

REVIEW OF THE AGED CARE COMPLAINTS INVESTIGATION SCHEME

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1. EXECUTIVE SUMMARY

The Aged Care Complaints Investigation Scheme ('the CIS') has been in operation for just over two years. The Minister for Ageing, the Hon Justine Elliot MP, requested a review to identify the areas of improvement to ensure the scheme achieves best practice aged care complaints management arrangements.

The review considered the following Terms of Reference:

- Whether the CIS provides natural justice to all parties involved;
- Communication between the CIS, its investigators, family members, residents and advocacy groups who lodge complaints as well as the aged care providers and their staff, and provide advice on improvements. This should include considering the treatment of anonymous complainants;
- The adequacy of training provided to investigators to assist them in undertaking their role, including in investigative methods, reporting and communications;
- Adequacy of access to clinical and investigative expertise;
- Appropriateness of the risk assessment framework used for the escalation of complaints;
- Adequacy of information collected and considered as part of the investigation;
- The relationship between the CIS and the Aged Care Commissioner, the Aged Care Standards and Accreditation Agency Ltd, and other relevant bodies;
- The processes, practices and the timeliness of responses to complaints to the CIS when compared to similar investigatory bodies; and
- Evidence based initiatives from similar investigatory bodies that might improve the operation of the Scheme so that it better meets the needs and expectations of consumers, their families and aged care providers.

Members of the public and key stakeholders were invited to make submissions to the review; 119 submissions were received, and are listed at [Appendix 1](#). I also held face-to-face consultations with more than 20 stakeholders, including representatives of provider and consumer groups, as well as staff from the Australian Government ('the Department'). A full list of participants in the face-to-face consultations is provided at [Appendix 2](#).

The submissions and the advice from Department officers were most helpful. A number of issues were raised, some relating to individual consumer experiences and others to the ongoing relationship of providers with the CIS processes. In broad terms, the key issues I have identified throughout this process are:

- the need for the CIS to improve its communication processes with both consumers and providers;
- the importance of encouraging a range of options for managing complaints – from resolution at the local provider level, to mediation and investigation by the CIS;
- the perception that as the funder and regulator of aged care services, the Department is not the appropriate body to manage the complaints investigation process;

- the need to revise the complex management and accountability structure within the CIS and the Office of Aged Care Quality and Compliance to ensure more effective complaints management;
- the impact of the workload and competing priorities of CIS staff on the ability to achieve quality outcomes;
- the need for more specific and ongoing training for CIS staff; and
- the necessity to amend current CIS processes and practices to achieve a more efficient and effective system which achieves satisfactory outcomes for all parties.

1.1. Acknowledgements

I would like to thank the many individuals, families, provider organisations, peak bodies and health professionals who have provided invaluable input to this review. Many people have given up their time to write submissions or meet with me in person to inform the review from their perspective or experience.

I would also like to acknowledge the contribution of the Department, particularly the staff working in the Complaints Investigation Scheme ('the CIS'), who have enabled me to understand the context and complexity of their work. There was plenty of evidence of their professionalism in difficult circumstances. I would also like to thank the Office of Aged Care Quality and Compliance ('the Office') within the Department, which has provided me with a small professional team who have assisted me in understanding the current policies and practices of the CIS. They provided secretariat support to me throughout the review.

1.2. Sources of Information

In undertaking this review, I have relied on a number of sources of information including:

- Internal CIS departmental documents include the National Aged Care Investigations Procedures Manual, policy documents and guidelines, CIS staff bulletins and training documents;
- CIS data from 2008-09 (unpublished data);
- Relevant sections of the *Aged Care Act 1997* ('the Act') and the Aged Care Principles;
- A sample of cases investigated by the CIS released to me under the Act in the public interest for the purposes of this review;
- Publicly available information and data in relation to other Australian and international health and aged care complaints bodies; and
- Written submissions from 119 individual consumers and providers, consumer and provider peak bodies and health care professionals.

The following witness list gives the sources of information obtained in face-to-face consultations:

- | | |
|--|---|
| • Aged and Community Services Australia | • Aged Care Crisis Team |
| • Aged Care Association Australia | • Aged Care Lobby Group |
| • Aged Care Standards and Accreditation Agency | • Panel member of the former Complaints Resolution Scheme |
| • ACT Disability, Aged and Carer Advocacy Service (ADACAS) | • Alzheimer's Australia |
| • Aged Care Commissioner | • Australian and New Zealand Society for Geriatric Medicine |
| | • Carers Australia |

- Catholic Health Australia
- Commonwealth Ombudsman
- Daniel's SHEILD
- Elder Rights Advocacy
- Health Services Union
- Council on the Ageing
- Liquor, Hospitality and Miscellaneous Union
- National Seniors Australia
- Royal College of Nursing Australia
- The Aged Care Rights Services (NSW) (TARS)
- Focus group with three consumers organised through TARS
- Department of Health and Ageing staff working within the Complaints Investigation Scheme.

1.3. Disclaimer

The reviewer appreciates the time and work of those individuals and organisations who provided written and oral submissions to the review. The discussion in this report, while drawn from the submissions, represents the opinion of the reviewer and does not necessarily represent the view of any author of a submission.

2. PREFACE

2.1. Background

The Aged Care Complaints Investigation Scheme ('the CIS') was introduced on 1 May 2007 to provide a greater capacity to the Department to investigate and appropriately deal with all concerns about the care or services provided in aged care.

The CIS provides a means through which concerns or complaints about a service or the care being provided to elderly people receiving Australian Government-subsidised aged care, including residential and community care, can be raised.

Anyone can contact the CIS with a complaint or concern - care recipient, family member, care provider, staff member or General Practitioner ('GP'). Complaints can be made openly, anonymously or in confidence. They can be about anything that affects the quality of care for aged care recipients, such as medical and personal care, catering, hygiene, security, activities, choice, comfort, safety, neglect or financial matters. The service is free and confidential.

2.2. CIS Objectives

When the CIS was formed its objectives were to:

- address consumer and provider preferences for greater investigatory powers and timely validation of complainant concerns;
- use powers to investigate anonymous information that previously could not be dealt with effectively through the Complaints Resolution Scheme ('the CRS');
- reduce the time taken between lodgement of a complaint and its finalisation;
- eliminate the blurring between complaints and compliance by integrating these functions under one Office of Aged Care Quality and Compliance ('the Office') in the Department;
- more clearly determine the roles of the Department and the Aged Care Standards and Accreditation Agency ('the Agency') in dealing with specific matters and, thereby, avoid overlap of respective functions;
- establish a less onerous process for all parties; and
- establish centralised accountability mechanisms, a coordinated quality assurance/improvement approach and education programs.

In developing this approach to complaints handling, it was considered critical that independent scrutiny remain a part of the new system and that the scope and capacity of complaint investigations be enhanced. A dedicated Aged Care Commissioner ('the Commissioner') was established to replace the role of then Commissioner for Complaints to provide an external review mechanism for actions taken by the Office.

2.3. Terms of Reference

The aim of this review is to gain insight into the public and the aged care industry's experiences with the CIS since its introduction, with a view to determining whether it has met the needs and expectations of all interested parties. I was specifically asked to review:

- Whether the CIS provides natural justice to all parties involved;
- Communication between the CIS, its investigators, family members, residents and advocacy groups who lodge complaints as well as the aged care providers and their staff, and provide advice on improvements. This should include considering the treatment of anonymous complainants;

- The adequacy of training provided to investigators to assist them in undertaking their role, including in investigative methods, reporting and communications;
- Adequacy of access to clinical and investigative expertise;
- Appropriateness of the risk assessment framework used for the escalation of complaints;
- Adequacy of information collected and considered as part of the investigation;
- The relationship between the CIS and the Aged Care Commissioner, the Aged Care Standards and Accreditation Agency Ltd, and other relevant bodies;
- The processes, practices and the timeliness of responses to complaints to the CIS when compared to similar investigatory bodies; and
- Evidence based initiatives from similar investigatory bodies that might improve the operation of the Scheme so that it better meets the needs and expectations of consumers, their families and aged care providers.

2.4. Definitions

For the purposes of this report, the following abbreviations or acronyms apply:

Aged Care Act 1997	the Act
Aged Care Commissioner	the Commissioner
Aged Care Complaints Investigation Scheme Procedures Manual	the Procedures Manual
Aged Care Standards and Accreditation Agency	the Agency
Approved Provider	the provider
Commonwealth Ombudsman	the Ombudsman
Complaints Investigation Scheme	the CIS or the Scheme
Department of Health and Ageing	the Department
Informant	complainant
Investigation Management System	the IMS
Investigation Principles 2007	the Principles
Notices of Required Action	NRA
Office of Aged Care Quality and Compliance	the Office
State and Territory Offices	STOs

2.5. Methodology

On 25 July 2009 the Minister for Ageing, the Hon Justine Elliot MP, invited interested organisations and individuals to make submissions to inform the review. To facilitate this, an advertisement inviting submissions was published, on 25 July 2009, in the following newspapers:

- The Australian;
- The Age;
- Sydney Morning Herald;
- Adelaide Advertiser;
- Brisbane Courier Mail;
- Canberra Times;
- Hobart Mercury;
- Northern Territory News; and
- The West Australian.

A consultation paper, outlining the terms of reference for the review, information regarding the reviewer and background on the current Complaints Investigation Scheme was published on the Department's website and is available at [Appendix 3](#).

In addition to providing comments against the review's terms of reference, feedback was sought from interested parties on the following matters:

- How can the communication between the CIS investigators and involved parties be improved (including family members, residents and advocacy groups who lodge complaints, aged care service providers and their staff)?;
- Is the current treatment of anonymous complaints by CIS appropriate? Where are the opportunities for improvement?
- What can the CIS do to better meet the needs and expectations of residents, their families and aged care service providers?

The Consultation Paper asked for individuals who have had contact with the CIS to specifically comment on their experience in relation to communication with the CIS and the timeliness of the investigation.

Face-to-face consultations with a number of key consumer and industry stakeholders were also undertaken during the consultation period. A full list of the participants in the face-to-face consultations is provided at [Appendix 2](#).

2.6. Other Material

In addition to information gathered through public submissions and face-to-face consultations, I have also examined the following documents:

- Relevant sections of the Act and the Principles, which govern the operations of the CIS;
- Internal CIS policies and procedures, selection processes, training documentation, template documents, advice to staff and CIS data since CIS's commencement;
- A sample of cases investigated by the CIS, including:
 - matters relating to out of scope issues;
 - matters relating to a reportable assault;
 - matters in which a breach was identified;
 - matters which resulted in Departmental compliance action;
 - matters which were referred to external agencies; and
 - matters which resulted in an examination or investigation by either the Commissioner and the Commonwealth Ombudsman ('the Ombudsman').
- A sample of cases examined by the Commissioner, where there was disagreement between the Commissioner's recommendations and the Department's reconsideration of the decision.
- Advice from the Australian Government Solicitor regarding whether the CIS provides natural justice to all parties.
- Alternative models of aged care and health complaints handling within Australia and internationally.
- Issues found through the Department's own internal quality improvement processes for the CIS.

A full list of references is provided at [Appendix 4](#).

3. RECOMMENDATIONS

3.1. Overview

Having considered all the submissions, CIS practices, documents and policies during this review, I recommend a number of key areas for immediate implementation. During the review it became clear to me that the difficulties experienced by consumers, providers, staff working in the CIS and the Office related mainly to the design and inadequate structure and resources of the CIS. Therefore my main recommendations relate to the structure and location of the CIS. I recommend that the aged care complaint scheme be restructured into three divisions; Assessment and Early Resolution, Investigations, and Communications and Stakeholder Relations.

3.2. Division of Assessment and Early Resolution

This Division would:

- have additional categories of assessment outcomes for complaints including local resolution, assisted resolution, and mediation;
- refer appropriate matters for local resolution at the local provider level;
- facilitate alternate dispute resolution methods and assisted resolution;
- ensure increased use of advocacy services or independent mediators;
- introduce timeframes for complaints management;
- use of a risk assessment framework to assess complaints including those for investigation;
- regularly review the risk management framework as to its reliability and validity (monthly); and
- have access to an internal panel of clinical advisers (nursing and medical).

3.3. Division of Investigations

This Division would investigate serious cases and would:

- provide summary reports of investigations and their status to senior managers;
- ensure investigation processes include gathering evidence from all relevant stakeholders;
- introduction of timeframes and case management principles;
- access to clinical expertise through an internal panel of clinical advisers; and
- make final investigation report available to the parties, including the Statement of Reasons.

3.4. Division of Communications and Stakeholder Relations

This Division would include the following functions in communication with the other two divisions:

- policy development;
- reports to the Secretary or delegate as required;
- communications with staff about legislative, procedural and process changes;
- writing and developing Procedures Manuals for each section; maintenance of the manual/policies;
- the provision of training in the Aged Care Act and Principles, aged care service responsibilities and dispute resolution;
- development of a new assessment data base that distinguishes matters into complaints, information and self reports;
- responding to requests for information from the relevant sections in the Department; and
- development of appropriate template letters and provide training in their application;
- maintaining consistency in approach and quality assurance;
- maintaining relationships with the Department and the Agency;

- education and training of staff;
- development of communication strategies for providers, advocacy groups and the community;
- management of ministerial correspondence and briefs;
- management of complaints about the Office; and
- developing and publishing information materials for stakeholders.

3.5. The location and positioning of the CIS

During the review, the location of the complaint system became a central focus. I have considered a number of options in relation to the location and positioning of aged care complaints, including:

- 1 Model One - Restructure and reorganise the current CIS within the Department;
- 2 Model Two - Transfer complaints to the Agency or the Commonwealth Ombudsman;
- 3 Model Three - Establish an Office of Aged Care Complaints responsible to a Commissioner for Aged Care Complaints; and
- 4 Model Four - Establish a new Aged Care Complaints Commission.

My recommendation is Model Four, as discussed below. Further discussion of the other three models can be found in Section 10 of this report (see page 78).

3.6. Recommendation to establish a new Aged Care Complaints Commission

I recommend the establishment of an independent Aged Care Complaints Commission and the creation of the position of Aged Care Complaints Commissioner who will report directly to the Minister for Ageing. The Commissioner would be required to consult with the Secretary or their delegate as required, particularly in relation to sharing of information that relates to the regulatory requirements under the Act and the Principles.

The Rudd Government has supported the Department of Finance and Deregulation's *Governance Arrangements for Australian Government Bodies*, implemented in August 2005 following the *Review of the Corporate Governance of Statutory Authorities and Office Holders* undertaken by John Uhrig AO. While acknowledging the recommendations from the 'Uhrig Report', I still recommend a separate statutory authority, thus removing aged care complaints management from the Department. My reasons include:

- The Department is responsible for the overall management and delivery of aged care services through the allocation of places, approval of providers, payment of aged care subsidies and compliance with the aged care standards. The focus is necessarily on aged care services for the community rather than on any individual complaint of a family or resident.
- Effective complaint management requires a dedication to the role of complaints in society and the need to build a professional organisation with a vision that meets community expectations. It is very difficult to achieve this in a large and complex bureaucracy.
- Complaint management directly impacts on the personal experience between a citizen and the bureaucracy; making trust in the 'neutrality' or 'impartiality' of the complaint body essential. The current system in which complaints are part of the bureaucracy responsible for aged care services makes it harder for a complainant to accept the final outcome if it is not favourable to their case. This adds to disquiet in the administration of the complaint scheme, as evidenced by the submissions from consumers and providers who shared their concerns about the impartiality or unreliability of decisions.

- The stakes are high for the complainants in a complaint investigation and when the same organisation is responsible for all the regulatory functions it lessens the will or capacity to admit failures and commit to improvements.
- Any complaint scheme requires transparency in its processes to engender trust from all the parties as well as the community; when complaints reside in the organisation responsible for overall quality of the services (that may be subject of complaints) there is incentive to limit data about complaints, the main areas complained about and the problems in the public arena.

I recognise that the mere status of 'independence' of a complaint body does not prevent bias. Conversely a complaint body within a government department may operate impartially; permitted by the neutrality of its public service bureaucracy.

The Aged Care Complaints Commission should replace the current CIS and be a statutory body headed by the Aged Care Complaints Commissioner who would be appointed as a statutory office holder appointed by and reportable to the Minister for Ageing. Staff would be employed under the *Public Service Act 1999*. A separate Aged Care Complaints Commission would establish itself as a best practice complaint handling organisation dedicated to the resolution of aged care complaints and appropriate investigations without the competing demands and potential conflicts which exist within the Department and the Office. It removes any residual concerns about 'partiality' and conflicts of interest. There is a substantial body of evidence supporting the independence of complaint handling. A robust and trustworthy complaint system will be an essential component of age care services of the future. Increasingly older people, many of whom will have grown up with the availability of effective complaint mechanisms, will expect to have access to an effective independent service; this expectation will grow rather than recede.

The Senate Inquiry in 2005 heard similar issues with the then Complaint Resolution Scheme ('the CRS') to those raised in this review. While there was a strong voice for an independent complaint scheme, that inquiry fell short of recommending a separate body. Over the last four years the issue of independence or perception of independence has not receded with the introduction of the CIS; rather the call for an independent complaint body has consolidated.

3.7. Additional Recommendations for immediate implementation

Recruitment and training

1. Review the position descriptions for aged care complaints officers to include two defined skill sets; complaint resolution skills and investigation skills.
2. Complete a mapping exercise on training needs, including:
 - provisions of the Act and the Principles and how to apply the relevant provisions in the context of the complaint organisation;
 - handling complainants who are grieving or angry, complainants with cognitive impairments, vexatious or serial complainants;
 - telephone counselling and questionnaire techniques;
 - use of the IMS database;
 - investigation and report writing;
 - managing documents and files;
 - exercising delegations;

- preparation of instruments for consideration by senior staff;
 - the role of the Agency;
 - de-briefing techniques for team leaders and managers;
 - responding to review by external agencies, e.g. the Commonwealth Ombudsman; and
 - Freedom of Information ('FOI') requests.
3. Develop an in-house investigation training program in consultation with appropriate agencies (the Commonwealth Ombudsman, other investigative bodies and external educational institutions) and ensure all staff complete the program.

Clinical advice

1. Establish an internal panel of clinical advisers (nursing and medical). The advisers should be readily available to assist in assessment and early resolution as well as investigations.
2. Establish a panel system for accessing external clinical and technical experts on a case by case basis.

Risk Assessment Framework

1. Using the recommended Risk Assessment Template in this report (see page 54) develop an aged care complaints risk assessment framework to assist officers to determine the most appropriate method for resolving complaints. The complainant should be provided with a right of review if the decision is not to investigate.
2. Provide stakeholders with an opportunity to comment on the framework and make the framework publicly available, once finalised.
3. Educate industry about the risk assessment framework.
4. Review the Procedures Manual to include guidance on the risk assessment framework.
5. Review job descriptions for CIS managers to include risk assessment responsibilities.
6. Review risk assessment framework on a monthly basis to ensure that it is responsive and reliable and provide monthly reports on its reliability and validity to the Minister and the Secretary.

Information collection and investigation

1. Review the investigation guidelines with attention to the components required in a quality investigation. Consult with the Ombudsman and appropriate experts from the Administrative Review Council in redrafting these guidelines.
2. Ensure the aged care industry is aware and understands the investigation processes outlined in the guidelines.
3. Develop best practice investigation reports that can be used in training.
4. Consult with the NSW Health Care Complaint Commissioner and the Commonwealth Ombudsman regarding the possibility of the organisations hosting senior CIS staff for a short period so they can examine the investigation processes and procedures at first hand.
5. Complete the review by *mpconsulting* of internal communications, letters, reports and other administrative documentation (including Statements of Reasons).

Natural justice

1. Amend section 16A.16 of the Principles to stipulate that a provider must be given an opportunity to respond to a complaint before deciding that the provider has breached its responsibilities or that an NRA should be issued.
2. Revise the CIS Procedures Manual or its replacement manual to:
 - Specify that the provider be given the opportunity to orally or in writing respond to a complaint or information. This does not apply to those situations where the complainant or care recipient would be at risk if the provider became aware of an investigation before it is concluded and an NRA is issued.
 - Include sections on managing conflicts of interest and the rules against bias.
3. Amend the Principles to provide that the complainant and the relevant provider receive a copy of the complaint in writing.
4. Amend sections 16A.21, 16A.22, and 16A.23 to allow 28 days for an application for examination by the Aged Care Commissioner. This is in the circumstances where the Office of the Aged Care Commissioner is retained.
5. Amend the Principles to expand section 16A.21 to include any person who makes a complaint may apply for an examination of the outcome of their complaint by the Aged Care Commissioner.

Provisions to review decisions

Based on the acceptance of my recommendation to establish a separate Commission, or Office of Aged Care Complaints.

1. Develop a protocol for requests for reviews by complainants for decisions made after the assessment process and after investigations, including:
 - The requirement for the complainant who wishes to have a decision reviewed to discuss the matter with the person who made the decision prior to asking that the Commission or Office review the decision.
 - The request for a review should be submitted in writing within 28 days from the date the Commission or Office advises the parties of the decision. If there is a request for review outside the 28 days, the decision to review the matter is discretionary.
 - If the Commissioner agrees to review a decision, the request for review will be assigned to an officer who was not involved in the original investigation. The review will consider:
 - i. the process adopted by the investigating officer and whether it was fair and adequate to address all the complaint issues raised; and
 - ii. the merit of the officer's conclusions and whether they were properly explained to the party concerned.
2. Maintain the right of any party to complain to the Commonwealth Ombudsman.
3. Providers retain the current appeal rights.

Relationship between the CIS, the Commissioner, the Agency and other relevant bodies

Based on the acceptance of my recommendation to establish a separate Commission, or Office of Aged Care Complaints.

1. Develop memoranda of understanding with aged care advocacy services, state/territory health care complaints commissions and the Australian Health Practitioner Registration Agency in relation to referral of complaints.
2. Develop fact sheets which clearly explain the role and functions of relevant bodies involved in delivering aged care services.
3. Educate Community Visitors on the role of complaints and how to assist a resident who has a complaint. Community Visitors should have no less a role than family members who visit their relatives. The capacity to make a complaint should be available to anyone.

Processes, practices and the timeliness of responses to complaints

1. Consult with the Ombudsman about the development of realistic timeframes for each stage of the complain management framework e.g. acknowledgement of complaints in writing, assessment outcome, and investigation timeframes.
2. Produce and publish an Annual Report that meets the requirements of best practice annual reports.

Other Recommendations

1. Develop a communications strategic plan to promote the complaint scheme.
2. Maintain the ability of the complaint scheme to accept anonymous complaints.
3. The name of the complaints scheme should remove the use of the word investigations. An investigation is only one way of many for resolving complaints.
4. Replace the word 'informant' with complainant.

4. NATURAL JUSTICE

4.1. Overview

Care recipients, irrespective of where they live, are usually dependent on the knowledge, skills and humanity of others. In such circumstances it is essential that any complaint process be fair and, except where the public interest requires otherwise, transparent. This means that all parties to a complaint (providers, recipients of care and/or representatives) need to be aware of the processes involved and have a clear understanding of them as well as the opportunity to know the outcomes of those processes including findings of any investigation.

The terms ‘procedural fairness’ and ‘natural justice’ are used interchangeably and refer to the common law duty on decision-makers to observe fair procedures when making certain decisions. Procedural fairness relates to the process of making decisions and not the merits of the decision itself.

I have had the benefit of reading 119 submissions from providers, families and carers who have ageing relatives in residential facilities, consumers, advocacy groups and professional associations who have provided comments in relation to natural justice. Many submissions raise both particular and general questions of fairness. I have also held face-to-face discussions with many of those who made written submissions.

After reading the submissions, I have taken a broad interpretation of the meaning of ‘procedural fairness’ and have included those CIS activities that raise issues of ‘fairness’ generally rather than confine myself to a narrow legalistic interpretation. Many of the submissions and most of the people consulted raised the significant vulnerability and powerlessness of the care recipients who use aged care services. In such circumstances procedural fairness means the CIS must ensure that care recipients or their representatives receive the same hearing as other parties to the complaint.

4.2. Legal Interpretation of Natural Justice

What is natural justice?

Natural justice or procedural fairness is a set of principles that ensure the following:

- The decision maker informs the appropriate people of the complaint or case against them or their interests;
- The person handling the complaint does not have any personal interest in the outcome of the decision (the ‘bias’ rule);
 - The person making the decision has not prejudged the decision;
 - There is no reasonable apprehension of bias;
- The subject of a complaint has the right to be heard (the ‘hearing’ rule);
 - There is sufficient notice of the decision;
 - There is notice of the particulars of the complaint or the issues involved;
 - There is sufficient opportunity to comment on any adverse material;
- The person handling the matter acts only on the basis of logically probative evidence (the ‘no evidence’ rule);
 - Responsibility to make findings based on fact;
 - Findings of fact to be supported by evidence; and

- Capacity to set aside a decision if there is no evidence or other material to justify the making of the decision.

Who is entitled to natural justice in the CIS investigation process?

Under the Act and the Principles there are three categories of persons to whom procedural fairness obligations would be owed under the CIS. These are:

1. 'Aggrieved persons' (section 16A.4 of the Principles - a care recipient or his or her 'representative' (including an advocate, legal guardian, carer or relative) to whom a matter under investigation relates);
2. 'Relevant providers' (section 16A.4 of the Principles - the approved provider to which an investigation relates); and
3. Persons about whom a complaint may be made to the Aged Care Commissioner under section 16A.26 of the Principles. This would include officers of the Department responsible for implementing the CIS as well as staff of the organisation nominated as the 'accreditation body' under the Act, i.e. the Agency.

