OPAN Older Persons Advocacy Network

The National Aged Care Advocacy Program Presenting Issues - Report 2

January – June 2022

OPAN receives funding from the Australian Government Department of Health and Aged Care for the delivery of the National Aged Care Advocacy Program.

Contents

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About OPAN

Formed in March 2017, the Older Persons Advocacy Network (OPAN) is a national network comprised of nine state and territory organisations that have been successfully delivering advocacy, information, and education services to older people across Australia for close to 30 years.

The OPAN Network Member Organisations are:

Australian Capital Territory: ACT Disability, Aged and Carer Advocacy Services (ADACAS)

New South Wales: Seniors Rights Service (SRS)

Northern Territory: Darwin Community Legal Service (DCLS)

Northern Territory Central: Catholic Care NT (CCNT)

Queensland: Aged and Disability Advocacy Australia (ADA Australia)

South Australia: Aged Rights Advocacy Service (ARAS)

Tasmania: Advocacy Tasmania

Victoria: Elder Rights Advocacy (ERA)

Western Australia: Advocare

OPAN's services support older people and their representatives to address issues related to Australian Government-funded aged care services. OPAN is funded by the Australian Government Department of Health and Aged Care to deliver the National Aged Care Advocacy Program (NACAP).

OPAN aims to provide a national voice for individual aged care advocacy and promote excellence and national consistency in the delivery of advocacy services under the NACAP.

OPAN is an independent body who is always on the side of the older person we are supporting. This independence is a key strength both for individual advocacy and for our systemic advocacy.

A message from the CEO

OPAN's member organisations received almost 28,000 calls from older people and their families last year. What they told us forms the basis of this report, which provides valuable insights into the challenges experienced by older people accessing and receiving aged care from January – June 2022.

The experience for the older people represented in the *National Aged Care Advocacy Program - Presenting Issues Report 2* fell far below what older people, the community and any good aged care provider would expect. There are 45 case studies highlighting the significant work still required to deliver the aged care older people deserve.

The stories documented in this report are harrowing. They compel us to do more to implement reform and quality improvement across a range of areas – from registration with My Aged Care, through assessment, to care in the home and residential aged care.

OPAN raises these issues with service providers and government not to point the finger of blame, but to hold all of us to account. Our goal is to work collaboratively with all sector stakeholders to improve the aged care system and to uphold the human rights of all older people.

Five key themes emerged from the top presenting issues raised with advocates in our nine state and territory organisations.

- Workforce shortages have resulted in decreased access to services, particularly in the community setting where providers of the Commonwealth Home Support Program and Home Care Packages are struggling to meet demand. Workforce shortages are also impacting on the quality of care delivered in both the community and residential aged care. This issue needs to be addressed at the local, provider and national levels. There is no 'magic wand' but both short and longterm sector and government led strategies are required.
- Poor quality of care is still a major problem. Concerns presenting in residential aged care have been wide ranging and include reports of substandard and neglectful clinical care, the use of restrictive practices, limited access to allied health services, hygiene issues, inadequate food and nutrition and care plans not being adhered to. The case studies in this report should be a clarion call to providers to ensure they have robust mechanisms in place to prevent neglect of older people in their care.
- Fees and charges continue to be cause of concern for older people. OPAN is calling for continued focus on how fees are managed, their appropriateness, and demonstration of the value of what is provided, particularly in case management in home care.
- The lack of communication, open disclosure and transparency between providers and those receiving care is another frequently reported issue that needs to be urgently addressed.

- Of significant concern in this reporting period are the number of troubling incidents of the inappropriate use of guardianship and attorney powers within aged care. Sometimes it's families, sometimes it's the provider, and sometimes it's a failure of the guardianship system. Older people's human rights are being impacted and we need to collectively do better in aged care, in the legal sector and in the community. We cannot accept when these important protective tools lead to the human rights of older people being breached. OPAN and its Members will seek to work collaboratively with all levels of governments and their agencies to better protect older people.

The number and breadth of issues that advocates have supported people with over this 6-month period demonstrates the value of the National Aged Care Advocacy Program. Now more than ever, access to aged care advocacy support will remain vital as the aged care system enters a significant period of reform.

Finally, thank you to every aged care advocate in each OPAN member organisation. You work tirelessly to each day support older people to have their voice heard and their rights upheld.

Executive summary

Provided below is a summary of the activity and key issues aged care advocates have supported older people with during 2021- 2022.

Total number of information provisions and advocacy cases in 2021-2022*

27,104

Q1	Q2	Q3	Q4
6,185	6,990	6,760	7,169

*Abuse of Older Person Advocacy and Information is included in these figures.

Information and advocacy support increase from 2020-2021 to 2021-2022

17%

Total information and advocacy cases

2020 - 2021	2021 - 2022
23,019	27,104

Percentage of information vs advocacy cases in 2021-2022*

New information provision cases

Q1	Q2	Q3	Q4
59%	71%	61%	66%

New advocacy cases

Q1	Q2	Q3	Q4
41%	29%	39%	34%

*Abuse of Older Person Advocacy and Information is included in these figures.

Information and advocacy cases per aged care service type

HCP	49%
Residential	39%
CHSP	9%
Respite, Transitional and Short Term Restorative Care	3%

Primary contact person for individual advocacy cases

Client / Older Person	63%
Family Member or Carer	27%
Other Representative	8%
Public / Private Legal Representative	2%

A focus on residential care* by issue**

Care delivery	47%
COVID-19 related	20%
Financial	14%
Abuse of Older Person	12%
Care access	7%

* This report includes a quantitative analysis of top categories for issues seen by advocates in Residential care. Future reports will provide analysis of top issues for additional aged care types.

**Information and advocacy cases often include multiple issue categories.

Disclaimer: The data provided in this report and executive summary is based on a sample of data from the majority of OPAN Members. It is based on emerging data from OPAN's NACAP minimum data set implemented throughout 2021/22. Further data detail and analysis will be provided in future reports.

Top three presenting issues in advocacy casework by aged care service type

Accessing care

- Support to understand and commence the journey of accessing aged care
- The timeliness and appropriateness of aged care assessments
- Challenges accessing assigned aged care services

Commonwealth Home Support Program

- Service availability
- Service cancellations
- Fees

Home Care Packages

- Application of the Inclusion and Exclusions Framework
- Fees and charges
- Impact of changes to the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2020

Residential care

- Quality of care
- COVID restrictions
- Fees and charges

Flexible care

- Understanding and accessing services
- Quality of care
- Flexible service delivery

Diverse and marginalised groups

- Culturally appropriate and trauma-informed care
- Rural and remote service availability
- Abuse of older people

The abuse of older people

- Financial abuse
- Misuse of Substitute Decision Making powers
- Unwanted admission into residential care

Policy Recommendations

This report summarises the top issues presenting in aged care advocacy cases from January to June 2022. The report is informed by quantitative and qualitative data submitted to OPAN by our Network's nine state and territory service delivery organisations. The themes presenting in this report provide valuable insight into the challenges experienced by older people accessing and receiving aged care services. The following policy recommendations offer solutions to address some of the key issues presented in the report. Many of the recommendations build on or aim to further inform reforms that are already on the agenda for aged care.

Recommendation 1:

Due to the significant and increasing impact of aged care workforce shortages on older people, the Australian Government implements and resources Australia's Aged Care Workforce Strategy (and other emerging workforce initiatives) as a matter of priority.

Recommendation 2:

In response to issues relating to service availability and suitability, the Australian Government must ensure appropriate and sustainable funding of CHSP and Home Care Package services so that older people have timely access to the services they need and are not forced into residential aged care prematurely. Particular consideration should be given to flexible funding models that address the unique service access challenges experienced in rural and remote areas.

Recommendation 3:

With new navigation supports being introduced, consideration must be given to how new and existing navigation services interact. Older people must continue to be offered face to face support to access aged care services with a 'no wrong door approach' applied across aged care advocacy, care finders and trusted facilitators.

Recommendation 4:

A commitment to, and resourcing of, timely assessments to reduce waiting times for an aged care assessment.

Recommendation 5:

In the interim period, prior to the introduction of a new Support at Home Program, the Australian Government must continue to address immediate issues impacting on the care of older people in the community. This includes availability of the Commonwealth Home Support Program and Home Care Packages and the impact of changes to the SCHADS Award on service access and delivery, particularly for those living in rural and remote locations

Recommendation 6:

In response to the ongoing issues Home Care Package recipients face in getting services, goods and equipment approved, a new Support at Home Program should, as a minimum, provide the same range of services, goods and equipment as provided in the National Disability Insurance Scheme (NDIS), including:

(a) A level of flexibility to ensure people are supported to access the services, goods and equipment they need to remain living independently in the community.

(b) Options which must not be limited by whom the provider deems a "supplier" but instead should be supplied by any organisation that is able to supply the needed services, goods or equipment.

(c) Costs, which should not be the determining factor where an item has been deemed as necessary to enable the person to participate in the community, maintain social connections and/or live at home.

Recommendation 7:

The Australian Government to demonstrate an ongoing commitment to implementing reforms around the transparency and capping of aged care fees and charges, and consideration be given to a review of residential aged care fees and charges.

Recommendation 8:

A broader ageing strategy is developed in collaboration with state, territory and local governments to examine, and respond to gaps in addressing the needs of older people in health and housing.

Recommendation 9:

In response to issues concerning COVID related visitor restrictions and the misuse of substitute decision-making powers, the new aged care act should legislate and enforce the rights of older people in residential aged care to access visitors of their choice. The restriction or banning of visitors against the preferences of the older person should be subject to an external approval and review process.

Recommendation 10:

Due to the broad range of communication and quality of care issues reported across both community based and residential care, all aged care staff to receive training on effective communication, care planning, responding to challenging behaviours, trauma-informed care, supported and substitute decision making and the rights of older people.

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Policy Recommendations (Continued)

Recommendation 11:

The Aged Care Quality and Safety Commission, as part of their quality auditing and education functions should focus on client communication (including the use of supported decision making), care planning, trauma informed care, fees and charges, the reporting of incidents under the Serious Incident Response Scheme and the application of open disclosure processes.

Recommendation 12:

In response to issues relating to untimely admission to residential care, a strong and widespread education and awareness raising campaign, delivered in hospitals and health services, is needed addressing the range of aged care service offerings available to older people, including restorative programs.

Recommendation 13:

Allow Home Care Package and Flexible Aboriginal and Torres Strait Islander Aged Care Services to be used to support Aboriginal and Torres Strait Islander people to return to Country on a selected basis, with travel and support associated with return to Country no longer viewed as an excluded item following appropriate review.

Recommendation 14:

The new rights based aged care act to require all parts of the aged care system, from assessment through to service provision, to use interpreters and translated materials (including First Nations languages and Auslan) where appropriate.

Recommendation 15:

An education program is developed for older people, their attorneys and aged care providers outlining the responsibilities and limitations of the attorney role and the requirement for the older person to be included in all decisions, to the greatest extent possible.

Accessing aged care

Delays and limitations in access to aged care is a theme that presents in nearly every section of this report. Access to care is becoming a significant area of concern as the demand for aged care services increases and the need for additional funding and workforce shortages continue to impact on aged care service supply. Advocates continue to play a critical role in supporting older people to commence their aged care journey, engage with My Aged Care and aged care assessors and access the services they are eligible for.

Starting the journey of accessing care

OPAN Members delivering NACAP receive many referrals from people looking for support to understand and access the aged care service system and engage with My Aged Care (MAC). Advocacy clients frequently present feeling overwhelmed, unsure of where to begin and confused about fees, terminology, different programs of funding, service providers and referral codes. Many are experiencing declining health and mobility and do not have access to the internet, the confidence to call MAC or the ability to travel to visit an Aged Care Specialist Officer for face-to-face support. Some advocacy referrals come from carers who would normally be very capable of engaging with MAC but due to carer stress and/or ill health are feeling overwhelmed by the whole process and seek advocacy support as they begin to reach a point of desperation (refer to Case example 1).

