Submission No 7

INQUIRY INTO PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

Name: Dr Marie Dela Rama

Date Received: 26 January 2021

Management Discipline Group
UTS Business School

26th January 2021

Select Committee
Legislative Council
NSW Parliament

Dear Committee,

Re: Submission to the Inquiry into the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020

I welcome the formation of this Select Committee to investigate the amendment to the NSW Public Health Act to ensure there are registered nurses in aged facilities in NSW and acknowledge the role of the Committee's Deputy Chair Mark Banasiak in proposing this amendment.

The passing of this amendment is a necessary step towards ensuring elderly vulnerable Australians in institutional settings are protected. It is in aged care that evidence based research seems to be ignored and policy decision making is done as a favour to connections rather than on its merits.

I write this submission as a management researcher who first documented the entry of private equity into aged care in 2007 and have seen the dysfunction of

the sector as the care motive was subsumed by the profit motive of operators in the intervening years.[1] [2]

Ineffective Federal regulation, opacity, dysfunction and harm.

The dysfunctional Federal response in aged care was magnified during COVID, especially those in privately-owned and privately-run aged care facilities where 685 deaths occurred in such facilities, mainly in NSW with 61 deaths (including in Anglicare Sydney's Newmarch House) and Victoria with 655 deaths.[3]

It took the Federal Senate COVID Committee under the chairmanship of Senator Katy Gallagher to persistently request the Federal Department of Health for the public disclosure and transparency of which aged care facilities had COVID deaths owing to that Department's reluctance, and most inappropriate and defensive response that such disclosure will result in the reputational damage of providers.[4] I even created my own Google Maps in April 2020[5] to chart out where COVID cases were occurring in aged care due to the information blackhole that came from the Federal Department of Health. The Commonwealth only started disclosing such information in September 2020, nine months after the first COVID case in aged care at Dorothy Henderson Lodge in Macquarie Park in March 2020.

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[1] dela Rama, M. (2007) Aged care money may be heading in the wrong direction, *The Age*, 17 September https://www.theage.com.au/business/aged-care-money-may-be-heading-in-wrong-direction-20070917-ge5u89.html

[2] dela Rama, M. et al (2010) Honourable Intentions? Analysing the interests of private equity in the aged care sector, *Third Sector Review*, 16 (3): 63-82

[3] Australian Department of Health (2021) COVID19 cases in aged care services – residential care https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#cases-in-aged-care-services

[4] Senate Select Committee on COVID-19 (2020) Parliamentary Inquiry Question on Notice to the Department of Health, List of residential aged care facilities with positive tested COVID-19 cases, PDR Number: IQ20-000107, 6 May https://www.aph.gov.au/DocumentStore.ashx?id=2cf8c29a-20aa-45b6-b465-ce53a1027221

[5] COVID19 outbreaks in Australian Aged Care https://www.google.com/maps/d/viewer?mid=1cElPbpg6STxXG4RWkU784a9diKqfcSJE&usp=sharing

The Federal bureaucracy and the Federal aged care minister's stance demonstrate that, at this point in time, the Commonwealth is unfit and unable to regulate the sector as it holds the interests of politically-connected providers above those of the community during a once in a century pandemic. Their stance is thus, despite the Federal funding of the sector at $22.6B this financial year.[6]

In addition there is little transparency on COVID cases in Federally-run home care as the Commonwealth Health Department does not disclose which home care providers have had cases of COVID.

The owners, operators and providers in the aged care sector have been treated differently compared to other sectors of the economy such as childcare, fitness, hospitality and retail. In these industries, operators that have had COVID have been publicly named to inform the community that cases have occurred at these places to heighten and raise awareness of COVID of cases. This helps in ensuring there is transparency around their cases. In comparison, there is a sectoral reluctance in aged care to disclose any information at all despite receiving public funding.

The Federal COVID response in aged care has resulted in Australia having three-quarters of its COVID deaths occurring in residential aged care.[7] This response is morally irresponsible and indefensible, with Commonwealth-sanctioned sectoral manslaughter occurring due to inadequate regulation and supervision.