When is there an obligation to afford a person procedural fairness under the CIS?

It is generally accepted that where a decision-maker has the power to do something which affects a person's rights, interests or legitimate expectations, the rules of natural justice will apply to the exercise of that power, unless expressly excluded by Parliament.

The decision must affect a person's rights, interests or expectations in a 'direct and immediate way',¹ rather than as a member of the public or a large group.² It follows that the rules of natural justice will apply to the exercise of a power under the Principles that directly affect a person's rights, interests or expectations.

4.3. Submissions, Consultations and Natural Justice

Analysis of the submissions - is natural justice afforded to all parties?

As stated above, I have taken a broad interpretation of the meaning of 'natural justice' rather than confine myself to a narrow legalistic interpretation of the term. Submissions received from the public raised issues relating to procedural fairness, and the lack of transparency of the CIS process. The following is a summary of those concerns.

Summary of issues for complainants (informants)

- Difficulty of accessing the complaints scheme;
- Complainants not involved or engaged in the complaint processes;
- Inadequate information about the complaint process and lack of transparency;
- A failure to adequately explain the reasons for the CIS decisions;
- Inadequate information on the outcome of an investigation;
- Inadequate protections for staff who are complainants;
- Fear of reprisals from the service if a person makes a complaint;
- The weight given to the complainant (family/friend) is less than that given to the provider;
- The standard of proof is unreasonably high;

¹ *Kioa v Minister for Immigration and Ethnic Affairs and Another* (1985) 62 ALR 321 (Mason J: 326).

² For example see *Controller General of Customs v Kawasaki Motors* (1991) 32 FCR 219.

- CIS Hotline at times goes to an answering service creating a barrier for complainants; and
- The 14 day time frame to lodge an appeal to the Aged Care Commissioner is unnecessarily restrictive.

The following case highlighted the problem experienced by one carer.

The care recipient (mother) is a resident at a residential facility. Previously the daughter had been the carer for the mother for many years. The daughter's mother complained to her that she was verbally and physically abused by staff at the aged care facility. The daughter contacted the Director of Nursing who did not wish to communicate or have any discussions about the matter with the daughter. The carer made a complaint to the Aged Care Complaints Investigation Scheme. The CIS investigated the complaint and was in communication with the Director of Nursing. The CIS reported 'no sign of abuse' when they visited.

The carer was dissatisfied with the way the investigation was conducted as she felt 'totally left out of the picture'. She stated that she was made to feel that she 'created the whole problem' and thought that the CIS had not spent enough time at the facility to get a clear picture.

Summary of Issues for Approved Providers

- CIS investigation officers biased in favour of the informants;
- CIS investigators and decision makers are unfair and partial;
- A lack of independent review;
- CIS concerned with absolute compliance with the Act rather than resolving the complaint;
- Failure to notify a provider about anonymous complaints, and to provide sufficient information to enable a response;
- Persons named in a complaint not advised of the substance or particulars of the complaint;
- A lack of transparency in the investigative and referral processes;
- Nature and details of the complaint and complainant not provided;
- Vaguely worded Notice of Required Actions ('NRAs');
- The 14 day time frame to lodge an appeal to the Aged Care Commissioner is unnecessarily restrictive; and
- A lack of support for persons being interviewed. No written or actual explanation as to the substance of the complaint being investigated, both at the commencement of the investigation and even at the completion.

The following case is an example of a concern from a provider's perspective³

An anonymous telephone complaint was made to CIS reporting physical and verbal abuse of 5 residents. There were no residents' names, no dates, no times and no witnesses to substantiate the complaint. As a result of the complaint the following actions have occurred:

- The staff member has been suspended on full pay;
- The police have been called and left without even issuing an incident number;
- The Management Team have spent two hours being interviewed (8pm-10pm);
- The Management Team remained at the facility until 1am;
- The Management Team spent the whole weekend investigating the reported incidents and found no evidence to substantiate the report;
- There have been 4 visits from the CIS investigator; and
- Significant documentation has been collated and forwarded to CIS.

The investigation has taken 3 weeks. The investigator has found that following his lengthy investigation there is no evidence to support this Complaint. This incident has created three weeks of significant stress on the Senior Nursing Staff with time wasted on the interviews and the preparation of documents which should have been spent caring for the Residents. The financial impact of standing down the staff member, and the cost of Agency staff to replace her places a burden on the provider not reimbursed in any way whilst the CIS cost is met by the taxpayers.

4.4. Analysis of CIS processes

Approved Providers

The Principles require that a provider must be notified of an investigation except in circumstances where the disclosure may place an informant or a care recipient at risk. The Principles do not require that a provider be given an opportunity to formally comment before a Notice of Required Action ('NRA') is issued as a result of a CIS investigation. However, the *Aged Care Complaints Investigation Scheme Procedures Manual & IMS User Guide, version 2.0 October 2007* ('the Procedures Manual') at section 2.5.2 last paragraph, states 'Where a relevant person has a legitimate interest in a decision they should have the opportunity to comment on the proposed decision before it is finalised...'

Complainant (Informants)

The Principles and the Procedures Manual make it clear that the approved provider is owed natural justice/procedural fairness but it is less clear on whether complainants are equally entitled. Complainants may have a range of interests which might be affected in a 'direct and immediate way' when delegates make decisions under the Principles. It is arguable that care recipients or their representatives (advocates, carers, relatives or legal guardians) may have a 'direct interest' in the complaint process and the outcome of an investigation.

Many of the submissions from consumers and carer organisations described the lack of engagement or involvement of complainants after a complaint had been made resulting in dissatisfaction with the outcome or contesting the evidence provided in the statement of reasons. Their main concerns related to the lack of opportunity to provide information, refute evidence, provide additional evidence and have a clear understanding of the reasons for the decisions taken. The Procedures Manual, as set out above, states 'Where a relevant person has a legitimate interest in a decision they should have the opportunity to comment on the proposed decision before it is finalised...'

³ Submission 75 – Catholic Health

In the context of aged care and the vulnerability of care recipients, common sense would suggest that complainants should be entitled to natural justice throughout the investigation. In investigations where a provider is facing an adverse finding or a complainant has an interest in how a matter might be finalised they should, in my view, be entitled to comment before a decision is made as to whether the provider has or has not breached its responsibilities or whether an NRA should or should not be issued.

While there is no legal requirement on the CIS to consult with the complainant before deciding on whether to investigate a particular matter, in a borderline case it would be prudent for the CIS to consult with the informant before deciding not to investigate. I have made recommendations elsewhere in relation to assessment and requests for review of decisions. I note however, that decisions not to investigate are currently examinable by the Aged Care Commissioner and subject to reconsideration by the Department.

The rules of natural justice require that a person making a decision about a matter must hear both sides otherwise justice may not be afforded or perceived not to be. A number of submissions were made that centred on the lack of opportunity to provide additional information once a complainant had made a complaint either over the telephone or in writing. Complainants have a legitimate expectation that they will contribute to the complaint process by: providing information; confirming or challenging facts; providing feedback about particular situations/information; and commenting on the findings.

Desk Reviews, as defined in section 4.4.2 of the Procedures Manual, were an exception in relation to consultations with the parties. In these cases, (usually concerning accommodation bonds, fees or charges, or where the provider is in a remote location), the investigation is confined to a document examination which may be unfair to the complainant, or perceived to be unfair. In these circumstances direct conversation with the complainant may be necessary to ensure 'fairness' for all parties.

Persons or bodies about whom complaints are made to the Aged Care Commissioner

Section 16A.26 provides that a written complaint can be made to the Aged Care Commissioner about:

- The Secretary's processes for handling matters under the *Investigation Principles 2007*; or
- The conduct of accreditation bodies relating to their responsibilities under the *Accreditation Grant Principles 1999*; or
- The conduct of persons carrying out audits, or making support contacts, under those Principles.

A person who is the subject of a complaint under this section arguably has an interest that could be directly or immediately affected by any decision based on the recommendation of the Commissioner in relation to the complaint. Accordingly, before finalising her recommendation and giving it to the Secretary, the Commissioner provides a draft of the recommendation to the complainant and the provider and invites them to comment.

Discussion

All relevant persons have the right to know what issues are complained about with an opportunity for a fair hearing.

The adoption of procedural fairness rules using a strict legal framework may not necessarily right the perceived wrongs raised in the submissions and consultations about fairness and natural justice. Administrative decision making in the context of a complex regulatory framework can sometimes be in conflict with the expectations of complainants' who want easily understood answers, or providers who want practical solutions to their problems.

In addition, the reporting structure and internal quality assurance framework in the Department necessitates that many different officers are consulted before a final decision is made. An effective complaint process must be transparent and fair to the person subject of the complaint but it also must be administratively efficient and beneficial to the other parties. Such efficiency can sometimes be in conflict with strict rules of natural justice.

Efficient services are by their nature more likely to be informal but also more likely to satisfy all the users of the service. Professor Julian Disney summarises this point as follows: 'When pursued with obsessive legalistic vigour, 'natural justice' is often the enemy of real justice.... Adoption of complex procedures to comply with traditional principles of 'natural justice' has meant that many people are effectively prevented from getting any form of justice at all. Well-meaning lawyers, and others who are involved in the administrative review system, should be very careful not to encrust the system at the lower levels with a whole range of apparent safeguards which, in practice, will harm many people in great need and may be of largely illusory benefit for many other people.'⁴

Decisions must be made without bias or personal preference

Submissions from both providers and consumers raised concerns about bias. Providers felt that the CIS had found them at fault before the investigations commenced, and the consumers thought that the CIS was on the side of the providers. These attitudes indicate a lack of trust in the processes.

The general test for bias, in broad terms, is whether the relevant circumstances would give rise, in the mind of a fair-minded and informed member of the public, to a reasonable apprehension or suspicion of a lack of impartiality on the part of the decision-maker.

The CIS Procedures Manual is clear on the need for CIS officers to be aware of potential conflicts of interest. Section 2.5.4 states:

'Intake and Investigation Officers and Managers need to be aware of any conflicts of interest that may arise during their work and how to deal with these. Conflict of interest is any instance where a staff member, contractor, partner, family member or close family friend has a direct financial or other interest which influences, or may appear to influence, proper consideration or decision-making'.

'Under the Public Service Act 1999, APS employees are required to act in accordance with the APS Code of Conduct. The Code of Conduct includes the requirement that an employee must disclose and take reasonable steps to avoid any conflict of interest (real or apparent) in connection with APS employment'.

⁴ Disney J, *Access, equity and the dominant paradigm*. 1992 AIAL Administrative Law Reform, 1992: p. 1-7.

Decisions must be based on evidence that can withstand scrutiny

In the context of the CIS, procedural fairness requires that a decision-maker base their decisions on logically probative evidence. At the end of investigations the CIS is required to provide the parties with a statement of reasons for their decision and the evidence on which the findings are based. The Procedures Manual provides detailed information to decision makers about the contents of a statement of reasons. (Manual page. A10.1). I am of the view that some CIS statements of reasons are too brief and do not set out the key findings on questions of fact, or the evidence supporting these findings.

Review of decisions

Sections 16A.21, 16A.22, 16A.23 of the Principles refer to the 14-day timeframe in which an approved provider or an aggrieved person may apply to the Aged Care Commissioner for examination of the decision.

The complaint process can be very demanding on providers and care recipients or their representatives, both emotionally and in terms of the resources and the time required to address the complaint issues. The time period of 14 days for an aggrieved person or providers to apply to the Aged Care Commissioner for an examination of a decision is very short. Many people who have concerns about the correctness of an outcome may not pursue the appeal avenue because they are emotionally exhausted. The 14 day requirement presents an additional hurdle because of the short time frame.

Sections 16A.21 and 16A.22 permit examination of a delegate's decision by the Aged Care Commissioner. Only an aggrieved person (under section 16.4 of the Principles) or a relevant provider is able to apply for review by the Aged Care Commissioner within 14 days after being told of a decision by the Secretary or delegate. Section 16A.5 allows 'any person' to make a complaint to the Secretary, yet persons other than aggrieved persons and relevant providers are not permitted to seek an examination of a delegate's decision.

I have made recommendations to extend the timeframe to 28 days and to allow any complainant to seek an examination by the Commissioner (see page 15).

Conclusion

Taking a strictly legal approach to natural justice, the CIS does in the main afford natural justice to those owed the duty. The CIS focus on procedural elements and administrative outcomes in relation to whether a breach has occurred under the Act or the Principles has created confusion and a lack of clarity about the process. There is confusion within CIS about their obligations to afford natural justice both to providers and complainants who do not have a clear understanding of the role and obligations of CIS in the complaint process.

Many submissions raised issues that demonstrated a lack of understanding of the regulatory framework and legislative requirements of investigations officers to make judgements according to the Act and Principles. The numbers of adverse findings in relation to providers is not indicative of a system that is punitive in approach. The relatively few requests for reviews of decisions by complainants cannot be relied upon as evidence of satisfaction with decisions made by the CIS; rather it may be, as the advocacy bodies explain, that complainants are exhausted by the process.

5. COMMUNICATION BETWEEN THE CIS, FAMILY MEMBERS, PROVIDERS AND THEIR STAFF

5.1. Overview

This section concerns communication between the CIS, its investigators, family members, residents, providers and their staff, and providing advice on improvements. This includes the treatment of anonymous complaints.

A common theme in most complaints, irrespective of the type of service, is poor communication. There are many reasons for this - pressure of time, workload, misunderstanding one's role and responsibilities, administrative requirements and inefficiencies within the system. We know that only a small proportion of people who are dissatisfied with a service will lodge a complaint.

When people make complaints they generally want open and timely communication and a resolution that prevents the same problem reoccurring. Research across a range of industries illustrates the crucial importance of communication and staff attitudes to those complaints.⁵ From the provider's perspective, complaints may be experienced as an attack on their competence and integrity, and they may adopt a defensive approach, denial or over focus on technical matters rather than address the complainant's issues.

Complaints systems have evolved over the last two decades with most organisations and health care providers now understanding the value of complaints. Defensive attitudes have been replaced by viewing complaints as an opportunity to improve services.

A good complaints system should work well for all the parties - those making a complaint and those who are subject of one. Overwhelmingly the submissions in this review have portrayed a complaints scheme which is not currently meeting the expectations of its stakeholders. Nearly half of the 39 submissions from providers of aged care services raised poor communication as a significant factor in complaints concerning their services. Many submissions acknowledge the hard working CIS staff and their professionalism. The design of the scheme, and the current significant case load, is the problem not the staff.

Best practice complaint management includes attention to:

- **Culture** - does the CIS strive to improve its administration and relations with the stakeholders and the community?;
- **Principles** - is the CIS modelled on principles of fairness, accessibility, responsiveness, efficiency and effectiveness?;
- **People** - are the staff appropriately skilled and professional?;
- **Process** - Does the CIS demonstrate the 7 stages of complaint handling - acknowledgement, assessment, planning, investigation, response, review and consideration of systemic issues?; and
- **Analysis** - Is the information about complaints examined to identify opportunities for improvements?

⁵ Romios P, et al., *Turning Wrongs into Rights: learning from consumer reported incidents An Annotated Literature Review*, DOHA 2003, Editor. 2003, Commonwealth of Australia: Canberra.

This review has found that the CIS has significant communication problems with both the providers and the complainants. While the context is different, providers and complainants are saying the same thing:

- need for upfront clarification about the nature of the complaint and the issues;
- better assessment and more appropriate resolution methods;
- more involvement in the complaint process;
- access to final investigation reports; and
- quality statement of reasons.

5.2. The Office of Aged Care Quality and Compliance ('the Office')

The Office was established in 2006 to provide a focus on the quality improvement of care and services to care recipients in Australian Government subsidised aged care services. The Office manages a number of national programs including the CIS.

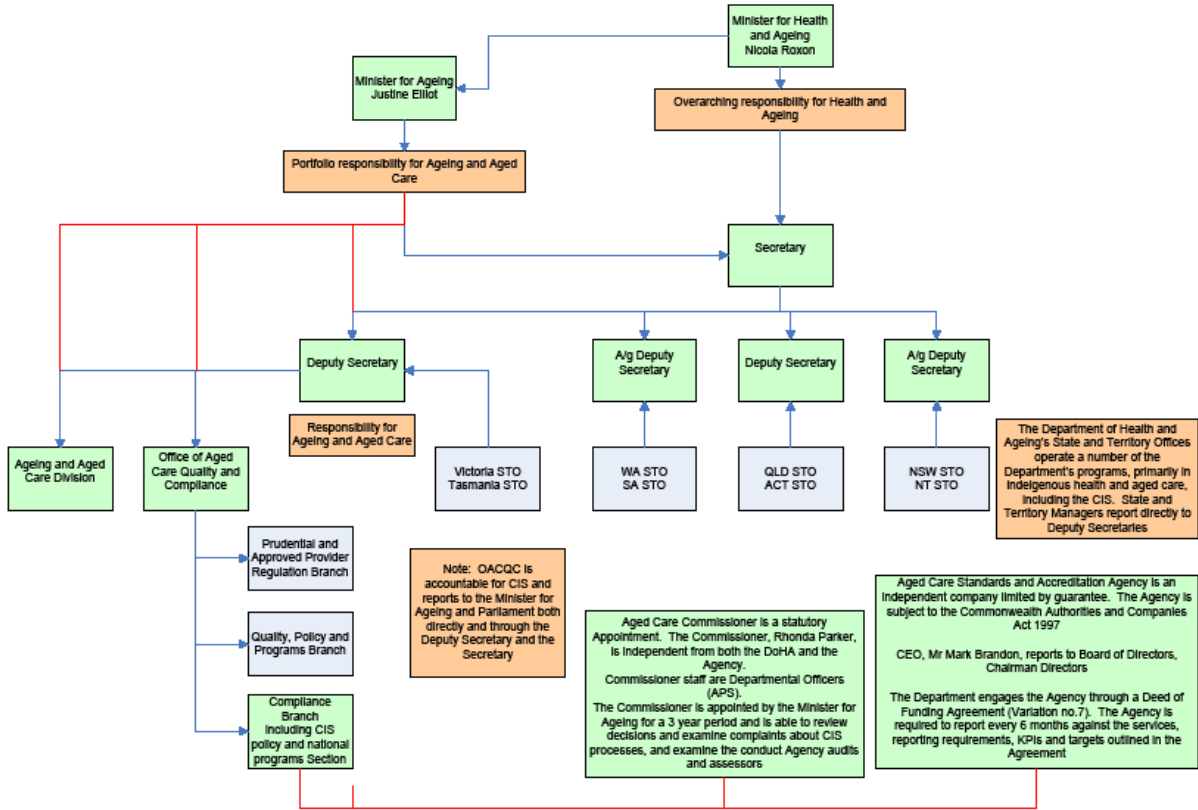
Staff are primarily recruited to the CIS to work as either intake officers or investigation officers. However, outside of the CIS, the Office also has responsibility for taking compliance action against approved providers who may not have met the requirements of a Notice of Required Action or where identified non-compliance may have more serious impacts on the health, safety or wellbeing of care recipients.

As a result, due to their clinical qualifications, some CIS staff may be required to perform other duties that fall outside the umbrella of the CIS. These may include undertaking visits to assess compliance in relation to disease outbreaks, site visits to determine whether non-compliance identified by the Agency may pose an immediate and severe risk to residents and other compliance-related activities.

Commonwealth Nursing Officers who undertake reviews under the Aged Care Funding Instrument may also at times be required to investigate CIS cases when the case needs are particularly high. These varied functions can cause confusion within the aged care sector about the precise role of the CIS officer. It also results in the CIS officer having to prioritise the competing demands of different areas of the Office and the broader Department.

5.3. Management of the CIS

The management of the CIS is complex and spread across all State and Territory Offices (‘STOs’), as well as different sections in the Department.



Within the Department’s STOs, the division between CIS and compliance responsibilities may vary depending on local arrangements, with some states opting to maintain separate CIS and compliance programs, and others maintaining a single CIS and compliance team.

States also have differing arrangements in relation to CIS Intake and Investigations teams, with some establishing dedicated intake officers and others rotating staff between intake and investigations. Staff in STOs are accountable to their State or Territory Manager, who in turn reports to a Deputy Secretary within the Department's Central Office. Staff within each STO hold the delegations for making decisions under the aged care legislation.

CIS staff in Central Office, Canberra, have responsibility for quality assurance, maintenance of national consistency, CIS policy development, CIS training and maintenance of relationships with the Commissioner and the Agency. The Senior Nursing Adviser and the Aged Care Legal Team within the Office also provide expert clinical and legal advice throughout the CIS process. CIS staff within Central Office are accountable to the First Assistant Secretary, Office of Aged Care Quality and Compliance.

The First Assistant Secretary of the Office is ultimately accountable to the Department's Executive, the Minister and to Parliament (through the Senate Estimates process) for the CIS.

Role of CIS Staff and internal communication processes

As part of this review I have consulted CIS staff including intake officers, investigation officers, investigation managers and senior departmental staff. I have also read the *Aged Care Complaints Investigation Scheme Procedures Manual & IMS User Guide* ('the Procedures Manual') and CIS Bulletins. The Department had already commenced reviewing some of the internal communication strategies prior to my review and I have also taken those findings into account.

The Procedures Manual sets out the roles of CIS staff. Staff receive advice on their role and delegations as part of the Aged Care Investigations training. This role is also reinforced through CIS program managers and individual performance development arrangements.

Role of Intake Officers and Managers in State and Territory Offices

Intake Officers and Managers are based in STOs and are the first point of contact members of the public have with the CIS. Their role includes receiving complaints and assisting complainants to provide effective and comprehensive information, determining case issues to be investigated and the relative urgency of the case, and advising complainants about the availability of advocacy and other support services. Intake officers may also make referrals to other parts of the Department or external organisations where appropriate.

Role of Investigation Officers and Managers in State and Territory Offices

Investigation Officers and Managers are also based in STOs and may undertake duties in relation to complaints or compliance or a combination of both. Their role includes:

- Seeking further information from complainants and providers;
- Liaising with and providing appropriate feedback to all entitled parties;
- Undertaking assessment and preliminary investigation of cases;
- Determining whether a site visit is required;
- Facilitating a conciliated outcome;
- Undertaking investigations including review of evidence, site visits, desk reviews and interviews;
- Developing action plans and investigation reports;
- Determining if there is a breach of provider responsibilities;
- Preparing, issuing and following-up NRAs;
- Making appropriate referrals;
- Supporting the internal reconsiderations process;
- Assessing cases that have been reassigned for non-compliance action;
- Determining appropriate non-compliance action;
- Monitoring services of concern and/or under sanction;
- Liaising with internal and external stakeholders; and
- Managing the information flow between the Department and other stakeholders.

Aged Care Act Delegations

CIS officers have a number of powers which are delegated to them under the Act. Training and procedural advice to CIS officers provides guidance on the nature of these powers and the responsibilities that are associated with exercising such powers.

Issues

The lack of a clear management structure for the national complaint scheme and the overly complex reporting and accountability requirements has led to different complaints management arrangements developing across the STOs. This is impacted by the pressure on STOs to maintain service delivery in the face of increasing numbers of complaints, compulsory reporting requirements and follow up, a growing backlog of cases, and external criticisms of their operations. This has resulted in wide variation and inconsistent handling of complaints across Australia.

Whilst doing their best to meet the requirements of the CIS, many investigators have competing priorities and responsibilities and feel that they have not received sufficient training to meet these requirements. Some staff appeared to either adopt an overly legalistic approach to their role in relation to investigating potential breaches, or adopt a quality improvement approach necessitating working hand-in-hand with the providers. Each approach has its merits but only when applied appropriately paying attention to the nature of the complaint and the context in which the complaint is being handled.

The fragmentation of responsibility for the national complaints scheme dilutes the integrity of the CIS; it needs to develop into a professional complaints organisation which will be the spring board to build trust. The CIS can only do this with strong leadership in complaint management, appropriately trained staff and standardised complaint operations and functions.

The following are some of the structural and operational problems that have led to miscommunications and /or a failure to communicate with CIS staff. This failure is not due to any lack of competence or lack of professionalism on the part of CIS staff, managers, supervisors or investigation officers. The problem is one of design and resourcing. The CIS is not designed to be a streamlined and professional complaint body, yet the stakeholders have those expectations. Rather it appears that the CIS has been designed to concentrate efforts on investigations and to include in their duties other regulatory responsibilities. Inevitably this has created some unintended consequences that have impacted on staff, complainants, providers and the Department.

5.4. Structural and Operational Problems with the CIS

The separation of policy responsibility from operations at the State and Territory level is one of the structural barriers to standardisation. Currently the Compliance Branch in the Office has policy responsibility but remains separate from the operational experience of the CIS. There are many challenges facing the CIS operationally such as; increasing complaints; prioritising competing objectives; risk assessment; and timeliness.

The best policy decisions come from integrating the needs of Government, the community, the industry and the CIS. Most established health complaint bodies try to resolve the majority of complaints locally and in the assessment phase and only investigating those that raise significant questions about the health and safety of care recipients or significant clinical issues. About 85-100% of complaints are resolved satisfactorily without investigation. The current CIS investigates about 63% of cases and resolves only a small percentage in the early stages; an inverse to how established complaint bodies function or allocate their resources.