The aged care system is complex and difficult to navigate, and advocates provide clients with information on how the system works and the steps they need to take to access care. Advocates also offer practical support to assist people to overcome barriers to accessing care (refer to Case example 2). This may include offering face to face engagement, arranging access to interpreting services, printing information off the MAC website and supporting clients in three-way phone calls to MAC. Advocates as Agents arrangements continue to make it easier for advocates to support older people to resolve and clarify issues with MAC in a timely manner.

OPAN recognises the investment of the Australian Government in a variety of initiatives and consumer supports to assist older people and their families to navigate the aged care system, with a number of these in commissioning and rollout phase. Programs such as Care Finders, Aged Care Specialist Officers and Trusted Indigenous Facilitators, once implemented and fully operational will assist some targeted vulnerable cohorts to better access the supports they need. However, the role of advocates in information support, assessment service issues resolution and navigation is likely to remain. There will need to be coordination and collaboration across these support programs to most effectively support all older Australians.

Case example 1

The primary carer (the carer) for a Level 4 Home Care Package recipient living with dementia sought advocacy support to access services. Although capable of contacting My Aged Care themself, the carer had reached a point of desperation and was feeling overwhelmed by the whole process. They were extremely stressed and unable to cope at home 24/7 without additional assistance. The carer had their own medical issues that required them to be hospitalised in a few months to undergo surgery. The carer wanted to put a plan in place, so the care recipient was looked after in Respite Care whilst they were recuperating from surgery.

Case example 2

An advocate recently assisted a client who is profoundly deaf with navigating My Aged Care.

The advocate had about 8 sessions with the client where they explained the difference between Commonwealth Home Support Program (CHSP) and Home Care Packages, supported them at interviews with prospective services providers, collated the information from the interviews and supported them to choose a service provider.

Assessment services

Advocates across the nation are reporting that clients are waiting significant periods of time to receive an aged care assessment. Advocates suggest that waiting periods for assessment or re-assessment have increased over time and are causing clients considerable anxiety. There is concern that people are not always informed that their referral to the Aged Care Assessment Team (ACAT) has been received or that waiting periods exist. This results in some older people feeling distressed by the thought that their requests for support have been overlooked. The wait times for assessment services vary across jurisdictions but it can be up to a 12 week wait between the client receiving initial registration with MAC and having an assessment service scheduled. On some occasions, MAC contact centre staff have inappropriately triaged to assessment services, and this has further delayed the process of accessing an assessment and necessary aged care services. In these circumstances, advocates have suggested a lack of knowledge and experience by MAC staff as to the appropriate assessment priority and service may have been contributing factors, though OPAN acknowledges protocols, scripts and pathways drive MAC staff practice and this may be a related factor.

In some jurisdictions, advocates have been able to establish good working relationships with assessment services and are able to have open and honest discussions about the need to prioritise certain clients for assessments. In other jurisdictions pathways for having assessment referrals prioritised remain unclear.

Advocates have expressed some ongoing concerns about assessment services being provided over the phone. This practice increased in the peak of the COVID-19 pandemic, and some assessment services are still adopting this approach despite the threat of COVID-19 easing. Advocates note that phone-based assessments fail to capture a person's physical environment, social interactions, and their body language and communication subtleties. Further to this, communication barriers such as hearing impairments mean that in some cases assessments cannot be completed over the phone. In some instances, advocates have had to step in and support people to complete a phone-based assessment. Advocates have also flagged concerns about assessors not engaging interpreter services when conducting assessments with people from Culturally and Linguistically Diverse (CALD) backgrounds. The inability to communicate during an assessment can have a significant impact on the outcome of assessments and an individual's future care options. The appropriate use of telephone and telehealth assessments should be considered.

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Accessing aged care (Continued)

Accessing assigned services

OPAN Members delivering NACAP report that they are often involved in providing support to people who have been assessed and approved for an aged care service and are not sure of what their next steps should be. Many advocacy clients have indicated that the instructions provided by MAC are unclear and they are unsure how to begin the process of choosing a service provider. The process can be particularly overwhelming for those who cannot use the online function of the MAC website.

The MAC website has become an essential tool to compare and choose providers and the functionality of this system has been significantly enhanced over recent years. However, many older people do not have access to the internet, or the computer literacy required to utilise the website. Advocates play an important role in supporting people to understand information received from MAC and explore their aged care service provider options.

It has been noted that the lack of service availability across the aged care service system is making it incredibly difficult for advocates to support people to identify available services and access services in a timely manner. Advocates report that services provided under the Commonwealth Home Support Program (CHSP) are becoming increasingly difficult to access, with many services at capacity and unable to manage a waitlist. People seeking CHSP services are having to make frequent phone calls to providers to check service availability. Significant time and effort is required to continually follow up, and without the support of an advocate many people give up on the process of accessing care. Advocates spend a substantial amount of time searching for providers and following up on their service availability. Advocates in some jurisdictions have expressed frustration with the search function on the MAC website, noting that the search parameters using the postcode results in the system bringing up a large list of services, but many of the providers do not actually service the towns within the postcode. Advocates report there is no way of knowing which of these providers is within the locality without contacting each of the providers directly. This can be a very long, drawn-out process that further delays the older person's access to care. OPAN looks forward to working with the Australian Government Department of Health and Aged Care to explore options for improving this functionality.

Commonwealth Home Support Services

Over recent years, the demand for Commonwealth Home Support Program (CHSP) services has been strongly influenced by the availability of Home Care Packages. With wait times for the appropriate level of Home Care Packages sometimes as high as 12-18 months, older people are increasingly relying on the CHSP services to fill the gaps in their care needs. OPAN does note some improvement in Home Care Package wait times with the release of new packages in the last two financial years. However, recently released data[1] indicates that older people are still waiting 3-6 months to receive a Home Care Package and OPAN would like to see wait times reduced to the '4 weeks' maximum wait for service commencement that older persons peak bodies have been advocating for. OPAN looks forward to the single Support at Home Program commencing in 2024 to combat some of these issues, but interim supports are likely to be required during the transition period.

Within the CHSP the most common issues advocates have provided support with have been service availability, service cancellations, unexpected modifications/decreases in services and a lack of provider communication especially with regards to service changes. A lack of CHSP funding and workforce shortages were identified as key contributing factors.

Service availability

A sample of quantitative data from OPAN Member reports indicates that 41% of advocacy cases for CHSP relate to service access (navigation/suitability/changing services). Across the nation, OPAN Members delivering NACAP are reporting that CHSP service supply is not meeting demand. OPAN Members have identified funding and workforce shortages as the main factors contributing to service availability. OPAN Members have heard reports from some CHSP service providers that they are insufficiently funded to hire and retain the staff needed to provide CHSP services. Providers have also suggested that staff wages remain a key influencing factor and have noted that NDIS support workers are paid considerably higher than aged care workers and this can make it challenging for the aged care sector to attract and retain staff.

OPAN Members have noted CHSP service availability is an issue that is particularly heightened in rural and remote locations. In some rural and remote communities, providers have 'closed their books' and are not taking on any new clients as they simply do not have the required staff. Advocates are concerned that the lack of timely access to CHSP supports in the home is increasing the risk of hospitalisation and premature entry into residential aged care for many older people. Rural and remote service availability is explored in greater detail in the Diverse and Marginalised Groups section of this report.

OPAN Member reports suggest that the Domestic Assistance, Home Maintenance and Home Modifications service types are the most difficult to access. The demand for these services is high and many providers have introduced waiting lists to manage demand. Advocates report the wait times for

[1] https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-3rd-Qtr-2021-22.pdf

these service types are often long and difficult to expedite. One OPAN Member reported that a client waited 8 months to receive domestic assistance from a provider in their area. In some locations, domestic assistance is not available at all.

OPAN Members delivering NACAP in some jurisdictions have observed that Regional Assessment Service (RAS) Assessors are increasingly unable to refer people to service providers for these CHSP service types due to lack of service availability. Some RAS assessors have not even provided approval codes to clients and are instead choosing to refer them for aids and equipment and to other practical supports available in their local community, due to the known lack of service availability

Advocates have also observed that some CHSP providers are accepting client referral codes when they do not have the capacity to deliver the required service (refer to Case example 3). Advocates note that in these circumstances, clients are often under the impression that they will be receiving services shortly after, but instead are left waiting months for services to commence. This practice often sees older people missing out on opportunities to connect with other providers in their area who may have availability.

Case example 3

A CALD client had been assessed for CHSP services by a RAS assessor. With the client's consent the RAS assessor made direct referrals to available providers. A CHSP provider accepted the direct referral and made initial contact. After waiting 18 months for the services to commence, the client sought advocacy support. An advocate spoke with the CHSP provider who stated they had accepted the referral and placed the client on their internal waitlist. The provider was unable to say how long the client would still have to wait to receive a service. With the client's permission, the advocate called My Aged Care and made a new referral, on behalf of the client, with a different provider.

Service cancellations

OPAN Members have reported an increase in calls from clients advising that their CHSP services have been cancelled, modified or decreased. In many cases[2], provider communication about the changes has been poor and clients are often not offered any alternative or make up services. For some individuals this is occurring on a weekly basis, and they are becoming increasingly frustrated by the unreliability of services.

OPAN Members have reported that unexpected cancellations and changes to social support and transport services are seeing some individuals missing out on important and difficult to schedule health appointments. OPAN's Queensland member, ADA Australia, has shared how the frequent cancellation of mowing services has been a particular area of concern in Queensland with ongoing periods of wet weather seeing grass growing at rapid rates and scheduled mowing days cancelled due to rain. ADA Australia reports that clients are rarely offered an alternative mowing day and in many circumstances another month will pass before their next mowing service is scheduled. Advocates have noted that lawns left unattended for extended periods of time are attracting snakes and are making the yards unsafe and difficult to navigate, especially for those using mobility aids. ADA Australia have shared that in some instances clients have reported that the unkept state of their yard has reduced their quality of life and made them feel unheard, stressed, depressed, and dehumanised.

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[2] A sample of quantitative data indicates that 27 % of cases relating to CHSP service delivery/quality are about provider communication

Commonwealth Home Support Services (Continued)

Discussion of these issues with aged care providers (including issues with increased charges) often has the provider responding that the care recipient should find another provider if not satisfied. Those who are experiencing frequent service cancellation often feel they have limited opportunity to exercise choice and change providers, as there are simply no alternative services available. Advocates have been involved in several cases where care recipients have cancelled services with a particular provider and then had trouble engaging a new provider due to a lack of service availability in their area.

CHSP Fees

In this reporting period, OPAN Members started to observe an increase in calls and cases relating to CHSP fees. A sample of quantitative data from OPAN Members indicated 13% of CHSP advocacy cases related to fees. Some of the cases related to provider invoices for CHSP being unclear and confusing. There were also some reports on it being difficult for consumers to find information on CHSP fees, with reference made to the absence of a fee comparison tool for CHSP services on the My Aged Care website.

The most common requests made relating to CHSP fees were requests for information and support on financial hardship. OPAN Member reports in this area suggested that older people are relying on CHSP services for longer, are often receiving multiple services at a time and are asked to pay a co-contribution for each of the services they receive. Many are finding it financially constraining having to pay for numerous services, particularly those whose only income is the pension. Advocates have supported people to explore financial hardship options and negotiate fee reductions with their provider, but the outcomes of these efforts are often subject to the discretion of the provider.

