Law Council
OF AUSTRALIA

Aged Care Quality Principles

Department of Health

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Telephone +61 2 6246 3788 • *Fax* +61 2 6248 0639
Email mail@lawcouncil.asn.au
GPO Box 1989, Canberra ACT 2601, DX 5719 Canberra
19 Torrens St Braddon ACT 2612
Law Council of Australia Limited ABN 85 005 260 622
www.lawcouncil.asn.au

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The Law Council advises governments, courts and federal agencies on ways in which the law and the justice system can be improved for the benefit of the community. The Law Council also represents the Australian legal profession overseas, and maintains close relationships with legal professional bodies throughout the world.

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- Law Institute of Victoria
- Law Society of New South Wales
- Law Society of South Australia
- Law Society of Tasmania
- Law Society Northern Territory
- Law Society of Western Australia
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- Northern Territory Bar Association
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The Chief Executive Officer of the Law Council is Mr Michael Tidball. The Secretariat serves the Law Council nationally and is based in Canberra.

Acknowledgement

The Law Council of Australia (**Law Council**) acknowledges the contribution of the Law Society of New South Wales, the Queensland Law Society, the Law Society of South Australia and its National Elder Law and Succession Law Committee to this submission.

Executive Summary

1. The Law Council thanks the Department of Health (**Department**) for the opportunity to make a submission in relation to the Aged Care Quality Standards (**Standards**).

2. The responsibilities of approved aged care providers under the *Aged Care Act 1997* (Cth) (**Aged Care Act**) include to provide a quality of aged care which complies with the Standards.[1] The Standards are prescribed in Schedule 2 to the *Quality of Care Standards 2014* (Cth) (**Quality of Care Principles**)[2] – an instrument made by the Health Minister under the Aged Care Act .

3. The Final Report of the Royal Commission into Aged Care Quality and Safety (**Final Report**)[3] recommended, to improve the efficacy of the Standards, that:

   - responsibility for setting the Standards be given to the Australian Commission on Safety and Quality in Health Care (**Health Care Commission**) by 1 July 2021, which already sets standards regarding the quality and safety of health care (Recommendation 18);

   - there be an urgent review of the Standards by the Health Care Commission, including in relation to matters within the standards regarding which concerns were raised by witnesses before the Royal Commission (Recommendation 19).

4. To date, those recommendations have not been fully implemented. The responsibility for setting the Standards does not appear to have been transferred to the Health Care Commission. Further, while the Standards are now subject to a review, the review is by the Department rather than the Health Care Commission. As part of that review, the Department has commissioned a survey of the aged care sector, seeking views on the current Standards.

5. In this context of that Departmental review, the Law Council makes the following recommendations:

   In relation to the Royal Commission recommendations

   - the Health Care Commission be given statutory responsibility for setting Standards, as recommended in Recommendation 18 of the Final Report;

   In relation to the Aged Care Act

   - starting from Recommendation 14 of the Final Report, the Aged Care Act should make clear the content of an aged care provider's duty to provide high quality and safe care, balancing a consumer's wishes and foreseeable risks of giving effect to those wishes.

   In relation to the Standards themselves

   - the Standards be amended to: (a) make the obligations of aged care providers clear; and (b) ensure those obligations are expressed in consistent terminology;
   - the Standards be amended to better clarify the requirements imposed on aged care providers where an aged care recipient's rights to exercise choice and to

[1] Aged Care Act, paragraph 54-1(1)(d).
[2] Ibid, section 96-1.
[3] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* (2021).

dignity intersect (and possibly conflicts with) an aged care provider's duty to provide a safe environment;

- there be clarification as to the relationship between representative decision-making under the new Aged Care Act and under state and territory laws.

Legislative framework

The Aged Care Act and Quality of Care Principles

6. Chapter 4 of the Aged Care Act sets the responsibilities of approved providers of aged care.

7. Section 54-1 sets out the responsibilities of approved providers in relation to the quality of aged care they provide.[4]

8. Some of these responsibilities are set out in section 54-1 itself, such as to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.[5]

9. Section 54-1 also provides that a number of these responsibilities are to be set out in the Quality of Care Principles, including:

    - to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;

    - to comply with the Standards which are made under the Quality of Care Principles;

    - manage incidents and take reasonable steps to prevent incidents in a residential setting through implementing and maintaining an incident management system that complies with the Quality of Care Principles;

    - to ensure a restrictive practice is only used in the circumstances set out in the Quality of Care Principles.

10. Each of the matters in the previous paragraph are addressed in the Quality of Care Principles, a legislative instrument made by the Health Minister under section 96-1 of the Aged Care Act. Relevantly, Part 5 of the the Quality of Care Principles provides for Schedule 2 to set out the Standards, which apply in relation to residential care, home care and flexible care in the form of short-term restorative care.

The Standards

11. There are eight standards, which deal with consumer dignity and choice, planning and assessment with consumers, personal and clinical care, services and supports, the service environment, feedback and complaints, human resources and organisational governance matters. Each standard consists of a 'consumer outcome', an 'organisational statement' and 'requirements'.

[4] Aged Care Act, Part 4.1.
[5] Ibid, paragraph 54-1(1)(b).

12. Compliance with the Standards forms part of the regulatory framework for approved providers and the services they provide.

