Serious Incident Response Scheme

Guidelines for residential aged care providers

Version 1.3
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Australian Government
Aged Care Quality and Safety Commission

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Safeguard

Acknowledgments

The Aged Care Quality and Safety Commission engaged mpconsulting to support development of external guidance relating to the introduction of the Serious Incident Response Scheme (SIRS). This resource, together with the forthcoming *Effective incident management systems: Best practice guidance,* and changes to the Commission's *Guidance and Resources for Providers to support the Aged Care Quality Standards* (in relation to amended Standard 8), will ensure the sector can successfully prepare to meet new requirements following commencement of the SIRS from 1 April 2021. The Commission would like to acknowledge Andrea Matthews, Elsa Kennett, Ashleigh Kennedy and Riaza Rigby from mpconsulting for their central role and principal authorship of this resource.

Serious Incident Response Scheme Guidelines for residential aged care providers

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Notes: This version of the guidance has been updated to include:

- Changes to definitions
- Changes to wording
- Updates to outdated guidance and outdated references

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Contents

Chapter 1: Introduction

The Serious Incident Response Scheme

The Serious Incident Response Scheme (SIRS) is a new initiative to help prevent and reduce the risk and occurrence of incidents of abuse and neglect in residential aged care services subsidised by the Australian Government.

The SIRS complements existing provider obligations under the Aged Care Act by establishing responsibilities for providers to prevent and manage incidents (focusing on the safety and wellbeing of consumers), to use incident data to drive quality improvement and to report serious incidents.

The SIRS will promote an aged care system that supports consumers to feel safe and confident about the quality of their care. It is also intended to ensure that the care and services that older Australians receive will continuously improve and that incidents will be prevented, managed and resolved, with enhanced outcomes for consumers.

The aim of the SIRS is to reduce the risk of abuse and neglect of older Australians in residential services by:

- building provider capacity to better identify and mitigate risks of potential harm, and respond to and manage serious incidents if and when they occur
- driving learning and improvement at a system and service level to reduce the number of preventable serious incidents
- holding providers to account to provide appropriate support to consumers in the event of an incident.

The effective management of incidents is critical to effective clinical governance and will enable you to manage risks to consumers and improve the quality of care and services you provide. By systematically recording and investigating incidents, you are better placed to identify trends and issues, and to pursue continuous improvement at your service.

In notifying the Aged Care Quality and Safety Commission (Commission) of reportable incidents, you enable the Commission to assess and respond to risk at a service level, as well as to identify and act on opportunities for education and improvement across the sector.

Context

Australians have a right to live free from abuse and neglect as a matter of human rights, current law and reasonable community expectation. These rights, which do not diminish with age, include the right to live dignified, self-determined lives, free from exploitation, violence and abuse. In addition, consumers of Commonwealth-funded aged care services have specific rights and expectations for safe and quality care and services.

Preventing and responding to serious incidents effectively is an essential part of providing safe and quality aged care. In support of these rights and the prevention of abuse and neglect in aged care, the Australian Government has introduced the SIRS for approved providers of residential aged care and flexible care delivered in a residential aged care setting.

Commencement of the SIRS

The SIRS will commence in two stages.

The first stage will commence on 1 April 2021. From this date, providers of residential care and flexible care in a residential setting are required to have in place an effective incident management system that enables their appropriate and timely prevention, identification, and response to all incidents.

Also from 1 April 2021, the same providers are required to report all incidents assessed as Priority 1 reportable incidents to the Commission.

On 1 October 2021, the second stage of the SIRS will commence. From this date, providers of residential care and flexible care in a residential setting must report all reportable incidents. Reportable incidents must still be assessed as 'Priority 1' or 'Priority 2' as this will determine the relevant time for notifying the Commission. Detail regarding what is a reportable incident, the distinction between Priority 1 and Priority 2 incidents, and when to notify the Commission is provided in the following chapters.

What is the relationship between incident management systems and the SIRS?

All aged care services are required to have effective systems and practices for preventing and managing all incidents, including the use of an incident management system (IMS). An IMS will support you to deliver safe and quality care and services ffor aged care consumers and to provide appropriate support for those affected by an incident. It will also assist you to take action to prevent incidents from recurring and to continuously improve.

For providers of residential care and flexible care in a residential setting, a subset of the incidents addressed through your IMS are likely to pose a high risk to consumers. These are known as 'reportable incidents' and must be reported to the Commission.

Notification of reportable incidents under the SIRS focuses on the provider's response to serious incidents, including the supports they put in place for impacted consumers, the actions they take to continuously improve and reduce the likelihood of incidents reoccurring and the way they use information about incidents to inform organisation-wide management of risks, feedback and education to staff and to improve the service's capability to prevent, manage and resolve incidents.

Broader regulatory framework

Provider responsibilities

Aged care consumers have the right to live a life free from abuse, neglect, exploitation and violence. In support of this, all providers of Commonwealth-funded aged care operate in the context of the aged care legislative framework. For approved providers of residential care and flexible care delivered in a residential setting, the SIRS is one element of the framework that supports the provision of quality care and services and a safe environment.

The introduction of the SIRS places greater obligations on providers to have an effective incident management system in place. The scheme also increases the range of incidents which must be reported to the Commission. The Commission has been provided with increased regulatory powers that will support a proportionate response to non-compliance with these obligations.

The SIRS complements other regulation including the integrated expectations of the Charter of Aged Care Rights[1] (the Charter), the Aged Care Quality Standards[2] (the Quality Standards) and open disclosure[3] requirements . Together, these settings support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to consumers.

1 https://www.agedcarequality.gov.au/consumers/consumer-rights
2 https://www.agedcarequality.gov.au/providers/standards
3 https://www.agedcarequality.gov.au/resources/open-disclosure

The Charter

Under the Charter, consumers have the right to safe and high-quality care and services, the right to be treated with dignity and respect, and the right to live without abuse and neglect. Providers are required to uphold these rights and ensure consumers in their care understand their rights under the Charter.

The Quality Standards

All providers must meet the requirements of the Quality Standards, which detail the standards of care all aged care consumers can expect.

The Quality Standards require providers to maintain effective organisation-wide governance and risk management systems and practices to prevent and manage incidents and to identify and respond to abuse and neglect of consumers.

Providers are also required to regularly review the care and services provided for effectiveness, including when incidents impact on the needs, goals or preferences of consumers, and to effectively manage the high impact and high-prevalence risks associated with the care of each consumer to ensure that each consumer gets safe and effective personal and clinical care.

Other requirements in the Quality Standards are also relevant to how providers prevent, assess and manage risks of and actual incidents. This includes requirements to provide consumers with choice, control and independence; to enable consumers to take risks to live the life they want; and to support consumers to maintain relationships of choice.

Open disclosure requirements

As outlined under the Quality Standards, providers must use an open disclosure process when things go wrong. This means that providers should facilitate an open discussion with consumers (and their representatives) when something goes wrong that has harmed or had the potential to cause harm to a consumer.

Providers are expected to practice open disclosure in their prevention and management of any incidents impacting consumers.

The Commission

The Commission is the national regulator of aged care services, and the primary point of contact for consumers and providers in relation to quality and safety.

Complaints or concerns about the quality of care and services can be made to the Commission and, like notification of serious incidents, complaints play an important part in helping providers to improve the quality of care and services through a continuous improvement process.

The Commission accredits, monitors and assesses the performance of providers against the Quality Standards and helps consumers resolve complaints about a provider's responsibilities or actions. This is part of the Commission's function to 'protect and enhance the safety, health, wellbeing and quality of life of aged care consumers'. Through the Commission's engagement and education work, it aims to build confidence and trust in aged care, empower consumers, support providers to comply with quality standards and promote best practice service provision.

The Commission is responsible for administering the SIRS and will receive serious incident reports from aged care providers. The Commission will monitor provider compliance with the SIRS requirements, including whether providers are responding appropriately and effectively to incidents to ensure the safety, health and wellbeing of consumers. The Commission has the power to take regulatory action(s) where appropriate to address non-compliance with provider responsibilities regarding SIRS obligations, including issuing compliance notices for suspected non-compliance, and commencing investigations.

The Commission will publish information on the operation of the SIRS and support providers to meet their responsibilities, including through providing guidance and education.

Purpose of this guidance

The Commission recommends you familiarise staff at your service with the legislative changes which support the introduction of SIRS. The changes affect both provider obligations and Commission regulatory powers. The Explanatory Memorandum[4] that accompanied the SIRS Bill when it was introduced to Parliament should be used alongside this guidance to further understand these changes and your obligations regarding SIRS.

This guidance describes provider responsibilities in relation to the SIRS, including:

- requirements relating to incident management, response and prevention
- types of incidents that must be notified to the Commission
- requirements for making a notification, including when and what must be notified
- the role of the Commission in managing reports and ensuring providers are notifying and responding to reportable incidents.

4 https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6642

Chapter 2: Incident management

Incident management and prevention

Providers of residential care or flexible provided in a residential setting have requirements under paragraph 54-1(1)(e) of the *Aged Care Act 1997* (the Aged Care Act) and Part 4B of the Quality of Care Principles 2014 to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system.

Your approach to managing incidents must focus on the safety, health, wellbeing and quality of life of consumers and meet the requirements of the aged care legislation and the *Effective incident management systems: Best practice guidance*. The legislation and guidance describe your responsibilities in identifying, responding to, managing and recording all incidents, and preventing the recurrence of similar incidents in future.

Reporting requirements under the SIRS relate to the range of serious incident types (including allegations and suspicions of incidents) outlined in Chapter 3 of this document. However, the definition of 'incident' which a provider is expected to prevent, manage and resolve through an effective incident management system is broader than this.

Definition of 'incident' for the purposes of incident management system requirements

Incident management system requirements relate to any acts, omissions, events or circumstances that occur in connection with the provision of care and services to a consumer that have, or could reasonably be expected to have, caused harm to a consumer or another person. Incident management system requirements also relate to any acts, omissions, events or circumstances that the provider becomes aware of in connection with the provision of care that have caused harm to the consumer.

This also includes incidents that have (or could reasonably be expected to have) caused harm to staff or visitors to the service – for example, where a visitor slips on a wet floor or where a staff member sustains a significant burn in the kitchen. As noted above encompasses a broader range of incidents than those that are reportable under the SIRS.

Responding to incidents

Under section 15LA of the Quality of Care Principles (*Aged Care Act 1997*), management of incidents must be focused on the safety, health, wellbeing and quality of life of the consumers at your service.

You must respond to an incident by:

- assessing the support and assistance required to ensure the safety, health and wellbeing of those affected by the incident and providing that support and assistance
- appropriately involving each person affected by the incident (or a representative of the person) in the management and resolution of the incident
- using an open disclosure process, which means you should facilitate an open discussion with those affected by an incident and engage with that person or people in the management and resolution of the incident.

In responding to incidents, you will need to consider the individuals involved, the level of harm (or potential harm) to these individuals and the circumstances surrounding the incident. Each incident will require a tailored and considered response to ensure the health, safety and wellbeing of all people involved and to explore how similar types of incidents can be prevented or mitigated in the future.

In some cases, you must also notify police of the incident within 24 hours of becoming aware of the incident. Police must be notified if there are reasonable grounds to do so.

The phrase 'reasonable grounds' may include scenarios where an approved provider is aware of facts or circumstances (alleged or known) that lead to a belief that an incident is likely to be of a criminal nature and therefore should be reported to police (e.g. if the approved provider suspects the incident involves an indecent assault, or if there is an ongoing danger). If you become aware of reasonable grounds at a later time, you must notify the police within 24 hours of becoming aware of those grounds.

Assessing incidents

As part of your approach to managing and preventing incidents, you should assess all incidents that occur to determine the appropriate support to provide to those impacted, and any reasonable and proportionate remedial actions to be taken. In doing this, you must consider the views of those impacted by the incident.

In accordance with section 15LA of the Quality of Care Principles, you must assess:

- whether the incident could have been prevented
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm
- how well the incident was managed and resolved
- what, if any, actions could be taken to improve your management and resolution of similar incidents
- whether other persons or bodies should be notified of the incident.

You are responsible for undertaking any actions identified through your assessment, including to notify the relevant persons identified, minimise risks, prevent future incidents from occurring and improve your approach to managing incidents.

Continuous improvement

In accordance with section 15LB of the Quality of Care Principles, you must collect information relating to incidents to enable you to continuously improve your prevention and management of incidents, including to:

- identify and address systemic issues in the quality of care you provide
- provide feedback and training to staff about preventing and managing incidents.

