Exposure draft - *Aged Care Bill 2023*

Submission of O'Loughlins Lawyers

Background

In December 2023, the Australian government released an exposure draft of *Aged Care Bill 2023* (**Exposure Draft**) for consultation.

The Exposure Draft was accompanied by a consultation document published by the Department of Health and Aged Care (**Department**) called *A New Aged Care Act: Consultation Paper No.2* (at https://www.health.gov.au/sites/default/files/2024-01/a-new-aged-care-act-exposure-draft-consultation-paper-no-2.pdf) (**Consultation Paper**).

The Consultation Paper indicates that once enacted (**new Act**), the *Aged Care Bill 2023* will replace existing legislation, including the current *Aged Care Act 1997* (Cth), the *Aged Care (Transitional Provisions) Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth).

The Consultation Paper relevantly states (on page 10):

> *The aim is to create a simplified, rights-based legislative framework that comprises one main piece of primary legislation that establishes and regulates the aged care system, and a single set of subordinate legislation, known as the Rules.*

It also indicates that information about parts of the Exposure Draft that are still being drafted, along with transitional arrangements and contents of the Rules, are provided in the Consultation Paper, wherever possible (page 8). As to future consultation, the Consultation Paper relevantly states (on page 8):

> *Aspects of the Bill not included in the Exposure Draft will reflect existing arrangements under the current aged care legislative framework, and are not the focus of this consultation process. Existing provisions will, however, need to be redrafted to fit into the new legislation. Some parts of the Bill, such as fees, subsidies and means testing, are also under active consideration by the Aged Care Taskforce, so further changes may be included following decisions of Government.*
>
> *We will consult on such matters separately where required, as well as on any policy changes not yet included in the Exposure Draft (for example, the proposed new critical powers for the Aged Care Quality and Safety Commission (Commission) discussed at Chapter 6).*
>
> *The text of the Consequential Amendments and Transitional Arrangements Bill will be the subject of more limited consultation with relevant groups of stakeholders in 2024.*
>
> *Drafts of the proposed Rules will also be released later for comment and feedback, ahead of commencement of the new Act.*

The parts of the Exposure Draft that are not yet available for review at the time of this submission are:

- Chapter 2, Part 4 – Prioritisation;
- Chapter 2, Part 5 – Place allocation;
- Chapter 4 – Fees, payments and subsidies;

- Chapter 6, Part 11 – Critical failures powers; and
- Chapter 8, Part 2 – Review of decisions.

In addition, we note that there are various individual sections in other chapters that are 'to be drafted' or refer to sections to be drafted, being s37(f), s296(1)(e) and (f), s296(2)(b), s365(1), s366(1), s367(1), s368(1), s369(1), s398(1)(b) and (3), s399(1) and (3) and s407(2).

The Department has invited submissions in response to the Exposure Draft by 16 February 2024, which has since been extended to 8 March 2024. The Consultation Paper notes that there are questions set out in the paper which can be used as a guide when drafting a submission. The paper also notes that the Department is particularly interested to hear views about the following (as set out on page 7):

- whether the reform timetable needs to be adjusted, noting the proposal for the new Act to commence on 1 July 2024;
- the operation of draft provisions included in the Exposure Draft and what is proposed for the Aged Care Rules (the **Rules**);
- whether the draft provisions give effect to the policy intent and the Royal Commission's vision for the future of aged care;
- how the Department has responded to feedback received to date on proposed inclusions in the new Act, and
- the intent for parts of the Bill still being drafted, as explained in the Consultation Paper.

Purpose of this document

This document comprises O'Loughlins Lawyers' (**we**, **us**, **our**) submissions on the new Act.

In the submissions, we comment on various material issues that we have identified in our review of the Exposure Draft.

We have felt unable to comment at all, or in a fulsome way, on many of the sections of the Exposure Draft given that the proposed new Rules, and indeed some sections of the Exposure Draft itself, are not yet available and also due to the limited consultation period.

Our comments in this document are therefore preliminary only and subject to our consideration of the complete Exposure Draft and Rules.

In addition, our comments in relation to state law and its interaction with the new Act apply to South Australia, except where specifically stated otherwise.

Issues

We submit the following issues for consideration.

1. Supporters and representatives

1.1 Right of older Australians to autonomy

Page 27 of the Consultation Paper states:

> *Establishing the roles and duties of supporters and representatives in the new Act responds to the Royal Commission's recommendation that the new Act uphold the right of older Australians to autonomy, the presumption of legal capacity, and in particular the right to make decisions about their care, the*

quality of their lives and the right to social participation (Recommendations 2(b)(ii)).

Section 28(1) of the Exposure Draft provides that a person must not make a decision under, or for the purposes of, the new Act on behalf of an individual unless the person is appointed as a representative of the individual under section 376.

Section 28(2) states that s28(1) applies even if the person has (among other things) guardianship under a law or holds an enduring power of attorney granted by the individual or any other form of authority or appointment referred to in s28(2) or is a person of a kind specified by the Rules (s28(2)(e)).

There is an extract of s28 in Schedule 1 to this submission.

Section 376 sets out the process of appointment of representatives. That section is extracted in Schedule 2 to this submission.

Section s376(1) of the Exposure Draft states: 'The System Governor may decide whether to appoint a person, for the purposes of this Act, to be a representative of an individual accessing, or seeking to access, funded aged care services.'

Further, the appointment may be made (a) on the request of a person (including the individual) or body; or (b) on the initiative of the System Governor (s376(2)).

While there is, as yet, no guidance as to when, or the circumstances in which, the initiative of the System Governor may be exercised, at a high level we query how the overlay of a requirement for a government-nominated delegate to appoint who is to represent an older person gives effect to the Royal Commission's recommendation referred to above.

In principle, the overlay of an appointment process under the Exposure Draft for those legally appointed representatives under state law to have rights to make decisions under the new Act contradicts the stated policy position. An older person might rightly ask – why does my private decision to appoint a particular person or persons to represent me need to be (in effect) ratified by the government before my chosen appointees can act under the new Act?

Further, there are other components of the proposed framework that also appear to be inconsistent with this stated policy position, as noted in paragraph 1.2 below.

1.2 **Amendments following consultation**

Page 29 of the Consultation Paper states:

- *People will now be able to have multiple supporters, or multiple representatives at the same time. However, they will only be able to have one of either a supporter or representative. This reflects the feedback that people often want to have more than one person appointed as a representative or supporter. It also recognises the complex reality of support networks and social/family relationships. Providing for multiple supporters or representatives, but not both at one time, aims to:*
    - *make it clear what kind of support network someone has*

- *allow people to appoint a number of trusted family/friends/advocates to reflect the complex reality of support networks*
- *allow people to replicate appointments made under state and territory schemes (for example, Enduring Power of Attorneys), and*
- *clarify who is authorised to receive information and/or make decisions.*

- *If someone is applying to be appointed as an individual's representative and they are already appointed:*

  - *as a Guardian under a law of the Commonwealth, or a State or Territory*
  - *by a court or tribunal and have power to make decisions for the person as an enduring power of attorney, or*
  - *as a nominee of the older person for the purposes of the NDIS or Services Australia*

  then the System Governor must appoint them as the older person's representative, unless there is a good reason not to (for example, where it is clear that the person is unable to comply with the duties of representatives). This also covers situations where there is evidence of elder abuse. This change responds to feedback that the supported decision-making framework under the new Act needs to recognise existing appointments under state and territory laws.

As a general observation, we query how the System Governor will have access to the facts and information required to know whether there is 'good reason not to' appoint a particular representative. This is not evident on the face of the Exposure Draft. There is neither power to compel, nor authority to provide, information on which such a decision could be based.

In our view, there are other components of the proposed framework that do not align with, or achieve, the above statements in all respects as set out below in paragraphs 1.3, 1.4, 1.5, 1.6, 1.7 and 1.9.

1.3 **Obligation to have regard to appointments under state law does not always apply**

As noted above in paragraph 1.1, s376 sets out the process of appointment of representatives for the purposes of s28.

Section 376(4) provides that if there is a person referred to in s28(2) of the Exposure Draft in relation to the individual and that person makes a request to be appointed as a representative of the individual, the System Governor *must*, subject to s376(6) and (7), appoint the person to be a representative of the individual under s376(1).

There is an extract of s28(2) in Schedule 1 to this submission and an extract of s376 in Schedule 2.

Section 376(5) provides that when considering whether to appoint a person under s376(1) to be a representative who is *not* a person referred to in s28(2) (that is, does

not hold any of the appointments listed), the System Governor must[1] have regard to whether there is any person referred to in s28(2) in relation to the individual.

However, where s376(5) does not apply because the person who has made the request *is* a person referred to in s28(2), there is not an equivalent obligation on the part of the System Governor to consider whether there are any *other persons* appointed under s28(2) who have not yet made the request.

Even if the person making the request gives the System Governor a copy of the document evidencing that there is a person referred to in s28(2), there may be other appointments made by the individual which are not referred to in that document. For example, the person making the request may be appointed as an attorney under a power of attorney document. Even if that is given to the System Governor, there may also be an advance care directive in place which appoints a different person.

Although s376(6)(c) requires the System Governor to take into consideration the wishes (if any) of the individual regarding the making of the appointment, this may not necessarily reveal whether there are in fact other relevant persons or documents in effect (particularly if the individual no longer has capacity to provide that information). Further, that subsection does not expressly require the System Governor to have regard to this question, as is required where s376(5) applies.

In our view, s376(5) should be amended (or incorporated into s376(6)) so as to apply to any appointment being considered, not only when the appointment being considered is a person not under s28(2), as there may be multiple persons under s28(2). Those other persons should be consulted by the System Governor as part of the appointment process.

1.4 Joint and several appointments only

Our state law allows an individual to appoint substitute decision-makers and attorneys jointly *or* jointly and severally (or 'together', in the case of an advance care directive which appoints more than one person).

In broad terms, if an appointment is made jointly this means that if a decision is made, the appointees must make the decision jointly and cannot act individually in that regard.

An older person might decide to appoint their children jointly when there are strained relationships or (say) where one child tends to 'dominate' the others. Joint appointment can also be significant if decisions about palliative care are being made as some individuals may wish to elevate this level of decision-making to require joint decisions.