13. As noted, compliance with the Standards is itself a responsibility of an approved provider.[6] Failure to comply with a responsibility can result in the imposition of sanctions on an approved provider under Part 7B of the *Aged Care Quality and Safety Commission Act 2018* (Cth) (**Quality and Safety Commission Act**).[7]

14. Further, in order to accredit a specific aged care service provided by an approved provider service, in accordance with Part 3 of the *Aged Care Quality and Safety Commission Rules 2018* (Cth) (**Quality and Safety Commission Rules**), the Commissioner must be satisfied that 'the approved provider will undertake continuous improvement in relation to the service as measured against the Standards'.[8]

15. For decisions on re-accreditation, the Commissioner must appoint an assessment team to conduct a site audit to (among other things) 'assess the quality of care and services provided through the service against the Standards'.[9] Once given a site audit report, the Commissioner must prepare a performance report which may specify areas of improvement that need to be made to ensure the Standards are complied with.[10]

Relevant Royal Commission recommendations and Australian Government response

Royal Commission recommendations

16. The Final Report recommended reform to the Standards. It found that the Standards do not:

    - define quality, or high quality, aged care – they set out the minimum acceptable standards for accreditation;[11]

    - set sufficiently high standards of quality and safety[12] and lack of objectively measurable standards.[13]

17. The Final Report also noted that there is no guidance in the Aged Care Act as to the process to be followed to make the Principles, and while the experts are consulted

[6] Ibid, paragraph 54-1(1)(d).
[7] Section 3-4 of the Aged Care Act and section 63N of the Quality and Safety Commissioner Act.
[8] Quality and Safety Commission Rules, subparagraph 29(3)(a)(iii).
[9] Ibid, paragraph 36(2)(a).
[10] Ibid, subsection 40A(3).
[11] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 1, Summary and recommendations*, 94 and Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 119.
[12] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 2, The current system*, 92 and Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 120.
[13] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 123.

by the Department in the development of the Standards, the views of those experts are not always followed.[14]

18. It contrasted the Standards to the quality standards for the health sector, which are set by the Health Care Commission.

19. The Health Care Commission is a corporate Commonwealth entity established by the *National Health Reform Act 2011* (Cth) (**NHR Act**). The Health Care Commission's functions largely relate to the safety and quality of health care services and includes to formulate written standards relating to health care safety and quality matters and to promote, support and encourage the implementation of such standards and monitor their implementation and impact.[15]

20. A person is not eligible to be appointed to the Health Care Commission Board unless the Minister is satisfied that they have substantial experience or knowledge *and* significant standing in at least one of a number of fields, including public administration, management of hospitals and health facilities, management, corporate governance, and representation of the interests of consumers, among others.[16] As flagged in the Final Report, these could be expanded to accommodate the responsibility for setting standards in relation to aged care, although this is already part of its remit.

21. The Final Report notes that the Health Care Commission 'is established with the express purpose of formulating written Standards, guidelines and indicators relating to "health care safety and quality matters"'.[17] It found that:

    - the health care standards set by the Health Care Commission are 'far more comprehensive, rigorous and detailed' than the existing Standards;[18] and

    - there should be 'greater harmonisation between the quality standards that apply in health care and those standards that apply in aged care'.[19]

22. The standards set by the Health Care Commission extend beyond clinical standards to certain quality of life measures which may be applicable in aged care settings.[20]

23. In evidence given to the Royal Commission, the Chief Executive Officer of the Health Care Commission, Professor Debora Picone AO, suggested that there be 'greater harmonisation between the quality standards that apply in health care and those standards that apply in aged care'.[21] Professor Picone indicated that 'a core set of Standards could be developed and implemented in the health and long-term aged care sectors' which 'would both improve quality and safety and reduce the

[14] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 1, Summary and recommendations*, 94 and Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 120.
[15] Section 9 of the NHR Act.
[16] Ibid, section 20.
[17] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 120.
[18] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 1, Summary and recommendations*, 94.
[19] Ibid.
[20] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 120.
[21] Ibid.

regulatory burden that arises currently from the requirement for providers to comply with more than one set of Standards on the same or similar topics'.[22]

24. The Final Report agreed with this suggestion and recommended the Health Care Commission acquire the function of setting aged care quality standards.[23] The advantages of this approach included that it 'is an existing body with the governance arrangements and processes in place to perform the role' and 'is well-respected and has many years of experience in setting health Standards'.

25. It noted that the standards set by the Health Care Commission already apply to all hospital and day procedure services and to residential aged care services provided by state and territory authorities and to Multi-Purpose Services[24] (the latter provide integrated health and aged care services to communities in areas that cannot support both a separate residential aged care facility and a hospital).[25]

26. The Final Report recommended:

- that the NHR Act be amended to rename the Health Care Commission the 'Australian Commission on Safety and Quality in Health and Aged Care' (**renamed Health and Aged Care Commission**), and confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality[26] – Recommendation 18;[27]

- that the renamed Health and Aged Care Commission should be asked by the Minister to urgently review and, if it considers appropriate, amend the Standards as it deals with a number of matters, with the review to be completed by 31 December 2022 – Recommendation 19;[28]

- following this, the renamed Health and Aged Care Commission should complete a comprehensive review of the Standards within three years of taking on the standard-setting function and every five years after that – Recommendation 20;[29]

- the first periodic review of the Standards by the renamed Health and Aged Care Commission should consider a number of additional matters – Recommendation 21.[30]

27. More generally, the Final Report considered that a 'measurable definition of high quality care needs to be formulated and refined over time'.[31] It recommended (Recommendation 13) that the Aged Care Act 'should be amended to provide that the [renamed Health and Aged Care Commission], in setting and amending safety and quality Standards for aged care following its initial review, give effect to the following characteristics of high quality aged care:

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[22] Ibid.
[23] Ibid, 121.
[24] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 120.
[25] Ibid, 192.
[26] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 1, Summary and recommendations*, 94 and Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 121.
[27] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 122.
[28] Ibid, 124.
[29] Ibid, 125
[30] Ibid.
[31] Ibid, 91.

- diligent and skillful care;
- safe and insightful care;
- caring and compassionate relationships;
- empowering care; and
- timely care.'[32]

Australian Government Response and Law Council comment

Recommendation 13 – amend the Aged Care Act to link the standards to certain characteristics of high quality aged care

Australian Government response

28. In its response to the Final Report,[33] the Australian Government indicated that it accepts this recommendation and is responding by:
    - developing a definition of high quality care in consultation with stakeholders; and
    - including that definition and relevant links to the standards and standard-setting bodies in the new Aged Care Act.[34]

Law Council comment

29. The Law Council welcomes this response, although it notes that the recommendation was that an amendment should occur expeditiously so it could inform the renamed Health and Aged Care Commission's urgent review and follow-on amendments.