It is clear that in its current form, the Federal response in aged care has been inadequate to respond to the continuous neglect that remains and persists in this sector. The market failure in this sector continues.

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[6] p.12 from Aged Care Financing Authority (2020) Eight report on the Funding and Financing of the Aged Care Industry, July 2020
https://www.health.gov.au/sites/default/files/documents/2020/07/eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2020-eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-may-2020_0.pdf

[7] Senate Select Committee on COVID-19 (2020) Chapter 4 Health response part II: aged care, First Interim Report, Commonwealth of Australia
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/COVID-19/COVID19/Interim_Report/section?id=committees%2freportsen%2f024513%2f73415

Due to ineffective responsibilities, oversight, the endless revolving door between the regulators and the regulated (previous CEOs of the Commonwealth's aged care regulatory agency now work for providers after their terms have ended including Mark Brandon formerly CEO of the Aged Care Standards and Accreditation Agency now at Estia Health and Nick Ryan previously at industry lobby group Leading Aged Services Australia before becoming CEO of the Australian Aged Care Quality Agency and now at Lutheran Services) , and ineffective regulation, has resulted in elder abuse in the sector, conservatively estimated at 40%.[8]

Without transparency, adequate supervision and responsive regulation, abuse in aged care will continue to proliferate.

In addition to COVID's magnification, the horror stories that have come out of the Aged Card Royal Commission demonstrate the lacklustre and ineffective regulation since the passing of the Federal 1997 Aged Care Act. The numerous reports and Federal inquiries into the sector since 1997 have resulted in little or no change at all. The culture of the sector results in the acceptance of elder abuse as a norm, rather than a criminal act. It is ironic that there is little care in aged care.

With the publication of the 2000 Federal Cabinet papers which revealed that the then Federal Aged Care Minister, Bronwyn Bishop, refused to have mandatory staffing ratios return[9] due to the lobbying by politically connected providers (such as Doug Moran who was instrumental in writing certain passages of the 1997 Aged Care Act[10]), the regulatory culture on the Commonwealth level has

[8] Aged Care Royal Commission (2020) Elder abuse in Australian aged care facilities, Research Paper, December https://agedcare.royalcommission.gov.au/news-and-media/elder-abuse-australian-aged-care-facilities

[9] pp.16 and 17 from National Archives of Australia (2020) The 2000 Cabinet Papers in Context: Associate Professor Chris Wallace https://www.naa.gov.au/sites/default/files/2020-12/cabinet-essay-2000.pdf

[10] Bagwell, S. (1997) How Doug Moran looks after himself, *Financial Review*, 18 October https://www.afr.com/politics/how-doug-moran-looks-after-himself-19971018-k7pj4

been dysfunctional and industry captured ever since - resulting in the disaster that we see today.[11]

It is clear that in the absence of effective Commonwealth regulation and supervision of the sector, the responsibility of oversight and regulation must now be exercised at the State level to ensure that vulnerable elderly Australians are looked after in their twilight years. Thus, I welcome this amendment.

Terms of reference

My response the terms of the committee are set out below:

(a) *the need to have a registered nurse on duty at all times in nursing homes and other aged care facilities with residents who require a high level of residential care,*

Agreed.

There must be an RN as a bare minimum 24/7 at an aged care facility that receives government (Federal or State) funding. There must also be public disclosure of the ratio of RN to aged care residents. Since the 1997 Federal Aged Care Act removed this requirement under the guise of deregulation and red tape reduction, the dysfunction in aged care has become catastrophic.