Our South Australia Civil and Administrative Tribunal (**SACAT**) can appoint a guardian and/or administrator in relation to an individual (where (say) an individual has not made a relevant appointment or the appointment made by the individual requires review). If more than one guardian and/or more than one administrator is appointed for an individual by SACAT, all of the guardians, or all of the administrators (as the case may be), must (subject to the order of appointment) concur in every act

[1] Again, and further to our general observation in paragraph 1.1 above, we query the process by which the System Governor will have regard to that circumstance.

done or decision made in relation to the individual or to the individual's estate (s52, *Guardianship and Administration Act 1993* (SA) (**GAA Act**).).

Section 376(3) provides that the System Governor may, under s376(1):

(a) appoint one person to be the representative under s376(1); or

(b) appoint 2 or more individuals, jointly and severally, as representatives of the individual.

This wording appears to preclude appointments as representatives under the new Act that are joint only.

To recognise 'the complex reality of support networks and social/family relationships' and to 'allow people to replicate appointments made under state and territory schemes', the Exposure Draft would need to (among other things set out in this submission) be amended to recognise and incorporate joint appointments (where appliable) into the framework.

There are other issues arising from this, as set out in paragraphs 1.5 and 1.6 below.

1.5 **Joint-appointees under state law and status under Exposure Draft**

It is unclear whether a joint-appointee in a position referred to in s28(2) would qualify to make a request under s376(4) without the other joint-appointee also applying. For example, does a person 'hold' an enduring power of attorney granted by the individual (as referred to in s28(2)(c)) if they can only act under that power jointly with another person? It is arguable that they do not *hold* a power, as they are only able to act under that power jointly with another person.

Further, and to expand upon the issue raised under the preceding paragraph 1.4 , if both persons apply under s376 and are appointed, then on the current drafting of the Exposure Draft they could only be appointed to act jointly *and* severally.

This would seem to contradict the basis of the right to make the request, being (in the above example) a *joint* power to act as attorney. It would also appear to be inconsistent with the wishes of the individual concerned and on the current drafting would not allow individuals to replicate appointments under state law.

1.6 **No delineation of roles as between representatives**

Under South Australian law, there are already long-established frameworks for older people to legally appoint who they would like to represent them in two, often distinct, areas:

(a) decisions related to care, accommodation and lifestyle matters (for example, substitute decision-maker(s) under an advance care directive); and

(b) decisions related to financial matters (for example, attorneys under a power of attorney or enduring power of attorney who, subject to the conditions of the power, can also 'stand in the shoes of' the individual for legal purposes).

The current drafting of the new Act does not allow for this type of delineation of roles.

Section 27(1) states that 'a representative' of an individual may, on behalf of the individual, do any thing that may or must be done by the individual under, or for the purposes of, the Act. Section 27(3) confirms that doing a thing includes making a decision.

At present, the only differentiation in decisions that is provided for is making a decision related to a restrictive practice (s27(2)). It would appear that the remainder of decisions are 'at large', with no ability to delineate between certain 'roles' as can be done at the state level and no ability to incorporate and have regard to limitations on authority (for example, where a person is appointed as a limited guardian by SACAT, rather than as a full guardian, or where there are limitations to a power of an attorney articulated in the appointing document).

An older person may wish to appoint one family member to assist with decision-making in relation to care (under an advance care directive) and another (different) family member to attend to financial matters (under a power of attorney). That level of detail and nuance is lost under the new Act. Under the current drafting, both family members may request to be appointed as representatives. Once appointed, it appears that the roles in effect converge for the purposes of the new Act, such that the family member who the individual had intended to manage issues related to care could validly make financial decisions for the purposes of the new Act and vice versa.

We make the following further comments:

(a) Firstly, this outcome would plainly be inconsistent with the particular arrangements that the individual had chosen and the new Act as currently drafted does not currently allow those arrangements to be fully replicated.

(b) In addition, the proposed framework may lead to inconsistencies between the right to make decisions under the new Act and the power to implement those decisions under state law, particularly in relation to financial and legal matters.

Under the above scenario, although the relevant decision may be validly made under the new Act (for example, the decision to enter into an agreement and consequently incur fees for the individual), it is unclear how a representative who is not also appointed as an attorney or administrator could effectively deal with the individual's bank or manage the individual's finances and assets, including liquidating assets, to put the decision into effect (if that was required). We would expect that the individual's bank would require the relevant representative who was appointed as attorney to carry out decisions concerning the individual's bank account, despite (it would seem) that both representatives could validly make the decision under the new Act.

Further, as noted above, decisions could extend well beyond (for example) putting in place a direct debit arrangement with a bank to facilitate payment of fees. If shares, real property or other assets need to be sold to ensure that there are funds in the account for payment this is arguably reaching well into the domain of an attorney's role. The new Act does not appear to address the status of a decision for the purposes of the new Act in relation to third parties and whether third parties can rely on it. Even so, we query whether it is appropriate from a policy perspective for the Act to be amended to provide for a representative under the Act to be given financial authority to deal with third parties to the extent of an attorney, where the representative is not

already appointed by the individual as attorney or as an administrator under the GAA Act. We are concerned that this may open up a further avenue for financial abuse.

(c) While the above issue may be 'manageable' where the representatives are family members who 'get along', we query how the joint and several status of representatives, coupled with the lack of 'role delineation', would operate where the appointees under state law are not related, are related but do not 'get along' and/or where one or both are appointed in a professional or other capacity. For example:

(1) A family member appointed as substitute decision-maker under an advance care directive and the individual's lawyer or accountant appointed as attorney;

(2) A family member appointed as substitute decision-maker under an advance care directive and Public Trustee appointed as administrator by SACAT;

(3) A family member appointed as guardian and Public Trustee appointed as administrator by SACAT;

(4) The Office of the Public Advocate (**Public Advocate**) appointed as guardian and a family member or other person(s) appointed as attorney;

(5) The Public Advocate appointed as guardian and Public Trustee appointed as administrator by SACAT.

Will a person in a professional services role or the role of the Public Advocate or Public Trustee wish to consent to act as a representative where there is a coalescence in roles and duties and in circumstances where representatives can act jointly and severally?

The role of the Public Advocate is a creation under the GAA Act. One of the functions of the Public Advocate is to perform such other functions as are assigned to the Public Advocate by or under that Act *or any other Act*. Public Trustee is created and regulated by the *Public Trustee Act 1995* (SA) (**PT Act**). Its scope and functions include that it may act in any other capacity provided for under that Act or any other Act.

In our view, it is arguable on the wording set out above that the GAA Act and PT Act would allow the Public Advocate and Public Trustee to act as representatives under the new Act. However, we submit that the new Act (and/or the state legislation) should expressly address this issue for certainty that their respective powers (and any corresponding immunities and indemnities under their founding legislation) will be enlivened.

Under the GAA Act, the Public Trustee may only be appointed by SACAT as a sole administrator (and will not be appointed jointly or jointly and severally). By comparison, the Public Advocate can be appointed along with another guardian – although in our experience, this is generally where each guardian holds a different category of decision-making (such as, the Public Advocate makes accommodation decisions, but another guardian makes health decisions). This multiple appointment, but for different reasons, is generally a

result of conflict within the family regarding the category of decisions granted to the Public Advocate, who is therefore appointed as a last resort. Relevant to the delineation discussed above in this paragraph 1.6, under the GAA Act Public Trustee will only manage the legal and financial affairs of a person while the Public Advocate will only manage accommodation, health and lifestyle affairs. We query whether either will take on a role as representative under the new Act that has essentially 'merged' all types of decisions and does not provide for delineation of decisions equivalent to South Australian law (particularly where Public Trustee can only be appointed as sole administrator under the GAA Act).

In summary, even if the Public Advocate and/or Public Trustee could technically accept an appointment as a representative under the new Act, we query - would they, given the issues set above? We make further comments on this issue in the following paragraph 1.7.

1.7 **Lack of clarity regarding operation of state laws**

It is unclear whether and to what extent state laws in relation to the appointment of substitute decision-makers, attorneys, guardians and administrators will operate concurrently with the new Act once a person is appointed as a representative under s376.

In other parts of the new Act, there is a statement that the part does not exclude or limit the operation of a law of a State or Territory that is capable of operating concurrently with the part (for example, s126 and s361). There is no such section in the parts of the new Act related to supporters and representatives, which adds to the uncertainty.

For example, when making a decision as a guardian under the GAA Act, the guardian will need to be guided by the decision-making principles in that Act, whereas if they are acting in their role as a representative under the new Act they will need to be guided by the duties and principles in the Exposure Draft. Currently, the GAA Act takes a more protective approach than the Exposure Draft (the latter of which is more in line with a supported decision-making framework). To deal with this, the representative will need to be able to determine which legislation they are acting under – that is, which Act is the decision being made under.

Even if the state-based laws are excluded in relation to decisions made under, or for the purposes of, the new Act there will be many 'things' and 'decisions' which are relevant to the aged care services being provided to the individual, but which are likely to fall outside of the new Act – for example, decisions made in relation to the individual while on hospital leave, or medical decisions made with the individual's general practitioner or specialist, or interactions with the individual's bank in relation to payment of aged care fees or accommodation costs (as the bank would likely require a representative to deal with the bank in the representative's capacity as attorney under the state legislation, as opposed to representative under the new Act). In those instances, the state law may apply (or need to apply) to the decision.

We anticipate that a person who holds an appointment in a professional or statutory capacity will be particularly interested in the answer to these questions before consenting to be a representative. There may be other relevant issues of liability, indemnity and/or insurance for the person which depend upon the answer.

If a person in a statutory role such as Public Trustee or the Public Advocate was not willing to accept appointment as a representative, who will be the representative of last resort if the individual does not have family members or friends who are prepared to be appointed?

We also note that there are various other duties of substitute decision-makers, attorneys, guardians and administrators which may apply under the relevant state legislation, such as the duty to keep records. If state law is not intended to operate concurrently where a representative is making a decision or doing something under, or for the purposes of, the new Act, will other relevant duties as set out under state law be articulated in the Rules?

1.8 **Interplay between supporters and representatives under the new Act and nominees under the NDIS Act**

Some residential care providers are dual registered under the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**) and the current Aged Care Act because they provide residential care to NDIS participants.