30. More generally, the Law Council's view is that legislation should be the primary means to set out and clarify the parameters for future aged care governance and accountability obligations. It looks forward to the opportunity to provide feedback on a draft bill. The Standards should support these statutory obligations and act as practical guidance alongside the substantive, legislative obligations.

Recommendation 18 – expansion of the remit of the Health Care Commission to include formulating standards, guidelines and indicators relating to aged care safety and quality

Australian Government response

31. In its response, the Australian Government indicated that it 'accepts-in-principle' this recommendation.[35]

32. Specifically, it indicated that 'responsibility for the formulation of clinical care standards for aged care will be transferred to the [Health Care Commission] from July 2021', while the 'Department of Health will retain responsibility for non-clinical

[32] Ibid, 92.
[33] Department of Health, 'Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety' (May 2021).
[34] Ibid, 14.
[35] Ibid, 17.

aged care standards'.[36] It did not explicitly endorse the renaming of the Health Care Commission.

33. As at 14 October 2021, the NHR Act has not been amended and nor has a Bill been introduced into Parliament to amend it. The Law Council would appreciate information on how this recommendation is being progressed and the relevant timeframes.

34. The Australian Government's Budget announcement which sets out its response to the Aged Care Royal Commission also does not record this work.[37] The document refers to the following activities taking place in 2021:

- Improve Quality Standards for dementia, diversity, food, nutrition.
- Enhanced regulatory and monitoring powers of the Aged Care Quality and Safety Commission to improve clinical standards.

35. In relation to the first point, while these would appear to include 'clinical standards' there is no suggestion they would be set by the Health Care Commission.

36. In relation to the second point, the Aged Care Quality and Safety Commission (**Aged Care Commission**) is a different body to the Health Care Commission. The Aged Care Commission is established by the Quality and Safety Commission Act, largely for the purpose of regulating aged care providers (approval, imposing sanctions, ensuring compliance) and aged care services (accreditation, quality reviews and monitoring). This dot point does not appear to refer to the Health Care Commission acquiring responsibility for determining clinical standards.

Law Council comment

37. The Final Report recommended that the Health Care Commission be renamed the Health and Aged Care Commission and take responsibility for setting all standards, including non-clinical standards. The rationale for this recommendation not being accepted is unclear and does not appear to be explained in the Government response.

38. The Law Council considers that the Royal Commission's recommendation that the Standards be set by a renamed Health and Aged Care Commission be accepted for the reasons it states – that is, to ensure the standards are set by industry specialists, are 'comprehensive, rigorous and detailed', and are consistent with the health care standards. It encourages further consideration of this recommendation.

39. The standards set by the Health Care Commission, the National Safety and Quality Health Service Standards (**NSQHS**), already cover similar kinds of matters as those set out in the Standards, including in relation to non-clinical matters such as governance,[38] engagement with consumers,[39] and comprehensive care.[40].

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[36] Ibid.
[37] The Hon Greg Hunt MP, Minister for Health and Aged Care, '$17.7 billion to deliver once in a generation change to aged care in Australia', (media release, 11 May 2021) <link>.
[38] Clause 8 of the Standards ('organisational governance') and the Clinical Governance Standard of the NSQHS, <link>.
[39] Clauses 1 ('consumer dignity and choice') and 2 ('ongoing assessment and planning with consumers') of the Standards and the Partnering with Consumers Standard of the NSQHS, <link>.
[40] Clause 3 ('personal care and clinical care) of the Standards, and the Comprehensive Care Standard of the NSQHS, <link>.

40. Alternatively, the new Aged Care Act could provide that the responsibility for setting standards to a body made up of statutory appointees, in possession of appropriate skills and experience to set such standards. This approach is not preferred by the Law Council to the recommendation in the Final Report, given it will not occur as quickly and given the standing expertise of the current Health Care Commission.

Recommendation

- **Further consideration be given to provide, through legislative amendments, a renamed Aged and Health Care Commission responsibility for setting all aged care quality and safety standards, consistent with Recommendation 18 of the Final Report.**

Recommendations 19-21 – the review function

41. Recommendation 19 of Final Report recommended the initial urgent review by the renamed Aged and Health Care Commission focus on the following matters:

    - requiring best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, and infection control, and providing sufficient detail on what these requirements involve and how they are to be achieved;
    - imposing appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard to a person's preferences and religious and cultural considerations;
    - sufficiently reflecting the needs of people living with dementia and providing high quality dementia care;
    - provider governance; and
    - high quality palliative care in residential aged care, including staff capacity (number, skill and type), processes and clinical governance, for recognising deterioration and dying.

42. It recommended that the new Health and Aged Care Commission perform periodic reviews (Recommendation 20) and that the Minister refer a number of matters for the Commission's first comprehensive periodic review (Recommendation 21).

Australian Government response to Recommendations 19-21

43. In its response, the Australian Government referred to a review of the Standards it announced on 1 March 2021.[41] It was indicated that this initial review will:

    - inform the subsequent implementation of strengthened quality Standards;
    - consider all matters raised by the Royal Commission in Recommendation 19;
    - inform the scheduling, scope, and frequency of periodic reviews.

[41] Department of Health, n 33, 18.

44. The Department has engaged KPMG to undertake an evaluation of the current Standards.[42] The Department's website suggests that the evaluation will consider:

- the clarity of the wording and intent of the Standards;
- the relevance of the Standards to each aged care service program;
- whether the Standards are achievable and measurable;
- the impact of the Standards on consumers, providers and other key stakeholders; and
- contextual factors that have impacted the implementation of the Standards.

45. KPMG is conducting focus groups and a survey[43] to inform this evaluation. The results of this process will inform Departmental decision-making.

Law Council comment

46. Consistent with the previous comments, the Law Council considers that it would be preferable that a renamed Health and Aged Care Commission perform this review, as recommended in the Final Report, given its particular depth of knowledge and expertise. Should the Law Council's above recommendation be accepted and an Aged and Health Care Commission be established, it considers that a further review by this body should be undertaken.

47. In the meantime, the Law Council notes that the Government has indicated that current review will consider the specific matters which the Royal Commission considered should be subject to the urgent review at Recommendation 19 will be addressed in the review. This is welcome. The Law Council looks forward to considering any publication of the results of this review.