You must regularly review this information to assess the effectiveness of your prevention and management of incidents and determine what, if any, actions could be taken to improve your approach.

You are responsible for undertaking any actions identified to ensure the continuous improvement of your approach to managing incidents.

Incident management system

You must implement and maintain an incident management system that meets the requirements of the aged care legislation and the *Effective incident management systems: Best practice guidance*.

Your incident management system must enable you to collect data relating to incidents in a way that enables you to:

- identify occurrences (or alleged or suspected occurrences) of similar incidents
- identify and address systemic issues in the quality of care you provide
- continuously improve your management and prevention of incidents
- provide information relating to incidents to the Commission (as required).

Incident management system procedures

You must establish incident management system procedures to be followed in identifying, managing and resolving incidents. In accordance with section 15MB of the Quality of Care Principles, your procedures must, at a minimum, describe the following:

- how incidents are identified, recorded and reported
- the person within your organisation to whom incidents must be reported
- how reportable incidents are notified and managed (in line with legislative requirements)
- the person within your organisation who is responsible for notifying reportable incidents to the Commission
- how you will provide support and assistance to those affected by an incident to ensure their safety, health and wellbeing (including providing information about access to advocates such as independent advocates and the National Aged Care Advocacy Program)
- how people affected by an incident (and/or their representatives) will be involved in the management and resolution of the incident
- when an investigation is required by you to establish:
  - the cause(s) of a particular incident
  - the harm caused by the incident
  - any operational issues that may have contributed to the incident occurring
- processes for undertaking an investigation
- when remedial action is required and the nature of those actions.

Your procedures may include different levels of investigation and may vary based on the seriousness or type of incident.

Documentation

Your incident management system must be documented, with written policies and procedures regarding your incident management system made available to consumers and staff, and to family members, carers, representatives, advocates and any other person significant to consumers.

Documented policies, procedures and information about your system must be accessible to the person reading the documents. It is your responsibility to support people to understand how your incident management system operates, including how to report an incident (or suspected incident), the process for assessing/investigating an incident and the actions you will take in response to incidents.

Record keeping

Section 15MC of the Quality of Care Principles states that, at a minimum, your incident management system must enable you to record the following details in relation to each incident, regardless of whether the incident is reportable under the SIRS:

- a description of the incident, including the harm that was caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and, if known, the consequences of that harm
- whether the incident is a reportable incident
- the time, date and place at which the incident occurred, or was alleged or suspected to have occurred (where this is known)
- the time and date the incident was identified
- the names and contact details of the people directly involved in the incident
- the names and contact details of any witnesses to the incident
- details of the assessment you have undertaken
- the actions taken in response to the incident, including to provide support and assistance to those affected and any notifications to other bodies or persons
- any consultations undertaken with the persons affected by the incident, including to determine the level of harm (or potential harm) to those persons and identify an appropriate resolution to the incident
- whether persons affected by the incident have been provided with any reports or findings regarding the incident
- the details and outcomes of any investigation undertaken by a provider (where this occurs)
- the name and contact details of the person making the record of the incident.

All incident records must be retained for a period of 7 years after the incident was identified. You should maintain appropriate controls in relation to the privacy and confidentiality of all incident information, particularly where it relates to sensitive and personal information of consumers.

Roles and responsibilities

Your incident management system must set out the roles and responsibilities of staff members in identifying, managing and resolving incidents and in preventing incidents from occurring.

It is your responsibility to ensure that staff are aware of your organisation's incident management system and understand their responsibility to comply with these requirements. Your incident management system must include requirements for the provision of training to staff in the use of, and compliance with, your incident management system.

Further guidance

For further guidance regarding establishing and maintaining an effective incident managing system, refer to the *Effective incident management systems: Best practice guidance*.

Chapter 3: Types of incidents to be notified

What is a reportable incident?

As an approved provider of residential care, or flexible care provided in a residential setting, you are required to notify the Commission of reportable incidents. The notification and management of reportable incidents is one part of your responsibility to have an incident management system.

The range of incidents that are reportable incidents under the SIRS is broader than those you were required to report under previous compulsory reporting requirements.

Under section 54-3 of the Aged Care Act, a reportable incident is any of the following incidents that have occurred, are alleged to have occurred, or are suspected of having occurred to a residential care recipient (consumer), in connection with the provision of residential care, or flexible care provided in a residential setting:

- unreasonable use of force against a consumer
- unlawful sexual contact, or inappropriate sexual conduct, inflicted on a consumer
- psychological or emotional abuse of a consumer
- unexpected death of a consumer
- stealing from, or financial coercion of, a consumer by a staff member of the provider
- neglect of a consumer
- use of physical or chemical restraint of a consumer (other than in the circumstances set out in the Quality of Care Principles)
- unexplained absence of a consumer from the service.

For all of the above range of incident types, the reporting requirements under SIRS also require a provider to report to the Commission allegations and suspicions of such incidents, as well as where evidence is unambiguous that an incident has occurred.

You must notify the Commission of all reportable incidents, even where you believe that you have acted and responded appropriately, or where an internal or police investigation is underway.

Your legislated responsibility to notify the Commission of a reportable incident applies regardless of whether the consumer and/or their representative or family wish the incident to be notified. You are required to determine how to appropriately involve people affected by the incident (or their representatives) in managing and resolving the incident, but this does not mean they can decide whether the incident is reported to the Commission or not.

You are also required, as part of your online notification of a SIRS reportable incident, to confirm that you have provided a notice of collection (where appropriate) to any person affected by the incident for whom you have recorded personal or sensitive information (whether in records regarding the reportable incident, or in the notification to the Commission).

Making the notification to the Commission does not replace your existing obligations to report particular events to another person or body with relevant responsibilities in relation to the incident.

'In connection with' the provision of care

The definition of a reportable incident includes the phrase 'in connection with'. The meaning of 'in connection with' the provision of residential care or flexible care provided in a residential setting is intended to be broad. It will cover incidents occurring during the course of care being provided to a consumer and incidents that arise out of the provision of that care (including because the consumer is in the residential setting). For example, incidents that occur while the consumer is outside of the service under the supervision of staff and for reasons that are in connection with the provision of care, such as when they are attending a specialist appointment or are on a social outing organised through the service, will be included under the SIRS.

The SIRS is not intended to apply in respect of incidents that occur when a consumer is on leave from the service, for example, because they are in hospital or are visiting family (without service staff supervision). However, if you become aware of incidents during such periods where a consumer is away from the service you must still act in the best interests of the consumer to protect their wellbeing, including considering amendments to your risk assessments relating to a consumer's independent travel and outings where relevant. Depending on the nature, suspicion or allegation of the incident about which you become aware, this may also mean reporting matters to the police or other authorities. If the consumer has been harmed by the incident you will also be required to manage the incident under your incident management system.

Further detail about each type of reportable incident is discussed below, including principles to help your consideration of whether an incident is a reportable incident.

Incidents that are not reportable under the SIRS

An incident does not need to be reported under the SIRS if the incident results from the consumer choosing to refuse to receive care and services offered by the provider.

For example, this may include where the consumer decides to decline health or medical advice regarding their care despite being informed of the risks. An example would be where a consumer chooses to eat food that is inconsistent with their dietary needs.

In supporting the consumer to make a decision for themselves, all reasonable efforts must be made to assist the consumer and, where appropriate, their family or representative, to understand the need for those care and services, including any potential consequences or impacts of that refusal on the consumer's health and wellbeing and measures for mitigating the risk to the consumer.

In these circumstances, the consumer's refusal should be recorded in relevant care planning documents. The record should include the circumstances in which the consumer has refused care and services and your understanding of why that decision has been made, as well as measures taken to mitigate risk and support the consumer's wellbeing in the circumstances.

Incidents involving consumers who are also participants of the National Disability Insurance Scheme

Registered National Disability Insurance Scheme (NDIS) providers are required to notify the NDIS Quality and Safeguards Commission (NDIS Commission) of 'reportable incidents' that result in harm to an NDIS participant or occur in connection with the provision of supports and services by registered NDIS providers.

Where a reportable incident occurs under SIRS that involves a consumer who is also an NDIS participant, you will be required to notify both the Commission and the NDIS Quality and Safeguards Commission.

It should be recognised that the definitions of what is considered a 'reportable incident' may differ between the SIRS and the NDIS. Timeframes for reporting, and the information to be reported, may also differ. For further guidance on reporting incidents to the NDIS Commission, refer to Reportable Incidents Guidance – Detailed Guidance for Registered NDIS Providers[5].

5 https://www.ndiscommission.gov.au/document/596

Unreasonable use of force

Subsections 15NA(2) and (3) of the Quality of Care Principles provide that unreasonable use of force:

- includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force
- does not include gently touching the consumer:
  - for the purposes of providing care
  - to attract the consumer's attention
  - to guide the consumer
  - to comfort the consumer when they are distressed.

This definition captures conduct such as shoving, pushing, hitting, punching or kicking a consumer. The use of force can be unreasonable regardless of whether it causes injury or visible harm such as bruising. It will still be notifiable to the Commission even where the consumer does not require medical treatment.

The definition is not intended to capture kind, considerate and respectful care, which may include gentle touching of a consumer that would be objectively appropriate and acceptable in the circumstances.

What is not unreasonable use of force?	What is unreasonable use of force?
• Gently touching a consumer to attract their attention or to guide them. • Gently touching a consumer to comfort them if they are distressed. • Accidental contact (unless it is careless or negligent). • Physical contact that has lawful justification. For example, pushing a consumer out of harm's way (such as out of the way of an oncoming car that would otherwise hit them or out of the way of a falling item). • Reasonable management or care of a consumer taking into account any relevant code of conduct or professional standard. For example, where a staff member is genuinely trying to assist a consumer and is acting in accordance with applicable professional standards and, despite the staff member's best intentions, the consumer receives a small scratch that causes them no discomfort. • Minor disagreements between consumers. For example, where one consumer taps another consumer on the hand as the result of a disagreement over a card game. • Potential incidents. For example, where a consumer is prevented from harming another consumer through the intervention of a staff member or other person.	• The use of unwarranted or unjustified physical force against a consumer, including any rough handling of the consumer in the delivery of care and services. • Deliberate physical attacks or assaults on a consumer. • Physical force includes actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards consumers or making threats of physical harm. • Any physical behaviour towards a consumer that is an offence under the law of a state or territory. • Incidents that in isolation may not be significant but when they occur over an extended period of time, have an impact on the consumer. For example, a pattern of rough handling during the provision of care. • Where a consumer (or anyone else) alleges there was an unreasonable use of force (regardless of whether physical injury occurred and regardless of whether the consumer alleged to have used the force or the consumer against whom force was used has a cognitive impairment).

The above examples are illustrative only. While some of these examples are clear cut reportable incidents, there are other instances that will necessarily depend on the provider examining the circumstances and making a reasonable judgment taking into account the impact on the consumer. It is important to note that reporting requirements under SIRS include the reporting of allegations of serious incidents regarding unreasonable use of force. In a scenario where a consumer or their representative believes that an incident should have been reported and the provider holds a different view, the Commission may receive a complaint about the provider's performance that we would then need to work to resolve.

Important information for staff

Staff should consider how effective verbal communication can best support the delivery of care and services. For example, it may be possible to engage a consumer in their care by asking them to sit themselves up in bed, rather than automatically touching them to assist them to sit up in bed. If the consumer does require assistance to sit up in bed, staff must ensure that they explain what they are doing to help and use the gentlest touch possible to achieve this.

Unlawful sexual contact or inappropriate sexual conduct

Subsections 15NA(4) and (5) of the Quality of Care Principles expand on the meaning of unlawful sexual contact or inappropriate sexual conduct inflicted on the consumer to describe that unlawful sexual contact or inappropriate sexual conduct as including:

- if the contact or conduct is inflicted by a person who is a staff member of the provider or a person who provides care or services for the provider who is providing such care and services at the time of the incident (e.g. while volunteering):
  - any conduct or contact of a sexual nature inflicted on the consumer, including but not limited to sexual assault, an act of indecency or sharing of an intimate image of the consumer
  - any touching of the consumer's genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the consumer
- any non-consensual contact or conduct of a sexual nature, including but not limited to sexual assault, an act of indecency or sharing of an intimate image of the consumer
- engaging in conduct relating to the consumer with the intention of making it easier to procure the consumer to engage in sexual contact or conduct.

The Principles also provide that it is not a reportable incident where there is consensual contact or conduct of a sexual nature between the consumer and a person who is not a staff member, for example is another consumer at the service or a volunteer (other than while they are providing volunteer services).

