehensive regulatory framework for the use of restrictive practices in residential aged care, with all the characteristics and protections recommended by the Australian Law Reform Commission in its report, *Elder Abuse – A National Legal Response:*

> ALRC 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.
>
> ALRC Recommendation 4–11 The Australian 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.

OPA makes the following further recommendations, based on the arguments articulated in this section. These recommendations have also been made to the Australian Parliamentary Joint Committee on Human Rights in the context of their inquiry into the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (Cth).

[30] See Recommendation 1 in Office of the Public Advocate (QLD), Submission 17; Australian Law Reform Commission, *Elder Abuse- A National Response: Final Report (*2017*)* 142-47.

Recommendation 2

The Australian Government should disallow the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (Cth). Instead, the Australian Government should amend the Aged Care Act 1997 (Cth) to implement the recommendations of the Australian Law Reform Commission 4-10 and 4-11.

The legislation should cure the following identified defects of the Minimisation of the Use of Restraint Principles:

- Analytical categories of the types of restraints used should be expanded
- Definitions of these categories should be expanded (as in the NDIS system)
- The need for a multi-layered authorisation system that includes
  - professional input into the development of a behaviour support plan
  - consent based on human rights principles commencing with the person's own consent; where this is diminished, with supported decision-making; and where the person lacks capacity, by a substitute decision-maker
- The determination of who is an appropriate substitute decision-maker should consider both appointed roles and roles associated with a close relationship with the person (for example, see Victoria's MTPD Act as to who may be appointed a medical treatment decision-maker).
- The Commonwealth Government should work with the States and Territories to determine whether it is appropriate for there to be explicit mention of a power to consent to the use of restraints in appointments of enduring guardians or attorneys for personal matters.
- The list of appropriate decision-makers should be hierarchical.
- A person should be able to veto the involvement of a person that they have not appointed to perform this role.
- In the absence of an appointed decision maker and where there are is no one to consent to the use of restraints on the person's behalf, there should be an office or body in each state and territory that consents to, or refuses consent, on behalf of the person.
- There should also be a system to manage and resolve disputes between providers and decision-makers.
- There should be guidance provided in the enabling legislation as to how a substitute decision-maker should make a decision to consent to or refuse to consent to the use of restraint.
- There should be guidance provided to aged care providers on the information they must give to persons, supporters and substitute decision-makers to enable informed decisions to be made about the use of and need for the use of restraint.
- There should be regulation to ensure the regular review the use of restraint in a person's behaviour support plan.

- Rather than create a role of the senior practitioner, this could be made explicit or added to the role of the Chief Clinical Advisor. A model could be that of the Senior Practitioner under Victoria's Disability Act 2006.
- Oversight and monitoring of the use of restrictive practices could be performed by the Aged Care Commission. There must be provision for enforcement of standards, reporting of breaches and, in the most serious of breaches, offence provisions. One potential model is that of the NDIS Commission.

Recommendation 3

The Aged Care Quality and Safety Commission should ensure that residential aged care facilities comply with existing state and territory laws concerning medical treatment decision making and advance planning laws, for example, the *Medical Treatment Planning and Decisions Act (2016)* (Vic.).

5. 2. Implementation of the Optional Protocol to the Convention Against Torture (OPCAT)

Australia's ratification of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) will have implications for RACFs if these facilities are identified as a 'place of detention'.

OPA's submission to the Australian Human Rights Commission's first consultation on the implementation of OPCAT in Australia, outlined a range of reasons as to why it is important for the National Preventive Mechanism (NPM) to have jurisdiction and responsibilities in relation to RACFs.

The national or domestic visiting body (i.e. the NPM) is only empowered to inspect 'places of detention'.[31] Therefore, it is important to understand the range of places that constitute places of detention and, consequently, which people will receive the benefit of the NPM's functions.

OPA endorses the position expressed in OPCAT's preamble that 'the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention'. Ensuring that the jurisdiction and responsibilities of the NPM are understood to include these places of detention is therefore critically important to help protect the rights of vulnerable people.

[31] *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* opened for signature on 18 December 2002, A/RES/56/199 (entered into force on 22 June 2006) art 4.

5.2.1. Legal framework

Australia has obligations to prevent torture, inhuman or degrading treatment.

Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) provides that

> each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment of punishment which do not amount to torture as defined article 1, where such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Similarly, article 15(2) of the Convention on the Rights of Persons with Disabilities (UN CRPD) provides that state parties must take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16(3) of the UN CRPD provides that, 'in order to prevent the occurrence of all forms of exploitation, violence and abuse, State Parties shall ensure that all facilities and [programs] designed to serve persons with disabilities are effectively monitored by independent authorities'.

Finally, article 14 of the UN CRPD provides that State Parties shall ensure that persons with disability, on an equal basis with others, enjoy the right to liberty and security of person and are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

The objective of the OPCAT as articulated in Article 1 is to 'prevent torture and other cruel, inhuman or degrading treatment or punishment'. It does not introduce any new rights, but rather seeks 'to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty'.

The national body charged with undertaking regular visits to places of detention is the NPM. OPCAT provides that 'Each state party must establish its own NPM, independent of government, to visit places of detention within its jurisdiction'.[32]

The Australian Government has decided to vest the NPM function across multiple federal, state and territory bodies, which will enable states and territories to harness and adapt existing inspection mechanisms. OPA coordinates one of the existing inspection mechanisms in Victoria, namely the Community Visitors Program, and recommends that a similar program be implemented within the aged care sector, as is explained in section 5.3.

The United National Subcommittee on the Prevention of Torture (SPT) is the international inspection body. 'The SPT is composed of international experts and conducts periodic

[32] Bronwyn Naylor et al, 'Foreword to the Special Issue on the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (2019) *Australian Journal of Human Rights* 1.

inspection of a selection of places of detention within state parties to OPCAT. The SPT can also provide technical expertise'.[33] The SPT is scheduled to visit Australia next year.[34]

5.2.2. RACFs as places of detention

Article 4(1) of OPCAT defines a 'place of detention' as 'any place under [a State's] jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'.

'Deprivation of liberty' is in turn defined in art 4(2) as follows:

> Deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.

Deprivation of liberty is taking place in Australian closed RACFs, particularly specialist dementia care units. In the 2016 Senate Community Affairs References Committee (Senate Committee) report, the Committee found that 'indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context' and that 'this detention is often informal, unregulated and unlawful'.[35] This detention ' can stem from restrictive practice or seclusion that creates a de facto form of indefinite detention. It can also be…as a result of practices within the…aged-care…homes'.[36]

The legality, necessity and justification for deprivations of liberty in these settings are increasingly being called into question. However, many people who are deprived of their liberty are vulnerable to coercion and pressure from those around them, have reduced ability to assert their rights and interests, and often have very limited contact with independent or external people (such as advocates or lawyers) who may be able to assist them.

As RACFs "are (partially or wholly) funded by government and/or subject to regulations and government oversight, they meet OPCAT's first criterion of being under the government's jurisdiction and control. They also meet the second and third criteria: they deprive persons of their liberty; and this deprivation is 'either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'."[37]

Social care settings have been recognised as places of detention in international law. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) noted that the Maltese NPM did not undertake regular independent

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[33] Ibid 2.
[34] Helen Davidson, 'UN inspectors primed for 'unfettered access' to Australian detention centres', *The Guardian* (online), 5 July 2019, https://www.theguardian.com/australia-news/2019/jul/05/un-inspectors-primed-for-unfettered-access-to-australian-detention-centres
[35] Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016) 169; Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 8.
[36] Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016) 169.
[37] Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 8.

monitoring of Malta's psychiatric facilities, police facilities or its social care homes. The CPT made a recommendation to the Maltese authorities to, as a matter of priority, establish the legal mandate for relevant independent bodies to adequately access and monitor all the different types of places of deprivation of liberty in Malta.[38]

Similarly, the Committee against Torture states that 'each State party should prohibit, prevent and redress torture and ill-treatment *in all contexts of custody and control, for example*, in prisons [and] institutions that engage in the *care of children, the aged, the mentally ill or disabled*' (emphasis added)'.[39]

To this point, in New Zealand, the Office of the Ombudsman is now responsible for monitoring dementia units in private aged care facilities under its responsibilities as an NPM in the implementation of OPCAT.[40]

Indeed, when announcing the forthcoming visit to Australia, Sir Malcolm Evans, Chair of the SPT, said that he expected that the Australian government "would understand and cooperate with the inspectors' expectation of 'completely unfettered access to all places of detention, to any person, place or thing, to people of all categories in detention'". The inspectors will have a broad brief, including […] and social care environments such as aged care and disability homes. 'The reality is these are institutions that are supported, regulated and run by the state'".[41] Further, the subcommittee is "particularly concerned about marginal groups in society which are often subject to poorer treatment than others for various reasons including disability, race, age and infirmity".[42]

At a national level, the 2016 Senate Committee report, legislation such as the Guardianship and Administration Act 1993 (SA) and other similar legislation that authorises orders of 'detention' or 'use of force', and the South Australian case of Public Advocate v C, B (2019) "point to an understanding within our arms of government that closed aged care facilities constitute a place of (civil) detention, albeit a less traditional place of detention." [43] Similarly, the Commonwealth Ombudsman noted that "[g]iven that OPCAT is not restricted to primary places of detention it will be necessary over time to consider all places where people are deprived of their liberty in Australia".[44]

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[38] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment, *Report to the Maltese Government on the visit to Malta carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 3 to 10 September 2015*, CPT/Inf (2016) 25, 13.

