Resolution and advocacy: essential partners in the management of aged care complaints

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Introduction

The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights; and
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from the Industry and Investment NSW for its work on energy and water, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

PIAC's work on healthcare rights

PIAC has undertaken a considerable amount of work on patient and health care rights over its 27 years of operation. Much of this work has focussed on patient safety, complaints and investigation processes and the development of an Australian Health Consumers' Charter.[1] PIAC was central to the consultation process leading to the enactment of the *Health Care Complaints Act 1993* (NSW). PIAC also provided legal representation in the New South Wales Royal Commission into Deep Sleep Therapy (the Chelmsford Royal Commission) and was involved in related processes dealing with the specific issues at the Chelmsford Hospital, but also more broadly, about the handling of serious complaints about medical practice in NSW. In the past six months, PIAC has made submissions to several health complaint related inquiries, including a response to the *Consultation Paper on proposed arrangements for handling complaints and*

1 See, for example, Carol Berry and Robin Banks, A tool for healthcare improvement: Comment on the *Draft National Patient Charter of Rights* (2008) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/sub2008030_20080307.html> at 28 August 2009.

dealing with performance, health and conduct matters[2], a submission to the Senate Community Affairs Committee Inquiry into the National Registration Scheme for health practitioners[3], and comment on the exposure draft of the Health Practitioner Regulation developed in response to the Senate Inquiry.[4]

Recently, PIAC made several submissions about aged care, including a response to the review and evaluation of the Aged Care Complaints Investigation Scheme (hereafter described as '2010 Complaints Submission').[5] PIAC also made a submission to the Australian Productivity Commission inquiry into aged care (hereafter described as '2010 Productivity Submission').[6]

PIAC wishes to declare that Merrilyn Walton, the author of the Review *of the Aged Care Complaints Investigation Scheme,* is a member of the PIAC Board.

1. Background

PIAC welcomes the opportunity to respond to the Department of Health Care and Ageing's Discussion Paper *Aged Care Complaints Scheme: Proposed Complaints Management Framework* (hereafter described as 'the Discussion Paper').

PIAC's 2010 Complaints Submission set out five principles of good complaint management. These are:

- *Transparency and accountability:* that any organisation or authority that affects the rights of individuals should have clearly defined powers and be accountable.
- *Separation of powers:* that there is a clear separation between the role of regulation of accreditation and standard-setting matters; the purchaser of services; and the role of assessment, investigation and prosecution of disciplinary and performance matters.
- *Independence, expertise and timeliness:* that investigation and prosecution should be carried out by an independent body that employs dedicated officers to carry out these tasks in a timely manner.

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2 Peter Dodd, *Maintaining a consumer focus in health complaints: the key to national best practice* (2008) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/sub2008112_20081124.html> at 23 March 2011.

3 Peter Dodd, Enhancing the rights-based approach to health care complaints in NSW (2008) Public Interest Advocacy Centre http://www.piac.asn.au/publications/pubs/sub2008121_20081212.html at 23 March 2011.

4 Peter Dodd, Putting healthcare rights to work (2009) Public Interest Advocacy Centre http://www.piac.asn.au/publications/pubs/sub2009071_20090717.html at 23 March 2011.

5 Brenda Bailey, Consumer Protection: a submission to the review of the Aged Care Complaints *Investigation Scheme* (2010) Public Interest Advocacy Centre http://www.piac.asn.au/publication/2009/09/090831-piac- aged-care-cis-sub at 23 March 2011.

6 Brenda Bailey, *Health Care Rights for Older Australians (2010*) Public interest Advocacy Centre http://www.piac.asn.au/publication/2010/08/health-care-rights-older-australians at 23 March 2011.

- *Free from perceived bias:* that there should be no potential for perception by consumers that the system is structured so that the service providers can protect their organisations and personnel at the expense of protecting the public interest and consumer safety
- *Procedurally fair, open and transparent:* that the processes to determine serious matters of abuse and neglect should comply with the rules of procedural fairness and be conducted in an open and transparent manner. Written reasons should be provided for all decisions. Hearings should be open unless there is a compelling reason for them not to be. All parties including the complainant should have a right to request a review of a decision, which should be conducted at arms length from the original decision-maker.