For a NDIS participant in residential care, the provision of residential care under the Aged Care Act will typically constitute the majority of the services provided under the NDIS participant's plan under the NDIS Act. In other words, there is significant overlap in services provided to a NDIS participant for the purposes of the current Aged Care Act and the NDIS Act.

Under section 376 of the new Act, a person who is appointed as a nominee of an individual under the NDIS Act is in the group of persons who may be appointed as a representative under the new Act (s376(4) and s28(2)).

The Exposure Draft does not delineate between decisions made and things done in respect of a NDIS participant by a person in their role as (a) a nominee for the participant under the NDIS Act and (b) a supporter or representative under the new Act (assuming the same person is appointed). Are they doing a thing, or making a decision, under the NDIS Act or the new Act and, if those roles are held by different people, who is a provider to take instructions from?

1.9 **Right to make decisions on behalf of individual**

We have concerns about the approach that a representative can make decisions for an individual when that individual still has the capacity to make the decision themselves. In South Australia, a guardian or a substitute decision-maker has no authority to make decisions for an individual until that individual lacks the capacity to make the decision themselves. In addition, an attorney cannot act under an enduring power of attorney if it is only effective once the donor suffers a legal incapacity.

We appreciate that there is a duty under the Exposure Draft to try help the individual to make their own decision, but we are concerned that this will not be sufficient to protect against the risk of overly controlling representatives who may believe that they know best and pressure the individual into deferring decision-making to them.

We think there is a risk of elder abuse in this approach, as opposed to not authorising the representative to make decisions until the individual lacks the capacity to do so and thereby ensuring that the individual remains at the centre of, and the contact point for, decision-making for as long as possible.

Related to that issue, we are concerned about the drafting of section 30(2)(b)(i) of the Exposure Draft. That subsection provides that it is a duty of a representative to refrain from doing a thing on behalf of the individual under s27 unless the representative is satisfied that it is not possible for the individual to do, or to be supported to do, the thing. Our concern with this drafting is that the determination of whether the individual is capable of doing a thing is a subjective assessment by the representative. In our view, this is an inappropriate test when dealing with the removal of decision-making from an individual. The test is not even objective, such as by using the wording: 'the representative is reasonably satisfied'. By comparison, under South Australian legislation dealing with decision-making[2] there is an objective test for decision-making capacity set out in the legislation to objectively determine whether an individual has the ability to decide something or not. For example, in the *Advance Care Directives Act 2013* (SA), the test is as follows:

> **7—Impaired decision-making capacity**
>
> (1) For the purposes of this Act, a person will be taken to have impaired decision-making capacity in respect of a particular decision if—
>
> (a) the person is not capable of—
>
> (i) understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision); or
>
> (ii) retaining such information; or
>
> (iii) using such information in the course of making the decision; or
>
> (iv) communicating his or her decision in any manner; or
>
> (b) the person has satisfied any requirement in an advance care directive given by the person that sets out when he or she is to be considered to have impaired decision-making capacity (however described) in respect of a decision of the relevant kind.
>
> (2) For the purposes of this Act—
>
> (a) a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature; and
>
> (b) a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time; and
>
> (c) a person may fluctuate between having impaired decision-making capacity and full decision-making capacity; and
>
> (d) a person's decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.

Setting out this objective test in the legislation ensures that the test is objective and that all relevant parties (the individual, the decision-maker, service providers, the courts and tribunals and medical professionals) are aware of the demarcation between when an individual can make a decision and when they cannot, as opposed the decision-maker deciding based on their own subjective opinion.

Another relevant issue is the process by which an individual may request the System Governor to cancel the appointment of a person as a representative under s387. In broad summary, if the individual wishes to cancel the appointment, they must make a

[2] For example, the GAA Act, s3(1) 'mental incapacity', the *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s4(2) and (3) and the *Advance Care Directives Act 2013* (SA), s7.

written and verbal request to the System Governor and the System Governor must consider and decide whether to cancel the appointment (s387(1)). If the individual has capacity, then under state law the individual is able to revoke any appointment that the individual has validly made and this takes effect upon that revocation occurring. The approach in s387 is at odds with the right of an individual who has capacity to revoke an appointment under state law – again, it is unclear why the rights of an individual under state law to make a decision should be fettered, and potentially overridden, by this type of regulatory overlay at federal level.

1.10 **Signing of agreement with registered provider**

We query whether it is intended that only a representative appointed under s376 may sign a service agreement between a provider and individual.

Sections 27 and 28 appear to be broad enough for this to be a requirement, although we have not yet seen the specific provisions about what agreements must contain and how they may be signed. In addition, there does not appear to be a 'statutory right to sign' provision equivalent to s96-5 of the current Aged Care Act.

Section 379(1) requires the System Governor to give written notice of the appointment of a supporter or representative to (among others), each registered provider that delivers funded aged care services to the individual. That contemplates that services may already be provided by the time the appointment is notified in writing, which in turn suggests that an agreement has already been signed by that point.

Similarly, s379(3) refers to an ongoing obligation on the System Governor to give notice of an appointment (while it remains in effect) to any registered provider that *subsequently* starts to the deliver funded aged care services to the individual. Again, this contemplates that an agreement may have already been entered into with the relevant registered provider by the time the written notice of appointment is given.

Although it is possible under ss376 and 381 for an appointment to be made verbally, we query how such a method of appointment can be practically effective where (presumably) the relevant conversation during which the appointment is made is between the System Governor and only one relevant party. If the conversation is between the System Governor and a representative, we submit that it would be unreasonable for this to take effect before written notice is given to the provider. Otherwise, how will the provider reliably know who is properly appointed to act for the individual, including to sign an agreement on behalf of the individual?

Further, and on a practical level, we would expect that requiring an agreement to be signed by a representative appointed under s376 will likely cause delays in the commencement of service. In the case of a residential care service, we query how this will impact upon providers accepting residents from (say) a hospital bed. And even where a representative is appointed under s376, delays may still ensue due to the various steps that a representative must take under s30(3) before the representative makes a decision or does a thing on behalf of the individual under s27. We understand that it is a two-week process to comply with the various requirements of the current Aged Care Act in the lead-up to admission of an individual into residential care. Further, we note that care planning must be done at the commencement of services and therefore the appointment of representatives needs to be early enough to align with that planning.

We also note the challenges mentioned above in paragraph 1.6 that are of particular difficulty when a representative is making legal and financial decisions that intersect with the scope of authority of an attorney or administrator.

It is unclear whether the authority of the representative to make a decision or do anything 'under or for the purposes of the Act' extends to binding the individual to the terms of an agreement with the provider to the extent that those provisions are not strictly required under the Act – for example, an agreement to pay for additional services or other terms required for commercial reasons. An attorney signing on behalf of an individual could clearly bind the individual in this way, but it is not clear whether a representative can do so. This gives rise to uncertainty and is likely to create an administrative burden on providers – for example, the provider may need to have the agreement signed by both the representative and the attorney (and if the same person, then in their respective capacities), to ensure that all obligations are binding.

We submit that taking the above provisions together, and the practical implications that arise in terms of likely delays, the Exposure Draft should amended so as to allow the agreements between an individual and provider to be signed by either the individual (if they have capacity) or a validly appointed attorney or administrator under state law or a representative under a provision equivalent to s96-5 of the current Aged Care Act.

1.11 **Appointment of representative should be made in writing only**

Further to our comments in the preceding paragraph 1.10, we submit that an appointment of a representative should be made in writing only.

We query how an appointment which affects the rights and obligations of multiple parties can reasonably and practically take effect verbally during a conversation between the System Governor and only one of those parties (presumably a representative). This would mean that between the time of the appointment and written notice being given, a person will have gained a statutory right to make decisions for an individual under the new Act without the provider – or in fact the individual concerned (who we note may still have capacity to make their own decisions) - having any independent and verifiable knowledge of the relevant appointment. The challenge and risk this presents outweighs the task of giving written notice.

1.12 **No clear avenue for providers to raise concerns about conduct of representatives**

There needs to be a clear avenue for a provider (or any other relevant person, such as a family member) to be able to raise concerns with the System Governor about the conduct of a representative and have these concerns addressed.

Also, there needs to be an avenue to resolve disputes where multiple representatives are appointed but disagree on the decision to make and/or are giving conflicting instructions (see our comments in the next paragraph 1.13).

In South Australia, there are two avenues for resolving improper conduct by a state level decision-maker or conflict between decision-makers where the relevant individual lacks capacity. The first is through an application to SACAT and the second is through an application for mediation of a dispute to the Public Advocate. There is also the potential for disputes to be elevated to the Supreme Court of South Australia.

The difficulty with the regime proposed under the Exposure Draft is that there are not established avenues or institutions such as there are at the state level to deal with issues of improper conduct or disputes in relation to representatives appointed under the new Act.

We query how this will be addressed – will the Department be setting up a dispute resolution process or 'quasi-hearing' process to address concerns about disputes or improper conduct by representatives or will the proposed new Administrative Appeals Tribunal have a role?

In addition, we also query whether the Exposure Draft is providing for the ability for professional advocates to be a last resort representative when an individual does not have capacity but there is no appropriate person to appoint as representative (for example, where there is no-one suitable to appoint and/or no-one has consented to act as representative).

1.13 **Functions of the Commissioner**

Unfortunately, at present there is currently no way for a provider to initiate a formal process with the Aged Care Quality and Safety Commissioner to resolve a dispute or concerns about the conduct of a representative.

This issue appears to be carried into the new Act.

For example, in the 'Functions of the Commissioner' section (s141), there is a reference to a complaints function. We submit that there should also be a mediation function, so that a registered provider, as well as an individual, can raise issues with the Commissioner to attempt to resolve them.

As currently drafted, what is proposed is a very 'complaints focussed' system, rather than a collaborative one focussed on resolving issues for the benefit of both the individual and the provider/provider's staff.

As noted in paragraph 1.12, there are currently avenues for providers where the individual lacks capacity (that is, by making an application to SACAT to assist). However, where an individual has capacity those avenues are not available to providers. Unfortunately, we have seen many examples of where a home care provider cannot get in contact with an individual due to the individual's informal representative blocking access, in circumstances where the individual has capacity (so there are no grounds to go to SACAT for assistance) and where the provider still has obligations to the individual.

