

AGED CARE
COMPLAINTS INVESTIGATION SCHEME
REVIEW

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August 2009

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Introduction

Aged Care Queensland Incorporated (ACQI) is a member funded, peak body organization representing 144 members and 326 services in the state of Queensland. As an industry, we support the principles of accountability and transparency by Approved Providers to residents and care recipients, their representatives and to the government.

It is our belief that the main aim in dispute resolution is a timely solution to a problem, using a cooperative, non-adversarial approach in order to achieve parties' satisfaction that includes the continued maintenance of relationships while enhancing the ability of those parties to communicate.

Feedback from our members reveals that their perception of the scheme is that it is adversarial and formal in approach where there is little encouragement or mediation attempted by the CIS for approved providers and complainants to work collaboratively together to resolve an issue. There is an emphasis on investigation with scant attention paid to conciliation, mediation and negotiation in an effort to resolve a complaint.

It is our contention that a distinction needs to be made by CIS between minor and major complaints and allegations. This distinction then determines the method of handling by the CIS. (See Appendix 1) Minor complaints for example may include such things as dissatisfaction with; service delivery (food, laundry, living environment etc), communication, procedures, delays or decisions made by the approved provider. Major Complaints/allegations are potentially more serious and include breaches of approved provider responsibilities under the Aged Care Act. According to the Aged Care Annual Report 2007/8, of the 7473 cases investigated, only 12.5% of cases were found to be breaches of the Aged Care Act. The relatively small number of breaches to the Act seems to indicate that the majority of complaints would be able to be resolved by relatively informal measures such as mediation or conciliation.

It is recommended that complaints of a more minor nature be recommended for mediation prior to becoming an investigation. Prior to mediation, it would be appropriate for the complainant to document the complaint and include the measures already taken to resolve the problem. The Approved Provider would also be required to reply in writing as to the measures that had been undertaken in an attempt to resolve the problem. When the appointed mediator has reviewed both documents, a mutually agreed mediation could be organised. It is our belief that this approach would assist many problems to be solved quickly and satisfactorily for all parties concerned.

For more serious allegations, an unbiased investigation should be conducted in a timely manner by CIS where information is sought from both parties prior to making a determination. If the allegation is upheld, then a Notice of Required Action should be implemented. If the allegation is not upheld, then communication should occur between CIS and both parties to ensure both parties are satisfied with the outcome.

Recommendation:

Adopt a non-adversarial, mediated approach to minor complaints resolution, with an aim to maintain relationships and achieve parties' satisfaction. In the case of more serious allegations a more formal unbiased investigation should be conducted following the rules of natural justice and seeking feedback from both parties.

1.0 Risk Assessment Framework

Currently, the threshold test for matters to be investigated includes a determination of whether the complaint is within the scope of the approved provider's responsibilities under the Act and the Principles. This is a very broad threshold test and does not operate within a risk assessment framework.

The only circumstances where the Secretary may decide not to investigate is where the information given is vexatious or frivolous or not given in good faith. It is currently unclear as to how the Secretary measures risk or determines if information is vexatious. It is the opinion of some of our members that many complaints forwarded to CIS are as a result of disgruntled staff who have incurred internal disciplinary action or counseling and are using the CIS as a means of retribution for the provider.

When receiving a complaint, CIS officers should ask whether the complainant has accessed the internal complaints mechanism of the facility or the Community Service Provider. If they have not accessed the internal complaints mechanism, they should be encouraged to do so before instigating a formal complaint with the CIS. Ascertaining if a person has been employed with the organization and reason for leaving could also provide information that would inform the risk management process.

Recommendation:

Determine whether the complainant has accessed the internal complaints mechanism before instigating a complaint with the CIS. Ensure a risk assessment distinguishes between minor complaints and more major complaints that are related to breaches of Approved Providers responsibilities. If a staff member generated complaint, assess the recent employment history of the complainant.

2.0 Processes & Practices**2.01 The Principle of Natural Justice / Procedural Fairness**

A core principle of the Australian legal system is the presumption of innocence until proven guilty where the allocation of liability is not undertaken until the elements of the action are proven. Unfortunately, the experience of many members is the opposite. Many providers perceive that they are treated as guilty before they are given an opportunity for reply. There is a general view that the process lacks procedural fairness. This view is unanimously held by our members but the examples of this perception are too numerous to mention.