These principles form the foundation and starting point for PIAC's response to the Discussion Paper. All forms of responses to aged care complaints, whether they are based on alternative dispute resolution (ADR) models or based on a more formal investigation model, should conform to these principles.

PIAC's 2010 Complaints Submission made the following ten recommendations:

Recommendation 1: Transparency and accountability

That the Aged Care Compliant Investigation Scheme:

a) make statistical data about complaints, including a description of the type of breaches and the naming of service providers, available to the public on a quarterly basis;
b) report to a Joint Parliamentary Committee;
c) have its statutory requirements strengthened to ensure it provides feedback to complainants with detailed reasons for decisions.

Recommendation 2: Create an independent organisation

That the Aged Care Compliant Investigation Scheme:

a) legislation be amended to create a statutory body independent from the Department of Health and Aged Care;
b) be granted powers that ensure that review decisions of the Aged Care Commissioner are binding and not able to be overturned by the Department of Health and Aged Care;
c) be granted powers to allow it to undertake or direct broader investigations, inquiries and reviews;
d) is provided with sufficient funds to undertake public information campaigns about the scheme; and how to engage in the complaint processes.

Recommendation 3: Expertise

That the Aged Care Compliant Investigation Scheme improve training of CIS staff by including modules on helping complainants resolve complaints that will not be investigated by the CIS; and to improve their knowledge of medical systems and legal frameworks within each state and territory.

Recommendation 4: Timeliness

That the Aged Care Compliant Investigation Scheme meet mandatory time limits for initial assessments and each stage of the investigation of complaints.

Recommendation 5: Form of complaints

That the Aged Care Compliant Investigation Scheme maintains the current provisions of allowing investigation of complaints:

a) that are communicated orally or in writing;
b) that are anonymous; and/or
c) where the complainant wishes his/her details to remain confidential.

Recommendation 6: Communicating investigation outcomes

That the Aged Care Compliant Investigation Scheme:

a) must provide written responses, including a full description as to how the issues raised were dealt with, to the complainant and the service provider;
b) must provide written responses to the complainant at each stage of the investigation, including detailed reasons for decisions;
c) formalise the circumstances where the right to a written response can be denied or deferred.

Recommendation 7: Consumer advocates

That the Aged Care Compliant Investigation Scheme be provided with funds to provide consumers and their family carers with access to assistance from independent advocates.

Recommendation 8: Protecting complainants

That the Aged Care Compliant Investigation Scheme be granted powers to recommend sanctions or prosecution against anyone who intimidates or otherwise victimises a complainant or a witness in support of the complaint.

Recommendation 9: Acceptance of complaints

That the Aged Care Compliant Investigation Scheme:

a) be funded to conduct a public information campaign to encourage appropriate direction of complaints, that explains the purpose of CIS and what it investigates;
b) accept complaints of incidents that occurred up to five years prior, or at least an ability to apply for an extension of time past the current 12-month time limit;
c) be permitted to investigate complaints that do not name an individual at risk.

Recommendation 10: Review process

That the Aged Care Compliant Investigation Scheme and the Aged Care Commissioner:

a) accept lodgement of requests for reviews of decisions up to 28 days following the decision;
b) accept applications for review of decisions from all relevant parties (being parties affected by the decision), including notifiers, complainants and industry, after every significant decision.

All these recommendations are relevant, to some degree, to the issues raised in the discussion paper.

Relevant to Recommendation 1, whatever the nature of a response to a complaint (i.e. whether it is an investigation, the use of ADR options or declining to deal with the complaint), the Aged Care Complaint Investigation Scheme must be transparent and accountable.

Mandatory reasons, provided in writing, to both the complainants and the respondents to complaints, for any decision (assessment decisions and outcomes from investigation) must be part of any future aged care complaints scheme.