The current CIS was set up as the gateway for all information about Australian Government subsidised aged care services to be captured. The original intent of the Scheme was to investigate all matters brought to it that may be a breach of a provider's responsibility under the Act. This was to remove the onus of resolving complaints from consumers and providers,

due to the previous issues with the timeframes for resolution of complaints under the former Complaints Resolution Scheme. However, the increasing workloads within the current CIS and the backlog can be directly attributed to the practice of investigating nearly every complaint and with a larger than expected number of complaints being lodged under the new arrangements.

In 2008-09 the CIS investigated 7,962 complaints with 1,093 (approximately 14%) of cases resulting in a finding of a breach of a provider's responsibilities.⁶ While workloads per CIS officers vary quite widely across the States and Territories staff in the larger states carry a much heavier caseload than smaller jurisdictions. But nation wide the average caseload per officer is approximately 84. If the majority of these cases are under investigation then the case burden is very high.

Most complaint bodies undertaking investigations would limit the number of cases under investigation at any one time to around 35 or less. This allows for quality investigations and timely finalisation. The high investigation case load suggests that there are many matters that are being investigated that should not be. High case loads can also prevent timely closing of cases that are resolved prior to the conclusion of the investigation through either conciliated, referral to an appropriate agency or there is no evidence to suggest that a breach has occurred. It also suggests that a substantial number of complaints could be managed locally or through some alternative resolution process.

The investigation of every complaint is clearly unsustainable and ineffective. It may also lead to situations where serious matters are missed because of the volume under investigation and the lack of capacity to prioritise.

Whilst recognising that a well-developed risk assessment framework would reduce the investigation case load burden on staff, a greater focus on the assessment and early resolution phase will result in the CIS needing to restructure its workforce, rather than reduce it. The retraining of staff in negotiation and mediation methods will require investment, and the complexities involved with mediating outcomes between parties is significant.

Further, with an increasing ageing population and demand in parts of the sector such as community care, it can only be envisaged that the work of the CIS will be maintained and indeed increase over time. This given, consideration must be given to how the CIS can be appropriately structured and resourced to reduce workload pressures on staff and improve the capacity and capability within the workforce to ensure that an appropriate client-focused service is delivered to consumers and providers.

The separation of functions between Central Office and state and territory offices heightens the need for robust communications between offices to ensure staff are aware and trained in the application of new policies and procedures as they emerge.

Each State/Territory CIS is under the management of a State/Territory Manager

The CIS is just one of the responsibilities of the Department's State and Territory Managers. In my meeting with the State and Territory Managers they identified the following problems:

- Workloads;
- Emphasis on investigation;
- Inconsistency in investigations;

⁶ CIS data 2008-2009 (unpublished data)

- Confusion about the role of investigators;
- A need for better training;
- Clarification of the role of the nursing officers; and
- Risk management.

Complaint management is one of the most difficult areas in public administration precisely because one has to instil trust from stakeholders who are often in a vulnerable position. Any sign of poor practices or communications can easily damage trust. Mistrust in the outcome of a complaints investigation can be a powerful motivation for further examination through external review of the decisions. Creating a professional and trustworthy complaints scheme requires dedication and focus.

The scheme as currently designed is fragmented throughout many layers in the Department. While the First Assistant Secretary, Office of Aged Care Quality and Compliance is responsible for the CIS nationally, at the local state and territory level, senior staff move in and out of their CIS role depending on what ‘hat’ they are wearing and the issue. Some State and Territory Managers appear to be very hands-on but their impact is local.

Investigations

The CIS is not required to investigate every complaint but for a number of reasons CIS officers are very risk averse and will exercise their discretion in the assessment process to accept most complaints for investigation. Contributing factors include:

- Officers are unclear of the role of the CIS in terms of its regulatory functions and have different interpretations of the legislation and how the policies are to be applied;
- Some officers lack the experience and confidence to make judgements;
- Officers are concerned about making mistakes. Responding to a ministerial request was seen as an indication that the officer had done something wrong rather than seeing it as a part of the Department's responsibilities to Government; and
- The lack of a robust risk management tool to assist CIS officers to appropriately assess complaints.

Confused roles

CIS investigation officers have to manage competing roles and may be confused as to which ‘hat’ they are wearing. For example a Commonwealth Nursing Officer may be requested to attend a facility for an infection outbreak but under which hat are they wearing? Is their role that of an inspector and adviser or an investigator? I was told that CIS staff view inspecting and investigating as the same thing. The two roles have different responsibilities and functions. Some States and Territories also manage complaints and compliance together in the same section and switch hats depending on the type of matter they are dealing with.

The use of template letters

The CIS has implemented a number of template letters and documents which were created to assist CIS officers to manage the internal complaints investigation process as well as provide consistent advice to complainants, providers and other relevant referral agencies throughout the investigation. The Procedures Manual makes reference to each of the templates to guide officers in their appropriate application. Templates are made available to officers through the Department's internal Investigation Management System (‘the IMS’). The CIS currently maintains 75 templates for a range of purposes including: acknowledgement letters, internal investigation reports, advice of conciliated outcome, notice of required action, statements of reason, referrals to other agencies, finalisation letters.

This number of templates, is a recipe for confusion and CIS officers are understandably confused as to which letter to use and in what circumstance. Some officers modify the letters appropriately but others use them without attention to the content matter or the person who will be receiving the letter. Senior management has acknowledged that the current templates are difficult for CIS staff to use and do not necessarily meet the requirements and expectations of stakeholders. The CIS has contracted an external consultant to assist in the review of some of the key templates, including the statement of reasons, and will implement training for staff on their correct application.

5.5. Communication with residents, family members, advocacy groups and providers

Making care recipients aware of their right to complain under the Aged Care Act 1997

The Act recognises that a person’s rights and responsibilities are not diminished when they move into an aged care home or when they are receiving community care in their own homes. A Charter of Residents Rights and Responsibilities in relation to residential care is included in Schedule 1 of the User Rights Principles 1997 under the Act. The Charter outlines the personal, civil, legal and consumer rights of all residents and the residents’ responsibilities in relation to other residents, staff and the residential aged care service community as a whole. In particular, the Charter provides the right for residents to complain and take action to resolve disputes, to have access to advocates and other avenues of redress, to be free from reprisal, or well-founded fear of reprisal, in any form for taking action to enforce his or her rights. These rights imply that if a matter is not resolved satisfactorily by the provider the residents have the right to complain to an external body.

Section 23.14 of the User Rights Principles states that providers must provide certain information to a resident when they enter the home including information about the Charter of Rights and Responsibilities. The CIS Procedures Manual also includes information about the rights of care recipients to have access to both internal and external complaint mechanisms.

Section 56-4 of the Aged Care Act also requires approved providers to establish a complaints resolution mechanism for the aged care service, use the mechanism to address any complaints, advise care recipients (and/or their representatives) of any other mechanisms that are available to address complaints, and provide such assistance as the person requires to used those mechanisms.

To raise awareness of the right of care recipients and their families to raise complaints with the CIS, the Scheme has produced a package of information for consumers about the role of CIS in complaints. A Brochure for consumers explains the role of the CIS and the following text box sets out the roles:

- | |
|---|
| <p>Our Role is to:</p> <ul style="list-style-type: none">• Listen to your concerns• Explain how the scheme works• Deal with any information we receive quickly, consistently and seriously;• Refer issues that may be best dealt with by others (police, nurses or medical registration boards)• Provide you with contact details for a free and confidential advocacy service• Investigate your concerns• Keep up to date on how your concern is being handled and• Provide you with a response in writing. (my emphasis) |
|---|

Information in relation to accessing the CIS is available on the Department's website and should also be made available to all care recipients by the relevant provider. In addition, the Accreditation Standards under the Act set out the requirements for approved providers in relation to the provision of internal complaints handling mechanisms (see Quality of Care Principles 1997). Expected outcome *1.4 Comments and Complaints* covers the requirement for a provider to provide access to residents (or his or her representative) and other interested parties to internal and external complaints mechanisms.

Further, the Community Care Standards under the Quality of Care Principles 1997 also require that each care recipient receiving community care has access to fair and effective procedures for dealing with complaints and disputes and the recently introduced Charter of Rights for community care recipients will mean they have the same rights as those living in residential care.

One submission on behalf of care recipients from culturally and linguistically diverse backgrounds highlighted the necessity to have complaints resolved as close as possible to the source. The submission advised that one in four people in residential care in Victoria are from a non- English speaking background and while there are brochures about the CIS in different languages it is highly likely that this population is unaware of their rights to make complaints. The CIS does not keep separate statistics about the language backgrounds of the care recipients whose care may have given rise to a complaint. A number of submissions also raised the invisibility of gay, lesbian, bisexual and transgender older people who are care recipients. In this context the issue for them is the reluctance to complain because they may be required to disclose their non- heterosexual identity or the same sex relationship for fear of victimisation.

Misunderstanding of the role and functions of the CIS

The CIS has regulatory responsibilities that are sometimes misunderstood by complainants and informants. The use of the word 'informant' to describe the person making the complaint was introduced as the CIS is intended to be the point of contact for all information about aged care, not just complaints. However, this term may have created the impression that the informant is a messenger and not someone who one needs to be kept involved. Informants clearly do not see themselves as merely messengers. They are making a complaint and like most complainants want to be involved in the process – to have their complaint heard, to have an understanding of what is to happen, know the outcome including answers to their particular issues. As discussed in the previous Term of Reference (1) the CIS is required to fulfil certain regulatory functions. Many submissions relate to the needs of the complainants versus the regulatory requirements of the CIS officers.

There nothing in the Act or the Principles that would prevent the CIS from focussing on the complainants' concerns in the majority of complaints. The CIS has developed practices and procedures that cover their regulatory functions; this is appropriate and in the public interest. Linking complaints and complaint investigations to broader safety and systemic issues is an important role. But the focus on the regulatory end of the spectrum has led to a mismatch between complainant expectations and the CIS main functions as they perceive them. One submission put it this way - the CIS is seen as 'heavy duty' when a more subtle approach is preferred.⁷

⁷ Submission 4 – by a consumer

A prevailing theme in complaints to the Commonwealth Ombudsman⁸ about the CIS is that the CIS processes do not meet the expectations of the complainants in resolving their particular matter. Complainants want explanations, accountability and redress for a particular incident which impacts on them or their relative. Many will also be seeking assurance that the incidence will not be repeated. The current CIS focus on its regulatory functions - has there or has there not been a breach of the legislation and whether that breach has been rectified - does not offer complainants accountability for past incidents.

Fear of making complaints/bias

Many family members, residents and advocacy groups confirm the importance of the CIS in light of the vulnerability of the care recipients and their relatives. Reluctance to complain for fear of reprisal from the service was raised during the consultations and in the written submission many times. It was noted that while there may not be overt victimisation or retribution for making a complaint there can be hostility. This is particularly the case for families of care recipients with dementia. Submissions indicate that carers who receive community care packages are also reluctant to complain for fear of losing services that were initially difficult to access and the fact that there may be nothing to replace the service they need. The submissions also highlight that care recipients and family members who live in rural and remote areas have the added fear that there may be no other care alternatives, and maintaining anonymity is more difficult in smaller place.

Handling the complaint

Many submissions recognised that under the old complaint resolution scheme there was more opportunity for complainant engagement and the potential for more satisfactory outcomes. While a wholesale return to the old system is not recommended (due to the issues raised regarding the CRS in the *2005 Senate Inquiry*⁹), it is clear that improvements in communications and broadening the range of resolution options available are critical to raising the confidence of stakeholders in the CIS.

The literature attests to poor communication as a cause of many complaints. Better partnerships are one way to avoid miscommunications and misunderstandings. This is particularly in the context where the care recipient is a permanent resident and the residential facility their substitute 'home'. The role of family members is vital to the successful transition for the care recipient. They can be a valuable resource for the aged care service. In this context the CIS should aim to resolve complaints as close to the situation as possible and involving all the relevant parties. The move towards a focus on investigations has had the unintended effect of alienating many complainants from the complaint process and has left them feeling they are left in the dark after having made their complaint.

Many complaints are not appropriate for the standard investigation track and are better managed by the provider, the care recipient and the family or advocacy group without the involvement of the CIS. The CIS in such cases is the facilitator. A consistent theme in the submissions was the lack of involvement of the complainant in resolving their matter. Many had the experience that having made the complaint the next contact was the receipt of a letter about the outcome.

⁸ Submission 112 by the Commonwealth Ombudsman September 2009

⁹ The Senate Community Affairs References Committee Inquiry into *Quality and equity in aged care*, June 2005.

5.6. Intake

Intake mainly concerns receipt of complaints, assessment and preliminary investigation. The CIS Procedures Manual has a number of templates with a set of questions for the CIS staff to ask depending on the type of informant. This aims to ascertain whether the matter is something that can be dealt with by the Scheme. One of consequences of this may be that staff adhere to the set questions and try to work out whether the complaint is ‘in scope’ or ‘out of scope’ rather than listening to the story of the complainant. If a matter falls outside the scope of a provider’s responsibility it is important to inform the complainant. But it is important that intake officers demonstrate a flexible and empathic attitude at the intake stage and give serious consideration to matters that might on first discussion appear out of scope. Because of workloads most of the business is done on the telephone; this is understandable but it does not give the complainant¹⁰ an opportunity to see a copy of what the CIS has determined to be the central issues.

Opportunity for local resolution

The intake officer is also tasked with establishing whether the complainant’s concerns have been discussed with the service or if any internal complaints mechanism has been used. In the event that they have not, officers are advised they should encourage the informant to do so.¹¹

Submissions from providers reported that this requirement may not be occurring as a matter of course, thus missing an opportunity to have the matter resolved locally. Most established complaint systems refer matters to be resolved as close to the source of the complaint as possible, unless it raises significant issues that require investigation. One submission wanted referral of the complainant to the source in the first instance to be mandatory, but there will be times when there are valid reasons for having the CIS receive the complaint in the first instant. The following example given by a provider¹² highlighted the importance of referral back to the provider for resolution:

A resident at one of our facilities made a number of complaints about the standard of the food being served. The CIS investigated on a number of occasions and found our facility to be serving high standard food. However the resident was not satisfied and continued to contact the CIS with complaints. This whole process was extremely time consuming and stressful for our staff and could have been resolved if the CIS had arranged a meeting between ourselves and the resident and attempted to reach agreement on a solution.

Introducing a system where the provider is expected to manage complaints requires a certain amount of trust from the referring complaint body and the complainants. A focus on local complaint resolution requires a commitment on the part of the providers to providing open accessible and competent complaint resolution. The Act requires providers to establish complaint mechanisms but if those mechanisms are not fair, the complainants will not want to engage with them thus losing an opportunity for local and quick resolution. Establishing an effective system for managing complaints requires that staff are also trained in complaints and complaint resolution methods.

Every call to the CIS is logged as a case (complaint). While the CIS’s Investigation Management System is able to distinguish between matters that are inquiries, self-reports of compulsory reporting requirements and complaints appear to be treated in a similar fashion to other complaints. Logging every call as a case creates the environment where all information

¹⁰ I prefer the word complainant and will use the word complainant in this review.

¹¹ Procedures Manual p2.4

¹² Submission 85 – Catholic Health Australia

is treated in the same way and follows the same procedure no matter if it relates to an incident unrelated to the service or a complaint about a suspected breach.

The IMS can distinguish between complaints and compulsory reporting and does report on the proportion of contacts made with the scheme that are in relation to compulsory reports. It is also able to report on the number of 'out of scope' cases, such as general inquiries for aged care information etc. Therefore there is capacity in the logging system to separate categories of information.

5.7. Written notification of complaints

Currently the parties to a complaint do not receive written notification of the complaint. The provision of written complaint to both the complainant and the provider is important for clarifying the nature and substance of the complaint. Even when the assessment outcome is local resolution the provision of a written complaint will assist the parties in the resolution process. This also enables the complaint body to collect accurate data about the types of complaints and allows reports to be generated that may assist providers to improve their services generally.

The Procedures Manual does require the CIS to notify a provider about the complaint and the commencement of an investigation but submissions reported that this is rarely done with the first notice of the complaint being the CIS investigators arrival on site. There may be legitimate circumstances where the CIS does not advise the provider of a complaint in the first instance, particularly where a decision has been made that an unannounced visit is appropriate. Further, the legislation and the Procedures Manual set out the circumstances where the CIS is not required to contact the provider. These circumstances are where notification will, or is likely to:

- harm the investigation; or
- place the safety, health or well being of the informant or a care recipient at risk; or
- place the informant or a care recipient at risk of intimidation or harassment.

However, it is the policy of the CIS that, these circumstances aside, the approved provider be notified as soon as possible after a complaint is received. The introduction of a requirement for this to occur in writing should alleviate concern within the industry that this is not occurring as a matter of course.

5.8. Investigations

Central to any robust and fair complaint investigation is the need for impartiality and the gathering of all the relevant evidence-including that from the complainants as well as providers, staff, other informants and witnesses.

The weight given to the evidence in any investigation needs to be given impartially and considered in the context and nature of the complaint. Many submissions raised the lack of involvement of family members or care recipients in the investigation process: residents not interviewed, complainants not interviewed, family members not consulted (investigators take details from the resident's file which may not be an accurate portrayal of the situation or events). Conflicting statements are not resolved.

One advocacy service¹³ submitted that many of their clients provide the CIS with credible, detailed, first hand accounts of incidents of inadequate or deficient care they have witnessed

¹³ Submission 105 - Elder Rights Advocacy (ERA)

but the CIS advises that it cannot give any weight to that evidence. They reported that the CIS told them that it cannot determine that a breach has occurred unless it finds evidence at the aged care facility substantiating what the informant has said. Reportedly where, the provider's documentation does not disclose a breach, or a breach is not witnessed by an investigator when present at the facility, a breach is not found to have occurred. One complainant reported to the advocacy service that information given to the CIS by the provider, including details of supposed conversations with the complainant was untrue. However the CIS accepted this information at face value and did not verify with the complainant whether it was correct.

The following two examples illustrate the evidentiary problems faced by complainants¹⁴.

The complainant (a relative of a resident) provided the CIS with specific details of numerous medication errors involving their family member. Some of the errors involved staff members handing the resident someone else's medication and the relative was able to intervene before the wrong medication was swallowed. On other occasions, the relative was present at the times when the resident was due to receive her medication but staff did not bring it to her. However, the resident's medication chart was completed as if all the correct medication had been given. The CIS did not find evidence of the errors at the facility and accordingly, no breaches were found to have occurred. This outcome was extremely frustrating for the complainant who was prepared to sign a statutory declaration about what she had witnessed.

The complainant (a relative of a resident) would frequently arrive at the aged care facility and find that the resident's continence pad and clothing were saturated and/or soiled. This caused the resident to be very distressed and embarrassed by the wet, smelly clothing. Because of this the resident avoided socialising with other residents. Staff would say to the complainant that they were too busy to take the resident to the toilet. The complainant kept a record of these occasions which they provided to the CIS. However, no breach was found to have occurred because the resident had a continence management plan which stated that the resident was to be taken to the toilet at set times. The fact that the staff were not following the plan was not taken into account.

Some submissions raised the concern that CIS is not seen by the care recipients or their relatives as independent or unbiased in their investigations. This perception may be due to CIS officers not seeking information or clarification from relatives/informants during the evidence gathering process. This can lead to a perception that the CIS officers take the provider's 'word' without checking or clarifying the situation with the relative.

In relation to providers, there are examples in the submissions where verbal communication with the approved provider at the initial point of contact by the CIS was effective. There were other instances where provider submissions reported no discussion regarding the nature of the complaint. This was then followed by a request from the CIS for documentation, often in voluminous amounts with uncertainty as to whether this fits within the scope of the complaint. In some cases providers said they were unaware at the conclusion of the investigation of the actual nature of the complaint. This does not enable the provider to learn from the experience or make system improvements.

Many provider submissions also raised the issue of unreasonable time frames for the provision of information to the CIS and delays in having matters finalised. Similar to complainants and advocate groups, providers reported inadequate communication on the progress of an investigation.

The impact of investigations on providers in terms of the resources required to respond to CIS requests is not insignificant and providers report that it detracts from providing care to the residents. They reported that in some circumstances investigation officers were perceived as being unnecessarily punitive and fault finding. Providers report feeling 'guilty' until 'proven

¹⁴ Submission 105 – Elder Rights Advocacy (ERA)

innocent' by the investigation process. A number of provider submissions raised this perception.

On the other hand an investigator when investigating serious matters should be very clear about their role and not be apologetic for exercising their legislated powers and functions in the public interest. It is not unusual in such circumstances for people who are subject of such investigations to feel uncomfortable or targeted.

Focused investigations, in contrast to routine document investigations, allow for more rigorous and robust attention to evidence gathering. Reduced number of cases allows closer attention to those matters requiring investigation. This would include interviewing key staff, witnesses, other relevant parties and conducting other forensic investigations.

One provider questioned the adequacy of clinical expertise available to the investigation team. Of the 15,759 individual issues identified by the CIS in 2008-09, 26% related to health and personal care. While 26% of CIS staff are registered nurses, a number of the clinical cases are complex and require expert clinical advice. Investigators need timely access to both nursing and medical advice. While many investigators have nursing qualifications, in their role as investigator it is safer to access additional clinical advice otherwise the perception of a fair investigation may be raised. The CIS has access to clinical advice from a Senior Nurse Adviser within the Office of Aged Care Quality and Compliance, however, the demand for expert clinical advice has created a significant workload for one person servicing the CIS across Australia in addition to other duties.

Many of the complaints about investigations (failure to notify, failure to record interviews and provide transcripts, failure to interview key staff, failure to be objective and neutral, failure to advise when referring a matter to a registration authority) could be addressed if there were strict criteria for referring complaints to investigations and well trained investigation staff with significantly reduced case loads. Excessive case loads lead to poor quality and delayed findings.

After an investigation

Submissions noted the variability in the details provided in the final correspondence about the outcome of an investigation. A review of a sample of investigation files and the correspondence with family members and advocacy groups suggests that there is substantial variation in the quality of final investigation reports and Statements of Reason. Submissions raised the inability of complainants to understand the reason for the decisions due to the complexity of the document; reports are not written in clear English; reports do not contain the findings on material questions of fact or the evidence on which the CIS is making its decisions.

A recent review conducted for the Department by *mpconsulting*¹⁵ also indicated areas for improvement in Statements of Reason and the need to produce documents that respond to issues raised by the complainant, give a clear understanding of the decision-making process and provide the complainant with specific information regarding the outcomes and required action by the provider (this work is discussed further in Section 5).

¹⁵ *mpconsulting* have been engaged by DOHA to review the internal communications.

The experience of one complainant¹⁶ demonstrates the need for timely and appropriate feedback:

A formal group complaint had been made by a group of relatives who were concerned about the quality of the food for their family members...The outcome of the meeting held in May still remains a mystery to those of us who attended the meeting...Not one of us who had attended the meeting received feedback from the CIS with the exception of the advocacy service. Their letter stated: We have decided the issues you raised may require action by another agency'. This agency was the Aged Care Accreditation Agency and therefore CIS was to take no further action...relatives later became aware that the facility was found to be non-compliant and copies of part of the Agency report was made available...appears that due to the problems at the facility were deemed to be systemic this resulted in the referral by CIS to the Agency...This resulted in no result for those who lodged the complaint...At no time did the person who originally made the complaint have any feedback as to how the matter is being handled and what the facility is going to do to correct it.

Appeals

Many submissions recommended that the 14 day appeal period was too short a time in which to mount a reasoned reply to a final decision by CIS. This issue was dealt with in Term of Reference 1.

5.9. Anonymous complaints

Between 1 July 2008 and 30 June 2009, the CIS received 12,573 contacts, 3,346 of which were made by an anonymous complainant. This represents approximately 27% of the total number of cases received by the CIS in the reporting period.

When information is provided on an anonymous basis, the identity and contact details of the complainant will not be known to the CIS. The Procedures Manual prompts the CIS officer to advise the complainant that if they provide information anonymously, then no further contact can be made with them by the Scheme. Providing information anonymously may also limit the scope of any investigation that the Scheme undertakes e.g. it may be difficult to investigate concerns in relation to an individual where the care recipient's details are anonymous.

If the complainant wishes to be kept updated on the progress of the case the Procedures Manual advises the CIS officer to suggest to the person that they may wish to consider providing information on a confidential or open basis.

A case is assigned for investigation if the information is in-scope and the concerns of the complainant cannot be dealt with by providing information or by referral to the relevant agency. This protocol is followed whether this complainant provides information openly, confidentially or anonymously.

Information received by the CIS can be dealt with if it is within the scope of matters that can be investigated. To be "in-scope" the information must:

- Relate to the Department's aged care responsibilities;
- Relate to a provider funded by the Act;
- Relate to a possible breach of a provider's responsibilities under the Act that has occurred or is occurring; and
- Have not been previously considered by the CIS.

¹⁶ Submission 105 – Elder Rights Advocacy (ERA)

Discussion

The capacity of any complaint scheme to receive anonymous complaints is often a source of contention particularly where the anonymous complaints can be made by disgruntled staff or individuals who have been disciplined by the organisation which is the subject of the anonymous complaint. On the other hand, anonymous complaints can trigger investigations that raise significant public interest issues that require investigation. Anonymous complaints can be difficult to assess because of the reduced capacity to gather sufficient detail, including interviewing witnesses and other parties, consequently many complaints do not proceed because of the inability to seek further information and details.