[39] Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 8 citing the Committee against Torture. 2008. *General Comment No. 2: Implementation of Article 2 by State Parties,* CAT/C/GC/2 (24 January).

[40] Michael White, 'The role and scope of OPCAT in protecting those deprived of their liberty: a critical analysis of the New Zealand experience' (2019) *Australian Journal of Human Rights*.

[41] Helen Davidson, 'UN inspectors primed for 'unfettered access' to Australian detention centres', *The Guardian* (online), 5 July 2019, https://www.theguardian.com/australia-news/2019/jul/05/un-inspectors-primed-for-unfettered-access-to-australian-detention-centres

[42] Ibid

[43] Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 2.

[44] Commonwealth Ombudsman, *Implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT), 2019, 9 [1.23]

Closed aged care facilities should be correctly understood as 'places of detention' to be monitored under OPCAT and older people in closed RACFS understood to 'come under the purview of the CRDP'.[45]

5.2.3. Restrictive practices can constitute "cruel, inhuman or degrading treatment or punishment"

The use of restrictive practices in RACFs can constitute cruel, inhuman or degrading treatment or punishment. This was confirmed by the Human Rights Council in the 2013 Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Mendez in the Special Rapporteur's 2013 report on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[46]

Similarly, the Committee on the Rights of Persons with Disabilities, in its Concluding observations on the initial report of Australia, expressed concerns in respect of article 15 of the UN CRPD (Freedom from torture and cruel, inhuman or degrading treatment or punishment) that

> persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals.

OPCAT is therefore enlivened in respect of these practices.

5.2.4. Scope of State obligations and responsibility extends others acting on behalf of the state

RACFs are subject to the purview of the CAT and the UN CRPD. Each of these impose obligations on state parties rather than individuals and impose responsibility on state parties for the acts or omissions of certain non-state actors who are acting under a 'colour of law'. The state's responsibility is enlivened at the moment that the State learns of, or should have learned of, the existence of the risk.

Articles 1 and 16 of the CAT reference the 'acquiescence of a public official'. If a public official becomes aware of such treatment taking place, for example via the media or other reports, the public official / government is acquiescing to that treatment if no positive action is taken to prevent it.

The scope of the obligations and responsibilities of states under the CAT is clarified in the CAT General Comment No.2, Implementation of Article 2 by State Parties as follows:[47]

[45] Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 1.
[46] Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Mendez* (2013) A/HRC/22/53 (1 February) 14-15.
[47] Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, *General Comment No. 2, Implementation of article 2 by States parties*, CAT/C/GC/2 4.

> 15. The Convention imposes obligations on States parties and not on individuals. States bear international responsibility for the acts and omissions of their officials and others, including agents, private contractors, and others acting in official capacity or acting on behalf of the State, in conjunction with the State, under its direction or control, or otherwise under colour of law. Accordingly, each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.
>
> 18. The Committee has made clear that where State authorities or others acting in official capacity or under colour of law, know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors consistently with the Convention, the State bears responsibility and its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts. Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission. The Committee has applied this principle to States parties' failure to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.

Reference on the Attorney-General's Department website to the scope of the right to humane treatment in detention under article 10 of the International Covenant on Civil and Political Rights is also instructive. The website advises federal public servants that the right to humane treatment in detention applies to legislation, policy or programs that enables or requires the detention of any person by either a public or private authority.[48]

This duty to prevent torture and other cruel, inhuman or degrading treatment or punishment as a positive obligation to protect is also articulated in the International Court of Justice (ICJ) case of *Application of the Convention on the Prevention and Punishment of the Crime of Genocide* (Bosnia and Herzegovina v. Serbia and Montenegro). In that case the ICJ found that

> a State's obligation to prevent, and the corresponding duty to act, arise at the instant that the State learns of, or should normally have learned of, the existence of a serious risk that genocide will be committed.[49]

[48] Attorney-General's Department, *Right to humane treatment in detention*, https://www.ag.gov.au/RightsAndProtections/HumanRights/Human-rights-scrutiny/PublicSectorGuidanceSheets/Pages/Righttohumantreatmentindetention.aspx

[49] Application of the Convention on the Prevention and Punishment of the Crime of Genocide (Bosnia and Herzegovina v. Serbia and Montenegro) *International Court of Justice* (2007) 222 [431] https://www.icj-cij.org/en/case/91/judgments

As a result, the conduct of RACFs should be open to scrutiny through the OPCAT inspection mechanisms. The Australian government must take positive steps to prevent violations of the CAT and the UN CRPD by non-state actors including RACFs.

5.2.5. Role of civil society

Civil society organisations have

> deep knowledge of the lived experiences and needs of persons deprived of their liberty, and a unique understanding of the challenges particular groups face in closed environments, including persons with a disability.[50]
>
> There is a range of potential roles that civil society can play in relation to OPCAT implementation in Australia, including formal or informal partnerships with NPMs, or a watchdog role.[51]

For example, visitor programs are

> well placed to identify and report on or refer systemic issues. Official visitor reports can inform the work of the inspectorate – for example, by identifying thematic issues of concern or particular places of concern.[52]

The OPA Community Visitor model in the context of disability and mental health services plays a crucial role in the oversight of the use of behavioural supports and restrictive practices. OPA has advocated for a legislated Community Visitor program in respect of RACFs, and recommends a role for Community Visitors in Australia's implementation of OPCAT. This is discussed further at section 5.3.

5.2.6. The application of OPCAT to the deprivation of liberty in RACFs

The use of restrictive practices and attendant deprivation of liberty in RACFs can constitute cruel, inhuman or degrading treatment or punishment and therefore comes within the purview of OPCAT.

Residents of RACF are particularly vulnerable to rights breaches. Significantly, there can be a sense that restrictive practices are applied in the best interests of the resident and are therefore permissible. Whilst in many cases the interference with the rights of a resident of a RACF may appear benign, this does not render the restriction lawful.[53] For example, restraints cannot be imposed simply because the person applying the restraint believes that it is in the best interests of the person to whom the restraint is applied.[54]

Existing regulation and oversight mechanisms across Australia are inconsistent and patchy.[55]

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[50] Rebecca Minty, 'Involving civil society in preventing ill treatment in detention: maximising OPCAT's opportunity for Australia' (2019) *Australian Journal of Human Rights*, 17.
[51] Ibid, 18.
[52] Ibid, 17.
[53] Michael Williams et al, 'Consent versus scrutiny: Restricting Liberties in post-Bournewood Victoria' (2014) *Journal of Law and Medicine*, 657.
[54] *Antunovic* v *Dawson* (2010) 30 VR 355 [135]
[55] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report 12 (2014) 248-251.

There is an

> absence of specific federal regulation and monitoring of […] (restrictive practices) to manage the behaviour and safety of patients/consumers residing in closed aged care facilities. No regulation explicitly addresses the use of these practices in the aged care context.[56]

The Restraint Minimisation Principles fall woefully short of filling the regulatory gap. Rather,

> Systems of proactive and preventive monitoring are acutely needed. Unannounced rigorous visits by qualified experts using standards (drawing on internationally recognised human rights standards) to assess risk relating to ill treatment are essential

and urgently needed given the vulnerability of older people with cognitive impairment whose liberty has been restricted.[57]

OPCAT NPM monitoring would 'provide important additional oversight of human rights standards in aged care'.[58]

There is a view that when implementing OPCAT, the Federal Government should prioritise particular places of detention, for example prisons and police cells, and then progressively ensure coverage of places of civil detention such as closed units in RACFs.[59]

However, in jurisdictions that have adopted this approach, for example New Zealand, the New Zealand Ombudsman's NPM mandate was not expanded to include monitoring of dementia units in private aged care facilities until 11 years after the Ombudsman was first designated as an NPM.[60]

The evidence in this submission and emerging from the Royal Commission establishes that older people in closed units in RACFs, who are at a disproportionately high risk of torture or cruel, inhumane or degrading treatment, cannot wait for effective regulatory oversight.

Recommendation 4

The Australian Government should implement OPCAT requirements in respect of all places of detention, including relevant RACFs, from the outset rather than starting the implementation process with a focus on 'primary places of detention'.

[56] Laura Grenfell, 'Aged care, detention and OPCAT' (2019) *Australian Journal of Human Rights*, 7.
[57] Ibid 9.
[58] Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, ALRC Report 131 (2017) 156.
[59] Commonwealth Ombudsman, *Implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT) (2019) 8 [1.21] to [1.23].
[60] Ibid 43 [3.11].

5.3. Community Visitors

The premise of the Community Visitors Scheme operating within Commonwealth-funded aged care services is to provide friendship and companionship; volunteers visit isolated residents but are not expected or trained to take on an advocacy role on their behalf. This differs from state-based volunteer Community Visitors schemes such as the Victorian Community Visitors Program that is coordinated by OPA and operates across a range of supported accommodation settings.

OPA's Community Visitors serve as the eyes and ears of the community. They advocate for the human rights of people with disability and represent an essential component of Victoria's safeguards for all residents, but most importantly for those who do not have family, friends, advocates or other representatives.

In Victoria, Community Visitors have a legislated mandate under the *Disability Act 2006* (Vic), the *Mental Health Act 2014* (Vic), and the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) to provide ongoing, on-the-ground monitoring that allows for the identification of issues in care that are affecting residents. They visit facilities announced and unannounced to observe the environment and staff interaction with residents and patients, make enquiries and inspect documents, identify any issues of concern and, where possible, communicate with residents and patients to ensure they are being cared for and supported with dignity and respect.[61] Perhaps most importantly, Community Visitors are empowered by law to inquire into any case of suspected abuse or neglect of a resident.