Local Government Services

The sustainability of CHSP services delivered by local government providers was identified as an emerging issue during this period. In Victoria and South Australia, some local government providers of CHSP services have ceased to deliver services and have handed over responsibility for their clients to other approved providers in the area. OPAN is aware that some local councils have made the decision to cease providing aged care services due to the financial implications associated with future reforms that will introduce funding in arrears arrangements and the need for system upgrades to support individual client budgets under a new Support at Home Program. Measures need to be put in place to ensure that other local government and small standalone CHSP providers do not exit the market for similar reasons. OPAN has raised these issues with the Australian Government's Department of Health and Aged Care and recognises the work underway with Local Government and affected states on these issues.

OPAN Members continue to hear reports that new providers are accepting Local Government CHSP contracts and clients without securing the required staffing to respond to an immediate surge in new clientele. Older people and the communities in these areas are concerned about how the ongoing care needs for CHSP clientele will be met. In some areas, community members who are ageing themselves are filling the gaps in care which is not a sustainable solution.

Home Care Packages

In the Home Care Package (HCP) space, the most common presenting issues were ongoing concerns relating to included and excluded items and the transparency and level of accountability applied to HCP fees and charges. As with the CHSP, workforce shortages presented as a key area of concern for consumers, with shortages impacting on provider communication, service availability and unexpected changes to service provision. During this reporting period, changes to the Social, Community, Home Care and Disability Services Industry Award (SCHADS) presented as an emerging HCP advocacy issue with numerous consumers impacted by the changes.

Home Care Package included items

Advocates have continued to support a number of care recipients to engage with their service provider and negotiate the purchase of goods, equipment and services with their Home Care Package funds3. For some care recipients, the process of having an item approved has been a very drawn-out process and at times detrimental to their wellbeing (refer to Case examples 4 and 5).

It has been reported that many service providers remain reluctant to approve items that are not expressly listed as an included item in the Home Care Package Operations Manual (the Operation Manual). This reluctance is present even when there is strong evidence that the items are essential to the client's wellbeing and necessary to support them to remain living safely and independently in their home. It has been suggested that providers are fearful that quality audits may deem items they have approved for purchase to be inappropriate, leaving them responsible for repaying funds from their own reserves.

The Operational Manual suggests that in circumstances where a care or service type is not specified in the inclusions and exclusions list, providers and care recipients should work in partnership to determine if the service, support or purchase:

- is directly linked to identified care needs and goals
- will optimise health and wellbeing
- is necessary to support the care recipient to remain living safely and independently in their home
- can be delivered within the available package budget
- would be considered an acceptable use of Government funds.

The Operational Manual provides an Inclusions and Exclusions Framework to support discussions of this nature, however, advocates report that this decision-making tool is often not utilised by providers. Advocates have played a significant role in reminding providers of the importance of working through the Framework with clients when making decisions about items that are not specifically listed as an included or excluded item. On some occasions, advocates have observed providers using the Inclusions and Exclusions Framework to the detriment of the care recipient. Case example 6, describes an instance where a provider prioritised value for money over the clients' individual goal and overall wellbeing.

OPAN Members often receive requests for support to discuss items that are considered excluded items. In these circumstances, advocates have a role to play as an independent source of information confirming excluded items with the client and to assist the client to understand the rationale. However, advocates still have a responsibility to support care

[3] These issues have presented in a sample of quantitative data as 19% of Home Care Package service/quality issues relating to choice and decision making and 21% relating to care planning.

recipients to have their voice heard on decisions and concerns relating to their care, including excluded items. In some instances, this support has led to excluded items being approved by the Aged Care Quality and Safety Commission (refer to Case example 7).

OPAN acknowledges there are many Home Care Package requests made for items, services and supports that are not considered the responsibility of the Department of Health and Aged Care. OPAN is concerned that gaps in the broader health, housing and social service systems means that older people often do not have access to timely and viable alternative options through other Commonwealth, State or Territory funded programs. OPAN has observed how these types of service system gaps can impact on the health and wellbeing of older people and can reduce their ability to remain living independently in their own home. Individuals experiencing financial hardship, and an inability to self-fund essential items, are often impacted the most.

OPAN suggests it may be useful to map trends in Home Care Package excluded item requests against the availability of other funded programs. A mapping exercise of this nature could assist in identifying gaps in supports and inform the future planning of Commonwealth, State/Territory and Local Government initiatives to support older people to remain living at home for longer. OPAN recognises the importance of a sustainable and cost-effective home care system with appropriate, checks, authorisations and controls. However, OPAN continues to advocate that there are times for nuance and reconsideration. The ability for a senior advocate to request a review of an exclusion, where there is an impact on client wellbeing, needs to be established.

Case example 4

A Level 4 Home Care Package recipient with a chronic health condition had their continued need for oxygen provision documented in their Home Care Package care plan, with funds allocated towards this cost in their budget. The client sought advocacy support when their oxygen supplier sought a direct deposit for the service and their Home Care Package provider refused to pay. The Home Care Package provider justified their decision by stating that the oxygen supplier was not one of their preferred suppliers and they had the capacity to refuse payment given oxygen is not listed as an approved item under the Home Care Package Manual. The client, after being left without access to oxygen for two days, had to ask their family for assistance to pay for the equipment. The client later sought advocacy support to change providers.

Case example 5

An OPAN Member provided support to an Aboriginal Elder to access aged care services following a traumatic experience engaging with the National Disability Insurance Scheme (NDIS). The individual had been approved for a Level 4 Home Care Package and had been assured by the service provider that they would receive support for domestic assistance, meals, gardening, goods and equipment, home modifications and a range of other supports. What followed was a period of non-service delivery on several agreed services and items. The service did provide cleaning services but frequently changed cleaners and appointment times. On some occasions the new cleaner would walk straight into the individual's home without announcing themselves. As a result of non-service delivery, the individual amassed over $20,000 in credit in their Home Care Package budget within a period of approximately 7 months.

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Home Care Packages (Continued)

The individual identified two items of equipment, a therapeutic bed and chair, that had been recommended through a previous Occupational Therapist (OT) assessment as critical to their care, and the individual wanted to use some of their unspent funds to purchase these. However, the service providers listings of preferred suppliers did not supply those specific items, and the provider refused to engage with other providers that could supply the items. Recognising that the service providers would not support the purchase of the item despite there being funds available in the client's Home Care Package, the client engaged with a bedding organisation independently and entered a repayment plan which they paid with their Disability Support Pension.

Case example 6

A Home Care Package recipient sought advocacy support when their provider would not purchase the three wheeled walker that had been recommended in an Occupational Therapist (OT) assessment. The OT had specifically recommended the walker because it had a narrow frame and would enable the client to move about in church and at home more easily, noting the client attended church two or three times a week and the church pews were quite close together. The provider advised the client they would not approve the purchase of the 'Rolls Royce' walker, and they could only approve the cheapest walker despite the difference between the two walkers only being around $60 - $80 and the client's Home Care Package budget being in surplus.

Case example 7

An advocacy client sought support when her Home Care Package provider declined to purchase a microwave. The client had severe arthritis and used heat as a method to manage the pain. The client had been using a hot water bottle to provide relief, but their physiotherapist identified this approach to be a risk, as the client's self-management of boiling water had proven to be dangerous. The physiotherapist recommended a microwave to minimise this risk. With the advocate's assistance, following continued denial by the provider, the client lodged a complaint with the Commission. The initial receiving officer refused to uptake the complaint, advising that it was clear that the item requested was excluded and the client should purchase the item using their own general income. The client decided to request a review of this Commission's decision. With the Commission's increased involvement, the provider explored alternative options and after eight months, the provider and Commission determined that the alternatives were not acceptable as they also presented as a burns risk for the client, and it was agreed that the purchase of a microwave would be a relevant use of HCP funds in this circumstance.

HCP fees and charges

In September 2021, OPAN received funding to introduce a new role to the Network – Financial Advocacy Officers. Financial Advocacy Officers help build the knowledge, skills and confidence of OPAN advocates, aged care consumers and their representatives to understand and address issues relating to aged care costs. The introduction of the role has been welcomed with 28% of Home Care Package advocacy cases relating to fees and charges[4].

[4] Based on a sample of quantitative data

During this period, similar to OPAN's last presenting issues report, issues with Home Care Package monthly statements have continued to be a top area of concern with trends in advocacy case work suggesting that a large number of statements remain confusing and difficult for care recipients to understand. Many Home Care Package recipients have expressed their frustrations over the lack of transparency around how their package funds are spent. One care recipient commenting he felt "in the dark" and concerned that his provider could be claiming for services that had not been provided. Together, aged care advocates and Financial Advocacy Officers have supported numerous Home Care Package recipients to understand their monthly statements and reconcile their package funds. Over time, OPAN will develop additional information and education resources to further support older people in this area.

In September 2021, the Department of Health and Aged Care introduced a Better Practice Home Care Package statement template to help improve the overall quality of statements. Adherence to the template has been voluntary and advocates have observed that provider uptake of the template has been very low to date. Mandatory elements resulting from the implementation of *Improved Payment Arrangements* were incorporated into the template in August 2022 and will come into effect from September 2022. OPAN is hopeful that the mandatory elements may lead to some greater transparency around funds.

Advocates have been involved in an increasing number of cases relating to income tested fees. This increase is potentially associated with increased Department communication on the topic following the introduction of *Improved Payment Arrangements* in September 2021. Throughout the period advocates and Financial Advocacy Officers have supported care recipients to understand the income and means assessment process and the application of income tested fees. They have also supported care recipients to negotiate for fees to be waived where they have accumulated unspent funds (Refer to Case example 8) and have assisted individuals to address errors associated with income tested fees (Refer to Case example 9).

Case management fees remained an ongoing area of concern, with care recipients often questioning why their fees are so high when the case management services received are so limited. Despite paying alarmingly high case management fees, many have reported that they only hear from their case managers once a year when it is time to renew their service agreements. OPAN was therefore pleased to see the Aged Care Amendment (Implementing Care Reform) Bill 2022 call for a cap on case management and administration fees. There is no specified legislative requirement for providers to report on the hours or types of activities that equate to the charges for case management. However, some good providers do provide this information and focus these activities on effective case management, rather than coordination of service delivery. OPAN made a submission to the Inquiry into the provisions of the Aged Care Amendment (Implementing Care Reform) Bill 2022. Our submission also called for greater provider transparency about what is included in the case management and administration fees charged to individuals. OPAN is aware of providers who stipulate that fees for case management only cover X amount of phone calls or Y amount of case management hours. They then charge the consumer a fee for additional admin/case management when they go over this threshold. Often the client is not aware of thresholds and additional charges remain hidden. Case example 10 provides an example of hidden charges associated with case management.

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Home Care Packages (Continued)

OPAN's position is that there should be a process for reporting and monitoring the frequency and effectiveness of case management, and at a minimum the requirement to report hours/activities against charges. This requirement should also be built into the design of the future Support at Home Program.

Case example 8

A Home Care Package recipient had accrued a large amount of surplus package funds and requested advocacy support to have the income tested fee waived. The client told the advocate they would like the extra money from the fees to cover the ever-increasing cost of other daily expenses and use the surplus to cover the cost of ongoing HCP services. The advocate supported the client to communicate this request to their service provider. The service provider agreed to temporarily waive the income tested fee with agreement that this would be reviewed to ensure there would be enough funds to cover the costs in the future.

Case example 9

An advocacy client received a letter from Services Australia three months after commencing with their Level 3 Home Care Package advising that they would not be required to pay an income tested fee. A month later the client received an invoice from their provider for $962.08 in income tested fees. The client placed their supports on hold while the matter was being resolved. The client contacted their provider multiple times about the matter but had not heard back from the provider about a resolution. With consent from the client, the Financial Advocacy Officer spoke to the provider's accounts department and questioned the invoice. The provider confirmed they had reversed the invoice of $962.08 and the clients account was no longer in arrears. The client was pleased the issue was resolved but were going to look at changing provider as they no longer trusted them.

