Australian Government
Aged Care Quality and Safety Commission

Aged care reforms

Serious Incident Response Scheme

Guidelines for providers of home services

Contents

Chapter 6.
Notifying reportable incidents

Chapter 7.
Common scenarios or issues providers may encounter

Chapter 8.
Role of the Commission

Acknowledgements

The Aged Care Quality and Safety Commission engaged mpconsulting to support the development of external guidance relating to the extension of the Serious Incident Response Scheme (SIRS) to home services. The Commission would like to acknowledge Andrea Matthews, Elsa Kennett, and Ashleigh Kennedy from mpconsulting for their central role and principal authorship of this resource.

Disclaimer

This guidance is currently being updated to align with the changes in the *Aged Care Act 2024*. An updated version will be published as soon as possible. While these updates are being made, please refer to the 'Reportable incidents and SIRS – A quick guide to changes from 1 November 2025'.

Introduction

Overview

- The Serious Incident Response Scheme (SIRS) is aimed at reducing the risk of abuse and neglect of older Australians receiving aged care services.
- The SIRS establishes responsibilities for all Commonwealth-funded providers of aged care, including approved providers under the *Aged Care Act 1997* (the Aged Care Act) to:
  - prevent and manage incidents, focusing on the safety, health and wellbeing of consumers
  - use incident data to drive quality improvement
  - notify reportable incidents to the Aged Care Quality and Safety Commission (Commission).
- The SIRS complements the Charter of Aged Care Rights (Charter), the Code of Conduct for Aged Care (Code), the Aged Care Quality Standards (Quality Standards) and open disclosure requirements.
- This guidance describes your responsibilities in relation to the SIRS for home services [1], including identifying the range of incidents which must be reported to the Commission.

Purpose of this guidance

This guidance describes the responsibilities of home service providers (you) in relation to the SIRS, including:

- requirements relating to the management, response and prevention of incidents generally
- the types of incidents that must be notified to the Commission (reportable incidents)
- requirements for making a notification, including when and what must be notified
- the role of the Commission in managing notifications and ensuring providers are meeting their responsibilities to notify and effectively respond to reportable incidents.

The Commission expects you and your staff to be familiar with the legislative changes that supported the introduction of the SIRS. The changes affect both provider responsibilities and the Commission's regulatory powers. The Explanatory Memorandum that accompanied the Royal Commission Response Bill 2022 [2] when it was introduced to Parliament should be read alongside this guidance.

This guidance will be reviewed and updated as the sector becomes more familiar with implementing the SIRS. The Commission will analyse trends in notifications over time and engage with providers to identify where updates to this guidance or additional resources may be useful.

1 Refer to page 7 for the definition of home service

2 https://www.legislation.gov.au/Details/C2022B00052

Context

All of us are shocked to hear of abuse and neglect of people receiving aged care services. The community expects older people to be cared for respectfully, safely and with dignity. Where people are receiving care and services, aged care providers have legal responsibilities to prevent, minimise the risk of, and respond effectively to any incidents of abuse and neglect in connection with the care they provide.

The SIRS was introduced in residential care in April 2021 and extended to home services in December 2022. It is an initiative to help prevent and reduce the risk and occurrence of incidents of abuse and neglect of older Australians receiving Commonwealth-funded aged care services by:

- building provider capacity to better identify and mitigate risks of potential harm, and respond to and manage incidents that occur
- driving learning and improvement at a sector and service level to reduce the number of preventable incidents
- holding providers to account to provide support to consumers (and others affected by the incident) in the event of an incident.

This supports consumers, their families and representatives to feel safe and confident about the quality of care and services. It is also intended to ensure providers act to continuously improve the care and services provided to older Australians, and to prevent, manage and resolve incidents affecting consumers.

Providers must do everything reasonable and possible to prevent the abuse or neglect of consumers and act quickly when incidents (including allegations and suspicions of serious incidents) do occur, to prevent them from happening again.

Each provider is required to have an incident management system (IMS) that allows them to systematically collect data about incidents related to the delivery of care and services. The data must be captured in a way that enables providers to identify occurrences (or alleged or suspected occurrences) of similar incidents and identify and address any systemic issues in the quality of care they provide. Providers are required and expected to regularly analyse incident data to identify ways to improve their management and prevention of incidents.

Under the SIRS, providers are also required to notify the Commission of a subset of reportable incidents that occur, including alleged and suspected events, as well as witnessed events. The Commission reviews all incident notifications to identify risk of harm to consumers. Where it determines an ongoing risk of harm to consumers and/or where the provider has not dealt with the incident appropriately, the Commission will take action. The action taken by the Commission may differ where a provider demonstrates they are willing and able to comply and will take all reasonable steps to do so, compared to where a provider appears indifferent to providing quality and safe care, or deliberately avoids compliance with its responsibilities.

Notifying the Commission of reportable incidents under the SIRS does not displace the provider's responsibility to report to police any incident that involves criminal or potentially criminal behaviour. It is the role of police to investigate potential crimes and prosecute offenders.

Commencement of the SIRS for home services

On 1 March 2021, the Royal Commission into Aged Care Quality and Safety (Royal Commission) Final Report: Care, Dignity and Respect[3] (Final Report) was publicly released and recommended that the SIRS be expanded to cover all Commonwealth-funded aged care, including in home services. Following the recommendations of the Final Report of the Royal Commission, the Australian Government announced the expansion of the SIRS to home services.

The expansion of the SIRS builds on existing requirements in Standard 8 of the Quality Standards for providers to have effective risk management systems and practices for managing and preventing incidents, including through the use of an IMS that enables incidents to be identified and responded to.

These guidelines focus on requirements of the SIRS for **home service providers**.

For the purposes of these guidelines, 'home service' refers to Commonwealth-funded aged care that is delivered in the home or community. This includes care and services delivered through:

- home care packages (home care)
- the Commonwealth Home Support Programme (CHSP)
- flexible care delivered in a home or community setting, including:
  - Multi-Purpose Services (MPS)
  - Short Term Restorative Care (STRC)
  - the Transition Care Program (TCP)
  - the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

The implementation of the SIRS for home services has been achieved through changes made to both the aged care legislation and to Commonwealth grant agreements. This is because providers that deliver care and services in the home and the community include both approved providers under the Aged Care Act, i.e. home care and flexible care services, and service providers under a grant agreement, e.g. CHSP and NATSIFACP services.

