Australian Government
Aged Care Complaints Commissioner

Submission from the Aged Care Complaints Commissioner

To The Senate Community Affairs References Committee inquiry into The Effectiveness of the Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

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Since 1 January 2016 the Aged Care Complaints Commissioner (Commissioner) has been responsible for independently resolving complaints about Australian Government funded aged care services[1] and educating people about the best ways to handle complaints[2]. The Commissioner's functions are set out in the *Aged Care Act 1997* (the Act) and the *Complaints Principles 2015* (the Principles). The Commissioner's approach to complaints is built on best practice principles advocated by Associate Professor Merrilyn Walton in her review of the Aged Care Complaints Investigation Scheme in 2009.

The Commissioner's objectives are 'Resolve, Protect and Improve'. This means: working to resolve aged care complaints in a timely and proportionate way that improves care and services; ensuring we take timely action on issues raised through complaints to ensure people receiving aged care are well cared for and protected; and working with the aged care community to learn from complaints and act on opportunities to improve care.

The Commissioner, the Department of Health (the Department) and the Australian Aged Care Quality Agency (Quality Agency) share responsibility for the quality and safety of Australian Government funded aged care in Australia. In simple terms we manage complaints about the quality of aged care services funded by the Australian Government, the Department regulates and funds aged care services and undertakes compliance action, and the Quality Agency is responsible for managing the accreditation and monitoring of Australian Government funded residential aged care homes and quality review of home/community services.

The Commissioner's role is largely reactive. Although we also have an important and proactive education function[3], our complaints work starts with concerns being raised by an individual or agency. Complaints and own initiative processes are prompted by the receipt of a complaint or other concerning information about the care provided by a service to one or more people.

Anyone can make a complaint[4]. It is free. A complaint can be open (we disclose to the approved provider who has made the complaint), confidential (we do not disclose the complainant's identity except where we may need to do so to protect a care recipient) or anonymous (we do not know the

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[1] Complaints about retirement villages and Supported Residential Services (SRSs) are outside the Commissioner's jurisdiction.

[2] Prior to 1 January 2016 aged care complaints were managed by the Office for Aged Care Quality and Compliance within the Department of Health

[3] The functions of the Aged Care Complaints Commissioner are set out in Section 95A-1 of the *Aged Care Act 1997*. One function is to educate people and develop resources about best practice in complaint handling and matters that arise from complaints.

[4] The majority of complaints are made by family members or representatives of care recipients.

identity of the complainant – although they may use a pseudonym so that they can receive feedback about the complaint).

Other agencies (such as the Department and the Quality Agency) can refer information to us if they have concerns. We can initiate a resolution process on receipt of any information. It does not have to be a complaint.

When we receive information, our first step is to assess any risk associated with the issues being raised. If a complaints officer considers the issues raise significant or major risk, the matter is quickly escalated to a manager whose main consideration at this point is to mitigate risk to the care recipient and/or any other care recipients. The manager may contact a service/approved provider and seek an immediate response to the concern(s) raised. If urgent action is needed the Commissioner will refer the matter immediately to the Quality Agency. The Commissioner may also refer the matter to other organisations and/or fast track the issue(s) straight to a formal resolution process for detailed consideration and where a site visit can be conducted. The Commissioner's clinical advice unit may be asked to provide a view on the seriousness of clinical issues and whether urgent action is needed.

Meeting community expectations about the worth and effectiveness of complaints processes is essential. These expectations include: independence, transparency, timeliness, an apology, assurance that an adverse incident will not be repeated, service improvement, and where appropriate, taking action against the approved provider.[5]

Australian and international research has found that complaints entities often fall short of meeting community expectations with more than one third of complainants dissatisfied with the way their complaints were managed.[6] Therefore it is encouraging to note that for the Commissioner, overall satisfaction with our operation is high with 87 per cent of consumers (complainants and approved providers) satisfied or very satisfied in the March quarter 2017[7] and only nine per cent unsatisfied or very unsatisfied.[8] Satisfaction with individual measures for the Commissioner are similarly high: 88 per cent were satisfied or very satisfied that we acted fairly and without judgement; 88 per cent were satisfied or very satisfied that we provided them with adequate opportunity to have their say; 86 per cent were satisfied or very satisfied that we kept them informed about our process; 89 per cent were satisfied or very satisfied that we clearly explained the process and 86 per cent were satisfied or very satisfied that our letter clearly explained the reasons for our decision.[9]

Addressing the terms of reference

This submission comments specifically on parts (a), (b), (c), (d), (e), and (f) in the terms of reference.