Observations about the existing Standards

Comments about the existing standards

48. The following comments are made in context of the KPMG evaluation of the current Standards, noting the parameters cited above.

49. In summary, the Law Council considers that the existing Standards:

- can be confusing and impractical in that they impose multiple, potentially conflicting obligations on organisations;
- confer potentially conflicting rights for consumers and obligations on organisations, without providing guidance as to how such conflict might be resolved; and
- require clarity as to how decisions are made by or on behalf of consumers in the aged care system, in the context of relevant State and Territory legislation.

[42] Department of Health, 'Evaluation of the Aged Care Standards Focus Group Registration, <link>, accessed 27 October 2021.
[43] Department of Health, Evaluation of the Aged Care Quality Standards Survey, <link>, accessed 27 October 2021.

Multiple standards for organisations

Drafting clarity

50. As noted, the Standards are expressed in three ways: a consumer outcome; organisational statement; and requirements.

51. The Quality of Care Principles do not expressly specify how to read the consumer outcome and organisational statement against the requirements. They are all articulated to form part of the 'standard'.[44] The terms used in the Standards do not link to any particular language in section 54-1 of the Aged Care Act, which relevantly provides that an approved provider must 'comply with the Standards'.[45]

52. The Explanatory Statement for the *Quality of Care Amendment (Single Quality Framework) Principles 2018* (Cth), which inserted the present Schedule 2 into the Aged Care Act, does not provide any explanation as to how to read the three expressions of each standard together.

53. The *Guidance and Resources for Providers to support the Aged Care Quality Standards* (**Standards Guidance document**),[46] a non-legal guidance document published by the Aged Care Commission, suggests that the consumer outcome, organisational statement and requirements are three different ways of expressing each standard and that the 'requirements' are to 'demonstrate that the Standard has been met'.[47]

54. From a statutory interpretation perspective, it would appear that the best way to read the Standards is to consider the consumer outcome and organisational statement as essentially providing context and anticipated outcomes of compliance with the 'requirements'.

55. However, the Law Council considers that from a drafting perspective, the obligations of approved providers for compliance should be expressed in terms that make it clear what needs to be 'complied' with by an aged care provider and should be objectively measurable, as recommended by the Final Report.

56. To demonstrate, it is useful to pick-up the example provided in the Final Report:[48]

> *The lack of objectively measurable Standards in aged care is concerning. Standard 7, which requires that a provider has a workforce 'that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services', provides a good example. The lack of any clarity about the meanings of 'sufficient', 'skilled' and 'qualified' serves no one's interests—not people receiving care, not approved providers and not the regulator itself.*

57. What is described here in the Final Report is in fact the 'organisational statement' for Standard 7 ('human resources'). Noting the above, the Law Council understands that the matters that the aged care provider need comply with are set down under the 'requirements' subheading, which are, in relation to Standard 7:

> *Requirements*

[44] Subsection 17(2) of the Quality of Care Principles.
[45] Ibid, paragraph 54-1(d).
[46] Aged Care Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards*, (March 2021), <link>, accessed 14 September 2021.
[47] Ibid, 3.
[48] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 123.

(3) The organisation demonstrates the following:

(a) the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services;

(b) workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity;

(c) the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles;

(d) the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards;

(e) regular assessment, monitoring and review of the performance of each member of the workforce.

58. These requirements provide additional detail but are still essentially impressionistic and somewhat circular. For example, requirement 7(3)(a) turns on what is understood to be 'safe and quality care and services' and 7(3)(d) turns on what is meant by 'required by these standards'. On the latter requirement, for example, it is not clear whether the requirement is met by establishing *a process* to recruit, train, equip or support or by some assessment of whether those processes sufficiently delivered 'the outcomes required by these standards', whatever that is understood to mean.

59. It would be preferrable to set a verifiable action or task or output in relation to each of those things (recruitment, training, equipment and staff support) on which to assess performance.

60. The Law Council would welcome the opportunity to be consulted on any proposed revised drafting.

Inconsistency within a standard

61. Further, in some cases, there are substantive differences in the drafting of the consumer outcome, organisational statement, and requirements for a particular standard.

62. In the experience of some legal practitioners, the differences add unnecessary complexity and potential confusion to the organisation's task of compliance and to the consumer's opportunity to enforce their rights.

63. For example, in Standard 3 (personal care and clinical care) the standards that apply to organisations are variously expressed as follows (emphasis added):

> Consumer outcome:
>
> (1) I get personal care, clinical care, or both personal care and clinical care, that is **safe and right for me**.
>
> Organisation statement:
>
> (2) The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, **in accordance with the consumer's needs, goals and preferences to optimise health and well-being**.
>
> Requirements
>
> (3) The organisation demonstrates the following:

(a) each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:
   (i) is best practice; and
   (ii) is tailored to their needs; and
   (iii) optimises their health and well-being;
(b) **effective management of high-impact or high-prevalence risks** associated with the care of each consumer;
(c) **the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved**;
(d) **deterioration or change** of a consumer's mental health, cognitive or physical function, capacity or condition **is recognised and responded to in a timely manner**.

64. It is possible to envisage circumstances in which an aged care recipient's expressed 'goals and preferences' with respect to their care are in conflict with 'best practice' (whatever that entails) and care that 'optimises their health and well-being'.

65. While the Law Council recognises that the Standards are intended to apply to a range of clinical and other forms of care provided by organisations, it suggests there is a need for greater consistency in their expression.

66. The Law Council would welcome the opportunity to be consulted on any proposed revised drafting.

Recommendation

- **The Standards be amended to:**
  - **make clear which aspects amount to the requirements against which an aged care provider or service would be assessed;**
  - **ensure that the obligations are expressed in consistent terms and set clear and objectively measurable standards.**

Conflict between consumer rights and organisation obligations

Source of obligations

67. In their provision of aged care services, aged care providers are subject to legal obligations with respect to the standards of care they provide, arising from:

- the common law obligations;
- contractual obligations; and
- statutory obligations, such as the Aged Care Act and, in particular, the Standards.