We submit that a provider should be able to go to the Commissioner in those circumstances for directions and gain some level of protection by doing so (for example, from being penalised for breach of duty where the provider is unable to access the individual to deliver services).

1.14 **Suspensions and cancellations of appointment**

Sections 382 to 384 and ss386 to 389 deal with suspensions and cancellations of the appointment of representatives.

Further to the issues raised in the preceding paragraphs 1.12 and 1.13, there is no ability given to providers to:

(a) make a disclosure to the System Governor of information about a representative which the provider in good faith believes should result in the suspension or cancellation of the appointment of that representative;

(b) make an application for such suspension and/or cancellation of the appointment of a representative.

In our experience, providers can sometimes be left with no option but to make an application to SACAT to replace the family member as representative where they hold material concerns about the welfare of the individual. We have seen this happen in a scenario where an individual lacks capacity to make decisions, the representative does not agree with the clinical recommendations of a provider and either (a) attempts to direct the provider to proceed in a way in which the provider believes puts the individual at serious risk or allows the individual to remain at risk and/or (b) 'goes to ground' and does not engage with the provider on the issue.

We have seen many occasions, particularly in home care settings where an individual can be more isolated, where SACAT has been sufficiently concerned about the safety and welfare of an individual that it has made an interim order for the appointment of the Public Advocate (if there are no other family members available and willing to act) until the full hearing can take place. Once an interim order is made, it then allows the provider to validly deal with the Public Advocate and for the safety of the individual to be secured while the process continues.

A material issue with the 'overlay' of representative appointments under the Exposure Draft in this scenario is that before taking steps to apply to SACAT, a provider would not only have to ensure that the Public Advocate is engaged in the proposed appointment as guardian under state law, but also that if such an order of appointment is made by SACAT, that the Public Advocate will then consent to be appointed as representative under the new Act. If the Public Advocate does not agree to that subsequent appointment at the outset, it may be futile for the provider to take any steps to apply to SACAT, because any order obtained (whether interim or final) will be of no effect unless and until the Public Advocate is appointed by the System Governor as a representative.[3]

Further, on the current drafting, a provider will have no formal mechanism to engage with the System Governor to advise if a SACAT process has commenced and/or the outcome, so as to instigate the suspension or cancellation of the appointment of the representative under the new Act in parallel and the appointment of the Public Advocate as representative (assuming that the Public Advocate can, and has, consented to that appointment).

1.15 **Other comments and transitional arrangements**

As set out above, it appears inevitable that an individual will, in many cases, still need an attorney/administrator to deal with legal and financial issues (at the very least, where interacting with the individual's bank) and potentially a substitute decision-maker/guardian (for example, if they spend time in hospital where presumably a representative under the Act will have no authority or in providing consent to a

[3] We refer back to paragraph 1.6 and the issue of whether the Public Advocate can, and if so, will accept an appointment, particularly if there is another representative already appointed as a representative because (say) that person was appointed as the individual's attorney under state law. This is not an unlikely situation. We have assisted a provider to make an application to SACAT to remove an adult child as guardian in circumstances where a lawyer was appointed as attorney for the individual (and the application to SACAT to remove the adult child as guardian and replace them with the Public Advocate was successful).

medical practitioner for medical treatment).[4] If an individual still needs those appointments, why overlay another regime?

It may be preferable to limit the regime to circumstances where no-one is appointed so as to reduce complexity for providers and their staff in having to manage two parallel regimes and to understand who to take instructions from.

This would also mitigate complexity for individuals when appointing substitute decision-makers under an advance care directive, and their appointees, in understanding the demarcation between a decision under the new Act (that requires a separate appointment as representative before an appointee can act) and decisions outside of the new Act.[5]

As noted above, there are many grey areas in terms of the proposed overlay of the supporters and representatives at federal level and to what extent the relevant state laws can/will operate concurrently. We submit that this will need to be clarified in order for the many relevant parties (individuals, representatives, providers, representatives in professional and statutory roles, SACAT and other third parties such as banks) to understand where the lines are.

There will in any event need to be a transition process in place that allows time for the appointment of representatives, especially in circumstances where an individual lacks capacity, to ensure that there is a representative in place to make decisions once this new arrangement commences.

There will need to be communication with, and education provided to, family members and providers about making applications to the Department for the appointment of representatives.

The Department will need to be conscious of the workload and timeframe to put the representatives in place to ensure there is not a gap in decision-making in the transition for individual's lacking capacity (which we expect will mostly be an issue in residential aged care).

We suggest that either there will need to be a delayed commencement for the supporter and representative arrangement, or in the months leading up to 1 July 2024 the Department will need to be putting in place those appointments.

Alternatively, there could be a transitional period where the state and territory level decision-makers still have authority to make decisions under the new Act pending the appointment of a representative.

2. Rights of staff members and other residents

2.1 Statement of Rights

The Statement of Rights is defined to mean the rights in s20.

[4] In addition, an advance care directive and power of attorney may provide a means by which an individual's will and preferences can be ascertained under the new Act.

[5] We note that under the *Advance Care Directives Act 2013* (SA), an individual making an advance care directive must be given a prescribed information statement and the legal effect of giving the advance care directive must be explained to them (s15(1)(b) of that Act). We query whether the Department has engaged with SA Health in relation to the process of updating that prescribed information statement to reflect the relevant demarcation in decision-making between state law and the new Act, so that an individual making an advance care directive (and their appointees) can be assisted to understand that demarcation.

The rights as set out in s20 itself are individualistic in approach and there is no acknowledgement of the rights of others, such as staff members and other residents and/or the responsibilities of individuals and their supporters and representatives to respect those other rights.

Section 21 relevantly provides:

> **21 Effect of Statement of Rights**
>
> (1) An individual is entitled to the rights specified in section 20 when accessing, or seeking to access, funded aged care services.
>
> (2) It is the intention of the Parliament that registered providers delivering funded aged care services to individuals must not act in a way that is incompatible with the rights specified in section 20, taking into account that limits on rights may be necessary to balance competing or conflicting rights and the rights and freedoms of other individuals.
>
> (3) Nothing in this Division creates rights or duties that are enforceable by proceedings in a court or tribunal.

Although s21(2) indicates that it is the intention of Parliament that providers may, in effect, take into account the competing rights of others when delivering funded aged care services to an individual, that intention and acknowledgment of competing rights is not carried through, and embedded into, the Exposure Draft generally.

For example, s30 prescribes the duties of representatives and states that (in summary) if the representative is doing a thing, or refraining from doing a thing, on behalf of an individual under s27, it is a duty of the representative to (among other things) act in accordance with the following principles:

(a) the individual's will and preferences must be given effect or, if they cannot be ascertained, the individual's likely will and preferences must be given effect;

(b) the individual's will and preferences, or likely will and preferences, may be overridden only if necessary to prevent serious risk to the individual's personal, cultural and social wellbeing;

(c) the individual's rights under the Statement of Rights must be promoted and upheld, and actions taken on the individual's behalf must be the least restrictive of those rights

(s30(3)(e))).

Section 30(4) then provides that if the representative cannot act in accordance with all of the principles in s30(3)(e) in doing a thing or refraining from doing a thing on behalf of the individual, the representative must give precedence to those principles in the order in which they appear in that paragraph.

As noted above, the Statement of Rights is defined to mean the rights in s20. Accordingly, it is possible that a representative is, in effect, required to comply with s30(3)(e) and (4) without having regard to s21 and the competing rights that are identified in that section.

There are other examples of this issue in the obligations imposed on the Commissioner. For example, the Commissioner has safeguarding functions which include 'to uphold the Statement of Rights' (s142(a)). Again, there is no mention of those functions being subject to s21.

There are also various obligations on providers and responsible persons to comply with the Statement of Rights, without express reference to s21.

For example, the Rules may make provision for how complaints may be made to the Commissioner about 'a registered provider acting in a way that is incompatible with the Statement of Rights' (s183(2)(a)). Again, there is no acknowledgement of the 'intent' of s21.

We are concerned that government publications and posters showing the Statement of Rights will only refer to the rights in s20 (as that is indeed how the Statement of Rights is currently defined).

In short, the above circumstances may make it more difficult for providers to have regard to, and apply, s21(2) in their dealings with residents, their supporters and representatives and the Commissioner in relation to the Statement of Rights.

In addition, we are concerned that the Commissioner may be constrained by the current drafting of the new Act from being able to give proper regard to the competing rights of others when assessing a registered provider's compliance with the Statement of Rights in certain circumstances.

Please refer to our further comments in paragraphs 2.2 and 2.3 below.

2.2 **Statement of Principles**

We submit that the Statement of Principles and the Statement of Rights should be complementary in effect.

The Statement of Principles includes the following principles (in s22(6)):

> *An aged care system that values workers and carers*
>
> (6) The Commonwealth aged care system:
>
> (a) supports funded aged care services being delivered by a diverse, trained and appropriately skilled workforce who are valued and respected; and
>
> (b) supports aged care workers of registered providers being empowered, including through access to relevant information, to:
>
> (i) provide feedback, suggest measures and take actions that support innovation, continuous improvement and the delivery of high quality care; and
>
> (ii) participate in governance and accountability mechanisms related to the delivery of funded aged care services; and
>
> (c) recognises the important role of volunteers in improving individuals' experiences of the Commonwealth aged care system.

We query how those principles, including the principle that the workforce be 'valued and respected', are properly supported where:

(a) the Statement of Rights does not incorporate an acknowledgment of those rights and there is not reinstatement of the responsibilities that were included in earlier Charters prescribed for the purposes of the current Aged Care Act (for example, the *Charter of Care Recipient's Rights and Responsibilities – Residential Care* and the *Charter of care recipients' rights and responsibilities—Home care*)[6];

(b) various sections of the new Act may technically require other participants in the system (such as representatives and the Commissioner) to perform their duties and functions without having regard to those competing rights (such as the examples in the preceding paragraph 2.1); and

(c) even the statutory duties, and conditions on registration, of providers omit a suitable confirmation and recognition of the effect of s21(2), so as to ensure internal consistency in the drafting of the legislation (s92(1) and s120(2)).