At the conclusion of each visit, Community Visitors write a brief report detailing who they have spoken to, what documents they have looked at, any issues of concern, as well as good practice they have observed. Community Visitors raise issues with the management of the service and with the Department of Health and Human Services. In cases of abuse or neglect, Community Visitors notify the Public Advocate. The Community Visitors Program has established escalation pathways with other statutory authorities, such as the Disability Services Commissioner and the Chief Psychiatrist, and is working on establishing a working relationship with the newly established NDIS Commission.

To ensure their advocacy function operates in an unbiased way, Community Visitors are independent from service providers and from the Department of Health and Human Services. In the Victorian model, Community Visitors are appointed by the governor-in-council, which has merit in maintaining independence.

While the ALRC report on elder abuse noted that 'ensuring aged care facilities are compliant with OPCAT will provide additional oversight of human rights standards in aged care'[62], it stopped short of recommending an 'official visitors' scheme based, for example, on the Community Visitors scheme in Victoria, in preference of establishing a robust serious incidents response scheme.

OPA considers a Community Visitor scheme modelled on the Victorian program would be a preferable and necessary model of advocacy in the aged care sector. Community Visitors

[61] https://www.publicadvocate.vic.gov.au/our-services/community-visitors
[62] Australian Law Reform Commission, *Elder Abuse- A National Response: Final Report (*2017*)* 156.

would be of great assistance to individuals who are unable to utilise or request advocacy without assistance and to other residents who are marginalised in some way (e.g. individuals whose culture or language is not 'mainstream'). Expanding on the ALRC's intention, OPA advocates for an expanded legislated scheme modelled on the Community Visitors scheme in Victoria to further empower visitors to inspect and report on residential aged care.

As previously mentioned, OPA envisages that the Community Visitors Program may have a role in the implementation of OPCAT and that it may be designated as an NPM along with other bodies. A recent article in the Australian Journal of Human Rights Human Rights Journal made the case for the contribution of civil society advocacy in the implementation of OPCAT.[63] In order to be successful, escalation pathways into the NPM will need to be established. OPA will remain engaged with the Australian Human Rights Commission on this topic.

Recommendation 5

The Australian Government should establish a legislated Community Visitors scheme, similar to the one existing in Victoria, in the aged care sector. In order to be effective, a Community Visitors scheme should incorporate the following aspects in legislation:

- **clear mandate to monitor abuse, neglect and social inclusion**
- **clear mandate to monitor the use of restrictive practices in RACFs**
- **independence**
- **access to records**
- **reporting line to a suitable authority.**

5.4. Aged Care Quality and Safety Commission

In *Navigating the Maze: An overview of Australia's Current Aged Care System* (Background Paper #1), the Royal Commission describes the regulatory landscape of the aged care system. The mechanisms that exist to protect the rights of users are: advocacy services, the Community Visitors scheme, and the Aged Care Quality and Safety Commission complaints process. OPA considers market-based protection mechanisms are insufficient as they do not apply in the same way to the provision of services to people with significant cognitive impairment. A more assertive approach is required to fully promote and protect the rights of older people.

[63] Rebecca Minty, 'Involving civil society in preventing ill treatment in detention: maximising OPCAT's opportunity for Australia' (2019) *Australian Journal of Human Rights*.

The Aged Care Quality and Safety Commission operates with a complaints-based system which requires a person to have the capacity to make a complaint and/or have the natural supports to take action on their behalf. Undoubtably, for those aged care residents who have capacity or only mildly reduced capacity, these safeguards can be very beneficial but OPA advocates for additional supports for residents who may lack capacity to undertake such actions.

The investigative powers of the Commissioner, which allow entry to premises and the exercise of search powers, are too limited in relation to aged care facilities as the trigger for an investigation relies on there being a 'complaint or information'. Many residents in residential aged care facilities lack agency to make complaints or to provide information to the Commissioner. OPA makes the following recommendation.

Recommendation 6

The Australian Government should amend the *Aged Care Act 1997* (Cth) to enable the Aged Care Quality and Safety Commission to launch own motion investigations when it suspects abuse, neglect or exploitation has occurred in a residential aged care facility, without having to wait for a specific complaint or information to be provided to the Commission.

Furthermore, OPA considers the Aged Care Quality and Safety Commission's legislative authority is too narrow to enact system-wide improvements.

In the story of Jasmine, the Aged Care Quality and Safety Commission advised OPA that it was not within their legislated mandate to conduct a wider investigation to determine whether a practice issue was system-wide (or common within the sector). Under the current Act, the Commission cannot make sanctions or directions at a sector-wide level; its powers are solely in relation to responding to individual cases.

Furthermore, Part 8 of the *Aged Care Quality and Safety Commission Act 2018* (Cth) sets out entry and search powers, which rely on residents having the capacity to consent to the entry.

Clause 64 states: 'premises may only be entered with the consent of the occupier of the premises and only for specified purposes'

Clause 65(2) states: An authorised complaints officer may: (a) enter any premises; and (b) exercise the search powers in relation to the premises; for the purposes of the Commissioner resolving the complaint or dealing with the information.

Clause 65(3) states: However, an authorised complaints officer is not authorised to enter premises unless the occupier of the premises has consented to the entry.

Some residents may benefit from an investigation by the Commission but lack the capacity to consent to an officer entering the premise. The provisions inhibit the capacity of an authorised complaints officer to effectively investigate a complaint where their admission to an aged care facility rests on the consent of the occupier.

Recommendation 7

The Australian Government should amend the *Aged Care Act 1997* (Cth) to enable the Aged Care Quality and Safety Commission to initiate investigations into systemic issues in the aged care sector. To give effect to these investigatory powers, it may be necessary for the Commission's authorised officers to have power of entry into the residential aged care facilities without consent of the occupier.

5.5. National Aged Care Advocacy Program

Advocacy is an essential safeguard but in OPA's view, the level of advocacy provided under the National Aged Care Advocacy Program is too restricted by its mandate, which is to attend only upon request. In practice, this means that an individual must request the involvement of an advocacy service or have someone make this request on their behalf. Advocacy in this format is useful if someone can convey the issue and what they are seeking. For the reasons explained above, this can be challenging for people with other than a mild cognitive impairment.

5.6. Incident reporting

In its 2015 submission to the Victorian Parliamentary Inquiry into abuse in disability services, OPA demonstrated how poor incident reporting contributes to inappropriate responses to abuse occurring in residential settings. The absence of a robust mandatory reporting framework reduces recognition of, and creates a silence around violence, abuse, and neglect, leaving victims feeling unsupported and placing them at further risk. This same argument applies to residential aged care where regulations are fewer in comparison with disability services.

OPA repeats its endorsement of recommendations 4-1 and 4-2 from the ALRC Report Elder Abuse – A national Legal Response for a legislated, serious incident response scheme to be monitored by an independent oversight body, in this case, the Aged Care Quality and Safety Commissioner. OPA also supports recommendation 4-3 proposing a legislative definition of 'serious incident' and recommendation 4-6 regarding the operational details of the reporting scheme.

OPA appreciates that the Australian Department of Health (the Department) is considering options for a National Serious Incident Response Scheme (SIRS). The Department has released an options paper entitled Strengthening protections for older Australians, published in February 2019. OPA notes that the KPMG report said that the majority of stakeholders consulted were in favour of a SIRS (option 3 in the options paper) but did not specify the model. OPA notes that the Federal Government has not yet responded and looks forward to the response soon. [64]

[64] Office of the Public Advocate (Vic). Submission to the Standing Committee on Health, Aged Care and Sport Inquiry into the quality of care in residential aged care facilities in Australia (2018)

Recommendation 8

The Australian Government should, in collaboration with States and Territories, amend the incident reporting requirements in the *Aged Care Act 1997* (Cth) as recommended by the Australian Law Reform Commission in its report *Elder Abuse – A National Legal Response*. The incident reporting scheme should replace the current responsibilities in relation to reportable assaults in s63-1AA of the *Aged Care Act 1997* (Cth).

ALRC Recommendation 4–1 Aged care legislation should provide for a new serious incident response scheme for aged care. The scheme should require approved providers to notify to an independent oversight body:

(a) an allegation or a suspicion on reasonable grounds of a serious incident; and

(b) the outcome of an investigation into a serious incident, including findings and action taken.

ALRC Recommendation 4–2 The independent oversight body should monitor and oversee the approved provider's investigation of, and response to, serious incidents, and be empowered to conduct investigations of such incidents.

ALRC Recommendation 4–3 In residential care, a 'serious incident' should mean, when committed against a care recipient:

(a) physical, sexual or financial abuse;

(b) seriously inappropriate, improper, inhumane or cruel treatment;

(c) unexplained serious injury;

(d) neglect;

unless committed by another care recipient, in which case it should mean:

(e) sexual abuse;

(f) physical abuse causing serious injury; or

(g) an incident that is part of a pattern of abuse.

ALRC Recommendation 4–4 In home care or flexible care, 'serious incident' should mean physical, sexual or financial abuse committed by a staff member against a care recipient.

ALRC Recommendation 4–5 An act or omission that, in all the circumstances, causes harm that is trivial or negligible should not be considered a 'serious incident'.