[5] Bismark, M.M., Spittal, M.J., Gogos, A.J., Gruen, R.L., & Studdert, D.M. 2011, 'Remedies sought and obtained in healthcare complaints', *BMJ Quality & Safety*, Vol. 20(9), pp. 806-810.

[6] Ibid, p. 807.

[7] Final financial year figures are still to be published

[8] Aged Care Complaints Commissioner 2017, *Quarterly performance report March 2017*, p. 22 (internal document) – 288 responses received in the March quarter to our survey sent to both complainants and approved providers for each case finalised.

[9] Ibid, p. 22.

(a) The effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical standards are maintained and practiced

To respond to this question, we have considered, from our perspective, the effectiveness of the wider aged care quality and safety 'framework' involving the Commissioner, the Quality Agency and the Department.

As mentioned earlier, the three Commonwealth agencies each have quite separate roles but share responsibility for quality and safety in Australian Government funded aged care. As such, we must work together co-operatively and effectively. Good intelligence sharing between the Commissioner, the Department and the Quality Agency is vital.

We are committed to working with the other agencies as effectively as possible in a co-ordinated and complementary way. There have been several good examples of how well it can work when, for instance, we identify high risk matters, inform the Quality Agency and the Department and then make urgent Quality Agency referrals. These have led to very quick action by the Quality Agency to visit services and assess the relevant quality standards[10]. Where the concerns have been verified there has been urgent follow up action, including compliance action by the Department, while we have continued to work on the complaint. Such a united and coordinated approach is strong and effective.

The Commissioner has Memoranda of Understanding (MOUs) with the Department and the Quality Agency which guide interactions between the agencies. During the past 18 months the three have been meeting nationally and at the local state and territory level, sharing information regularly and as necessary while at the same time recognising each has a distinct and independent role. As mentioned previously and discussed further later in this paper, the Commissioner makes referrals arising out of complaints cases and own initiative processes to both the Quality Agency and the Department at various times and in various circumstances. Both the Department and the Quality Agency are able to refer information to the Commissioner. For example, the Department can refer concerns about a provider's management of an incident involving care recipients, from information obtained from a compulsory report[11]. The Quality Agency can refer information where it has identified concerns such as a service provider's failure to appropriately address complaints. The latter is relevant information for the Commissioner in considering how to approach subsequent complaints about that service. Provision is made in the Act for the Commissioner, the Secretary of the Department and the CEO of the Quality Agency to request and share information[12].

The Commissioner also has exchanged letters of understanding with other complaints bodies such as the Australian Health Practitioner Regulation Agency (AHPRA) and state based health complaints entities. As the Commissioner's jurisdiction does not include the actions of individual registered health professionals it is essential that the Commissioner has established good working relationships with those agencies that do.

[10] The 44 accreditation standards for quality and care in aged care are set out in Schedule 2 of the *Quality of Care Principles 2014*.

[11] A compulsory report is a report of an alleged or suspected assault as defined by Section 63-1AA of the *Aged Care Act 1997* and a report of a care recipient is absent from the service that is unexplained and the absence has been reported to the police as outlined in Section 25 of the *Accountability Principles 2014*.

[12] Part 6.6 of the *Aged Care Act 1997* provides for the Complaints Commissioner, Secretary of the Department and CEO of the Quality Agency to request and share information as required.

