The importance of clear, achievable and sustainable definitions is the foundation for any policy and procedure yet alone legislation.

We derive our policies and procedures from legislation and the proposed definitions in the draft exposure Aged Care Act – in particular High quality care, are aspirational to say the least. They give unrealistic expectations for the consumer and a bar so high for providers many will find them unachievable.

You can not always provide services at a time, manner and worker preferred to a consumer- there will be many variables and barriers that will prevent this to happen – one most obvious is workforce.

To think you can have a consumer determining roster, duties, responsibilities is unfair- yes the consumer needs to be engaged but there needs to be compromise and flexibility by all relevant parties.

Rights

Rights of consumers need to be observed however it is not a one way process- rights of workers also need to be observed and it needs to be emphasized that at times the Rights of the consumer can be over ridden with existing legislation ie WHS, Anti Discrimination, Mandatory reporting to name just a few.

Complaints process

So we add another layer to the complaints process- will the Aged Care Commissioner have any regulatory power to address complaints with ACQSC?

We know ACQSC is provider focused- again and again they have stated their role is to assess and mitigate risk, to provide advice and resources to providers and monitor. Well we know how well that has gone- refer to [redacted] as a prime example of what a travesty of events over a 3 yr period.

Many consumers, families and workers adversely effected yet the current board remains insitu.

Responsible persons

Responsible persons to be board members, responsible members to be providers- criteria, who is monitoring, report mechanisms

We see an associated provider- who does not need to be registered- what, who and how will they be regulated?

We see a code of conduct for aged care workers- why no registration process?

Applies to disability sector why not to the aged care sector?

Why are we not viewing varying levels of scope of practice for aged care workers ?

Level 1- basic duties not involving any personal care

Level 2- personal care, recreational activities

Level 3- Personal care with technical skills ie mobility transfers, application of assistive aids

Level 4- Specialist care- ie advanced dementia care, palliative care and technical skills within their scope of practice

Registered Nurse, including Enrolled nurses, have scope of practices- why not PSW's??

Retention of staff is reliant on culture and culture is reliant on the board members down- to have board members who are not aged care savvy and no/ minimal currency in clinical governance is a roadmap for disaster.

So who and what monitors appointment of board members??

Consumer advisory reps and panels- who is monitoring those and what is the terms of appointment?

So many questions which I do not find answers to, or cursory reference only, in the exposure draft.

Supporters and Representatives

Have others ASSUME the older person is able to make their own decisions.

Wow that is leaving a very open door and not one I would like legally tested

Reliant on the skillsets, qualifications, experience and knowledge of the consumer will determine the level of assumption and **ASSUME is never a word** to be used.

Should be evidential based .

There will be a need to use both supporters and representatives.

Appointment of a representative should be actively encouraged.

There will be times when the consumer is unable to make informed decisions and they need to have this safeguard in place.

Governance and Regulatory powers

Looks good but the test will be in accessibility, response time, actions.

ACQSC is a toothless tiger at the moment and I fear their focus will continue to be provider and softly, softly approach.

Complaints Commissioner- who, what and how will this operate in a meaningful manner?