Case example 10

A client sought advocacy support to enquire about their Home Care Package provider charging an additional $12.00 per week for a service described as "access to case manager – phone". With the client's permission the advocate spoke with the service provider who advised that this charge facilitates client access to their case manager's mobile number. When challenged about the additional charge and why it was not a part of the care management fees, the service provider said they deem it as an additional service to the client. After discussions referencing the Home Care Package guidelines the provider agreed that they should not continue to charge that additional fee and would adjust the billing from a forward date.
The advocate suggested that the provider should also reverse previous charges and return funds to the clients HCP accumulated amount. The client reported the following monthly statement had indicated that the reversal of charges had occurred.

Communication

Communication between provider/worker and client has been a substantial issue during this period, with OPAN Members receiving multiple referrals for care recipients experiencing poor provider communication. Communication[5] issues have presented as:

- calls to service providers going unanswered with no return calls
- care recipients not being informed of shift changes or cancellations, which often results in consumers being late to appointments

[5] A sample of quantitative data from OPAN Members delivering NACAP indicated that 26% of service delivery/quality cases for Home Care Packages related to communication issues.

- care recipients calling their provider and being placed on hold for extended periods of time and then transferred to the wrong person
- challenges reaching care coordinators in a timely manner
- care recipients unable to connect with local services when contacting providers with 1800 or 1300 national phone lines.

Workforce shortages were cited as an underlying issue influencing the growing number of advocacy cases relating to communication. OPAN Members noted that the sector experienced high levels of staff turnover during this period and COVID-19 continued to influence workforce supply issues associated with staff sick leave and carers leave.

Workforce shortages have also impacted the ability of older people to access Home Care Packages, with many waiting extended periods of time to access the services they require. It has been observed that many services are at capacity and do not have waiting lists available. OPAN Members report that many older people are feeling exasperated by the increasing delays, with some giving up on the process of accessing care altogether. There is growing concern that a continued lack of available services may result in increased hospital admissions and cases of early entry into residential aged care.

OPAN Members also report that the staff shortages and Home Care Package supply issues are starting to influence the ability of older people to exercise their right to choose or change providers (refer to Case example 11). Thin markets, even in metropolitan areas, are increasingly leaving older people in a position where they feel grateful to have any service at all, even if it is not a consistent and reliable service or a service delivered by a qualified, competent workforce.

Case example 11

An older person sought advocacy support to address communication issues with their Home Care Package provider. The older person noted that they recently had a fall at home and had broken their wrist. They were seeking additional support whilst they recovered but reported that their Home Care Package services had been inconsistent and had been cancelled many times due to staffing shortages. The older person also stated that they felt very isolated and did not have access to transport. They had tried to connect with their provider to discuss their concerns and had left numerous phone messages, but their provider did not return their calls. The older person expressed disappointment with the provider and indicated that they would like to change providers but were fearful to do so as they were aware that there were few alternative options in their rural community with most services already at capacity and not taking on new clients.

Changes to the Social, Community, Home Care and Disability Services Industry Award 2020

In January 2022, the Fair Work Ombudsman published their final determination on the four-year review of the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2020. The determination detailed changes to the award, effective from 1 July 2022. The most significant change introduced included an increase in the minimum shift requirements for casual and part-time workers from one hour to two hours, two new broken shift allowances and new rules around pay and make-up time that apply where a care recipient cancels a service.

As the 1 July deadline for the changes

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Home Care Packages (Continued)

approached, OPAN Members started to receive an increasing number of calls from Home Care Package recipients impacted by the changes. With many home care workers falling under the SCHADS award, home care recipients were receiving advice from their providers that they would be making changes to their service cancellation policies and either introducing a new minimum 2-hour requirement for all home care visits, increasing their fees and charges or introducing new charges such as charges for time spent travelling to the client's home. This advice left many Home Care Package recipients feeling very anxious about their future care and their ability to remain living independently at home. These concerns were particularly heightened for people who relied on short, but twice daily, supports (refer to Case examples 12 and 13).

As older people's concerns grew, OPAN was pleased to be able to support the development of Department of Health and Aged Care factsheets addressing the impact of changes to the SCHADS Award. In some cases, the factsheets were useful resources that advocates could refer to when supporting care recipients to discuss with their providers unexpected changes to their care plans or fees and charges. However, cases relating to changes to the SCHADS award continued to rise well after the release of the factsheets. Some advocates have reported that Home Care providers are expressing concern about the changes and the detrimental impact they may have on both care recipients and the ongoing sustainability of their business. Many are concerned that they will not be able to deliver adequate care. In some cases, some providers have been suggesting care recipients seek alternate service providers and have acknowledged that this may not be an easy task given current supply issues.

Case example 12

A care recipient with a Level 4 Home Care Package required a daily afternoon service to support them into bed for the evening. Prior to the changes to the Award, their Home Care Package provider charged a minimum of one hour fee for this support, despite it only taking 15 minutes to complete. The care recipient noted that their already stretched Home Care Package could not accommodate a daily two-hour service and expressed frustration that the two hours of support was also not needed. The care recipient shared their concerns that the change would force them into residential aged care where they feared they would "die mentally".

Case example 13

A care recipient with a Level 4 Home Care Package received daily domestic assistance services in the morning. The care recipient had severe incontinence and required support to wash the floors and bed linens daily. The care recipient expressed concern that the introduction of a minimum 2-hour shift time would force them to either have days where they would have to live with soiled bed linen and floors or prematurely enter residential aged care, a prospect that triggered a lot of distress.

Residential care

COVID related lockdowns and visitor restrictions continued to be one of the most common advocacy issues in residential care, in this and previous reporting periods, with some improvement over this six-month period. This qualitative data was provided during OPAN's discussions with Advocacy Managers as part of the COVID Response Management Team process and correlated with OPAN and other consumer peaks (and aged care sector stakeholders) work with governments on more appropriate visitation practices following the January Omicron wave. An increase in cases relating to the resident's right to leave the facility on outings was observed, with some facilities enforcing isolation and restrictions upon residents returning to facilities. Closely associated with COVID restrictions, were concerns about social isolation, quality of care and the abuse or neglect of residents. Again, workforce shortages were identified as a key influencing factor for many of the presenting issues in residential care. Residential care fees and charges also presented as a top issue. The new Financial Advocacy Officers were kept busy informing people about residential care fees and addressing errors in residents' accounts.

COVID lockdowns and visitor restrictions

COVID-19 restrictions were one of the top presenting advocacy issues for people in residential aged care during this period[5]. People living in residential care were faced with restrictions that went beyond those imposed on the general community. In some areas, restrictions were applied in residential care despite COVID health directives easing and the broader community opening again.

Facilities were responsible for implementing their own plan for managing COVID-19 and many did not effectively communicate or involve residents and/or their representatives through the planning and implementation process. Several facilities continued to manage risk associated with COVID-19 with a facility-wide approach that did not provide due consideration of the wellbeing and rights of individuals. OPAN recognises consistency and timeliness of public health unit advice at the state and territory level as a contributing factor to this issue, and this improved in most locations over the second quarter of 2022.

Many facilities self-imposed strict lockdowns and visitor restrictions to reduce the risk of COVID-19 infiltrating their facility (refer to Case example 14). OPAN Members continued to hear from people who could not visit their families/ friends, despite being classified as essential visitors/partners in care. Advocates were involved in several cases where harsh visitor restrictions were being enforced upon the family and friends of residents that were palliative. Lockdowns and ongoing visitor restrictions in residential care separated and isolated many older people from their regular support networks, including family members and friends who play a critical role in supplementing their care. These restrictions have taken a significant toll on the physical and mental health of many aged care residents. OPAN Members have suggested that residential aged care facilities require more education on 'essential visitors' to ensure that access to visitors is as least restrictive as possible. OPAN notes reports of some providers being able to zone areas impacted by outbreaks or to facilitate Partners in care/Essential Visitors with appropriate public health and safety measures, but this was not universal.

[6] Quantitative data was captured across two data categories - care service access (7%) and COVID-19 (20%)

Facility lockdowns continued to see residents' movement restricted as they were required/ requested to remain in their rooms. In some instances, isolation was enforced despite there being no COVID cases within the facility. Several facilities confined residents to separate parts of the facility and would not let residents out at all, even when there were no active COVID cases within the facility at the time. Residents were often not informed of the facility's COVID-19 management plans and experienced confusion and distress when placed in isolation (refer to Case example 15). Advocates observed that some residents were being placed in isolation for up to 7 days after leaving the facility to go on outings with family and friends. Isolation was imposed even in circumstances where individuals tested negative upon return to the facility and there was no evident COVID threat.

In some locations this continued in the January to July period even as the guidance was adjusted and the epidemiology of COVID and its prevention/management changed.

Some facilities were very resistant to implementing any changes to their COVID management plans. Advocates played an important role in raising awareness of the Visitation Guidelines and reiterating the rights of residents to access visitations safely. The Visitation Guidelines were a useful resource to refer to when supporting individuals to advocate for improved visitation. Advocacy support generally resulted in improved visitation access. In circumstances where facilities were resistant to applying flexibility to their visitation policies, the cases were escalated to the Aged Care Quality and Safety Commission. OPAN Members report the trend has now shifted to improving access for visitors and less restrictions on movement. OPAN Members will continue to monitor this in our next reporting period.

Advocates have engaged with several residents who have experienced isolation and depression as a result of ongoing COVID restrictions in residential care (Case example 16) and who have sought to return to living in the community where their movement and social engagements would be less restricted. Unfortunately, this move was not possible for many (Case example 17). Both the community and residential aged care system are failing to meet the care needs of older people and provide them with reliable service options that would support them to exercise choice and control over their life.

Case example 14

An advocacy client had been prevented from leaving their Residential Aged Care Facility (RACF) premises for 2 months. The RACF where they resided had established a COVID-19 mandate which

- *prohibited any resident from leaving the premises*
- *restricted visiting hours to Monday – Friday 9am – 11am and 1pm - 3pm*
- *Made it compulsory for all family and friends to complete an excursion form that needed to be approved by a permanent staff member or Registered Nurse (RN) before a resident was able to leave the premises.*

The client and their family were distressed about these arrangements. The client had missed out on attending the funeral of a close friend and the RACF was preventing the client's daughter/ Guardian who worked full time from visiting after hours. The family sent an email to the Director of the RACF advising of their concerns about restrictions and their impact on the client's mental wellbeing. An advocate provided the family with information about the current health directives and interim guidance on managing public health restrictions in residential aged

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Residential care (Continued)

care facilities. The advocate, with the client's permission, sent an email to the RACF Clinical Manager asking for an explanation regarding the restrictions. The advocate requested evidence of Department of Health guidance instructing the RACF to restrict residents on exiting the facility for outings/excursions with family and/or friends. The facility did not respond to these requests. The advocate then arranged for a conference call between family members and the Director of RACF with the advocate present for support. At the meeting all parties agreed there was no reason to restrict the client from leaving the RACF for outings/excursions with family and/or friends. Following discussions, the Director became aware of the impact that continued social isolation was having on the client's mental health and wellbeing. It was agreed that after hour visits could take place provided visitors were willing to perform a RAT prior to any visits and provide evidence of a negative result before entering the RACF. Recurring visiting appointments were agreed to and were booked in with the reception team.

Case example 15

An older person requiring palliative care moved into a residential aged care facility from hospital. Upon arrival at the facility there was an outbreak of COVID-19. The resident's partner was told that they could not visit the resident for a week after they'd entered the facility, even though they had tested negative for COVID. The partner was concerned that their loved one may pass away during the lockdown and wanted assistance to understand the restrictions and communicate with the facility management. The advocate supported the partner resulting in agreed visitation.