3 https://www.royalcommission.gov.au/aged-care/final-report#:~:text=Aged%20Care%20Quality%20and%20Safety%20In%20their%20Final,in%20the%20Australian%20Parliament%20on%201%20March%202021

Broader regulatory framework

Provider responsibilities

The SIRS complements other provider responsibilities including the integrated expectations of the Charter[4], the Code[5], the Quality Standards[6] and open disclosure[7] requirements. Together, these support providers to engage in risk management and continuous improvement activities to deliver safe, quality care and services to consumers.

The Charter

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

The Charter is set out in Schedule 1 of the *User Rights Principles 2014*[8].

The Code

The Code of Conduct for Aged Care is a set of behaviours that approved providers and their governing persons, workers, contractors and volunteers are expected to meet in the delivery of care and services. The Code is aimed at promoting safe and quality delivery of care and services, and consistent standards of behaviour across the sector.

The Code requires approved providers and their staff to (among other things): provide care and services in a safe and competent manner with care and skill; act with integrity, honesty and transparency; take all reasonable steps to prevent, respond to, and provide care and services free from all forms of violence, discrimination, exploitation, abuse and neglect of consumers; take all reasonable steps to prevent, respond to, and provide care, supports and services free from sexual misconduct.

The Code is set out in Schedule 1 of the *Aged Care Quality and Safety Commission Act 2018*[9] (Commission Act).

Please refer to the Code of Conduct for Aged Care: Guidance for Providers[10] for further information.

The Quality Standards

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

The Quality Standards are set out in Schedule 2 of the Quality of Care Principles 2014[11] (Quality of Care Principles).

Standard 8: Organisational governance requires providers to maintain effective organisation wide governance systems, and effective risk management systems and practices.

4 https://www.agedcarequality.gov.au/consumers/consumer-rights
5 https://www.legislation.gov.au/Details/F2022L01457/Html/Text#_Toc115191710
6 https://www.agedcarequality.gov.au/providers/standards
7 https://www.agedcarequality.gov.au/resources/open-disclosure
8 https://www.legislation.gov.au/Series/F2014L00808
9 https://www.legislation.gov.au/Series/C2018A00149
10 https://www.agedcarequality.gov.au/resources/code-conduct-aged-care-guidance-providers
11 https://www.legislation.gov.au/Details/F2021C00887

Under this Standard, providers are expected to manage the high impact and high prevalence risks associated with the care of each consumer; identify and respond to abuse and neglect of consumers; support consumers to live the best life they can; and manage and prevent incidents, including through the use of an IMS.

Open disclosure requirements

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

- Standard 6 Feedback and complaints, Requirement (3)(c)
- Standard 8 Organisational governance, Requirement (3)(e)

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

Further information relating to open disclosure can be found in the Commission's Open Disclosure Framework and Guidance [12].

The Commission

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

Through its engagement and education work, the Commission aims to build confidence and trust in aged care, empower consumers, provide information and guidance to the sector and promote best practice.

Complaints and concerns about the quality of care and services can be made to the Commission and, like the notification of reportable incidents, complaints and feedback also play an important part in helping providers to improve the quality of care and services.

The Commission receives reportable incident notifications from providers and monitors providers' compliance with other responsibilities, including compliance with the Charter, the Code and the Quality Standards.

The Commission has the power to take regulatory action(s) as appropriate to respond to non compliance with provider responsibilities, including SIRS responsibilities. The regulatory response may include issuing compliance notices and/or conducting investigations.

The Commission also publishes information on the operation of the SIRS on its website.

For further detail on the role of the Commission in relation to the SIRS, please refer to Chapter 8 of this guidance.

12 https://www.agedcarequality.gov.au/resources/open-disclosure

Further information and enquiries

If providers have an enquiry about the SIRS, they can:

- call the Commission for free on **1800 081 549** between 9:00 am and 5:00 pm (AEST) Monday to Friday, or between 8:30 am to 5:00 pm (AEST) Saturday and Sunday
- email the Commission at sirs@agedcarequality.gov.au.

For all enquiries, providers, consumers and the general public can:

- call the Commission for free on **1800 951 822**
- email the Commission at info@agedcarequality.gov.au
- write to the Aged Care Quality and Safety Commission, GPO Box 9819 in their capital city.

Overview of incident management and reporting responsibilities

Overview

- The effective management of incidents is critical to good governance and enables you to manage risks to consumers and improve the quality of care and services you provide.
- The requirements of the Quality Standards (Standard 8) set out specific responsibilities for providers to manage and prevent incidents including through the use of an IMS.
- The SIRS introduces additional requirements in relation to incident management and prevention and notifying the Commission of reportable incidents.
- Incident management and prevention responsibilities apply to all incidents; however, under the SIRS additional responsibilities also apply to a subset of incident types that must be notified to the Commission.
- Provider incident management and prevention requirements only apply to incidents that occur in connection with the provision of care. However, as part of a provider's broader responsibility to protect the safety, health and wellbeing of consumers, you must take appropriate protective steps about any abuse or neglect of consumers (including allegations or where suspected) that you become aware of.

Overview of responsibilities

Under Standard 8 of the Quality Standards, all aged care providers are required to demonstrate effective risk management systems and practices, including but not limited to:

- managing high-impact or high-prevalence risks associated with the care of consumers
- identifying and responding to abuse and neglect of consumers
- supporting consumers to live the best life they can
- managing and preventing incidents, including the use of an IMS.

The SIRS introduces additional requirements for providers in relation to:

- **incident management and prevention**, including requirements for:
  - responding to, assessing and managing incidents
  - notifying other persons or bodies (including the police) of certain incidents
  - continuously improving incident management and prevention
  - implementing and maintaining an IMS, including:
    - establishing procedures for identifying, managing and resolving incidents
    - documenting and record keeping in relation to incidents
    - supporting staff to use and comply with the IMS
- **notifying the Commission of reportable incidents**, including requirements for:
  - ensuring staff escalate and report reportable incidents within the organisation
  - notifying the Commission of Priority 1 reportable incidents within 24 hours
  - notifying the Commission of Priority 2 reportable incidents within 30 days
  - including specific information about a reportable incident in the notification.

Your incident management and prevention responsibilities (as described in Chapter 3 of this guidance) apply to **all** incidents that occur in connection with the provision of care. A subset of these incidents (reportable incidents) must also be notified to the Commission. Reportable incidents under the SIRS for home services include:

- unreasonable use of force
- unlawful sexual contact or inappropriate sexual conduct
- psychological or emotional abuse
- unexpected death
- stealing or financial coercion
- neglect
- inappropriate use of restrictive practices
- missing consumers [13].