This ensures, for example, that a consumer who wishes to engage in a consensual sexual relationship with their partner, who is a volunteer at the service, is not prevented from doing so. In this scenario, it is expected that the provider would support both the consumer and the volunteer, such that volunteers working in an aged care service are clear as to what is appropriate conduct while engaged as a volunteer.

The definition also ensures that any conduct or contact of a sexual nature inflicted on the consumer by a staff member is always a reportable incident (i.e. consumer consent in this circumstance will not negate the requirement to report the incident).

While reports of unlawful sexual contact inflicted on a consumer were required under the previous compulsory reporting scheme, and providers will therefore be familiar with the concept, the requirement to notify incidents of this nature has been extended under the SIRS to also include inappropriate sexual conduct. This is consistent with similar incident reporting schemes, including the NDIS.

It is important to note that SIRS notification requirements are designed to protect vulnerable consumers, not to restrict their sexual freedoms. Unlawful sexual contact or inappropriate sexual conduct refers to non-consensual sexual activity involving consumers (unless the alleged offender is a staff member, in which case the incident must be notified).

Consumers' right to maintain relationships of choice

Consumers have the right to have control over and to make choices about their personal and social life, including the right to sexual freedom and to give and receive affection. The Quality Standards require providers to support consumers to exercise choice and independence, including to make connections with others and maintain relationships of choice, including intimate relationships. It is expected that you will support the consumers at your service to maintain connections of importance to them.

These rights and freedoms include consumers with a mental or cognitive impairment. This means you must balance your responsibilities in providing a safe environment for vulnerable consumers with the consumer's right to maintain relationships of choice.

Understanding capacity to consent

Consent and decision making capacity are central to the requirements in the Quality Standards. You should therefore be familiar with assessing capacity and have existing systems and processes (including relationships with relevant health professionals who undertake such assessments) that support you to understand a consumer's capacity to make informed decisions and provide consent. This may include speaking with a consumer's family and/or carer to gain additional information and further understand the consumer's capacity to consent, and ensuring that consumers are supported to effectively communicate their concerns, wishes and consent.

It is acknowledged that consumers may have decision making capacity for some matters and not others and that capacity can fluctuate, including for consumers with cognitive impairment who may have moments of lucidity, such that their capacity to provide consent varies at different points in time. However, it is expected that your workforce is trained and equipped to manage issues of consent and determine a consumer's ability to make decisions.

When considering the nature of a sexual contact, it can be useful for providers to consider the following questions:

- Does the consumer have the capacity to consent to this particular activity, at this time?
- Does the consumer have the capacity to refuse participation in the activity?
- Does the consumer have the capacity to agree to participate in the activity?
- Does the consumer show signs of distress?

Determining a consumer's capacity to consent to sexual activity is a decision that may also be informed by an assessment by a health professional, which should be considered on a case-by-case basis. If it is determined that the consumer has the capacity to consent to the particular activity at that particular time, and the consumer's family and/or carer disagree with that assessment, providers should manage that through careful and sensitive discussion. Capacity to consent should be reviewed on a regular basis.

If you have doubt about a consumer's capacity to consent to an incidence of sexual contact, then the incident should be notified. Any incident of sexual contact that results in a consumer being distressed or upset should also be notified.

Important information for staff

At times staff may witness consumers engaging in activities that they are unsure about whether to report. For example, where they see a consumer kissing another consumer, or where a consumer has their hand under the clothing of another consumer. In determining whether the incident is reportable, staff should be encouraged to consider the person's capacity to consent to the activity, and the relationship between the parties. It is critical to note that consumers with a cognitive impairment may not be aware or able to comprehend the nature of what is happening to them during sexual activity and in the absence of apparent resistance or obvious distress, staff may wrongly assume that "no observable impact" means the activity is consensual.

Broader commentary on unlawful sexual contact

There may be a range of emotional, behavioural, and physiological responses to unlawful sexual contact, including symptoms related to post-traumatic stress, such as depression and withdrawal. Sometimes these will mirror symptoms of cognitive impairment such as agitation, distress and confusion. There may be no discernible response. This does not mean that the person has not suffered from physical, emotional or psychological trauma.

What is not unlawful sexual contact or inappropriate sexual conduct?

- Consensual acts of affection such as greeting someone with a kiss on the cheek or a hug.
- Consensual sexual relations between consumers, or between a consumer and their partner who is not a consumer at the service.
- Gestures of comfort, for example a carer rubbing a consumer's back or patting a consumer on the knee.
- Helping a consumer to wash and dry themselves, where the carer is acting in accordance with applicable professional standards.

What is unlawful sexual contact or inappropriate sexual conduct?

- Any conduct or contact of a sexual nature inflicted on the consumer by a staff member or a person who provides care or services for the provider, while that person is providing such services (e.g. while volunteering).
- Sexual contact without the consumer's consent, against their will or where consent is negated for other reasons such as lack of capacity to consent.
- Having sexual intercourse or sexually penetrating a consumer (with a body part or an object) without consent.
- Touching consumer's genitals (or other private areas) without a care need.
- A person masturbating, showing their genitals to a consumer or exposing themselves in the presence of a consumer.
- Undressing in front of a consumer or watching consumers undress in circumstances where supervision is not required.
- Inappropriate exposure of consumers to sexual behaviour of others.
- Sexual innuendos, sexually explicit language or showing pornography to a consumer or using a consumer in pornography.
- Grooming, stalking or making sexual threats to or in the presence of a consumer.
- Forcing, threatening, coercing or tricking a consumer into sexual acts.
- Unlawful sexual contact encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory or the Commonwealth.

The above examples are illustrative only. Whether contact or conduct of a sexual nature is unlawful or inappropriate will need to be assessed in each individual case. For example, in the context of someone making a gesture of comfort, it is important to understand whether the consumer perceives that gesture to be comforting. Some consumers will be more comfortable with physical touch than others, and you will need to assess the situation based on your knowledge of the consumer and their relationships with those providing comfort.

Important information for staff

Staff are expected to engage with consumers appropriately and respectfully, and to maintain professional boundaries. For example, it is not appropriate to encourage consumers to engage with staff in a sexually inappropriate manner, such as telling sexual jokes or making sexual innuendos or crude comments.

Psychological or emotional abuse

Subsections 15NA(6) and 15NA(7) of the Quality of Care Principles expand on the meaning of psychological or emotional abuse to provide that psychological or emotional abuse of a consumer includes conduct that has caused, or that could reasonably have caused, the consumer psychological or emotional distress, including actions such as:

- taunting, bullying, harassment or intimidation
- threats of maltreatment
- humiliation
- unreasonable refusal to interact with the consumer or acknowledge the consumer's presence
- unreasonable restriction of the consumer's ability to engage socially or otherwise interact with people
- repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which has caused, or could reasonably have caused, the consumer psychological or emotional distress.

As part of the Quality Standards, consumers must be treated with dignity and respect at all times. It is expected that you have systems and processes in place to ensure consumers feel accepted and valued (regardless of their needs, ability, gender, age, religion, spirituality, mental health status, ethnicity, background or sexual orientation) and that consumers feel safe to report disrespectful care or discrimination. The systems and processes you have in place should ensure, for example, ongoing education and training for the workforce and feedback to staff about how they provide care and services in a way that is respectful, culturally appropriate and ensures consumers feel valued and heard.

Patterns of abuse

In addition to incidents that comprise a single event, such as a staff member yelling at a consumer, this category includes incidents that are part of a pattern of abuse. While the behaviour may not cause significant harm or suffering to the consumer in each instance, the repetitive nature of the behaviour (over time) has a cumulative effect which intensifies the level of harm to the consumer, or in some circumstances, consumers.

Your incident management system must be able to record incidents in a way that allows for repeated minor instances of these types of behaviour to be identified easily so that any pattern of abuse can be recognised and notified as a single reportable incident (as well as acted on by the service to prevent recurrence).

Important information for staff

Staff may witness others interacting with consumers in a way they consider inappropriate or disrespectful. Examples include, a staff member giving abrupt, terse or brusque orders to consumers, or a visiting family member making inappropriate or cruel comments or jokes to a consumer or within earshot of a consumer.

Where this occurs, staff must be encouraged to raise it with the person directly or with service management and consider whether it should be reported. Any incident or series of incidents that cause a significant negative impact on a consumer should be reported.

What is not psychological or emotional abuse?	What is psychological or emotional abuse?
• A person raising their voice to attract attention or speak with a consumer who has hearing difficulties. • Minor disagreements between consumers. • Making reasonable requests of a consumer to enable the safe and effective delivery of care and services (for example, asking a consumer to cooperate or encouraging a consumer to eat their dinner).	• Yelling, name calling, bullying or harassing a consumer. • Humiliating or intimidating a consumer. • Making threatening or aggressive gestures towards a consumer or feigning violence. • Unreasonably ignoring a consumer, threatening to withhold care or services from a consumer or threatening to mistreat a consumer. • Unreasonably refusing a consumer access to care or services (including as a punishment). • Taunting, making disparaging comments about a consumer's gender, sexual orientation, sexual identity, cultural identity or religious identity or constantly criticising a consumer. • Making repeated actions such as flicks, taps and bumps to a consumer (which of itself does not constitute physical assault but the repetitive nature causes psychological or emotional anguish, pain or distress). • Any action inflicted on a consumer where the individual is knowingly causing anguish or distress to a consumer (for example, calling a consumer by the wrong name or ignoring a consumer's expressed (and reasonable) preferences).

The above examples are illustrative only and each case will need to be assessed. While any incident resulting in a consumer being evidently upset or humiliated should be notified, as noted above under the heading Understanding capacity to consent, incidents of abuse involving a consumer who is not notably 'harmed' or who, due to a cognitive impairment, does not recognise the action as abuse, are also reportable incidents.

Unexpected death

Subsection 15NA(8) of the Quality of Care Principles expands on the meaning of unexpected death of a consumer to provide that this includes death in circumstances where:

- reasonable steps were not taken by the provider to prevent the death
- the death is the result of care or services provided by the provider or a failure by the provider to provide care and services.

Providers are required to notify any death where the provider, including staff and health professionals engaged by the provider:

- did not take appropriate steps to prevent or mitigate an incident which resulted in the death of a consumer
- did not take appropriate action to assess and treat a consumer following an incident and the consumer died as a result of injuries related to the incident
- was (or reasonably should have been) aware of a consumer's condition and did not take timely and adequate steps to assess and treat the consumer
- made clinical mistake(s) resulting in death
- did not deliver care and services in line with a consumer's assessed care needs or provided clinical care and services that were poorly managed or not in line with best practice, resulting in death.

A death may occur immediately, or some time, after a 'mistake' was made or a 'failure' or incident occurred. Where the death could reasonably be considered to be related to a mistake, failure or incident, this should be notified to the Commission, even where a coroner has not yet determined the cause of death, or where the provider is advised of such a death which may not have occurred at the service.

All unexpected deaths are considered Priority 1 reportable incidents for the purposes of notifying the Commission (see Chapter 4).

Additional reporting obligations for deaths

Each state and territory has specific requirements in relation to the obligations of providers to notify a death to other bodies, such as the coroner and police.

If a death is required to be reported to the coroner of a state or territory, it is the coroner's role to determine the date, place and circumstances and medical cause of that death. It is acknowledged that this process can take some time and, as a result, you may not be able to provide all required details at the time of reporting an unexpected death to the Commission. The Commission will negotiate reporting timeframes with providers as necessary, but you are expected to notify the Commission as new information becomes available.

As there may be multiple reporting obligations, providers are strongly encouraged to have policies and procedures for staff to understand how to respond to a death, including who is responsible for notifying the Commission and other bodies and the timeframes for reporting.

Important information

It is acknowledged that unexpected deaths may occur even where staff do everything within their power to appropriately assess and manage a consumer's condition (including injuries sustained from an incident).

While you may not be able to ascertain whether the death is related to an incident or the actions (or lack of action) until a coroner has assessed the death, any time you are unsure of the cause of death, or whether it was related to a specific incident or poor management or care – including where a resident is admitted to hospital following an incident and then dies in hospital – this should be reported.

Deaths may be referred to a coroner for a range of reasons, including if a person dies unexpectedly, or from an accident or injury, or if the death is unnatural or violent, or a doctor has not been able to sign a death certificate because the cause of death is unknown.