In 2016/17 the Commissioner made about[13] 400 referrals to the Quality Agency. Referrals may be Type 1 (relevant issue/concern), Type 2 (significant issues/concerns) or Type 3 (major issues/concerns). In 2016-17, 81.8% were Type 1, 16.8% were Type 2, and there were six Type 3 referrals. The Commissioner made 33 referrals to the Department and 36 referrals to AHPRA.

The Commissioner also makes formal and informal referrals to a wide range of other government agencies and non-government organisations. Other formal referrals may include to State/Territory police services, State/Territory coroners, local councils, and State/Territory health departments. Informal referrals include advising the complainant of other resources that may be able to assist them such as My Aged Care, advocacy services, and corporate entities (e.g. telecommunication providers), when they raise concerns that are outside the Commissioner's jurisdiction.

(b) The adequacy and effectiveness of complaints handing processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms

The adequacy and effectiveness of complaints handling processes

Where people are unable to resolve complaints directly with a service provider or with the assistance of an aged care advocate[14], the Commissioner is the primary mechanism for the individual resolution of concerns that arise in Australian Government funded aged care. It is important to note that this includes complaints about care provided in people's own homes as well as residential aged care, and complaints about the former are increasing more quickly than complaints about residential care. We receive in excess of 4500 complaints a year. There are more than 10,000 contacts[15] with us annually.

Through our work we also provide early warning of problems with care and services; identify potential system failures and opportunities for improvement; support safe, high quality aged care service delivery in conjunction with the Quality Agency and the Department; and we give the public confidence that there is oversight in handling complaints about Australian Government funded aged care and services that is independent of funding and regulation.

As well as resolution a key focus is on protecting care recipients from harm and ensuring that the service provider is meeting its obligations under the Act. We do this not by penalising but by seeking timely and effective resolution and remedial action.

We expect and seek service improvement where deficiencies are identified. Aged care service providers are held accountable by us through having to engage actively and co-operatively with the complaints process and take appropriate action to address the concerns that have been raised and any failings identified. As mentioned earlier, where systemic concerns are identified we refer these to the Quality Agency for consideration in its ongoing monitoring and accreditation processes. We also consider and take into account service providers' complaints history on receipt of new complaints and in considering referrals. We cannot impose sanctions on an approved provider to make them comply with their responsibilities - this is the role of the Department.

[13] Preliminary end of year figures.

[14] Free aged care advocacy services are available through the Older Persons Advocacy Network (OPAN), a national network of nine state and territory organisations that deliver advocacy, information and education services to older people in metropolitan, regional, rural and remote Australia. It is funded by the Australian Government.

[15] A contact is an enquiry or complaint about care and services from Australian Government funded providers of aged care, referrals from other organisations and out-of-scope enquiries that relate to matters beyond the Commissioner's jurisdiction.

We do not have the powers to investigate and hold individual staff directly accountable; this is the role of the service provider and in a regulatory context, other agencies such as AHPRA and the state based health complaints entities under the National Law.

Approach to complaints resolution

The key to effective complaints resolution is flexibility - this is a particular strength in the current processes available to us under the Principles. Most complaints involve multiple and often complex issues. Different approaches may be needed to effectively deal with a matter.

For instance, depending on the issues, circumstances, and the complainant's wishes, what we call the 'Early Resolution ' process may involve any or some of the following: providing the complainant with relevant information so that they can raise the matter directly with the service provider[16]; encouraging the two parties to discuss their concerns without our direct involvement; Commissioner staff facilitating a meeting between the complainant and service provider; and/or acting as a go between with the two parties without bringing the parties directly together. It can also involve us seeking and taking into account internal expert advice on any clinical, legal or policy issues raised, and/or providing information regarding the provider's relevant responsibilities.