These different types of reportable incidents for home services are described in detail in Chapter 4. Your responsibilities in relation to notifying the Commission of reportable incidents are outlined in Chapter 5 and Chapter 6.

While the SIRS introduces requirements for providers to manage and prevent incidents and notify the Commission of certain types of incidents, providers have a broader responsibility to protect consumers from abuse and neglect. If you become aware of abuse or neglect, you should take appropriate steps to protect the person's health, safety and wellbeing, such as raising concerns with their loved ones, reporting it to the police and/or contacting the Australian Human Rights Commission.

These responsibilities are summarised in Figure 1. The Commission has also published a quick reference guide regarding the steps to take following an incident [14].

13 See section 54-3 of the Aged Care Act. Service providers have similar requirements applied under the relevant funding agreements and program manuals.

14 Reportable incidents workflow, https://www.agedcarequality.gov.au/resources/reportable-incidents-workflow

We all have a responsibility to help prevent the abuse and neglect of older people.

If you become aware of elder abuse or neglect, you should take appropriate steps to protect the person's health, safety and wellbeing, such as raising concerns with their loved ones, engaging with a consumer advocacy service, contacting the Australian Human Rights Commission or reporting it to the police.

Aged care providers also have specific responsibilities under the SIRS to prevent and manage incidents and notify the Commission of reportable incidents. This helps to improve the quality of care and services and keep older people safe.

	Your responsibilities	Definition / scope of incident
Incidents	**Incident management responsibilities** • Must take actions to assess the incident, respond to the incident and support those affected. • Must take actions to prevent similar incidents from reoccurring. • Must record certain incident details in your IMS. • Must use your IMS to inform continuous improvement of care and services.	For all acts, omissions, events or circumstances that: • occur (or are suspected to have occurred) in connection with the provision of care and services to a consumer, **and** • have caused harm (or could reasonably have been expected to have caused harm) to a consumer, worker or another person. There must be a relationship between the incident and the provider, worker or services.
Reportable Incidents	**Priority 2** **reportable incident responsibilities** As per your incident management responsibilities, **plus** must be notified to the Commission within **30 calendar days.**	As above; however limited to incidents where harm is caused to the consumer, **and** the following types of incidents: • unreasonable use of force • psychological or emotional abuse • stealing or financial coercion • neglect • inappropriate use of a restrictive practice.
	Priority 1 **reportable incident responsibilities** As per your incident management responsibilities, **plus** must be notified to the Commission within **24 hours.**	As above; however limited to incidents that cause 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. **Plus** all incidents involving: • unlawful sexual contact or inappropriate sexual conduct • unexpected death, or • missing consumers.

Figure 1. Summary of incident management and reporting responsibilities

Incidents that occur in connection with the provision of care

It is a provider's responsibility to prevent, manage, respond effectively to, and minimise the risk of incidents, noting that this applies to all incidents not just the subset of incident types reportable under the SIRS.

Providers have responsibilities to prevent, minimise the risk of, and respond effectively to any incidents of abuse and neglect in connection with the care they provide.

Incident management and prevention responsibilities [15] apply to incidents that occur 'in connection with' the provision of care and services to consumers.

This includes:

- any acts, omissions, events or circumstances that occur, are alleged to have occurred, or are suspected of having occurred **in connection with the provision of care and services to a consumer**, and
- that have, or could **reasonably have been expected** to have, caused harm **to a consumer or another person**.

For home service providers, 'in connection with' refers to the relationship or association between the incident and the provider. It includes all incidents that have occurred (or are suspected to have occurred) during the course of providing care and services or due to the provision (or lack thereof) of care and services. In these incidents, relevant harm may have (or could reasonably have been expected to have) been caused to a consumer or 'another person', for example a staff member, or family member of a consumer.

For example, incidents that occur in connection with the provision of care include incidents that:

- **occur while care and services are being provided**, such as a consumer falling while a staff member is helping them into the shower; a consumer tripping over while being taken to an appointment; a staff member burning themselves while making tea for a consumer; a staff member falling over in a consumer's house while delivering care and services; a staff member being bitten by a consumer's dog while delivering care and services (see Links to work health and safety requirements)
- **arise out of the failure to provide care and services**, such as a staff member not arriving to provide scheduled services where this has (or could reasonably have been expected to have) caused harm to the consumer
- **may not have occurred while services were being provided but are connected because the harm (or potential harm) arose from the provision of services**, such as where a grab rail has been installed in the consumer's shower and, due to poor installation, it collapses, and the consumer is injured.

'In connection with' does **not** include suspected, alleged or witnessed incidents that did not occur in connection with the provision of care. Refer to the next section of this guideline for more information about incidents that do not occur in connection with the provision of care.

15 This is described under Part 4B of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

Links to work health and safety requirements

Providers have responsibilities under State and Territory work health and safety (WHS) legislation, including to minimise risk and ensure a safe work environment for staff and to notify their WHS regulator when serious injuries, illnesses and dangerous incidents happen at work [16].

The types of incidents that are required to be reported under WHS regulations differ to those required to be notified to the Commission under the SIRS. However, there may be instances where you are required to notify certain incidents to both your WHS regulator and the Commission.

While the WHS requirements differ between jurisdictions, the information to be reported in relation to WHS incidents is largely similar to the information to be notified to the Commission for reportable incidents. Maintaining an effective IMS, including detailed records of each incident that occurs in connection with the provision of care and services, can help you to meet your notification requirements for both. It will also support you to continuously improve the delivery of care and services to consumers and maintain a safe and healthy workplace for staff.

Could reasonably have been expected to have caused harm

In assessing incidents, you should consider whether an incident could reasonably have been expected to have caused harm (whether distress, discomfort or injury, etc.) to the affected person, even where the incident does not appear to have caused actual harm to the person.

Example

A staff member providing personal care to a consumer who has limited mobility, supports the consumer to the toilet but then leaves them on the toilet unattended for an extended period of time. When they return, the consumer seems unaffected — they are not physically harmed and they do not express their distress in any discernible way. However, it is reasonable to consider that the consumer might have been uncomfortable and/or concerned about being left unaided. As such, this incident could reasonably have been expected to have caused harm to the consumer.

Establishing whether harm might be reasonably expected will require you to consider the particular physical and psychological conditions, limitations, vulnerabilities and past experiences of consumers. For example, a consumer with a cognitive impairment may be more vulnerable and therefore an incident might be more likely to cause them harm, where it might not have to a less vulnerable individual (e.g. leaving them on their own near a hazardous environment).