Case example 16

An advocacy client stated he had a positive diagnosis of COVID and had been moved into a small room downstairs to isolate at the residential aged care facility. The client was distressed and felt pressured to leave his usual room without being informed of alternative options or being offered a choice in the decision. The client wanted to isolate in the comfort of his own room and requested support in having his rights upheld and his voice heard.

Case example 17

An advocacy client dissatisfied and depressed by the rolling lockdowns, a lack of community access and a decline in the quality of care provided in their residential care facility, requested advocacy assistance to return to living in their home. An advocate worked with their provider to develop a plan for a possible return home including a social leave trial and an updated ACAT assessment for Home Care Package support. The advocate and older person discussed options with the family, however they were met with resistance as the family were already caring for the older person's partner at home and were receiving ineffective Home Care services. The plan to move home is on hold.

Quality of care and clinical care

Quality of care concerns in residential care have been numerous (47% of residential care cases) and wide ranging. Quality of care issues have included reports of substandard and neglectful clinical care (refer to Case example 18), the use of restrictive practices, limited access to allied health services, hygiene issues, inadequate food and nutrition, and care plans not being adhered to. Nominal staffing numbers and inadequate training continues to contribute to issues of poor-quality care and neglect in residential

aged care, with OPAN Members reporting that residential care facilities frequently lack the level of staffing needed to maintain standards of care.

Inadequate care planning has been identified as an underlying issue in many advocacy cases relating to quality of care. OPAN Members have observed numerous facilities failing to ensure that care plans are updated in a timely manner and remain an accurate reflection of the older person's current care needs, goals and preferences. Advocates have suggested that high levels of staff turnover and sickness has meant that staff on the ground have limited time to review and adhere to care plans. In addition to this, residents are not receiving care from a consistent team of care workers that can afford the time to familiarise themselves with a resident's care plans (see Case examples 19 and 20). This lack of familiarity between care workers and residents also means that care workers are often not able to recognise changes in a resident's presentation and initiate a care plan review. Advocates have raised concerns about the ability of care workers to respond to residents presenting with behavioural issues, noting that in some facilities responses have included the use of restraint and threats to the resident's security of tenure.

Despite the introduction of the 2021 Basic Daily Fee supplement to support aged care providers to deliver better food and nutrition to residents, OPAN Members have continued to be engaged in numerous advocacy cases related to the food and nutrition. Advocates have noted an increase in cases demonstrating a lack of adherence to the Aged Care Quality Standards regarding food and catering, with providers failing to meet the residents' needs or not improving their overall daily experience. Concerns relating to food have included food not meeting cultural or dietary needs, insufficient amounts of food provided at mealtime, poor quality, food served on paper plates and cups, prepared offsite, and lacking in variety and nutritional value. OPAN Members have heard stories of residents using the limited funds they have available to them to buy takeaway meals to help supplement the poor-quality food they have been provided at their facility. Advocates have also been involved in several cases relating to support to assist residents with eating. This issue has been heightened by COVID-19 restrictions on visitation and ongoing workforce shortages.

Advocates across the country have also been involved in a number of cases involving serious incidents. Incidents have included cases of neglect, emotional, psychological, physical and sexual abuse with perpetrators of abuse including both aged care staff and residents. Advocates have expressed concern over the ability of some residential care facilities to proactively prevent and respond to cases of abuse (see Case example 21). Advocates have also observed that there are many instances where residential care facilities do not:

- acknowledge that an incident has occurred
- report the incident to Serious Incidents Response Scheme
- follow open disclosure processes (refer to Case examples 22 and 23).

Advocates play a role in reminding facilities of their obligations in this area and work closely with those who have experienced abuse to develop a plan with facility management to help them feel safer.

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Residential care (Continued)

Case example 18

A family member of a resident with dementia sought advocacy support after the resident fell and sustained injuries in their residential care facility. The family member had been informed that the General Practitioner (GP) had visited following the fall and sutured a wound on the resident's head. Upon visiting the resident two days later, the family member noticed bright blood on the resident's sleeve and discovered a large laceration on their elbow. On removing the resident's shirt, the family member noticed that there were also grazes and significant bruising on the resident's back. They informed the facility staff of these findings and the staff applied dressings to the injuries. Ten days later, the family member noticed the resident wince when moving their arm, so they removed the resident's shirt and saw that the forearm was inflamed and swollen. Again, the family member informed staff but it was days before antibiotics were commenced for treatment of the wound infection. The family member informed the advocate that they were increasingly concerned about the facility's quality of care. They noted that there were different staff providing care each day, and they were concerned that the staff did not know or understand the resident's needs. The advocate assisted the family member to lodge a complaint with the facility, and to report the incident to the Aged Care Quality and Safety Commission. The advocate also supported the family member at a meeting with the facility's manager where a plan of action was enacted to review/update the resident's care plan, improve communications with the family and rebuild a trusting relationship.

Case example 19

An advocacy client had entered residential aged care with a sore foot but no broken skin or visible wound. The heel on their foot became progressively worse and their spouse (representative) was told by nurses, 'not to worry'. Eventually photos were sent to the GP who advised that the resident be taken to hospital. The hospital informed the resident and their representative that the foot would require amputation, but surgery would pose too great a risk. An advocate had been assisting the resident and their representative in communicating with facility management and the Aged Care Quality and Safety Commission about concerns regarding lack of care, the RACF failing to involve a GP or hospital during the period taken for the foot wound to develop to the stage it required amputation, old dressings left on for extended periods and failure to follow Serious Incident Response Scheme (SIRS) or an open disclosure process. During this process the resident became terminal and passed away.

Case example 20

A family member sought advocacy support to address quality of care concerns experienced by their partner in residential aged care. The family member reported that their partner was not being showered and cleaned correctly, could regularly be found sitting in their faeces and had developed bed sores. An advocate was engaged to support the family member to address the issues. The advocate observed that care instructions were clearly listed in the resident's care plan, however, the instructions in the care plan were not being adhered to. The advocate called the manager at the aged care facility to discuss their processes for ensuring that tasks in the care plan are being implemented. The manager stated that there was currently

no system in place to ensure tasks are being completed, and it is up to the staff if they want to update progress notes. The advocate and the resident's family member are working together to compile a list of concerns to discuss with the manager and care coordinator and are hopeful the facility will implement a process encouraging staff to follow the care plan.

Case example 21

A family member sought advocacy support to assist with an allegation of sexual assault. The family informed the advocate that the older person had been reporting to both staff and family, over a period of time, that they were afraid of another resident at the facility, who had been presenting in the older person's room at night, and forcibly sexually assaulting them. The older person's behaviour had changed significantly during this time due to being afraid, anxious, and unable to sleep at night. Management at the facility had obtained information regarding the sexual assault and moved the alleged perpetrator to another wing in the building immediately. The alleged perpetrator had been assessed with full mental and physical capacity. The facility had undertaken a risk assessment and put in place strategies and client monitoring to help prevent the abuse from occurring again. However, the family of the older person had been informed that due to Security of Tenure, the alleged perpetrator may be moving back to their room. The facility offered to move the older person to another room, but the family did not think this was right as the older person was settled in their own room. The family were also concerned that staffing levels at the facility were not adequate enough to protect the older person, and that the alleged perpetrator would continue to cause further trauma if returned to their original room due to the close proximity of their rooms and shared living spaces.

The advocate helped to facilitate communications between the family and the facility, provided safeguarding strategies for the older person, and supported the family to lodge an Intervention Order against the alleged perpetrator. The advocate expressed concern with the facility's lack of action in immediately assessing and managing the perpetrator's behaviour following the initial report from the older person, noting the facility's initial approach was to restrict the older person's movement/access in the facility. The advocate was also concerned about whether other residents had experienced similar incidents but had not reported them.

Case example 22

A client residing in a RACF stated he had rung his call bell requesting his continence aid be changed for the night. After the client asked to use the toilet prior to changing the aid, the carer ignored him and started to remove the aid, to put the new one on. The client continued to ask to use the toilet, but the carer then started to complain and criticise him for asking to use the bathroom. The client was shaken by the incident and left feeling as though they had done something wrong. As a result of the incident, the resident suffered anxiety and was still required to have the same carer attend to their support. There had been no communication or open disclosure process followed, and no acknowledgement from management that an incident had occurred, resulting in harm to the resident.

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Residential care (Continued)

Case example 23

An older person noticed and felt uneasy about another resident watching, following, and focussing on them throughout the day. The resident reported concerns to staff who did not document the reports or take any action. The older person was eventually physically assaulted by the other resident whose behaviour was a result of their dementia. An advocate requested the provider report the incident, develop the appropriate plans to ensure the older person's safety, monitor both residents and provide counselling, reassurance, and support to the assaulted older person.

Financial issues

Advocates across the nation have been involved in a number of cases[7] relating to financial issues. Many of these cases have involved provider errors that have led to residents being overcharged or accumulating unexpected debt (refer to Case example 24). The involvement of the new Financial Advocacy Officer (FAO) role has been extremely beneficial in these types of cases. The FAOs are skilled in auditing the relevant paperwork, identifying where errors have occurred and supporting residents to rectify errors with their provider. In many cases the FAO involvement has resulted in large debts being cleared (refer to Case example 25).

There have also been several cases relating to income tested fees. Advocates have flagged concerns that providers are not thoroughly discussing the Schedule of Fees and Charges for Residential Care or informing residents of the impact of not submitting an income and means assessment to Services Australia (refer to Case example 26). In some instances, errors have occurred with the processing of income and means assessments within Services Australia (refer to Case example 27). Advocates and FAOs have played an important role in supporting residents and their families/representatives to understand the schedule of fees and charges, submit relevant paperwork and liaise with Services Australia.

An emerging issue relating to fees and charges is the additional services fees being charged by some residential care facilities. OPAN Members have suggested that many of these additional items ought to be covered within the schedule of care and services. Examples of additional fees have included fees for additional bedding if the resident is cold, meals provided in resident's rooms, chef oversight into meal choice and quality, new pillows at admission date and support to video conference with family and friends. One OPAN Member reported on a number of facilities where residents are being charged a late fee for not paying their fees on time. One facility was charging 5% per day if fees weren't paid within 14 days of being due. Advocates are concerned that this approach could significantly impact on the financial and emotional wellbeing of residents.

Case example 24

An advocacy client entered residential care for respite and two weeks later they became a permanent resident. The facility charged the client the accommodation fees for part of the respite period. The client was upset about the charges as they weren't expecting them. With the consent of the client, the advocate contacted the facility to question the fees and provided a signed agreement which stated the permanent care didn't start until after the 2 weeks respite. The RACF credited the fees in question as they had insufficient evidence of having provided the client clear information regarding the fees, nor an agreement signed by

[7] A sample of quantitative data indicated that 14% of residential care cases related to financial issues.

the client. The RACF has provided a new statement of account to the client. The client was very pleased with the outcome

Case example 25

A resident sought advocacy support to address an outstanding debt of $12,000 with their residential aged care facility. A Financial Advocacy Officer (FAO) visited the resident and audited their service agreement and bank account statements from the past 2 years. The FAO identified that the facility had not set up the direct debit for the payment of fees at the correct amount from date of entry. This meant the resident's account had not been debited enough to cover monthly fees. The facility did not realise this error and hadn't processed the increase for 18 months. The FAO supported the resident with a meeting at the facility to discuss this issue and enquired as to why the facility had not approached the resident earlier about the direct debit error. The facility agreed to waive the outstanding debt on the account. They also reviewed and decreased the resident's extra services charges.