Most complaints are resolved relatively quickly with high levels of co-operation from approved providers who work with us and complainants to resolve concerns. This is evidenced by our statistics which indicate that in 2016-17 about 92 per cent of complaints were completed in 'Early Resolution', with 74 per cent of all complaints completed within 30 days. More than half of the 10,232 complaint issues we finalised in 2016-17 were closed on the basis they had been resolved to the satisfaction of the complainant.[17]

Where early resolution is not possible or appropriate, the formal resolution approaches include:

- Service Provider resolution – this is where we formally ask the approved provider to examine and attempt to resolve the issue and report back to the Commissioner, and if we are not satisfied with the response we will take it further.
- Conciliation – request the complainant, the approved provider and any other person to participate in a formal conciliation process.
- Investigation – undertake an investigation of the issue(s).
- Mediation – refer the issue to mediation.

Even within these more formal processes, flexibility of approach remains important for effective complaint resolution. This means that the resolution approach may change during the resolution process. For example, an investigation may initially be undertaken due to reluctance by either party to conciliate, however, during the process, based on the information considered; the parties may agree to meet.

Although the issues may be dealt with in different ways, the Commissioner remains focused on ensuring that the service provider acts in accordance with their responsibilities under the Act and that any resolution outcome is in the best interests of the care recipient. Regardless of the resolution approach all information and responses from both parties are carefully considered, and where necessary clinical and legal advice is sought and considered.

[16] A complainant is not required to have raised their concerns with the service provider before approaching the Commissioner. Although this approach is encouraged (in order to establish, build and maintain positive relationships between care recipients, their family and friends and the service provider), if a complainant indicates that they do not want to do this the Commissioner will commence a resolution process.

[17] Aged Care Complaints Commissioner internal data (preliminary end of year statistics).

We can and do conduct announced and unannounced site visits to residential services when it assists in the resolution of the complaint. Most site visits by us are announced. This is for many reasons, including that we need to speak with a number of care recipients about an issue of concern and/or interview staff and need to ensure the right people are there and available. We may also need to examine documentation and/or to understand the layout of the facility.

We will conduct an unannounced visit where necessary. Reasons for this may include that there is conflicting information being provided by the complainant and service provider and the only way to resolve it is to see for ourselves without giving notice we are coming, or where there is risk to a care recipient and the initial response from the service provider has not satisfied us that the risk has been mitigated.

Outcomes from complaints

The outcomes from a complaint vary and the process is guided by what the complainant says they want to achieve as well as ensuring problems are fixed and relevant obligations are met by the approved provider. Outcomes can include an acknowledgement by the approved provider that their delivery of care did not meet expectations, a commitment and action to improve service delivery and revised practices to minimise the risk of repeat failures.

Many complainants tell us they want an acknowledgement that their concerns are valid and an apology. Under the national quality and safety standards for health, all Australian hospitals and many other health providers are required to openly disclose[18] adverse events to patients and their families, to respond appropriately, and to say "sorry". There is no such requirement in aged care.

We regularly encounter providers who fear that telling people when something has gone wrong and apologising for it, will get them sued despite the existence of "apology laws" offering differing levels of protection across the country. While the Commissioner actively encourages services to apologise for failings in care (and many do) if they refuse (and some do) she cannot enforce it. Falls and medication errors are the most common issues we get complaints about in residential aged care and these are the types of incidents which in health care are required to be openly disclosed.

The proposed new standards for aged care, the Single Quality Framework[19], if adopted as they are, include open disclosure in the new complaints standard[20]. This will assist with resolving complaints about aged care. Requiring proactive and appropriate open disclosure of adverse events is one of the key steps to ensuring failures of care are acknowledged and appropriately and promptly remediated.

Complainants also commonly tell us they do not want what happened to them to happen to someone else. Before closing a complaint on the basis an issue has been addressed, we seek

[18] 'Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers. The elements of open disclosure are: an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'; a factual explanation of what happened; an opportunity for the patient, their family and carers to relate their experience; a discussion of the potential consequences of the adverse event; an explanation of the steps being taken to manage the adverse event and prevent recurrence. It is important to note that open disclosure is not a one-way provision of information.' Australian Commission on Quality and Safety in Healthcare

[19] In the 2015-16 Budget, the Government announced its intention to develop the Single Aged Care Quality Framework (Framework). The Framework includes the development of a single set of quality standards that will apply to all aged care services. The consultative process ended on 21 April 2017 and submissions are under consideration by the Department. < https://agedcare.health.gov.au/quality/public-consultation-on-the-single-quality-framework>.