According to the Australian Government Attorney-General's Department, the rules of procedural fairness require:

- A hearing appropriate to the circumstance
- Lack of bias
- Evidence to support a decision
- Enquiry into matters in dispute.

A critical part of procedural fairness is the 'hearing rule', where the approved provider is clearly informed of any negative information the CIS has about them and they should be given an opportunity to reply that is appropriate for the circumstances and the information is given due consideration before a decision is made. When an investigation is being conducted by the CIS, the approved provider is given an overview, but they are often not informed of many of the details of the complaint. It is the belief of ACQI that disclosure must occur and that both parties should be given sufficient information to know the case of the other party.

The CIS appears to be unduly pressured or even directed at times by the Minister in response to sensational claims in the media. One of the principles of the Benchmarks for an Industry-based Customer Dispute Resolution Scheme developed by the governments Federal Bureau of Consumer Affairs is that of independence. A point that is made in this principle is "the decision-maker should have no relationship with the scheme members that fund or administer the scheme which would give rise to a perceived or actual conflict of interest." The CIS is currently funded by DoHA, so a perceived and actual conflict of interest exists and reduces the independence of the scheme.

An example of this is where an approved provider had a Norovirus outbreak. They had implemented the appropriate and recommended protocols including notifying the Public Health Unit. The Minister for Ageing released a statement about the outbreak and within hours the CIS appeared to investigate the issue. This caused damage to the provider's reputation and was an unnecessary distraction for the staff that were very busy managing the situation.

The evidence to support a decision by the CIS invariably becomes the duty of the Approved Provider. As the CIS investigates all complaints without any substantial evidence from the complainant, the onus of proof of innocence lies with the Approved Provider. This has resulted in Approved Providers at times having to spend disproportionate amounts of time and resources photocopying / faxing files to the CIS to assist them with their investigations, often over an extended period of time.

The CIS often requires the facility or service to fax multiple care plans, assessments, minutes of meetings, agreements, progress notes, communication sources and memo's. There are also many occasions where information is sought that does not appear to pertain directly to the complainant and /or the complaint.

As an example, one provider had a complaint received about a minor issue relating to a piece of furniture. The CIS officers then requested a plethora of information, including clinical files of other random residents to be sent in addition to care plans, assessments, allied health assessments and minutes of meetings. The provider is well ware of the rules of evidence and challenged the CIS on the basis of relevance. The response from the CIS was that they could ask for anything. This is further evidence of the lack of procedural fairness, a lack of focus on the matters at hand, an open ended approach without concentrating on closure and these elements of the scheme result in provider distrust of the intentions of CIS officers.

A recent Community Care example illustrates the difficulty in obtaining information required by the CIS whilst concurrently not violating the privacy of other clients not covered under the Aged Care Act. Recently, an Approved Provider of Community Packages was required to produce all staff rosters for all Packaged Care Clients in a large geographical area of its statewide service. The rationale was to keep the complainant care recipients identity anonymous however this resulted in extensive hours of work extracting information and streamlining rosters to ensure the CIS did not have access to information that was out of scope of the Aged Care Act.

We reiterate if documentation is to be faxed to the department; the amount of data should be commensurate with the severity of the complaint.

Sometimes the investigation becomes a desk audit only, where the complainants and relevant parties are not interviewed. Where adverse decisions are made from a desk audit it is often the case that natural justice has not been provided to the approved provider and in these examples of simple complaints, the misunderstanding can often be solved in a 30min mediation. If the investigation requires more widespread action, the CIS officers should be required to visit the site to conduct interviews and to review procedures to ensure there is triangulation of evidence that would support an adverse decision.

It is the view of ACQI and its members that if the CIS wish to undertake an investigation that requires substantial resources and time to produce evidence, they should provide their own staff and time to procure such items.

Recommendation:

- a. To ensure principles of natural justice are followed, it is the belief of ACQI and its members that both parties should have sufficient information to know the case of the other party and to be given a fair hearing before a decision is made.
- b. Develop a complaints resolution process that is independent of both Approved Providers and DoHA to reduce perceived conflicts of interest.
- c. If documentation is to be faxed to the CIS, the amount of data should be commensurate with the severity of the complaint.