What is not an unexpected death?	What is an unexpected death?
• Where a consumer dies as a result of an ongoing illness, disease or condition that was appropriately assessed, monitored and managed (including where the consumer was receiving palliative care and appropriate end-of-life medications). • Where a consumer is involved in an incident and later dies as a result of an unrelated condition or illness. • Deaths resulting from outbreaks of disease (for example, separate reporting processes have been established in relation to outbreaks of COVID-19).	• Where a consumer falls while being moved or shifted, with the injuries sustained contributing to or resulting in the consumer's death. • Where the actions of another contribute to or result in the death of a consumer. For example, the death follows an assault by another consumer, a staff member or a family member. • Where poor quality clinical care is provided to a consumer contributing to or resulting in their death. For example, a pressure injury or wound is untreated or not regularly tended to and becomes infected resulting in the consumer's death. • Where medical assessment or treatment is delayed, contributing to or resulting in a consumer's death. For example, a consumer falls and is not assessed immediately afterwards and later dies as a result of injuries sustained from the fall. • Where a consumer dies suddenly or unexpectedly, and the police have been contacted, or where there are delays in the preparation of a death certificate due to concerns regarding the cause of death, or if the provider otherwise considers that the circumstances of the death may give rise to the need to involve the coroner.

While the above examples are illustrative only, all unexpected deaths of a consumer must be notified to the Commission.

Stealing or financial coercion by a staff member

Subsection 15NA(9) of the Quality of Care Principles confirms that stealing from, or financial coercion of, a consumer by a staff member includes:

- stealing from a consumer by a staff member of the provider
- conduct by a staff member of the provider that:
  - is coercive or deceptive in relation to the consumer's financial affairs
  - unreasonably controls the financial affairs of the consumer.

Incidents of stealing or financial coercion notifiable under the SIRS are limited to the actions of a staff member of the service. A staff member is defined in the legislation to include an individual who is employed, hired, retained or contracted by the provider (whether directly or through an agency) to provide care or other services.

When assessing whether you are required to report an incident, suspicion or allegation of stealing by a staff member, not every missing item must be notified to the Commission. However you are required under the SIRS to notify the Commission if you have a reasonable belief that a staff member is responsible for a missing or stolen item or items.

The obligation to report the staff member's actual, suspected or alleged conduct is not dependent on the nature of the theft or financial coercion. However, from a consumer's perspective, it is important to recognise that the effect on a consumer is not necessarily greater where items of greater value or large sums of money are stolen; for example, items of emotional or sentimental value or day to day items that the consumer uses regularly may have a more significant psychological or emotional impact on the consumer. You should consider the impact the incident has on the consumer and not merely the financial significance of the items in question, so that relevant impacts are included and explained when categorising and reporting such an incident to the Commission. Therefore in order to determine the timeframes in which the Commission must be notified of such an incident, it is important to be clear whether the conduct has caused, or could reasonably have caused, psychological injury or discomfort to the consumer, and/or whether there are reasonable grounds to report the incident to the police.

Repeated cases of theft or a pattern of missing/stolen items should be considered more serious. Your incident management system must be able to record incidents in a way that allows for repeated minor instances of stealing or financial coercion to be readily identified so that any pattern or series of incidents can be recognised and notified as a single reportable incident.

Missing items and unknown offenders

Where a consumer's money or valuables go missing without explanation, you should try to help the consumer to locate the item(s). If they cannot be found and the consumer is concerned or distressed about the loss, this should be notified to the Commission. If the item is subsequently located, you should provide an update to the Commission.

It is acknowledged that you may not always be able to identify an alleged offender at the time of reporting an incidence of stealing. However, it is expected that you will conduct an investigation to try to locate the item and/or to identify who stole the item or how it came to be missing/ reported stolen.

Financial coercion

Financial coercion relates to the forced, deceptive or fraudulent control of a person's finances. This can include a staff member:

- encouraging a consumer to give them gifts or money
- advising a consumer to change their will
- using power of attorney to inappropriately control a consumer's finances
- obtaining financial advantage by deceiving a consumer
- pressuring, bullying or threatening a consumer in any way to obtain a financial benefit.

Important information for staff

There may be circumstances where staff are out with a consumer (for example, accompanying them to an appointment) and the consumer offers to purchase the staff member a coffee or lunch. While this should generally be discouraged (and your organisation may have rules or a professional code of conduct that prevents this), this is not the type of incident that would qualify as a serious incident for notification purposes. However, if you witness (or receive an allegation/hold a suspicion about) a staff member specifically asking or coercing a consumer to purchase something for them (even items of low value, particularly on a repeated basis), this should be reported.

What is not stealing or financial coercion?	What is stealing or financial coercion?
· Where a consumer willingly, of their own volition, buys a staff member a coffee while out for an appointment. · Where a consumer or their family give a carer a gift to thank them for their support. · Where items go inexplicably missing but are quickly found.	· Where a staff member coerces a consumer to change their will in favour of the staff member. · Where a staff member steals money or valuables from a consumer. · Where a staff member asks or coerces a consumer to buy something for them or another person. · Where a staff member uses power of attorney to steal money from a consumer. · Where an item goes inexplicably missing and cannot be found and the consumer (or their family) are concerned.

The above examples are illustrative only and each case will need to be assessed individually.

Neglect

Subsection 15NA(10) of the Quality of Care Principles states that neglect of a consumer includes:

- a breach of the duty of care owed by the provider, or a staff member of the provider, to the consumer
- a gross breach of professional standards by a staff member of the provider in providing care or services to the consumer.

Breach of duty of care

A duty of care refers to the obligation to take reasonable care to avoid injury to a person who, it can be reasonably foreseen, might be injured by an act or omission. A duty of care exists when someone's actions could reasonably be expected to affect other people. If a consumer is relying on you and your staff to be careful, and that reliance is, in the circumstances, reasonable, then it will generally be the case that you owe them a duty of care.

Neglect includes an action, or a failure to act, by the provider or a staff member towards a consumer that has resulted in harm, injury, poor health outcomes, emotional distress or the death of a consumer. It can be a single significant incident where, for example, a carer fails to fulfil a duty, resulting in actual harm to a consumer or where there is the potential for significant harm to a consumer. Neglect can also be ongoing, repeated failures by a provider to meet a consumer's physical or psychological needs.

Choice and control

As part of the Quality Standards, consumers have the right to have control over and make choices about their care, and to do things that involve a level of risk in line with their personal freedoms. You are required to balance your duty of care to consumers with your responsibilities under the Quality Standards and the Charter to support consumers to make their own choices, even if those choices come with risk.

For example, this category of reportable incident is not intended to capture situations where a consumer chooses not to shower (where showering is provided in line with the consumer's preferences) or a consumer with diabetes who, knowing the risks, chooses not to eat a diabetic diet and, as a result, has a wound with poor healing prognosis.

Where a consumer with cognitive impairment refuses to receive care and services in line with their assessed care needs, and this refusal may result in harm to the consumer or impact negatively on the consumer's health and wellbeing, all reasonable efforts must be made to encourage the consumer to receive those care and services.

For this reason, the Quality of Care Principles expressly state that an incident will not be notifiable under the SIRS if the incident results from the consumer choosing to refuse to receive care and services offered by the provider. In these circumstances, the consumer's refusal should be documented in relevant care planning documents.

Gross breach of professional standards

All staff members tasked with the provision of care and services to consumers are required to carry out their duties in accordance with their job descriptions, with the knowledge and skills attained as part of their profession or any qualifications, and in accordance with any applicable codes of conduct, practice or standards expected of their employer.

Not all staff will have professional standards tied to their role. For example, personal care workers do not have a universal professional code of practice or standards. However, staff members may be subject to codes of behaviour or practice relevant to their role under their terms of employment.

For those staff members who are subject to professional standards as a consequence of registration or accreditation (for example, medical, nursing and allied health professionals), there will be a higher threshold of professional training and qualifications, knowledge and skills, and scope of practice, and hence a higher threshold of conduct expected.

The content of professional standards varies but may relate to:

- the manner in which a consumer is to be treated (including their rights to privacy and dignity)
- the need for tailored, frequent and clear communication with a consumer
- ensuring informed consent and good record keeping
- providing culturally appropriate care
- providing quality care and services.

There are pathways for reporting breaches of professional standards to the overseeing agency (for example, the Australian Health Practitioner Regulation Agency – AHPRA) where these professional standards are not met.

While professional and other standards set a minimum expectation of behaviour and conduct, not all breaches of standards will be reportable to the Commission for the purposes of this category of reportable incident.

Where there have been breaches of standards that result in misunderstandings, near misses[6], short term consumer distress or poor outcomes that affect a consumer's confidence in a staff member, these incidents are not necessarily reportable, and may be best addressed through continuous improvement, professional development and complaints management.

In contrast, a gross breach may be evident where a staff member has an obligation to provide care and services, and they have failed to perform their duties in line with relevant standards, and to the level a reasonable person would expect of them in their role, and their failure directly leads to harm to a consumer's health or wellbeing including significant injury (physical, mental or emotional) or death.

For example, these may include instances where:

- a consumer has been provided with treatment and any requisite informed consent was not obtained
- a consumer with poor proficiency in English was denied the right to an interpreter to support the development of a care plan or to seek consent to a particular medical treatment
- vital medication or treatment has not been provided which would have prevented an adverse incident
- assistance to a consumer has been withheld without a lawful reason for such a period as to lead to harm to the consumer
- a consumer's rights to privacy and confidentiality have been breached resulting in their personal information being widely disclosed or inappropriately provided to unauthorised individuals such as to have a significant impact on a consumer
- a consumer has suffered significant injury or death as a direct result of a staff member's incompetence or failure to provide quality care and services.

6 A 'near miss' is when an occurrence, event or omission happens that does not result in harm (such as injury, illness or danger to health) to a consumer or another person, but had the potential to do so. Please refer to the *Effective incident management systems: Best practice guidance* for further information.

What is not neglect?	What is neglect?
• An isolated incident of late or missed administration of medications where there is no significant impact on the consumer. • Rapid weight loss as a result of disease, where all reasonable efforts are made to ensure the consumer is receiving adequate nutrition. • Where a consumer chooses not to receive care and services in line with their assessed care need, for example: – where a consumer with dysphagia chooses not to eat a liquified diet and is appropriately supervised while eating – where a consumer with diabetes chooses not to eat a diabetic diet – where a consumer with liver disease chooses to drink alcohol – where a consumer chooses not to shower, brush their teeth or brush their hair – where a consumer with a chronic condition or disease chooses not to undergo clinical treatment – where a consumer chooses to smoke despite having a chronic respiratory condition or other condition exacerbated by smoking.	• Depriving a consumer of basic necessities, including food, drink or clothing. • Withholding personal care, such as showering, toileting or oral care. • Regular late or missed administration of medications, or failure to administer time critical medications. • Failing to supervise a consumer in an environment that leaves them susceptible to injury. For example: – leaving a consumer outside unprotected in the sun resulting in significant burns – leaving a consumer enclosed in a vehicle on a hot day where the temperature in the vehicle is likely to increase rapidly and cause significant harm to the consumer – failing to supervise consumers where they may wander into unsafe environments such as busy roads, construction sites or bodies of water. – failing to appropriately dress a consumer for the weather conditions. • Failing to monitor a consumer's nutrition and hydration, resulting in rapid weight loss and clinical complications.

What is not neglect?	What is neglect?
	• Failing to seek appropriate medical assessment and treatment for a consumer where they appear unwell or are injured. For example: – failure to treat injuries or wounds – failure to assess and manage pain – failure to seek medical diagnosis or treatment when a consumer shows signs of illness – failure to call an ambulance when the consumer's injuries or illness require treatment in hospital. • Failing to ensure a consumer is reviewed regularly by a health professional or specialist in line with their documented care needs. • Failing to appropriately modify a consumer's meals to account for their difficulty of swallowing as recorded in their care plan, or failure to give sufficient assistance to a consumer to eat their food, resulting in the consumer not being able to eat meals or choking. • Lack of consistent clinical oversight exacerbating conditions requiring acute care, such as, lymphedema, contractures, catheter care and infections.

These examples are illustrative only and each case will need to be assessed individually.

Where a consumer chooses not to receive care or services, it is important for approved providers and their staff to maintain consumers' rights, including their autonomy and choice. However, a provider remains responsible for ensuring choices are informed, that any tension between refusal of care and services and professional or legal obligations is managed, and that any relevant discussions and consideration are appropriately documented.

Inappropriate physical or chemical restraint

Section 54-3 of the Aged Care Act provides that the use of physical restraint or chemical restraint in relation to a consumer (other than in the circumstances set out in Part 4A of the Quality of Care Principles) is a reportable incident.