Recommendation 2 reflects an important principle ('Investigation and prosecution should be carried out by an independent body that employs dedicated officers to carry out these tasks in a timely manner').
The *Review of the Aged Care Complaints Investigation Scheme* (the 'Walton Report')[7] sets out the reasons why aged care complaints' assessment, investigation and resolution should be carried out by an independent body. PIAC endorses these principles and the reasons set out in the Walton Report.

Independence means that assessment decisions and decisions consequent to investigations cannot be overturned or ignored by the relevant Department or the relevant Minister. PIAC recommends a change in the current legal and administrative frameworks to implement this change. This would remedy the most significant concern that consumers have about the existing aged care complaints system.

Recommendation 3 is very relevant to the issues raised in the Discussion Paper. If staff are involved in either investigation or a form of less formal resolution of an aged care complaint, they should have a degree of knowledge of the health system and the system of healthcare complaints in the jurisdiction they are operating. Further education and training should lead to better understanding and coordination of complaints about aged care.

Recommendation 4 is also relevant. Legislative time frames should be also imposed on alternative dispute resolution strategies. Otherwise, resolution of complaints could be delayed by bureaucratic inaction or stonewalling by aged care providers.

Recommendation 5 is also important and relevant. Generally speaking, complaints should be able to be received verbally, rather than necessarily in writing. Many complaints do not necessarily require formal investigation, but do require urgent resolution. The future aged care complaints system should be sufficiently resourced, and sufficiently flexible, so that verbal complaints can be quickly resolved in appropriate circumstances. If the system has this capacity, escalation of conflicts and communication failures can be avoided, with appropriate benefits to consumers, as well as facilitating significant cost savings by avoiding unnecessary extended complaints processes.

PIAC notes with approval that one of the key features of the proposed framework in the Discussion Paper at page 7 is 'clearer procedures for detecting and prioritising complaints that require immediate investigation by the Scheme'. If verbal complaints are accepted and quickly acted upon, this can be more effectively achieved.

Anonymous complaints are important to any effective system of aged care complaints. Aged care professionals and allied workers often are reluctant to make complaints about their employers and/or fellow workers because of fear of retribution or dismissal. Anonymous complaints cannot

7 Merrilyn Walton, *Review of the Aged Care Complaints Investigation Scheme* (2009) 12-13.

be resolved by informal resolution or conciliation. However, if the allegations made in an anonymous complaint raise prima facie serious matters, regarding potential risk of harm to patients in aged care facilities, they should always be investigated.

Recommendation 6 also is relevant to all categories of complaints resolution. Reasons, in writing, should be provided to all parties after assessment of complaints and after an investigation of a complaint is completed. If matters are referred for supported resolution, conciliation or approved provider resolution, there still should be an obligation on the part of the independent body responsible for aged care complaints to confirm the outcome of the resolution process with all relevant parties.

Recommendation 8 is very relevant to PIAC's response to the issues raised in the Discussion Paper. PIAC is firmly of the view that independent advocates for consumers should be an essential part of any future system of aged care complaints which utilises alternative dispute resolution strategies, particularly supported resolution and approved provider resolution. (This is a matter we expand on below).

Recommendation 9 refers to PIAC's view that there should not be pressure on consumers and families of consumers to make complaints within a short timeframe. This is particularly relevant to complaints that involve the death of a family member, where it may be difficult, because of the grieving process, for family members to make a complaint soon after that death.

Finally, referring to recommendation 10, PIAC submits that there should always be the opportunity for complainants to seek a review of assessment decisions and the outcome of investigations. This should involve wide-ranging internal review provisions, and a provision for a more limited appeal to the Administrative Appeals Tribunal. This issue is canvassed below.

2. Response to the Discussion Paper

2.1 Overview of the Framework

PIAC agrees with the general idea of using ADR strategies for complaints where there has been a decision not to investigate the complaint.