A related example of this incongruence can be found in the definition of 'high quality care', being (among other things) a service delivered in a manner which upholds the rights of the individual under the Statement of Rights, which also prioritises (among other things) 'worker retention' (s19(c)). How can a provider effectively do this without the Statement of Rights itself incorporating the principle of competing rights and suitable responsibilities of individuals and their supporters and representatives to respect the rights of staff and other residents?

In that regard, we also note that s27(5) and the responsibilities of representatives only extends to requirements of the individual under, or for the purposes of, the new Act. Without including express responsibilities of individuals and representatives in the new Act itself to respect the rights of staff to work in a safe environment, we query how this principle can be practically enforced.

In the Consultation Paper, the Department states (on page 24):

> - We have not expanded the Statement of Rights to include workers' or carers' rights as requested by some stakeholders. This is because such rights are covered by other legislation. Our focus is on what older people should be able to expect when accessing, or seeking to access, services under the new Act.
>
> We also heard from some stakeholders that the new Act should include a list of the responsibilities of older people, as well as their rights. This feedback has not been actioned at this time – noting such responsibilities were removed from the aged care framework several years ago and can be dealt with outside of the legislation if considered useful.

In our view, the intent of those statements does not align with the effect of the new Act. For example, how can one resident accessing residential care services have an expectation of a right to be treated in a respectful manner by another resident if that

[6] See paragraph 2.3 below.

other resident only has 'rights' under the Statement of Rights, and no corresponding responsibilities to treat the first resident in a respectful manner?

Further, under the current drafting, providers appear to be left in the situation where they have positive obligations to protect the safety of staff under other workforce laws, but where there are no specific responsibilities of individuals and/or supporters and representatives in relation to worker safety to point to under the new Act to assist with the provider's compliance with those other laws. The importance of including responsibilities on individuals (and their supporters and representatives) within the legislation to respect the rights of other people, including other residents, visitors and staff, is demonstrated through the statutory interpretation undertaken in the judgment of *McGough v The Aged Care Quality and Safety Commissioner* [2022] FCA 523 [141]-[159], which was applying the legislation when it included responsibilities imposed on individuals (and their supporters and representatives). Please see our comments under paragraph 2.3 below for further comments relevant to this issue.

2.3 **Suggested amendments**

To mitigate the above issues, ensure that providers are enabled to balance the competing rights of others, comply with other laws (including workplace safety and bullying and harassment laws) and give practical effect to the Statement of Principles regarding worker retention, we submit that the Statement of Rights should be amended to:

(a) expressly incorporate the effect of section 21(2), such that it is clear to all parties involved in funded aged care services that providers may take into account 'that limits on rights may be necessary to balance competing or conflicting rights and the rights and freedoms of other individuals' in complying with the Statement of Rights and that the provider's obligations in respect of the Statement of Rights throughout the new Act will be measured having regard to s21(2);

(b) incorporate specific responsibilities on individuals and their supporters and representatives to respect the rights of staff to work in a safe environment;

(c) incorporate specific responsibilities on individuals and their supporters and representatives to respect the rights of other residents under the Statement of Rights.

Further to paragraph 2.2(a), we have set out in Schedule 3 extracts of the *Charter of Care Recipient's Rights and Responsibilities – Residential Care* and the *Charter of Care Recipient's Rights and Responsibilities – Home Care*, as formerly prescribed under the *User Rights Principles 2014* (Cth).

We submit that the government could incorporate the responsibilities set out in those Charters in the proposed Statement of Rights as a means of addressing the issues referred to above.

3. **Definition of high quality care**

3.1 Under s99 of the new Act, the following condition of registration is proposed:

> *…a registered provider that is registered in a provider registration category prescribed by the rules must demonstrate the capability for, and commitment to, continuous improvement towards the delivery of high quality care.*

3.2 'High quality care' is defined in s19 of the new Act and includes an extensive list of matters.

3.3 Given the proposal to link continuous improvement towards the delivery of 'high quality care' with provider registration, it is concerning that the breadth and generality of the wording used reads more like a statement of principles than a definition that is clear and specific enough to link it to provider compliance. There are many subsections of that definition that are open to interpretation and/or may not be able to be safely complied with by all providers in all circumstances.

3.4 In that regard, we query whether the definition of 'high quality care' will be sufficiently aligned with the new Standards and reasonably supported by the funding model to be introduced under Chapter 4 of the new Act (noting that Chapter 4 and the Rules are not yet available for comment).

3.5 We also query how the definition of 'high quality care' will practically interact with the statutory duties, offences and penalties discussed in paragraph 6 below. In our view, the drafting of the definition and the generality of wording used adds to the concerns as expressed in that paragraph.

4. Privacy issues

4.1 Interaction with Privacy Act

We submit that the interaction of the new Act with the *Privacy Act 1988* (Cth) (**Privacy Act**) should be clarified, such that the new Act clearly explains how the Privacy Act applies in the context of aged care and does not create inconsistency and uncertainty in that regard.

For example, s117 of the Exposure Draft relates to protection of personal information. 'Personal information' is defined to have the same meaning as in the Privacy Act, and yet s117 repeats (but not in exactly the same words) some key concepts in the Australian Privacy Principles without explanation of how the two Acts should together be interpreted. We query whether it is appropriate to include this section at all, if it is not intended to alter the operation of the Privacy Act. If it is intended to alter the operation of the Privacy Act, then the extent of that alteration should be made clear.

In that regard, we also refer to the recent Government Response to the Privacy Act Review Report[7] and note that it contains the paragraph below:

> *Reducing inconsistency*
>
> *The Privacy Act is one piece of legislation in a broader digital and data regulatory framework. There are a number of other legislative provisions (at both the Commonwealth and state and territory level) that authorise the handling of personal information. In order to reduce complexity and compliance costs, the Privacy Act should provide a baseline set of protections that are interoperable with other frameworks that deal with the handling of personal information. To reduce inconsistencies and guide coherence, the Government agrees in-principle the Attorney-General's Department should develop a law design guide to support Commonwealth agencies when developing new schemes with privacy-related obligations (proposal 29.1). The*

[7] Page 16 of the report at Government response to the Privacy Act Review Report | Attorney-General's Department (ag.gov.au))

> *Government also agrees in-principle that a working group should be convened to work towards harmonising key elements of Commonwealth and state and territory privacy laws, with the forward work agenda for the working group subject to agreement with states and territories (proposal 29.3). Opportunities for harmonisation of Commonwealth laws that regulate the handling of personal information should also be considered as part of implementing reforms to the Privacy Act.*

Given the current review of the Privacy Act that is underway and the view of government as already expressed in the course of that review, we submit that it would be preferable to omit s117 and leave issues relating to personal information to be dealt with under the Privacy Act. If necessary, guidance material could be issued to assist the aged care sector to understand how the Privacy Act applies in the context of aged care – rather than embedding potentially contradictory provisions in the new Act.

Another example is the following right in the Statement of Rights (in s20(5)):

> *Respect for privacy and information*
>
> (5) An individual has a right to have the individual's:
> (a) personal privacy respected; and
> (b) personal information protected.

There are many exceptions to the right to privacy in the Privacy Act. The above statement does not recognise those exceptions. Is it intended that those exceptions under the Privacy Act will apply, despite the wording in the Statement of rights above? If that is the intention, then arguably the Statement of Rights should reflect that intention so as not to be misleading as to the scope of that right.

4.2 Protection of certain disclosures by provider to System Governor

Further to our comments under paragraphs 1.12 to 1.14 above that providers should be given a clear statutory avenue to approach the System Governor and Commissioner to express concerns about the conduct of representatives, we submit that any such disclosure should be a permitted disclosure by the provider of the personal information of the relevant supporter or representative for the purposes of the new Act and the Privacy Act. Otherwise, a provider will be at risk of breaching the Privacy Act in circumstances where, from a policy perspective, a provider should be able to disclose information where relevant to the safety and welfare of an individual. In our view, the general protection in s333 would not be sufficiently particular to those circumstances.

As discussed in paragraph 1.14, where individuals are isolated, their safety is at risk and a representative is acting improperly, we have seen in our practice that providers will often step in at their own time and expense to take steps to apply to SACAT to replace the representative. Providers should be protected in disclosing information to the System Governor and/or Commissioner about any such circumstances and any steps the provider intends to take, or is taking, in SACAT to seek to replace the representative under state law.

4.3 **Disclosure of information to representatives**

In our view, the rights of representatives to access information, and the obligations on providers to make disclosures to representatives of that information, under s29 is broader than is required for the representative to fulfil their duties.

In addition, our comments in paragraph 1.6 on the coalescence of roles of representatives delineated under the state law when those representatives are appointed as representatives under the new Act also apply here. What if the individual has deliberately appointed different people under state law to manage care requirements and financial requirements? It may be that the individual does not wish for certain family members to access particular financial information or even the will of the individual.

The drafting of s29 would allow a representative originally appointed by the individual under state law to manage care needs to have access to financial information, and vice versa. Further, the right to the information, along with the duty of a provider to provide that information, is 'at large' and not suitably linked to the fulfilment of a particular duty of the representative and/or the care needs of the individual at a given time.

We suggest that s29 be narrowed accordingly to ensure that the right to information, and the obligation to provide it, is not 'at large' and is linked to particular duty of the representative and/or the care needs of the individual at a given time.

5. **Allocation of residential care places to individuals**

We note that one of the significant changes under the new Act will be the allocation of residential care places to individuals rather than providers. This has been expected for some time.

While the removal of allocated places may ostensibly support 'choice' for individuals receiving residential care, some of the potential consequences seem at odds with the Statement of Principles in the new Act, which includes principles stating that the regulation of the aged care system should promote innovation, and ensure that the sector is sustainable and resilient. These potential consequences are discussed below.

As a result of this, and as noted in paragraph 9.4 below, there is a requirement in the new Act for a residential care home to be 'approved' in order to provide funded aged care services at that home. As noted below, it appears that the requirements for approval of a residential care home will be specified in the Rules, which are not yet available.

The Consultation Paper indicates that the requirements are likely to include certification that the home is in a good state of repair and appropriately maintained, does not exceed its maximum occupancy and complies with health and safety laws and building standards.