Part 4A of the Quality of Care Principles specifies that providers must minimise the use of physical and chemical restraint where possible. Only when providers have explored alternatives to restraint (and those alternatives have been used to the extent possible), and have satisfied a number of conditions, can restraint be used as a last resort.

Any use of restraint that is inconsistent with the requirements in the Quality of Care Principles must be notified to the Commission. For example, where physical or chemical restraint is used without prior consent or without notifying the consumer's representative as soon as practicable; where physical restraint is used in a non-emergency situation; or when a provider gives a drug to a consumer to influence their behaviour as a form of chemical restraint.

Use of physical restraint

You must not use a physical restraint in relation to a consumer unless, in relation to that use of the restraint:

- an approved health practitioner who has day to day knowledge of the consumer has assessed the consumer as posing a risk of harm to themselves or another person, and as requiring the restraint, and this assessment has been documented
- alternatives to restraint have been used to the extent possible and the alternatives considered or used have been documented
- the restraint used is the least restrictive form of restraint possible
- you have the informed consent of the consumer and/or the consumer's representative to use the restraint.

Use of chemical restraint

You must not use a chemical restraint in relation to a consumer unless, in relation to that use of the restraint:

- a medical practitioner or nurse practitioner has assessed the consumer as requiring the restraint and has prescribed the medication
- this decision has been recorded in the consumer's care and services plan in accordance with the Quality Standards
- the consumer's representative is informed before the restraint is used if its practicable to do so.

If a medical practitioner or nurse practitioner prescribes medication, including psychotropics, for the purpose of chemical restraint, they are responsible for seeking informed consent. In doing so, the practitioner must be aware of their ethical and legal obligations, including under relevant state and territory laws.

While the provider is not responsible for obtaining consent for chemical restraint, the Commission expects clinical governance arrangements to be in place to ensure that consent has been obtained, and that this is consistent with state and territory laws. This falls predominantly within Standard 8 of the Quality Standards. Providers are expected to:

- have effective organisation-wide governance systems in place including a clinical governance framework which minimises the use of restraint; and
- have effective organisation-wide governance systems for regulatory compliance.

Requirements for using restraint

If you do use physical restraint in relation to a consumer, you must:

- use the restraint for the minimum time necessary
- regularly monitor the consumer for signs of distress or harm while they are subject to the restraint
- regularly monitor and review the need for the restraint
- document in the consumer's care and services plan:
  - the consumer's behaviours that are relevant to the need for the restraint
  - the alternatives to restraint that have been used
  - the reasons the restraint is necessary
  - the care to be provided to the consumer in relation to the consumer's behaviour.

If restraint is used in an emergency, the above information must be documented as soon as practicable after the restraint starts to be used. If restraint is used without consent (in an emergency situation), the consumer's representative must be informed as soon as practicable after the restraint starts to be used.

If you do use chemical restraint in relation to a consumer, you must:

- regularly monitor the consumer for signs of distress or harm while they are subject to the restraint
- provide information to the prescribing practitioner regarding the use of the restraint
- document in the consumer's care and services plan:
  - the consumer's behaviours that are relevant to the need for the restraint
  - the alternatives to restraint that have been used
  - the reasons the restraint is necessary (if known)
  - the information (if any) provided to the prescribing practitioner that informed the decision to prescribe the medication.

Further guidance on the use of restraint in residential care services can be found on the Commission's website[7].

7 https://www.agedcarequality.gov.au/providers/assessment-processes/minimising-restraints

What is not inappropriate use of physical or chemical restraint?	What is inappropriate use of physical or chemical restraint?
• Where a provider uses physical or chemical restraint on a consumer consistent with the requirements in the Quality of Care Principles. • Where a provider uses physical restraint without consent in an emergency situation and informs the consumer's representative as soon as practicable after the restraint starts to be used. • Where a provider administers a drug to a consumer as prescribed for the treatment of a diagnosed health condition (and this is documented, and the consumer's representative is informed in advance of administering the drug).	• Restricting a consumer's movement other than in line with the appropriate use of physical restraint, for example, inappropriate use of bed rails or a lowered bed that makes it difficult for a consumer to get out; placing a table or something in front of a consumer in order to limit their ability to move; using vortex illusions (such as floor rugs) that prevent the consumer from moving out of fear of the illusion. • Seclusion or confinement of a consumer where voluntary exit is prevented or not facilitated. • Use of a bed belt or lap sash restraint. • Physically blocking a consumer's path, holding onto a consumer preventing their movement or holding a consumer down. • Removing the battery out of consumer's electric wheelchair or putting mobility aids out of a consumer's reach, in order to limit their movement. • Physical restraint used in an emergency that does not comply with the requirements in the Quality of Care Principles. • Any drug that is used to control, sedate or restrict the movement or behaviour of a consumer instead of for the treatment of a diagnosed health condition.

Use of physical or chemical restraint that is not reportable under the SIRS

The use of physical or chemical restraint in relation to a consumer is not a reportable incident if the use of restraint is:

- in transition care (in a residential setting), and
- in accordance with the requirements under the Quality of Care Principles (assuming that those restraint requirements applied in relation to consumers receiving transition care).

Unexplained absence from care

Subsection 15NA(11) of the Quality of Care Principles provides that an unexplained absence of a consumer from the residential care service of the provider means an absence of a consumer from the residential care service in circumstances where there are reasonable grounds to report the absence to police.

This means that the Commission must be notified where:

- a consumer is absent from the service
- the absence is unexplained (i.e. the consumer is missing from the service and you are unaware of any reason for their absence), and
- there are reasonable grounds for reporting the absence to the police (whether or not the absence has been reported to the police).

It is expected that you will report an unexplained absence to the police within a reasonable timeframe so an appropriate response and actions can be taken to locate the consumer. You are also required to report the absence to the Commission as soon as reasonably practicable, and within 24 hours after becoming aware of the incident.

All incidences of unexplained absence of a consumer are considered to be Priority 1 reportable incidents for the purposes of notifying the Commission (see Chapter 4).

Absent consumers who return

If a consumer returned to the service before you became aware that they were missing, there is no requirement to notify this to the Commission. However, you must notify the absence to the Commission if the police are aware of the consumer's absence or where the consumer has been returned to the service by the police.

All unexplained absences of a consumer should be recorded in your incident management system, and the consumer's care plan, so that consumer behaviours or wandering patterns can be understood and appropriately managed.

Indicators of a reportable incident

In addition to reportable incidents that are disclosed to staff, there are also additional signs that may indicate a consumer has been affected by what may be a reportable incident. Some consumers may be uncomfortable or unable to notify of an incident that has occurred for fear of the offender finding out, of being hurt or having care and services taken from them. All staff at your service should be aware of, and alert to, indicators of potential incidents.

The following table provides some examples of potential indicators and signs associated with different types of reportable incidents. These are examples only and staff should always be alert to any consumers displaying unusual or out of character behaviours.

Incident types	Possible indicators
Unreasonable use of force	· Avoiding certain activities or areas of the service · Being overly compliant with staff where this is out of character · Frequent and overall drowsiness (associated with head injuries) · Out of character aggression · Being unusually withdrawn, sad or emotional, crying · Depression

Incident types	Possible indicators
Unlawful sexual contact or inappropriate sexual conduct	· Dropping hints that appear to be about abuse or making vague or incomplete references to unlawful sexual contact · Sudden changes in behaviour or character, such as depression, anxiety attacks, or social or emotional withdrawal (e.g. crying, sweating, trembling, distress, agitation, anger, violence, absconding, seeking comfort and security) · Bruises, pain, bleeding – including redness and swelling around breasts, thighs or genitals · Presence of a urinary tract infection or unexplained sexually transmitted disease · Torn or stained clothing or bedding · Avoiding or being fearful of a particular person (staff member, consumer or other) · Sleep disturbances, refusing to go to bed, and/or going to bed fully clothed · Refusing to shower · Requesting a lock on their room
Psychological or emotional abuse	· Depression, withdrawal, crying or emotional behaviour · Being secretive · Trying to hide information and personal belongings · Speech disorders · Weight gain or loss · Feelings of worthlessness about life and themselves, low self-esteem · Self-abuse, self-destructive behaviour, suicidal ideation · Attention-seeking behaviour, disruptiveness, aggressiveness · Being overly compliant with staff

Incident types	Possible indicators
Stealing or financial coercion	· Reported sudden decrease in bank balance · No financial records or incomplete records of payments and purchases · Person controlling the finances does not have legal authority · Sudden changes in banking practices · Sudden changes in will or other financial documents · Unexplained disappearance of money or valuables · Consumer does not have enough money to meet their budget or is often unable to attend outings and activities due to lack of funds. · Borrowing, begging, stealing money
Neglect	· Weight loss · Requesting food more often, being very hungry or thirsty · Constant fatigue, listlessness or falling asleep · Poor hygiene or poor grooming – overgrown fingernails and toenails, unclean hair, unshaven, unbathed, wearing dirty or damaged clothing · Inappropriate or inadequate clothing for the weather · Unattended physical problems, dental, and/or medical needs, for example: – wounds that will not heal or are weeping – dirty dressings – continence pads are soaked or not regularly changed · Dropping hints that appear to be about neglect · Extreme longing for company, social isolation, loss of social and communication skills
Inappropriate physical or chemical restraint	· Red marks, bruising, tears or grazing on the skin that appear to be associated with a physical restraint · Tiredness, drowsiness or confusion · Observed increase in frustration, anger, complaints · Refusal to take medication or fearfulness of medication

Chapter 4:
Notifying a reportable incident

Reportable incidents

Types of reportable incidents

As detailed in Chapter 3, a reportable incident is any of the following incidents that have occurred, or are alleged to have occurred, or are suspected to have occurred, in connection with the provision of residential care, or flexible care provided in a residential setting, to a consumer:

- unreasonable use of force against a consumer
- unlawful sexual contact, or inappropriate sexual conduct, inflicted on a consumer
- psychological or emotional abuse of a consumer
- unexpected death of a consumer
- stealing from, or financial coercion of, a consumer by a staff member of the provider
- neglect of a consumer
- use of physical or chemical restraint of a consumer (other than in the circumstances set out in the Quality of Care Principles)
- unexplained absence of a consumer from the service.

Actual, suspected or alleged incidents

You are required to notify all actual, suspected or alleged reportable incidents to the Commission. This includes where the person who is suspected or alleged to have committed the incident is a staff member or volunteer, a visiting health professional, a family member, friend or visitor to the service or another consumer at the service; or if the person making the allegation has a cognitive impairment.

Reportable incidents involving another consumer at the service must be reported irrespective of whether that consumer has an assessed cognitive impairment. For example, if a staff member witnesses an incident involving unreasonable use of force on a consumer by another consumer with a diagnosis of dementia, this must be notified. The exemption from reporting under the previous compulsory reporting scheme no longer applies.

You must notify the Commission of all reportable incidents, even where you believe that you have acted and responded appropriately, or where an internal or police investigation is underway.

As noted earlier in Chapter 3 under the heading 'In connection with' the provision of care, incidents that occur while the consumer is outside of the service under the supervision of staff and for reasons that are in connection with the provision of care, are reportable under the SIRS. The SIRS is not intended to apply in respect of incidents that occur when a consumer is on leave from the service, for example, because they are in hospital or are visiting family (without service staff supervision). However, if staff become aware of incidents occurring during such periods you must still act in the best interests of the consumer to protect their wellbeing, including using the service's incident management system in tracking any relevant follow-up actions taken.

Reporting to the police

You must report an incident to the police when there is reasonable grounds to do so. This would include where the incident is a consumer's unexplained absense from the service and when all reasonable avenues to locate the consumer have been exhausted.

Your responsibility to report an incident to the police applies regardless of whether the consumer and/or their representative or family seek to have the incident reported. When an incident is reported to police, notifying the consumer and/or their representative that this has occurred demonstrates a commitment to open disclosure, and good practice communication of actions and outcomes in incident management.

If there are reasonable grounds to report the incident to police it must be reported within 24 hours of you becoming aware of the incident. If you become aware of grounds to report the incident to police (i.e. not within the first 24 hours) you must report the incident to police within 24 hours of becoming aware of those grounds.

Circumstances in which reportable incidents are not required to be notified to the Commission

Section 15NG of the Quality of Care Principles states that a reportable incident is not required to be notified to the Commission if the Commission has made a determination under section 95D of the Commission Rules. Under section 95D of the Commission Rules, if the reportable incident relates to a particular consumer who has been diagnosed with dementia and experiences delusions, and continues to report a particular event which has been investigated and is based on delusions, you may apply to the Commission for a determination that further repeat allegations of the same reportable incident do not need to be notified.