The Australian Nursing and Midwifery Federation (ANMF) have been active in their campaign to have mandatory RNs in aged care and they have compiled research that support that RNs in aged care provide a safe environment for both the employees and residents of the facility. [12]

[11] dela Rama, M. (2019) Lobby Groups and the Australian Aged Care Sector, 1 October https://medium.com/lobbywatch/lobby-groups-and-the-australian-aged-care-sector-ced7d9babf18

[12] See ANMF https://anmf.org.au/campaign/entry/ratios-for-aged-care

International academic researcher Emeritus Professor Charlene Harrington of the University of California San Francisco has investigated the performance of poorly run nursing homes based on lack of experienced staff such as RNs. [13]

The Queensland Government has also passed the Health Transparency Act (2019)[14] in light of the Earle Haven debacle, [15]another aged care event that demonstrated the debacle between Federal and State confusion over responsibilities and regulation.

The Victorian Government passed its Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act in 2015 to make mandatory nurses and staffing ratios in their publicly-owned aged care facilities. [16]When COVID swept through the Victorian winter in 2020, this legislation protected the aged care residents in Victoria's state-owned aged care facilities. Not a single aged care death from COVID has occurred in a government-owned aged care facility in Victoria.[17] This is one of the few successes from that state's experience of COVID.

The COVID aged care catastrophe in Victoria also provides crucial evidence to the deep flaws in the private for profit aged care business model which the Commonwealth Government does not wish, nor seem, to acknowledge.

Having a requirement to have RNs 24/7 in aged care to be responsible for a populace that has comorbidities is a no-brainer but due to the lobbying by providers and their lobby groups in the aged care sector in Canberra, this

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[13] UCSF (2021) Profile: Charlene Harrington – list of publications https://profiles.ucsf.edu/charlene.harrington#toc-id4
[14] Queensland Legislation (2019) Health Transparency Act https://www.legislation.qld.gov.au/view/whole/html/asmade/act-2019-038
[15] Commonwealth Department of Health (2019) Inquiry into events at Earle Haven https://www.health.gov.au/resources/publications/inquiry-into-events-at-earle-haven
[16] Victorian Department of Health (2020) Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015, https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act
[17] Commonwealth Department of Health (2021) COVID-19 outbreaks in Australian residential aged care facilities https://www.health.gov.au/resources/collections/covid-19-outbreaks-in-australian-residential-aged-care-facilities

baseline requirement has become politicised. The evidence demonstrates that having RNs and qualified staff reduces harm in aged care.

This proposed bill must reflect the needs of the community, not the politically-connected few who enrich themselves on taxpayer funding. Safe care of the elderly must be the goal of any government that regulates aged care. While Federal Senator Stirling Griff has tried unsuccessfully twice to pass his financial transparency bill to ensure that taxpayer funds are being expended on what they are meant for (the care of the elderly and not reward the rent-seeking behaviour of some providers)[18], the current Commonwealth Government has been most reluctant to shine light on the financial affairs of its taxpayer funded providers. This, despite that as a Federally funded and regulated sector, the use of offshore financial vehicles by some aged care owners to reduce their tax obligations in this country should be prima facie be overseen by AUSTRAC and the Australian Federal Police.

Events such as Earle Haven, Newmarch House and Victoria's multiple COVID cases in private aged care point to the obvious need to have State, and not Commonwealth, regulation of the sector.

(b) the impact registered nurses have on the safety and dignity of people in care,

As above.

In particular, the research conducted by the ANMF, the rationale by the Victorian Department of Health in passing the Safe Patient Care Act (2015), the explanatory notes[19] behind Queensland's Health Transparency Bill (now Act) and the Aged Care Royal Commission's interim report, entitled Neglect. [20]

[18] Griff, Stirling (2020) Aged Care Legislation Amendment (Financial Transparency) Bill 2020, 30 November https://stirlinggriff.com.au/senate/speeches/aged-care-legislation-amendment/
[19] See p.3 of the State of Queensland (2019) Health Transparency Bill 2019 Explanatory Notes https://www.legislation.qld.gov.au/view/pdf/bill.first.exp/bill-2019-011
[20] Aged Care Royal Commission (2020) Interim Report https://agedcare.royalcommission.gov.au/publications/interim-report

(c) the impact on residential care of a lack of registered nursing staff on duty in a nursing home or other aged care facility at all times,

See response to (b). In the absence of Federal urgency, the State Government must intervene and improve the lives of aged care residents in NSW.