Thirty-six of the 119 submissions received had a view about anonymous complaints. The majority were made by providers with only seven submissions from consumers. Most providers believed the treatment of anonymous complaints, particularly those of a non-serious matter is currently ineffective. They gave instances of unannounced visits or investigations relating to anonymous complaints which could have been addressed by a phone call or review of the provider's procedural and policy documentation.

In other cases providers reported that anonymous complaints have resulted in unnecessary and lengthy investigations where the complaints or issues are ultimately determined to be unfounded. There may also have been cases where an anonymous report led to examination of significant health and safety issues; such examples were not part of any providers' submissions.

Many provider submissions suggested that complaints are being made by aggrieved staff members (anonymously) and may be malicious or vexatious in nature, and the CIS does not have an evidence based approach to recognising and managing such complaints. Some providers also suggest that the investigation of complaints made vexatiously by staff members can cause a great deal of stress and an additional workload and there is no protection for providers or reprisal for malicious or vexatious complainants.

The submissions against accepting anonymous complaints say that these complaints are very difficult to deal with because, by their nature, there is often not sufficient information for the provider to get a real understanding of what the exact complaint is.

Further one provider suggests that the 'anonymity' of the complainant can result in an investigation which is repetitive. They suggest that it is not uncommon for the CIS, the Department's Compliance Unit and the Agency to all conduct their own investigation of a matter. The submission contends that these groups do not share information due to the need to remain 'objective'.

One of the difficulties with anonymity is the limitation placed on how the complaint can be managed. There is no opportunity for open dialogue and discussion of the issues between the key parties involved, nor is there the ability for follow through to resolution with the individual complainant. Since most complaints are received by telephone, there is opportunity to discuss with the complainant the capacity to make confidential complaints. The Act offers the protection of confidentiality to complainants and officers of CIS are not required to disclose to the provider the details of the complainant. With this protection in place, there is an argument that complainants should provide their personal details to the CIS; the relationship of the person to the facility or community service e.g. care recipient, family, staff; the reasons why they are making the complaint; what they hope to achieve as a result of the

complaint; and evidence that they have used the internal complaints mechanism (or why they have chosen not to use it).

Some submissions to this review however, supported the availability of anonymous complaints, particularly as a safety mechanism to support complainants where there is genuine fear of retribution. This was specifically raised in relation to gay lesbian bisexual transgender and intersex care recipients or carers because of the fear of homophobic/transphobic retribution. Some care recipients have been threatened with 'outing' by providers if they raise a complaint about service standards.

Further, the 2005 Senate Inquiry into quality and equity in aged care, and protection for 'whistleblowers' recommended that staff members who are at the coal face should be protected from adverse outcome as a result of making a complaint.¹⁷

5.10. Reportable Assaults

All Australian Government subsidised aged care homes must report incidents or allegations of sexual assault or serious physical assault. In this context, 'reportable assault' is defined in legislation and means unlawful sexual contact or unreasonable use of force that is inflicted on a person receiving residential aged care. Under these arrangements, aged care providers are required to:

- Report to the police and to the Department within 24 hours of incidents involving alleged or suspected reportable assaults;
- Take reasonable measures to ensure staff members report any suspicions or allegations of Reportable assaults to the provider;
- Take steps to protect the security of residents in the facility;
- Take reasonable steps to protect the identity of any person who lodges a report; and
- Keep consolidated records of all incidents involving allegations or suspicions of reportable assaults.

In 2008-09 the Department received notification of 1,411 alleged reportable assaults. Of those, 1,146 were recorded as alleged unreasonable use of force, 279 as alleged unlawful sexual contact and 18 as both. This is an increase from the 925 reports that were received in 2007-08.

One of the principle difficulties with reportable assault is determining whether an incident falls within an interpretation of 'unreasonable use of force' or 'unlawful sexual contact'. Additional training is recommended for CIS Staff and providers in relation to reportable assaults. Some submissions have requested that better protocols be provided regarding reportable assaults, particularly outlining each party's responsibilities in the reporting process.

From a consumer perspective, there has been criticism that the requirement to report does not respect the rights of residents to choose not to report an incident. However, in relation to abuse, the need to protect both the victim and other potential victims within a communal environment is paramount.

Role of the CIS in investigating reportable assaults

Providers report reportable assaults to the CIS. The CIS is operational seven days a week to enable providers to comply with the 24 hour reporting timeframe. The CIS does not

¹⁷ The Senate Community Affairs References Committee Inquiry into *Quality and equity in aged care*, June 2005.

investigate the alleged or suspected assault; this is the responsibility of the police. Some submissions have highlighted impact on staff that may be wrongfully accused on assault and the lack of natural justice for staff who are required to be stood down until the matter is investigated by police.

The CIS validates the information received to determine whether the provider has complied with their obligations and responsibilities under the Act. The CIS will also:

- Assess if the alleged or suspected assault is a reportable assault and/or whether there are behavioural management issues which need to be considered;
- Determine whether the provider has advised the relevant care recipient's family and taken appropriate steps to ensure the health, safety and well being of the relevant care recipient;
- Determine whether the provider has taken action to ensure the alleged offender is no longer able to have unsupervised access to care recipients;
- Determine whether the provider has procedures in place to deal with reportable assaults and whether employees are aware of these procedures;
- Determine whether the approved provider and staff have followed their procedures; and
- If the alleged perpetrator is a staff member, determine if a police check was undertaken and whether convictions were recorded.

Department policy is that all reportable assaults are assigned a critical priority and require a site visit. Where possible, the visit is timed so as not to interfere with any police investigation or presence in the home.

Some providers believe they should be allowed sufficient time to undertake their own assessment of the incident before reporting to police and the Department. Some submissions contend that it is not always necessary for the CIS to undertake a site visit each time a report is made. The CIS should take into consideration that providers are self-reporting and are aware of their responsibilities. They suggest that the CIS could rely on information provided by the home obtained through internal investigation rather than undertaking a visit.

Where the CIS finds that a provider has breached their responsibilities in relation to reportable assaults, compliance action will follow. Providers have raised concern that relatively minor breaches can have serious impacts where the provider is issued a Notice of Non-Compliance and this information is published on the Department's website.

One submission suggested that the CIS adopts a punitive approach and continues to scrutinise individual providers each time they make a report, even where they have had a previous record of good practice.

Communication with police services regarding reportable assaults

Where the CIS becomes aware of a potentially criminal matter, including a reportable assault, the CIS Procedures Manual prescribes that these matters must be referred to the relevant state police service.

Relevant information is released to the police service by the delegate under the Act. Many of the CIS units in each State and Territory have formalised arrangements in place with police services regarding communication and referral of information, or are in the process of negotiating these arrangements.

In referring matters to the police, the Department asks the police to provide advice as to what action is taken as a result of the referral. However, due to the confidential criminal nature of

many of the cases, the police services are only able to provide limited details to the Department. The level of feedback that is provided by police services varies between States and Territories. Further, some submissions raised concerns that the police capacity to investigate reportable assaults is often limited.

5.11. Unexplained absences

Since 1 January 2009, providers are also required to advise the Department about unexplained absences of residents from residential care. The criteria for reporting are:

- If a care recipient is absent from a residential care service; and
- The absence is unexplained; and
- The absence has been reported to the police.

The provider must report such instances as soon as practicable after reporting to the police, and in any case, within 24 hours.

Since 1 January 2009, the Department has received 367 reports of missing residents.

Role of CIS in investigating unexplained absences

The requirements for reporting unexplained absences do not override a provider's responsibility to comply with the Charter of Resident's Rights and Responsibilities, which include the resident's right to move freely both inside and outside the service without undue restriction.

This notification will enable the CIS to determine whether appropriate action has been taken by the provider in respect of the missing residents, and whether there are adequate systems and processes in place to ensure other resident's safety. This reporting requirement is part of a provider's responsibility under the Act to provide a safe and secure environment.

The CIS's response to the notification will be to review the matter to establish whether there is an ongoing risk to residents. For example, it is unlikely further action will be taken where a missing resident turns up, having spent a day with family or friends. Whereas, if a resident is reported as missing without reasonable explanation and it is considered that the provider did not have adequate systems and processes in place to prevent the absence, then the CIS will investigate.

6. ADEQUACY OF TRAINING AND ACCESS TO EXPERTISE FOR INVESTIGATORS

6.1. Overview

The Commonwealth Ombudsman¹⁸ observed that while issuing an NRA and identifying breaches of provider obligations are important, they should not drive the response to a complaint at the expense of resolving complaints amicably. It is important that the delivery of training and setting of performance indicators for the CIS includes a strong focus on complaint resolution as well as investigation, because different skills and training are required for the two activities.

Most of the current complaint training is focussed on investigation training rather than on alternative dispute resolution training. Many of the provider and consumer submissions raised this area of training as important and considered it a priority.

Most current complaints staff are involved in investigations, though some investigations would not fit the definition of ‘an investigation’ because of the limited tasks and activities undertaken. This is not necessarily reflective of the competence of the investigators; rather it is one of interpretation of their roles and understanding of what is expected in complaints management. CIS investigations from my review of the files are generally more limited than investigations by other established complaint bodies.

6.2. The Procedures Manual

The CIS Procedures Manual states that purposes of an investigation are to:

- Establish and document the facts of the case;
- Reach appropriate conclusions based on the available evidence;
- Determine a suitable outcome; and
- Identify whether there is a breach of the provider’s responsibilities.

Investigations should be independent, competent, proportionate and timely and should focus on assessing the matter raised, rather than commence with the assumption that a person is to blame.

The Manual also emphasises the importance of a nationally consistent investigative approach and open communication with all parties. Elsewhere I make comments about the lack of a standardised approach to complaint handling and investigation across the States and Territories.

6.3. Role of CIS officers

CIS officers are authorised officers under the Act. Part 6.4 of the Act outlines the powers of authorised officers. These powers include the ability to:

- Search a premises;
- Take photographs (including video recording), or making sketches of the premises or any substance or thing at the premises;
- Inspect, examine and take samples of any substance or thing on or in the premises;
- Inspect any document or record kept at the premises; and
- Take extracts from, or make copies of, any document or record at the premises.

¹⁸ Submission 112 Commonwealth Ombudsman

Authorised officers may only enter premises and exercise these monitoring powers with the consent of the occupier of the premises and the occupier may withdraw this consent at any time. If consent is refused, the authorised officer may apply to a magistrate for a warrant. These powers are sufficient to enable thorough investigations.

Initial recruitment

Prior to the commencement of the CIS in early 2007, the Office managed a national recruitment process to select CIS staff for STOs. The recruitment campaign targeted people with appropriate skills, backgrounds and expertise. Of particular relevance were:

- Judgement, analytical and reasoning skills;
- People, negotiation and communication skills;
- Ability to manage the workload of a busy team;
- Ability to manage multiple tasks in a fast-paced environment within strict deadlines;
- Investigation and complaints resolution skills; and
- Conflict resolution and/ or mediation skills or experience.

Clinical skills, investigative or complaint handling skills were also desirable, but not essential.

At the time of appointment, approximately 35% of those individuals recruited had nursing qualifications. An additional 27% had an investigations background (approximately 10% of these had been in the police force).

6.4. Current skills base

As of May 2009, the CIS employed 156 staff in the Department's STOs. Approximately 26% of these officers were, or are, registered nurses. Other professional backgrounds include:

- Health - nursing occupational therapy and physiotherapy;
- Law - ex-police officers, prosecutors and private legal practice;
- Social services- social work, disability services, crisis counselling and child protection;
- Administration- government funding programs, public health, government regulation, monitoring financial services; and
- Aged care industry - personal carers, nursing and administration.

Current training

Each CIS officer has access to the following training:

Certificate IV Investigation (Government)

All CIS staff complete five modules of the Certificate IV Investigation (Government). This is a nationally accredited vocational education training course. It is delivered over three days by an external training provider (CIT Solutions). Assessment work is completed in a participant's own time and a Certificate of Attainment is issued if a participant is assessed as competent.

The modules are as follows:

- Receive and validate data;
- Gather and manage evidence;
- Gather information through interviews;
- Investigate non-compliance; and
- Use advanced workplace communication strategies.

The training was adjusted in early 2008 following a training needs analysis which identified the need for a greater focus on aged care matters.

Administrative law and aged care legislation

All CIS officers undertake one 3 hour training course in *Introduction to Aged Care Legislation* and one 3 hour training course in *Introduction to Administrative Law - Good Decision Making under the Aged Care Act 1997 and the Aged Care Principles*. Both courses are delivered by internal legal officers.

Good complaints handling

A 3 hour *Good Practice in Administrative Inquiries* (for Health Complaints) training course was conducted by the Commonwealth Ombudsman in each STO between June and December 2007.

Specified Care and Services (Quality of Care Principles, Schedule1)

This 3 hour session undertaken by CIS officers provides them with the legislative framework for Specified Care and Services. This is the major area of the legislation where a provider may be in breach of the Act for failing to provide the care or service. Knowledge of this aspect of the legislation is vital to good decision making during an investigation. Links with other areas of the legislation are provided as well as a range of scenarios for staff to work through. This workshop is delivered by a senior officer from Compliance Branch who specialises in both the policy and program support for Specified Care and Services.

Use of the Investigation Management System

All CIS staff receive training in the Investigation Management System (IMS) database, which is used to record, track and progress all cases received by the CIS as well as all compliance action taken. Initially IMS training was delivered as a one day course in addition to CIS Investigation training, however, as the skill levels of staff varied considerably feedback from staff suggested this was not the optimum method for teaching. Consequently, computer based training for IMS was developed in 2008 and updated in mid 2009, so that all new officers can have immediate access to an introductory session on IMS as well as access an 'IMS training environment'. A range of scenarios accompany this training material so that staff can practice intake, investigation and compliance scenarios from a legal, procedural and system aspect before undertaking any 'real' cases. This training relies on support and mentoring by managers in the STOs. Support from Compliance Branch is available by phone or email and additional IMS training is supported by officers from Compliance Branch working on a one-to-one basis with STO staff as needed.

Addressing training needs

When departmental officers require specific training to enable them to competently perform their duties, they request the Department's People Branch to develop and fund such training. This is the case with the current training provided to CIS staff i.e. delivery of five modules from Certificate IV in Government Investigation which is provided up to four times per year. Any amendment to the current training or additional training must be arranged and resourced through People Branch.

In 2007 and 2008 a comprehensive evaluation of training of all CIS officers indicated that staff wanted more information in regard to aged care, legislative links, delegations, specific scenarios in undertaking an investigation, compliance, writing statements of reason and clinical investigations. This feedback, plus recommendations made by the Commissioner, has been taken into account in developing a comprehensive needs analysis for all CIS officers and

decision makers. People Branch are currently working with the training area of the Office in developing a comprehensive scoping document which takes into account these training needs.

6.5. Clinical Protocol for CIS Registered Nurses

I have been advised that the Office has also been proactive in initiating additional training for CIS Registered Nurses. In April 2009, the *Clinical Protocol for Registered Nurses working in the Aged Care Complaints Investigation Scheme* was developed in conjunction with the Department's Senior Nurse Adviser for aged care, and aged care industry peak bodies.

Workshops were held for all registered nurses who undertake investigations, to assist them to understand the role of the nurse and what specific clinical matters should be taken into account during an investigation. This protocol and the associated workbook were placed on the internal CIS intranet site following the workshops so that all staff could readily access the information.

The Senior Nurse Adviser supports ongoing clinical skills for registered nurses in the CIS by regularly visiting STOs and being available for support at all time by phone or email.

6.6. Statements of Reason

During this review it became evident that writing concise and legislatively supported Statements of Reason (SoRs) was an area in which CIS officers require significant additional skills. The Aged Care Commissioner, CIS Managers, officers themselves and provider and consumer submissions see this as a critical area for improvement.

Currently *mpconsulting* is working with the Office to address this issue. To date over 200 SoRs have been reviewed and analysed to determine the skills gap. A training package is being developed incorporating the legislative requirements for SoRs and hands-on practice.

A booklet with a range of 'good' examples is also being developed and the associated templates will be amended to support staff with this task. Training will be provided to all STOs from October 2009. Options for videoing this training are being investigated so that it can be made available to new staff as they join the CIS.

6.7. Compliance Action

The CIS not only incorporates intake and investigation, but also compliance action, such as Notices of Non-Compliance and Sanctions. The process for taking compliance action is another area where CIS Managers and staff have identified a skills gap and have requested training and support. The Office has held discussions with State and Territory Managers to determine the needs of the officers and develop appropriate training strategies. Additionally, the compliance part of the CIS Manual is being rewritten to provide more detailed advice. Training will be provided to all STOs starting in October 2009. Again, the opportunity for making this training available via video is being explored.

6.8. CIS Orientation

All STOs appear to have an 'orientation' pack for new starters in CIS. The Office is working with STOs to develop a national orientation pack which would also incorporate information on the aged care sector. This project is currently underway.

The internal CIS intranet site is used as an information and training site. All CIS Bulletins, the procedures manual, IMS manual, new policies, templates and guidelines are placed on this site so that all officers have easy and ready access to this information.

One of the important factors in ensuring the success of training is that staff are supported and mentored to maintain and develop their skills. State offices use a range of strategies to encourage this practice. I am advised that the Department is working to develop a more consistent approach in this area.

6.9. The Submissions

Knowledge of the aged care industry

Submissions, particularly from the providers, referred to CIS investigator's lack of knowledge about the aged care industry, which they surmised led to unrealistic expectations on providers in terms of the level of care and services that are available to a care recipient.

One provider¹⁹ provided the following example of insufficient knowledge about the sector.

The investigation of mandatory reporting requirements appears to have influenced some CIS officers to assume a philosophy that is contrary to the least restrictive alternative and resident's rights in relation to risk, and contrary to contemporary aged care practice. They advise that providers report that CIS officers have assumed that all residents require secure (locked) environments and are high care. They identified additional training in statutory interpretation and familiarisation with aged care recipients and the environment in which they live.

Another provider's submission²⁰ gave an example of a similar issue but from a different perspective.

The investigation was the result of an anonymous complaint that had been lodged with the Scheme after we had introduced a practice of locking the bedroom doors of residents in our Dementia specific wing at night to prevent certain residents from entering and disturbing the occupant's sleep and interfering with their possessions. Following its initial investigation, the Department in its notice to us regarding the complaint, advised that it was referring the matter to the Aged Care Standards and Accreditation Agency because....

...The CIS letter referred to the practice of the service locking residents' doors posed a serious risk to them. The service has all of the necessary fire safety precautions in place including sprinkler systems in every room and a zoned alarm system. All staff carry keys to the rooms and have regular fire evacuation training. The coded key-pad locks on the front doors and gates to the house are automatically opened by the system when an alarm goes off. In any case, residents are able to unlock their doors from the inside. Our procedures manual also covers the process staff must follow in evacuating residents from locked rooms in the case of an emergency....

All residents in the House have dementia and none of them would have been able to tell the Investigators why they were agitated. One of the notable points regarding this investigation was the apparent lack of basic investigation skills exhibited by the Investigating Officers of the scheme. Of particular note is the comment regarding the 'agitation of a resident because she could not freely access her room.' The first time that we were presented with this evidence was in the letter written to us by the Department following the investigation. There was no mention of it in the investigators' exit interview, and if there had been, we would have been able to refute it immediately. Clearly assumptions were made about residents that indicate the investigators had not been properly trained in investigation techniques and rules of evidence. Decisions are based on some of their observations without conducting a thorough investigation.

6.10. Investigative approach

Many submissions described the approach to investigations as almost entirely based on an exhaustive examination of documentation rather than reliance on discussions with staff to

¹⁹ Submission 49 – Aged and Community Services WA

²⁰ Submission 75 – Catholic Health Australia

elicit information and explanations. Providers also described the disruption to the normal operations and the enormous stress on staff involved in the investigation process. They observed that many situations could have been clarified and resolved quickly through more open communication with staff and management during the course of the investigation.

6.11. Training

Provider submissions recognised that the CIS undertakes specific training. Some saw an opportunity to expand this training to ensure all CIS Officers have an understanding of the ageing process, especially in relation to dementia, mental illness or previous trauma experienced by an older person as with a refugee or veteran.

They reported a strong need for the CIS Officers to consider the changing circumstances in care recipient health and well-being that could potentially impact on the investigation outcomes. For example, investigators need to have a basic understanding of mental health illness in order to identify the presence of such illness in a complainant and/or family member who is unable to engage in a reasonable manner, and to know when to take it into account as part of the investigation. This may be difficult for investigators but at a minimum it would be desirable for investigators to know when to seek advice about such issues.

The training should also include an understanding of the community and residential aged care systems. The CIS Officers also need to be equipped with skills in mediation or linked to internal or external mediators to enable them to work effectively when dealing with complaints across the aged care sector.

6.12. Clinical Expertise

Providers noted that the CIS team needs to have broad expertise to enable complaints to be thoroughly examined by appropriately skilled personnel, fostering nationally consistent standards of investigation.

Where an investigation is dealing with issues of a clinical nature, the investigator should have clinical training or, where this is absent; to have access to appropriately trained experts. Another provider²¹ suggested that the qualifications of the CIS officers should be reviewed. It might be that it is preferable that the majority of officers should have some clinical qualifications or alternatively external experts may be used if required, to review complaints or issues that are raised regarding clinical matters. Having clinical skills does not in itself guarantee a person will have investigative skills as noted in the discussion section below.

One submission²² gave examples where investigators have not understood the clinical issue at hand, but have continued to investigate nevertheless and even suggested courses of action for the provider to take. They saw this as inappropriate, not to mention insulting, to the clinical staff receiving the "advice."

Discussion

During the consultations I was advised that there had been a high turn over of staff in the CIS. This has an impact on the preparedness of new investigators as well as interruption to existing investigations.

²¹ Submission 81 BUPA care services

²² Submission 99 Aged care Association Australia SA

6.13. Training requirements

The argument that investigators should have specific training in the area of the subject of investigation is a common theme in many complaint areas, not just aged care. Medical practitioners once argued that only doctors could investigate a complaint about treatment. Today it is widely accepted that investigators require skills that are not usually part of the training of health professionals. Having expertise in a particular area may be useful but it is not the essential component; other attributes are more important such as skills and knowledge about evidence gathering, analytic skills, capacity to examine facts and excellent writing skills. Knowing when to seek expert advice is the key.

CIS staff told me during our face-to-face consultation that the compulsory training modules undertaken by investigators did not equip them for investigating aged care complaints. Notwithstanding the high level of expertise that most of the CIS staff bring to the job, they still thought they needed specific training particularly in work preparation and professional development. Many commented that their training was too generic and oriented more towards criminal investigations than handling complaints in the human service sector.

Steps have been taken to modify the course to be more focused on investigations in the aged care environment. As outlined above, the Department is working with People Branch to analyse and map the training needs of staff at all levels across the CIS so that an appropriate range of ongoing training can be provided to officers from intake through to compliance.

Carers Australia²³ suggests that the training does not prepare investigators for dealing with the complainants and their relatives. A focus is the investigation of service records and communication with workers or providers. Submissions from care recipient relatives and advocates recommended that training in communicating with clients and carers would greatly improve the ability of investigators to examine a wider and more balanced range of evidence that includes the needs of clients and their carers.

The suggestion in some submissions that there is an over focus on document examination may relate to the investigator interpretation of their role in relation to finding possible breaches of the provider's responsibilities. It may also be because of the lack of training and skills in conducting a proper investigation; it is easier to be preoccupied with checking whether the documentation meets a particular standard than conducting comprehensive examination of all the evidence, including interviewing witnesses and taking statements.

6.14. Culture

The culture of investigation units and the attitude of the people responsible for investigations have significant bearing on how a particular investigation body functions.

The CIS Service Charter requires professional conduct when undertaking investigations. A report by a provider²⁴ indicates that some CIS officers appear to continue to search for supporting evidence of a breach until they find something or return on subsequent visits when one visit did not establish evidence of a breach. Good investigations are guided by a well written Procedures Manual. When complaint guidelines are inconsistently applied it affects the quality of investigations. Good supervision is required to facilitate investigations that are fair and just. Having a clearly written Procedures Manual is an important step, but if people

²³ Submission 30 – Carers Australia

²⁴ Submission 49 – Aged and Community Services WA

do not follow it or have different interpretations of the meaning of instructions, then it is inevitable that there will be varying approaches.

6.15. Recruitment

Training cannot be divorced from recruitment. The Job Requirements for an APS 5 Investigation Officer, APS6 Senior Investigation Officer and Executive Level 1 Investigation Manager, all consider conflict resolution, mediation, and investigation skills desirable. These are essential skills for anyone working in complaints, but particularly for senior staff and managers. In making it only a 'desirable' skill a heavy onus then falls on the organisation to provide the appropriate level of training.

In the box below is an example of the job description used by the NSW Health Care Complaints Commission for investigation officers. The box below sets out the knowledge and skills requires as well as the selection criteria.

KNOWLEDGE, SKILLS AND EXPERIENCE (Health Care Complaints Commission)

The Investigation Officer requires investigative experience including interviewing, information collection and analysis, interpretation and application of legislation and capacity to manage an individual caseload effectively.