The Discussion Paper asks the question:

> Should the Scheme have the power to require complainants to take reasonable steps to resolve their issues in the complaint with the approved provider before the Scheme will take action in response to the complaint? If so, why? If not, why not?

PIAC does not believe there should be a requirement to resolve issues with a provider before the Scheme deals with a complaint. While we do not object to encouraging some complainants to seek their own resolution, this should not be mandatory.

There are many complainants, for example those from disadvantaged groups or people with a mental illness or an intellectual disability, who do not have the skills or capacity to effectively advocate for themselves in negotiation directly with a provider.

Crucial to PIAC's view on these matters is the contention that consumers and providers are not on an equal footing in the resolution of complaints. Aged Care providers have the resources of either government or private enterprise (and sometimes of the community sector) to answer and deal with complaints. They hold the overwhelming majority of any written documentation relevant to any given complaint. Consumers have to seek access to this information. Large private sector providers of aged care often have large and well-funded complaints and risk management departments, with dedicated officers skilled in complaints handling. Consumers just cannot match these resources.

Consumers and/or their family and friends, are unlikely to have the skills or temperament to match the skills and relative dispassionate approach of complaints managers, general managers and health professionals when trying to resolve a complaint without advocacy or assistance. They are often angry and frustrated with a provider before they make a complaint. Complaining relatives and friends, after the death of a family member or friend, are also likely to be going through different stages of the grieving process, at the very same time as the complaints resolution process is taking place.

This means, that, particularly after a critical incident, consumers or their family and friends are not in the right frame of mind to negotiate a successful and appropriate resolution that responds to their concerns; at least, not without the assistance of dedicated advocates.

The Discussion Paper also asks the following question:

> Should the non-investigative resolution processes outlined above be available to all complainants (staff or other interested parties)? Or should these resolution methods be limited to care recipients and their representatives? If so, why? If not, why not?

PIAC's response to this question is based on its position that to both fairly and efficiently operate a scheme that utilises the resolution options set out in the discussion paper, there must be available to complainants, a funded and independent advocacy service that can assist the complainant in resolving their concerns that led to the complaint.

As stated above, providers have the resources to provide effective advocacy on their own behalf. Providing complainants with advocacy services, because of the power and resource imbalances set out above, simply levels the playing field, rather than providing any advantage to complainants.

PIAC believes that the above question is based on a false premise — that is, that providers can initiate complaints. PIAC does not understand the purpose of the question in that none of the ADR options set out in the Discussion Paper could possibly work without the consent and (some) participation from the complainant and the provider. Staff, if they have interests, separate to the interests of the provider, that need to be protected in resolution processes are able to seek advice from professional organisations and unions, and in the case of medical practitioners, medical defence unions.

The Walton Report emphasised the importance of the principle of natural justice (or procedural fairness) in dealing with aged care complaints. PIAC supports the adherence to the rules of

procedural fairness in aged care complaints. However, these rules have been developed to protect the rights of the respondents to complaints, more than to protect complainants.

PIAC develops its argument about the need for independent advocacy services as an essential part of ADR options below.

2.2 Assessment and response framework

PIAC supports the inclusion of this or a similar framework in any future aged care complaints scheme.

2.3 Investigation by the scheme

PIAC has no objection to the proposed referral criteria for investigation set out in the Discussion Paper.

However, PIAC is concerned that the model of internal merits review proposed in the Discussion Paper does not represent best practice. PIAC is concerned that the Discussion Paper seems to suggest that the Aged Care Commissioner would consider and determine appeals/reviews of his or her assessment and post-investigation decisions. PIAC believes that there should be some sort of 'Chinese walls' between those making the initial decisions and those undertaking the internal review process.

2.4 Supported Resolution - Advocacy

PIAC accepts the concept of supported resolution and its inclusion in the models of complaint management in any future independent aged complaints resolution scheme.

As stated above, PIAC believes that with regard to supported resolution (and approved provider resolution), complainants should have the assistance of independent advocates in the resolution process.