(d) the need for further regulation and minimum standards of care and appropriate staffing levels in nursing homes and other aged care facilities,

See response to (b). In the absence of Federal urgency, the State Government must intervene and improve the lives of aged care residents in NSW.

(e) the administration, procurement, storage and recording of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings,

I raise concerns about the ability of the current aged care workforce to handle complicated administration, procurement, storage and recording of medication, and resultant responsibility from failure to properly do the above tasks. The workforce is predominantly female, underpaid and unskilled (with many holding Certificate III qualifications) employed in poor working conditions.[21]

Hiring of such a workforce is the domain of aged care providers. The onus is on providers who hire unqualified and unsuitable staff (to avoid the resultant higher pay grade) and they must be held accountable for their hiring decisions. The existing workforce reflects poorly on the race-to-the-bottom decision by some owners and operators in the sector. There must be a minimum requirement and threshold for those who are responsible in dispensing

[21] Senate Standing on Community Affairs (2017) Chapter 3: Attracting, training and retaining aged care workers in Future of Australia's Aged Care Sector Workforce Report https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report/c03

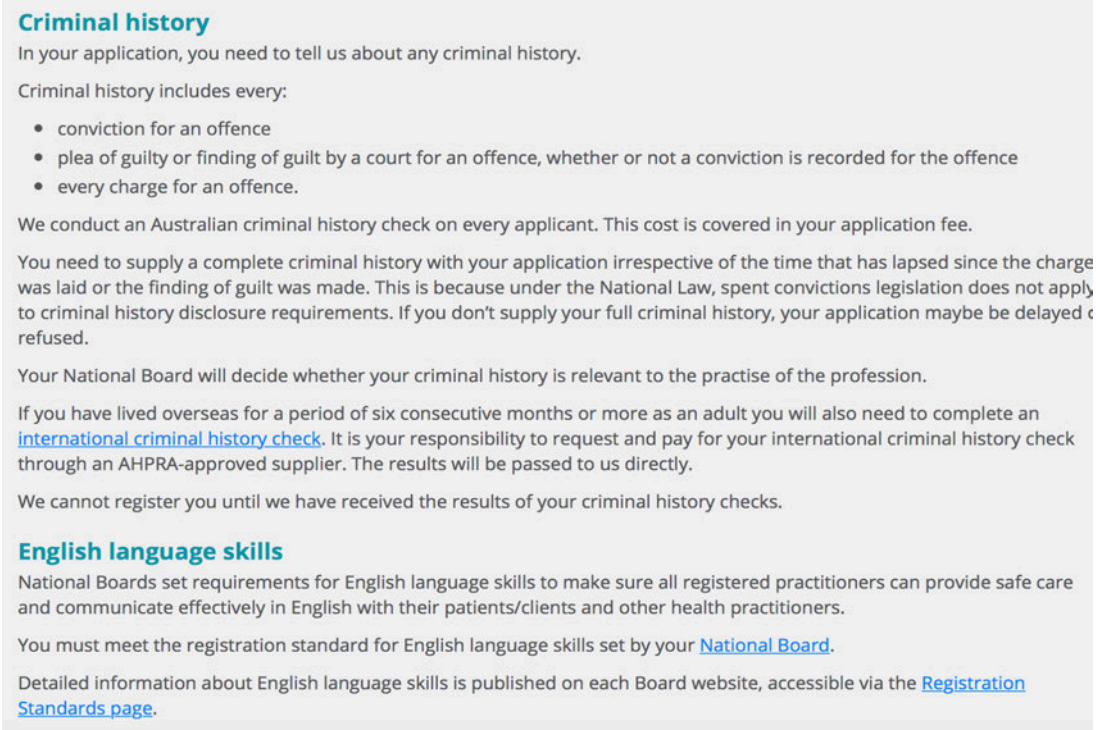
medication and that would require professional (such as RNs, pharmacists and other medical staff) and not unskilled staff to bear such responsibility.