2.02 Anonymous Complaints

The Aged Care Act offers the protection of confidentiality to complainants and officers of CIS are not required to disclose to the Approved Provider details of the complainant. With this protection in place, complainants should only be taken seriously if: they are willing to 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. This would assist to minimize the number of vexatious and frivolous complaints being investigated, particularly by disgruntled staff members. A signed affidavit by staff that are making complaints may also assist to reduce the number of complaints made by staff that have been or may be the subject of disciplinary action.

Recommendation:

- a. Anonymous complaints should not be taken seriously, as there are already protections in place to protect complainant confidentiality from the Approved Provider.
- b. Members of staff or ex-staff who make complaints should sign affidavits to ensure the veracity of their complaint and to stipulate that it is made in good faith.

2.03 Timeliness of Investigations and Decisions

One of the aims of an effective complaints resolution scheme is the timely resolution of issues and problems. The Investigation Principles do not currently stipulate a timeframe for investigations to be completed and for decisions to be made. Consequently, complaints that are investigated can take disproportionate amounts of time to be resolved or closed. During this period, the Approved Provider often does not hear the results of the investigation and are kept waiting for prolonged periods while a decision is being made.

One provider has been waiting for the outcome of a complaint investigation that commenced in October 2008. This has already taken 10 months and no correspondence has been given to the Approved Provider during this time. In the meantime, a full accreditation visit was conducted and the facility achieved compliance in the 44 expected outcomes.

Numerous examples could be given that duplicate the experience of this provider.

Recommendation:

ACQI recommends that time frames for notification of decisions be legislated for serious allegations and that the time to resolve complaints are benchmarked and made available to the public and to the industry.

2.04 Communication between CIS and Approved Providers

In order to promote an environment of continuous improvement, the aged care industry would benefit from a more robust review of data captured by

the CIS. It is important that information on the effectiveness of the CIS is readily available in order for the aged care sector to become confident in the system. For example, the six monthly report on the operation of the Office of the Aged Care Quality and Compliance (to Dec 07) suggests that 36% of contacts were related to concerns about health and personal care. It would be of benefit to the industry to know what areas and in what context these issues were raised. We are also aware that 14% of issues raised related to the physical environment. It would be of benefit for the industry to know further detail on what parts of the living environment were of concern. The industry would benefit from an analysis of trends in complaints, so that it could be used as a stimulus for industry education and continuous improvement.

Frequent delays in correspondence between the CIS and the approved providers are of particular concern. Many approved providers have reported lengthy delays in notification from the CIS as to whether the complaint has been finalized or is still on-going. Delays of up to 4 to 6 months are not uncommon.

Approved Provider concerns about an investigator's behaviour or conduct are not routinely dealt with in a professional and confidential manner by the CIS.

In one example, an Approved Provider was concerned by an investigator's professionalism and called the CIS to speak about the issue. The team leader proceeded to use a speaker phone so the investigator in question could hear the complaint about them.

Recommendation:

Analysis of complaints, decisions, outcomes, timeframes and trends in complaints should be made available to the industry for continuous quality improvement.

Where delays occur in decision making, frequent contact in writing to the Approved Provider should occur at least fortnightly to update on the progress of the investigation.

2.05 Access to Expertise

According to the Annual Report on the Aged Care Act 2007-2008, the CIS received 3106 complaints of which 41% related to Health and Personal Care. As a result, it is our contention that at least 50% of CIS investigation officers should have clinical aged care experience and the remaining 50% should have significant industry knowledge so they can contextualize the complaint within the parameters the industry has to work within. CIS officers should have access to expertise within their fields of investigation, care settings and clinical knowledge.

Recommendation:

At least 50% of CIS Officers should have clinical aged care experience. The remainder should have significant industry knowledge for adequate contextualization of the complaint.