Given the substantial cost involved in developing new residential care homes, we expect that providers would want some certainty that any proposed new development would be likely to receive approval as a residential care home before committing to the development – and it is to be hoped that the Rules will provide for some kind of 'pre-approval' process.

Smaller scale, staged developments or developments that are capable of being used for multiple purposes could minimise the risk associated with the significant capital cost of developing new residential care facilities. However, the 24/7 registered nurse requirements may present a barrier to innovative smaller scale and staged developments, as the

requirements apply to each individual facility (with very narrow criteria for the current exemption) - and small facilities may not be able to support a full-time nurse under the current funding arrangements. To encourage innovation and new developments, in our view, it would be appropriate to expand the range of exemptions from the 24/7 registered nurse requirements to allow for innovative models of care where the provider can demonstrate that the model will provide safe, quality care – and particularly where the model aligns with the aspirational 'high quality care' definition. It may also be appropriate to enable temporary exemptions for staged developments, so that the 24/7 registered nurse requirement does not apply in full until the development is completed (provided that the provider can demonstrate that it will have adequate alternative care arrangements in place in the interim).

The removal of allocated places for residential care could also result in there being more physical 'places' in approved aged care homes than individuals who have been allocated a place – meaning that some residential care homes could have difficulty filling vacancies, which could also have a significant impact on financial viability given that most providers rely on having a full or nearly full facility in order to meet their costs. In our view, this is an issue that the Independent Health and Aged Care Pricing Authority will need to consider in making its recommendations in relation to pricing for residential aged care, to assist in achieving the desired outcome of a sustainable and resilient sector.

6. Statutory duties of registered providers and responsible persons

Another significant change in the new Act is the introduction of statutory duties for registered providers and responsible persons, with corresponding offence provisions and penalties.

The fundamental duty for registered providers is to ensure, so far as reasonably practicable, that the conduct of the provider does not cause adverse effects to the health and safety of individuals to whom the provider is delivering funded aged care services.

The corresponding duty for responsible persons is to exercise due diligence to ensure that the provider complies with its duty.

In each case, there are various 'levels' of offence, with penalties corresponding to the level of harm resulting from a breach of the duty and increasing where there has also been recklessness by the provider or responsible person.

We make the following comments:

6.1 Penalties

We note that for providers (other than individuals), the maximum penalty which applies to an offence resulting in death or serious injury is 9,500 penalty units – which is equivalent to nearly $3 million under the current penalty units value.

For responsible persons, the maximum penalty is 1000 penalty units (equivalent to $313,000) or 5 years imprisonment, or both.

These penalties are significantly higher than the penalties in the current Aged Care Act and the NDIS Act.[8]

[8] It appears that they are however still below corresponding penalties in the *Corporations Act 2001* (Cth) and the Australian Consumer Law (under the *Competition and Consumer Act 2010* (Cth)).

A provider or responsible person has a defence if they have a 'reasonable excuse' – which the defendant bears the burden of proving.

6.2 Issues

We query what the impact of these changes will be on a provider's insurance arrangements – firstly, whether their insurer will cover them and their directors and officers for the cost of a penalty for breach of duty, and secondly, what impact that might have on their insurance premiums (and noting that indemnification in relation to civil penalties may, in and of itself, pose a challenge from a legal perspective).

It is significant to note that this duty extends to all 'responsible persons' – not just the board. This means that some senior executives and senior registered nurses will be bound by the statutory duty (and potentially liable for significant penalties). Given current workforce shortages, it may be that this adds an additional challenge to recruitment, particularly for senior registered nurses.

The imposition of these statutory duties on senior staff members seems to undermine the general principle that an employer is vicariously liable for the acts of its employees – removing a degree of protection from employees who are acting in good faith in their role. That is all the more concerning given our understanding that directors and officers insurance would not ordinarily extend to those types of roles.

Although the offences do not apply if the responsible person has a 'reasonable excuse', we suggest that this is 'cold comfort' where the meaning of 'reasonable excuse' will be open to interpretation, the person will bear the evidential burden of proving that there is a reasonable excuse and where it is possible that insurance coverage may not be available.

We note that the proposal to extend the statutory duties to other aged care workers was removed following consultation – which we think is a sensible choice to avoid additional barriers to recruitment.

Finally, and as a general observation, there seems to be a threshold issue in terms of the general increase in duties and penalties in circumstances where the boards of many approved providers (particularly in regional areas) are filled by members of the community on a volunteer basis. If it is determined that directors and officers insurance will not provide coverage for the proposed new penalties, will this deter participation in the sector? Will volunteer board members only be prepared to participate in the sector if they receive payment on account of the increased responsibilities?

Providers have already undertaken a significant piece of work in digesting and implementing the governance arrangements which have gradually been introduced over the last couple of years, with the most significant changes only taking effect as recently as 1 December 2023. We ask whether the government should allow sufficient time to be able to assess the impact of those changes, before overlaying more duties and personal risk for responsible persons in circumstances where many are in fact volunteers and where their contribution is (we would submit) very much needed (especially in regional settings) to keep the sector sustainable. Indeed, one of the principles articulated in the Statement of Principles is that the system is managed to ensure it is 'sustainable and resilient' (s22(12)(a)).

While we of course appreciate the need the protect individuals accessing funded aged care services, we are worried that these further changes do not strike the right balance in a sector already under significant workforce pressures.

The issue also applies to paragraph 7 below.

7. **Compensation pathways**

In addition to the proposed penalties for breach of the statutory duties referred to in paragraph 6, the new Act includes a compensation pathway that applies if an entity is found guilty of an offence, and serious injury or illness resulted from the commission of the offence.

The limitation period for compensation claims is 6 years from the day the cause of action relating to the commission of the offence accrued.

We query the benefit in requiring a provider to make a payment of compensation in addition to substantial penalties for breach of duty, in a sector where financial sustainability is already an issue for many providers. In addition, an individual who suffers loss due to a provider's breach of their common law duty of care already has a cause of action in negligence. It seems unnecessary to add a statutory compensation pathway.

8. **Whistleblower protections**

We note that a disclosure qualifying for protection can be made to a range of people and entities, including an 'aged care worker' of the registered provider (s355(a)). An aged care worker includes (in summary) persons employed or otherwise engaged by the provider (including volunteers) and can extend to include individuals employed or otherwise engaged (including as a volunteer) by an associated provider of the registered provider, where engaging in conduct under an arrangement with the registered provider related to the delivery of funded aged care services (s10(4) and (5)).

The discloser must have 'reasonable grounds to suspect' that the information indicates that an entity may have contravened a provision of the new Act. However, there is no requirement for the disclosure to be made in 'good faith'.

We submit that a disclosure qualifying for protection under s355 of the Exposure Draft should be required to be made in good faith to mitigate against vexatious complaints.

Further, it is concerning that a provider will be required to take 'reasonable measures' to ensure that the fact that an individual was the maker of a disclosure is not disclosed (unless to (among others) a responsible person of the registered provider) where 'aged care workers' are included in the list of people and entities that can receive a disclosure (s360). The reality of training an entire aged care workforce (including a large sub-contracted workforce) to recognise what is a 'disclosure' that requires this protection and for that 'disclosure' to then be reported to the appropriate body or entity makes this obligation practically impossible to implement and comply with.

We suggest that a more workable model would be to allow a registered provider to appoint and train a specific person or persons to receive and manage disclosures.

We also note that there is a proposed change to the types of disclosures qualifying for protection – under the current Act, s54-4(2)(c) refers to a situation where there are 'reasonable grounds to suspect that the information indicates that a reportable incident has occurred'. The proposed new s355(c) refers instead to 'reasonable grounds to suspect that an entity may have contravened a provision of this Act'. While we presume that the intention of

this change is to broaden the types of disclosures qualifying for protection, it may have the unintended consequence that the disclosure of information about some reportable incidents may not qualify for protection, if the reportable incident is not also a contravention of the Act – for example, where the reportable incident involves conduct by a family member of a care recipient. In addition, it is more likely that aged care workers will be familiar with the concept of 'reportable incidents' than understanding what conduct amounts to a contravention of the Act, and we query whether the protection should still expressly include reportable incidents as well as contraventions of the Act.

Finally, we query whether any consideration has been given to how the proposed arrangements may interact with respective rights and obligations under the *Fair Work Act 2009* (Cth), as well as privacy and confidentiality obligations that may be owed to staff members.[9]

9. Consistency with state legislation - retirement villages and supported residential facilities

We submit that detailed consideration is required at state and/or federal level to ensure that the regulatory frameworks will interact as intended once the new Act commences. We raise the following issues:

9.1 Definition of residential care home

Section 9 includes a definition of 'residential care home'. That definition includes, among other things, a place within a retirement village that has been converted to a place described by s9(2) (s9(3)(b)).

Section 9(2) provides that a *residential care home* means a place that:

(a) is the place of residence of individuals who, by reason of sickness, have a continuing need for aged care services, including nursing services; and

(b) is fitted, furnished and staffed for the purpose of providing those services.

We note that section 9(1) states that a funded aged care service can be delivered in (a) an approved residential care home; or (b) a home or community setting.

An approved residential care home is defined as a residential care home that is approved in relation to a registered provider under s67(1)(b).

There is no definition of retirement village in the Exposure Draft. For clarity, but noting our comments in paragraph 9.2, a definition should be included (if that term is used in the final new Act), being a retirement village within the meaning of the applicable Retirement Villages Act for the state or territory in which the village is situated.

There are other issues that are unclear. For example, it is unclear whether all of the individuals in the 'place of residence' need to meet the above criteria or (say) a majority only. Further, does the reference to a place *within* a retirement village that has been converted to a place described by s9(2) mean that the place was formerly part of (or within) the retirement village but following conversion will no longer be so?

[9] Also noting that an issue under consideration in the current review of the Privacy Act is the current exclusion of employee information from the protections of that Act in some circumstances.

How is this intended to apply from a regulatory perspective, in terms of the application of state-based legislation following 'conversion' and its interaction with the new Act?

We make further comments (and raise other queries) below.

9.2 **Exclusion of aged care facilities from RV Act**

The definition of 'retirement village' under the *Retirement Villages Act 2016* (SA) (**RV Act**) is, on its face, broad enough to include a service such as a residential care service operated under the Aged Care Act, because the service is intended for older people and some residents pay a lump sum on entry.