There is also no registration required for non-RN employees in aged care such as the requirement for RNs to be registered with AHPRA.[22] The community must have confidence that staff members in aged care are tasked to do what they are qualified to do so, and not be expected to over-reach their qualification and be tasked with issues that are beyond their scope or skill set.

All aged care employees with direct care responsibilities should be covered by a registration scheme. It may be possible to have such a registration scheme to be State based rather than wait for the Commonwealth to act.

As with many things in aged care, one does not need to reinvent the wheel. The processes and oversight of AHPRA have shown what a body should do to operate a registration scheme. They already have extensive information when it comes to criminal history checks and English language requirements as the screenshot from the AHPRA website below shows:

[22] Australian Health Practitioner Regulation Agency (AHPRA) https://www.ahpra.gov.au



Criminal history

In your application, you need to tell us about any criminal history.

Criminal history includes every:

- conviction for an offence
- plea of guilty or finding of guilt by a court for an offence, whether or not a conviction is recorded for the offence
- every charge for an offence.

We conduct an Australian criminal history check on every applicant. This cost is covered in your application fee.

You need to supply a complete criminal history with your application irrespective of the time that has lapsed since the charge was laid or the finding of guilt was made. This is because under the National Law, spent convictions legislation does not apply to criminal history disclosure requirements. If you don't supply your full criminal history, your application maybe be delayed refused.

Your National Board will decide whether your criminal history is relevant to the practise of the profession.

If you have lived overseas for a period of six consecutive months or more as an adult you will also need to complete an international criminal history check. It is your responsibility to request and pay for your international criminal history check through an AHPRA-approved supplier. The results will be passed to us directly.

We cannot register you until we have received the results of your criminal history checks.

English language skills

National Boards set requirements for English language skills to make sure all registered practitioners can provide safe care and communicate effectively in English with their patients/clients and other health practitioners.

You must meet the registration standard for English language skills set by your National Board.

Detailed information about English language skills is published on each Board website, accessible via the Registration Standards page.

Source: AHPRA webpage *https://www.ahpra.gov.au/registration/registration-process.aspx*

However, given the current remit of AHPRA and the resources required, it may be more timely to establish a state board body. This administrative body can be called the NSW Aged Care Employee Regulation Board (NSW ACERB) under the aegis of NSW Health. This board could cover personal care workers and other aged care employees not covered by existing Federal oversight.

Given the community demand and expectations for high quality and safe aged care, the first year's registration to the NSW ACERB should be free for registrants given the amount of paperwork that would be required. From the second year and onwards of registration, a nominal amount to reflect the low wages of aged care workers, such as $50 per year could be considered. The NSW ACERB would set out the minimum training provisions and would monitor the requirements for ongoing training and upskilling, enforcement, and deregistration when necessary.

(f) the potential for cost-shifting onto other parts of the public health system as a result of any legislative change to the current provisions for care in nursing homes or other aged care facilities,

From aged care experiences such as Earle Haven and Newmarch, when the private aged care sector fails in their duties to look after their aged care residents, it inevitable and nominally falls on the public sector to intervene and rescue them. A generation of deregulation, privatisation and neoliberalism has resulted in fewer government-owned facilities. Outsourcing our health and aged care responsibilities to those with business models that focus on profit and not the care has resulted in human rights abuses. It is the taxpayer that underwrites and intervenes in the sector when it fails. The potential cost-shifting in privatisation has resulted in a more expensive sector as taxpayer funds are used inefficiently.

Ideally, an aged care facility must be attached to a public hospital that has aged care/gerontological expertise.

In Sydney, we have two major children's hospitals: Westmead (affiliated with Sydney University and Randwick (affiliated with UNSW). These two hospitals have some of the world-leading and world's best practice when it comes to care of children. For us to envisage world's best practice aged care, ideally we should have two major geriatric hospitals that are also research and teaching hospitals.