In this instance, an initial notification of the reportable incident must be made, and you would still be required to notify the Commission if anything regarding the circumstances of the reportable incident changes. For example, if the consumer mentions something new, that information would need to be notified to the Commission for the Commission's further consideration.

The Commission will make determinations on a case by case basis, and only where the provider submits evidence that an appropriately qualified health professional has assessed the consumer and advised that the behaviour (i.e. the repeat allegation regarding the specific circumstances of the reportable incident) is related to a diagnosed cognitive impairment.

You can seek a determination by contacting **sirsqueries@agedcarequality.gov.au** and providing the required information.

Where the reportable incident does not need to be notified, you are still required to refer to your service's incident management system to ensure the consumer's wellbeing is protected and that the incident is appropriately assessed, managed and recorded.

Who must notify a reportable incident?

Notifying reportable incidents

Providers of residential care services and flexible care (where the flexible care is provided in a residential setting) must ensure that all alleged, suspected or actual reportable incidents are notified to the Commission.

As part of the requirement to have an incident management system, you must ensure that staff are trained to use and comply with the service's incident management system, and that they understand their role in identifying, managing and resolving incidents and in preventing incidents from occurring.

For the purpose of notifying reportable incidents, you must ensure that staff who become aware of a reportable incident notify one of the following people as soon as possible:

- a member of your key personnel
- that staff member's supervisor or manager
- the person who is responsible for notifying reportable incidents to the Commission.

Staff at your service are responsible for alerting you to a reportable incident. As such, you have a responsibility to ensure staff are provided with education and are trained in how to recognise a situation that may need to be notified to the Commission, the police, or both, and know how to respond and make notifications.

You should consistently promote a culture that encourages staff to raise suspicions, concerns or incidents when they occur. The training provided should be part of a more comprehensive training program for staff in the use of the service's incident management system and processes which encompasses all incidents (and not just reportable incidents) to ensure that staff understand and can respond to incidents that occur in line with the requirements of the aged care legislation.

This will enable you to respond quickly to any incidents and ensure those affected by an incident receive timely help and support. It will also enable you to review your processes and practices and put strategies in place to prevent similar situations from occurring again. In turn, this can support you to maintain a safe and secure environment for consumers and staff, and enable you to continuously improve the safety and quality of the care and services you deliver.

Important information for staff

Staff will often be the first person to suspect or become aware that a consumer has been involved in a reportable incident. They may become aware of this in numerous ways including by witnessing an event, witnessing signs of possible abuse or distress, disclosure by a consumer or receiving information from another person.

Staff must know who to speak to within the provider organisation so that an appropriate response can be initiated without delay, including making a notification to the Commission.

Staff must also be informed that if they do not feel comfortable reporting an incident within the organisation (for example, to their manager), they can make a report directly to the police or the Commission without fear of reprisal. The law provides protections for staff who report suspicions or allegations of reportable incidents in good faith (discussed below).

Anyone can raise concerns about an incident

You should encourage any person who is concerned about an incident or a consumer's wellbeing to raise these concerns directly with you in the first instance.

Alternatively, the Commission provides a free service for anyone to give feedback, raise a concern or make a complaint about the quality of care or services provided to people receiving Commonwealth-funded aged care services (noting that the disclosure of information must meet the requirements described below in order to attract the protections afforded to a reportable incident notification). Information is available on the Commission website about how to lodge a complaint[8].

8 https://www.agedcarequality.gov.au/making-complaint/lodge-complaint

Protections for those providing information or reports

You are expected to promote a culture of integrity and accountability that encourages staff and others to disclose information about reportable incidents and protects the health, safety and wellbeing of consumers.

When is a disclosure of information protected?

Protections for people who disclose reportable incidents are strengthened under the SIRS. The enhanced protections in sections 54-4 to 54-6 of the Aged Care Act mean that protections for the disclosure of information now extend to existing and former staff members as well as current and past consumers, their families and others supporting them, including volunteers and advocates.

For the protections to apply, the disclosure must meet the following requirements:

- the disclosure is made to any of the following: the provider, one of the provider's key personnel, a staff member of the approved provider, another person authorised by the approved provider to receive reports of reportable incidents, a police officer or to the Commission
- prior to making the disclosure, the person disclosing the information must give their name to the person to whom the disclosure is made
- the discloser must have reasonable grounds to suspect that the information indicates that a reportable incident has occurred, and
- the disclosure must be made in good faith [9].

What is the person disclosing a reportable incident protected from?

If the disclosure of the information qualifies for protection, then the person making the disclosure:

- will be protected from any civil or criminal liability for making the disclosure
- will have qualified privilege in proceedings for defamation relating to the disclosure
- is not liable to an action for defamation relating to the disclosure
- is protected from someone enforcing a contractual or other remedy against that person based on the disclosure.

For example, if a staff member's contract of employment specifies that the staff member must not discuss issues arising in the service with anyone outside the service, a disclosure of a reportable incident by the staff member that qualifies for protection would mean the person's contract of employment could not be terminated on the basis that the disclosure constitutes a breach of the contract.

9 N.B. "good faith" (in layperson's terms) may be taken to mean truthfully relaying information known at the time including any context and qualifications, and without prejudice or malicious intent

If a court is satisfied that an employee has made a protected disclosure and the employer (be it the provider or a recruitment or employment agency who employs the person) has terminated the discloser's contract of employment on the basis of the disclosure, the court may order:

- the employee to be reinstated in that position or a position at a comparable level, or
- the employer to pay the employee an amount instead of reinstating the employee, if the court considers it appropriate to make the order.

A person who makes a protected disclosure is also protected from victimisation. This means that the person who disclosed the information may be compensated if they suffer an actual detriment or a detriment is threatened. Compensation will be paid by the person who caused the detriment or made the threat.

If the person who made the disclosure is a staff member, approved providers, managers and all staff have a responsibility to ensure, as far as reasonably practicable, that other staff or contractors comply with the prohibitions against victimisation.

If a person makes a report to you or one of your key personnel, you are responsible for taking reasonable measures to ensure that the identity of the person as the maker of the report is not disclosed (except to another of your key personnel, the Commission, police or as required by law). You are also responsible for ensuring that a staff member who receives the notice of the reportable incident does not disclose the identity of the person.

Transition to the SIRS and extended protections

Transitional arrangements are in place to support continued reporting of incidents to the Commission. This means that reportable incidents occurring on or from 1 April 2021 must be reported in accordance with the SIRS, and that the strengthened protections for people who disclose information about reportable incidents will apply.

In addition, if a person has reasonable grounds to believe a reportable incident occurred on or from 1 January 2020 and the person discloses that information, the strengthened protections will also apply in relation to that report.

Existing protections in the Aged Care Act (see previous section 96-8) will continue to apply to a disclosure of information made under the previous compulsory reporting provisions (i.e. information about a reportable assault that was made prior to the commencement of the SIRS).

Distinguishing types of incidents

Categorising incidents

The period of time within which to report a reportable incident to the Commission will depend on your categorisation of the incident based on your assessment as to the impact on the consumer.

A reportable incident can be categorised as either:

- a Priority 1 reportable incident, or
- a Priority 2 reportable incident.

Subsection 15NE(2) defines a Priority 1 reportable incident as a reportable incident:

- that causes, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or
- where there are reasonable grounds to report the incident to police, or
- that is a consumer's unexpected death or a consumer's unexplained absence from the service.

Categorisation of the incident as Priority 1 or Priority 2 determines the relevant timeframe for reporting the incident to the Commission and the information required to be reported. (Please refer to the section Timeframes for notification below.)

Assessing the impact on the consumer

Even if an incident is assessed as causing little concern or discomfort to the consumer, if it is within the scope of a reportable incident, the Commission must be notified.

When assessing the impact of a reportable incident on the consumer it is important to remember that the impact does not have to include visible physical harm (such as bruising or scratches); psychological and emotional impacts are relevant types of harm. As noted in the previous chapter under the heading Understanding capacity to consent, this is a critical consideration when considering the potential impact on a consumer of an incident of a sexual nature where the absence of visual harm or distress does not mean that a lack of harm can be assumed.

Reportable incidents without visible impact on a consumer may still have a significant impact depending on the individual situation and the context of the contact. For example, incidents of unreasonable use of force may cause a consumer to become withdrawn, deter a consumer from providing feedback on their care and services, or cause a consumer to try to avoid a worker or another consumer.

You are expected to use your judgement and knowledge of the consumers in your care, their history and individual preferences to determine the degree of impact a reportable incident has on a consumer.

It is stressed that every single incident involving a consumer at a residential aged care service, whether or not a reportable incident, should be addressed by the service using its incident management system.

Responding to reportable incidents involving consumers as actors

When you are responding to incidents that involve the alleged actions of a consumer in the service, it is important to ensure that your focus on consumer wellbeing relates to both the consumer impacted by the reportable incident and the consumer who engages in offending behaviours. Your approach to managing incidents should be respectful and responsive to each consumer's individual needs and dignity. You should consider how the privacy of consumers will be protected (particularly within the service environment community), the appropriate interventions based on the circumstances of the incident, how offending behaviours can be prevented in future and the supports available to all consumers.

Consumers (and their representatives) should be actively engaged in the resolution of incidents and any remedial actions put in place to prevent incidents from recurring. Providers must use the data collected from their analysis of incidents and the remedial actions taken, to continuously improve incident management and prevention. This may include de-identified communication of outcomes of a reportable incident where changes are made to systems, procedures and practices.

When will a reportable incident be a Priority 1 reportable incident?

A Priority 1 reportable incident includes any reportable incident that causes, or could have reasonably caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve. In this instance, reportable incidents will be Priority 1 regardless of whether:

- the impact on the consumer is temporary or permanent
- the medical or psychological treatment is provided at the service or elsewhere.

A Priority 1 reportable incident includes but is not limited to:

- consumer distress requiring emotional support or counselling
- cuts, abrasions, burns, fractures or other physical injury to a consumer requiring assessment and/or treatment by a nurse, doctor or allied health professional
- bruising, including large individual bruises or a number of small bruises over the consumer
- head or brain injuries which might be indicated by concussion or loss of consciousness
- injury or impairment requiring the consumer's attendance at or admission to a hospital
- the death of a consumer.

If a consumer is hospitalised in relation to a reportable incident, the incident should be treated as a Priority 1 reportable incident. There will be instances in which consumers are hospitalised for reasons unrelated to injury or harm resulting from an incident, and these instances are not reportable incidents. Hospitalisation includes a consumer's presentation or admission to an emergency or other ward within a hospital facility (including short-stay admissions) where this is related to an injury acquired from an incident.

A Priority 1 reportable incident also includes incidents that could have reasonably caused a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve. This ensures that incidents that a reasonable person would consider could have caused a consumer harm or distress are also captured, particularly where a consumer has a cognitive impairment, memory deficit or such other condition that prevents them from articulating or displaying evidence of harm or distress.

When will a reportable incident be a Priority 2 reportable incident?

A Priority 2 reportable incident includes any reportable incident that results in a low level of harm to a consumer.

In considering what is a low level of harm, consider the impact on the consumer. Examples of low impact may include where the consumer is momentarily shaken or upset or where the consumer experiences temporary redness or marks that do not bruise.

In these cases, where medical or psychological treatment for the consumer is not required, the reportable incident will be a Priority 2.

Where you are uncertain as to the impact, or where the impact appears low, but the consumer (or their representative) expresses ongoing distress or concern, the incident should be treated as a Priority 1.

Timeframes for notification

Nothing in this section in any way reduces a provider's obligation to prevent, manage and mitigate potential harm arising from any incident affecting a consumer, whether that incident is reportable or not.

Commencement of the SIRS

The SIRS will commence in two stages. The first stage will commence on 1 April 2021. From this date providers are required to report all reportable incidents assessed as Priority 1 reportable incidents.

The second stage will commence on 1 October 2021. From this date, providers must report all reportable incidents. Reportable incidents must still be assessed as 'Priority 1' or 'Priority 2' as this will determine the relevant time for notifying the Commission.

Notifying Priority 1 reportable incidents

Priority 1 reportable incidents involve a staged reporting process. Stages beyond the initial notice of a Priority 1 reportable incident will be advised by the Commission depending on the information available to you at the time of reporting and the appropriateness of your response to the incident.

In other words, the Commission will determine on a case by case basis whether you are required to complete all stages of reporting and the information to be reported through an incident status report or a final report.