The ability to compile briefs of evidence is required combined with skills in planning investigations, working effectively as a team member, identifying appropriate resources and using them effectively, project management and good written communication skills.

The Investigation Officer requires the capacity to exercise judgement appropriately and to make appropriate recommendations and exercise discretion where diverse interests are present. The Investigation Officer requires a level of skill that allows them to represent the Commission appropriately when dealing with members of the public, interviewing complainants, health care providers and staff of health organisations. Investigation Officers are required to prepare complex investigation reports and compile briefs of evidence effectively. Investigation Officers are also periodically required to prepare Ministerial correspondence.

Selection Criteria

1. Experience in conducting investigations. analysing complex information, preparing complex reports, and preparing briefs of evidence.
2. High level interpersonal, oral and written communication skills and experience in conducting interviews and taking statements.
3. Demonstrated ability to manage a diverse, high volume caseload.
4. Demonstrated ability to exercise sound judgement; interpret and apply relevant legislation, write clear reports and draft correspondence on complex matters.
5. Capacity to work effectively and efficiently in a team setting.
6. Tertiary qualifications in a relevant field and/or equivalent experience.
7. Hold a current NSW Drivers Licence and have the capacity to undertake intrastate travel as required.
8. Common selection criteria: a knowledge and understanding of Equal Employment Opportunity; Ethical Practice; Ethnic Affairs Priority Statements and Occupational Health and Safety as they relate to the job.

7. RISK ASSESSMENT AND ESCALATION OF COMPLAINTS

7.1. Appropriateness of risk assessment framework and escalation of complaints

The Aged Care Complaints Investigation Scheme Procedures Manual (the ‘Procedures Manual’) currently provides limited guidance for CIS officers regarding risk assessment and management of cases. The Office is currently putting in place more formalised guidance for CIS staff and their managers regarding risk assessment and management. In relation to prioritising of cases as they are received within the CIS, the Procedures Manual provides the following advice:

Once information is received, the Investigation Officer will have to determine the urgency of each issue in the case. The following three options are available:

- Critical – the case must be referred to the Intake Manager within 2 hours, and is immediately considered. Depending on the circumstance, a site visit may be organised;
- Major - the case must be referred to the Intake Manager within 24 hours, and is put on the high priority list for early complaints management and/or investigation; and
- Minor - the case must be referred to the Intake Manager within 48 hours, and management of the complaint will occur as soon as possible.

Examples of critical issues are:

- Assault;
- Harassment;
- An immediate threat to the security of tenure of the care recipient;
- Immediate threat of loss of accommodation bond (these cases should be reported to the Prudential Regulation and Approved Provider Branch in Central Office immediately);
- The care recipient is demonstrating severe distress;
- Issues relating to a criminal investigation; and
- Issues that could immediately threaten the health, safety or wellbeing of a care recipient.

Examples of major issues include:

- Slow response to call bells;
- Adequate hydration; adequate nutrition;
- Pain management;
- Management of constipation;
- Behaviour management;
- Number of care staff available; and
- Medication management.

Examples of minor issues include:

- Possible overcharging on pharmacy bill;
- Limited choice of menus;
- Wheelchairs do not have foot plates.

7.2. Information from the submissions

All submissions about the risk assessment framework came from providers. The following is a summary of the issues raised in relation to risk assessment:

- Generally not aware of the risk assessment framework used for escalation of complaints;
- Current risk assessment framework is onerously risk averse resulting in high volume of unannounced visits;
- Support the use of a risk framework to escalate complaints;

- Too many provider reports investigated after meeting mandatory reporting obligations;
- The threshold test for matters to be investigated is a very broad test and does not operate within a risk assessment framework;
- Very limited circumstances where the Secretary may decide not to investigate (where the information given is vexatious or frivolous or not given in good faith);
- Currently unclear as to how the Secretary measures risk;
- Loss of focus of the original complaint when other issues are identified during a complaint investigation that has escalated the matter. Where other issues are identified during a complaints investigation and these pose no immediate or severe risk to care recipients, further investigation should only occur once the initial complaint has been finalised; and
- All complaints should be subjected to a filtering process whereby only complaints judged to be serious or which present a risk to residents, are assessed for immediate investigation, while the remainder are referred for mediation.

The following provider²⁵ gave an example of inadequate complaint management with the threat of escalation.

Because of the mandatory 24 hour reporting a service manager reported that there was a possible incident of abuse (not yet investigated). Within a minute of the service starting to outline the possible issue, a young, obviously untrained CIS person (reading from a script) asked the service manager if this assault (not alleged, not investigated) had been reported to the police and had the resident's doctor been called. She then said that this was a terrible incident and would have to go to the Minister - keep in mind the service still didn't even know if any incident/s had actually occurred. The service manager tried to inform this person that the possible incident/s had occurred at least 2 to 3 weeks previous, and that a resident's daughter was not raising a complaint but letting us know in a family conference that she thought that we might have had a process problem, not an assault.

Discussion

CIS staff have adopted a very low threshold of risk in their assessment of complaints for investigation, notwithstanding the risk assessment protocols outlined above. This is no doubt related to the CIS policy that 'in scope' complaints require investigation. There is also the perception that if they make a mistake in the assessment, harm may befall the resident (and possibly reflect badly on the CIS). Fear of mistake becomes a significant factor in complaint management when a risk assessment framework is not used, or inconsistently applied.

A strategic approach to risk assessment includes providing a decision-making tool that permits everyone to understand the basis for a decision. Providing complainants with an opportunity to request review of a decision is an additional safeguard for complainants in relation to how their complaint has been managed.

Understanding the problem

No one would dispute that complaints need to be assessed to decide the most appropriate course of action and to ensure serious incidents receive immediate attention. This is particularly the case in aged care where the care recipients are frail and elderly and dependent on the providers for their personal health and wellbeing. The first level of assessment in the CIS is at intake where staff assess whether the complaint comes within their jurisdiction. The designated CIS complaints manager performs risk assessments at this level.

²⁵ Submission 75 – Catholic Health Australia

The first step is to understand the problem. Submissions from care recipients, relatives and advocates report that instructions/information from complainants may not reflect their real concerns. The CIS advises that this information is recorded in the IMS. Skill, time and patience are required to gain an understanding of complainants' underlying issues. Research by Professor Linda Mulcahy²⁶ in the United Kingdom found that up to 40 per cent of people who had made complaints to the National Health Service were not clear about what they wanted, or minimised the seriousness of their complaint because they did not feel confident to question the standard of clinical care. Residents and carers who are equally vulnerable may need assistance with articulating their complaint and exploration of the issues they are worried about.

7.3. Assessing risk

All complaints should be assessed immediately after they have been received to identify the level of risk and the appropriate course of action that needs to be taken. The purpose of risk assessment at this stage is to identify high risk or 'serious risk to the health, safety and wellbeing of a care recipient(s)'. Officers should be alert to complaints that raise significant safety, legal or regulatory issues and need to be notified to senior management immediately.

A risk assessment framework is a useful tool to assist with consistent and reliable risk assessment. A fixed rank rating can be obtained by combining the consequences (or impact) of an incident with the probability (or likelihood) of the same type of incident recurring. The rank rating correlates with actions that need to be taken, providing the complaints manager with a clear course of action that is linked to the risk assessment system. For example, the highest rank rating of '4' prompts notification to senior management and detailed investigation of the causes of an incident. A rating of '2' or '1' is managed in the routine way, which means the complaint is still reviewed to find out what happened and possible improvement strategies.

Many health agencies²⁷ have developed risk assessment matrixes to assist them to determine risk. One such severity assessment matrix is set out on the next page. Details of its use in the NSW Department of Health are provided at [Appendix 5](#). The matrix template should be reviewed and developed to reflect the issues raised by aged care complainants.

²⁶ *Turning wrongs into rights*, keynote address by Professor Linda Mulcahy, Birbeck College, University of London, 2003, available at www.hccc.nsw.gov.au.

²⁷ *Guidance Document to the Queensland Health Complaints Management Policy, Making feedback work for you!*, Queensland Health, 2002; *Severity Assessment Code*, NSW Severity Assessment Code (SAC) November 2005 http://www.health.nsw.gov.au/pubs/2005/pdf/sac_matrix.pdf; Department of Health Western Australia, *Complaints Management Policy*, 2003. Australian Standard, *Risk Management AS/NZ 4360:1999*; *Open Disclosure Standard*, Australian Council for Safety and Quality in Health Care, 2003; *Open Disclosure: Health Care Professional's Handbook and Open Disclosure: Manager's Handbook*, Australian Council for Safety and Quality in Health Care, 2004, available at www.qualityandsafety.org

Risk Matrix

		Consequences				
		Serious	Major	Moderate	Minor	Minimum
Likelihood	Frequent	4	4	3	2	2
	Likely	4	4	3	2	2
	Possible	4	3	3	2	2
	Unlikely	4	3	2	1	1
	Rare	2	2	2	1	1
		Risk Rating				

Performance of individuals

Risk assessment also requires assessment of individual workers to enable the identification of behaviour that may give rise to a breach of a standard or necessitate referral to another agency.

7.4. External referral

There needs to be a clear policy in the Procedures Manual setting out when the complaint officer is legally obliged to notify agencies such as police and coroners, and circumstances where the officer will consult with professional registration boards and health care complaints commissioners about the behaviour of an individual.

The senior manager should consult with the relevant professional registration board or health care complaints commissioner where there is a significant risk to the health and safety of care recipients, or raises a significant concern as to the appropriate care or treatment of a care recipient. All providers and staff need to have a basic awareness of this policy and the identity of the person responsible for making notifications.

7.5. Reliability of the Risk Assessment Framework

To ensure that the risk assessment framework is reliable and valid, senior managers should review how it has been used and the appropriateness of the decisions made. This should occur on a monthly basis to ensure the framework remains reliable and valid. These reports should be made available to the Minister and the Secretary (or delegate) of the Department.

8. ADEQUACY OF INFORMATION COLLECTED

8.1. Overview

Many of the issues associated with the quality of investigations – type of information collected and gaps in investigations- have been covered in earlier sections. I need to re-emphasise that the problem is not the competency of individual investigation officers, but the design of the CIS, inadequate training and resources and the current practice of investigating most complaints, except the most minor. Many providers commented on the investigation officers being professional, informative and balanced.

8.2. The Submissions

Many submissions made suggestions for improvement as well as expressed their concerns about investigations. One submission described a practice in NSW where an investigator was assigned to a provider with the result being a more open investigation process, setting the foundation for mutual respect and understanding as well as contextualising complaints. This is commendable but another side to this might include the perceived closeness of the CIS and the provider by a complainant.

Most submissions addressing this term of reference came from providers. Below is a summary of the matters raised in relation to investigations:

- No written notification of the complainant outlining the particulars (only telephone notice);
- Treating self-reported incidents as complaints;
- Unannounced visits do not allow for timely assembling of the documentation requested;
- Unclear about what information is required;
- Unrealistic timeframes within which to provide documentation;
- Requests for large volume of documentation gives impression that CIS officers not clear what they are seeking and also entails enormous costs to the organisation, including human and administration resources;
- Time consuming - apart from the meetings with the investigation officers - several hours of work by senior managers required to provide the documentary evidence required by the process;
- Over reliance on documents and little reliance on observations and interviews;
- CIS processes and responsibilities are ambiguous or unclear;
- Feedback from CIS very slow;
- Findings of the investigations take weeks to be formally confirmed;
- At the end of the investigation providers sometimes unaware of the details of the complaint;
- Lack of information about what weight the evidence has been given;
- Unclear how documents are used;
- Lack of transparency in the investigation process;
- Employees who have had complaints against them are often unaware of the nature of the of self complaints;
- CIS investigation often results in prescriptive measures being applied to the provider when no NRA has been issued;
- The provision of written information to the CIS without consultation can result in information being misinterpreted;
- Lack of use of site meetings involving the key parties to discuss the type of information wanted which will allow CIS to access the relevant documentation on site;

- In many instances providers have no idea who has been contacted which can result in duplication and conflicting information which can sequentially impact on the investigation and the subsequent outcome; and
- CIS staff take a confrontational approach and make unreasonable demands on provider's time.

It is not uncommon to have two investigators on-site for six hours. Significant documentation demands are made. Investigators are found to lack aged care operational and clinical knowledge/experience. Where there is a reportable offence and staff are required to be 'stood down' the investigation should occur quickly. Some aged care staff have resigned as the result of this process having felt that they have already been judged as guilty, regardless of the CIS outcome.

8.3. Current trend to explore additional issues of concern

The original complaint is left unresolved while other issues are explored. Providers are given exceptionally short timelines to respond/provide information regarding a complaint when the length of time taken by CIS before a complaint is finalised is often several months.

There is no provision to permit providers to confidentially raise issues about individual officers with CIS management. When providers have had issues to raise management has included the officer in the discussion. Providers should have the ability to raise issues confidentially. Many of the providers²⁸ included case examples to strengthen their submission. I have included two below:

Prescriptive measures are understandable in decisions where there is a breach of Approved Provider responsibilities; however in the case of no NRA it would be more appropriate to determine a negotiated outcome for complaints of a clearly minor nature. For example, there have been some instances where a CIS officer has not liked the wording of an organisational policy and has requested change, or has suggested inappropriate case conferences. ACQI and its members do not believe that is within the scope of CIS officers role to require changes to organisational policy that is not specific to the parameters of the Aged Care Act. There have been other examples where CIS Officers have used rules or examples of practice/s that are not relevant to the aged care sector.... One example is of a low care service where a CIS Officer said that she was not comfortable leaving the service until they had a Registered Nurse on duty overnight. This is not a requirement of the Aged Care Act 1997 as the service was fully compliant with the requirements of the Act. However, they were forced to employ an Agency RN from a neighbouring town for a number of nights at significant expense and inconvenience to the service (Aged Care Queensland).

Additional information was requested about the resident making the complaints about a week or so after the initial documentation had been furnished. The later documentation appeared to have no bearing on the nature of the complaint under investigation and for this reason was very disturbing for management and staff of the homes. The way in which this material was used in the eventual finding of the investigation was never made clear (The Freemasons Home of Southern Tasmania).

8.4. The Aged Care Commissioner²⁹

The Commissioner's Office is a second pair of eyes on investigations that are subject of appeal. To that extent they have experience of reviewing CIS investigations. However, it should be noted that in 2008-09, only 161 matters (or approximately 2%) of CIS cases were raised with the Commissioner. This includes 142 requests to examine decisions made by the CIS and 19 complaints about CIS process. In 2008-09 the Commissioner completed 139

²⁸ Submission Numbers: 65 – Aged Care Queensland and 15 – The Freemasons Home of Southern Tasmania.

²⁹ Submission 107 The Aged Care Commissioner

reviews. Of these reviews, 125 were applications to review an examinable decision and 14 were for a review of the CIS investigation process.

The Commissioner advised that:

- In the cases examined by the Commissioner, the CIS often only gathers information from the provider and then, only documentation;
- Site visits to the aged care facility, and direct discourse with the provider, takes place in 40 per cent of investigations examined by the Commissioner;
- The Commissioner's Office receives feedback and complaints from complainants that, despite undertaking a site visit to the aged care facility, the investigating officers often do not directly observe the care provided by facility staff or the care of the individual care recipient whose care is the subject of the complaint;
- Cases examined by the Commissioner indicate that the investigating officers rarely gather information from the complainant, or engage with the complainant after gathering information from the provider;
- On occasion information such as invoices and photographs has been offered by the complainant either at the start of an investigation or during it, but not accepted by the CIS. The case has been concluded while the complainant continued to presume the material would be called for. This causes great concern to the complainants; is perceived as lacking fairness; and fails to gather information from external service providers like hospitals or private medical officers; and
- Arrangements should be made to facilitate adequate information gathering of this kind, particularly in light of the length of time it takes for the complainant to access such information under FOI.

The Commissioner observed that when the complaints model was changed from an alternative dispute resolution model to an investigations model, the responsibility for the investigation was removed from the parties and allocated to the CIS. The onus for the conduct of a thorough investigation rests with the CIS. That onus includes the responsibility to provide equity of access, to gather all relevant information, and to test that information with the parties involved, as well as with relevant experts.

8.5. Statements of Reasons

The Aged Care Commissioner³⁰ in her submission and face-to-face consultation with me raised her long standing concerns about the inadequacy of the CIS's Statements of Reason. She particularly noted that the CIS's decisions she has examined are deficient in relation to the findings on the material questions of fact, the evidence used in coming to those findings and the reasons for the decision.

She observed that poorly written and documented Statements of Reasons had the effect of leaving the parties to a complaint (and her Office) unsure of the reasons for the decisions made i.e:

- Findings not based on the material questions of fact;
- Failure to note the evidence that is credible, relevant and significant to those findings; and
- Failure to provide all the reasons for the decision being made.

It also disadvantages the parties in making a decision about whether to appropriately access their appeal rights.

³⁰ Submission 107 Aged Care Commissioner at p.16

She advised that in some cases, the CIS has not provided the fact sheet outlining the parties' review rights and has not always sent decision letters by registered mail so determining when parties were 'told' about the decision is unclear.

She also submitted that some Statements of Reasons read as if officers appeared to make the decision and then construct the Statements of Reasons to make the findings fit that decision. The Commissioner's office has also recommended the Statements of Reasons developed by the CIS act as a tool in assisting the decision-making process, rather than justifying a decision which may, or may not, accord with the findings on the material questions of fact.

8.6. The quality of the final report to providers and complainants

On completion of an investigation the providers and complainants are provided with a final report which includes a covering letter and Statement of Reasons. The Department recently commissioned *mpconsulting* to undertake a review of Statements of Reasons. *mpconsulting* has undertaken a desk review of in excess of 100 Statements of Reasons, and will now undertake consultation with staff to determine whether there are any underlying problems with the associated Statement of Reasons template.

During the course of the desk audit, *mpconsulting* identified the following five areas requiring improvement. The Department has advised these will be incorporated into staff in training over the coming months:

1. Level of detail - needs to be clear and concise.
2. Structure of information – establish clear structure of complaint issues, decision and reasons for decisions.
3. Reasoning and logic – improve presentation of material facts and evidence, the reasoning behind the decision and how the required action will address the issues raised.
4. Tone and language – revise tone and language in order to present the facts in a way that is empathetic and useful to both the complainant and the provider and remove technical, bureaucratic language.
5. Quality Control – increase level of quality control within the CIS documentation clearance process.

Discussion

The investigation plan is crucial for clarifying what it is that requires investigation, and for what purpose. Usually the purpose is to resolve the complaint by reaching a fair and impartial view on the issues raised by a complainant and to identify an appropriate remedy. Where a complaint will not be investigated an explanation should be provided to the complainant; similarly if an investigation is closed without a conclusion. The options available to the complainant, to seek internal review of any adverse finding or to pursue the complaint in another place, should be outlined. If appropriate; the complainant can also be invited to contact the investigating officer to speak about the complaint and the investigation.

Efficient complaint management involves narrowing the facts in issue. There are guidelines [6-8] available to assist with quality investigations. The Commonwealth Ombudsman[6] identifies three principles of fair investigation:

1. Impartiality: Each complaint should be approached with an open mind, and the facts and contentions in support of a complaint should be weighed objectively.

2. Confidentiality: A complaint should be investigated in private, and care should be taken when disclosing to others any identifying details of a complaint.
3. Transparency: A complainant should be told about the steps in the complaint process and be given an opportunity to comment on adverse information or before a complaint is dismissed.

Best practice guidelines on investigations³¹ are also found in documents published by the Administrative Review Council. The following activities are a summary of the basic requirements in complaints:

- A finding on a disputed factual matter must be based on evidence that is relevant and logically capable of supporting the finding - not on guesswork, preconceptions, suspicion or questionable assumptions;
- A written record should be kept of evidence that is provided orally. A complainant is not obliged to substantiate each fact or element in their complaint, although it is reasonable for the investigator to ask them to assist the investigation by providing documents they have or explaining things they know;
- The rules of evidence that apply in court proceedings do not apply to administrative investigation, and an investigator can use reliable information obtained from any source; and
- To accord natural justice, a complainant should be given an opportunity to comment on contrary information or claims from another source before a decision is made to dismiss the complaint.

Many of the submissions from care recipients, relatives or advocates referred to the lack of weight given to the evidence supplied with or after lodging their complaint. Not all complaint investigations have a definitive outcome. Sometimes it is not possible to resolve each disputed matter. The evidence available might be scant, inconclusive or evenly balanced. In these circumstances extra care is required to explain the decision-making to the complainant. Investigation officers should also consider other ways to resolve the complaint by exploring the options for reaching a resolution, settlement or understanding between the complainant and the providers or their staff.

Response

On completion of an investigation all the parties should be provided with the particulars of the investigation, including any findings or decision reached. Advocates gave information to the effect that when the investigation widened in scope the complainants were left in the dark in relation to their original complaint. When new areas are being investigated the complainant should still receive an interim explanation of what has been finalised, what has not and why.

Most communications between the CIS, complainants and providers, is by telephone or email. This is acceptable if the parties are agreeable to this form of communication. Most of the stakeholder submissions realised the importance of quick and timely communications but they strongly expressed a wish for written confirmation of the complaint and the issues being investigated.

The final explanation and investigation report should be presented in a style that both the provider and the complainant can understand. The report should deal with each issue raised in the complaint, or if an issue is not dealt with, an explanation as to why not.

³¹ The guidelines can be found at www.ag.gov.au/arc.

Submissions from care recipients, relatives and advocates repeatedly raised the fact that the original issues complained about were not the subject of the investigation. There may be good reasons for not disclosing certain information or not investigating a complaint, but it is important to explain this in clear language to the complainant and/or the provider. The CIS may be concerned about privacy reasons, for example they would be careful about disclosing how a complaint against a provider staff member was dealt with. This is an important consideration, but it should not be a barrier to transparency and accountability.

8.7. Follow-up

An effective complaints system encourages complainants and those affected by a decision to seek clarification and further explanation if necessary as to how their complaint was handled and resolved. If a complainant is dissatisfied with an investigator's findings or decision, a review should be carried out by an officer who has not been involved in the matter. Usually this will be a more senior officer.

The procedure for seeking internal review of this kind should be explained in the letter of notification and on the agency's website or in its other published literature. In order to bring finality to the investigation, it is common to set a limit on the period in which the complainant must seek internal review and to require that the review be sought in writing. The complainant should also be asked to specify what exactly they would like reviewed and why they disagree with the investigator's view.

An external review option should always be part of the final letter to the complainant. Under current legislation, 'Informant type A' and providers can seek review of their matter by the Aged Care Commissioner. The option of appealing to the Commonwealth Ombudsman or seeking tribunal review of a decision should be mentioned in any letter of notification from the CIS. Mediation of an unresolved dispute between a complainant and an agency is another option. A mediator can help clarify matters, provide an impartial perspective, and propose solutions that both parties can agree to.

8.8. Evidence

The question as to veracity of information provided to CIS investigators also requires explicit comment in the investigation report. Claims made by either the provider or the complainant not accepted by the investigating officer, as well as the reasons why, should be included. Guidelines for balancing competing considerations are discussed in *Australian Public Service Commission Circular No.2008/3, Providing Information on Code of Conduct Investigation Outcomes to Complainants*. These guidelines cover the aspects to be covered in a report.

All investigations require evidence to come to a final decision. The following activities or items can be part of the evidence gathered during an investigation:

- Information, documents and other material that can be used to demonstrate the existence of a fact or the truth of something. (information provided in an application form or email, a fingerprint, information provided orally by a person); or
- Can be a decision maker's own observations—for example, of a site, a demonstration, or someone's demeanour when making a statement or answering questions.

There are some rules associated with evidence gathering:

- Evidence is amenable to testing and evaluation and can be accepted or rejected when it comes to making findings;

- Findings in relation to the facts in issue must be based on evidence that is relevant and logically capable of supporting the findings;
- Decisions must not be based on guesswork, preconceptions, suspicion or questionable assumptions. This does not preclude a decision-maker from taking account of ‘notorious facts’, which are part of ordinary experience or common knowledge—for example, that each person’s handwriting is unique;
- Evidence can be provided orally or in documentary form and includes electronic communications and data. When evidence is provided orally—as during an interview or telephone call—the decision-maker should make a file note or written record of the interview at the time or soon afterwards, while the memory is fresh. The particulars recorded should be the name, position title and address of the person spoken to, the date, time and place of the conversation, and the main pieces of information provided;
- For record-keeping purposes, it is a good idea to ask that the information provided be confirmed in writing or supported by documents. For example, if a person produces an original document as evidence, the decision-maker should take a photocopy of it for their file and make a note that it is a true copy of the original; and
- Evidence in the form of emails and electronic documents should be printed and kept on file.

Requirements can also vary depending on the consequences of the decision, the risk of deception, and the difficulty of obtaining better evidence. If required, particularly in circumstances where the consequences are significant, a person may be asked to provide a statutory declaration. This is a solemn statement a person makes and declares to be true before a witness authorised under the *Statutory Declarations Act 1959 (Cth)* and the *Statutory Declaration Regulations 1993* or similar State or Territory legislation. A person who makes a false statement in a statutory declaration commits an offence that, under the Commonwealth legislation, is punishable by imprisonment.