2.06 Consistency of Decision-Making

There is considerable variance between the state's CIS processes with regard to Notices of Required Action. According to the six monthly report on the operation of OACQC up to the 31st December 2007, there were 113 Notices of Required Action (NRA's) raised nationwide and 42 (**37%**) of those were issued in Queensland. Queensland's rate of issued NRA's is 55% higher than NSW where only 27 NRA's were issued. To add to this statistic, 78% of the NRA's issued in QLD were still outstanding after the six month reporting period.

There is no evidence to suggest that Queensland has a higher level of non-compliance than other states yet this would seem to suggest that CIS officers in Queensland are more compliance driven, pursue negotiated outcomes less often, and issue NRA's more readily than their interstate counterparts.

Recommendation:

Notices of Required Action should be consistently applied and benchmarked across Australia.

2.07 Prescriptive Outcomes

Advice from members indicates that a CIS investigation often results in prescriptive measures being applied to the provider when no NRA has been issued. 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 organizational 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 officer's role to require changes to organizational 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 – 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.

2.08 Considerations for Community Package Care Services

In the Report of Operation of the Office of Aged Care Quality and Compliance 1 July – December 2007 statistics from the Complaints Investigation Scheme highlighted that the number of cases handled by the CIS included 3792 cases related to residential care services, whilst a small number of cases (96) related to community care. Whilst these statistics perhaps highlight the need to create greater awareness amongst the public and industry that the CIS is a system to be utilized in the community care field, it must also be acknowledged that the community aged care industry has consistently demonstrated a high level of quality and compliance (Productivity Commission, 2008).

Community care service providers deliver services across multiple funding programs and as a consequence are often required to operate under multiple quality systems each incorporating standards around complaints resolution. Reform in this area has progressed more recently with the Department of Health and Ageing piloting a Draft Community Care Common Set of Standards which aims to streamline quality processes.

Current quality processes in community care incorporates a key standard around complaints. This standard specifies that complaints are to be dealt with fairly, promptly and confidentially and without retribution; that each service user and their representative is provided with information about the complaints process and how it is assessed and that the service provider evaluates and modifies service provision as appropriate in response to complaints. Further to this complaints and disputes are identified as a core community care principle in the Quality of Care Principles 1997 (Table 1.1).

Table 1.1 : Quality of Life and Quality of Care Standards

<i>Community care</i>	<i>Residential care</i>
<ul style="list-style-type: none"> • Information and consultation • Identifying care needs • Coordinated, planned and reliable service delivery • Social independence • Privacy, dignity, confidentiality and access to personal information • Complaints and disputes • Advocacy 	<ul style="list-style-type: none"> • Health and personal care • Resident lifestyle • Management systems, staffing and organisational development • Physical environment and safety systems

Source: Productivity Commission 2008

Aged Care Queensland recommends that any reforms to the CIS must be aligned to future activities in respect to the Draft Community Care Common Set of Standards and consider the unique settings that community care services are provided in.

It must also be acknowledged that historically as part of the quality improvement process the community care industry in Queensland has formed a strong relationship and worked collaboratively with the Queensland Aged

and Disability Advocacy (QADA) service. Numerous community care service providers as part of their quality improvement processes provide clients with QADA brochures in their initial meetings, invite QADA to present to their clients about their rights and actively encourage clients to engage with QADA if they feel their rights have been breached. The importance of building relationships with advocacy services should not be underestimated and should be considered in the CIS review. QADA reports a high level of activity in this state in relation to awareness raising and education sessions for service providers and care recipients. These records outline that for the period May 2007 to May 2008 183 sessions were undertaken and for the period from June 2008 to August 2009 542 sessions were held.

The low levels of community care referrals to the CIS are reflective of community care service providers connections with advocacy groups, their commitment to consumer rights, internal complaints mechanisms and their efforts with conciliation and mediation.

Whilst the community care sector maintains a relatively low level of cases within the CIS, Aged Care Queensland community care members have been active in providing feedback to the CIS discussion paper.

ACQI community care members have reported difficulties amongst CIS investigators in understanding and acknowledging the uniqueness of the community care setting. The community care setting deals with complaints within the home of care recipients and thus requires CIS policy and procedures around access issues, human rights principles and care recipient self determination to be strengthened.

Recommendation:

Aged Care Queensland recommends that:

- a. Any reforms to the CIS must be aligned to future activities in respect to the Draft Community Care Common Set of Standards and consider the unique settings that community care services are provided in.
- b. That CIS define and enhance its interface with advocacy services.