Case example 26

An advocacy client recently moved into residential aged care and was informed his fees would be 85% of his pension per fortnight. The provider confirmed there would be no additional, 'hidden' fees as he was not able to pay any more than $749.84 per fortnight. After the client moved into the RACF, he received the first statement and realised his fees were significantly more than the agreed amount. The advocate explained to the client the importance of completing an income and asset assessment for Services Australia – if one is not completed and lodged correctly, Services Australia will instruct the aged care facility to charge the client the highest rate.

The client directed the advocate to speak with the facility's finance contact to ascertain whether an assessment had been completed and lodged correctly. The facility confirmed that the resident had not been assisted through this process resulting in the full amount being charged. The facility agreed that as it was almost certain the client would be assessed as making no further contributions to his care needs, it would move to reissue his statements with the contribution removed. The facility agreed to ensure the assessment was lodged correctly and would organise a staff member to follow up with the resident to ensure they were satisfied with the outcome.

Case example 27

An advocacy client received a bill for $20,000 from their aged care facility.

The client was unsure why the bill was issued and what the fees are meant to be for permanent care. A Financial Advocacy Officer (FAO) arranged a meeting online with the client's family and their general aged care advocate to discuss the residential aged care fee structures and supported them to complete a fee calculator on the My Aged Care website.

The FAO contacted the facility to follow up on the accounts and the facility advised that Services Australia had not back dated the assessment from date of entry and that a means tested fee was charged for 5 months. The FAO provided a letter and supporting documentation to their general aged care advocate to support family with call to Services Australia. The FAO also sent documents to Services Australia to request a back dated assessment letter to correct overcharges.

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Flexible care

Flexible care services include the Transition Care Program, Short Term Restorative Care, Flexible Aboriginal and Torres Strait Islander Aged Care Services and Multi-Purpose Services. Only around 2% of aged care consumers access flexible care services, as such the number of advocacy cases relating to flexible care is relatively low.

Understanding and accessing services

OPAN Member reports suggest that advocate involvement is most prominent amongst the Transition Care and Short-Term Restorative Care Programs. Both programs have a focus on restorative care. The Transition Care Program offers short-term care to help older people recover after a hospital stay. The Short-Term Restorative Care Program supports people experiencing functional decline to regain their ability to carry out activities of daily life. Generally, the assistance provided is information provision and support to access services. Advocates note that older people are often not provided with information on these service types and have flagged the need for greater promotion of the Transition Care Program within relevant health services and hospital departments.

Both programs are time limited. The Transition Care Program provides care for up to 12 weeks, whilst the Short-Term Restorative Care Program is up to eight weeks. Advocates regularly provide information and support to people that are receiving these programs and are considering what their care options may be once the programs come to an end (refer to Case examples 28 and 29).

Case example 28

An advocacy client who had been living in a unit in a residential village, had a fall and was in hospital for 3 weeks, rehab for 4 weeks and then accessed the Transitional Care Program. A social worker had recommended the client be permanently placed in a residential facility rather than return home. The client was upset about the social worker's recommendation that they should not return home as they felt mentally and physically able to do so, albeit requiring use of a walker. The client asked the advocate to call the social worker and advise them that they wanted to return home. The advocate contacted the social worker who advised that the client had seven weeks left in transitional care before a decision needed to be made. The advocate called the client back and advised them of the time left to make a decision. The client advised the advocate that at 91 years of age and with a bad knee from the fall, they would consider residential care in a facility nearby.

Case example 29

The carer for an older person who is currently receiving transition care called regarding her carer's burnout and the difficulty she is having finding appropriate care for the older person. The older person is in transition care but needs to find a provider for either a Home Care Package or a place at a residential care facility. The advocate assisted the client by discussing the challenges in finding appropriate service provision. The advocate assisted the client to contact My Aged Care (MAC). The advocate requested that MAC appoint a case manager. MAC appointed a case manager for both the carer and the older person. The advocate contacted the client to follow up after the call to MAC. The client expressed how happy she was with the outcome.

Service delivery and quality of care

As with all program types, there are some service delivery and quality of care issues that arise within these program types. Issues observed in this period include; provider communication, lack of flexibility in responding to client's specific health needs and difficulties accessing equipment within the Short-Term Restorative Care Program. Transition care provided in the residential care setting was impacted by COVID-19 and workforce shortages. This resulted in some Transition Care recipients facing challenges in accessing necessary allied health services, engaging in rehabilitation programs and in some instances receiving a level of basic care (refer to Case example 30)

Case example 30

A client was receiving transitional care at a residential care facility following discharge from hospital. While in residential care, the client had been left for extended periods of time without accessing the toilet and left in bed for up to 8 hours through the day. The client needed to start walking again and had a new walker at home; however, due to COVID-19 implications at the facility, they had not been supported to exercise or access required treatment from a physiotherapist. The client was instead given a piece of paper with some exercises to complete on their own. The client stated that they had asked staff for showers but was informed that due to COVID-19 this was not possible. The client attempted to inform staff that they would be able to shower themselves if they were hoisted onto a shower seat but was told this could not happen. The advocate explained the client's right to receive high quality care and services, to be treated

Continued on the next page

Flexible care (Continued)

with dignity and respect, to live without abuse and neglect and to have control over and make choices about their care. The client directed the advocate to raise their concerns with facility management. This resulted in an apology and immediate improvement in service delivery. The facility advised that there had been positive cases in the wing where the client was residing, and the residents in that wing had been using a communal shower. The provider communicated that residents were still able to choose if they would like to shower despite the COVID risk and reinforced this by sending a similar message out to all facility staff. The client was also able to access allied health and physiotherapy in their room rather than a communal area.

Flexible service delivery

Several OPAN Members have flagged concerns about the level of flexibility permitted within the Flexible Aboriginal and Torres Strait Islander Aged Care (FATSIAC) Program. OPAN Members have reported that FATSIAC services have struggled to convince auditors from the Aged Care Quality and Safety Commission (ACQSC) of the need for more flexibility to ensure the delivery of culturally safe care. Support for Elders to return to Country has been a particular area of concern. A couple of OPAN Members delivering NACAP have been involved in cases where FATSIAC clients have sought support from the program to return to Country. Supports sought have included travel and the assistance of a support worker to accompany them on the journey. There is limited program guidance addressing this topic and providers are often unclear if these trips, which are of significant cultural importance can be supported with program funding.

In one case, an Aged Care Quality and Safety Commission Auditor deemed program funding used to support a return to Country trip to be a breach of program guidelines. Understanding the cultural significance of this service offering, the provider involved made the decision to self-fund the client's trip but expressed concern about the need for ongoing funding for this essential activity. OPAN Members have called for consideration of return to Country travel in both the FATSIAC and Home Care Package programs. They have also suggested ACQSC auditors could benefit from training on culturally appropriate care and safety for First Nations care recipients.

Diverse and marginalised groups

Throughout the year, OPAN Members across the nation provided advocacy support to 2,957 people from diverse and marginalised groups including

- **people from Aboriginal and/or Torres Strait Islander communities**
- **people from culturally and linguistically diverse (CALD) backgrounds**
- **people who live in rural or remote areas**
- **people who are financially or socially disadvantaged**
- **people who are veterans of the Australian Defence Force or an allied defence force including the widow/widower of a veteran**
- **people who are homeless, or at risk of becoming homeless**
- **people who are care leavers (which includes Forgotten Australians, former child migrants and Stolen Generations)**
- **parents separated from their children by forced adoption or removal**
- **people from lesbian, gay, bisexual, trans/ transgender and intersex (LGBTI) communities**

The advocacy issues raised amongst these groups were often similar to those presented in other sections of this report. However, many of the cases involved added layers of complexity associated with language, cultural factors, family and community dynamics and/or elements of social disadvantage.

Some of the topics highlighted in OPAN Member reports on advocacy support for people from diverse and marginalised groups included culturally appropriate and trauma informed care, access to and use of interpreters, the availability of aged care services in rural and remote communities, the abuse of older people and fees and charges.

Culturally appropriate and trauma informed care

During the first half of 2022, advocates were involved in several cases where they supported people from a diverse range of backgrounds to engage with their providers about better meeting their unique care needs.

There were some cases where advocates supported clients to call for greater flexibility in the delivery of their Home Care Package supports. Case example 31 provides a demonstration of how a little flexibility applied to Home Care Package service provision can help individuals with diverse characteristics and life experiences to receive care that better meets their needs.

Several OPAN Members reported on cases where Aboriginal and/or Torres Strait Islander people sought support from their Home Care Package or Flexible Aged Care services to travel or return to Country for cultural business and noted concerns that guidance in the Home Care Package Operational Manual fails to recognise the cultural significance of this type of travel.

Advocates were also involved in numerous cases where they supported people in residential aged care and their representatives to engage with their provider about the provision of culturally appropriate care. OPAN Members noted that they were involved in several cases where they supported clients to advocate for a trauma informed approach to care (refer to Case example 32). It was noted that training on trauma informed care is not always available to residential care services, nor welcomed by facility management. OPAN notes that investment was made by the Australian Government Department of Health and Aged Care in awareness raising activities and trauma informed supports in the early phases of the COVID-19 pandemic, although the reach and impact of these initiatives is not known.

Numerous cases involved supporting clients to overcome barriers to communication through

the increased use of interpreting and translation services. Advocates regularly assisted individuals who were deaf, Culturally and Linguistically Diverse or who were Aboriginal and Torres Strait Islander people to access interpreters so that they could engage with My Aged Care and assessors, navigate and implement aged care services, raise and address issues relating to their care and in some instances share concerns about abuse.

OPAN Members have indicated that there is a general lack of available interpreters for some language groups, and in some instances, this can place some older people at risk of harm. For example, one OPAN Member shared that they received a referral for an older Hungarian person experiencing elder abuse but struggled to communicate with them in a timely manner, as they could not access an appropriate interpreter.

Advocates have observed that key aged care information and service documents, such as service agreements, support plans and the Charter of Aged Care Rights are often not provided to clients in their primary language. OPAN Members are exploring options for some translation options in selected Aboriginal languages in the Northern Territory, but a broader approach is required.

OPAN is aware that approved providers of government-subsidised aged care can use the Translating and Interpreting Services for free when discussing care needs, fees, care plans and budgets with clients and is concerned that these services are not being utilised. Whilst the translation of service agreements may require some time and effort on a provider's behalf, it appears that readily available translated resources such as the Charter of Aged Care Rights which is available in up to 18 languages are often not being shared as part of standard practice.

Case example 31

A Forgotten Australian sought advocacy support after their Home Care provider repeatedly ignored their requests for support to complete insurance and hospital documentation. The nature of their childhood experiences meant their literacy levels were low, making it difficult to complete forms without assistance. An advocate assisted the client to raise and resolve this issue with their HCP who agreed they could help provide support. The advocate also informed the client of other community options that could assist them with tasks they may need support with in the future. The client expressed that they were pleased that they didn't have to explain what a Forgotten Australian was to the advocate. This highlighted how Forgotten Australians/Care Leavers are often not understood or considered within the aged care system.

Case example 32

An Aboriginal resident requested advocacy support because they were not being provided with adequate supply of continence aids. In discussions with the advocate, the client revealed intersectional issues associated with mental health and past experiences of sexual abuse. The advocate worked extensively with the residential care facility and the client to ensure appropriate referrals to specialist services were in place. The advocate also reminded the facility of the need to enact an appropriate care plan. The client had indicated that they were unable to receive personal hygiene support from male carers due to previous assault and whilst this had been noted in their care plan, this had not been always implemented.

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Diverse and marginalised groups (Continued)

Rural and remote service availability

Service access issues presented in 49% of advocacy cases involving people from diverse and marginalised groups[8]. OPAN Member qualitative reports have suggested there is a large cohort of older people that are being denied access to aged care services based on where they live. In many rural and remote areas there are limited aged care providers and in some instances, no providers. Advocates have been involved in numerous cases where people in rural and remote locations cannot access any aged care services or have had their regular services reduced significantly (refer to Case example 33). There are a number of factors contributing to the availability of services in rural and remote areas. Providers in rural and regional centres are unwilling to service these areas due to the high costs associated with delivering services into remote communities. For example, CHSP funding does not adequately provide for the distance many support workers have to travel to attend to a client.