The RV Act utilises various other definitions and concepts (including some concepts in the current Aged Care Act) as a means to expressly exclude residential care services operated under the Aged Care Act from the application of the RV Act.

For example, there is a note under the 'Application of Act' section (s5) of the RV Act which states:

> **Note—**
>
> This Act does not apply in relation to aged care facilities under the *Aged Care Act 1997* of the Commonwealth.

Further, the *Retirement Villages Regulations 2017* (SA) (**RV Regulations**) provides that for the purposes of the definition of 'ingoing contribution' in section 4(1) of the RV Act, an ingoing contribution does not include (among other things) 'an amount paid or required to be paid in consideration for entry into residential care at an aged care facility provided by an approved provider under the *Aged Care Act 1997* of the Commonwealth…' (reg 4(e)).

The effect of those provisions is to confirm the exclusion of residential care facilities operated under the Aged Care Act from the application of the RV Act. This gives residents, operators of retirement villages and providers of residential care facilities, certainty as to which legislation applies.

Further to that, and importantly, it also gives certainty as to the manner in which the relevant lump sum repayment by the resident is regulated and secured. Under the RV Act, a statutory charge (**statutory charge**) applies to land in a retirement village which (in summary) is intended to secure, and give priority to, the repayment of ingoing contributions to residents and the land must be endorsed with a notation to show that it is used as a retirement village. For residents of residential care facilities under the Aged Care Act, the relevant 'guarantee scheme' in respect of refundable deposits applies.

It is evident that consistency will be needed between the relevant definition of an approved residential care home regulated for the purposes of the new Act and the RV Act, so as to maintain the stated exclusion of Commonwealth funded residential care facilities from the operation of the RV Act.

9.3 **Concept of 'conversion'**

As a general observation, and further to our comments in the preceding paragraph 9.2, it appears that any such 'conversion' of a place within a retirement village to a residential care home would need to have regard to the removal of the statutory

charge from that part of the village land, whether that 'place' includes areas that are used by residents of the remaining parts of the village (for example, common corridors and communal facilities such as dining rooms) and the contractual rights of the residents of the village as a whole.

We point out that the RV Act does not prescribe a specific process that can readily be used to excise part of a village for use as an approved residential care home without impacting the rights of existing residents.

If the relevant part is not properly excised from the village in a manner that addresses rights under the statutory charge on the land, as well as contractual rights of residents (which may include rights to use the relevant part), those issues would obviously impact the ongoing operation, and any subsequent sale, of the village and/or the residential care home (including any sale instigated by the Commissioner following the exercise of powers under the new Act).

9.4 **Linking approved residential care home status to registered provider**

We are concerned about the proposal to link the definition of an approved residential care home to the registration status of a particular registered provider. In the Exposure Draft, 'approved residential care home' means a residential care home that is approved in relation to a registered provider under paragraph 67(1)(b)'.

It appears that the requirements for approval of a residential care home will be specified in the Rules, which are not yet available. It may be that the Rules will provide for the preservation of the rights of residents, and the effective status of a residential care home as regulated under the Aged Care Act, should a provider lose registration status. However, this is not yet clear and our comments below are therefore preliminary in nature.

In our view, once agreements are entered into with residents under the Aged Care Act, the status of the residential care home as an 'approved' home regulated under the Aged Care Act should be a 'static' concept and not contingent upon the registration status of a particular provider. This is especially so given the proposal to require providers to re-register every 3 years (or less) and the potential for providers to lose their registration status.

For example, decoupling the approval status of a residential care home from the registration of a particular provider for the purposes of the Aged Care Act may more readily allow the RV Act to (say) exclude 'approved residential care homes' under the Aged Care Act from the operation of the RV Act, without the risk of a residential care home 'falling into' the regulatory framework of the RV Act if the provider loses registration status.

In other words, the operation of the express exclusion under the RV Act and the regulatory framework that applies to individuals receiving residential care should not be dependent upon a fluid concept (such as, the registration status of a provider).

As noted above, we do not yet have the full detail of how this will be managed under the Rules, including whether and how the Rules will provide for the preservation of the rights of residents, and the effective status of a residential care home as regulated under the Aged Care Act, should a provider lose registration status.

In South Australia, short of amendments to the RV Act and RV Regulations, we anticipate any changes required to reflect changes in terminology under the Aged

Care Act and maintain the current stated exemption of residential care services under the RV Act may need to be achieved by a Ministerial exemption. However, it appears that the relevant Minister will need to be able to reference terminology in the Aged Care Act that is sufficiently consistent to identify residential care homes that are regulated for the purposes of Aged Care Act.

We query whether the Department has commenced discussions with state-based regulators to ensure that the 'status quo' under the state-based Retirement Villages Acts can continue.

Given the short timeframe to commencement of the new Act, it may be that suitable transitional arrangements are required in the new Act itself to ensure that the current exclusion of residential care services from the application of the RV Act is not inadvertently disturbed.

9.5 Supported residential facilities

Commonwealth-funded residential care services are currently excluded from the operation of the *Supported Residential Facilities Act 1993* (SA) (**SRF Act**) under a Ministerial exemption. The Ministerial exemption is in the following form:

SUPPORTED RESIDENTIAL FACILITIES ACT 1992, SECTION 4 (3): EXEMPTION BY THE MINISTER

Preamble

Section 4 (3) of the Supported Residential Facilities Act 1992, allows the Minister to whom the administration of that Act is committed to confer exemptions from that Act in relation to specified classes of facilities.

NOTICE

PURSUANT to section 4 (3) of the Supported Residential Facilities Act 1992, I exempt from the Supported Residential Facilities Act 1992, facilities that provide residential care services approved under Part 2.1 of the Aged Care Act 1997, of the Commonwealth.

I declare that this exemption will come into operation on 1 March 2009.

JENNIFER RANKINE, Minister for Housing

It is apparent that the definitions and terminology referred to in the above exemption noticed will be superseded by the new Act.

In line with our comments above in respect of the RV Act, it will be important to ensure that there is consistency in terminology between the new Act and any relevant Ministerial exemptions under the SRF Act, to remove any risk that Commonwealth funded residential care services fall within the ambit of the SRF Act where that is not intended at state level.

10. Reform timetable

We submit that the reform timetable needs to be adjusted to allow sufficient time for consultation on the Exposure Draft (along with sections not yet drafted) and the proposed Rules (once released) to be completed in an orderly way and for necessary amendments to the Exposure Draft and Rules to be drafted.

We would suggest that the current reform timetable is simply too tight to allow for this process to be run in an orderly way, including for providers to have sufficient time to digest, and then implement, the changes and to make amendments to relevant contracts, policies and

procedures. In our view, such a short timeframe for implementation is likely to require a substantial redirection of providers' limited resources towards preparing for the changes, which may compromise their ability to focus primarily on the provision of care and services.

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Schedule 1 – Sections 27 to 30 of the Exposure Draft

The sections extracted in this Schedule 1 are variously referred to in paragraphs 1.1, 1.3, 1.5, 1.6, 1.9, 1.10, 2.1, 2.2 and 4.3 of this submission.

Subdivision B—Actions and duties of representatives

27 Actions of representatives

(1) A representative of an individual may, on behalf of the individual, do any thing that may or must be done by the individual under, or for the purposes of, this Act.

Note 1: If there is more than one representative of an individual, the representatives may do a thing under this subsection jointly or severally: see paragraph 376(3)(b).

Note 2: For the provisions about how supporters and representatives are appointed: see Part 4 of Chapter 8.

(2) However, subsection (1) does not apply to the doing of a thing, including the giving of consent, in relation to a restrictive practice.

Note: The giving of consent in relation to a restrictive practice may be dealt with by rules made for the purposes of section 106 (condition of registration in relation to restrictive practices).

(3) To avoid doubt and for the purposes of subsections (1) and (2), doing a thing includes making a decision.

(4) Any thing done by a representative of an individual under this section has effect, for the purposes of this Act (other than this Part), as if it had been done by the individual.

(5) If an individual is required under, or for the purposes of, this Act to do a thing, failure by a representative of the individual to comply with the requirement on behalf of the individual is taken, for the purposes of this Act (other than this Part), to be a failure of the individual to comply with the requirement.

28 Role of guardians etc.

(1) A person must not make a decision under, or for the purposes of, this Act on behalf of an individual unless the person is appointed as a representative of the individual under section 376.

(2) Subsection (1) applies even if the person:

(a) has guardianship of the individual under a law of the Commonwealth, a State or a Territory; or

(b) is appointed by a court, tribunal, board or panel (however described) under a law of the Commonwealth, a State or a Territory, and has power to make decisions for the individual; or

(c) holds an enduring power of attorney granted by the individual; or

(d) is a nominee of the individual (within the meaning of the *National Disability Insurance Scheme Act 2013* or the *Social Security (Administration) Act 1999*); or

(e) is a person of a kind prescribed by the rules.

29 Giving information and documents to representatives

(1) Any information or document that is required or authorised under, or for the purposes of, this Act to be given to an individual must also be given to the representative (if any) of the individual.

(2) Any information or document given to the representative of an individual under subsection (1) must, in every respect, be in the same form, and in the same terms, as if it were being given to the individual.

30 Duties of representatives

(1) A representative of an individual has:

(a) the duties set out in this section; and

(b) the duty set out in section 31 (duty to inform of matters affecting ability or capacity to act as supporter or representative); and

(c) the duty to act honestly, diligently and in good faith in discharging the representative's other duties; and

(d) any duty prescribed by the rules.

(2) It is a duty of the representative to:

(a) apply the representative's best endeavours to maintain the ability of the individual to make the individual's own decisions; and

(b) refrain from doing a thing on behalf of the individual under section 27 unless:

(i) the representative is satisfied that it is not possible for the individual to do, or to be supported to do, the thing; or

(ii) it is possible for the individual to do the thing but the individual does not want to do the thing themselves.