68. The Law Council considers that there is the potential for conflict as between the rights of 'consumers' (i.e. aged care recipients) expressed in the Standards and the legal obligations of organisations arising from the common law, contract and statute.

69. Specifically, a conflict may be encountered in relation to obligations on an aged care provider to empower and support an aged care recipient to exercise choice on one hand, and to provide a safe environment on the other.

70. The Final Report cited that aged care providers have a 'non-delegable common law duty to exercise reasonable care for the health and safety of residents', with the concept of reasonableness evolving 'as scientific and medical knowledge increases and in line with changing community expectations'.[49]

71. Further, from a contractual perspective, residential care agreements between aged care providers and recipients may set out the responsibilities of aged care providers in relation to the care they provide, as agreed by the two parties, which could conceivably address matters of safety.[50]

72. As a general principle, obligations arising from the common law or contract are capable of being overridden by clearly expressed statutory provisions. However, here, the aged care legislative scheme itself does not express obligations in clear terms.

73. In terms of statutory obligations, these matters are currently addressed, respectively, by Standards 1 and 5 of the Standards.

74. Standard 1 relevantly provides:

> *Requirements*
>
> (3) The organisation demonstrates the following:
>
> (a) each consumer is treated with dignity and respect, with their identity, culture and diversity valued;
>
> (b) care and services are culturally safe;
>
> (c) each consumer is supported to exercise choice and independence, including to:
>
> (i) make decisions about their own care and the way care and services are delivered; and
>
> (ii) make decisions about when family, friends, carers or others should be involved in their care; and
>
> (iii) communicate their decisions; and
>
> (iv) make connections with others and maintain relationships of choice, including intimate relationships;
>
> (d) each consumer is supported to take risks to enable them to live the best life they can;
>
> (e) information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice;
>
> (f) each consumer's privacy is respected and personal information is kept confidential.

75. Standard 5 relevantly provides:

> (3) The organisation demonstrates the following:
>
> (a) the service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function;

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[49] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 98. See also, *Regis Aged Care Pty Ltd v Secretary, Department of Health* [2018] FCA 177 at [63].

[50] See section 59-1 of the Aged Care Act and subsection 15(5) of the *User Rights Principles 2014* (Cth). See also, Department of Health, 'Resident agreements for residential aged care' (website), <link>, accessed 21 October 2021.

(b) the service environment:
    (i) is safe, clean, well maintained and comfortable; and
    (ii) enables consumers to move freely, both indoors and outdoors;
(c) furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

76. Standard 1(d) flags an obligation to assist an aged care recipient to exercise choice – requiring providers to support consumers to take risks. Standard 5 infers a need for balance between providing for choice and safety. Neither are explicit in stating the way these matters are to be managed.

77. The Standards Guidance document acknowledges the possibility that a person's freely expressed choice may be harmful. That document encourages organisations to take a balanced approach to managing risk and respecting consumer rights, stating, in relation to Standard 1, that:[51]

> *If a consumer makes a choice that is possibly harmful to them, then the organisation is expected to help the consumer understand the risk and how it could be managed. Together they should look for solutions that are tailored to help the consumer to live the way they choose.*

78. The Law Council submits that 'expectation' should be enshrined in the Standards themselves, rather than the Guidance document, and it should be clear what the minimum standard expected is of aged care providers.

Capacity or obligation to intervene when there is a risk of harm?

79. As a result of this lack of clarity, at present, a question may arise for aged care providers as to what actions are permissible or expected when a reasonable and objective assessment is that a care recipient's choice may cause harm to either the care recipient or another person. That is, whether the obligation to give effect to a person's dignity in exercising choice is unassailable or is in fact circumscribed by some obligation to step in to override that choice when it may result in harm to the person or another.

80. While not addressed explicitly in the Standards, the right to express choice does appear to be in effect curtailed by the restrictive practices scheme in Division 2 of Part 4A of the Standards.

81. The *Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021* (Cth) (**Amendment Act**) introduced a statutory definition of 'restrictive practices' into the Aged Care Act. Specifically, since 1 July 2021, subsection 54-9(1) of the Aged Care Act has defined 'restrictive practice' as 'any practice or intervention that has the effect of restricting the rights or freedom of movement of the care recipient'.

82. Also since 1 July 2021, section 15E of the Quality of Care Principles defines individual kinds of restrictive practices: 'chemical restraint', 'environmental restraint', 'mechanical restraint', 'physical restraint', and 'seclusion'. However, these do not limit the broad definition of 'restrictive practices' in subsection 54-9(1).

83. The Law Council addressed the new definition of 'restrictive practice' in its submission to the Senate Standing Committee on Community Affairs regarding its

[51] Department of Health, n 46, 8.

inquiry into the Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Bill 2021 (Cth).

84. The Law Council noted that the definition replicated the definition of 'restrictive practice' in section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**). It also pointed out that while the NDIS Act articulates several human rights of persons with disabilities as general principles guiding actions under that Act, thus linking into the reference of 'rights' in that definition, there is not, presently, any scheme in the Aged Care Act for recognising human rights.

85. The Law Council would support the inclusion of a human rights framework into the Aged Care Act, but without this framework of human rights, 'it may not be clear to a provider on each occasion whether an activity or intervention may constitute a restriction on 'rights'. (It was understood the reference to 'rights' in subsection 54-9(1) was not a reference to the consumer rights in the *User Rights Principles 2014* (Cth) (**User Rights Principles**).)

86. Section 15FA of the Quality of Care Principles sets out a checklist of criteria which must all be satisfied in order for a restrictive practice to be permitted to be used, unless an emergency exists, in which case only some must be satisfied. In summary, these are, divided by reference to whether or not they apply while an emergency exists:

Do not apply in emergency situations

- used as a last resort to prevent harm to the care recipient or others;
- best practice alternative strategies have already been used and documented in recipient's behaviour support plan;
- the use complies with any relevant provisions in the behaviour support plan;
- informed consent has been provided by the care recipient or their substitute decision maker;

Continue to apply in emergency situations

- the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the care recipient or other persons;
- the use of the restrictive practice:
    - complies with the Standards;
    - is not inconsistent with the Charter of Aged Care Rights set out in Schedule 1 to the *User Rights Principles 2014* (Cth) (**User Rights Principles**);
    - meets any applicable law of a State or Territory.