In addition, the following issues are also faced:

- high rates of burnout and staff turnover
- a limited pool of potential workers to draw from when recruiting
- high cost of living and lack of accommodation for staff in rural and remote areas
- a lack of support and training for aged care workers located in rural and remote areas.

In the residential care settings, OPAN Members have shared stories of facilities that had to reduce the number of beds they offer and close down entire wings of their facility because they simply do not have the staff to service them. In some jurisdictions OPAN Members have reported on facility closures that have had a significant impact on the communities they service.

Facility closures often force residents to move to facilities in towns a long distance from their families and friends and this can exacerbate feelings of isolation and distress for both residents and families. Advocates have observed that residential care shortages have had an effect on access to residential respite which has placed undue stress on informal carers. In some circumstances older people have been left to fend for themselves because the aged care system does not have the capacity to provide in-home support or residential respite and their carers are reaching breaking point.

OPAN Members have also reported on cases where a lack of service availability has seen Aboriginal Elders removed from their communities and hospitalised in regional centres. In many cases, they are unable to return to their family and community and this can result in increased distress and depression. It has been noted that this separation from family and Country adds to past experiences of trauma and can impact on the overall health and wellbeing of Elders.

In some areas, Local Governments and State/Territory health services are the sole provider of CHSP services. OPAN Members have observed reductions in the service offerings delivered by some of these providers and are concerned about their potential closure as aged care reforms progress (refer to Case example 34). The CHSP section of this report has touched on the impact that service closures of this nature can have on communities.

OPAN Members have identified access to transport services as a particular area of concern for both those living in the community and residential care. OPAN Members have shared examples of aged care residents cancelling important health appointments, such as cancer assessments, because they

[8] Based on a sample of quantitative data.

cannot afford to get to the appointment by private means and there is no affordable service to assist. Older people living in rural and remote communities often need to travel long distances to go shopping and more importantly access specialist health services. CHSP transport services are often limited, underfunded and restricted from transporting people living in residential care. Public transport, community transport, Ubers and taxi services can be non-existent in some communities and people must rely on family and friends (who are often working and don't live in the area) to transport them to appointments. This is not a viable solution nor a solution that is available to all. Social and financial disadvantage often contributes to concerns in this area, with the cost of taxis being unaffordable particularly for those on a pension. In some instances, the older person or their friends/family have the capacity to drive but have limited funds for fuel or required car maintenance. The Home Care Packages Operational manual declines the use of package funds to purchase petrol or vehicle maintenance that would in many instances enable the older person to access medical appointments. Increased access to specialist appointments via telehealth may assist in relieving some transport pressures. But this would also require investment in infrastructure to support the use of telehealth in rural and remote communities.

Case example 33

An elderly Aboriginal person living with family on a rental property in a rural area has multiple comorbidities including incontinence, hearing and vision impairments, and dementia. The older person was receiving personal hygiene twice weekly from a Home Care Package provider, but they informed the family that they were an entry level service and unable to continue to deliver an appropriate level of care. The family had exhausted all efforts to try and find a service provider in their area, but none were able to deliver the services the older person required. The older person was approved for a Level 4 HCP but due to being unable to find a service provider within the 84 days criteria, the package was relinquished, and the older person was placed back on the waiting list. At the same time, the family were also informed that they needed to vacate their rental property by the end of the month. The older person's family were very reluctant to place the older person into a permanent residential care facility due to cultural reasons. With the older person's and the family's consent, an advocate sourced and spoke to a service provider about respite in a facility in a metropolitan town as interim measure. This provided some welcome relief to both the older person and the family whilst they sourced another property and awaited the Home Care Package notification.

Case example 34

A State Government Country Health Service recently went on red alert and scaled back services to only essential services. This led to a significant number of clients losing or having significantly reduced services. In one such case a client who had significant allergies and breathing issues that were exacerbated by dust had cleaning services reduced from weekly to monthly which could have severely impacted the client's health and ability to stay home if it was not for the intervention of an advocate.

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Diverse and marginalised groups (Continued)

Abuse

Abuse was identified as a significant issue of concern across a number of diverse and marginalised groups. Financial abuse and neglect presented as the most common form of abuse. In many cases, housing issues, including overcrowded living arrangements, social and financial disadvantage and complex family and community dynamics were identified as key contributing factors. Perpetrators of abuse were often family members, and in many instances the victims were hesitant to take action and potentially damage relationships or get their family members in trouble. Advocates reported that these types of cases were often very complex and required a case management approach and collaboration with other community-based services.

Widespread housing supply issues, coupled with ongoing challenges accessing community based aged care supports, placed some older people in a position where they were fearful that abuse prevention interventions may lead to them having to be placed in residential aged care. This prospect was particularly frightening for people who are from Stolen Generations and Forgotten Australians, two groups that experienced past trauma in institutional settings. Advocates also noted a reluctance to engage with legal services, with some individuals referencing past negative experiences with lawyers and the legal system.

A new area of concern that emerged during this period is in relation to Public Guardians. Several jurisdictions reported on Public Guardians that appeared to lack cultural understanding when making decisions for people from diverse and marginalised backgrounds. South Australian member, ARAS raised concerns that guardians appointed through the Public Advocate may not be suitably trained in cultural competencies and best practice for Aboriginal clients. ARAS shared an example of a Public Guardian making decisions about where an Aboriginal client should live without taking into consideration the spiritual and cultural wellbeing of the Aboriginal Elder and their connection to land and Country/ community.

Other OPAN Members have raised concerns about how Public Guardians engage with their clients, particularly those from Culturally and Linguistically Diverse backgrounds. Case example 35 demonstrates how some Public Guardians are making important decisions without even meeting with their clients or engaging interpreters so they can have a discussion with the client about their views and preferences. OPAN recognises guardianship and powers of attorney are State and Territory legislative responsibilities, but misuse of these powers does affect the rights of older people, their experience of aged care and their wellbeing. Further cross jurisdiction policy responses in these areas are required. The role of the Aged Care Quality and Safety Commission and approved aged care providers in supporting effective use of these orders and powers may be limited but needs consideration, particularly when the Charter of Aged Care Rights has not been followed or breached (see 'Misuse of Enduring Powers of Attorney' and 'Unwanted Admission to Residential Aged Care' sections below).

Case example 35

A Spanish speaking client living with dementia was placed in a residential care facility against their wishes by the Public Guardian. No one in the facility speaks their language and they have expressed that they want to live with their family member who has the means to provide 24-hour care. The client has had four public

guardians this year. None of them have met with the client, or even spoken to the client, to find out what their wishes and preferences are. The Public Guardian has challenged the advocate's right to access documents, such as geriatrician reports and an accommodation proposal put forward by the residential aged care facility. The advocate spoke to the client three times with the support of a Spanish interpreter and discussed the client's concerns with their Public Guardian. The advocate raised issues around the Charter of Rights noting that the client has the right to be listened to and understood - yet none of the previous Public Guardians have met them or spoken to them. The advocate also informed the Public Guardian that people with dementia can live in the community with support. The Public Guardian met face-to-face with the client for the first time, engaged an interpreter and encouraged the client to discuss their preferences for living arrangements. The client is now residing in the community with their family member.

Fees and charges

Fees and charges have been identified as a top area of concern across all aged care service types and amongst advocacy clients from diverse and marginalised backgrounds. The issues experienced by people from diverse and marginalised backgrounds reflect commentary provided in the CHSP and Home Care Packages section of this report. The key points of difference have primarily related to an increased need for support around financial hardship applications and the negotiation of fee reductions.

Advocates and Financial Advocacy Officers have also provided information provision and advocacy support to address errors in the calculation of fee and charges for Veterans accessing the aged care system (refer to Case example 36). The errors often occur at the systems level where information is shared between Services Australia and the Department of Veterans' Affairs. Advocates note that when accessing aged care, Veterans often get confused about why they must report their income and assets to Services Australia when they would normally engage with the Department of Veterans' Affairs for these types of matters. It has been suggested that consumer resources to help explain the interaction between the Department of Veterans' Affairs and Services Australia when accessing aged care would be useful.

Case example 36

A resident sought advocacy support when their residential care facility told them that their fees needed to be paid within a week or they would have to leave. The resident was already paying the facility 85% of the pension they receive from Centrelink and the Department of Veterans' Affairs. The resident noted that their partner still lives in their home, are paying off a mortgage and are in the middle of a mould insurance claim. The advocate provided information on fees and charges, support to discuss the situation with their provider and assistance to complete and lodge a financial hardship form. It was later revealed that the facility had not lodged the correct paperwork to Services Australia.

The abuse of older people

Between January and June 2022, OPAN Members provided information and advocacy support to over 700 people concerned about the abuse of older people. OPAN Member reports suggest the nature of the abuse is complex and often will not be contained to one issue. Financial abuse for example, presented as the most common type of abuse, but was often seen alongside instances of verbal, social and emotional abuse.

OPAN Members have indicated that in most of the abuse cases their advocates are involved in, the abuse occurs at the hands of family members, and more specifically adult children. Many cases have involved the misuse of formal decision-making authorities such as Enduring Powers of Attorney/Power of Attorney. Several influencing factors have been observed in many of the abuse advocacy cases. These have typically included housing shortages and the extended reliance on home sharing, mental illness, substance abuse and addiction, carer stress and financial stress.

One of the most common challenges for advocates working in this area is supporting clients who fear the abuser and are reluctant to consider potential interventions. Some fear reprisal in the form of social isolation and are concerned that connections with family, including grandchildren will be severed. For others, their reliance on their abuser for care and support and in some instances accommodation, places them in a vulnerable position. An undersupply of affordable housing and accessible aged care services makes it more challenging for people in these circumstances to leave abusive situations.

Financial abuse

In the area of financial abuse, advocates are seeing many cases involving adult children manipulating the system to gain Enduring/Power of Attorney and exert control over the older person's finances. In some cases, adult children are enacting decision-making powers whilst the older person still has decision making capacity or are making major financial decisions whilst the older person is in hospital and experiencing a temporary loss of capacity. Advocates have been involved in cases where adult children have removed an older person's access to their personal bank accounts, withdrawn money from their accounts, taken and in some instances sold all their belongings and put their house on the market.

OPAN Members are also seeing a number of cases relating to older people being coerced into handing over the titles to their properties, selling their properties and purchasing a new property with their children or lending large sums of money to their adult children to purchase a property of their own (refer to Case examples 37 to 40). In many of these cases, the older person agrees to these actions on the proviso that they can live with and receive care and support from the family member involved, however, these arrangements often don't go to plan. Advocates have been involved in cases where adult children have become aggressive, introduced restriction on living arrangements such as limiting visitors to the house, are distributing bills unevenly (to the adult child's benefit) and are threatening to evict the older person and place them in residential care if they don't comply with their demands.

In these types of cases, advocates provide older people with information about their rights and potential options for addressing their concerns. Advocates will often connect older people with

legal services, family violence services and in some instances the relevant state/territory police service.

Many cases ended up at tribunal hearings, which can be a confusing and distressing process for the older person. Advocates often help to alleviate this stress by providing information on what to expect from the tribunal process and by attending and providing support at tribunal hearings (refer to Case example 41).