Initial notice to Commission

If you have reasonable grounds to believe that a reportable incident is a Priority 1 reportable incident, the Commission must be notified **within 24 hours** of you becoming aware of the reportable incident.

If, after you have given initial notice, you become aware of significant new information in relation to the reportable incident, you are required to notify the Commission as soon as possible.

Notifying additional information to Commission (if required)

If your initial notice contains less than full information because some details are unavailable within 24 hours after you become aware of the reportable incident, then further information may need to be provided to the Commission through a second notice.

The Commission will decide on a case by case basis if notification of additional information is required. This will depend on the information that was able to be provided in the initial notice.

If required by the Commission, a second notice must be provided to the Commission **within 5 days** (or by a date specified by the Commission), using the Commission approved form, after the start of the 24 hour period in which to give the initial notice. The second notice should include any of the information required in the initial notice that was not known at that time, along with any further information required by the Commission.

You are required to notify the Commission of any significant new information about the incident as soon as possible using the Commission approved form.

Notifying Priority 2 reportable incidents

Priority 2 reportable incidents must be notified to the Commission **within 30 days** of you becoming aware of the reportable incident.

Priority 2 reportable incidents involve a single notification only. However, you must respond to any requests for further information regarding the incident and notify the Commission of any significant new information about the incident as soon as possible using the Commission approved form. You may also be required to submit a final report.

Final report (if required)

Where the Commission has required you to undertake an internal or external investigation of an incident, a final report must be provided to the Commission **within 84 days** (12 calendar weeks) of submitting the initial notice (or such other period that is specified by the Commission).

If required by the Commission, the final report must be submitted to the Commission in writing using the Commission approved form and include details of matters specified by the Commissioner, such as a summary of the investigation and its findings, and any corrective action taken as a result.

Making a notification

Notifying the Commission of a reportable incident

The questions you will be required to address when notifying the Commission of a reportable incident are at Attachment A.

Notifications must be lodged electronically using the form available through the My Aged Care service provider portal[10].

Once a notification has been submitted, a receipt number will automatically be issued, and the Commission will be in contact to provide a case number and to request any further information that may be required.

The Department of Health provides information and support to access[11] and log in[12] to the provider portal. Facts sheets are also available with further information about My Aged Care[13].

10 https://www.health.gov.au/resources/apps-and-tools/my-aged-care-service-provider-portal

11 https://www.health.gov.au/initiatives-and-programs/my-aged-care/using-my-aged-care/set-up-access-to-my-aged-care

12 https://www.health.gov.au/resources/publications/my-aged-care-logging-in-to-the-my-aged-care-provider-portal-using-mygovid

13 https://www.health.gov.au/initiatives-and-programs/my-aged-care/using-my-aged-care/my-aged-care-for-service-providers

Information to be notified

Sections 15NE and 15NF of the Quality of Care Principles set out the information to be provided when notifying the Commission of a reportable incident.

If you are making an initial notification in respect of a Priority 1 reportable incident or notifying a Priority 2 reportable incident, the following information will be sought through the online notification form:

- name and contact details of the provider and service
- name, position and contact details of the person making the notification
- a description of the reportable incident (including the kind of incident)
- a description of the harm caused (or that could reasonably have been expected to have been caused) to the consumer(s) affected by the incident and the consequences of that harm (including if a death has occurred)
- the immediate actions taken in response to the reportable incident, including actions taken to ensure the health, safety and wellbeing of the consumer(s) affected by the incident
- whether the incident has been reported to police or any other body (including the coroner)
- any further actions proposed to be taken in response to the reportable incident
- the time, date and place where the reportable incident occurred or was alleged or suspected to have occurred (if known)
- details of the consumer who is the subject of the incident
- details of the alleged offender (including if the person is a staff member, or if they are a consumer in the service, and if they have been involved in any previous incidents)
- whether next of kin and/or representatives of the consumer(s) have been notified
- the names of the persons directly involved in the reportable incident
- the level of cognition of the consumers directly involved in the incident (if known)
- any other information required by the Commissioner.

If you are providing an initial notice in respect of a Priority 1 reportable incident, then you are only required to provide the information that is known to you at that time. The second notice will need to include any of the information described above that was not known at the time of the initial notice, along with any further information required by the Commission.

If you later become aware of significant new information after making a notification, you must as soon as practicable make a (further) notification.

Unexplained absence

If the incident is an unexplained absence, the following information will be sought through the online notification form:

- the date/time the absence was reported to the police
- whether the consumer has been located
- details of how the consumer came to be absent from the service
- the consumer returned or was returned to the service
- if the consumer has not been located, the actions being taken by the provider to locate the consumer
- whether an unexplained absence has occurred for the consumer in the past.

Record keeping requirements

Information to be recorded

As part of your responsibility to maintain an incident management system, you are required to keep a record in relation to each incident that occurs in the service, regardless of whether it is a reportable incident. This includes incidents investigated and recorded in compliance with incident management requirements. For further information regarding your responsibilities for incident management, refer to the *Effective incident management systems: Best practice guidance*.

Your incident management system must also allow the collection of data that enables you to review and analyse recurrent issues, continuously improve your prevention and management of incidents and provide information to the Commission.

Incident records must be made available to the Commission on request to enable the Commission to fulfil its assessment, monitoring, compliance and complaints handling functions.

Incident records must be kept for 7 years after the incident was identified. At a minimum, the information that must be in a record includes:

Subject	Details
Details of the incident	· a description of the incident · a description of harm caused (or that could reasonably have been expected to have been caused) to any person affected by the incident · whether the incident is a reportable incident · the time, date and place where the incident occurred (if known) · the time and date the incident was identified
Person reporting the incident	· the name, contact details, and position of the person making the record of the incident
Related incidents	· whether there are previous incidents that should be linked (your incident management system and records must enable you to identify and respond to any patterns of abuse)
People involved in the incident	· the names and contact details of the persons directly involved in the incident · the names and contact details of witnesses of the incident (if any)
Assessment and investigation	· details of the initial assessment of the incident · if you have undertaken an investigation – the details and outcomes of the investigation
Consultation	· details of consultations undertaken with consumers affected by the incident (and the consumers' representatives where appropriate) · details of consultations undertaken with any consumers or others who witnessed the incident · whether the consumers affected by the incident have been provided with any reports or findings regarding the incident · whether you have notified police or reported the incident to any other authorities
Response to the incident	· the actions taken in response to the incident, including to support or assist consumers involved · what you have done to effectively resolve the incident · what you have done to continuously improve internal systems, processes and practices to better address, prevent or mitigate incidents of this nature from occurring in future

Privacy and confidentiality

You should maintain appropriate controls in relation to the privacy and confidentiality of information, particularly where it relates to individual consumers. This includes ensuring that personal and sensitive information, including incident reports, are securely stored and that privacy and confidentiality is maintained when reports are required to be shared (either within the service, or to other parties such as the Commission or police).

You are required, as part of your online notification of a reportable incident, to confirm that you have provided a notice of collection (where appropriate) to any persons affected by the incident for whom you have recorded personal or sensitive information (whether in the notification to the Commission or in records regarding the reportable incident).

Section 62-1 of the Aged Care Act sets out your responsibilities in relation to the protection of the personal information of consumers, which apply alongside regulatory requirements in relation to privacy contained in relevant state, territory or Commonwealth legislation, such as the *Privacy Act 1988* and the Australian Privacy Principles (APPs).

Chapter 5: Role of the Commission

Role of the Commission

The Commission is responsible for administering the SIRS and will receive serious incident reports from aged care providers. Information notified through the SIRS gives the Commission valuable regulatory intelligence, informs risk profiling of providers and enables trends to be identified over time. The Commission will monitor and investigate provider compliance with the SIRS requirements to ensure the safety, health, wellbeing and quality of life of consumers. The Commission has the power to take regulatory action(s) where appropriate to address non-compliance with provider responsibilities regarding SIRS obligations.

The Commission's functions in relation to the SIRS include:

- taking proportionate regulatory action in response to findings of non-compliance by providers with their legal obligations, including compliance with the Aged Care Quality Standards
- administering the legislated recording and reporting arrangements for serious incidents
- holding providers to account in relation to having in place effective systems for recording, reporting, preventing, managing and responding to alleged, suspected and witnessed incidents
- supporting providers to develop and implement an effective incident management system and to build provider capability to prevent and manage incidents
- collecting, correlating, analysing and disseminating information relating to incidents, including reportable incidents, to identify trends or systemic issues.

Intelligence and trend analysis

Information notified through the SIRS gives the Commission valuable regulatory intelligence and data to enable the Commission to more effectively detect, analyse and respond to risks to consumers. Intelligence and data informs the Commission's risk profiling of providers; the prioritisation and scope of monitoring and performance assessment activities; as well as education, campaigns and targeted regulatory approaches on particular issues.

Notifications (or absence of notifications) also enable trends to be identified over time, including commonly notified reportable incidents; characteristics of consumers, providers or types of care that may influence the number, types and response to incidents; who is making the notifications; areas in which providers are not making notifications; the influence of notifications on a positive safety culture; and the nature of improvements in care and services and in incident management systems.

Information that the Commission publicly reports on the operation of the SIRS may include quarterly, annual and trend reporting (that is both quantitative and qualitative) to assist the sector, policy makers and regulators understand current trends and emerging issues. Such information would also be of interest to current and prospective consumers and their families.

Receiving and referring information

The Commission may also receive information about a reportable incident through complaints and can examine whether the provider is meeting its responsibilities in relation to incident management and the notification of reportable incidents either through the complaints resolution process, and/or through quality monitoring and compliance.

In addition, the Commission has the power to use and share information provided through the SIRS in accordance with existing arrangements for the protection of information (see Part 7 of the Commission Act). For example, the Commission may refer the information to police or another body with responsibility in relation to the incident.

SIRS information will be shared with the Department of Health to inform research and support future policy, regulatory and funding considerations. In this way, the SIRS will help to build provider capacity and enable continuous improvement across the sector.

Commission's regulatory response and actions

The Commission has a responsive and proportionate approach to regulation in relation to the SIRS, using the full range of educational and regulatory tools to address provider level and sector wide risks. This includes:

- providing guidance and education to build the capacity of providers to develop effective systems to prevent and respond to incidents
- feedback to the sector to promote understanding of reportable incidents and effective responses, and to support continuous improvement by providers in the quality and safety of care
- use of monitoring and performance assessment activities, campaigns and targeted regulatory approaches on particular SIRS or incident management issues
- application of enforceable regulatory actions and regulatory powers, as appropriate.

The regulatory actions taken by the Commission regarding reportable incidents will depend upon the incident itself, and the Commission's confidence in the provider that it has or will take action relating to that reportable incident and the circumstances surrounding it.

When the Commission receives a notification of a reportable incident, it can:

- require the provider to give the Commission information, further reports or documents
- request the provider to complete remedial action(s) in relation to the incident
- request the provider to undertake an internal investigation into the incident and report to the Commission
- require the provider to appoint an independent expert to undertake an investigation into the incident and report to the Commission
- conduct an inquiry in relation to a particular reportable incident or series of reportable incidents (whether or not a notification was made), request information relevant to the inquiry or consult with individuals, organisations and government on matters relating to the inquiry
- refer the reportable incident to another responsible body, including the police or the Coroner.

For more information about the Commission's approach to regulation and to explain what we mean by responsive, risk-based regulation refer to the Regulatory Strategy[14].

Monitoring

The Commission may also exercise monitoring powers in relation to the reportable incident.

Following a reportable incident notification, the Commission may seek further information about the incident to determine whether there is non-compliance, the extent of any non-compliance, or the appropriate compliance response. If required, further information may be obtained by:

- communication with the provider to discuss the identified concerns relating to the incident
- a formal request for further information
- an assessment contact to monitor quality of care and services
- a performance assessment against the Quality Standards
- an investigation of the reportable incident including compliance with the provider's incident management responsibilities.

The Commission's monitoring powers can be utilised regardless of whether or not there has been non-compliance, and may support, precede or follow other actions.

14 https://www.agedcarequality.gov.au/resources/regulatory-strategy

Enforcement

To ensure that the SIRS delivers outcomes including reducing risks to consumers and improving the quality and safety of care, the Commission now has additional regulatory powers.

In considering the appropriate response to a reportable incident notification, the action we may take if a provider of a service demonstrates they are willing and able to comply and to take all reasonable steps to do so will be different from action taken for a provider that is indifferent to providing quality of care and safety or deliberately avoids compliance obligations and, perhaps, places consumers at risk of harm.