In Sydney, there are two hospitals that have notable geriatric wards – Concord Repatriation and Prince of Wales. We can use the existing resources and repository of knowledge these hospitals already have and build with the necessary resources to turn them into fully-fledged world-class geriatric hospitals. There should also be associated research facilities in gerontology and aged care innovation in these two hospitals to attract the world's best researchers in this area.

This centralisation of best-practice aged care clinical knowledge in these two hospitals will give us the network model of care whereby doctors specialising in aged care and gerontology, aged care nurses and allied health can undergo further training in these two hospitals. Their expertise can then be accessed by

those providing or in receipt of care. The "flying squad" would be based out of these hospitals. Similar to the Royal Flying Doctor Service, an aged care RFDS can be deployed to help regional or rural areas in dearth of clinical care[23].

The promotion of best-practice aged care also returns this responsibility to the Health system instead of the illusion that hotel facilities are perfect substitutes for nursing care. The two-tiered system in aged care we now have can formally evolve to those that supply hospitality services and extra value added services (less the government subsidies), and those who can supply clinical care with mandatory staffing care ratios (with government subsidies). See the figure below over the possibility of funding being divided between the two models:

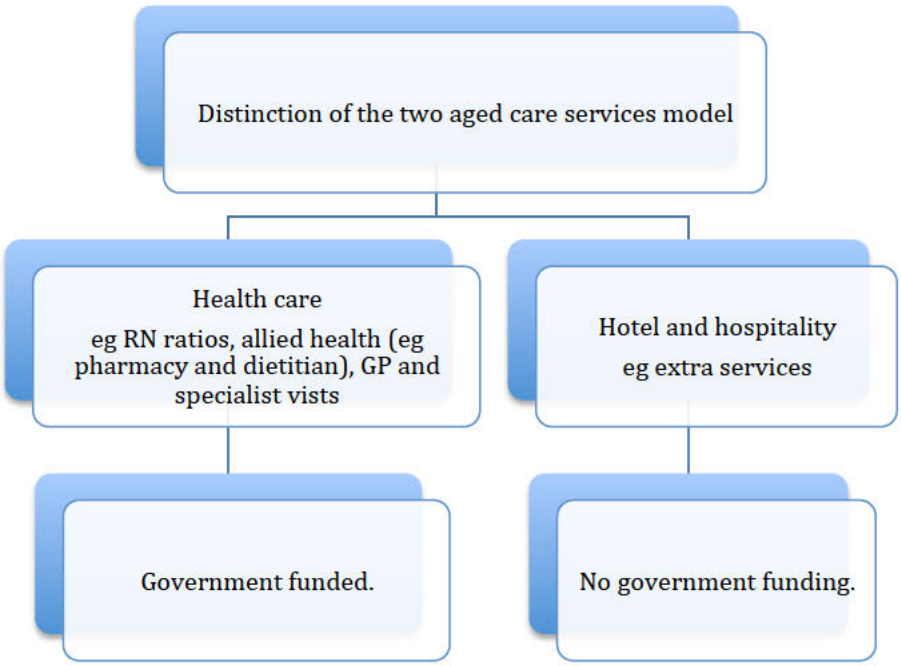


Figure 1: Possible aged care model funding[24]

Federal Government policy must be clearer over these two models of care and what it will fund. But in the absence of the Commonwealth, the State Government must intervene and fill in the gaps and unwillingness to regulate by Canberra.

[23] https://www.smh.com.au/national/aged-care-facilities-in-country-towns-likely-to-go-under-without-more-funding-20191104-p5374c.html

[24] The ACCC has an action against BUPA over misrepresentation of their extra services. This can be used as a guide on what is covered by their hospitality model. https://www.accc.gov.au/media-release/bupa-aged-care-in-court-for-alleged-misrepresentations-about-services

Where there is cross over, there must be clear boundaries of what the government will fund (health care staff), and what taxpayer funding will not. Taxpayer money must be devoted towards funding health care and clinical care in RACFs governed by rigorous standards and regulation. The hoteling and hospitality model should not receive direct government funding. This will allow room for both models but a clear distinction that hospitality is a private sector responsibility, while health care is public.