ALRC Recommendation 4–6 The serious incident response scheme should:

(a) define 'staff member' consistently with the definition in s 63-1AA(9) of the Aged Care Act 1997 (Cth);

(b) require the approved provider to take reasonable measures to require staff members to report serious incidents;

(c) require the approved provider to ensure staff members are not victimised;

(d) protect informants' identities;

(e) not exempt serious incidents committed by a care recipient with a pre-diagnosed cognitive impairment against another care recipient; and

(f) authorise disclosure of personal information to police.

5.7. Leaving Residential Aged Care Facilities

Section six of the User Rights Principles 2014 made under the *Aged Care Act* 1997 (Cth) provides security of tenure for residents of RACFs. The section provides that a provider may only ask a care recipient to leave the RACF in certain prescribed circumstances. One of these circumstances is that the RACF no longer provides accommodation and care suitable for the care recipient, having regard to the care recipient's long-term needs. The long term needs of the care recipient must be assessed by either an aged care assessment team, or at least two medical or other health practitioners who meet the specified criteria, namely one must be independent of the provider and must be chosen by the care recipient, and both must be competent to assess the aged care needs of the care recipient.

Importantly, the RACF must not take action to make the care recipient leave the RACF before suitable alternative accommodation is available that is affordable by and meets the needs of the care recipient.

OPA guardians have reported cases where a RACF that is experiencing difficulties managing the behaviour of a resident will arrange for the transport of the resident to hospital, and then refuse to take the resident back once they are ready to be discharged from hospital.

OPA guardians can advocate for people in these situations to ensure that their right to tenure is respected and upheld. However, this practice may result in older people without that support being placed in unsuitable accommodation or becoming homeless.

Tony's story- Wrongful eviction from a RACF

OPA was guardian for a resident residing in a RACF. The RACF arranged for him to be admitted to hospital for medical care. When Tony was to be discharged from hospital, the RACF did not want him to be discharged back to the RACF. The guardian provided the RACF with information about the security of tenure provisions. As a result, the RACF

accepted Tony back, and then undertook the appropriate steps to evict him in accordance with the provisions of the Principles, including ensuring that Tony had alternative accommodation.

Jerry's story- Wrongfully attributing an expression of pain as a behaviour of concern

OPA was guardian for a man with intellectual disability and dementia who was non-verbal. Jerry lived in an RACF quite successfully after being transferred from a group home because of his age. After several months of no news, the guardian was advised by a hospital that the client had been admitted with 'behaviours of concern' and that the RACF refused to have him back. The hospital reported the client had presented with altered behaviour, was aggressive, assaulted a number of nursing staff and had a fever. He was treated with antibiotics but the RACF was 'resistive' to accepting Jerry back, claiming his placement there had been 'inappropriate'. The hospital changed some medications and decreased the doses of anti-psychotic the client had been prescribed by the GP. The guardian expressed concern that none of these behaviours had been evident before the client's placement at the RACF. The RACF advised that the client had not received any pain relief and that after he became aggressive, he was prescribed anti-psychotic medication which had not reduced the behaviours. On the day before he was sent to hospital, he was self-harming.

The RACF eventually accepted him back after the 'issues' with his health had been resolved. The hospital discovered that Jerry had a septic infection after swallowing some objects. Jerry's 'behaviours of concern' were his attempt to communicate with the RACF staff about his pain. The RACF staff are now aware that if Jerry behaviours of concern re-appear then he should be checked for an infection.

In addition to the following recommendation, OPA refers to and repeats comments made in section 5.5. in relation to the importance of the National Advocacy Program, and to recommendation 6 in this submission regarding a proposed power to commence an own motion inquiry.

Recommendation 9

The Australian Government should amend the Aged Care Act 1997 to require RACFs to notify the Aged Care Quality and Safety Commission whenever a recipient is transferred to hospital.

6. Decision making

All adults are presumed to have decision-making capacity unless there is evidence to the contrary. OPA recognises that capacity is specific to each decision and that a person has decision making capacity to make a decision if they are given practicable and appropriate support to do so.

If a person lacks decision making capacity, a substitute decision maker may be legally authorised to make decisions on their behalf. Substitute decision-makers include guardians or administrators appointed by an administrative tribunal (i.e. VCAT in Victoria) or an attorney for personal or financial matters appointed by the person. The exercise of substitute decision making (largely through guardianship and power of attorney legislation) in aged care will vary from state to state, as it is dependent both upon the legislation and the interpretation by the various Tribunals entrusted with determining the need for guardianship.

By reason of its mandate and by the nature of its work, OPA sees only a small proportion, and an atypical one, of all persons entering aged care. The guardianship that is provided by OPA for older persons is limited in what it can do simply by the limited nature of the appointment: guardianship orders are time-limited and relate to specific decisions that need to be made. In the aged care sector, OPA notes that most of the decisions made by OPA guardians relate to risk management or to privacy. Once the relevant decisions have been made, the guardianship order can be revoked and therefore OPA does not and cannot provide a constant presence or monitor the wellbeing of the represented person.

In the period following the introduction of the User Rights Principles to the *Aged Care Act 1997* (Cth) in 2014, OPA guardians were often unable to place a person on the waitlist for a RACF unless the person had an appointed power of attorney or administrator. It would appear that this requirement was to ensure administrative efficiency for the RACFs concerned— who probably wanted to ensure that they were paid on time —rather than to promote the rights of the resident. While this practice seems to be less common now, it still occurs in some instances. In many instances, where the resident does not have the capacity to make an EPA, a family member may be able to pay RACF accounts without having to be appointed as an administrator by VCAT. This would be a far less restrictive intervention on the rights of the resident.

Furthermore, it is OPA's experience that there is a widespread misunderstanding in the aged care sector of the legislative obligations around decision making mechanisms as is evident in the following observations:

- The reliance on informal mechanisms for decision making is variable from one facility to another. Such mechanisms often work well but are not necessarily transparent or consistent across the sector.

- Facilities often incorrectly attribute decision make authority to attorneys that go beyond the scope of their authority (e.g. financial powers of attorney will be asked to consent to matters requiring a power of attorney with authority for personal decisions).

- Some RACFs deal with a person's appointed attorney despite the person having capacity.

- Some guardians face difficulties in having their authority as a substitute decision-maker recognised, which can delay the implementation of services for the person.

OPA supports the Qld OPA observation that

> there has been little support or guidance provide by the Australian Government to residential aged care providers in relation to appropriate policy and practice in terms of recognising and upholding the rights of older people to make their own decisions and exercise their legal capacity.[65]

In this section, OPA recommends systemic changes that would promote the autonomy of aged care consumers and support them to exercise their decision-making capacity whenever possible.

Recommendation 10

The Australian Government should provide amend the principles to of the Aged Care Act 1997 (Cth) so as to prevent residential aged care facilities from requiring prospective residential aged care residents to have an enduring power of attorney or guardianship order in place as condition of entry into a facility.

6.1. Decision making principles

As identified above, aged care services often do not respect or acknowledge the decision-making ability of older persons. OPA continues to advocate for the equal rights of all adults to make decisions that affect their lives and to be supported to do so.

In *Equality, Capacity and Disability in Commonwealth Laws*, the ALRC proposed four decision making principles, consistent with the UN CRPD, as a framework for a national decision-making model. The decision-making principles are:

1. The equal right to make decisions: All adults have an equal right to make decisions that affect their lives and to have those decisions respected.

2. Support: Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.

3. Will, preferences and rights: The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.

4. Safeguards: Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.

[65] Office of the Public Advocate (QLD), Submission 17.

OPA supports OPA Qld's recommendation 11 in its submission to this Royal Commission.[66]

Recommendation 11

The Australian Government should formally incorporate the four decision-making principles and accompanying guidelines recommended by the Australian Law Reform Commission in its report *Equality, Capacity and Disability in Commonwealth Laws* report into the Quality of Care Principles.

OPA notes the Australian Government has yet to respond to the ALRC report. Standard 1 of the new Aged Care Quality Standards touches upon a consumer's right to be supported to exercise choice and independence but does not go so far as replicating the ALRC decision making principles. In Victoria, the *Guardianship and Administration Act 2019* incorporates these principles. Notwithstanding this, OPA continues to advocate for reform across state, territory, and Commonwealth laws to fully translate the principles into practice and ensure consistency across the aged care sector.

Recommendation 12

The Aged Care Quality and Safety Commission should provide education and training for the aged care sector about:

- **decision-making support**
- **the roles and responsibilities of attorneys, guardians and financial administrators**
- **the rights of people with impaired decision-making capacity to:**
    - **respect and dignity;**
    - **have their views and preferences considered and acted upon; and**
    - **be supported to exercise their autonomy and agency to the greatest extent possible.**

The Aged Care Quality and Safety Commission should also collaborate with the Australian Guardianship and Administrators Council (AGAC) when developing the education and training to ensure that it accurately represents the relevant law in each state or territory.[67]

6.2. Supported decision making

Decision-making capacity exists if a person is given practicable and appropriate support to do so. In order to achieve genuine and meaningful person-centred and consumer driven aged care, consumers must be provided with the supports they require to maintain their autonomy. Indeed, The UN CRPD requires that people with disability are 'closely consulted and actively involved [in] decision making processes [involving them]'.[68]

Supported decision-making is the provision of decision-making support which enables people with cognitive disabilities to exercise their legal decision-making rights (also called legal capacity). Supported decision-making is one of the most important human rights

[66] Ibid.
[67] Ibid. OPA has amended recommendation 12 of the Office of the Public Advocate (QLD) in line with its own preferred position.
[68] UN CRPD Article 4 (General Obligations) (3).

concepts for people with cognitive disability. It points to the rights of all people to play active roles in decisions that affect them.

