Submission from the South Australian Public Advocate Re: Aged Care Act 2024 Rules consultation release 3

I make this submission regarding release 3 of the Aged Care Rules under the *Aged Care Act 2024* (AC Act) in my role as South Australian Public Advocate.

I am public guardian to approximately 2,260 people, appointed by the South Australian Civil and Administrative Tribunal (SACAT). Of these clients, approximately 520 (23%) reside in residential aged care and 115 (22% of clients in Residential Aged Care) have one or more approved restricted practices in use by their aged care provider. Part of my role as guardian is to consent to a request for a restrictive practice when it is reasonable and necessary and no less restrictive alternative exists. The restrictive practices a guardian can authorise include chemical restraint (where there is no force), environmental restraint (excluding detention and seclusion) and mechanical restraint. Only the SACAT can authorise detention and the use of force (physical restraint), and only once an appointed guardian has applied to the SACAT for those authorisations.

South Australian legislative landscape

In South Australia, there are a number of legal mechanisms that enable the lawful use of a restrictive practice in a range of settings.

The National Disability Insurance Scheme (NDIS) sector is required to seek authorisation for use of a restrictive practice from the Senior Authorising Officer (SAO) pursuant to Part 6A of the *Disability Inclusion Act 2018* (DI Act). This scheme was developed to meet the requirements of the NDIS, and it enables the SAO to authorise 'regulated restrictive practices' but excludes those involving a 'detention'. Where the restrictive practice involves a 'detention' the *Guardianship and Administration Act 1993* empowers the SACAT to authorise its use, and this process requires an application to be made by a guardian. I am often appointed by SACAT solely for this purpose where the person has no other suitable person in their life to be their guardian. The restrictive practices authorisation scheme under the DI Act is functioning well is SA. The Senior Authorising Officer has oversight of the use of restrictive practices across the NDIS sector, requires behaviour support plans for reduction and minimalisation of their use, and ensures due process for their use. When the participant has a guardian there is an obligation on the service provider to inform the guardian of the use of restrictive practices, but the guardian plays no role in the authorisation process.

The DI Act authorisation scheme applies only to NDIS participants, but some participants also receive aged care services and this cross over will increase as NDIS participants age. I have been keen to explore opportunities to better align processes in the disability and aged care sectors for the authorisation/consent to the use of restrictive practices. My clear preference is that guardians are *not* required the be the substitute decision-maker for consent to the use of a restrictive practice in aged care. The Rules appear to allow the substitute decision-maker to be a State-appointed senior authorising officer. This needs to be made explicit. To require guardianship just to provide a vehicle for the authorisation of restrictive practices risks needlessly bringing many more people under guardianship with the concomitant loss of their right to independent decision-making.

To this end, I make the following submission and request consideration of amending the draft Rules accordingly:

1. **Definition of restrictive practices substitute decision-maker**

The definition at rule 6-20 is as follows:

6-20 Meaning of restrictive practices substitute decision-maker

(1) An individual or body is the restrictive practices substitute-decision maker for a restrictive practice in relation to an individual (the individual concerned) if the individual or body has been appointed, under the law of the State or Territory in which the individual concerned accesses funded aged care services, as an individual or body that can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent.

While I understand the intention that the rule should ensure compliance with the law of the state or territory, the term "appointed" is likely to be unnecessarily restrictive. As there are a number of legal mechanisms operating in South Australia, a person may be duly empowered *under* a law but not "appointed" as far as that term is given its ordinary meaning. It would be better to use broader phraseology as per the following (bold and underline added):

> An individual or body is the restrictive practices substitute-decision maker for a restrictive practice in relation to an individual (the individual concerned) if the individual or body has been appointed, **by or** under the law of the State or Territory in which the individual concerned accesses funded aged care services, as an individual or body that can give informed consent to the use of the restrictive practice in relation to the individual concerned if the individual concerned lacks capacity to give that consent.