87. These criteria demonstrate an intention that an aged care provider work with an aged care recipient to agree on the way in which care is provided. Further, the criteria demonstrate the only circumstances in which the use of a restrictive practice may conceivably be used, even in emergency situations, is when there is a risk of harm to the care recipient or another person.

88. In non-emergency situations, the aged provider is not permitted to apply an emergency practice, even as a last resort to prevent harm, unless they have a person's informed consent. However, the consent requirement does not apply when the use of a restrictive practice is 'necessary in an emergency'.

89. It is not clear what 'necessary in an emergency' means – it would be helpful if this were made clear in the legislation. However, noting that in all situations a restrictive practice may be 'used only to the extent that it is necessary and in proportion to *the* risk of harm to the care recipient or other person' (emphasis added) it appears to be understood to be available to prevent the occurrence of that harm when consent cannot be obtained.

90. In this way, the concept of a 'last resort to prevent harm' in subparagraph 15FA(1)(a)(i) in effect captures a care recipient sanctioned or agreed 'last resort' action. If the care recipient has not agreed the use of the restrictive practice in any circumstances, but the aged care provider considers that the risk of harm remains imminent in a particular situation, the use will then need to be justified as 'necessary in an emergency'.

91. This scheme appears to require an aged care provider to acquiesce to a recipient's determination to proceed along a course of action that could cause them foreseeable harm, until the moment at which harm is directly imminent at which time an intervention by way of a restrictive practice may be justified.

92. Importantly though, even if the use of the restrictive practice is 'necessary in an emergency', ostensibly enabling it to be applied regardless of whether consent has been obtained, it still must be used in a manner which complies with the Standards.[52] If it is an action which cuts against an aged care recipient's freely expressed and informed choice (as it could foreseeably be in several cases), then it is difficult to see how it can be consistent with Standard 1.[53]

93. This in effect leaves the aged care provider apparently unable to impose a restrictive practice, even when necessary in an emergency to prevent harm, unless it is consistent with a provider's freely expressed choice which is protected in Standard 1. This appears to create, in effect, an irreconcilable loop in the legislation with the scheme ostensibly permitting a restrictive practice to be employed without consent (i.e. that is the implication of the consent requirement being carved out by subsection 15FA(2) when an emergency exists) but yet effectively preventing it when it is not consistent with the aged care recipient's freely expressed choice.

94. As expanded on below if would be helpful if the Aged Care Act expressly dealt with whether the use a restrictive practice to prevent a risk of imminent harm is a matter of obligation or discretion (i.e. with no legal consequences for an aged care provider if they choose not to use a restrictive practice and foreseeable harm results). Currently, the Law Council understands that aged care providers are not clear as to where a common law duty of care sits with respect to the statutory scheme

95. Before working through the implications in law for this position, it may be helpful to present some examples of where an aged care provider may feel that the use of a restrictive practice is ostensibly justified to prevent harm.

[52] Paragraph 15FA(1)(h) of the Quality of Care Principles.
[53] See also, right 7 of cl 2 of Sch 1 to the User Rights Principles, as applied by paragraph 15FA(1)(i) of the Quality of Care Principles.

96. A care recipient who experiences some level of cognitive impairment may lack the appropriate insight into the risks or the ability to safely engage in the desired activity.

97. In these situations, the organisation may need to decide the time (if any) at which it is permissible to deny the aged care recipient's expressed choice (expressed following any counselling about an attendant risk) on the basis that it may breach the organisation's obligations to provide quality care and services and not to allow the care recipient or another person to suffer harm or damage as a result of neglect.

98. The Law Council has been advised of a number of circumstances in which a choice of a care recipient may expose them to a risk of harm, including the following.

Food and digestion

99. An aged care recipient expresses the choice that they would like to have solid foods (or similar) as instances of preference when the approved provider knows or has advice to suggest that the practice will cause harm to the individual including choking. If the aged care provider ultimately denies that request, it could arguably be a practice which has the effect of restricting the rights of the care recipient (to choose their nutrition) under the broad definition in subsection 54-9(1) of the Aged Care Act. (Even if the reference to 'rights' in subsection 54-9(2) of the Aged Care Act does link to the rights expressed in the User Rights Principles, those rights include 'to have control over and make choices about my care, and personal and social life, including where the choices involve personal risk'.[54])

Freedom of movement

100. An aged care recipient expresses a desire to leave the care service without being inhibited by a keypad lock, when the approved provider considers that person or other residents may not be sufficiently cognisant to manage the risks and thus may be at risk of harm. The imposition of a keypad lock is would likely be a practice which has the effect of restricting the freedom of movement of a care recipient under the broad definition in subsection 54-9(1) of the Aged Care Act and may also amount to environment restraint under subsection 15E(3) of the Quality of Care Principles.

Aggressive behaviour

101. An aged care recipient who has some aggressive behaviours or anti-social behaviours being denied access to a common area for a period until it is reasonably assessed their behaviours are sufficiently mitigated from entering certain environments. If the aged care recipient does not consent to that restriction, this may be a restrictive practice in the same way as the previous example. The aged care provider may need to decide when the risk of harm posed by that person arises to such a level of imminent risk that a restrictive practice is potentially justified.

Bed rails

102. An aged care recipient expresses a desire not to have bedrails, but the aged care facility believes they are necessary to prevent harm. Bedrails again may be either a restrictive practice under the broad definition in subsection 54-9(1) or amount to a mechanical restraint under subsection 15E(4) of the Quality of Care Principles. Again, this may be a difficult one to apply only when 'necessary in an

[54] Right 7 of cl 2 of Sch 1 to the User Rights Principles

emergency', as it may be difficult to identify a moment of imminent risk as opposed to a pervasive risk.