Consider how you might feel if the incident happened to you or a loved one.

16 Safe Work Australia, https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/incident-reporting

Near misses

A 'near miss' is when an occurrence, event or omission happens that does not result in harm to a consumer or another person but had the potential to do so. This is different from an incident that did actually occur and result in harm. Near misses should be captured in your IMS and you should consider the effect the near miss could reasonably have been expected to have had on a consumer. Please refer to the Effective incident management systems: Best practice guidance [17] for further information.

Incidents that did not occur in connection with the provision of care

Staff members in home and community settings may witness, suspect or become aware of elder abuse due to their close or regular contact with a consumer. Consumers may also report incidents of elder abuse to staff members.

Elder abuse

Elder abuse is defined by the World Health Organisation as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'.

Elder abuse can take various forms, including financial, physical, psychological, emotional and sexual abuse, or neglect. No older person should be subjected to any form of abuse.

States and Territories may also have laws regarding elder abuse that you need to consider.

Your incident management and prevention requirements and reportable incidents requirements under the SIRS **do not** apply to suspected, alleged or witnessed incidents that do not occur in connection with the provision of care.

17 www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance

For example, you are **not** required to prevent, manage or report to the Commission the following types of incidents:

- a consumer tells a staff member in passing conversation that their adult child recently pressured them for money and they felt coerced to provide access to their bank account
- a consumer discloses to a staff member that their spouse has emotionally manipulated or intimidated them
- a consumer tells a staff member that they burned themselves making dinner
- a staff member sees bruises and is informed that the consumer tripped over while out shopping with their daughter
- a staff member witnessing a spouse roughly handle a consumer
- a staff member witnessing a consumer being bullied by a family member
- a staff member notices a consumer has become withdrawn and fearful, particularly around a certain family member.

While these types of incidents are not captured by the SIRS, any potential abuse or mistreatment of an older person is unacceptable and must not be ignored. As a provider of aged care in regular contact with consumers, you are in a unique position to be able to support and assist consumers who may be subjected to such abuse and should act in the best interests of the consumer to protect their wellbeing. You may also be able to connect consumers, their carers and loved ones with a range of services that offer support, information, education and advice about identifying and responding to elder abuse such as the Older Persons Advocacy Network[18] (OPAN) and the free national elder abuse phone line, 1800 ELDERHelp (**1800 353 374**).

If you are in any doubt about whether an incident is of a criminal nature, make a report to the police. Police are the appropriate authority to investigate and identify whether an incident may involve criminal conduct.

Depending on the nature of the incident, and the circumstances in which it is suspected or alleged to have occurred, you may also need to report matters to other authorities. Please refer to relevant information in Chapter 4 under each reportable incident type.

18 https://opan.org.au

Incident management

Overview

- Providers must manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an IMS [19].
- These requirements are in addition, and complementary, to the existing requirement in Quality Standard 8 to manage and prevent incidents, including the use of an IMS [20].
- The legislation (or funding agreements) and Effective incident management systems: Best practice guidance [21] describe your responsibilities in identifying, responding to, managing and recording all incidents in connection with the provision of care and services to a consumer, and preventing the reoccurrence of similar incidents in future. This includes:
  - assessing all incidents that occur to determine the appropriate support to provide to those affected, and any remedial actions to be taken
  - undertaking any actions identified through your assessment
  - collecting and regularly reviewing information relating to incidents to enable you to continuously improve your approach, and undertaking identified actions to ensure continuous improvement
  - implementing and maintaining an IMS that meets the requirements of the aged care legislation as reflected in the guidance
  - ensuring your IMS enables you to record specified details in relation to each incident, regardless of whether the incident is reportable under the SIRS.
- This Chapter summarises the key concepts and requirements of your incident management responsibilities which apply to all incidents, not just the subset of reportable incidents which must be notified to the Commission through the SIRS.

19 Approved providers must meet requirements under section 54-1(1)(e) of the Aged Care Act and Part 4B of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

20 See requirement 8(3)(d)(iv).

21 https://www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance

Responding to incidents

Management of incidents must be focused on the safety, health, wellbeing and quality of life of the consumers that receive your care and service [22].

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 then 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 facilitating an open discussion with those affected by an incident and engaging 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 or reasonable expectation of harm) to these individuals, and the circumstances surrounding the incident.

Each incident will require a tailored and considered response to ensure the safety, health and well being 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. Further information on reporting to police is available below under Reporting to police.

Assessing incidents

As part of your approach to managing and preventing incidents, you must assess all incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, to determine the support you need to provide to people affected. In doing this, you must consider the views of those affected by the incident to determine any reasonable and proportionate remedial actions to be taken.

You must assess:

- whether the incident could have been prevented
- what, if any, remedial actions need 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 in the future
- whether other persons or bodies should be notified of the incident. [23]

22 Approved providers must meet requirements under section 15LA of the Quality of Care Principles. Service providers have similar requirements under relevant funding agreements.

23 Approved providers must meet requirements under section 15LA of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

You are responsible for taking 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. You are also responsible for deciding:

- whether an internal investigation is required to be undertaken to determine:
  - the causes of the particular incident
  - the harm caused by the incident
  - any operational issues that may have contributed to the incident occurring
- the nature of any such investigation.[24]

Continuous improvement

You must collect data 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.[25]

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

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

IMS requirements

You must implement and maintain an IMS that meets the requirements of the aged care legislation and reflects the Effective incident management systems: Best practice guidance[26]. The key elements of an effective IMS are also summarised in this resource[27].

Your IMS must enable you to collect data relating to incidents in a way that assists 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 certain incidents to the Commission and other authorities (as required).