[20] Draft standard 6.1: 'The organisation uses an effective feedback and complaints resolution system based on fairness, accessibility, responsiveness, open disclosure, resolution and learning'. The rationale states: 'the requirement to demonstrate open disclosure aligns the standard with contemporary practice regarding the principles of open communication and transparent processes, including acknowledgement and apology when failings are identified.'

evidence to support what the provider says they have done. Also, complainants are encouraged to come back to us with a new complaint if issues arise again and have not been fixed. The Commissioner can look into a matter further in this way, or as an own initiative on receipt of concerning information.

The Principles do not provide for the Commissioner to actively monitor a complaint once a matter has been closed. As noted earlier, the Commissioner may make a referral to the Quality Agency so that they can be aware of potential systemic matters when carrying out their regular assessment and monitoring of services. However, the Quality Agency is not expected to monitor compliance with agreed outcomes or actions arising from individual complaints to the Commissioner.

Investigation powers

When investigating a complaint the Commissioner obtains information from sources including: the care recipient and family members, the approved provider, hospitals, doctors and other health professionals, the ambulance service, and Aged Care Assessment Services.

The legislation allows us to request information from any person and the Commissioner's 'authorised complaints officers' can visit and collect information from the premises of an approved provider. However, we cannot compel approved providers or other agencies and organisations to allow us on premises or to provide information. We rely on good will and co-operation to provide us with the information we need to examine a complaint thoroughly.

Notices and Directions

Ultimately if the Commissioner is not satisfied with the action taken by the provider, she gives approved providers formal notice of her intention to issue directions (notices). If the provider still does not respond appropriately, the Commissioner will direct them to take certain actions (directions) to ensure they are meeting their obligations. The Act requires service providers to comply with the Commissioner's directions.

In practice, notices and formal directions are not required often. Simply knowing these powers are there is usually enough to ensure providers respond appropriately to complaints. Even when notices are issued, most providers then take the necessary actions thereby avoiding the need for directions.

In a small number of cases approved providers are reluctant to assist with the resolution of a complaint. This does not happen often but it can take the form of delaying or refusing to provide documents or refusing to acknowledge failure and correct it and apologise for it.

As mentioned previously, in such circumstances the Commissioner can ultimately direct the approved provider to take specific action to meet their responsibilities under the Act and the approved provider must comply with these directions. The Commissioner relies on the Department to enforce this. If an approved provider fails to comply with a direction or directions, the Commissioner must notify the Department. The approved provider will be referred to the Department for consideration of compliance action and any further action is up to the Department. At this point, the Commissioner can do little else for the complainant.

Consumer awareness of the Aged Care Complaints Commissioner

Since 1 January 2016 we have worked actively to raise our public profile using multiple strategies. These include interviews and providing information in response to media requests; presentations and participating in panel discussions at seminars and conferences; meetings with other state and Commonwealth government agencies, approved providers and consumer groups; and an annual

mail out distribution of promotional materials to aged care services and the general public. This has included the development and circulation of some new materials such as The Commissioner's Ten Top Tips for raising a complaint; and free fridge magnets and pens carrying the Commissioner's contact details which have been popular at seniors and elder rights awareness events where we have had booths. Commissioner staff also joined Department and Quality Agency staff to visit remote and rural aged care services in the Northern Territory and Far North Queensland (including Thursday Island) this year to raise awareness of our services.

We have an online presence through our website (www.agedcarecomplaints.gov.au), and this year we have taken to social media.

We are now on Facebook (https://www.facebook.com/AgedCComplaints/?ref=br_rs), Twitter (@AgedCComplaints) and using Youtube.

The Commissioner has also established an external consultative committee with members from the aged care community[21]. Committee members provide the Commissioner with ideas, advice and feedback on resources, education initiatives and complaints work. This ensures that the Commissioner's complaints handling, public messaging and educative resources are as inclusive as possible and reflect the diversity of the aged care community. The committee helps the Commissioner to connect with the wider public, including as a means to ensure that people are aware of and feel able to access the Commissioner.