Adjusting the definition as suggested would more clearly accommodate the diversity of current and possible future state legal mechanisms. It would clearly allow alignment of the restrictive practice consent arrangement in Aged Care with the well-functioning processes already used in the disability sector.

2. **The restrictive practices to which the registered provider condition applies**

The definition of "restrictive practice", in AC Act s17, is expressed in general terms to be "a practice or intervention that has the effect of restricting the rights … of an individual". Its generality, together with the new Statement of Rights (e.g. independence, autonomy, freedom of choice, equitable access, privacy,) may enable classification of a range of other actions – beyond chemical restraint, environmental restraint, mechanical restraint, physical restraint, and seclusion – as "restrictive practices". Under s23 and s24 these rights are relevant to the way an individual accesses and receives funded aged care services. This could see an unintended widening of what actions by service providers are considered "restrictive practices" which would then require informed consent.

To avoid this situation and clearly define restrictive practices for which informed consent is required, Proposed Rules s162-5 and s162-10, should be confined to *specified restrictive practices*. This is the device used in the NDIS context ("regulated restrictive practices"), which serves to avoid the same ambiguity arising from the generality of the shared definition of "restrictive practices".

Drafting could include (bold and underlining added):

> **162-10 Requirements relating to the use of restrictive practices**

For the purposes of section 162 of the Act, this Part prescribes requirements relating to the use of **specified** restrictive practices in relation to an individual to whom a registered provider is delivering funded aged care services in an approved residential care home.

3. Consent and Authorisation

The term 'consent' for using a restrictive practice has some fundamental difficulties as a concept and denial of a human right. The "authorisation" of restrictive practices is more appropriate in recognising that restrictive practices are actions often used against a person's will and preferences.

4. Residential care homes and community care

The rules should clarify the extent to which they apply only to residential care homes and if they extend to regulating aged care supports in a person's home in a community setting. The Rules (Rule 16.15) do not require reporting of a restrictive practice if used in a home or community setting *and* was set out in the care and services plan for the person. Within the NDIS sector, all unauthorised restrictive practices must be reported regard=less of whether this occurs in a home, community, or residential care setting. The Aged Care Rules should embrace a comparable requirement.

5. Positive Behaviour Support Plans

Sections 162-45 to 162-75 of the rules deal with the requirements, use, alternative strategies, ongoing use, review, and consultation regarding positive behaviour support plans. The rules should be strengthened in the sections on the use of alternative strategies, ongoing use, and reviewing behaviour support plans, to specify strategies to 'fade out' and work toward the elimination of the restrictive practice/s._Rule 5-5 defines an approved health practitioner as a medical practitioner, nurse practitioner, or registered nurse. This rule should be redrafted to include behaviour support practitioners such as those deemed eligible by the NDIS Quality and Safeguards Commission, or a person with demonstrated knowledge and understanding of restrictive practices.

6. Support for restrictive practices substitute-decision makers

I note that the restrictive practices substitute-decision maker (SDM) will be subject to independent oversight and guidance, depending upon the extent of such provisions in the state or territory regime. This could range from rigorous oversight and guidance to none. There is an opportunity for the Rules to include provisions regarding how a restrictive practices SDM should operate, including by placing obligations upon providers to require that they:

1. Provide written explanation in plain English to the SDM addressing why the restrictive practice is necessary and include all components of behaviour support considerations in an easy-to-understand format. This is important considering that many restrictive practice SDMs are likely to be the spouse or partner of an older person.
2. Enable the SDM to disagree with the provider's request to use a restrictive practice and facilitate support for the SDM from the Aged Care Quality and Safety Commission.
3. Require heightened oversight of the provider by the Commission where the SDM is a private citizen, in recognition of the reduced state or territory oversight of such arrangements and the opportunity for providers to exploit such arrangements.

4. Ensure the SDM has access to support, complaints mechanisms and all other aspects of a system expected to accompany facilitation of “informed consent”.

I thank you for the opportunity to make this submission.

Sincerely