9. PROVISIONS TO REVIEW DECISIONS

9.1. The Aged Care Commissioner (the Commissioner)

The Commissioner is a statutory appointment by the Minister for Aging and has no powers to make final determinations; she can only make recommendations when considering an appeal of a decision of the CIS or a complaint against the Secretary's processes.

Appeals - Overview

During the financial year 1 July 2008 to 30 June 2009, the Commissioner received 142 applications to examine the CIS's examinable decisions (appeals). The Commissioner examined and finalised 125 cases (approximately 1.6% of all cases investigated by the CIS). The Commissioner recommended 62 (49 per cent) be confirmed, 47 (38 per cent) be varied and 16 (13 per cent) be set aside and substituted with a new decision.

The Secretary (or the departmental delegate) on receipt of the Commissioner's examination report and recommendations, must take into account the recommendations made by the Commissioner and must decide whether to confirm, vary, or set aside the Delegate's original decision and provide reasons for the decision.

The Secretary is required to advise the Commissioner of the CIS's decision on reconsideration. During the reporting period the delegate advised the Commissioner of the reconsideration decision in relation to 120 cases and provided advice about an additional five cases that were completed by the Commissioner in the previous financial year. Of the total 125 reconsideration decisions, the delegate agreed with the Commissioner in all but 12 instances. In nine instances (or 7.2% of cases) the Department disagreed with the Commissioner's recommendation. The Department partially agreed with the Commissioner's recommendation in a further three instances (or 2.4% of cases).

9.2. Outline of Review Processes and Procedures

Broadly, the Commissioner has the following functions in relation to departmental investigation action under the Investigation Principles:

- To examine decisions that are made by the Secretary under the Investigation Principles and are identified by those Principles as being examinable by the Aged Care Commissioner, and to make recommendations to the Secretary arising from the examination; and
- To examine complaints made to the Aged Care Commissioner about administrative processes adopted by the Secretary in relation to the handling of matters under the Investigation Principles, and to make recommendations to the Secretary arising from the examination.
- On the Commissioner's own initiative, examine the Secretary's processes for handling matters under the Principles, and make recommendations to the Secretary arising from the examination.

Right to seek examination of the Secretary's decision by the Aged Care Commissioner

Both approved providers and care recipients or their representatives have a legislated right to seek a reconsideration of "relevant decisions" made under the Act, as set out in the Investigation Principles.

Under the legislation the definition of a representative of a care recipient includes:

- an advocate for the care recipient; and
- a legal guardian of the care recipient; and
- a carer or relative of the care recipient.

Approved providers

If an approved provider is dissatisfied with a “relevant decisions,” the approved provider may, within 14 days of being notified of the relevant decision, apply to the Aged Care Commissioner (the Commissioner) for examination of the decision. “Relevant decisions” are:

- a decision by the Secretary that there has been a breach of the approved provider’s responsibilities;
- a decision by the Secretary to issue a NRA;
- a decision setting, adding or varying the conditions of a NRA.

Care recipients or their representative

If a care recipient or their representative is dissatisfied with any “relevant decisions,” they may, within 14 days of being notified of the relevant decision, apply to the Commissioner for examination of the decision, “Relevant decisions” are:

- a decision not to investigate a matter;
- a decision to end an investigation;
- a decision that there has not been a breach of the approved provider’s responsibilities;
- a decision not to issue an NRA; and
- a decision setting, adding or varying the conditions of an NRA that concerns them.

Format of application

An application for examination by the Commissioner:

- can be made orally or in writing,
- must state the reasons (other than mere dissatisfaction with the decision) why examination is sought; and
- must be received by the Commissioner within 14 days after the day when the person (be it the aggrieved person or the relevant provider) was notified of the decision (in the case of the relevant provider) or given feedback on the decision (in the case of the aggrieved person).
- The application may be supported by additional information.

Decision not to undertake a review

The Commissioner may refuse to examine an examinable decision if the Commissioner is satisfied that:

- the application for examination is frivolous or vexatious or
- the application was not made in good faith or
- the application relates to a matter that has been, or is, the subject of a legal proceeding.

Recommendation to delegate

The Commissioner has 60 days to undertake an examination and provide a report back to the Scheme. It should be noted that the Commissioner delegates her decision-making powers to other staff within the Commissioner’s Office.

The Commissioner’s report includes recommendations which may include that the Delegate confirm, vary or set aside the decision. The Commissioner may also recommend that the Scheme undertake further investigation of particular issues.

The Scheme has 21 days to consider the Commissioner's report, taking into account the Commissioner's recommendations. The Delegate who undertakes the reconsideration will not be the person who made the original decision. The Scheme then makes a decision to confirm, vary or set aside the original decision and substitute a new decision.

Where the Delegate does not agree with a recommendation made by the Commissioner, the Department has established a clear process to ensure Senior Executive oversight and that the decision is robust and based on appropriate expertise. In developing a response to the Commissioner, where the delegate disagrees, legal advice is sought regarding legal aspects of a matter and clinical advice is sought from the Department's Senior Nurse Adviser on matters of a clinical nature.

Senior officers from the Department also have a discussion with the Commissioner about her recommendations to ensure that they have a comprehensive understanding of the recommendations and the reasoning behind the recommendation.

Once the Delegate has reconsidered the matter and made a decision, all parties to the complaint are advised of the new decision, with a statement of reasons explaining the decision.

Requesting the Commissioner to examine administrative process

Any person can request that the Commissioner examine the process for handling a complaint at any time. Requests to the Commissioner to examine administrative process must be in writing.

Aged Care Commissioner initiated reviews

The Commissioner also has the capacity to undertake "own motion" reviews. On the Commissioner's own initiative, they are able to examine the Scheme's processes for handling matters under the Investigation Principles, and make recommendations to the Scheme arising from the examination.

Submissions

Three main issues surfaced in the submissions in relation to review - the time frame in which to lodge an appeal, the powers of the Commissioner and the right of third parties to request a review. The following concerns were raised:

- Information about the appeal process to be included in the final letter to the Complainant;
- When an appeal to a decision by the CIS has been lodged with the Aged Care Commissioner, there is an expectation complainants and providers that an independent decision by the Commissioner will be final;
- Complainants and providers are dissatisfied when the Commissioner's decision goes back to the Department which has the ability to overthrow the higher authority's decision, and indeed, does;
- Little confidence in the appeal process because Commissioner has no final determining powers; and
- A 14 day appeal period is insufficient time in which to mount a reasoned reply to a decision. While the CIS and the management of an aged care home usually have access to a secretariat and other assistance, a resident or their relative do not necessarily have similar support.

Two of the advocacy services³² said:

We note that clients' particular circumstances, which can be the cause of great grief or stress, may prevent them from understanding that the 14 day appeal period is non-negotiable. We are aware of one such case where the letter was sent to an incorrect address, and the clients had no redress for the error. Also clients have been away on business or holiday and have missed the 14 day deadline and have felt disadvantaged in not being able to pursue justice in the matter. Where they are involved, The Aged-care Rights Service (TARS) advocates also need time during which to assist the client with any appeals processes. Due to funding and resource constraints TARS's advocates are not able to travel to meet with clients throughout NSW, as a result the majority of our work is done by telephone or in writing adding to the length of time required to assist the client.

The Commissioner is, in effect, "a toothless tiger", as the recommendations made are not mandatory. As an independent statutory officer reviewing decisions of the CIS, the Commissioner should have determinative powers consistent and comparable to other entities with review functions. For the Commissioner's recommendation to be re-considered by the CIS amount not only to double-handling of complaints, but undermines the integrity of the Commissioner's role as a 'watch-dog' of the CIS. There are concerns of fairness and procedure where the original decision of a Department is reconsidered by the same Department following an independent but non-binding external examination.

Third parties

The issue of the capacity of third parties to request a review has been raised in an earlier section. I have already recommended that third parties should have a right of review. Aged care complaints similar to other areas of health care are likely to involve an independent party who will lodge a complaint. (This was the subject of much discussion in the Senate Inquiry in 2005³³). It is important that interested third parties should have the capacity to appeal to the Aged Care Commissioner using the review methods available. Treating all complainants equally is an added protection for care recipients who may not be able to speak for themselves, or may not have representatives who can act for them.

Discussion

I was advised during the consultation process that since the Aged Care Commissioner has no determining powers that complainants had lost faith and confidence in the review process. The Commissioner herself told me that she thinks her office has limited impact in the current complaints scheme.

In the section on natural justice, I recommended that the timeframe for lodging appeals (on the assumption that the current scheme remains) should be amended to 28 days. If the current scheme is retained, the Aged Care Commissioner should be retained and provided with determining powers. If my recommendations for a separate aged care complaints commission/office are accepted, the current appeal provisions would not be appropriate.

The right to make a complaint to the Commonwealth Ombudsman about how complaints were handled would remain under the existing and recommended models.

³² Submission 63 – The Aged-care Rights Service (TARS) and Submission 10 – Office of the Public Advocate

³³ The Senate Community Affairs References Committee Inquiry into *Quality and equity in aged care*, June 2005.

10. RELATIONSHIP BETWEEN THE CIS, THE COMMISSIONER, THE AGENCY, AND OTHERS

10.1. Overview

Many submissions raised the need for clarification of the roles of the CIS, the Office, the Commissioner, the Agency and the Commonwealth Ombudsman in managing aged care complaints. Confusion may arise as some of the CIS staff also undertake other departmental activities not related to CIS functions. Providers and care recipients, relatives and advocates also appear unsure of the referral arrangements between the CIS and the Agency. The Department is a large complex bureaucracy with many functions - funding, approval of aged care providers, accreditation policy, compliance and complaints management. Under these circumstances role definition becomes extremely important. Misunderstanding can create a whole host of different and misdirected expectations. The lack of clarity between the intersections of complaints, compliance, and accreditation is a major factor in the lack of certainty surrounding the CIS role and functions.

10.2. The Office of the Aged Care Commissioner

The Commissioner has established protocols with the CIS to provide a framework for the working relationship. She advises that in general these protocols have worked well.

The Office of the Aged Care Commissioner (the Commissioner's Office) was established to provide independent oversight of the CIS and the Agency. The Commissioner advised me that over the last two years her capacity to effect change and drive quality has been limited. In 2007-08, the Department disagreed with approximately 12% of the Commissioner's recommendations and for the financial year 2008-09 the figure is in the order of 10%. Submissions noted that the current limitations on the Commissioner did not engender confidence in the system by providers and residents alike. Others referred to the Commissioner as a 'toothless tiger'.

The Commissioner's Office is a specialist body, with experienced staff who are empowered to investigate appeals and receive new evidence. In this context, the Commonwealth Ombudsman suggests that the rate of rejections of the Commissioner's recommendations should be very low. The Commissioner offers complainants an independent examination of the CIS decision, the value of which is undermined by a high rejection rate. The lack of final determining powers has already had an impact on the community confidence in the review process and the role of the Commissioner in complaint handling.

The Commonwealth Ombudsman points out that they have not always been able to identify sound reasons for the disagreement between the Department and the Commissioner. It is usual for recommendations of an independent expert review body to be accepted unless there is a good reason not to do so. The Commonwealth Ombudsman has found that on occasions the disagreement would appear to have been based on no more than the taking of a different view of the same facts, rather than an identified error, new information or other probative reason.

10.3. Complaints

The Commissioner stated that her reports on the CIS processes for handling complaints, and her associated recommendations for best practice, are not well received. Her interpretation of her role is supported by the Commonwealth Ombudsman who sees the value of the

Commissioner in providing commentary on best practice. In my view, the Commissioner will frequently be in a position to draw lessons that relate to best practice. On the other hand, the Department may perceive recommendations about best practice to go beyond the role and functions of the Commissioner. In the case of process reviews conducted by the Commissioner (as opposed to examination of CIS decisions) there does not appear to be any obligation on the Department to respond to the recommendations. The protocol between the Department and the Commissioner however provides that the Department will provide a response to the Commissioner's recommendations and will advise the Commissioner of any actions taken.

The Commissioner advised me that she personally handles the complaints about the Department's processes and delegates responsibility for the requests for review of decisions following investigation to departmental staff employed in her office. This means that the final decision-maker reviewing decisions made following a CIS investigation is not done by the Commissioner, but by someone less senior in her office.

10.4. The Aged Care Standards and Accreditation Agency (the Agency)

The Agency's relationship is with Department, not the CIS. A protocol for managing this relationship is in place. The protocol between the Department and the Agency identifies 4 types of referral – ranging from information only to a request for full review audit. Referrals about potential systemic failures come from a number of areas in the Department, e.g. the CIS, the Department's Prudential Regulation and Approved Provider Branch, and Aged Care Funding Instrument (ACFI) validators. The Agency responds taking into account the type of referral and how the referral will add to the Agency's 'picture' of a home.

The referral relationship between the CIS and the Agency caused many providers concerns because of the perception of double-handling. A referral to the Agency is a judgement call by the CIS officer as to whether a matter is confined to a particular incident or indicative of wider systemic failure. If a home has appropriate systems and processes in place and staff are trained, one incident may merely be a mistake, multiple incidents suggests systems, processes or training problems.

Submissions in relation to duplication

- CIS strays into areas the province of the Agency rather than focusing on the actual substance of a complaint;
- Perceptions of double handling;
- CIS officers have a dual role - investigation of a complaint and monitoring compliance with legislative requirements related to mandatory reporting. The same staff may be used as departmental compliance officers;
- CIS investigated cases and then referred matters to the Agency which in turn has investigated the same issue and found compliance, yet the CIS investigation has continued;
- Duplication of resources and demand on providers to provide information to two different organisations has not resulted in improved outcomes;
- Differentiate the roles between the CIS and the Agency;
- The referrals between the different agencies can result in additional participants in the process, resulting in duplication, confusion and more significantly, enormous human and financial cost to the provider;
- Lack of clarity in relation to the CIS's relationship with the Office and STOs; and

- Lack of transparency on how what type of information is exchanged between the Agency and the CIS.

A submission from the Aged and Community Services Association (NSW, ACT)³⁴ gave examples where the CIS, prior to closing a complaint, has referred the matter to the Agency:

The CIS referred a complaint to the Agency following their identification of a breach. The Agency then visited the home and found three non compliances. In just over six weeks later the full Accreditation Audit was attended by the Agency and the service was compliant in all 44 standards. The CIS was not aware that the Agency had completed a full accreditation audit. Whilst the home was found to be compliant by the Agency the CIS wanted further responses from the organisation before they would consider closing off the complaint.

10.5. National Aged Care Advocacy Program (NACAP)

The Australian Government will provide funding of \$2.582 million in 2009-10 for the National Aged Care Advocacy Program (the Program). Under the NACAP, the Department funds nine community based advocacy organisations in each State and Territory (two in the Northern Territory) to assist people to exercise their rights through various advocacy processes including advice and support. Advocacy services also provide partisan representation for consumers of aged care services. Advocacy services assist consumers to become involved in the decision-making processes that affect their lives.

Advocacy programs also aim at promoting the rights of consumers of aged care services through educational programs and information sessions. Advocacy services are available to all consumers of Australian Government-subsidised aged care services, their representatives and their families free of charge.

NACAP was established in response to a need to enhance the rights of people receiving funded aged care services and has its legislative basis in the *Aged Care Act 1997*, (Part 5.5, Division 81 Section 1), and *the Advocacy Grant Principles 1997*.

In 2007-08, Advocacy services nationally dealt with over 9100 enquiries and cases relating to the provision of services in residential and community care.

	2007-08
General Information Enquiries	5,603
Advocacy Cases	3,500
Total Contacts	9,102
Referrals to CIS	292
Education sessions	1,302

Generally the relationship between the CIS and advocacy groups, where it existed, was positive. The advocacy groups are handling a substantial case load. The role of advocacy groups in early resolution is important and can provide complainants with support during local resolution. The advocacy groups are staffed by experienced professionals who have years of experience in advocacy and aged care.

³⁴ Submission 73 – Aged and Community Services (NSW and ACT)

10.6. Community Visitors Scheme (CVS)

Everyone who visits a residential facility is a pair of eyes and ears looking out for the quality and safety of residents. The CVS provides one-on-one volunteer visitors to residents of residential aged care services who are lonely and isolated, either for social or cultural reasons or because of disability. The CVS aims to improve the quality of life of residents, through companionship and friendship, and by helping them to maintain links to the community.

The Department provides funding to 158 community-based organisations (known as auspices) nationally, to recruit, train and support approximately 7,500 community visitors to undertake regular visits to residents.

CVS visitors are aware from their commencement that their role as a visitor is simply to be a friend to the resident. There are specific roles that CVS visitors are advised that they are not to undertake which include being responsible for monitoring standards of care provided at the aged care home or being involved in investigating or following up complaints.

CVS visitors are advised that if they do become concerned about some aspect of a resident's care, they should report this to their CVS Coordinator. Where a CVS visitor raises concerns with the CVS Coordinator, the CVS Coordinator will typically contact the aged care home to advise the concerns raised. Alternatively, depending on the seriousness of issues raised, the CVS Coordinator will contact the CVS program management area of the Department which will refer relevant matters to the CIS for further investigation as appropriate.

Due to the regular contact that CVS visitors have with residents and aged care services, it is critical that they, similar to family members and carers, are aware of their right to raise concerns about care and services provided. It is recommended that awareness of this issue is required to be formally integrated into all training provided by CVS auspices to their volunteers.

10.7. State Health Care Complaint Commissions

The Commonwealth Ombudsman has identified areas where the relationship between the CIS and state-based health complaints commissioners has not been effective resulting in areas of overlap and gaps.

I recommend that the CIS or its replacement establish protocols with the relevant State and Territory health complaint bodies to ensure accurate referrals and certainty about how referred complaints will be handled. It is usual for complaint bodies to develop memoranda of understanding to clarify the way that complaints are to be handled and how jurisdictional overlaps are to be resolved.

10.8. National Health Registration Boards

In July 2010 there will be one system for the regulation of all health professions. The CIS currently refers individual health professionals to the relevant state or territory registration authority. The CIS or its replacement body should enter into memoranda of understanding in relation to referral of health professionals to the Australian Health Practitioner Registration Agency.

11. CIS COMPARED TO SIMILAR INVESTIGATORY BODIES

11.1. Number of complaints investigated

The CIS received 12,573 contacts between 1 July 2008 and 30 June 2009. Approximately 63 per cent (or 7,962) of these contacts were considered 'in-scope' cases - that is, relating to a provider's responsibilities under the Act - and subsequently investigated.

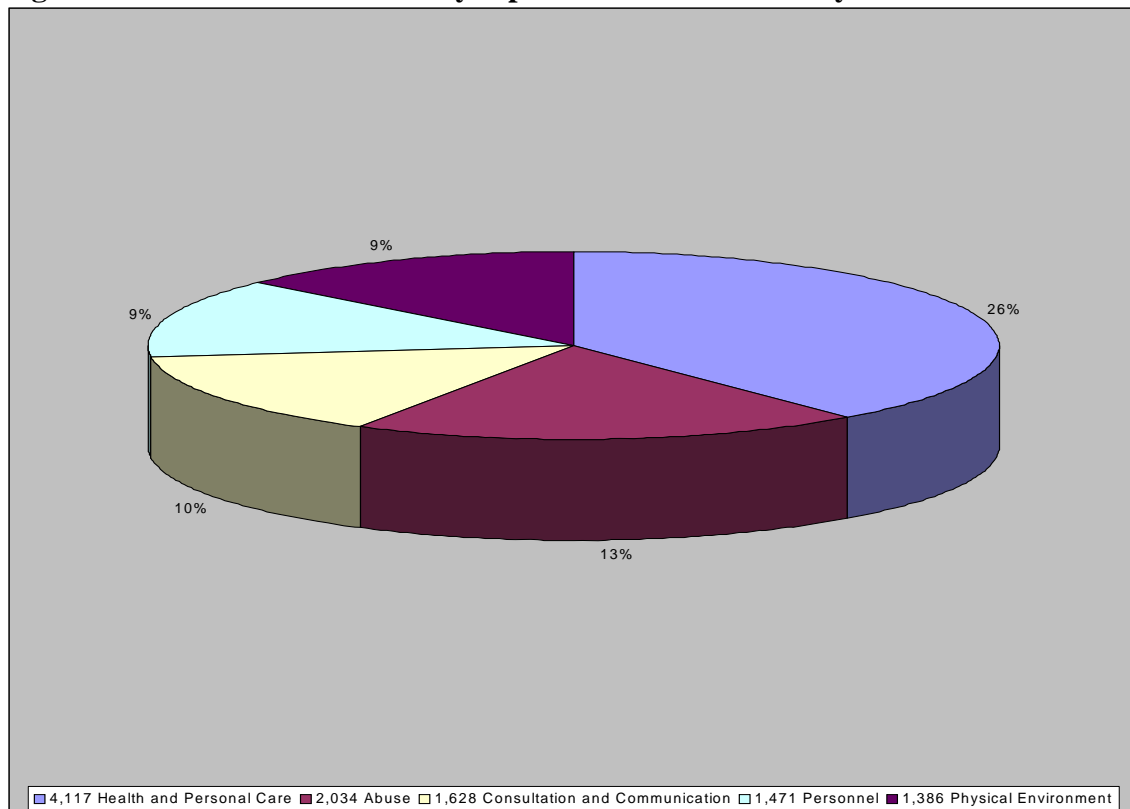
In-scope matters are managed and resolved in various ways – some are resolved through an in-depth investigation; others are managed with just a call to the provider – either approach would be considered an 'investigation'. The remaining 37 per cent (or 4,611) of contacts to the CIS raised 'out-of-scope' issues and were therefore not investigated.

11.2. Most commonly reported issues raised in complaints

CIS cases often incorporate more than one issue. Between 1 July 2008 and 30 June 2009, 15,759 individual issues were identified. The majority of these issues were grouped under the following five keywords:

1. Health and Personal Care (main issues included continence management, clinical care and infectious diseases);
2. Consultation and Communication;
3. Physical Environment;
4. Abuse; and
5. Personnel.

Figure 1: The five most commonly reported issues from 1 July 2008 to 30 June 2009



11.3. Referrals to External Agencies

During the course of investigating a case, the CIS may refer issues to an external agency more appropriately placed to deal with the matters raised in the complaint. Aged care legislation requires providers to report reportable assaults to the police. Issues that relate to the conduct (other than reportable assaults) of a health professional are referred to the relevant health professional regulatory body, such as the Nurses Registration Board, Medical Board and the relevant Health Care Complaints Commission.

Between 1 July 2008 and 30 June 2009, the CIS made 1,811 referrals to external agencies. Approximately 90 per cent (or 1,638) of these referrals were made to the Agency. Of these referrals approximately 39 percent were for information regarding matters considered to be non urgent, 59 per cent were requesting a support contact and the remaining 2 percent was for a review audit of a home.

11.4. Notices of Required Action

A Notice of Required Action (NRA) is issued when a provider is found to be in breach of their responsibilities under the Act or Principles, and has not already taken action to address the breach. Each NRA sets out the details of the breach, what the provider must do to address the breach and the timeframe in which this action must be taken. The intention of a NRA is to give the provider an opportunity to address the breach before compliance action is considered.

Between 1 July 2008 and 30 June 2009 the CIS issued 181 NRAs. NRAs were issued in all States and Territories.

In addition, there were 1,093 instances where a breach was identified as a result of an investigation, where either no NRA was issued because the matter was remedied immediately through a negotiated outcome, or it was referred to another agency.

11.5. Discussion on issues raised in Submissions

Most of the concerns about processes and practices have been discussed in earlier chapters. However, timeliness was an issue raised in the submissions. Providers were concerned about the time it took for an investigation to be finalised, while consumers were more concerned about lack of feedback after an investigation. Some of the observations about the CIS are listed below:

Submission 19 from ECH Inc, Eldercare Inc and Resthaven Inc
CIS's emphasis should be less about fault-finding and more about managing relationships and achieving positive outcomes. A more affective outcome might be achieved if the CIS were to meet with each of the parties to firstly discuss the complaint and determine whether the matter might not be resolved without a formal investigation. The efficiency of the current processes and practices is extremely poor. The intense examination of large amounts of documentation; the investigation of matters outside the complaint; and the lack of communication with staff and managers all contribute to the inefficiency. Complainant and providers should not have to wait several months for a decision. The inordinate delays only serve to exacerbate any existing tensions between the parties and contribute little to the outcome.

Submission 41 from Benetas (Anglican Aged Care Services Group)

- Transparent process for reaching decisions;
- Taking a more conciliatory approach to resolving complaints;
- Provide timeframes for resolving a complaint;
- Taking a less adversarial approach;
- Improve timeliness of communication especially if the complaint is open for a long period of time; and
- Educate CIS officers on customer service, communication skills and the principles of continuous improvement.

Submission 49 Aged and Community Services WA

- The CIS response to an initial complaint generally appears to be swift (as is desirable). However, once advised of a complaint it is not always clear to an approved provider as to what their response or action should be – whether to undertake their own investigation and any subsequent action, or wait until the CIS process is completed. This may occur at a number of stages throughout the investigation process from the initial contact to the conclusion of matters. This disempowers the approved provider in appropriately managing dissatisfaction or problems, and in implementing system changes for improvement, and thus can delay resolution of the complaint.
- The timelines for each step of the CIS complaint process are not made known on the website of the Department, and are not generally known by approved providers or other stakeholders.
- As discussed above, receipt of the final decision can appear to be a protracted process and can leave approved providers in “limbo” about whether and when to act or what actions they might need to implement.