Such activity has resulted in a 20 per cent increase in complaints nationally in our first year. We expect to handle more than 5,000 complaints next financial year. But we know there is more to be done to raise our profile and ensure people feel they can raise concerns with us and it is worthwhile doing so. We also need to ensure that wherever possible people feel they can raise concerns directly with a service and that this results in prompt resolution.

Many people who could complain don't. We know this from international research[22], feedback and our own experience. We need to continue to actively find ways to ensure highly vulnerable aged care consumers and their families know they can raise a complaint with their aged care service or with us, feel safe to do so, and know that it will make a positive difference.

Internal research[23] in June 2016 showed that service provider referrals (materials, staff advice etc.) accounted for nearly a quarter (23.2%) of all contacts with us. Other agencies (Commonwealth and State/Territory government departments and organisations) (15.2%) and Internet searches (14.3%) are the next highest sources of information about us and all three account for over 50 per cent of consumer knowledge about the Commissioner. These results are similar to responses from complainants to our satisfaction survey[24] mailed out at the completion of complaints.

[21] The consultative committee membership now consists of representatives from the Commissioner, National Aged Care Alliance (LASA and COTA), National LGBTI Alliance, Federation of Ethnic Communities Council of Australia, Institute of Indigenous Urban Health and Australian, Carers Australia, Alzheimer's Australia and the College of Nursing.

[22] For example:Bismark M.M., Brennan T.A., Paterson R.J., Davis P.B., & Studdert D.M. 2006, *Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events*, Qual Saf Health Care, 15: pp. 15-22.

[23] Aged Care Complaints Commissioner 2017 (unpublished data), Survey conducted nationally with 112 new contacts to the Aged Care Complaints Commissioner between 19 and 24 June 2016. All new callers to the Commissioner's 1800 number were asked the question "How do you know about us?" Free text responses were then grouped into nine categories.

[24] Aged Care Complaints Commissioner 2017 (unpublished data) – 412 responses to surveys from 1 January 2016 to 21 July 2017.

(c) Concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

The way the Commissioner responds to complaints about standards of care is described earlier so here we have focused on feedback arrangements when concerns are raised with us.

People who make open or confidential [25] complaints to the Commissioner are offered feedback about what was done and found in relation to their concerns, the outcome and decisions and reasons for these. Depending on the how the complaint is finalised, we may be required to provide written feedback to either the complainant or the complainant and the provider. The level of feedback provided to the provider (and third party complainants[26]) takes into consideration privacy provisions including confidentiality. Depending on the resolution process adopted, people may also be given oral or written preliminary feedback prior to decisions being made.

Further, the move to an independent Commissioner from 1 January 2016, with a standalone annual report, means that more complaints data and de-identified information about issues and complaints processes is available publicly than previously. For example, we are now publishing quarterly data and associated information about what we do on our website.

However, the Commissioner's ability to share identifiable information about complaints more widely is restricted by the 'protected information' provisions in the Act[27]. These limit the ability of the Commissioner to disclose information about 'the affairs of the approved provider' except in specified circumstances, usually requiring formal release mechanisms.

In light of this, the Commissioner has publicly challenged service providers to talk more openly about complaints, how many they get and what they do about them. Service providers have a greater ability to do this than the Commissioner.

Greater transparency for the public could boost public confidence in the value of complaints as part of service improvement; help to reduce fear of making complaints, and provide more information for people making aged care choices. Greater transparency and the release of more information could help to achieve resolution for families where there have been serious failings in care for a relative who is deceased. It is not uncommon in these circumstances for people to feel that while improvements have been made for others there has been insufficient recognition of what has happened to them.