Issues with substitute decision-makers

103. The provisions regulating restrictive practices which commenced from 1 July 2021, introduced the position of a 'restrictive practices substitute decision-maker'. [55]

104. A 'restrictive practices substitute decision-maker' is defined in section 4 of the Quality of Care Principles as

> *a person or body that, under the law of the State or Territory in which the care recipient is provided with aged care, can give informed consent to:*
>
> *(a) the use of the restrictive practice in relation to the care recipient; and*
>
> *(b) if the restrictive practice is chemical restraint—the prescribing of medication for the purpose of using the chemical restraint;*
>
> *if the care recipient lacks the capacity to give that consent.*

105. The relevant State and Territory laws are not incorporated by reference. The Explanatory Statement for the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021* (Cth) (**Amendment Principles**), which inserted this definition into the Quality of Care Principles, sets out in a table what is described as the 'relevant legislation' at the time of the amendments.[56]

106. The Law Council understands that not all State and Territory legislation explicitly provides for the use of a restrictive practice by a substitute decision-maker.

107. Take, for example, guardianship orders under the *Guardianship Act 1987* (NSW) (**NSW Guardianship Act**), which are listed in the table in the Explanatory Statement.[57] Unlike, for example, the *Guardianship and Administration Act 2000* (Qld),[58] the NSW Guardianship Act does not explicitly provide for guardianship orders to authorise (or otherwise) a guardian to make decisions about the use of restrictive practices.

108. The NSW Civil and Administrative Tribunal (**NCAT**) has adopted its practices to ensure that it considers guardianship appointments to make decisions about restrictive practices to be directed to the Commonwealth scheme.[59]

109. Practitioners have raised that it will be necessary for providers to make applications to determine State tribunals to seek appointment of such decision-makers may lead to a backlog of matters and inconsistencies between jurisdictions which may have different definitions of 'capacity' and criteria determining when a guardian may be appointed.

110. This issue was also raised by the Queensland Office of the Public Advocate in a reform options paper[60] published earlier this month:

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[55] Paragraphs 15FA(1)(f) and 15FC(1)(c) of the Quality of Care Principles.
[56] Explanatory Statement, Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021 (Cth), 16.
[57] Ibid.
[58] See Chapter 5B.
[59] VZM [2020] NSWCATGD 25, [54] and [56] and TZD [2021] NSWCATGD 14.
[60] Office of the Public Advocate (Qld), *Reform Options Paper*, 5 October 2021, <link>.

In many states and territories, including Queensland, it is unclear exactly who would have the authority to consent to a restrictive practice in a residential aged care setting. An attorney for personal matters under an enduring power of attorney, and a guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT), may have such power in Queensland, however this is far from certain.

This uncertainty has left aged care providers unsure of their obligations under the changed Quality of Care Principles.

111. The Office of the Public Advocate paper also raised a number of issues with the consent-based approach to the use of restrictive practices introduced by the recent amendments to the Quality of Care Principles.

Reform options

112. The Law Council considers that the Aged Care Act should directly attend to the tension between giving effect to dignity in choice and providing for a safe environment through overarching statement of principles.

113. The Final Report, which also pick up this tension, provides a useful starting point for this.

114. Recommendation 13 of the Final Report, accepted by the Australian Government,[61] recommended the Aged Care Act be amended to give effect to characteristics that include 'diligent and skilful care' and 'safe and insightful care' on the one hand, and 'empowering care' on the other.

115. On its face, this formulation arguably retains the inherent conflict outlined above and would not necessarily overcome the difficulties described. However, these are overarching principles to inform the content of the Standards. The latter should indicate the way the principles may intersect or overlap in certain circumstances.

116. Recommendation 14 of the Final Report recommended that the Aged Care Act includes a general duty on an approved provider to (emphasis added):

to ensure that the personal care or nursing care they provide is of high quality and safe so far as is reasonable, having regard to:

*(a) **the wishes of any person** for whom the provider provides, or is engaged to provide, that care*

*(b) any **reasonably foreseeable risks** to any person to whom the provider provides, or is engaged to provide, that care, and*

(c) any other relevant circumstances.

117. This recommendation responded to a concern regarding the 'lack of a clear statement of responsibility to provide care that is safe and of high quality'.[62] The Royal Commission noted that the focus needs to be to provide the highest quality care that is reasonable, while also respecting the dignity and choices of individuals receiving care.[63]

118. The Law Council considers that Recommendation 14 – that the Aged Care Act impose a clear statutory duty to provide high quality and safe care – will provide a touchstone to inform the content of rights and duties under the Aged Care Act. The recommendation is a starting point – it may not be sufficient for the law to simply ask

[61] Department of Health, n 33, 14.
[62] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect – Volume 3A, The new system*, 97.
[63] Ibid.

aged care providers to 'have regard to' a person's wishes and reasonably foreseeable risks. The duty should chart how these matters are to be balanced against each other.

119. In drafting any provision (or set of provisions) which imposes that duty, it will be necessary to understand substance and permissible limitations on any international human rights obligations which apply. As the noted in its submission to the Royal Commission, the Law Council supports the reference to a person's right to be treated with dignity and respect, and to have control and make decisions about their care and other aspects of their life in Standard 1.[64] As it stated there, the freedom to make choices about one's own life is an important human right as an essential feature of a person's dignity.[65]

120. Ultimately, the objective of this duty will be to enable the Aged Care Act to both:

- provide clarity to aged care providers as to when (if ever) a restrictive practice may be employed, despite this being contrary to the aged care recipient's wishes;
- authorise objectively measurable standards which explicitly address the way in which the obligation to support a person exercise choice may be circumscribed by an obligation to provide a safe environment (if at all).

121. The Law Council would welcome the opportunity to be consulted on any proposed revised drafting.

Recommendation

- **Working from Recommendation 14 of the Final Report, the Aged Care Act should make the clear the content of an aged care provider's duty to provide high quality and safe care, balancing a consumer's wishes and foreseeable risks of giving effect to those wishes.**
- **Consideration be given to setting objectively measurable standards that make clear the requirements of an aged care provider where there is an apparent conflict between an aged care recipient's right to choice and dignity and an organisation's duty to provide a safe environment.**

Representatives

Overarching comment

122. The Law Council considers that it would be beneficial if the aged care legislation – specifically, the Aged Care Act, Quality of Care Principles, and the Standards themselves, to be clearer with respect to the role of representatives of aged care recipients, and the interaction between representatives and the obligations of aged care providers.