24 Approved providers must meet requirements under section 15MB(1)(f) of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

25 Approved providers must meet requirements under section 15LB of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

26 https://www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance

27 https://www.agedcarequality.gov.au/sites/default/files/media/What%20is%20an%20effective%20incident%20management%20system%20SIRS%20-%2019%20March%202021.pdf

IMS procedures

You must establish mandatory IMS procedures to be followed in identifying, managing and resolving incidents. Your procedures must, at a minimum, describe the following:

- how incidents are identified, recorded and reported
- the person or position within your organisation to whom incidents must be reported, including arrangements for when this identified person may be unavailable in the required timeframes (for example, while on leave)
- how reportable incidents are notified and managed 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 managing incidents, undertaking investigations of incidents and improving incident management and prevention [28]
- when remedial action is required and the nature of those actions. [29]

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

Documentation

Your IMS must be documented, with written policies and procedures regarding your IMS 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, including for people with differing communication needs. It is your responsibility to support your staff, consumers and other stakeholders to understand how your IMS 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

Your IMS must, at a minimum, enable you to record the following details in relation to each incident, regardless of whether the incident is also reportable to the Commission 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 to the Commission under the SIRS and/or reportable to any other authorities e.g. the police or the NDIS Quality and Safeguards Commission

28 Approved providers must meet requirements under sections 15LA and 15LB of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

29 Approved providers must meet requirements under section 15MB of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

- 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 (i.e. the known, alleged or suspected perpetrator of the incident and any others affected by 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.[30]

All incident records must be retained for a period of seven years after the incident was identified. You must maintain appropriate controls in relation to the privacy and confidentiality of all incident information (including any disclosures of information about an incident), particularly where it relates to sensitive and personal information of consumers. This includes ensuring that any personal and sensitive information including incident notifications is securely stored, and that privacy and confidentiality are maintained when notifications are required to be shared (either within the service, or to other parties such as the Commission or the police).

Your responsibilities[31] in relation to the protection of the personal information of consumers 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*.

Roles and responsibilities

Your IMS must set out the roles and responsibilities of different staff members in preventing, identifying, escalating, managing and resolving incidents.

The term staff member encompasses a broad range of persons employed or engaged by home service providers and includes employees and 'agency' staff as well as individual contractors who provide services on a regular basis, who become aware of a reportable incident and might have a responsibility[32] to notify others in the organisation as soon as possible.

It is your responsibility to ensure that staff understand what they must do to comply with your IMS. Your IMS procedures must outline how staff will be trained in the use of, and compliance with, your IMS.

30 Approved providers must meet requirements under section 15MC of the Quality of Care Principles. Service providers have similar requirements applied under relevant funding agreements and program manuals.

31 Approved providers must meet requirements under section 62-1 of the Aged Care Act. Service providers have similar requirements applied under relevant funding agreements and program manuals.

32 Under section 15ND of the Quality of Care Principles 2014

Reporting to police

Police are the appropriate authorities to investigate and identify whether an incident involves criminal conduct. If there are reasonable grounds to report an incident to the police, you are required to do so within 24 hours of becoming aware of the incident. If you later become aware of reasonable grounds to report the incident to police, you must do so within 24 hours of becoming aware of those grounds.

Reporting to police in relation to potential criminal conduct should occur whether the incident is known, alleged or suspected to have taken place. If you are in any doubt about whether an incident is of a criminal nature, make a report to the police.

It is recognised that in some cases, consumers, their family members or carers may not want a matter to be reported to the police. For instance, this may occur if the consumer is experiencing coercive control by their partner, or due to mistrust of the Government authorities (for example if the family was affected by the Stolen Generation).

In these circumstances, it is important to explain your responsibility to report certain incidents to police. While meeting this responsibility, as much as possible you must also meet your responsibilities to uphold the rights of consumers to autonomy, choice and control over their lives. You should seek to understand their hesitations in a matter being reported and take reasonable steps to address any underlying concerns. However, your engagement with the consumer and their families or representatives should not, delay your reporting to police where this is necessary.

Reasonable grounds to report to police

'Reasonable grounds to report to police' may include scenarios where a 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 (i.e. the incident would be considered a criminal offence under Commonwealth, State or Territory laws) and should therefore be reported to police.

Again, consider how you might feel if the incident happened to you or a loved one and whether a reasonable person would expect police to be informed in the circumstances.

In practice, if you become aware of an incident and you consider that incident is potentially or likely to be criminal in nature, then the incident should be reported to the police. If you are in any doubt about whether an incident is of a criminal nature, make a report to the police.

Types of reportable incidents

Overview

- Section 54-3 of the Aged Care Act defines a reportable incident and outlines the eight types of reportable incidents that are required to be notified to the Commission under the SIRS.[33]
- Reportable incidents are those that:
  - occur in connection with the provision of care and services
  - have caused harm to a consumer, and
  - are one of the eight types of reportable incidents for home services (described in this Chapter).
- This includes incidents that are suspected or alleged to have occurred (i.e. not just witnessed incidents) and incidents that could reasonably have been expected to have caused harm (i.e. not just where a consumer verbally expresses pain or discomfort).
- All home services providers must notify the Commission of all reportable incidents.

Reportable incidents

Reportable incidents are a subset of the incidents to which your incident prevention and management responsibilities apply (as described in Chapter 2 under Incidents that occur in connection with the provision of care).

A reportable incident is:

- an incident that has occurred, or is alleged or suspected of having occurred, in connection with the provision of care to a consumer
- the incident has caused harm, or could reasonably have been expected to have caused harm, to a consumer, and
- the incident is one of the following types of incidents (described in detail in this Chapter):
  - unreasonable use of force
  - unlawful sexual contact or inappropriate sexual conduct
  - psychological or emotional abuse
  - unexpected death
  - stealing or financial coercion
  - neglect

33 Section 7 of the *Aged Care Quality and Safety Commission Act 2018* (the Commission Act) specifies that, for approved providers, the meaning of reportable incident is as per the Aged Care Act, and for service providers, the similar meaning of reportable incident is applied under the funding agreement or program manual that relates to the service.

— inappropriate use of restrictive practices, or

— missing consumers.[34]

For home services, this may include any incidents:

- resulting from the action (or inaction) of a staff member of the provider. This includes subcontracted individuals or organisations, those managing care coordination, administration, etc. and volunteers
- that occur while care and services are being delivered to a consumer (e.g. where the consumer is participating in an activity outside of the consumer's home organised by the provider and is bullied or harassed by another consumer).

This Chapter describes the eight types of reportable incidents for home services, including a range of examples for each incident type. The examples provided are illustrative only. While some of these examples are clear-cut reportable incidents, you must always examine the circumstances surrounding an incident and the physical or psychological harm and/or discomfort caused, or that could reasonably have been expected to have been caused, to determine whether the incident is reportable through the SIRS.

The period of time for notifying a reportable incident to the Commission will depend on your classification of the incident as Priority 1 or Priority 2. See Chapter 5 for guidance on how to classify reportable incident priorities.

34 See section 54-3 of the Aged Care Act. Service providers have similar requirements applied under relevant funding agreements and program manuals.

What is not a reportable incident?