It is the latter that government resources must be devoted to.

(g) *the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions and unnecessary ambulance call outs and the consequent effect of this upon the provision of ambulance services to the wider community,*

As some aged care facilities do not have skilled expertise and some aged care employees have poor English skills, it is incumbent to ensure that there should be an upskilling of aged care employees in NSW including training overseas RNs to a recognised standard. There are unnecessary hospital admissions and callouts because some RNs in aged care are unsure what they need to do as there lacks the collegiate knowledge and experience available in a hospital setting for more serious cases in aged care.

In the handover from hospital to aged care facilities, at times there may be no qualified staff available to receive handovers of residents which unnecessarily delays the provision of ambulance services to other members of the community. We saw this at Newmarch House and in Queensland at Earle Haven, where there was a lack of qualified staff to deal with the urgent issues that were raised during these events.

With the lack of Federal urgency and oversight, it is incumbent upon the State Government to ensure a baseline skill set of protocols of receipt and transfer of residents at aged care facilities.

(h) the lessons that can be learnt in New South Wales from the impact of the COVID-19 crisis on private aged care facilities where staffing ratios are not mandated, and

I cite the response by NSW Health on the report on Newmarch House which showed the inadequacy of the Federal response and Anglicare's lack of clinical experience. In particular, this response from NSW Health to the Newmarch House report is illuminating:

> "The challenges faced in the staffing of Newmarch by Anglicare were well documented in the review with a 25% reduction in rostered shifts worked in the first five days and increased acuity of residents and workload. The reluctance of General Practitioners to continue supporting the clinical care of residents further exacerbated the situation. This was despite the Commonwealth expanding Medicare-subsidised telehealth services for General Practitioners and other health practitioners from 30 March. With the failure of Anglicare Executive to ensure adequate General Practitioners and adequate registered nurses and care staff to support medical and clinical care of residents, NSW Health put in a team of highly-skilled specialists in infectious diseases, geriatrics, palliative care and intensive care from NBMLHD. This team provided round-the-clock care on-site and also through a dedicated 24-hour advice line for Newmarch staff. NSW Health believes this clinical team was best positioned to understand the clinical needs of the residents as they were personally assessing patients. They assisted in the ongoing management of the

outbreak in the absence of a durable response from Anglicare to provide a stable and expert workforce." [25]

This response demonstrates, again, my belief that aged care should be a State rather than Federal responsibility. This will allow a more proactive and quick response to events and incidents rather than waiting for another layer of Commonwealth bureaucracy remote from the location itself to intervene.

The failure of the current Commonwealth regulator Aged Care Quality and Safety Commission (ACQSC) to respond in a timely manner and its deployment of an Airtasker/Uber type of service called Mable (politically connected and Federally funded) to deal with Anglicare's dramatic reduction in workforce, and the Commonwealth Health Department's reliance on third party medical staff such as Aspen Medical resulted in delays, confusion in the hierarchy of responsibility, of the command and control, and also redundant duplication of existing NSW Health staff in the responsibilities over Newmarch House.

My only censure of NSW Health's role in Newmarch House is that some of their medical principals treated Newmarch residents with ageism. The use of the word "decanting" by Dr James Branley, in reference to triaging Newmarch residents when Nepean Hospital had the capacity to receive these aged care residents demonstrated the ageism that currently exists in the medical profession and dismissive attitude towards residents in aged care. Below is an excerpt from the Aged Care Royal Commission transcript dated 11 August 2020 which demonstrates this discrimination:

"MR MILLARD [Anglicare CEO]: There was one of the conference calls on the 16th of April where there was a heated interaction or robust discussion about cohorting strategies, decanting either positives or negatives, and this issue had been on the table, I think, for a couple of