The model for this scheme should be the New Zealand (NZ) Health and Disability Advocacy Service. This service was established in 1996, under the NZ Health and Disability Commissioner's legislation, as a result of the Cartwright Inquiry[8] recommendation that there was a need for advocates to be on the side of the consumer to ensure their healthcare rights were upheld.

The Advocacy Service is a free service available to any person in NZ who has a concern or a complaint about a health or disability service. The Advocacy Service also deals with complaints referred by the Health and Disability Commissioner. The NZ model is very similar to the proposed supported resolution model, except that, in NZ, the independent advocates play an active role, on behalf of the complainant, in initiating and guiding the resolution process.

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8 Silvia Cartwright, an Auckland District Court Judge was appointed by the NZ Minister of Health, Michael Bassett in June 1987 to conduct an Inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital, and other related matters. The *Report of the Committee of Inquiry* is found at http://www.nsu.govt.nz/current-nsu-programmes/3233.asp at 22 March 2011.

Significantly, the NZ service operates independently of the Health and Disability Commissioner, practitioners/providers, government agencies and organisations' funding services. Advocates also have a key education role, in that they provide education sessions for both consumers and providers, to promote awareness and understanding of the rights of consumers, and responsibilities of providers as outlined in the Code of Health and Disability Services Consumers' Rights. “Health and disability advocates use what is called ‘empowerment advocacy’ to assist or act on behalf of a consumer. This requires them to direct the process to assist the consumer to resolve his or her complaint rather than directing the content of the complaint.”[9]

PIAC notes that services, such as the Aged Care Rights Service (TARS) in NSW, have been previously funded to provide advocacy services for complainants to assist them with the resolution of their complaints and concerns about aged care services. PIAC would be very concerned if there were no specifically funded advocacy services available to assist complainants with supported resolution under the scheme.

2.5 Approved Provider Resolution

While PIAC does not object to the inclusion of approved provider resolution, PIAC is very cautious about endorsing extensive use of this option. PIAC would certainly not endorse approved provider resolution unless there is a free and accessible advocacy service that can assist a complainant in resolving the complaint with the provider.

Most complainants have tried one form or another of informal resolution before they make a formal complaint. Unless advocacy services are also provided, many consumers would therefore perceive that a process to refer a complaint back to the provider, as a rejection or abrogation of responsibility to resolve their complaint.

There also should be strict report back responsibilities placed on the provider in these circumstances. These reporting obligations should not only include report back on the outcome of the resolution process, but also on the details of the methods used to try to resolve the complaint.

The scheme should also have a proactive role in educating and training providers and their staff in the skills and concepts involved in best practice complaints resolution. Monitoring the results of approver provided resolution has the potential to be part of this process.

2.6 Conciliation and Mediation

PIAC supports these forms of ADR being available in aged care complaints resolution. Conciliation and mediation are particular recognised (and accredited) skills. Conciliation and mediation should always be carried out by persons with relevant experience and accreditation.

Free, accessible and appropriately funded advocacy services should be available to assist complainants in conciliation and mediation processes. PIAC does not support any restriction on the participation of lawyers or advocates in these forms of ADR.

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9 Health and Disability Advocacy (NZ) *Models of Advocacy* <http://advocacy.hdc.org.nz/resources/models-of-advocacy>at 21 March 2011

If a person is a conciliator or a mediator, he or she is potentially conflicted if they play another subsequent role in the complaints process. The scheme should consider using independent conciliators and arbitrators in the community. In NSW, it might be possible to come to agreement with the Health Conciliation Registry (HCR)[10] for facilitators. The HCR uses accredited conciliators in the community as one option in the Health Care Complaint's Commission complaints resolution processes.

2.7 Post–Investigation Conferencing

PIAC supports the concept of post-investigating conferencing. Complainants should have the opportunity to access free advocacy services to assist them at the post-investigation conference.