In Victoria, a number of legislative instruments allow a person to legally appoint a decision-making supporter and under the new *Guardianship and Administration Act 2019* (Vic), VCAT will also be able to make such an appointment if a person lacks the capacity to do so. These provisions have strong regard to the UNCRPD, recognising the need to support persons with a disability to make, participate in, and implement decision that affect their lives.

Supported decision-making provides an important alternative to substitute decision making and in OPA's experience, it can work well although it is more resource intensive. Unless adequate allowance is made for the resources required, supported decision-making will not succeed.

Supported decision-making provides an important alternative to substitute decision making and must be provided with adequate resources to succeed.

6.3. National consistency of enduring powers of attorney laws

As identified above, in many cases staff at RACFs do not respect or acknowledge the decision-making ability of older persons. There has been growing awareness in Australia, and internationally, that enduring powers of attorney (EPOA) are not well understood and are often misused. The misuse of these documents is a form of elder abuse, and the impacts of that abuse on older people can be devastating.

However, the laws concerning enduring powers are different in each of the eight states and territories. As a result, it is difficult for RACFs and other institutions and organisation to offer nationally consistent training for staff. Nationally consistent laws concerning enduring powers would result in elevated expectations on RACFs to safeguard the rights of older people.

To that end, the 2017 ALRC Report, *Elder Abuse – A National Legal Response*, recommended, amongst other things, the establishment of a national online registration scheme after achieving consistency of these laws.

In March 2018, the Australian Attorney General's Department asked AGAC to prepare an options paper about enduring appointment laws and practices throughout Australia, for consideration by the Council of Attorneys-General (CAG).

The options paper analyses:

- similarities and differences in the variety of laws and appointments, focusing on laws and practices concerning enduring appointments with financial responsibilities, and
- the possible future development of model national, or nationally-consistent legislation for EPOAs.

It identifies three options, two of which may achieve some degree of national consistency of financial enduring appointments, which may mitigate and prevent elder abuse.

Work on the options paper was led by OPA and was overseen by a governance group, comprising representatives from AGAC member organisations and the Australian Attorney-General's Department. In researching the options paper, OPA sought feedback on drafts of the options paper from AGAC members, state and territory government officials via the Working Group, and the Law Council of Australia (LCA). The LCA provided feedback on the penultimate draft of the options paper via a formal submission developed in consultation with their sixteen member associations.

In November 2018, CAG 'supported the Australian Government advancing the development of a National Register and agreed to continue work on developing options for greater consistency of national arrangements for financial EPOAs'.

Victoria has committed to reviewing Victorian laws against the options identified in the AGAC paper.

OPA recommends that the remaining states and territories also agree to review the laws in their jurisdiction against the options identified in the paper, and that state and territory governments continue to work on developing options for greater consistency of national arrangements for financial EPOAs.

Recommendation 13

State and territory governments should agree to review their laws concerning financial enduring powers of attorney against the options in the Australian Guardianship and Administrators Council paper and continue to work on developing options for greater consistency of national arrangements for financial Enduring Powers of Attorney.

6.4. Advance care planning

Advance care planning in Victoria is the process of planning for future medical treatment that may be required at a time when the person is not able to make the medical treatment decision Advance care planning is grounded in the human right not to have medical treatment without full free and informed consent. It is an expression of autonomy that involves making and communicating decisions and expressing preferences and values.

In Victoria, advance care planning may consist of electing one or all of three options set out in the MTPD Act, namely the appointment of a medical treatment decision maker, the appointment of a support person, and the completion of an advance care directive. A person with decision making capacity can make an advance care directive in relation to any type of medical treatment.

There are many life stages and transitions that can provoke a person to consider advance care planning. This could include, for example, an admission into a RACF, which is a time when a person typically has increasing health-related needs, such as support with their daily activities. Some states and territories have developed legislative instruments to

improve discussions around end-of-life care, for instance, the MTPD Act in Victoria and the *Advance Care Directives Act 2013* in South Australia. It should be noted that this is an area that lacks national consistency as these interventions are also enshrined in state law.

OPA advocate guardians observe that it is common practice for RACFs to request incoming residents to complete advance care planning forms that specify whether residents are to be resuscitated or not, in the event that such a decision is required in the future, or to enable family members of residents to make the decision on their behalf.

While OPA recommends that all adults consider advance care planning options, there is no doubt that the timing of the approach when a resident is entering the RACF and the directness with which this issue is broached by many facilities can be highly confronting for individuals and families. Certainly, no person should be coerced by well-meaning family members or health systems to engage in any particular form of advance care planning. OPA encourages RACFs to promote advance care planning to their residents in a respectful way and to use documentation that is consistent with the relevant legislation.

On occasions, OPA has been concerned that the documentation developed by some RACFs have not been consistent with Victorian law. In particular, OPA has seen some forms that purport to invest a person with decision making authority in relation to a resident that they do not have, or cannot have, under Victorian law.

Advance care planning is what a person does for him or herself. While the terminology of advance care planning is used in different ways in the health and aged care sectors, the advance care planning options provided for in the MTPD Act require the person to have decision making capacity.

If a person does not have decision making capacity to make an advance care directive, they may nonetheless have the ability to communicate their preferences and values for medical treatment. Under Victorian legislation, no other person, not even a medical treatment decision maker, can make an advance care directive for another person whether that person does or does not have decision-making capacity.

OPA advocates for individuals to be encouraged and supported to express their preferences and values, so long as they are able to do so. Advance care planning should incorporate the following key elements: respectful conversations, the appointment of support persons, and the documentation of wishes if that is the appropriate outcome for the person involved.

To give effect to this, OPA has published a practical tool for family members who wish to document what they understand to be the resident's preferences and values. It is called *Supported Decision Making in Victoria: A guide for families and carers*. This document is intended to be used by a medical treatment decision maker if they need to make a medical treatment decision, however, it is not legally binding.

The Royal Commission's background paper on advance care planning attributes low uptake to 'a lack of awareness and understanding about advance care planning in the community' OPA questions whether the low uptake may also be explained by its implementation.

Most importantly, OPA notes that the number of completed advance care planning documents may not be the most meaningful measure of a successful approach to advance care planning, given that advance care planning is voluntary and the choice to elect to complete any of the documentation ultimately lies with the resident.

OPA is aware that RACFs do not always follow these principles for reasons of administrative convenience and resource constraints. OPA encourages the Australian Government to develop an approach that is predicated on human rights and that enables RACFs to fully support residents to express their preferences and values. Alongside measuring the number of documents signed, a more indicative key performance indicator may be around the quality of engagement with clients.

RACFs must now comply with the Aged Care Quality Standards that commenced on 1 July 2019. The standards emphasise the rights of consumers to exercise choice and independence, to be supported to do so, to make decisions about their own care and to make decisions about when others should be involved in their care.

Standard 2 of the Aged Care Quality Standards prescribes ‘ongoing assessment and planning with consumers’, which is particularly relevant to advance care planning. Part of the requirement of this is: ‘assessment and planning identifies and addresses the consumer’s current needs, goals and preferences including advance care planning and end of life planning if the consumer wishes’.

OPA considers advance care planning should be implemented within a human rights framework, in full recognition that it is an expression of a person’s autonomy. Substitute decision-making, when required, should be an implementation of the person’s autonomy.

Recommendation 14

The Australian government should develop guidelines and improved training for residential aged care staff to ensure that they understand and meet their obligations regarding advance care planning and decision making including meaningful engagement with residents on these topics.

7. Quality of aged care services

The nature of guardianship limits OPA's involvement to times when a decision needs to be made and a person does not have the capacity to do so. While OPA's evidence is partial to its unique experience, it can nonetheless reasonably be extrapolated from it as to what might be the more widespread experience of aged care consumers who have limited supports and do not have someone to advocate for them.

OPA observes that while some services excel in the delivery of high-quality services, there is considerable variability across the sector. The inconsistencies result in inequities, with some residents being provided care of a lower standard than others.

At a cultural level, OPA identifies a failure to fully recognise personhood. Aged care services should be delivered in a holistic manner, for instance considering a person's mental and emotional wellbeing rather than concentrating on the management of outward behaviours. Presently, this is prevented by staffing and other pressures which force the focus of care onto a person's physical care needs. The consequence is a failure to prioritise life affirming activities. OPA repeats that older persons can continue to live fulfilling lives, and that the loss of capacity should not equal a full loss of autonomy or dignity.

In this section, OPA analyses operational barriers to the realisation of a person-centred approach in aged care services.

7.1. Navigating the aged care sector

There are built-in barriers that prevent aged care consumers and potential consumers from accessing and engaging with the Aged Care Assessment Service (ACAS) and the My Aged Care portal. Currently, the only ways to engage with these two services are through their website or via telephone. This lack of accessibility can disadvantage persons with cognitive impairment and lead to accommodations that are overly restrictive. For instance, OPA worked with a client living in a disability accommodation service who required an ACAS assessment but because of their disability, was not able to communicate over the phone. An application for the appointment of a guardian was made to VCAT for the sole purpose of organizing a referral to ACAS. This was further complicated by the administrative requirement that ACAS receive a referral before being able to intervene in an outreach capacity.