If a reportable incident raises a compliance issue or where a provider is not complying with its responsibilities, the Commission has a range of regulatory response powers. This includes new powers in addition to existing enforceable regulatory actions. Under its full range of powers, the Commission may:

SIRS-specific power

- issue a compliance notice where a provider is not, or may not be, complying with its incident management responsibilities (note that a compliance notice may only be issued in relation to the legislated responsibilities); this notice is to specify actions the provider must take, or refrain from taking, within a reasonable period to address the identified or potential non- compliance

Broader powers (also apply to SIRS)

- ask a court to impose a civil penalty for a breach of the Commission Act or Aged Care Act; under the SIRS a civil penalty applies if the provider fails to comply with a compliance notice (new)
- seek an injunction from a court (new)
- issue an infringement notice in certain circumstances; for example, causing detriment to a person who has made a disclosure regarding a reportable incident (new)
- impose sanctions under Part7B of the Commission Act
- accept a written undertaking given by a provider that it will take specified actions to comply with its responsibilities and/or will take specified actions to ensure that these responsibilities are not contravened in the future; this can be used for incident management and reportable incident responsibilities. An enforceable undertaking may then be enforced by court order (new)
- prior to imposing sanctions, issue a Non-Compliance Notice that may require the provider to give an undertaking about remedying the non-compliance and/or issue a notice of requirement to agree to certain matters (Notice to Agree), including if the Commission is satisfied that there is immediate and severe risk to the safety, health and wellbeing of consumers as a result of non-compliance by a provider.

The Commission may take one or more of these actions where it is deemed appropriate and proportionate in order to address the non-compliance.

A number of these powers may be applied, as appropriate, where a provider is not complying with its other aged care responsibilities.

For more information on the Commission's approach to compliance and enforcement, including use of its regulatory powers, refer to the Compliance and Enforcement Policy[15]. Please note the current policy is being revised to include the Commission's additional regulatory powers that take effect from 1 April 2021.

Further information on the Commission's approach to these powers will be disseminated to providers by separate communications.

15 https://www.agedcarequality.gov.au/media/89299

Glossary

Term / acronym	Meaning
***Aged Care Act 1997* (Aged Care Act)**	The Aged Care Act is the overarching legislation which outlines the obligations and responsibilities that aged care providers must follow to receive subsidies from the Australian Government.
aged care consumer/ consumer	A person who is receiving residential care or flexible care in a residential care setting.
Aged Care Quality and Safety Commission (Commission)	The national regulator of aged care services, and the primary point of contact for consumers and providers in relation to quality and safety in aged care in Australia. The Commission's primary purpose is to protect and enhance the safety, health, wellbeing and quality of life of aged care consumers; to promote aged care consumers' confidence and trust in the provision of aged care services; and to promote engagement with aged care consumers about the quality of their care and services.
***Aged Care Quality and Safety Commission Act 2018* (Commission Act)**	The Commission Act sets out the functions related to the Commission.
Aged Care Quality and Safety Commission Rules 2018 (Rules)	The Rules set out the process for how the Commission performs its functions as defined in the Commission Act.
Aged Care Quality and Safety Commissioner (Commissioner)	The Commissioner of the Aged Care Quality and Safety Commission as established by the Commission Act.

Term / acronym	Meaning
Aged Care Quality Standards (Quality Standards)	The Quality Standards with which organisations approved to provide aged care services in Australia are legally required to comply. Refer to the Commission's website for Quality Standards guidance and resources.
Charter of Aged Care Rights (Charter)	Describes the rights of consumers of Australian Government funded aged care services. Provides the same rights to all consumers, regardless of the type of subsidised care and services they receive. The Charter is made under the Aged Care Act.
clinical care	Health care that encompasses the prevention, treatment and management of illness or injury, as well as the maintenance of psychosocial, mental and physical wellbeing. It includes care provided by doctors, nurses, pharmacists, allied health professionals and other regulated health practitioners. Organisations providing clinical care are expected to make sure it is best practice, meets the consumer's needs, and optimises the consumer's health and wellbeing.
clinical governance	An integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support safe, quality clinical care and good clinical outcomes for each consumer. The purpose of clinical governance in aged care is to support the workforce and visiting practitioners to provide safe, quality clinical care as part of a holistic approach to aged care that is based on the needs, goals and preferences of consumers.
cognitive function or ability	Brain based skills and abilities which relate to carrying out tasks, memory and thinking processes, such as attention, language, decision making and learning.
consumer representative	A nominated person given consent by an aged care consumer to speak and act on their behalf. Includes: · a person appointed under relevant legislation to act or make decisions on behalf of a consumer; and · a person the consumer nominates to be told about matters affecting the consumer.

Term / acronym	Meaning
continuous improvement	A systematic, ongoing effort by an organisation to raise its performance in achieving outcomes for consumers under the Quality Standards. Continuous improvement: · responds to the needs and feedback of consumers · supports the workforce to improve and innovate in providing safe and quality care and services · can address practices, process or outputs to achieve a desired outcome.
incident	Incidents are any acts, omissions, events or circumstances that occur, are alleged to have occurred, or are suspected to have occurred in connection with the provision of care to a consumer and have (or could reasonably be expected to have) caused harm to a consumer or another person (such as a staff member or visitor to the service).
incident management system (IMS)	Any system that helps an organisation to prevent incidents and to identify, respond to and manage any incidents that occur during the course of delivering care and services to consumers. An incident management system should apply to all incidents, including near misses, that are known, suspected or alleged to have occurred in connection with the delivery of care and services.
key personnel	A person defined in section 8B of the Commission Act to be a key personnel of a person or body.
open disclosure	Open discussions with consumers, their family, carers and other support people of incidents that have caused harm or had the potential to cause harm to the consumer. It involves an expression of regret and a factual explanation of what happened, the potential consequences and what steps are being taken to manage this and prevent it happening again.
personal information	Information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.
Principles	The principles made under the Aged Care Act.

Term / acronym	Meaning
Priority 1 reportable incident	An incident that causes, or could have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or an unexpected death or unexplained absence of a consumer (see subsection 15NE(2) of the Quality of Care Principles.
Priority 2 reportable incident	An incident that results in a low level of harm to a consumer.
provider (also referred to as 'you' in this document)	Provider approved under the Aged Care Act to provide residential aged care and/or flexible care in a residential setting or a service provider funded to deliver National Aboriginal and Torres Strait Islander Flexible Aged Care with responsibilities in relation to incidents. In many cases this will include management and staff but where separate requirements rest with certain staff or management this has been identified.
provider responsibilities	Responsibilities approved providers have in relation to the aged care they provide through their services to aged care consumers/care recipients. These responsibilities, under the Aged Care Act relate to: · the quality of care they provide · user rights for the people to whom the care is provided · accountability for the care that is provided, and the basic suitability of their key personnel.
***Quality of Care Principles 2014* (Quality of Care Principles)**	The Quality of Care Principles specify the care and services that an approved provider must provide and the quality standards to which that care must be delivered.
regulatory action	Any and all administrative or regulatory action and formal or informal enforcement action undertaken by the Commission in response to non-compliance with provider responsibilities.
reportable incident	An incident described in section 54-3 of the Aged Care Act (and section 15NA of the Quality of Care Principles).

Term / acronym	Meaning
residential care recipient (also referred to as a 'consumer')	Includes both residential care recipients and flexible care recipients who are receiving flexible care in a residential setting (see subsection 54-3(3) of the Aged Care Act).
risk	The chance of something happening that will have a negative impact. It is measured by the likelihood of occurrence, and consequences of occurrence.
risk assessment	A process or method to identify risks or hazards which have the potential to cause harm.
service	The business run by an approved provider through which Commonwealth funded residential care or flexible care is provided
Serious Incident Response Scheme (SIRS)	The scheme established to prevent, and reduce the risk of, incidents of abuse and neglect in Australian Government-subsidised residential aged care. It requires providers to have an effective incident management system in place and to identify, record, manage, resolve and report all serious incidents that occur, or are alleged or suspected to have occurred.
staff member	Individual who is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruiting agency) to provide care or other services.
***User Rights Principles 2014* (User Rights Principles)**	The principles which set out the responsibilities of approved providers in providing residential or home care services, and deal with security of tenure for consumers, access for persons acting for consumers, and the information the provider must give consumers in particular situations. Also describes the rights and responsibilities of consumers of both residential care and home care.
you	Approved provider or service provider with responsibilities in relation to incidents. In many cases this will include management and staff but where separate requirements rest with certain staff or management this has been identified.

Attachment A: SIRS notification form questions

All questions are mandatory, unless otherwise stated.

SIRS portal user details

- First Name
- Last Name
- Position/Role at Residential Aged Care Facility
- Contact numbers *(at least one contact number is required)*
- Mobile Number
- Email Address
- Name of the Approved Provider
- Name of the Residential Aged Care Facility
- Notice of Collection *(Agree/Disagree)*

Incident details

- Who initially raised concern/made the allegation? *(Provide further details if unspecified)*
- Date/Time Incident Reported
- Date/Time the Alleged Incident Occurred
- Has a death occurred as the result of this incident?
- Select the most relevant Incident Type *(the eight incident types are available to select)*
- Please provide a detailed description of the alleged incident
- If the most relevant incident type is Neglect, how long has the Victim been subjected to this form of neglect?

People involved

Victim Details

- Victim Unique ID *(look-up, not mandatory)*
- Victim First Name
- Victim Last Name
- Victim Gender *(provide further details if "Other" is selected)*
- Please select the appropriate level of cognition of the victim *(provider further details if "Unknown")*
- Has the Victim been named or described in any incident previously?
- Did the Victim suffer psychological impacts?
- Select the appropriate level of psychological impact to the victim *(provide further details if some level of impact is selected)*
- Did the Victim suffer physical impacts?
- Select the appropriate level of physical impact to the victim *(provide further details if some level of impact is selected)*
- Does the Care Recipient reside within a secure unit?

Unexplained absence

- When was the unexplained absence reported to Police?
- Has the Care Recipient been located?
- Where was the Care Recipient located? *(provide further details if "Other")*
- Please enter the date and time when the Care Recipient was returned to the Service
- Has an unexplained absence involving this Care Recipient occurred in the past?
- Please enter details of the actions being undertaken to locate the missing Care Recipient
- Please provide a description of how it is believed the care recipient came to be absent from the service

Alleged offender details

- Is the Alleged Offender an Aged Care Recipient?
- If "No":
  - Describe the Alleged Offender Relationship to the AP or Service
  - Has the Alleged Offender been named or described in any incident previously?
- Alleged Offender Unique ID *(look-up, not mandatory)*
- Alleged Offender First Name
- Alleged Offender Last Name
- Alleged Offender Gender *(provide further details if "other" is selected)*
- Please select the appropriate level of cognition of the Alleged Offender *(provide further details if "unknown" is selected)*
- Has the Victim been named or described in any incident previously?
- Did the Alleged Offender (Care Recipient) suffer psychological impacts?
- Select the appropriate level of psychological impact to the Alleged Offender *(Care Recipient)* (provide further details if some level of impact is selected)
- Did the Alleged Offender (Care Recipient) suffer physical impacts?
- Select the appropriate level of physical impact to the Alleged Offender *(Care Recipient) (provide further details if some level of impact is selected)*

Action taken

- Has the incident been reported to the police? *(provide a reason if "No" is selected)*
- Please provide the date and time the police were contacted
- Police station reported to *(not mandatory)*
- Method used *(provide further details if "Other")*
- Have the police arrested or charged a person in relation to this incident?
- Please provide any details known of the police response to the incident
- Has the Victim's Representative been contacted about the incident?
- Has the Victim's Representative expressed any ongoing concerns regarding the incident?
- Has the Alleged Offender (Care Recipient)'s Representative been contacted about the incident?
- Has the Alleged Offender (Care Recipient)'s Representative expressed any ongoing concerns regarding the incident?
- If the incident is an unexpected death, has the death been reported to the Coroner?
- What specific actions have been taken to ensure the health, safety and wellbeing of the care recipient(s) involved?

- What specific actions have been taken to manage or minimise the risk of recurrence of this or a similar incident in future?
- Is there any other information or details you wish to include in relation to this notification? *(Not mandatory)*
- Please upload any attachments that you believe are relevant for the Commission *(not mandatory)*
- Has the Service returned to compliance regarding the method of restraint used?

Review and submit

Please ensure all fields are completed before submitting this Notification to the Aged Care Quality and Safety Commission. By clicking 'Submit' you agree to provision further information regarding this incident upon request.

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, In Your Capital City