3.0 Relationship to Other Agencies

It is understood that the Complaints Investigation Scheme 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 in a timely fashion. Unfortunately, the pendulum has swung significantly from a dispute resolution service that seeks to maintain relationships by a negotiated outcome, to an inefficient punitive investigative process where principles of natural justice are not consistently applied.

Advice from ACQI's membership indicates that a large percentage of complaints that are **resolved** continue to be referred to the Agency. Statistics from the Annual Report on the Aged Care Act 2007-2008, indicate that almost 24% of all cases investigated by the CIS are referred on to the Aged Care

Standards and Accreditation Agency. In Queensland, of the investigations referred to external agencies, 97.5 % are to the Agency. If the role of the CIS is to investigate and resolve issues, there should not be the need for such a high percentage of referrals to other agencies. This is a duplicative process and we contend that the CIS function should remain separate to that of the Agency.

It is a requirement of the Investigation Principles 2007 to disclose to the approved provider if a referral is made to other external agencies or other internal areas within the Department. This requirement is rarely met, as approved providers will often receive an unexpected visit from the Aged Care Standards and Accreditation Agency or from the Community Care Quality Review process within a short timeframe after a CIS visit. A common expectation within our membership is that if the CIS visit they can expect a visit from the Aged Care Standards and Accreditation Agency within a very short period of time.

There is often duplication between the CIS and the Aged Care Standards Agency and the Departments own Community Care Quality Review Process. There are multiple examples where both CIS and the Agency are investigating the same issues simultaneously or within weeks of each other, even when there has been no substantive basis for the complaint. The two departments do not seem to coordinate their resources to ensure there is an efficient use of time and resources for all parties.

There is significant confusion about the complaints process mechanism across various agencies such as the CIS, the Office of Quality and Compliance, the Departments Community Care Quality Review process, the Aged Care Commissioner and the Aged Care Standards and Accreditation Agency. The functions of each department are often blurred and lack clarity for care recipients, their representatives and providers.

The whole system as it stands presently smacks of a Public Service mentality where officers are keen to be seen to take every step necessary even though a complaint/allegation can barely be substantiated. There is a tendency for serial complainers to be shunted onto other agencies in the hope that someone may uphold their complaint. In reality, the complainant is never likely to be satisfied with the outcome and is often a candidate for counseling rather than being encouraged by the system to keep complaining.

Recommendation:

Improved clarity for consumers and Approved Providers with respect to the roles of the various agencies that are accessible in the event of a complaint. It is not efficient use of resources for the DoHA or the Provider for an investigation already conducted and resolved by the CIS to be referred to other regulatory bodies for repeat investigation.

4.0 Training and Skills of CIS Officers

If the model of differentiating between more minor complaints and allegations is used, it would be of benefit for all CIS officers to be trained as mediators

and be registered with a nominated mediator registration association. Mediators should be required to be mentored with an experienced mediator for at least 20hrs prior to working independently.

In addition to the 5 modules in the Certificate IV in investigation (Government), it is suggested that attention be paid to personality testing to ensure the CIS officer has the propensity to be able to mediate effectively. It is suggested that people who have a collaborative conflict resolution style would be best suited to the job of a CIS officer.

ACQI has grave concerns about the way in which complaints are taken and recorded. It seems that many complainants seem to believe that the Approved Provider is in the wrong or is in breach of the Act because of comments (probably unintentional) made by the person recording the complaint. The receipt of a complaint should just be one of recording the information without comments about who might be in the right or wrong. Both sides of the story need to be examined before conclusions are drawn.

Recommendation:

The CIS officers should be trained in mediation and registered with an approved registration body. Officers should have the propensity to be able to investigate appropriately and mediate for an acceptable outcome. Complaints should be taken verbatim without comment or apportionment of blame or guilt.

5.0 Aged Care Commissioner

ACQI supports the role of an umpire that is independent of the Department of Health and Ageing. Unfortunately, the current umpire (ACC) does not have a determination role and is only able to make recommendations, and these are referred back to the Secretary for a final decision. The efficacy of the role of the Aged Care Commissioner is limited at best and does not engender confidence in the system by provider and resident alike. In the last annual ACC report (1997/8) the commissioner's recommendations to set aside or vary a decision was not implemented in 24% of cases by the Secretary. In other words, only 1 in every 4 recommendations made by the ACC are accepted by the Secretary.