(3) If the representative is doing a thing, or refraining from doing a thing, on behalf of the individual under section 27, it is a duty of the representative to:

(a) act in a manner that promotes the personal, cultural and social wellbeing of the individual; and

(b) act honestly, diligently and in good faith; and

(c) make reasonable efforts to ascertain the will and preferences of the individual in relation to the thing or, if the individual's will and preferences cannot be ascertained, to ascertain the individual's likely will and preferences based on all the information available to the representative; and

(d) take reasonable steps to consult the following:

(i) any person referred to in subsection 28(2) (which deals with guardians and persons in other similar positions);

(ii) any other representative of the individual;

(iii) when appropriate, any other person who assists the individual to manage the individual's day-to-day activities or, if there is no such person, any family members or other persons who have a close continuing relationship with the individual; and

(e) subject to subsection (4), act in accordance with the following principles:

(i) the individual's will and preferences must be given effect or, if they cannot be ascertained, the individual's likely will and preferences must be given effect;

(ii) the individual's will and preferences, or likely will and preferences, may be overridden only if necessary to prevent serious risk to the individual's personal, cultural and social wellbeing;

(iii) the individual's rights under the Statement of Rights must be promoted and upheld, and actions taken on the individual's behalf must be the least restrictive of those rights.

(4) However, if the representative cannot act in accordance with all of the principles in paragraph (3)(e) in doing a thing or refraining from doing a thing on behalf of the individual, the representative must give precedence to those principles in the order in which they appear in that paragraph.

(5) It is a duty of the representative to avoid or manage any conflict of interest in relation to the representative and the individual, and to inform the System Governor of any such conflict as it arises.

Schedule 2 – Section 376 of the Exposure Draft

Section 376 is referred to in paragraphs 1.1, 1.3, 1.4, 1.5 and 1.7 of this submission.

376 Appointment of representatives

(1) The System Governor may decide whether to appoint a person, for the purposes of this Act, to be a representative of an individual accessing, or seeking to access, funded aged care services.

(2) The appointment may be made:
  (a) on the request of a person (including the individual) or body; or
  (b) on the initiative of the System Governor.

(3) The System Governor may, under subsection (1):
  (a) appoint one person to be the representative of the individual; or
  (b) appoint 2 or more individuals, jointly and severally, as representatives of the individual.

(4) If:
  (a) there is a person referred to in subsection 28(2) (which deals with guardians and persons in other similar positions) in relation to the individual; and
  (b) the person makes a request to be appointed as a representative of the individual;

the System Governor must, subject to subsections (6) and (7), appoint the person under subsection (1).

Note: Guardians and persons in other similar positions must not make a decision under, or for the purposes of, this Act on behalf of an individual unless the person is appointed as a representative of the individual: see section 28.

(5) When considering whether to appoint a person under subsection (1) who is not a person referred to in paragraph (4)(a), the System Governor must have regard to whether there is any person referred to in that paragraph in relation to the individual.

(6) The System Governor must not appoint a person under subsection (1) to be a representative of an individual unless:
  (a) the System Governor is satisfied that the person is able to comply with the duties of representatives referred to in subsection 30(1); and
  (b) the person has given consent to the appointment; and
  (c) the System Governor has taken into consideration the wishes (if any) of the individual regarding the making of the appointment; and

(d) the System Governor has taken into consideration any other matters prescribed by the rules.

Note: The consent of the individual is not required for the appointment of a person as a representative of the individual.

(7) The System Governor must not appoint a person to be a representative of an individual if an appointment of a supporter of the individual is in effect.

Note: If the System Governor intends to appoint a person as a representative but there is already a supporter of the individual, the System Governor must cancel the appointment of the supporter: see subsection 388(2).

(8) An appointment under subsection (1) may be made verbally or in writing.

Note: Written notice of the appointment must be given under section 379 as soon as practicable after the appointment is made.

Schedule 3 – Extracts of previous Charters

Further to paragraphs 2.2(a) and 2.3 of this submission, we set out below extracts of the *Charter of Care Recipient's Rights and Responsibilities – Residential Care* and the *Charter of Care Recipient's Rights and Responsibilities – Home Care* as formerly prescribed under the *User Rights Principles 2014* (Cth).

Schedule 1—Charter of care recipients' rights and responsibilities—residential care

Note: See section 9.

1 Care recipients' rights—residential care

Each care recipient has the following rights:

(a) to full and effective use of his or her personal, civil, legal and consumer rights;

(b) to quality care appropriate to his or her needs;

(c) to full information about his or her own state of health and about available treatments;

(d) to be treated with dignity and respect, and to live without exploitation, abuse or neglect;

(e) to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;

(f) to personal privacy;

(g) to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;

(h) to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;

(i) to continue his or her cultural and religious practices, and to keep the language of his or her choice, without discrimination;

(j) to select and maintain social and personal relationships with anyone else without fear, criticism or restriction;

(k) to freedom of speech;

(l) to maintain his or her personal independence;

(m) to accept personal responsibility for his or her own actions and choices, even though these may involve an element of risk, because the care recipient has the right to accept the risk and not to have the risk used as a ground for preventing or restricting his or her actions and choices;

(n) to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions;

(o) to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;

(p) to have access to services and activities available generally in the community;

(q) to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;

(r) to have access to information about his or her rights, care, accommodation and any other information that relates to the care recipient personally;

(s) to complain and to take action to resolve disputes;

(t) to have access to advocates and other avenues of redress;

(u) to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

2 Care recipients' responsibilities—residential care

Each care recipient has the following responsibilities:

(a) to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;

(b) to respect the rights of staff to work in an environment free from harassment;

(c) to care for his or her own health and well-being, as far as he or she is capable;

(d) to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and current state of health.

Schedule 2—Charter of care recipients' rights and responsibilities—home care

Note: See section 19.

1 Care recipients' rights—home care

General

(1) Each care recipient has the following rights:

(a) to be treated and accepted as an individual, and to have his or her individual preferences respected;

(b) to be treated with dignity, with his or her privacy respected;

(c) to receive care that is respectful of him or her, and his or her family and home;

(d) to receive care without being obliged to feel grateful to those providing the care;

(e) to full and effective use of all human, legal and consumer rights, including the right to freedom of speech regarding his or her care;

(f) to have access to advocates and other avenues of redress;

(g) to be treated without exploitation, abuse, discrimination, harassment or neglect.

Consumer directed care—choice and flexibility

(2) Each care recipient has the following rights:

(a) to be supported by the approved provider:

(i) to set goals in relation to the outcomes he or she seeks from home care; and

(ii) to determine the level of ongoing involvement and control that he or she wishes to have in the provision of the home care; and

(iii) to make decisions relating to his or her own care; and

(iv) to maintain his or her independence as far as possible;

(b) to choose the care and services that best meet his or her goals and assessed needs and preferences, within the limits of the resources available;

(c) to have choice and flexibility in the way the care and services are provided at home;

(d) to participate in making decisions that affect him or her;

(e) to have his or her representative participate in decisions relating to his or her care if he or she requests it or if he or she does not have capacity;

(f) to choose the approved provider that is to provide home care to him or her, and to have flexibility to change that approved provider if he or she wishes.

Consumer directed care—care and services

(3) Each care recipient has the following rights:

(a) to receive reliable, coordinated, safe, quality care and services which are appropriate to meeting his or her goals and assessed needs;

(b) to be given before, or within 14 days after, he or she commences receiving home care, a written plan of the care and services that he or she expects to receive;

(c) to receive care and services that take account of his or her other care arrangements and preferences;

(d) to ongoing review of the care and services he or she receives (both periodic and in response to changes in his or her personal circumstances), and modification of the care and services as required.

Consumer directed care—individualised budget and monthly statement of available funds and expenditure

(3A) Each care recipient has the following rights:

(a) to receive an individualised budget for the care and services to be provided;

(b) to have his or her individualised budget reviewed and, if necessary, revised if:

(i) the care and services to be provided, or the costs of providing the care and services, change; or

(ii) he or she requests the approved provider to review and, if necessary, revise the individualised budget;

(c) to receive a monthly statement of the funds available and the expenditure in respect of the care and services provided during the month.

Personal information

(4) Each care recipient has the following rights:

(a) to privacy and confidentiality of his or her personal information;

(b) to access his or her personal information.

Communication

(5) Each care recipient has the following rights:

(a) to be helped to understand any information he or she is given;

(b) to be given a copy of this Charter;

(c) to be offered a written agreement that includes all agreed matters;

(d) to choose a person to speak on his or her behalf for any purpose.

Comments and complaints

(6) Each care recipient has the following rights:

(a) to be given information on how to make comments and complaints about the care and services he or she receives;

(b) to complain about the care and services he or she receives, without fear of losing the care or being disadvantaged in any other way;
(c) to have complaints investigated fairly and confidentially, and to have appropriate steps taken to resolve issues of concern.

Fees

(7) Each care recipient has the following rights:
(a) to have his or her fees determined in a way that is transparent, accessible and fair;
(b) to receive invoices that are clear and in a format that is understandable;
(c) to have his or her fees reviewed periodically and on request when there are changes to his or her financial circumstances;
(d) not to be denied care and services because of his or her inability to pay a fee for reasons beyond his or her control.

2 Care recipients' responsibilities—home care

General

(1) Each care recipient has the following responsibilities:
(a) to respect the rights of care workers to their human, legal and workplace rights including the right to work in a safe environment;
(b) to treat care workers without exploitation, abuse, discrimination or harassment.

Care and services

(2) Each care recipient has the following responsibilities:
(a) to abide by the terms of the written home care agreement;
(b) to acknowledge that his or her needs may change and to negotiate modifications of care and service if his or her care needs change;
(c) to accept responsibility for his or her own actions and choices even though some actions and choices may involve an element of risk.

Communication

(3) Each care recipient has the following responsibilities:
(a) to give enough information to assist the approved provider to develop, deliver and review a care plan;
(b) to tell the approved provider and their staff about any problems with the care and services;
(c) before the care recipient changes approved providers, to tell the approved provider and their staff of the day the care recipient intends to cease to receive home care services from the approved provider.

Access

(4) Each care recipient has the following responsibilities:

(a) to allow safe and reasonable access for care workers at the times specified in his or her care plan or otherwise by agreement;

(b) to provide reasonable notice if he or she does not require home care to be provided on a particular day.

Fees

(5) Each care recipient has the responsibility to pay any fees as specified in the agreement or to negotiate an alternative arrangement with the provider if any changes occur in his or her financial circumstances.

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