Incidents occurring during the delivery of care and services resulting in harm to staff members, the consumer's family members or others — where the consumer was not affected — are **not** required to be reported. For example:

- where a staff member is involved in an accident while travelling to or from the home of a consumer
- where a consumer's spouse falls over a vacuum cleaner left in the lounge room by the staff member while the staff member is providing home cleaning services.

However, your incident management and prevention responsibilities would still apply to these incidents, and they should be captured by your IMS and managed appropriately.

While there are limits as a home services provider on what you can do to prevent and manage certain incidents that happen within the consumer's home or in the community, if you become aware of incidents that affect a consumer's or a staff member's wellbeing, you should act in their best interests (i.e. to support their health, safety and wellbeing). This could include making changes to consumer risk assessments and care planning (e.g. in relation to the consumer's functional ability or the safety of the consumer's home environment); or making changes to organisational policies regarding the work health and safety of staff, or the safe delivery of care and services in a consumer's home.

Unreasonable use of force

The definition of unreasonable use of force is consistent across residential and home services.

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.[35]

This definition captures conduct such as shoving, pushing, hitting, punching, kicking or rough handling of a consumer.

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

What is <u>not</u> unreasonable use of force?	What is unreasonable use of force?
• Gently touching a consumer, for example to attract their attention or to guide them. • Gently touching a consumer to comfort them if they are distressed (where this aligns with the consumer's personal preferences). • Physical contact that has lawful justification. For example, pushing a consumer (which would otherwise amount to an unreasonable use of force) out of the way of an oncoming car that would otherwise hit them or out of the way of a falling item necessary to avoid death or serious injury to the consumer. • Gently helping a consumer into a transport vehicle or helping to buckle their seatbelt. • Gently guiding or supporting consumers when walking around the shops.	• Any physical behaviour towards a consumer that is an offence under the law of a state or territory. • 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. • Physical force including actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards consumers or making threats of physical harm. • Deliberate physical attacks or assaults on a consumer. • Incidents of non-consensual physical contact that, in isolation, may not be significant but when they occur over an extended period of time, cause harm and/or discomfort to the consumer.

35 See sections 15NA(2) and (3) of the Quality of Care Principles.

Important information

Some consumers may feel uncomfortable by any gentle physical touch. 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 rise from their armchair independently, rather than automatically touching them to assist them to stand. If the consumer does require assistance to stand, staff should first seek consent and 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

The definition of unlawful sexual contact or inappropriate sexual conduct is consistent across residential and home services.

Unlawful sexual contact or inappropriate sexual conduct includes:

- 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 and 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 the taking and/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 the taking and/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.[36]

36 See sections 15NA(4) and (5) of the Quality of Care Principles.

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).

All incidents of unlawful sexual contact or inappropriate sexual conduct are Priority 1 reportable incidents and must be reported to the Commission within 24 hours of the provider becoming aware of the incident. Incidents that are unlawful or considered to be of a criminal nature (for example sexual assault), must also be reported to police within 24 hours of the provider becoming aware of the incident. Refer to Chapter 3 under Reporting to police for more information.

If you are in any doubt about whether an incident is of a criminal nature, make a report to the police. Police are the appropriate authorities to investigate and identify whether an incident may involve criminal conduct.

Consent

The definition of consent differs under the criminal law in each State and Territory. However, it is typically considered the free and voluntary agreement for something to happen or to do something.

Consent can be withdrawn at any time, and you should be aware that while the consumer may have consented to the conduct previously, it does not mean that the consumer consents to the same conduct in the future.

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. However, where the subject of the allegation is a staff member, any sexual contact is a reportable incident.

Consumers have the right (unless legally determined otherwise through the appointment of a substitute decision-maker) 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 Charter and the Quality Standards require providers to support consumers to exercise choice and independence, including to maintain relationships of choice, including intimate relationships. Consumers in their homes may have greater capacity for decision-making than many of those in residential care, and this extends to their capacity to engage in consensual sexual relationships. Staff should respect a consumer's privacy and choices but be alert to indications of any non-consensual contact or conduct of a sexual nature.

What is not unlawful sexual contact or inappropriate sexual conduct?	What is 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 a consumer and another person who is not a staff member of the provider. • Consensual sexual relations between two consumers receiving services from the provider. • Consensual gestures of comfort, for example a staff member rubbing a consumer's back or patting a consumer on the knee where this aligns with the consumer's personal preferences. • Helping a consumer to wash and dry themselves, where the staff member is acting in accordance with applicable professional standards.	• 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. • 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 or providing brokered services), including: — having sexual intercourse or sexually penetrating a consumer (with a body part or an object) — touching a consumer's genitals (or other private areas) without a care need — 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 — taking an intimate image of a consumer — 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.

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 be aware of cultural sensitivities and other personal preferences and assess the situation based on your knowledge of the consumer and their relationships with those providing comfort.

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, or there may be no discernible response. This does not mean that the person has not experienced physical, emotional or psychological trauma.

Important information

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

The definition of psychological or emotional abuse is consistent across residential and home services.

Psychological or emotional abuse of a consumer includes conduct that has caused, or that could reasonably have been expected to have caused, psychological or emotional distress to a consumer, 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 been expected to have caused, the consumer psychological or emotional distress.[37]

As part of the Charter and the Quality Standards, consumers must be treated with dignity and respect at all times and have the right to live without abuse and neglect as specified under the Charter. 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

37 See sections 15NA(6) and 15NA(7) of the Quality of Care Principles.

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 type of reportable incident includes incidents that are part of a pattern of abuse. While the initial behaviour may not cause (or may not reasonably have been expected to have caused) psychological or emotional distress to a consumer, the repetitive nature of the behaviour (over time) can have a cumulative effect which intensifies the level of potential harm to the consumer.

Your IMS must be able to record all incidents in a way that allows for repeated minor instances of such behaviour to be identified easily, so that any pattern of abuse can then be recognised and notified through the SIRS as a single reportable incident (as well as acted on to prevent reoccurrence).

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 (for example, when participating in activities at a day therapy centre). • Making requests of a consumer to enable the safe and effective delivery of care and services (for example, asking a consumer to cooperate, encouraging a consumer to shower, etc.). • Where a consumer is witnessed arguing with their spouse or family member.	• 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 other personal attributes), or constantly criticising a consumer.

What is not psychological or emotional abuse?	What is psychological or emotional abuse?
	• Making repeated actions such as flicks, taps and bumps to a consumer (which of itself does not constitute unreasonable use of force 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. • Moving items around the consumer's house or out of their reach due without their permission or against their wishes to confuse or irritate them.