Further, the ACC only confirmed the original decision made by the Secretary 50% of the time, recommended 30% of decisions be varied and 20% to be set aside. A 50% confirmation rate does not support confidence in the capacity of the CIS to conduct their business effectively.

The Annual Report also revealed that the ACC had raised 16 concerns in relation to natural justice, investigative procedures and record keeping within this period. It seems from the report that the Secretary did not take these concerns seriously, and only responded to 3 out of the 16 cases. It was also clear that the ACC was restricted in their ability to provide timely recommendations due to apparent obstruction within the department.

Recommendation:

The Aged Care Commissioner should be autonomous and have the ability to make decisions that are binding.

6.0 Mandatory Reporting

The requirement of Aged Care Providers to notify the police and CIS of reportable assaults has resulted in Approved Providers being subject to an unreasonable amount of scrutiny by CIS. Members have indicated that after notifying CIS of a reportable assault, this often results in a visit where CIS officers adopt a punitive approach and arrive with a pre-existing bias of approved provider guilt, often suggesting that the provider is negligent because an incident occurred.

There are a number of significant issues that have emerged as a result of this legislative change:

1. Police Disinterest:

Members consistently report that when they contact the local police to notify them of a reportable incident, they are met with apathy and are often treated rudely. Responses such as “what do you expect us to do” or “we haven’t got time to deal with this” are commonplace.

2. Lack of natural justice for staff:

As providers need to report any allegation of suspected abuse, many experienced and caring staff are being caught up in the process and treated as guilty by the CIS. Officers have often been prescriptive and have required approved providers to “stand-down” staff until they have finished their investigation. Many investigations are taking a prolonged period of time to resolve and in the meantime the approved provider is paying for staff members to be off work. This has also resulted in experienced, valued staff leaving the industry due to their lack of confidence in natural justice. Where some providers have dismissed employees as a result of a reportable assault, they have then been taken to the industrial relations commission for unfair dismissal. Providers are placed in an invidious position.

3. Prescriptive solutions by CIS:

In one known investigation of a reportable assault, the CIS officer told the provider that they were satisfied that the staff knew what to do with respect to mandatory reporting as a result of several interviews conducted. Despite this, they insisted that the staff have further formalized training relating to mandatory reporting.

It is the opinion of ACQI and its members that the volume of documentation and referrals to CIS and police is onerous and does not provide the public with additional confidence in resident’s safety and well-being. Approved Providers demonstrate that they have the best interests of residents in mind and have always been mindful of the vulnerability of the residents.

Recommendation:

Approved Providers should have the capacity to conduct internal investigations into allegations of assault and only notify CIS and the police if their investigations have revealed substance to the allegations.

7.0 Conclusion

The move from a complaints resolution scheme to a complaints investigation scheme has resulted in a process that is more punitive, adversarial, non-transparent and administratively burdensome.

Principles of natural justice are not consistently applied, relationships are often not maintained and protracted amounts of time are taken for decisions to be made.

It is recommended that an independent mediated approach be implemented to resolve the majority of complaints where the aim is to restore relationships and to negotiate satisfactory outcomes between the parties within a reasonable timeframe.

The investigative nature of the complaints resolution process need only occur for those matters where there is a serious breach of the Aged Care Act.

The roles of the various government agencies (CIS, Office of Quality and Compliance, Aged Care Standards and Accreditation Agency, Community Care Quality Review) need to be distinct and transparent and better promoted for widespread understanding by all stakeholders. A single entry point for complaints would be clearer and less confusing for residents and their representatives.

Decisions referred to the Aged Care Commissioner should result in outcomes that are binding.

There is little evidence available to suggest that mandatory reporting requirements have resulted in better outcomes for care recipients. It is the opinion of ACQI and its members that the onerous requirements of the process has led to frequent violations of natural justice and has created an administrative burden that is not delivering an improved perception of better consumer protection.

Appendix 1: New Suggested Model