11.6. Comparison with other similar investigative bodies

Australia has well established complaint management organisations in health care as well as public administration. A table setting out some state, national and international organisations involved in aged care complaints (Complaint Management Costs and Statistics – September 2009) is at [Appendix 6](#). The models range from statutory organisations (NZ, NSW, and England) to individual ombudsman individually employed on a contract basis (NY).

In comparison to these complaints organisations, the CIS is the only organisation that:

- Does not have time frames for complaint resolution;
- Whose main activity is investigation;
- Does not routinely provide alternate dispute resolution;
- Focus does not appear to be to resolve complaints during the assessment phase;
- Is not independent from the bureaucracy responsible for funding and regulating aged care services; and
- Does not, as a matter of course, refer back to the organisation for local resolution.

The Department funds advocacy services which some other bodies do not, and that is to its credit particularly in the context of the vulnerability of care recipients.

In comparison with other complaint bodies the CIS - understandably given its infancy when compared to the others - is in a rudimentary complaint management phase and does not yet have the attributes of best practice complaint management. The current structure and design goes against best practice complaint management. The lack of time frames, lack of focus on early resolution and often poorly executed investigations are a consequence of bad design and not the fault of the managers of CIS or the investigation staff.

Further, the consequence of a complaint system that is not housed in the one body impacts on the way staff see their roles and responsibilities. Staff I spoke with saw themselves primarily as employees of the Department. This impacts on how they respond to departmental challenges, which may or may not be in conflict with good complaint management. The most

effective complaint bodies are those with a strong culture of professionalism and pride in their complaint work. They see the relevance of transparent complaint processes and the necessity to maintain a high standard; particularly when the consequences of investigations can be grave.

In relation to funding, it is difficult to compare the budgets in the various complaint bodies. The CIS funding is primarily for departmental resources, but also includes a significant component for capital fit-out and information technology development (approximately \$10 million).

Funding for the establishment of the CIS was provided in 2006-07, and the funding has not subsequently been reviewed. Under the old Complaints Resolution Scheme, 6157 contacts were received in 2006-07. This increased by nearly 84% to 11,323 in the first year of operation of the CIS (2007-08). By comparison, the original funding anticipated an increase in contacts of just 30%. The original funding also estimated that the number of contacts would continue to increase at a rate of 2.96% per annum. Between 2007-08 and 2008-09, contacts actually increased by 11.04%. In addition, when the CIS was established it was estimated that 50% of contacts would be 'in scope' of the scheme. In fact, in its first two full years of operation 66.2% and 63.4% of contacts respectively were 'in scope'.

In addition, there is also a significant compliance activity component to the work of the CIS. This is an additional responsibility to many other complaint bodies and brings with it significant workload with an urgency where there is judged to be an immediate and severe risk to care recipients. There is also significant legal cost associated with this activity.

The Commonwealth Ombudsman handled 19,621 cases at an annual cost of \$20 million, the CIS on the other hand handled 12,573 contacts (including investigation of 7,962 complaints) for a budget of around \$23.5 million (in the 2008-09 financial year). The NSW Health Care Complaints Commissioner ('the HCCC') received 4,407 complaints and had an annual budget of \$10.2 million. The HCCC is also required to prosecute the health professionals before professional health tribunals and committees which is a significant legal cost.

While the expenditure on the CIS may seem high when compared to other complaints bodies in Australia, there are a few factors which make the CIS unique:

- The CIS is a national program, undertaking complaints investigations in all regions of Australia. For this reason, there is a large component of funding that is allocated to travel for CIS staff to undertake their investigations. The following funding has been allocated for travel purposes over the first three years of the program:
 - \$705,000 in 2006-07 (CIS only operating for part of the financial year);
 - \$1.978 million in 2007-08; and
 - \$1.978 million in 2008-09.
- In addition to staff travel, the CIS also leases a number of vehicles to allow CIS staff to travel to homes State or Territory wide. Costs for lease vehicles and fuel charges for 2007-08 alone were in the vicinity of \$250,000.
- Budget allocation staff travel and leasing vehicles is critical to ensure that the CIS can undertake site visits to any region of Australia, particularly in relation to reportable assaults or where there may be an immediate risk to the safety and well-being of care recipients. Visits may occur at any location and at time of the day or night, and can occur over weekends and public holidays.

- The CIS operates 24 hours a day, 7 days a week, with staff on-call outside standard office hours. This results in the requirement to pay retention allowances and overtime. This cost was approximately \$200,000 in 2007-08.
- As a national program covering almost 4500 residential, community and flexible aged care services, the CIS requires intake and investigation staff across all States and Territories. The CIS was also set up to investigate all matters that were referred to it that may be a breach of provider responsibilities under the Act which requires significant staffing allocation.
- The scope of matters that may potentially be a breach under the Act are also broad and range from clinical care issues to security of tenure, financial matters to lifestyle choices, meaning that the scope of cases the CIS can investigate is wide and cases often involving a number of complex issues. This requires a high volume of staff with varied skills to manage. As at May 2009, there were 156 staff employed within the CIS State and Territory offices across Australia and approximately 15-20 staff in Central Office either directly or indirectly involved with the CIS.
- The CIS is often the first point of contact people have with the Department in relation to aged care matters. While the CIS will refer out-of-scope matters to the correct area, this initial contact creates a significant workload at the intake stage.
- A review of the average cost of an individual CIS case was undertaken in 2008 which indicated that the average cost of investigating a case during weekday hours is comparatively low. This cost increases over weekends. It is the volume and complexity of complaints and 24-hour nature of the scheme which influences overall cost.
- There were also a number of one-off expenses involved with the set-up of the office in 2007. These included:
 - National recruitment campaign;
 - Legislation development;
 - Development and publication of internal procedures manual;
 - Training of all staff; and
 - Communications strategy with consumers and industry.

These initial set-up requirements cost the CIS in the vicinity of \$2 million in the first year.

Complaint Management Costs and Statistics – September 2009 is at [Appendix 6](#).

12. OPPORTUNITIES TO IMPROVE THE OPERATIONS OF THE CIS

12.1. The CIS meeting the needs and expectations of consumers, their families and aged care providers

The 119 submissions I received raised a broad range of issues in relation to aged care complaints handling and ways to improve the operations of the CIS. Many of these concerns have been covered in earlier sections of the report, however, I feel it is important to cover some additional issues that do not fit neatly into the other terms of reference.

12.2. Independence

A number of submissions suggested that the CIS be independent of the Department. The same issue was raised by people during the face-to-face consultations. In comparison to other bodies, the CIS is the only complaints body that sits within the agency responsible for regulating the same services that it investigates.

Issues raised in submissions in relation to independence include:

- Having the complaints system within the Department gives the impression that it is not independent;
- Residents and carers do not feel they are receiving an impartial service;
- The involvement of the Department ‘muddies the waters’;
- Confusion between the role of the Department, the Agency and the Commissioner;
- Complaints resolution should not be aligned with compliance if we are to encourage resolution at the local level.

Many submissions raised the issue of conflicting interests in relation to the various regulatory functions that the Department is responsible for. I have previously set out the reasons supporting a separate complaint management body. Conflicts of interest, or, at a minimum, a perception of a possible conflict of interest, are real in the circumstances where the Department is responsible for maintaining quality aged care services. The conflict arises in circumstances where a complaint may raise issues about the quality of aged care services. The Department is a large complex organisation with many concurrent responsibilities; complaint handling is just one of them. This sometimes requires CIS staff to wear different hats when visiting /investigating or inspecting an aged care facility.

This complexity impacts on the management of complaints and leads to role confusion for staff, provider concerns about natural justice and complainant concerns about bias. A restructure within the Department is not likely to remove these conflicts. Over the last four years the Department has made every effort to improve complaint handling but the experience of the stakeholders to date suggests that, notwithstanding these efforts, the trust in the complaint system for aged care has been substantially lost. A major change is required in the culture of complaint handling as well as in the structure and management. The increased workloads are a sign of the future and are unsustainable as the system currently stands. A fresh start is required to get the structure right and the communications right to enable a stable and reliable complaint system to build.

In addition, a complaints system needs to nurture, train and retain a skilled workforce which does not easily fit into a bureaucracy where people move around to gain experience of different sections. Because complaints can have a significant financial and reputation impact on a provider and influences community trust in aged care services, the complaint system must be robust, trustworthy, competent and professional. A single-minded focus is required;

one that is transparent in its processes, has clear lines of accountability and can demonstrate improvement outcomes.

Further discussion on possible options for restructuring the CIS is provided in Section 12.

12.3. Unannounced visits

Some concerns have been raised in submissions regarding the impact of unannounced visits undertaken by CIS officers as part of complaints investigation. While I can understand the anxiety that may be caused for providers and staff when such visits are conducted, the capacity to visit unannounced is part of the set of tools that the CIS has available to it to test issues raised within a complaint, particularly where it is considered there may be a significant risk to care recipients. I consider that the continued use of unannounced visits represents an important part of the CIS's response to these critical matters.

12.4. Protection for Whistleblowers

Some submissions have suggested that there is a need for the aged care legislation to provide broader whistleblower protections for those who raise matters with the CIS. These are in addition to the protections that are afforded to approved providers and their staff in reporting reportable assaults.

Despite the absence of specific aged care whistleblower legislation, when a person provides information to the CIS they can do so confidentially or anonymously. In either case, the *Investigation Principles 2007* expressly provide that the CIS must, if requested by a complainant, protect their identity. The only exception to this is if the maintaining of confidentiality will jeopardise the investigation or is likely to cause harm to the complainant themselves or resident.

12.5. Community Care

Through the review process I have only received a small number of submissions in relation to consumer and provider experiences of how the CIS has managed complaints regarding Community Aged Care and Extended Aged Care at Home packages.

This could be as a result of a number of factors: the community care system is working; people are able to resolve the majority of concerns at the local level; the CIS has been successful at managing community care complaints; or recipients of community aged care either are unaware of the availability of the CIS or do not wish to complain for fear of losing access to services.

As a result of the limited information that I have received on community care, I have consulted with the Department on work that they have undertaken in relation to community care programs. I am advised that the Department has undertaken substantial work in this area, particularly in relation to developing a charter of rights and responsibilities for community care recipients. I understand that the Charter of Rights and Responsibilities for Community Care became law on 1 October 2009 thus ensuring that care recipients receiving community care will have the same rights and responsibilities as care recipients in residential care. I am further advised that a package of information is being developed to inform all care recipients of what they can expect from their service providers, and what they can do if they have concerns about the service they are receiving. It is expected that the CIS will have greater involvement in complaints management as care recipients understand what they can expect from service providers.

In addition, further growth of the CIS will also be fuelled by growth in the community care sector. While the number of complaints relating to community care is relatively low (approximately 3% of in-scope cases in 2008-09) the number of community aged care packages throughout Australia is significant (approximately 40,000 in 2007-08) and have grown at a faster rate than anticipated in 2006.

12.6. Timeliness

The timeliness of the CIS's investigations has been the subject of appeals and complaints from time to time. Lengthy and delayed finalising investigations were raised in submissions. I was advised by CIS staff that the increasing numbers and the low risk threshold for investigating complaints meant that investigations were not completed and left open because staff moved onto managing incoming complaints. I could not find evidence that time frames existed for different stages of the complaint process. Best practice complaint management includes time frames for completion of particular tasks associated with complaint handling.

12.7. Other issues

The scheme's title, incorporating the word "investigation" suggests a limited role for complaints. A change of name is required to reflect the wide range of options for managing and resolving complaints.

13. ADDITIONAL OPTIONS FOR RESTRUCTURING THE CIS

13.1. Model One - Restructure the current CIS within the Department

This option will retain the Complaints Investigation Scheme (renamed) under the Office of Aged Care Quality and Compliance in the Department, with the complaint process managed through the Department's State and Territory offices and national management from Canberra. The CIS would continue to report through the First Assistant Secretary, Office of Aged Care Quality and Compliance to the Secretary to the Department and the Minister for Ageing.

Under this model, the position of the Aged Care Commissioner would be retained but the Commissioner would be given greater powers so that her decisions would be determinative rather than just recommendatory. That is, the Aged Care Commissioner would make final and binding decision on the issues under appeal rather than just making recommendations to the Department for their consideration. I have formed this view after considering the submissions from consumers, providers and other complaints management bodies.

Discussion

The Department funds and regulates aged care services under the *Aged Care Act 1997* ('the Act'). Under the Act, the interests of the care recipient are paramount and include:

- To provide for funding of aged care that takes account of the quality, access and appropriateness of care;
- To promote a high quality of care and accommodation for care recipients; and
- To protect the health and well-being of the recipients of aged care services.

The Department ensures that providers of aged care meet their responsibilities under the legislation and does this through a variety of mechanisms. The CIS is one of them. A number of submissions raise the potential conflict for the Department, which both funds and manages complaints about the providers.

Dissatisfaction with the operations of the current CIS has resulted in a call from some consumers and provider groups for independence of the CIS from the Department. An analysis of the submissions indicates substantial concerns about the operations of the CIS which may have been a factor in their recommendations for independence.

The community has vast experience of other complaint schemes. It may be that consumers who made submissions about independence are aware of other complaint schemes which operate independently and have more trust and support from the stakeholders.

Common themes in the submissions and covered throughout this report, include:

- Lack of transparency in the investigation and decision-making process;
- Over-investigation and CIS demands for voluminous documentation on minor matters;
- Perception that greater weight is given to the evidence of the provider (including documentation) than to the evidence of the complainant;
- The information, including the Statement of Reasons for the decision, provided to the complainant at the end of an investigation does not provide sufficient useful information to the complainant, nor does it clearly explain the reasons why certain decisions were made and what outcomes they could expect;
- Investigations by the CIS do not always meet the expectations of the complainants; and

- Many complaints would best be resolved at the local level or by CIS staff using alternative options such as mediation.

When I commenced the review of the CIS, the Office of Aged Care Quality and Compliance was implementing a number of improvements to the CIS as a result of the lessons learnt since its commencement in May 2007. These improvements include:

- A review of the CIS Statements of Reason; and the current development of Statements of Reason training for CIS staff;
- The implementation of clinical protocol training for all CIS staff with nursing qualifications; and
- The development of additional training to CIS staff around the provider responsibilities, specified care and services requirements under the Aged Care Act, compliance and new induction training.

These improvements are appropriate and need to continue. See Model one at [Appendix 7](#).

13.2. Model Two - Transfer complaints to the Agency or the Ombudsman

Aged Care Standards and Accreditation Agency

A few providers suggested the Agency should manage aged care complaints. While this may assist in meeting expectations of independence from the Department it will not resolve the confusion as to who undertakes the tasks of complaints management/inspecting/audit. I think it will add to the confusion and lead to criticisms from the industry of the conflicting roles between the continuous improvement and educative focus of the Agency, and the focus of complaints investigation.

Commonwealth Ombudsman

Some submissions suggested that aged care complaints be managed through the Office of the Commonwealth Ombudsman.

This option would not fit easily within the existing scope of the Commonwealth Ombudsman's role which is to consider and investigate complaints from people who believe they have been treated unfairly or unreasonably by an Australian Government department or agency.

The establishment of the entire aged care complaints handling arrangements within the Office of the Commonwealth Ombudsman would not only be out of scope of usual business, but would also require a significant dedication of resources.

The Commonwealth Ombudsman's 2007-08 Annual Report indicates that the Office investigated approximately 4,700 matters across whole of government (of the 19,621 approaches and complaints received which were within the Ombudsman's jurisdiction). In contrast, in 2008-09 the CIS investigated 7,962 cases across the aged care industry (of the 12,573 contacts received). These figures indicate that a significant resource investment would be required for the Commonwealth Ombudsman's Office to have the capacity to take on aged care complaints management.

I have not provided any diagram for this model because I do not think either agency will solve the problems currently experienced by consumers and providers. Neither the Agency or the

Commonwealth Ombudsman made reference in their submissions to assuming responsibility for aged care complaints.

13.3. Model Three - Establish the Office of Aged Care Complaints

This model would require the creation of a new Office of Aged Care Complaints. While the Office of Aged Care Complaints would be separate from the Department it would be staffed by officers from the Department. This is a similar model to that currently used for the Aged Care Commissioner and her staff. A new statutory position of Aged Care Complaints Commissioner would be established to be responsible for the Office of Aged Care Complaints.

The Aged Care Complaints Commissioner as a statutory office holder would be appointed by, and reportable to, the Minister for Ageing and would make an Annual Report to Parliament. This differs from the existing Aged Care Commissioner in that all responsibilities for administration of the complaints management process and review of decisions would fall within the responsibility of the Aged Care Complaints Commissioner.

Under this option, the position of Aged Care Commissioner would convert to the Commissioner for Aged Care Complaints and the current staff of the Aged Care Commissioner would transfer to the new Office of Aged Care Complaints. All reviews would be done by the Office of Aged Care Complaints with a right to approach the Commonwealth Ombudsman following an internal review process, similar to the model currently in place at the NSW Health Care Complaints Commission.

The Commissioner would be required to consult with the Secretary (or delegate) of the Department as required and to transfer any complaint information as required. This is to enable the Department to have all relevant information in relation to its regulatory obligations. Formal reporting mechanisms would be established to enable the free flow of information between the Department and the Office of Aged Care Complaints.

Review of decisions

Most established complaint bodies have internal review processes for reviewing their decisions. The Commonwealth Ombudsman relies solely on an internal process for review requests. The NSW Health Care Complaints Commission has a statutory obligation to notify a complainant that they may ask for a review by the Commission of a decision made after assessment if the decision is not to investigate.

In this model complainants should be provided with an opportunity to request a review of an assessment decision which acts as an additional safeguard to ensure that the correct decision is made. If a complainant disagrees with an assessment decision, they should be able to request a review of that decision with the Director of Assessment and Early Resolution who will organise a person not connected with the assessment to review.

In the first instance a complainant who wishes to have a decision reviewed should discuss the matter with the person who made the decision. If a complainant and/or a provider remain dissatisfied, they can ask the Office of Aged Care Complaints to review the decision. A request for a review should be submitted in writing within 28 days from the date the Office of Aged Care Complaints advises the parties of the decision. If there is a request for review outside the 28 days the Commissioner for Aged Care Complaints can exercise their discretion as to whether accept the request.

If the Commissioner for Aged Care Complaints agrees to review a decision, the request for review will be assigned to an officer who was not involved in the original assessment or investigation of the complaint. The review will consider:

- The process adopted by the investigating officer and whether it was fair and adequate to address all the issues raised in the complaint; and
- The merit of the officer's conclusions and whether they were properly explained to the party concerned.

Under this model, it is recommended that the new Office of Aged Care Complaints should be co-located with the Department. A separate office would allow a focus on aged care complaints resolution and investigation without the competing demands and potential conflicts which exist within the Department and the Office.

See Model 3 which is at [Appendix 8](#).

13.4. Model Four - Establish a new Aged Care Complaints Commission

This is my preferred model and is described in the Recommendation section. This model involves the establishment of an independent Aged Care Complaints Commission and the creation of the position of Aged Care Complaints Commissioner who will report directly to the Minister for Ageing. The Commissioner would be required to consult with the Secretary or their delegate as required, particularly in relation to sharing of information that relates to the regulatory requirements under the Act and the Principles.

The Rudd Government has supported the Department of Finance and Deregulation's *Governance Arrangements for Australian Government Bodies*, implemented in August 2005 following the *Review of the Corporate Governance of Statutory Authorities and Office Holders* undertaken by John Uhrig AO. While acknowledging the recommendations from the 'Uhrig Report', I still recommend a separate statutory authority, thus removing aged care complaints management from the Department. My reasons include:

- The Department is responsible for the overall management and delivery of aged care services through the allocation of places, approval of providers, payment of aged care services and compliance with the aged care standards. The focus is necessarily on aged care services for the community rather than on any individual complaint of a family or resident.
- Effective complaint management requires a dedication to the role of complaints in society and the need to build a professional organisation with a vision that meets community expectations. It is very difficult to achieve this in a large and complex bureaucracy.
- Complaint management directly impacts on the personal experience between a citizen and the bureaucracy; making trust in the 'neutrality' or 'impartiality' of the complaint body essential. The current system in which complaints are part of the bureaucracy responsible for aged care services makes it harder for a complainant to accept the final outcome if it is not favourable to their case. This adds to disquiet in the administration of the complaint scheme, as evidenced by the submissions from consumers and providers who shared their concerns about the impartiality or unreliability of decisions.
- The stakes are high for the complainants in a complaint investigation and when the same organisation is responsible for all the regulatory functions it lessens the will or capacity to admit failures and commit to improvements.
- Any complaint scheme requires transparency in its processes to engender trust from all the parties as well as the community; when complaints reside in the organisation responsible for overall quality of the services (that may be subject of complaints) there is incentive to

limit data about complaints, the main areas complained about and the problems in the public arena.

I recognise that the mere status of 'independence' of a complaint body does not prevent bias. Conversely a complaint body within a government department may operate impartially; permitted by the neutrality of its public service bureaucracy.

The Aged Care Complaints Commission should replace the current CIS and be a statutory body headed by the Aged Care Complaints Commissioner who would be appointed as a statutory office holder appointed by and reportable to the Minister for Ageing. Staff would be employed under the *Public Service Act 1999*. A separate Aged Care Complaints Commission would establish itself as a best practice complaint handling organisation dedicated to the resolution of aged care complaint and appropriate investigations without the competing demands and potential conflicts which exist within the Department and the Office. It removes any residual concerns about 'partiality' and conflicts of interest. There is a substantial body of evidence supporting the independence of complaint handling. A robust and trustworthy complaint system will be an essential component of age care services of the future. Increasingly older people, many of whom will have grown up with the availability of effective complaint mechanisms, will expect to have access to an effective independent service; this expectation will grow rather than recede.

The Senate Inquiry in 2005 heard similar issues with the then Complaint Resolution Scheme (CRS) to those raised in this review. While there was a strong voice for an independent complaint scheme that inquiry fell short of recommending a separate body. Over the last four years the issue of independence or perception of independence has not receded with the introduction of the CIS; rather the call for an independent complaint body has consolidated.

See Model 4 which is at [Appendix 9](#).

14. APPENDICES

The following Appendices are listed here for additional information.

Appendix 1	List of Submissions to the Review
Appendix 2	List of face-to-face consultations
Appendix 3	Consultation Paper
Appendix 4	References
Appendix 5	NSW Health Complaints Commission risk severity assessment matrix
Appendix 6	Complaint Management Costs and Statistics - September 2009
Appendix 7	Model 1 - Restructure the current CIS within the Department
Appendix 8	Model 3 - Establish the Office of Aged Care Complaints
Appendix 9	Model 4 – Establish an Aged Care Complaints Commission

LIST OF SUBMISSIONS TO THE REVIEW

Submission	Name
1	Individual submission
2	Individual submission
3	Individual submission
4	Individual submission
5	Individual submission
6	The Royal Australian College of General Practitioners (RACGP)
7	Blue Care
8	Individual submission
9	Queensland Aged and Disability Advocacy Inc. (QADA)
10	Individual submission
11	Anglican Retirement Villages
12	Individual submission
13	Individual submission
14	Individual submission
15	Freemasons Homes of Southern Tasmania Inc.
16	Summit Care Australia
17	Lesbian and Gay Solidarity, Melbourne
18	Blue Care
19	ECH Inc, Eldercare Inc, and Resthaven Inc
20	Individual submission
21	The Returned & Services League of Australia (Tasmania)
22	Illawarra Retirement Trust
23	National Aged Care Alliance
24	Gympie Nursing Centre
25	Mary's Grange Inc
26	Individual submission
27	Uniting Care Ageing NSW
28	Individual submission
29	Individual submission
30	Queensland Law Society
31	Individual submission
32	Queensland Aged and Disability Advocacy Inc (QADA)
33	Individual submission
34	Individual submission
35	The INS Group
36	Individual submission
37	Individual submission
38	Aged Care Lobby Group
39	The Salvation Army Aged Care Plus
40	Health and Community Services Complaints Commissioner (HCSCC)
41	Benetas
42	Koroit Health Services (KHS)
43	Individual submission
44	Aged Care Crisis Team
45	Alzheimer's Australia
46	Individual submission
47	Individual submission
48	Individual submission
49	Aged and Community Services WA
50	Australian and New Zealand Society for Geriatric Medicine (ANZSGM)
51	Proactive Complaints Management
52	Individual submission

Submission	Name
53	The Partners of Veterans Association of Australia (PVA)
54	Southern Cross Care Tasmania
55	Elder Care Watch
56	Individual submission
57	Advocacy Tasmania Inc
58	Individual submission
59	The National LGBT Health Alliance
60	Country Health South Australia (CHSA)
61	Uniting Aged Care Victoria and Tasmania
62	Australian Polish Community Services
63	The Aged-Care Rights Service (TARS)
64	ACT Health Services Commissioner
65	Aged Care Queensland Inc
66	Health Services Union
67	James Brown Memorial Trust
68	Individual submission
69	Silver Chain
70	Australian Nursing Federation
71	Anglicare Australia
72	Goulburn Valley Health
73	Aged and Community Services NSW and ACT
74	Individual submission
75	Catholic Health Australia
76	Aged Care, Residential and ABI Services, Northside Health Services District
77	Individual submission
78	Individual submission
79	Goodwin Aged Care Services Ltd
80	Individual submission
81	Bupa Care Services
82	Froniditha Care
83	Individual submission
84	Multicultural Aged Care Australia (MACA)
85	Brotherhood of Saint Laurence
86	Baptist Community Services
87	Individual submission
88	Advocare Inc
89	Queensland Aged Care Action Group (QACAG) Inc
90	Coalition of Activist Lesbians Australia Inc
91	Individual submission
92	Aged Rights Advocacy Service
93	Aged Care Association Australia (ACAA)
94	Aged and Community Services SA and NT
95	Health Services Commissioner
96	Combined Pensioner and Superannuants Association (CPSA)
97	Older Women's Network (OWN)
98	Carers Australia
99	Aged Care Association Australia SA
100	Aged Care Association Australia NSW
101	Public Interest Advocacy Centre (PIAC)
102	Aged and Community Care Victoria (ACCV)
103	Office of the Public Advocate
104	Royal College of Nursing Australia (RCNA)
105	Elder Rights Advocacy
106	Aged and Community Services Australia (ACSA)
107	Office of the Aged Care Commissioner
108	The Aids Council of NSW (ACON)

Submission	Name
109	National Seniors Australia
110	ACT Disability Aged and Carer Advocacy Service (ADACAS)
111	Individual submission
112	Commonwealth Ombudsman
113	Individual submission
114	Individual submission
115	Legacy Coordinating Council
116	Civilian Maimed and Limbless Association
117	Prime Minister's Advisory Council on Ex- Service matters
118	Individual submission
119	Matrix Guild Vic Inc

FACE-TO-FACE CONSULTATIONS

Aged and Community Services Australia

Aged Care Association Australia

Aged Care Standards and Accreditation Agency

ACT Disability, Aged and Carer Advocacy Service (ADACAS)

Aged Care Commissioner

Aged Care Crisis Team

Aged Care Lobby Group

Former panel member under the former Complaints Resolution Scheme

Alzheimer's Australia

Australian and New Zealand Society for Geriatric Medicine

Carers Australia

Catholic Health Australia

Commonwealth Ombudsman

Daniel's SHEILD

Elder Rights Advocacy

Health Services Union

Council on the Ageing

Liquor, Hospitality and Miscellaneous Union

National Seniors Australia

Royal College of Nursing Australia

The Aged Care Rights Services (NSW) (TARS)

Focus group with consumers organised by TARS

Department of Health and Ageing staff working within the Complaints Investigation Scheme



Australian Government

Department of Health and Ageing

Consultation Paper

Aged Care Complaints Investigation Scheme

July 2009

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Appendix A: Complaints Investigation Scheme

PART 1: Purpose of this paper

The Australian Government has engaged Associate Professor Merrilyn Walton to conduct a review of the operation of the Aged Care Complaints Investigation Scheme. The review of the complaints scheme coincides with the Government's review of the aged care accreditation process.