Guardianship legislation cites that guardianship appointments should be used as a last resort and that less restrictive options need to be explored prior to the appointment of a guardian. If guardianship appointments are made instrumentally, that is to compensate for the shortcomings of an inaccessible system (e.g. in the case above for the simple task of organising a referral), this constitutes a form of disability discrimination. This is because it imposes a restriction on a person's freedom of decision-making rather than requiring reasonable accommodations to be put in place by the service provider (in this case, ACAS).

OPA considers there should be an ACAS and My Aged Care 'shop front' to provide an option for clients with limited capacity to communicate to engage with the service in person.

Recommendation 15

The Australian Government should fund an Aged Care Assessment Service/My Aged Care 'shopfront' to provide an accessible option for all clients, including those with cognitive disability, to communicate to engage with the service in person.

7.2. Access

When organising aged care services (whether in a person's home or in a RACF), OPA guardians are often restricted by the low number of ACAS packages. There is an important flaw in the system whereby a person can be assessed by ACAS as requiring a certain level of supports, but if the quota for packages of that level has been allocated, the person is defaulted to a lower level package.

An allocation system that operates on a 'first come, first serve' basis rather than on assessed needs is inequitable. Indeed, in this environment, a person who has the financial means may choose to fund in-home supports out-of-pocket while they wait for an adequate package, while those without this privilege suffer and can see their health and wellbeing deteriorate more quickly than it would have had they been provided with the supports to stay well.

Home care packages are a critical service; they can sustain a person's supports and enable them to remain in their homes, a more comfortable and less restrictive environment, for as long as possible. OPA observes a significant shortage of higher-level packages (i.e. level 3 and 4) for its clients. The consequence is real; OPA guardians have resorted to prematurely consenting to relocating a person into residential aged care facility where they can access the level of supports they need, even though it may not be the preferred option for the represented person.

OPA appreciates that My Aged Care operates with a priority triage system, however even for clients under guardianship who would typically classify as 'high priority', the average wait time edges on eighteen months. A person's wellbeing can significantly deteriorate during this time if they are not accessing the required supports.

The discrepancy between supply and demand points to a serious failure of the market.

A further issue is the cost of case management, which can eat up half the cost of the package, reducing the funding available for direct supports. OPA recognises that it can take time to set up services for a person. However, OPA fails to understand why once services are set up and less case management is required, the fees for case management do not diminish accordingly. There needs to be greater transparency in how case management fees are calculated. It would also be useful if consumers and guardians of these services were able to compare the value for money of case management fees from different agencies.

Lily's story- Cost of case management in aged care packages

OPA was appointed guardian by VCAT for Lily and had the authority to make decisions regarding accommodation and access to services. Lily received an ACAS assessment. Lily self-funded her care supports including a private case manager. Eventually, Lily ran out of funds to fund her supports. Without these supports, Lily could not remain at home. Shortly afterwards, Lily required hospitalisation and surgery, after which her health deteriorated further. The guardian then placed Lily in an RACF.

The impost of additional transport costs can further disadvantage people living in rural and regional areas. OPA Guardians have commented that in these areas, because of the distances travelled, agencies charge their clients travel time for the support worker. This cost of this is deducted from their direct support hours. This impost further reduces the support available. Additional funding should be provided to cover carer transport in these areas so that consumers do not lose direct support hours because they live rural and regional Victoria.

OPA is also aware that the waiting time for a home care package in a rural area can be excessive. Guardians have reported a wait of two years in some rural areas.

Peter's story- Premature admission to an RACF in a rural area

Peter has dementia and lived on an isolated rural property. Because of his ill-health, he was taken to hospital. The hospital felt that Peter could not return home without an appropriate home care package. The guardian was advised that the wait in their region for a package was two years. Peter could not fund the level of support he required. The hospital wanted Peter discharged. The guardian felt that Peter should have the right to live in the community however, no support package was available to enable the guardian to give effect to his wishes. The guardian, therefore, had no option but to place Peter in an RACF prematurely.

Recommendation 16

The Australian Government should increase funding for level 3 and level 4 aged care funding packages to adequately meet demand. An additional amount of funding is required for rural areas to ensure equity of access to packages is maintained regardless of a person's location.

Recommendation 17

The Australian Government should fund a component of case management in home care packages.

Recommendation 18

The Australian Government should fund the cost of travel time for support workers in rural and regional areas.

7.3. Health care

If a person is faced with reduced physical mobility, but can nonetheless remain at home, they should be able to receive home visits from their general practitioner (GP). A person should not be required to move into a RACF, an unnecessarily restrictive environment simply to access health care services. This misplaces responsibility onto consumers to make up for the accessibility shortcomings of the health system. OPA recommends increased financial incentives for GPs to conduct home visits.

Recommendation 19

The Australian Government should increase the financial incentives for general practitioners to visit older people in their homes to prevent premature admission to residential aged care facilities solely for the purpose of accessing health care services.

OPA guardians are aware that access to general practitioners for people living in RACF is particularly difficult in rural areas, where there is a shortage of GPs. Those GPs that are available are reluctant to take on new patients in RACFs because of the lower level of reimbursement they receive from these patients. The lack of access to GPs risks residents receiving sub-optimal care and will over time place additional strain on tertiary health services in the area.

Recommendation 20

The Australian Government should increase the financial incentives for general practitioners to visit older people in residential aged care facilities in rural areas.

Once a person enters a RACF, they are automatically connected with medical practitioners associated with the facility. OPA agrees that all residents should be afforded access to health care, however, residents should also have the opportunity to continue to receive health care from another general practitioner should they wish to do so.

Recommendation 21

The Australian Government should amend the principles of the *Aged Care Act* 1997 (Cth) to require that residents of aged care facilities are able to have a general practitioner of their own choosing visit them in the facility, if the resident wishes that to occur.

OPA also stresses the importance of allied health services and recommends that access to these services be facilitated for consumers within RACFs. See section 7.5 below for a discussion on mental health.

Recommendation 22

The Australian Government should amend the principles of the Aged Care Act 1997 (Cth) and provide financial incentives to enable allied health professionals to visit residents in residential aged care facilities.

7.4. Palliative and end of life care

Most people entering residential aged care are likely to remain there until their death. As they approach the end of their lives, all people should be entitled to relief from pain, suffering, and discomfort. Yet, OPA is aware that, despite most RACFs offering palliative care, RACFs continue to refer residents to hospitals to receive palliative care when treatment and care could instead be provided in the facility. This can happen despite a individual's stated wish to remain at the facility. A lack of staffing, lack of awareness and access to community palliative care services, as well as appropriate training on the provision of palliative care— particularly on weekends and evenings— may lead to locum doctors and/or ambulances being called to transport people to hospital unnecessarily. All RACFs should be equipped and resourced to provide palliative care when necessary.

RACF staff should be appropriately skilled, resourced and trained to provide palliative care to residents who wish to be cared for at the facility. Aged care facilities should be able to identify when they need more specialised input from community palliative care services who, in turn, require adequate resourcing to provide this additional support. All efforts should be made for residents to receive care in the RACF rather than being sent to hospital unnecessarily.

OPA further supports Qld OPA's submission to this Royal Commission on this topic (Recommendation 9).

Recommendation 23

The Australian Government should incorporate the *Principles for Palliative and End-of-Life Care in Residential Aged Care* into the Quality of Care Principles for aged care and require that compliance with these standards be a component of the assessment for accreditation of aged care providers.

7.5. Mental health and wellbeing

The discussion around mental health services for older people is complicated by the fact that mental health services are funded by both state and Australian governments. Notwithstanding this shared responsibility, OPA considers mental health and wellbeing to be an important topic to raise in the context of this Royal Commission.

7.5.1. Access to mental health supports for older people

The evidence provided to the Royal Commission into Victoria's mental health system is confirming that the Victorian mental health system operates with a 'missing middle'. In other words, the system is crisis driven and few services are available for people until they reach a point of crisis. This is true across adult services but for older people the only age-appropriate option is aged mental health residential care facilities.

Older people with mental illness are confronted with unique challenges when seeking mental health supports. Individuals over the age of sixty-five are ineligible for the NDIS and thus cannot access psychosocial disability supports through the scheme. Consumers in RACFs cannot access community based mental health supports but are not consistently provided with an equivalently comprehensive network of mental health supports. These systemic barriers result in the mental health needs of older people often being neglected until they reach a crisis point. If, and when this occurs, consumers are directed to acute mental health services, where, in Victoria, they are predominantly referred to aged mental health residential care facilities by reason of their age.

These facilities are a needed specialised service and are generally well suited to individuals with severe and complex cognitive impairments. Typically, the individuals who are admitted are those with complicated presentations of dementia such as challenging behaviours and a limited ability to communicate. However, OPA observes that these facilities can sometimes be used less appropriately for more fit and able older persons with mental illness. For a person with a symptomatology that is less acute or not related to dementia, an acute aged mental health facility can be a distressing place and it can impede their recovery and wellbeing.

In terms of community-based mental health supports, the NDIS reform has caused significant shifts in the service landscape. The closure of two Commonwealth funded community-based outreach mental health services (i.e. Personal Helpers and Mentors Service (PHaMS) and Day to Day Living) has been a noticeable loss. Clients within these services were supported to test their eligibility for the NDIS and for people over sixty-five years of age who would not be eligible for the scheme, the Commonwealth Continuity of Support (CoS) program was established. The Commonwealth CoS program funds mental health supports through Primary Health Networks. OPA welcomes the intention of the CoS but notes that there is likely to be substantial differences between a community based mental health service and one that is provided through a primary health network. Indeed, they will take radically different approaches in their model of care. The shift to the NDIS disproportionately affects older persons with mental illness who were not afforded equivalent supports in the transition. OPA queries whether assessment carried out as part of ACAS are sufficiently geared towards identifying mental health issues.