(d) The adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden

Dr Groves' report[28] on the review of Oakden highlighted medication errors and increased use of restraint as areas of concern. Between 1 January 2016 (when the Commissioner began operations) and 17 March 2017[29] the Commissioner did not receive any complaints or enquiries (contacts) about

[25] Feedback cannot be provided if the complainant is anonymous

[26] People who are not the care recipient or do not represent the care recipient

[27] Protected information is defined by Section 86-1 of the *Aged Care Act 1997* and includes personal information (as defined by the *Privacy Act* 1988) or relates to the affairs of an approved provider.

[28] Groves, A 2017, *The Oakden Report*, Government of South Australia.

[29] On 17 March 2017 the Department imposed sanctions on the approved provider of Makk and McLeay.

Makk and McLeay Nursing Home (Makk and McLeay)[30]. We also did not inherit any open cases from the former Aged Care Complaints Scheme (the Scheme) in the Department. Therefore our comments on medication handling practices and restraint relate to what we have seen in other complaints nationally since 1 January 2016.

Of the 10,179 complaint issues raised with the Commissioner in 2016, 589 (6%) involved medication administration and management. These related mostly to concerns about medication administration errors, e.g. wrong medicine/ wrong dose/ wrong time; omission of medicine and/or the wrong method of administration. An examination of these issues identifies two common concerns:

- Complaints show there can be inconsistency in the skill levels of staff who administer medicines in aged care facilities. The risks seem particularly high in relation to administration of high risk medicines and 'as required' (PRN) medicines. In these cases an understanding of the pharmacological impact on a person is essential to safe administration and evaluation of the medicine's effects.
- The failure of some service providers to identify medication errors and to apply a systemic approach to assessing the risks and implementing strategies to prevent the errors and control those risks.

Complaints about chemical restraint have most commonly been about the use of antipsychotics (e.g. risperidone, olanzapine and haloperidol) and anxiolytics (e.g. oxazepam and lorazepam). These medicines, along with hypnotics and antidepressants, are known collectively as psychotropics. Not all administration of psychotropic medicines is intended as chemical restraint. In examining a complaint about the use of psychotropic medicines we consider if informed consent has been obtained from the care recipient or their representative, what the drugs are being used for, the involvement of medical practitioners, and whether there is appropriate monitoring when these medicines have been introduced to a person's medication regimen to determine their efficacy and early identification of adverse side effects.

Where we find gaps in care in relation to medication management or the use of psychotropic medicines that relate to a single care recipient then we work directly with the service provider to address the deficiencies. Issues that are systemic in nature and affect multiple care recipients are referred to the Quality Agency for their consideration, and where there are concerns about the actions or competency of registered nurses, referrals are made to AHPRA or health complaints entities (many of whom can now also deal with complaints about unregistered carers).

(e) The adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents: and

(f) The division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and federal governments for reporting on and acting on adverse incidents

Complaints about any incident that poses a serious risk to a care recipient are examined thoroughly by the Commissioner. Our examination will consider information from the service provider that includes incident reports, policies, procedures, progress notes, care plan(s) and statements from staff and other individuals as appropriate. Where relevant we will obtain documentation from hospitals, treating physicians and ambulance services. We will then work with the service provider

[30] Makk and McLeay is the aged care part of the Oakden service and the only part we have jurisdiction for.

to address any deficiencies identified and where appropriate refer matters to the Quality Agency, Department, AHPRA and others.

Where a complaint has been made about an incident that has resulted in the death of care recipient the Commissioner will, before taking any action, check if the incident has been or should be reported to the coroner. It is not the role of the Commissioner to determine the cause of death. In circumstances where a death has been referred to the coroner, the Commissioner may examine other aspects of the care prior to the death. The Commissioner may also look at whether there is any ongoing risk to other care recipients.

Compulsory reporting

Prior to 1 January 2016 the responsibility for aged care complaints, compliance and regulation (including compulsory reporting) resided under the one team within each state and territory office of the Department. In practice this meant that a complaints officer in taking a compulsory report from an approved provider would: assess whether the allegation met the definition of a reportable incident; determine if the approved provider had met its reporting obligation; and, determine if there were issues that warranted further consideration.[31] When the complaints function came to the Commissioner, responsibility for compulsory reports remained with the Department.