This Consultation Paper provides background information on the Aged Care Complaints Investigation Scheme to inform input from interested organisations and individuals.

PART 2: Introduction

The Complaints Investigation Scheme (CIS) was developed in response to the inability of the former Aged Care Complaints Resolution Scheme to investigate and appropriately deal with all concerns about the care or services provided in aged care.

The CIS began on 1 May 2007, with compulsory reporting requirements coming in to effect on 1 July 2007. In its first two full years of operation, the CIS received almost 24,000 contacts, of which more than 15,000 were 'in scope'.

The CIS provides a means through which concerns about a service or the care being provided to elderly people receiving Australian Government-subsidised aged care, including residential (hostel or nursing home) and community care, can be raised.

Anyone can contact the CIS with a concern – care recipient, family member, care provider, staff member, GP etc. Complaints can be made openly, anonymously or in confidence.

Concerns or complaints can be about anything that affects the quality of care for aged care recipients, such as medical and personal care, catering, hygiene, security, activities, choice, comfort, safety, neglect or financial matters. The service is free and confidential.

The CIS is two years old and it is now appropriate to consider and evaluate its effectiveness to ensure that it continues to meet the needs and expectations of service recipients, service providers and other interested parties.

Additional information on the CIS is provided in Appendix A.

PART 3: The Reviewer

Associate Professor of Medical Education, Faculty of Medicine, University of Sydney

The review of the operation of the CIS is being undertaken by Associate Professor Merrilyn Walton. Associate Professor Walton's career in health care spans nearly twenty-five years. During that time she has been the Director of the NSW Health Complaints Unit (1985-1994),

Commissioner for the NSW Health Care Complaints Commission (HCCC) (1994-2000) and Associate Professor in the Faculty of Medicine (2000-2009).

As Director of the NSW Health Complaints Unit and Commissioner of the HCCC, Associate Professor Walton was responsible for all investigations of health care professionals and health care services, including all NSW nursing homes.

Professor Walton investigated the Chelmsford Deep Sleep case, convened the inquiry into schedule 5 hospitals and facilities (NSW psychiatric hospitals and nursing homes) and the Cosmetic Surgery Inquiry, and investigated and conducted cases before the Medical and Nurses' Tribunals.

Associate Professor Walton was pivotal in the planning and introduction of the New South Wales Health Care Complaints Act 1993 between 1989 and 2002, and had a major role in improving the regulation of the health professions and accountability of health organisations. During this period Associate Professor Walton authored or co-authored 15 major government reports and convened six ministerial/government inquiries. In March 2009 she was appointed to the Agency Management Committee (statutory appointment) for the National Registration and Accreditation Agency for Health Professionals.

PART 4: The Review

The review of the operation of the CIS will consider the following aspects of the scheme:

- Whether the Complaints Investigation Scheme (CIS) provides natural justice to all parties involved;
- Communication between the CIS, its investigators, family members, residents and advocacy groups who lodge complaints as well as the aged care providers and their staff, and provide advice on improvements. This should include considering the treatment of anonymous complainants;
- The adequacy of training provided to investigators to assist them in undertaking their role, including in investigative methods, reporting and communications;
- Adequacy of access to clinical and investigative expertise;
- Appropriateness of the risk assessment framework used for the escalation of complaints;
- Adequacy of information collected and considered as part of the investigation;
- The relationship between the CIS and the Aged Care Commissioner, the Aged Care Standards and Accreditation Agency Ltd, and other relevant bodies;
- The processes, practices and the timeliness of responses to complaints to the CIS when compared to similar investigatory bodies; and
- Evidence based initiatives from similar investigatory bodies that might improve the operation of the Scheme so that it better meets the needs and expectations of consumers, their families and aged care providers.

While a number of the above terms of reference require Associate Professor Walton to examine internal processes within the Department of Health and Ageing, other terms of reference pertain to the relationship between the scheme and external parties, including residents and their family and representatives, advocacy groups and aged care providers, and the views of these important stakeholders are sought to inform the review.

PART 5: Opportunity for comment

Input is invited from interested organisations and individuals to inform the review. Submissions may address the issues raised in this Consultation Paper which, in particular, seeks feedback from interested parties on the following matters:

- How can the communication between the CIS investigators and involved parties (including: family members, residents and advocacy groups who lodge complaints, aged care service providers and their staff) be improved?
- Is the current CIS treatment of anonymous complaints appropriate? Where are the opportunities for improvement?
- What can the CIS do to better meet the needs and expectations of residents, their families and aged care service providers?

Persons who have had contact with the CIS (whether as a complainant, an aged care provider, or staff member for example) may wish to specifically comment on their experience, particularly in relation to communication with the CIS and the timeliness of the investigation.

Lodgement of submissions

Submissions, via mail, facsimile or email, should be made by 28 August 2009 to:

CIS Review Project
Department of Health and Ageing
MDP 68
GPO Box 9848
CANBERRA ACT 2601

Email: CISreview@health.gov.au
Fax: (02) 6289 1504

Appendix A: Complaints Investigation Scheme

Background

The Aged Care Complaints Investigation Scheme (CIS) commenced on 1 May 2007. The operation of the CIS is governed by the Aged Care Act 1997 (the Act) and the Investigation Principles 2007 (the Principles), which are regulations made under the Act.

The CIS can investigate issues or concerns:

- relating to the delivery of both residential and community aged care services that are subsidised by the Australian Government; and
- relating to an approved provider's responsibilities under the Aged Care Act.

The CIS has no power to investigate concerns relating to aged care services that are not subsidised by the Australian Government. Similarly, the CIS is not able to investigate issues that do not relate to an approved provider's responsibilities under the Act, such as industrial matters or matters relating to who should make financial, legal or health decisions on behalf of a care recipient.

The CIS is a free service and is available to anyone who wishes to provide information or raise a concern about an Australian Government funded aged care service, including care recipients, family members, legal representatives, general practitioners and aged care staff.

The complaints investigation process

Making a complaint

Information can be provided orally via the CIS phone line (1800 550 552), in writing, or by using the complaints form on the Department of Health and Ageing's website.

The person providing information to the CIS may choose to do so openly, anonymously (in which case the CIS does not have the name and contact details of the person) or they may provide their name and contact details but request that this information remain confidential.

The CIS process for receiving and managing complaints can be broadly broken into three stages: intake, investigation and decision.

Stage 1 - Intake

When a CIS officer receives information about an aged care service, they will assess the information to ensure that it:

- relates to an Australian Government subsidised aged care service; and
- relates to an approved provider's responsibilities under the Aged Care Act.

Cases that meet these criteria are determined to be 'in scope' of the CIS. If a case does not meet these criteria the intake officer will generally try to refer the informant to the appropriate authority, such as state or territory health complaints commissions or professional registration bodies.

Cases that are determined to be 'in scope' are then further assessed to ascertain if an investigation is warranted. Decisions regarding the requirement for an investigation are made in consultation with CIS managers. Under the Investigation Principles 2007 the CIS may

choose not to investigate a matter relating to an approved provider's responsibilities if it is satisfied that:

- the provision of information is frivolous or vexatious;
- the information was not given in good faith;
- the matter relates to an issue that has been, or is, the subject of a legal proceeding;
- the matter relates to an issue that has been dealt with already by the CIS or the previous complaints handling arrangements (the CRS);
- the matter relates to an event that occurred more than 1 year before the information was provided and that is not ongoing; or
- having regard to all the circumstances, investigation of the matter is not warranted.

During the intake process, the CIS officer will seek to obtain as much information as possible from the informant and detailed case notes are recorded on the CIS database.

Following assessment at intake, cases are referred to the investigation stage.

Stage 2 - Investigation

Investigated cases are assigned to an investigations officer who assesses the information and, in consultation with an investigations manager, will decide how to undertake the investigation. This may involve an announced or unannounced visit to the service (or office if the case relates to a provider of community aged care).

In undertaking an investigation the officer may also:

- review documents and analyse written information;
- meet with the person who provided the information which gave rise to the investigation;
- meet with the approved provider, or any other person, to whom the investigation relates; and/or
- request information from the informant, the approved provider or any other person affected by the investigation.

In addition to investigating a case, the CIS may, where appropriate, help to broker a solution between interested parties to a complaint.

Communication

At the start of an investigation, the investigations officer will generally advise the relevant approved provider, via the phone or in writing, that information has been received about their service and an investigation has commenced. The CIS may choose not to immediately notify the approved provider if it considers that this is likely to:

- harm the investigation;
- place the safety, health or well being of the informant or a care recipient at risk; or
- place the informant or a care recipient at risk of intimidation or harassment.

Throughout the investigation, CIS officers seek to provide feedback to all relevant parties to the complaint. This includes both oral and written communication. In particular, the Investigation Principles 2007 provide for the CIS to advise both the complainant and the approved provider of:

- a decision to undertake an investigation;
- a decision to not investigate information that relates to an approved provider's responsibilities under the Act or the Principles;
- a decision to end an investigation;
- any referrals of information to internal areas of the Department or external agencies;

- the outcome of an investigation, including the decision as to whether or not a provider has breached its responsibilities; and
- the conditions of a Notice of Required Action, where one is issued.

Where information is provided to the CIS anonymously, no feedback on the investigation is provided to the informant. Informants who request that their details remain confidential are able to receive feedback on an investigation from the CIS.

The CIS may also refer information to other areas of the Department and to external agencies at any stage in the investigation process. For example, if during the course of an investigation the CIS becomes concerned that a matter may indicate that the home has systemic problems (as opposed to a one-off incident that may have resulted from human error) the CIS may refer the matter to the Aged Care Standards and Accreditation Agency Ltd for their consideration and action as appropriate.

Stage 3 – Decision

In coming to a decision about whether or not an approved provider has breached their responsibilities under the Act, the CIS is required to assess the evidence – through scrutinising documentation relating to the events in question and considering and triaging any information from the informant, the approved provider, staff, and others who may have been a party to the events in question, such as other health professionals or witnesses. A judgement can only be made based on what this evidence shows. It can't be made on speculation or hearsay.

If an investigation finds that the approved provider has not breached their responsibilities under the Act or Principles, no further action is taken by the CIS.

If the investigation identifies that the approved provider has breached their responsibilities, the CIS may:

- determine that the approved provider has already taken appropriate action to remedy the breach, in which case the CIS will make note that a breach has occurred but take no further action;
- issue a written Notice of Required Action (NRA), which outlines the steps that the approved provider must take in order to address the breach and the timeframe in which this must occur. Compliance action can be taken if a provider fails to comply with a NRA; or
- due to the serious nature of a breach, undertake appropriate compliance action.

In considering whether to issue an NRA or undertake immediate compliance action, the CIS considers the:

- seriousness of the breach and the likely risk to care recipients;
- extent of the breach;
- urgency of the situation; and
- history of the aged care service or Approved Provider.

Where an investigation finds an immediate and severe risk to care recipients, or a risk which is considered sufficiently critical, compliance action may be instigated immediately. Compliance action may include the issuing of a notice of non-compliance to the approved provider or the imposition of sanctions.

Advice about a decision

The CIS will advise both the informant (unless they are anonymous) and the approved provider about the outcomes of the investigation and the reasons behind the decision that has been made. Information is also provided on the rights of the informant and the approved provider to seek a review of the decision.

Reviewing decisions

Approved providers, care recipients or their representatives may ask the Aged Care Commissioner to review certain decisions made by the CIS. These decisions are referred to as 'examinable decisions' under the Investigation Principles 2007. An application for an examination of an examinable decision must be received by the Commissioner within 14 days of the applicant having been notified of, or given feedback on, the examinable decision.

The Commissioner has 60 days to review the decision and make a recommendation to the Department to confirm the decision, vary the decision, or set aside the decision and substitute a new decision.

Following receipt of the Commissioner's recommendation, a delegate of the Secretary of the Department of Health and Ageing, who was not involved in the original CIS decision, will re-consider the original CIS decision and, taking into account the Commissioner's recommendation, will confirm the original decision, vary the decision, or set aside the decision and substitute a new decision.

In undertaking this reconsideration, the Department works cooperatively with the Commissioner's Office to ensure appropriate outcomes. The Department also seeks legal and clinical advice where appropriate.

Where the Department does not agree with a recommendation made by the Commissioner, the Department has established a clear process to ensure Senior Executive oversight and that the decision is based on appropriate expertise.

The Department advises all parties to the complaint of its new decision after it has considered the Commissioner's recommendation and provides a statement of reasons explaining the decision.

Following reconsideration of a Commissioner's recommendation all parties are advised that if they are not satisfied with the outcome the complainant may lodge a complaint about how the CIS has handled the matter with the Commonwealth Ombudsman.

Examinable decisions

Care recipients or their representatives may request an examination of the following decisions:

- a decision not to investigate a matter;
- a decision to end an investigation;
- a decision that there has not been a breach of the approved provider's responsibilities;
- a decision not to issue a NRA; and
- a decision setting, adding or varying the conditions of a NRA that concerns them.

An approved provider may request an examination of the following decisions:

- a decision that there has been a breach of the approved provider's responsibilities;
- a decision to issue a NRA; and
- a decision setting, adding, or varying the conditions of a NRA.

Approved providers, care recipients or their representatives may also ask the Aged Care Commissioner to examine the administrative processes used by the CIS in handling a matter that concerns them.

The Aged Care Commissioner may commence an examination either as a result of a request or on the Commissioner's own initiative.

During 2007-08 the Aged Care Commissioner received a total of 134 requests for review. Of the requests for review finalised during this period, the Commissioner recommended that the scheme's decision be:

- confirmed in 46 cases;
- set aside in 17 cases; and
- varied in 27 cases.

The Department did not agree with the Commissioner's recommendation in 10 cases, seven related to a recommendation to vary a decision and three related to a recommendation to set aside the original decision.

The Commissioner also completed seven reviews of the CIS investigation process during 2007-08 making recommendations to improve processes in three cases.

Complaints Investigation Scheme staff

The CIS employs staff located in the Department's offices in each state and territory. Staff are recruited to the CIS on the basis of their skills, expertise and background. Many officers have clinical and/or investigatory skills and more than a quarter of CIS staff have registered nurse qualifications.

Powers of CIS officers

CIS officers are authorised officers under the Aged Care Act 1997. Part 6.4 of the Act outlines the powers of authorised officers. These powers include:

- search of premises;
- taking photographs (including video recording), or making sketches of the premises or any substance or thing at the premises;
- inspecting, examining and taking samples of any substance or thing on or in the premises;
- inspecting any document or record kept at the premises; and
- taking extracts from, or making copies of, any document or record at the premises.

Authorised officers may only enter premises and exercise these monitoring powers with the consent of the occupier of the premises and the occupier may withdraw this consent at any time. If consent is refused, the authorised officer may apply to a magistrate for a warrant.

To prepare them to exercise their powers under the Act, CIS staff are provided with:

- training in five modules from a Certificate IV Investigation (Government) course, which is nationally accredited. The modules have been adapted to include an aged care focus and include modules entitled:
 - ~ Receive and validate data;
 - ~ Gather and manage evidence;
 - ~ Gather information through interviews;
 - ~ Investigate non-compliance; and

- ~ Use advanced workplace communication strategies.
- legislative training, to enable them to understand their powers under the Act and how to apply the Act and Principles in undertaking investigations and determining an approved provider's compliance with the requirements; and
 - training in the use of the CIS database to record all information about a case.

REFERENCES

1. NSW Ombudsman (2005) Natural justice/Procedural Fairness. Public sector Agencies fact sheet No 14, 2.
2. Hall M, Introduction to Administrative Law: Good decision making under the Aged Care Act 1997., DOHA, Editor. 2009, Australian Government: Canberra.
3. McMillan J, Natural Justice: too much, too little or just right?, in National Administrative Law Forum. 2008, Australian Institute of Administrative Law: Canberra.
4. Disney J, Access, equity and the dominant paradigm. 1992 AIAL Administrative Law Reform, 1992: p. 1-7.
5. Romios P, et al., Turning Wrongs into Rights: learning from consumer reported incidents An Annotated Literature Review, DOHA 2003, Editor. 2003, Commonwealth of Australia: Canberra.
6. Commonwealth Ombudsman, Better Practice Guide to Complaint Handling, C. Ombudsman, Editor. 2009, Commonwealth of Australia: Canberra.
7. Australian Council on Safety and Quality in Health Care, Complaints Management Handbook for Health Care Services, I.T.a.t.A. Department of Communications, Editor. 2005, Commonwealth of Australia: Canberra.
8. Administrative Review Council, Decision Making: EVIDENCE, FACTS AND FINDINGS, C.o.A. 2007, Editor. August 2007: Canberra.

NSW DEPARTMENT OF HEALTH RISK SEVERITY ASSESSMENT MATRIX

Severity Assessment Code (SAC) November 2005

This matrix should be used in conjunction with the NSW Health Incident Management Policy Directive

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

	Serious	Major	Moderate	Minor	Minimum
CLINICAL CONSEQUENCE	Initial Patients with Death unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ■ Suspected suicide ¹ ■ Suspected homicide ² or any of the following: The National Sentinel Events ■ Procedures involving the wrong patient or body part ■ Suspected suicide in hospital ■ Retained instruments ■ Unintended material requiring surgical removal ■ Medication error involving the death of a patient ■ Intravascular gas embolism ■ Haemolytic blood transfusion ■ Maternal death associated with labour and delivery ■ Infant discharged to the wrong family	Patients suffering a Major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident	Patients requiring increased level of care including: ■ Review and evaluation ■ Additional investigations ■ Referral to another clinician	Patients with No Injury or Increased level of care or length of stay
	CORPORATE CONSEQUENCE	Staff Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff	Permanent injury to staff member; hospitalisation of 2 staff; or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff	First aid treatment only with no lost time or restricted duties
Visitors Death of visitor or hospitalisation of 3 or more visitors		Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to 2 visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
Service Complete loss of service or output		Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
Financial Loss of assets replacement value due to damage, fire etc > \$1M, loss of cash/investments/assets due to fraud, overpayment or theft > \$100K or WorkCover claims > \$100K		Loss of assets replacement value due to damage, fire etc \$100K-\$1M, loss of cash/investments/assets due to fraud, overpayment or theft \$10K-\$100K or WorkCover claims \$50K-\$100K	Loss of assets replacement value due to damage, fire etc \$50K to \$100K or loss of cash/investments/assets due to fraud, overpayment or theft to \$10K	Loss of assets replacement value due to damage, fire etc to \$50K	No financial loss
Environmental Toxic release off-site with detrimental effect fire requiring evacuation		Off-site release with no detrimental effects or fire that goes no larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Missions releases

¹ Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;

² Suspected homicide committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

Action Required	
1	Extreme risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	High risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	Medium risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. Exception – all financial losses must be reported to senior management.
4	Low risk – message by routine procedures – Aggregate data then undertake a practice improvement project.

NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.

STEP 3 SAC Matrix

	CONSEQUENCE					
	Serious	Major	Moderate	Minor	Minimum	
LIKELIHOOD	Frequent	1	1	2	3	3
	Likely	1	1	2	3	4
	Possible	1	2	2	3	4
	Unlikely	1	2	3	4	4
	Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

COMPLAINT MANAGEMENT COSTS AND STATISTICS – SEPTEMBER 2009

COMPLAINTS INVESTIGATION SCHEME (CIS) INFORMATION					
Name	No. of complaints	Complaints finalised	ADR – Mediation, conciliation	Anonymous Complaints	Financials – over one financial year
CIS (National)	In 2008/09 12,573 contacts, 7,962 'in-scope'	In 2008/09, across states, average time to finalise ranged from approximately 11 days to 53 days.	Possible, but primarily investigative	√	\$23.5 million
OMBUDSMAN INFORMATION (data obtained from ANNUAL REPORTS 2007-08)					
Commonwealth Ombudsman (National)	19,621	76% of all approaches and complaints within 1 month; 91% within 3 months	√	√	\$20 million
Victorian (VIC) Ombudsman (State-based)	16,344	46% on the same day; 23% within 1 week; 21% within 1 month; 9% within 6 months; 1% took over 6 months	√	√	\$6.8 million
South Australian (SA) Ombudsman (State-based)	2,335	27 cases (1%) took greater than 12 months to finalise	√	No – unless classified as a 'whistleblower'	\$1.7 million
Western Australian (WA) Ombudsman (State-based)	1,249	78% within 3 months; 95% within 12 months	√	√	\$2.5 million
New South Wales (NSW) Ombudsman (State-based)	34,021	All cases finalised within 12 months	√	√	\$22 million
Queensland (QLD) Ombudsman (State-based)	7,084	1.2% of total complaints open were open for more than 12 months	√	√	\$6.2 million
Tasmanian (TAS) Ombudsman (State-based)	433	Health Complaints Act (1995) requires that complaints be assessed within a period of 45 days, extendable to 90 days. Of the 433 complaints received by TAS ombudsman, 420 were closed within the 2007-08 year	√	√	\$1.8 million
Northern Territory (NT) Ombudsman (State-based)	1,962	74% of cases were closed within 90 days.	√	√	\$1,834,000

HEALTH SERVICES COMMISSIONER INFORMATION (data obtained from ANNUAL REPORTS 2007-08)

Name	No. of complaints	Complaints finalised	ADR – Mediation, conciliation	Anonymous Complaints	Financials – over one financial year
NSW Health Care Complaints Commissioner (State-based)	4,409	88.2% assessed within 3 months; 66.3% finalised within 3 months 23.4% finalised within 6 months All but 2 cases were finalised within 12 months	√	√	\$10.2 million
Health Quality and Complaints Commission(QLD) (State-based)	2,675	Closed 42% within 1 month	√	√	\$9.3 million
Human Rights Commission (ACT) (State-based)	228	11% within 3 months; 54% within 6-12 months; 7% after 12 months	√	√	\$3 million
Health and Community Services Complaints Commission (SA) (State-based)	1,048	Cases have a 2 year time limit (Health and Community Services Complaints Act 2004); Aim is to finalise every complaint within 6 weeks; 36 cases were still open after 100 days	√	√	Approximately \$1.4 million
Office of the Health Services Commissioner (VIC) (State-based)	1,139	79% within 3 months 2% within 18-24 months 2% over 24 months	√	X	\$2.1 million
Office of Health Review (WA) (State-based)	1,734	Average length of time taken to finalise a complaint was 87.8 days	√	X	\$1.6 million
Health Complaints Commissioner (TAS) (State-based)	475	18% within 3 months 9% greater than 1 year	√	√	Approximately \$641,607
Northern Territory Health and Community Service Complaints Commissioner (please see NT Ombudsman above) (State-based)			√	√	\$425,000