Recommendation 24

ACAS should be reviewed to ensure it uses appropriate tools to screen for mental health issues and that it responds with an appropriate and streamlined referral pathway.

Similarly, consumers living within RACFs face limited choice when accessing mental health services. Mental health services for older people living in RACFs are also limited to those provided through their Primary Health Network. This removes the option for community-based services (if there were any available) and restricts opportunities to access allied health services. Furthermore, older people in RACFs are excluded from the Medical Benefits Schedule provision for GP mental health treatment plans. All these restrictions limit the types of mental health supports RACF residents can access and make it all the more likely that people in RACF will obtain mental health support from their general practitioner. As a result, it is likely that a medical model that relies on medication will be favoured. This, coupled with a weak safeguarding environment, can lead to the use of restrictive practices (in this case, chemical restraint) without an appropriate or evidence-based consideration of alternative, possibly more therapeutic or recovery-oriented approaches.

OPA recognises the Australian Government's investment in this area but considers more could be done and makes the following recommendation

Recommendation 25

The Medical Benefits Schedule should be amended to provide access to specialist mental health services, allied health services, and in-reach specialists to all residents in residential aged care facilities.

In section 8.6. of this submission, OPA expands on workforce issues.

7.5.2. Recovery model

By virtue of its investigation and guardianship functions, OPA is in contact with many older people who are living with mental illness and/or caring for someone (e.g. an adult child or a life partner) with mental illness.

OPA guardians note that the medical approach to the treatment of mental illness is often favoured with this population. Furthermore, a large proportion of age-specific mental health services are specialised in the treatment of dementia.

OPA questions whether there is a need to reconsider the recovery-oriented practice framework to improve the response to challenges that are unique to older persons. For instance, some of the key life transitions that can impact one's mental health and wellbeing in ageing are: retirement or job loss, loneliness and social isolation, physical wellbeing and mobility, loss and grieving. An approach that is based on social determinants of health understands that 'good' mental health is the result of wellbeing in all aspects of one's life. A person's physical health, spirituality, sense of social participation for example can influence their state of emotional and mental wellbeing.

OPA recommends that a 'life-stages' paradigm could inform a more holistic model of care.

In its submission to the Royal Commission into Victoria' mental health system, OPA recommended that 'the Chief Psychiatrist and the Chief Mental Health Nurse should review the clinical governance, referral pathways, and model of care of aged mental health residential care facilities across Victoria to ensure care is consistent across all aged mental health facilities.' While this recommendation was addressed to state-based authorities and was made in relation to aged mental health residential services, it has relevance for this Royal Commission.

Given the shared responsibilities across the mental health, health, and aged care for the mental health of older people, OPA considers there is a role for clinical leadership at a national level which could inform state-based approaches.

Recommendation 26

The Australian Government and the Victorian Chief Psychiatrist and the Chief Mental Health Nurse and their equivalents in other states and territories should review the clinical governance, referral pathways (including age requirements), and model of care of aged mental health residential care facilities to ensure care is consistent across all aged mental health facilities.

7.5.3. Prevention

Human services will be increasingly called on to support an ageing population. OPA considers there is a pressing need to consider prevention initiatives to support people to thrive in their old age and maintain good mental health for as long as possible.

A holistic approach is one that considers all aspects of a person's life that contribute to good mental health. This should be the standard within home based aged care services, as well as within RACFs.

7.6. Workforce

In any sector, the workforce represents an essential component and has the potential to elevate the quality of services that are provided.

The aged care sector has high rates of casualization and staff turnover which has implications for the quality of care. A stable and regular workforce generally provides better service than a casual one because of the benefits of continuity and stability in care. This means that the individual needs of residents could be passed over in the interests of organisational efficiency. At a practical level, for example, staff turnover within a facility means that the same resident would frequently be showered by different staff members. The constant turnover of staff can be very distressing for residents, particularly for those who do not cope well with change. This may unsettle residents, leading to some exhibiting challenging behaviours. This environment can contribute to the use of restrictive practices, such as chemical restraint to manage these challenging behaviours.

OPA questions whether the training provided to personal support workers equips them with the skills they will require once on-the-ground. The curriculum for personal care attendants (in a Certificate III in Aged Care) does not include compulsory training on mental health or

dementia. While OPA observes that many personal care attendants are trained in responding to dementia related behaviours and symptoms, it is also true that few are trained in responding to mental health and/or disability related needs.

Poorly trained staff are unlikely to have a sophisticated understanding of disability and complex behaviours and may be unable to manage people with complex needs or to recognise and report actions that put residents at risk. Strong leadership and continuous professional development, supervision and support on the ground by more highly trained and experienced staff is needed to support less experienced staff to better understand and to learn appropriate communication, support and behavioural management strategies.

More than 50 per cent of RACF residents have a diagnosis of dementia. However, for most health practitioners (doctors and nurses), mental health is only a small component of a more general training schedule and therefore only a small portion of that training focuses specifically on dementia, disability and other mental health issues in older people. Unless staff are properly trained in responding to the behavioural and psychological symptoms of dementia in a compassionate and supportive way, medication and restrictive interventions will continue to be the preferred way to manage residents (especially when this is condoned through the prescriptions made by GPs and psychiatrists).

Additional training and minimum qualifications of staff should be mandatory, and the curriculum should better align with the skills that are required.

Recommendation 27

The Australian Government should amend the curriculum for training in the aged care sector to include compulsory training on the behavioural and psychological symptoms of dementia and mental health management strategies. Training should focus on increasing the skills of staff to better manage symptoms so that a reliance on restrictive practices is reduced.

OPA also considers the workforce in this sector should receive additional training on mental health and endorses a recommendation made by Mental Health Victoria in their submission to this Royal Commission.

Recommendation 28

The Aged Care Workforce Strategy should include explicit consideration of the workforce's requisite mental health capability requirements. The Australian Government should investigate the mental health skills and experience competency needs of the aged care workforce.

No one system can fully ensure that staff are safe to work with people with disability. It is critical, therefore, that robust safeguarding requirements are implemented in order to protect persons with disability from violence, abuse, neglect and exploitation.

Guardians have commented that when they visit RACFs, they often find that the staff are so busy, it can be hard to find a staff member to talk to on a visit about an OPA client who had been placed there. Moreover, this also leaves little time for residents to simply have a chat or share a cup of tea with their staff. These are the activities that are life affirming, but

unfortunately fall to the bottom of the priority list. In a similar way, physical care outweighs emotional care, because of seeming ‘urgency’.

As mentioned throughout this submission, pressure to increase organisational efficiency within the sector has come at the detriment of a person-centred approach that recognises the humanity and dignity in each one of us. Low staff-to- resident ratios can result in reduced in-house recreational activities for residents. These activities are an important means for maintaining quality of life, assisting residents to be engaged and to live a meaningful life. OPA understands that practitioners have good intentions but often work in facilities that are understaffed. When facing time pressures, it is inevitable that the tasks that are favoured are those relating to physical care as these seem most urgent. It will be impossible to shift the paradigm within the sector towards a more holistic model until staffing pressures and staff training is addressed.

Workplace culture is a central determinant of the way staff treat people with disability. Workplace culture inevitably affects the way staff report and respond to allegations of abuse, neglect and exploitation within their own workplace. A workplace culture that is person-centred and human rights focussed is the type of workplace that will respond most effectively to any allegations of abuse, neglect and exploitation of residents that occur and promote zero tolerance of such behaviour.

8. Young people in nursing homes

When the NDIS was introduced, 6,000 young people were living in RACFs and were deemed a 'priority group' in the transition to the NDIS. Yet, five years on at the end of 2018, most of the cohort had an active NDIS plan but 5,905 were still residing in a RACF.

The development of the NDIS Specialist Disability Accommodation (SDA) market will inevitably take time. This is compounded by delays in the planning process and SDA approval. Indeed, OPA Guardians from the hospital and intake team have remarked that the administrative process to move someone into aged care is much quicker than the NDIS SDA pathway. When a younger person is awaiting discharge from a hospital, these bureaucratic hurdles often result in guardians consenting to a placement into a residential aged care facility, for lack of an alternative NDIS-funded vacancy. It takes strong and persistent advocacy from guardians to prevent younger people being moved from hospital into RACFs.

Joseph's story- Young person at risk of premature entry into a RACF

Joseph is in his forties and was in hospital with a severe medical condition that requires significant carer support. The hospital wanted him to go into aged care because he had been in their ward for more than six months. The guardian contacted both the Young Person in Nursing Home Coalition to assist in identifying appropriate accommodation options and the NDIS. After several weeks, a non-SDA property was found, and the person will move in soon.

Earlier this year, the Australian Government announced the *Younger People in Residential Aged Care Action Plan*. OPA welcomes the development of the Action Plan but considers that its timelines are too long and that the goal to reduce the number of younger people by half by 2025 is a worthy goal that does not go far enough.

Lisa Corcoran's account of her experience of living as a young person in a RACF to this Royal Commission supports OPA's view of the inappropriateness of RACFs for young people with disability. Lisa's transfer to SDA accommodation in the near future is most welcome and highlights the importance of making more SDA readily available to avoid further inappropriate admissions.[69]

OPA is aware of the Summer Foundation's work to build a prototype portable accessible home, known as 'rapid interim housing',[70] which could be rapidly deployed to create a temporary housing option, until the person is able to move into SDA or other accessible housing. Further investment in this type of housing could reduce the number of younger

[69] https://www.agedcareguide.com.au/talking-aged-care/royal-commission-my-number-one-goal-is-to-get-the-f-out-of-a-nursing-home

[70] https://www.summerfoundation.org.au/project/rapid-interim-housing/

people in nursing homes, more quickly and more efficiently than the Australian Government's Action Plan.