[64] Law Council, 'Aged Care Quality and Safety' (29 July 2020), <link>, [241].
[65] Dignity is a key principle in a number of international human rights instruments. See eg, ICCPR, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976); ICESCR, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) and CRPD, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 30 March 2008). Also see discussion ALRC, 'Elder Abuse – A National Legal Response' (Report No 131,14 June 2017) 50.

123. In particular, it would be beneficial for there to be greater clarity in relation to the role and expectations of representatives under the Commonwealth aged care framework and the numerous state and territory laws which empower and regulate representatives (for example, through power of attorney, guardianship or public advocate arrangements).

The role of representative in the Aged Care Act and in the Quality of Care Principles

Aged Care Act

124. There is no definition of 'representative' in the Aged Care Act.

125. Section 96-5 of the Aged Care Act provides that for the purposes of the Act generally, a person 'representing' a care recipient may enter into an agreement with an aged care provider on behalf of the care recipient, if the care recipient is unable to enter into the agreement 'because of any physical incapacity or mental impairment'.

126. Section 96-6 of the Aged Care provides that, in general, an application made or information given by a care recipient for the purposes of the Act may be made or given by a person 'authorised to act on the care recipient's behalf'.

127. In each case, there is no indication as to what standards apply, or evidence is required, to satisfy an aged care provider that a person is properly authorised to represent or act on behalf of a care recipient.

Quality of Care Principles

128. The Quality of Care Principles define 'representative' to mean a person nominated by the consumer to be told about matters affecting them, or who, in the organisation's view, has a sufficient connection with the consumer and is concerned for their safety, health and well-being.[66]

129. The definition specifies that a person has a connection with a consumer if the person, amongst other things, holds an enduring power of attorney given by the consumer or has been appointed by a state or territory guardianship board to deal with the care recipient's affairs.[67] That would seem intended to cover persons who are legally authorised by a care recipient to make decisions on their behalf.

130. However, such persons are just a class of persons who are taken to satisfy the general definition. The definition itself is non-exhaustive and aged care providers are otherwise left to make their own judgement about whether a person has the 'sufficient connection', which may extend to persons who are not legally authorised under state and territory law to make such decisions. It may be that more than one person at any time may satisfy the definition.

131. In any event, with the passage of the Amendment Principles, the role of representatives in the Quality of Care Principles has reduced.

132. Prior to the amendments which commenced on 1 July 2021, representatives had a substantive role with respect to the application of restrictive practices. In particular, a representative (or the consumer in the case of physical restraints) was able to

[66] Subsection 5(1) of the Quality of Care Principles.
[67] Ibid, subsection 5(2).

provide informed consent with respect to the use of a restraint[68] and must have been informed if a restraint was used without that informed consent.[69]

133. Following the recent amendments, a representative is only referred to in the context of consultation or procedural management requirements of approved providers,[70] rather than given any substantive role.

134. Unlike sections 96-5 and 96-6 of the Aged Care Act and the definition of 'representative' in the Quality of Care Standards, the definition of 'restrictive practices substitute decision-maker' draws entirely from the relevant state and territory legislation in determining who is a lawful representative for restrictive practices decisions where a care recipient lacks capacity.

135. The Law Council suggests consideration be given to taking a consistent approach throughout the Aged Care legislative framework in relation to who may be a representative for a care recipient where they lack capacity. The role of representatives in the Standards

136. The term 'representative' is not used in the Standards. Nor is there any global reference to an aged care provider's obligations with respect to a representative.

137. Standard 1(3)(c) provides that each consumer is supported to exercise choice and independence, including to make decisions about their own care and the way care and services are delivered.

138. The Standards do not address how this is achieved where a care recipient's representative is involved in a decision-making capacity.

139. Standard 1(3)(c) in its terms is arguably at odds with the state and territory legislative frameworks that provide for some kind of representative decision-making via enduring guardianship, enduring powers of attorney and advance care directives. These laws are themselves not consistent, providing for different principles to underpin representative decision-making.[71]

140. The Aged Care Commission website suggests that 'consumers may choose to involve others as representatives in making their decision' and 'may have a court or tribunal-appointed guardian to make decisions on their behalf' when they lack the capacity to make decisions.[72] The Law Council considers it would be preferable to have clarity in the law regarding the role of representatives, both in circumstances where a person maintains or lacks capacity.

141. The experience of practitioners is that this inconsistency can cause confusion to consumers and organisations. In circumstances of conflict where a representative decision-maker is not actually making decisions in the interests of the consumer, an organisation may be left with the options of ignoring their wishes or seeking clarification from a Tribunal.

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[68] Paragraphs 15F(1)(e) and 15G(1)(c) of the Quality of Care Principles as they were on 30 June 2021.
[69] Paragraphs 15F(2)(b) and 15G(2)(a) of the Quality of Care Principles as they were on 30 June 2021.
[70] Paragraphs 15HB(h), 15LA(2)(d) and (d), and 15MB(1)(e) and subparagraph 15MC(1)(b)(iii) of the Quality of Care Principles.
[71] Compare, for example: cl 7 of Sch 2 to the *Powers of Attorney Regulation 2016* (NSW) (and the reference there to acting in the principal's best interests, in line with substituted decision-making principles); section 21 of the *Powers of Attorney Act 2014* (Vic) (which takes a supported decision-making approach); and section 32 of the *Power of Attorney Act 2000* (Tas) (which takes a hybrid approach).
[72] Aged Care Commission, 'Standard 1. Consumer dignity and choice' (website), <link>, accessed on 27 October 2021.

Recommendation

- **Consideration be given to making provision in the Standards, the new Aged Care Act or elsewhere in the new aged care framework, to acknowledge and clarify the relationship between representative decision-making under the new Aged Care Act and under state and territory law.**