2.8 Review Rights

PIAC is concerned that the Discussion Paper does not advocate the general principle that there should be opportunity for complainants and providers to seek an internal review of significant decisions made in the complaints investigation and resolution processes.

PIAC submits that it is unrealistic to suggest, as the Discussion Paper does on page 17 for example, that a 'decision to resolve the complaint using supported resolution processes is a decision made by the complainant, not the scheme'. Whilst not suggesting that participation in supported resolution should be forced or compulsory, a complainant would, in most situations, be offered one of the ADR options, only in situations where the complaint is not being investigated because it failed to meet the referral criteria for investigation. The complainant then would have the limited choice of the offered ADR option, or no action at all.

A complainant, in this situation, should be able to seek a review of the assessment decision not to formally investigate the complaint. For example, s.28(9) of the *Health Care Complaints Act 1990* (NSW) states that the Commissioner must review assessment decisions if the request for review is made within the 28 days after an assessment decision.

PIAC, on the other hand, agrees that decisions and/or agreements that come out of the Supported Resolution and Approved Provider Resolution processes are voluntary agreements, and not administrative decisions that would be subject to internal merits review. With regard to conciliation and mediation, PIAC agrees with the propositions stated in points 62 and 70 on pages 24 and 26 respectively of the Discussion Paper.

2.9 The Charter of Healthcare Rights

PIAC has consistently supported the need for a national health rights charter and welcomed the decision of Australian Health Ministers to adopt the *Australian Charter of Healthcare Rights*[11] in 2008. PIAC believes the next step is to give some power of enforcement to the Charter.

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10 See Parliament of NSW, Committee on the Health Care Complaints Commission, *Discussion Paper on the Health Conciliation Registry* June 2004 http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/AEA605DC0160D679CA256EA90020A7C7 at 22 March 2011

11 The Australian Commission on Safety and Quality in Health Care*, Australian Charter of Healthcare Rights*< http://www.health.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01> at 22 March 2011

PIAC submits that the Charter of Healthcare Rights should be enforceable, and that breaches of the Charter, if they apply to aged care, should be the subject of complaints under any future aged care complaints scheme.

PIAC submits that such a provision is not without precedence in Australian law. Section 12 of the *Human Rights Commissioner Act 2005* (ACT) provides that:

> (1) A person may complain to the Commission about a health service if—
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> (a) the service is not being provided appropriately; or
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> (b) the person believes that the provider of the service has acted inconsistently with any of the following:
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> (i) the health code;
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> (ii) if there is no health code—the health provision principles
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> (iii) a generally accepted standard of health service delivery expected of providers of the same kind as the provider;
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> (iv) any standard of practice applying to the provider under the Health Professionals Act 2004 ;
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> (v) the National Standards for Mental Health Services endorsed by the Australian Health Ministers Advisory Council's National Mental Health Working Group, as amended from time to time;
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> (vi) any other standard prescribed by regulation; or
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> (c) the service is not being provided.

The ACT legislation provides a model as to how the conduct and competence of health practitioners can be tested against both the traditional 'peer review' centred standards and objective standards, such as the *Charter of Healthcare Rights*.

Another relevant example is the *Health and Disability Commissioner Act* 1994 (NZ). The purpose of that legislation, set out in section 6, is to

> promote and protect the rights of health consumers and disability services consumers, and, to facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringement of those rights.

The relevant rights of consumers are set out in the *Code of Health and Disability Services Consumers' Rights.* Complaints are either considered using the Code as a benchmark or if they are against health professionals, can be channelled into a disciplinary stream, as in Australian jurisdictions. Matters can be referred to the New Zealand Human Rights Review Tribunal that has the power to make a declaration that an individual's actions are in breach of the Code and has powers to issue restraining orders if necessary. As referred to above, New Zealand Health and Disability Advocacy Service also plays a vital role in providing advocacy for consumers in complaints that are not referred to an investigation and/or disciplinary stream.

PIAC submits that these models show that the traditional tests applying standards of care can operate side by side with benchmarks that are more focused on consumer rights.