Guardians have noted that it is particularly difficult to find age-appropriate disability specific accommodation in rural and regional areas, particularly if the person has complex needs. In a rural area, the particular people with complex support needs are known to the few available service providers, who often say they cannot support the person concerned. This can mean that no appropriate service provider is available, which can either lead to a lack of necessary care or it may force the person to move to a larger metropolitan city away from their family and friends. This situation may be particularly disconcerting for Aboriginal and Torres Strait Islander peoples who may wish to live on country and be near their kin.

OPA repeats a recommendation made in its report *The Illusion of Choice and Control.*

Recommendation 29

In order to reduce the number of younger people in residential aged care, the National Disability Insurance Agency, in conjunction with the Australian and Victorian Governments, should adjust market levers (including the pricing framework) to stimulate and ensure that the Specialist Disability Accommodation provision is able to meet existing and future demand.[71]

OPA is aware that many younger people living in RACF have complex health needs which cannot be met by disability support workers. This is often one of the reasons that young people are forced to move int RACFs. OPA strongly supports Qld OPA's recommendation on this issue to this Royal Commission.

Recommendation 30

The Australian Government should, as a matter of urgency, seek to clarify and finally settle with State and Territory governments the funding issues associated with the provision of necessary health supports for NDIS participants with complex health and disability needs who are wanting to transition from residential aged care facilities (and other health and disability facilities) to community-based accommodation.[72]

[71] Office of the Public Advocate (Vic), *The Illusion of Choice and Control* (2018) 45.
[72] Office of the Public Advocate (QLD) *Submission 17.*

9. What makes a good residential aged care facility?

By way of conclusion, OPA would like briefly to make some suggestions about what a safe and quality RACF should look like. These suggestions have come out of the issues raised in this submission and from the issues raised in OPA's Notice to Give previously supplied to this Royal Commission.

1. The RACF has a person-centred environment

2. There is a balance between safety and dignity of risk

3. The care is adapted and modified to fit the individual needs of the residents. People with complex needs would benefit when their support needs are looked after in a more individualised manner.

4. There is flexibility in scheduling and/or choice of activities for residents, and in finding ways to incorporate individualised passions into the day-to-day operation of the aged care facility.

5. Activities outside the facility are regularly provided for residents.

6. The care model is based on residents having a purpose to their day and engaging in activities that tap into their personal histories and interests.

7. Higher resident-to-staff ratios that enable staff to have sufficient time to get to know the residents contributes to higher satisfaction for residents and for staff.
8. Residents are able to eat or wake up when they want and are able to engage in activities that have provided joy in the past.

9. Providing choice about when and what a resident eats, including the quality of food variety in food, and the availability of culturally appropriate food.

10. RACFs are engaged with their local community to enable residents to access community activities and shared places. In rural and regional centres, RACFs are attached to a health network to facilitate access to resources and responses when needed.

11. There are comfortable rooms with a choice of single rooms, double rooms and double beds.

12. There are smaller sized aged care facilities.

13. The RACF benchmarks their practice against the new Aged Care Standards and against recognised good practice, informed by residents of the RACF.

Appendix A

This appendix is an example of a form used by an RACF to meet the Restraint Minimisation Principles which are discussed in section 5.1.1. of this submission. It is de-identified. To open this pdf double click it.

OPA VIC submission Append

Appendix B

This appendix relates to Julia's story on p.24 of this submission and has been deidentified except for the unidentified doctor's comments regarding Julia. To open this pdf double click it.

OPA VIC submission Append

Restraint Authorisation

NOTE: *This form is to be read in conjunction with the latest restraint assessment, the restraint assessment is to be printed and attached to this document. This form must be replaced in its entirety every 12 months or earlier if required.*

Restraint is defined in the Quality of Care Principles 2014 to mean: "*any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement*". No restraint can be applied without medical review and consumer/ representative's consent.

Consumer's Name:	
Neighbourhood	Room No:

Physical restraint *means any restraint other than:*
(a) a chemical restraint; or
(b) the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

Physical Restraint ☐

Type of restraint to be used:

_____

Note: A physical restraint must not be used unless there is:
(i) an assessment by a GP or Nurse Practitioner – this person must have day-to-day knowledge of the consumer (i.e. not a Locum GP) and must determine that the consumer poses a risk of harm to themselves or any other person and it is necessary to use the restraint due to the risk of harm;
(ii) evidence of alternatives – restraint must be the last resort and a temporary solution. Other options to restraint must have been considered and/or used unsuccessfully;
(iii) evidence that this is the least restrictive form of restraint possible for the total period of the restraint;
(iv) documentation to support the physical restraint – by the GP or Nurse Practitioner on this Authorisation form (see below) and in TRAX; and
(v) informed consent – the consumer or their representative must have consented to the use of the physical restraint before the restraint is used.

All consumers who are subject to restraint must be regularly monitored for signs of distress or harm, and for the necessity for the restraint.

Chemical restraint *means a restraint that is, or that involves:*

The use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

Chemical Restraint ☐

Type of restraint to be used:

_____

Note: a chemical restraint must not be used unless there is:
(i) an assessment by a GP or Nurse Practitioner – the person who has undertaken the assessment must be the same person who prescribes the medication that is, or is involved in, the restraint;
(ii) documentation to support the chemical restraint – on this Authorisation form and in the Care Plan and Progress Notes in TRAX as well as in BestMED;
(iii) informed consent – the consumer or their representative must have consented to the use of the chemical restraint before the restraint is used.

Environment (MSN) ☐

All consumers residing in a secure memory support neighbourhood require a restraint authorisation form completed:

- before admission to the memory support neighbourhood;
- at least annually; or
- otherwise as required.

Key Pad Entries ☐

Homes with Key Pad entries: The assessment/ restraint authorisation needs to be completed with the Consumer and/ or their representative especially for all Consumers who do not have the capacity to remember/understand/use the key pad codes.

In regards to our Consumers that do have capacity to remember/understand and use the codes, the home needs to ensure they have access to the codes on

	admission and as required.		
What are the consumer's behaviours or concerns that create a risk of harm and a need for the restraint to be applied? What are the reasons the restraint is necessary (i.e. what is the risk of harm without the restraint)?			
What are the alternative interventions to restraint that have been used (if any)? NB: Trial chemical and restraint free environment prior to applying any restraint (if possible). When is the restraint to be applied? NB: While the consumer is subject to the restraint the home must regularly monitor the consumer for signs of distress or harm.			
When restraint is released which interventions will be undertaken?			
What information (if any) has been provided to the GP or Nurse Practitioner by the provider that informed the decision to prescribe the chemical restraint or apply physical restraint?			
Restraint background information above completed by (Care Manager or Senior RN only):	Signature: Print Name/Position:	Date	
GM/CM/Ops Manager confirmation:	Signature: Print name/Position:	Date	

Medical rationale for restraint following assessment of need:	
Doctor Name :	
Doctor's signature	

Consumer/ Representative
The need for restraint for me/ consumer has been explained to me. I acknowledge this information has been given and I

understand the risks and necessity for this action.

Resident Name:	Representative Name and Relationship to the Consumer:
Signature	Date

Monitoring and Review (at least every three months)

All consumers subject to restraint (either physical or chemical) must be regularly monitored for signs of distress or harm. The necessity for the restraint must be regularly monitored and reviewed to determine if it is still required and optimal.

Consumer's Name:		
Neighbourhood	Room No:	
RN/CM Review Notes:	Have there been any signs of distress or harm since the restraint has been applied? Yes/No (please circle one) Comments:	Date:
RN/CM Review Notes:	Is the restraint still required and optimal? Yes/No (please circle one) Comments:	Date:
Doctors Signature and comments:		Date:
Consumer/ Representatives Signature		Date:
Care Manager/ GM		Date:

RN/CM Review Notes:	Have there been any signs of distress or harm since the restraint has been applied? Yes/No (please circle one) Comments:	Date:
RN/CM Review Notes:	Is the restraint still required and optimal? Yes/No (please circle one) Comments:	Date:
Doctors Signature and comments:		Date:

Consumer/ Representatives Signature

Date:

Care Manager/ GM

Date:

Restraint Authorisation

Surname	Given Names	C Code	Room No.	DOB

Do all nursing assessments & the outcomes of any alternatives suggest restraint is an appropriate intervention. tick (✓) YES. ☐ Yes

Assessment by General Practitioner (to be completed by GP only)

Medical Diagnosis related to use of restraint

dementia - unspecified

Circumstances When Restraint May Be Used

Type Of Restraint

Chemical Restraint

Duration Of Restraint

General Practitioner Signature	Print Name	Date
		12/8/19

Resident/Representative Consultation

The need for restraint of _____ has been explained and discussed with me.

(Resident's Name)

I acknowledge this information has been given to me and I understand the necessity for this action.

Signature	Print Name	Relationship	Date
Witness Signature	Print Name		Date

Restraint Authorisation

Surname	Given Names	C Code	Room No.	DOB

4 Weekly Nursing & Medical Evaluation of Restraint Used

Date	Evaluation & Comments	RN Signature	GP Signature