The MOU[32] between the Department and the Commissioner allows for the Department to refer any concerns arising from compulsory reports to the Commissioner. As mentioned earlier, an example would be where the Department has concerns about whether a service provider has met its responsibilities in responding to a reportable assault. This could include not telling the family and/or ensuring any care recipients are medically reviewed and whether any behavioural issues have been addressed. Where the Commissioner receives such information, we can make enquiries and take action using the own initiative powers[33].

The Australian Law Reform Commission (ALRC) has recently recommended a new expanded serious incident reporting scheme for aged care. It is recommending that this be run by an independent agency (which it indicates could be the Commissioner), and a more comprehensive definition of 'serious incident.' Decisions on these recommendations are now a matter for the government.

Links to background information about the Aged Care Complaints Commissioner

Aged Care Complaints Commissioner Website

[31] Walton, M 2009, *Review of the Aged Care Complaints Investigation Scheme*, p. 41, "The CIS validates the information received to determine whether the provider has complied with their obligations and responsibilities under the Act. The CIS will also: assess if the alleged or suspected assault is a reportable assault and/or whether there are behavioural management issues which need to be considered; determine whether the provider has advised the relevant care recipient's family and taken appropriate steps to ensure the health, safety and wellbeing of the relevant care recipient; determine whether the provider had taken action to ensure the alleged offender is no longer able to have unsupervised access to care recipients; determine whether the provider has procedures in place to deal with reportable assaults and whether employees are aware of these procedures; determine whether the approved provider and staff have followed their procedures; and if the alleged perpetrator is a staff member, determine if a police check was undertaken and whether convictions were recorded." On 1 September 2011 the CIS transitioned to the Aged Care Complaints Scheme. Compulsory reporting functions stayed the same.

[32] Australian Government Department of Health 2016, *Memorandum of Understanding between Department of Health and Aged Care Complaints Commissioner*, p 6, Section 2.5 – "The department and the Complaints Commissioner may hold information that is relevant to the functions of the other party. Such information may include but is not limited to: current and historical complaints, compliance and prudential or Aged Care Funding Instrument information related to a provider"; and p 7, Section 2.5.6 – "The department may refer issues or provide information relevant to the Complaints Commissioner's responsibilities. This may include, but is not limited to: where the department considers an issue more closely aligns with the Complaints Commissioner's responsibilities; and, where the department identifies issues or information that it considers supports the functions of the Complaints Commissioner."

[33] If the Aged Care Complaints Commissioner receives information (whether in a complaint or otherwise) that raises an issue about the responsibilities of one or more approved providers under the Act or under principles made under section 96-1 of the Act, the Commissioner may undertake a resolution process in relation to the issue. *Complaints Principles 2015.*

https://www.agedcarecomplaints.gov.au/

About the Aged Care Complaints Commissioner

The Aged Care Complaints Commissioner has approximately 150 staff across seven locations (Canberra, Melbourne, Sydney, Brisbane, Adelaide, Perth and Hobart). Its budget for the 2017-18 financial year is $18.3 million.

https://www.agedcarecomplaints.gov.au/about/

Aged Care Complaints Commissioner Annual Report

https://www.agedcarecomplaints.gov.au/wp-content/uploads/2016/09/Aged-Care-Complaints-Commissioner-Annual-Report-2015-16.pdf

Aged Care Complaints Commissioner Corporate Plan

https://www.agedcarecomplaints.gov.au/wp-content/uploads/2017/07/Aged-Care-Complaints-Commissioners-Corporate-Plan-2017-and-2018.pdf

Aged Care Complaints Commissioner Facts and Figures

https://www.agedcarecomplaints.gov.au/quarterly-reports/

Aged Care Complaints Commissioner Legislation and Policies

https://www.agedcarecomplaints.gov.au/about/legislation-and-policies/

Aged Care Complaints Commissioner Service Charter

https://www.agedcarecomplaints.gov.au/about/service-charter/