Case example 37

An older person contacted an OPAN Member, concerned that their family member had paid off their home mortgage using the older person's savings. The family member had enacted the Enduring Power of Attorney without the older person's permission, despite the older person being found to have full capacity following a geriatrician's assessment. An advocate supported the older person to contact a lawyer, and a mobile law service was able to visit the older person and assist in reviewing and amending the Power of Attorney documentation and making some changes to the older person's will. The older person was very pleased with the outcome and expressed that they felt confident to contact the advocate and/or lawyer if they experienced any retribution from the family member.

Case example 38

An advocacy client was persuaded by their daughter to relocate to the town where their daughter lived. The client advised they had been coerced into lending their daughter's family $350,000 to build a house that they explained would accommodate all of them including the client. The client advised the advocate that their daughter and her family listens to all of their phone calls and become verbally abusive if they disagree with them or acts independently. The client has another daughter who is not allowed to visit the client in the home. Client is also not allowed to bring any friends into the home.

Case example 39

A client had sold their home so their son could purchase a new property with the understanding that the client could reside in the property rent free. After a period, the son became increasingly abusive and difficult, threatening to evict the client if they did not maintain the property to his standards. The client reported their son is extremely controlling in all aspects of the client's life. Eventually the son threatened to sell the house and place the client into a residential aged care facility.

Case example 40

An advocacy client was concerned about how their daughter was treating them. The client had started making inquiries about the home they had purchased together, and it appeared that the client was making more payments than their daughter. The client wanted to find out more about their share of the property because they wanted to make sure they would be able to choose an aged care facility of their liking when the time came. The daughter refused to provide the required documentation and became quite aggressive towards the client. Following further inquiry, the client discovered other financial concerns and also reported money had been stolen directly from their wallet. Other members of the family were also alarmed at their sibling's behaviour which had seen the client banned from the house. The advocate was able to link the client to legal support.

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The abuse of older people (Continued)

Case example 41

The client had been a patient in hospital for several weeks following a fall. The social worker at the hospital became alarmed after investigating the client's current financial situation and discovering the client's Power of Attorney had been using the client's money to gamble. An application was made by the social worker to the relevant tribunal for an urgent review and possible revocation of the client's current Power of Attorney. An advocate met with the client on the hospital ward to discuss the issue and upcoming tribunal hearing. The client was very distressed about the situation and did not understand the tribunal process. The advocate explained the process, and the support advocacy could provide. The client consented to the support. The tribunal hearing was held a week later, and the Power of Attorney was revoked and replaced with public decision makers.

Misuse of Enduring Powers of Attorney

Whilst financial reasons appear to be the main motivator for the misuse of Enduring/Powers of Attorney, advocates have also been involved in numerous cases where powers have been used in ways that could be considered social or psychological abuse. Examples in this area include Enduring/Powers of Attorney not involving the older person in decisions about their care, not responding to the older person's requests for information, restricting access to family, friends or engagement in community activities and taking control of every aspect of the older persons life without their agreeance.

Many cases of this nature occur in the residential aged care setting. In some instances, staff at the facilities recognise that the older person's right to freedom, choice and decision-making is being violated and support them to connect with an advocate (refer to Case example 42). Unfortunately, advocates are also involved in cases where residential care facilities are supporting Enduring/Power of Attorney to make decisions without taking into consideration the expressed views and wishes of the resident (refer to Case example 43). A common example of this is facility managers supporting Enduring/Powers of Attorney to restrict residents from visiting or receiving visits from certain family members or friends, despite the resident expressing that they would like to see the visitor. OPAN Members have suggested that residential care facilities appear to lack an in-depth knowledge of Enduring/Powers of Attorney, the application of assumed capacity and the legislated rights of residents.

A growing concern in this area is Enduring/Powers of Attorney instructing facility managers to deny resident's access to an OPAN advocate. In some of the cases where this has occurred, the resident has engaged an advocate to support them to address concerns about their Enduring/Power of Attorney and potential abuse. The facilities have ignored the expressed concerns of the resident, their right to access an independent advocate and are potentially preventing abuse intervention from occurring. In extreme circumstances, some Enduring/Powers of Attorney have threatened advocates with legal action or engaged lawyers to write letters instructing advocates not to contact the resident or their attorney.

Case example 42

An OPAN Member received a call from a manager at a residential care facility who then introduced a resident with English as their second language. The facility manager relayed that the resident had concerns about a scheduled visit

from their daughter. An intake advocate spoke to the resident and manager about how to ensure the older person felt safe and supported. The older person informed the advocate that their daughter had said to them she would be taking them to the bank to withdraw money as she was now their Enduring Power of Attorney, and are in charge of their finances. The older person did not want to be taken out of the facility by their daughter the next day, as they were fearful that their daughter would then withdraw all their money. The advocate discussed with the manager and the older person the possible safeguards to keep the older person safe when their daughter arrives and to prevent the daughter trying to take control of the older person's money. The intake advocate suggested to the facility manager to only allow the daughter to visit the older person in a safe place within the facility. An advocate later provided supports to introduce financial safeguards for the older person.

Case example 43

A client stated their son was restricting their freedom and preventing them from accessing the community by using his authority as an appointed Guardian. The client wanted an advocate to assist them in understanding their rights and communicating their wish to regain freedom. The client wanted to be able to come and go from their residential aged care facility as they pleased. The advocate supported the client to talk to both their guardian and the aged care facility and the client was able regain some independence and continue visiting friends who lived locally.

Unwanted admission into residential care

An ongoing issue raised in relation to the abuse of older people is unwanted admission into residential care. Advocates have engaged with so many older people who have felt like they have been dropped off at a facility with no choice in the decision and no opportunity to engage in discussions about alternative options. Advocacy clients in these cases often express a deep unhappiness over the perceived lack of power they have over their life and future decisions.

Many of these cases involved Enduring/ Powers of Attorney placing an older person into residential care following a hospital visit or an Enduring Power of Attorney informing an older person they are attending residential care for a short respite stay and then permanently admitting them into residential care against their wishes. Of course, it could be said that not all these cases involve abuse but are instead a reflection of an aged care system that is not capable of supporting older people with high level complex needs to remain living independently in their home. However, in some instances, it is clear that the admission into residential care is associated with some form of financial abuse as the older person's assets and possessions have clearly been sold or given away without their consultation or consent.

In these types of cases, advocates support older people to have their capacity reassessed and support them to attend tribunal hearings and voice their concerns about their appointed decision makers. Where the older person is deemed by the tribunal to have capacity, the older person often successfully revokes their substitute decision-makers. In these circumstances, advocates will support the

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The abuse of older people (Continued)

older person on what can sometimes be a long journey returning to life back in the community (refer to Case examples 44 and 45).

Case example 44

An advocacy client had been assessed by a geriatrician and found to have capacity to make decisions. Since their admission many months earlier the resident had expressed their wish to return home. The resident's family had expressed concern about the resident's history of alcohol misuse which had resulted in several hospital admissions and other mishaps. The family made an application to the relevant tribunal regarding the matter and the subsequent hearing found the resident was capable of making a decision about where they lived provided appropriate supports were in place. The resident is awaiting access to community-based supports.

Case example 45

A resident at a facility sought advocacy as they believed that they should not have been placed in the facility nor should they have a guardian appointed. The advocate supported the older person to have the tribunal's decision reviewed and seek another guardian. Following the tribunal hearing another guardian was appointed as well as an administrator. The older person was consistently unhappy in the residential care facility they were in. They said the diet was terrible, they had lost weight and the lack of activity and exercise were contributing to a decline in their health. The older person reported they would be left for long periods without their walker, so they had to ask for help when they wanted to move. The advocate met with the older person and the manager of the RACF addressed these issues. In every conversation the older person maintained that they felt unsafe and wanted to return to their

home. After a period of time the residential care facility requested a capacity assessment, and the advocate supported the older person to attend a tribunal hearing. The tribunal determined they had no jurisdiction, and both the administrator and guardianship were revoked. As a result, the older person can now make their own lifestyle and financial decisions. A system navigator is now supporting the older person to have their Level 4 Home Care Package approval, that was issued prior to the entering residential care, reinstated so they can return home.

Conclusion

The themes presented in this report provide invaluable insights into the challenges experienced by older people accessing and receiving aged care between January – June 2022. These themes are derived from the top presenting issues in aged care advocacy cases that OPAN's nine state and territory service delivery organisations have supported older people with.

Workforce shortages were identified as a key influencing factor for many of the issues presenting in this report. Workforce shortages have been observed across all aged care program types and appear to be most significant in rural and remote communities. Workforce shortages are contributing to decreasing service access, particularly in the community setting where providers of the Commonwealth Home Support Program and Home Care Packages are struggling to match workforce supply with service demand.

Workforce supply is also impacting on the quality of care delivered in both the community and residential care. Common quality of care issues presenting in the community setting include poor communication with care recipients and unexpected service changes and cancellation. Quality of care concerns presenting in residential care have been wide-ranging and included reports of substandard and neglectful clinical care, the use of restrictive practices, limited access to allied health services, hygiene issues, inadequate food and nutrition and care plans not being adhered to.

Issues with fees and charges have presented across all aged care program types, demonstrating the need for the newly introduced OPAN Financial Advocacy Officer roles. Financial Advocacy Officers across the nation have provided older people with information on aged care fees and charges and supported them to discuss concerns about fees and charges with their providers, apply for financial hardship, negotiate fee reductions, and engage with Service Australia.

The use of interpreting and translating services was identified as an issue that presents at all points of the aged care service system including service access and assessments. Approved providers of government-subsidised aged care can use the Translating and Interpreting Service however, advocates have been involved in numerous cases where these resources have not been utilised. This suggests that greater enforcement of the use of interpreting and translating services may be required.

Cases relating to the abuse of older people continue to feature the misuse of substitute decision-making powers. In many cases the primary form of abuse is financial, and this financial abuse often occurs at the hands of adult children. OPAN has identified the need for greater awareness of the roles and responsibilities of substitute decision-makers and the rights of older people with substitute decision-makers. Education and awareness raising efforts should be targeted at both the general public and aged care service providers.

The number and breadth of issues that advocates have supported people with over this 6-month period demonstrates the value of the National Aged Care Advocacy Program. Access to aged care advocacy support will remain vital as the aged care system enters a significant period of reform.

Acronyms

ACAT
Aged Care Assessment Team

ACQSC
Aged Care Quality and Safety Commission

ADAA
Aged and Disability Advocacy Australia (ADA Australia): OPAN member in Queensland

ADACAS
ACT Disability, Aged and Carer Advocacy Services: OPAN member in ACT

ARAS
Aged Rights Advocacy Service: OPAN member in South Australia

CALD
Culturally and Linguistically Diverse

CCNT
CatholicCare NT: OPAN member in Northern Territory

CHSP
Commonwealth Home Support Program

DCLS
Darwin Community Legal Service: member of OPAN in Northern Territory

ERA
Elder Rights Advocacy: OPAN member in Victoria

GP
General Practitioner

HCP
Home Care Package

LGBTI/LGBTIQ+
Lesbian, Gay, Bisexual, Transgender, Intersex and/or Queer plus other identities

MAC
My Aged Care

NACAP
National Aged Care Advocacy Program: the program OPAN is funded under

NDIS
National Disability Insurance Scheme

OPAN
Older Persons Advocacy Network

OT
Occupational Therapist

RN
Registered Nurse

RACF
Residential Aged Care Facility

RAS
Regional Assessment Service

Member Service Delivery Organisation: how OPAN Members are referred to

SIRS
Serious Incident Response Scheme

SRS
Seniors Rights Service: OPAN member in NSW

OPAN Older Persons Advocacy Network

OPAN member organisations by state or territory:

ADACAS ADVOCACY

Advocacy Tasmania

ERA Elder Rights Advocacy
Supporting your right to quality care

Seniors Rights Service

Darwin Community LEGAL SERVICE

ADAAustralia

aras

Advocare
Empowering older people in WA

CatholicCare NT