[25] NSW Health (2020) NSW Health response to final report of the independent review into the Newmarch House COVID-19 outbreak, 24 August https://www.health.nsw.gov.au/Infectious/covid-19/Pages/newmarch-house-response.aspx

> days. It wasn't being resolved. There was a high degree of frustration. And James Branley [from NSW Health] opposed the idea of transferring positive residents or even negative residents out of the home. His view, as I understand it, was that even those who had, at that stage, tested as positive were really incubating the virus and they would be positive. And he was concerned about spread of the virus to outside Newmarch House. And I was greatly concerned that James Branley would walk away. And the concern came out from a subsequent telephone discussion, which one of my regional managers had with Dr Branley. He was gravely concerned about who would make decisions here. And he was also threatening to walk, but he was – he was really saying that he couldn't operate under this environment where it wasn't clear that what would be done in the best interests of residents, in his perspective, would be followed. I was greatly concerned about that and sought to how look how could this impasse be resolved."[26]

Every person in NSW has the right to access hospital care if and when they need to, not because of the ageist culture and attitude possessed by some to prevent aged care residents from accessing our world class public hospital care.

(i) any other related matter.

I wish to add two additional matters to this submission: 1) the NSW Aged and Disability Ombudsman and 2) elder abuse legislation.

I note the establishment of the NSW Aged and Disability Commission (NSW ADC) in 2019. However, its remit is limited in not covering elder abuse that occurs in aged care facilities and institutional settings. This is a missed opportunity and grievous oversight. My hope is that elder abuse is eventually covered by this agency and that people with concerns about the elder abuse their loved ones experience in residential aged care are heard and they are empowered to raise

[26] Aged Care Royal Commission (2020) Day 84 Hearing, Tuesday, 11 August https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/11%20August%202020%20-%20Transcript.docx

their complaints and can access remedies as part of our expectations of natural justice under the rule of law. Complaints of criminal acts such as sexual assaults raised to the NSW ADC must be mandatorily reported to NSW Police as the main law enforcement agency in this state.

Unfortunately, sexual assaults in aged care occur but there is a reluctance to take legal action due to the existing condition of the victim (especially if they suffer from dementia). Protocols must be established so that criminal acts in aged care are covered by law and public prosecutions must be part of the suite to deter elder abuse in residential aged care.

Concurrently, I note the amendment of the ACT Crimes Act to incorporate elder abuse in institutional settings such as aged care facilities in 2020. This makes the Territory the first state or territory in Australia to specifically pass elder abuse legislation.[27] The new sections, 36A to 36C, in this Act comprehensively defines what abuse of a vulnerable person is, failure to protect, neglect and the associated penalties with such abuse and remedies.

My suggestion is that NSW passes a similar legislation covering elder abuse in aged care facilities.

Conclusion

Overall, my recommendation to Honourable members of this Committee is not to wait for the Commonwealth to act on fixing aged care in this country. States, during the pandemic year, have demonstrated their willingness to protect their borders, not compromise on public safety and to ensure the health and welfare of their citizens by acting in a timely and transparent manner.

[27] ACT Government (2020) Crimes (Offences Against Vulnerable People) Legislation Amendment Act https://www.legislation.act.gov.au/View/a/2020-41/current/PDF/2020-41.PDF

Aged care policy formulation and implementation on the Federal level is a mess. We have seen this dysfunction occur during 2020 and with the COVID cases at Dorothy Henderson Lodge and Newmarch House.

The Commonwealth does not have the ability nor the willingness to fix aged care anytime soon. It has demonstrated its dysfunction on the political and bureaucracy level.

It is hard to undo 25 years of dysfunctional Federal legislation and to break the embedded system of lobbying, political donations, revolving doors and general industry capture of government in Canberra on aged care.

This amendment is the first step to ensure we have quality aged care available to NSW citizens. I hope this will be the first of many.

I look forward to your response in due course.

Kind regards,

Dr. Marie dela Rama

Dr. Marie dela Rama