Important information

Staff may witness other staff they work with interacting with consumers in a way they consider inappropriate or disrespectful. Examples include, giving abrupt or terse orders to a consumer, or 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 to the Commission.

Where multiple aged care providers are delivering care to a consumer, staff may witness or become aware of an incident or allegation concerning staff of another provider. Expectations of you in those situations are outlined under Where multiple aged care providers are delivering care to a consumer.

Unexpected death

The circumstances in which home service providers are required to report unexpected deaths are more limited than in residential care.

Unexpected death is a reportable incident where the death is the result of care or services provided by the provider or a failure by the provider to provide care and services.[38]

The definition of this reportable incident type for home services differs from that used in residential care. The difference acknowledges that you have limited control and visibility over a consumer's day-to-day living circumstances when compared to residential care settings and that you may not become aware of a consumer dying until sometime later and you may never be aware of the circumstances of their death.

As such, the circumstances in which home service providers are required to report unexpected deaths is more limited than in residential care. Providers are required to notify the Commission of any death where the provider, including staff and health professionals engaged by the provider:

- made a mistake resulting in death
- did not deliver care and services in line with a consumer's assessed care needs, resulting in death
- provided care and services that were poorly managed or not in line with best practice, resulting in death.

A consumer's death may occur immediately, or some time after the care and services were provided or failed to be provided. You may not be aware for some time that a consumer has died or the circumstances of the consumer's death. The consumer's family is not obligated to share this information with you and, as such, you may not know the circumstances of a consumer's death.

The reporting responsibility only exists where the provider is aware of the death and where the provider has reasonable grounds to believe the unexpected death has occurred, or is alleged or suspected to have occurred, as a result of the provider's action or inaction. You are not required to notify the Commission of the death if the cause of death was unrelated to the care or services provided by the provider or a failure by the provider to provide care and services.

You are not required to report all deaths where the cause of death is yet to be confirmed. You should only report those where there are reasonable grounds to consider it may have occurred as a result of the provider's action or inaction. For example, there may be circumstances where a consumer dies at home unexpectedly and the Coroner is required to determine the cause of death. In these circumstances, the provider is not required to notify the Commission unless the provider reasonably believes the death could have occurred as a result of the provider's provision of, or failure to provide, care and services.

All reportable unexpected deaths are Priority 1 reportable incidents and must be reported to the Commission within 24 hours of the provider becoming aware of the incident (see Chapter 6).

38 See section 15NA(8) of the Quality of Care Principles.

What is not an unexpected death?	What is an unexpected death?
• Where a consumer dies as part of an accident that was not connected to the care and services. • Where a consumer is involved in an incident and later dies as a result of an unrelated condition or illness. • Where a consumer dies due to an outbreak of disease, unconnected to the provision of care and services. • Where a provider is responsible for providing clinical or palliative care, a consumer dies as a result of an ongoing illness, disease or condition that was appropriately assessed, monitored and managed.	• Where a consumer falls while being moved or assisted by a staff member, with the injuries sustained resulting in the consumer's death. • Where a consumer was using equipment or supports provided by the service that malfunctioned and caused their death. For example, where grab rails have been installed and, due to poor installation, they break during use causing the consumer to fall and die. • Where poor quality clinical care is provided to a consumer resulting in their death. For example, where a provider is responsible for treating a consumer's wound and this is not appropriately treated and becomes infected resulting in the consumer's death. • Where a consumer is reliant on regular care and services and dies as a result of lack of services where a staff member repeatedly fails to attend (noting this would also be considered 'neglect').

Important information

While you may not be able to ascertain whether the death is related to the provider's action or inaction until a Coroner has assessed the death, any time you reasonably suspect that a death may be related to the care and services you provided or failed to provide, you must report it to the Commission.

Additional reporting responsibilities for deaths

Your responsibility to notify the Commission is in addition to notifying the coroner in accordance with state/territory requirements.

Each state and territory has specific requirements in relation to the responsibilities of providers to notify a death to certain authorities, such as the coroner and police.

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.

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.

Refer to Chapter 6 regarding how to notify the Commission of additional information as this becomes available.

As there may be multiple reporting responsibilities, 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.

Stealing or financial coercion

The definition of stealing or financial coercion is consistent across residential and home services.

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.[39]

Reportable incidents of stealing or financial coercion notifiable under the SIRS are limited to the actions of a staff member of the provider. A staff member includes an 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. You are required under the SIRS to notify the Commission if you have a reasonable belief that a staff member is, or is alleged or suspected to be, responsible for a consumer's missing or stolen item(s).

39 See section 15NA(9) of the Quality of Care Principles.

Missing items and unknown subject of the allegation

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 events or circumstances support a suspicion that a staff member is responsible (for example a consumer has told you that a staff member is responsible), you should notify the reportable incident to the Commission. If the item is subsequently located, you should provide an update to the Commission (see Notifying additional information to the Commission).

It is acknowledged that you may not always be able to identify the subject of the allegation at the time of reporting an incident of stealing. However, where a consumer accuses a staff member of stealing, it is expected that you will try to locate the item and/or to identify who stole the item.

What is not stealing or financial coercion?	What is stealing or financial coercion?
• Where a consumer who has the cognitive capacity to freely and voluntarily do so, buys a staff member a coffee while out in the community. • Where a consumer or their family give a staff member a gift to thank them for their services and support. • Where items go missing but are quickly found to have been misplaced. • Where a consumer complains to a staff member that they feel financially pressured by their family.	• Where a staff member coerces a consumer to change their will in favour of the staff member or any other person. • Where a staff member steals money or valuables from a consumer. • Where a staff member uses a consumer's personal property for their own purposes (e.g. where a staff member borrows an item of furniture from a consumer's home without asking their permission or without their consent). • 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 missing from the consumer's home and the consumer (or their family) have alleged or suspect that a staff member is involved.

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 a gift or money
- advising a consumer to change their will
- using power of attorney to inappropriately control a consumer's finances
- obtaining financial advantage for themselves or any other person by deceiving a consumer
- pressuring, bullying or threatening a consumer in any way to obtain a financial benefit.

In considering whether an incident is reportable or whether an action amounts to 'stealing or financial coercion', it is important to note that the responsibility to report the staff member's actual, suspected or alleged conduct is not dependent on the nature of the theft or financial coercion. It does not matter if the theft involves items of significant financial value or large sums of money, items of emotional or sentimental value or items of low value.

Important information

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 reportable incident for SIRS 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), this should be reported.

Neglect

The definition of neglect is similar across residential and home services.

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.[40]

However, for home services providers, neglect is **not** a reportable incident where:

- the incident results from a choice made by the consumer about the care or services provided to them, or how the care or services are to be provided, and
- before the incident occurred, is alleged to have occurred, or is suspected of having occurred, the choice had been communicated by the consumer to the provider, the provider had communicated any risks associated with that choice to ensure the consumer was informed, and the provider had recorded the discussion and the choice in writing.[41]

Breach of duty of care

A duty of care refers to the responsibility to take reasonable care and skill 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 harm other people.

If a consumer is reasonably relying on you and your staff to be careful, 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 or contributed to (or could reasonably have been expected to have resulted in) harm and/or discomfort, injury, poor health outcomes, emotional distress or the death of a consumer. It can be a single 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 harm to a consumer. Neglect can also be ongoing, repeated failures by a provider to meet a consumer's physical or psychological needs.

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.

Many staff will not have professional standards tied to their role (particularly those providing home services). For example, cleaners, gardening or maintenance staff or 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.

40 See section 15NA(10) of the Quality of Care Principles.

41 See section 15NB(4) of the Quality of Care Principles.

Note: This element of the Neglect reportable incident type is unique to home and community care settings, and differs from criteria for not reporting consumer decisions to refuse to receive care offered in the residential care setting.

In addition, all staff members providing Commonwealth-funded aged care services must comply with the Code, which sets out expectations for providers and staff members regarding the safe and ethical delivery of care and services. The Commission has published detailed information about the Code as it applies to providers and to staff members.

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 required level of professional training and qualifications, knowledge and skills, and scope of practice, and hence different expectations of their conduct.

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 safe and 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. These pathways differ depending on the relevant overseeing agency.

Where there have been breaches of standards that result in misunderstandings, near misses, 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 responsibility to provide care and services, and has failed to perform their duties in line with relevant standards, or to the level a reasonable person would expect of them in their role, and their failure directly causes or contributes to harm (or could reasonably have been expected to have caused harm) to a consumer's safety, health or well being 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 from the consumer (or their authorised representative) was not obtained
- a consumer with poor proficiency in English was denied the right to an interpreter to support them to consent to a particular medical treatment
- assistance to a consumer has been withheld without a lawful reason for such a period as to result in harm and/or discomfort 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 caused harm and/or discomfort to a consumer
- a consumer has suffered injury or death as a direct result of a staff member's incompetence or failure to provide quality care and services.

Consumer choice to not receive care and services

Where a consumer makes an informed choice not to receive certain care and services (even when they are assessed as requiring these) and this results in an incident, it is not reportable. See where consumers choose not to receive certain care and services (Chapter 7).

Where a consumer is awaiting a higher level of care

You may be providing care and services to a consumer who has been assessed as requiring a higher level of care and is awaiting availability of those services – for example, the consumer is receiving CHSP and is assessed as requiring a home care package or the consumer is receiving a home care package Level 2 and is assessed as requiring a Level 4 package.

In this case, you should discuss with the consumer (and their representative where appropriate) the care and services you are able to provide within their current package and options for accessing the additional services they require while they wait. You should discuss any risks associated with the consumer's care and services and consider strategies that can be implemented to address these risks until a package becomes available to more appropriately meet their needs.

If a consumer is not receiving certain care and services because these services are not funded or within the scope of services delivered by the provider, it is not considered neglect where the provider does not deliver these services to the consumer. For example, where a home service provider is funded to deliver gardening services but the consumer has wounds that require medical attention, the provider is not responsible for providing wound care. However, in line with their IMS responsibilities and duty to support the health, wellbeing and safety of consumers, the provider should consider how they might support or encourage the consumer to get medical treatment where this is needed.

What is not neglect?	What is neglect?
• An isolated incident of late or missed medications, where the provider is responsible for assisting the consumer to administer medications and there is no harm and/or discomfort caused (or could reasonably have been expected to have been caused) to the consumer. • Rapid weight loss as a result of disease, where the provider is responsible for delivering meals and all reasonable efforts are made to ensure the consumer is receiving adequate nutrition. • Where a consumer has made an informed choice not to receive care and services in line with their assessed care need, for example: — where the provider is responsible for delivering meals and a consumer with diabetes chooses not to eat a diabetic diet — where the provider is responsible for delivering personal care and a consumer chooses not to be showered or have their teeth or hair brushed — where the provider is responsible for delivering garden maintenance and a consumer chooses not to have their lawn mowed — where the provider is responsible for delivering clinical care and a consumer chooses not to have their wound cleaned and dressed.	• Where a staff member does not arrive to provide care and services, resulting in harm and/or discomfort to the consumer, e.g. where: — a staff member does not arrive to assist a consumer into bed, so the consumer remains in their wheelchair all night — a provider fails to deliver meals to the consumer, resulting in the consumer going hungry — a staff member providing assistance with hygiene and toileting does not arrive to change a consumer's continence aids resulting in emotional distress to the consumer — a staff member does not arrive to change a consumer's dressing and their wound worsens as a result. • Frequent or regular missed instances of care without the consumer's prior agreement. • Failing to consistently deliver or withholding personal care (such as showering, toileting or oral care) or agreed outings to community settings (such as not taking the consumer shopping). • Frequent or regular late or missed assistance with administration of medications, or failure to assist a consumer to administer correct or time critical medications (where this is the responsibility of the staff member).

What is not neglect?	What is neglect?
	• Failing to supervise a consumer in an environment that leaves them susceptible to injury. For example: — failing to appropriately monitor/support a consumer at risk of falls when taking a consumer shopping resulting in the consumer falling over — 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 recognise and respond appropriately when a consumer experiences acute deterioration while services are being delivered. • Failing to appropriately modify a consumer's prepared meals to account for specific directions from an assessment and as recorded in their care plan, resulting in the consumer not being able to eat meals or choking. • Failing to change soiled continence aids in a timely manner.

There may be incidents that are minor and do not necessarily need to be reported to the Commission (for example, a single instance of a staff member failing to show up to provide care and services, where this does not cause harm to the consumer). In these instances, the incident should be addressed through the service's IMS and continuous improvement processes.

Inappropriate use of restrictive practices

The inappropriate use of restrictive practices in relation to a consumer is a reportable incident.

Restrictive practice includes any practice or intervention that has the effect of restricting the rights or freedom of movement of a consumer [42]. Whether the use of a restrictive practice is a reportable incident (i.e. it is an inappropriate use of restrictive practice) depends on the circumstances in which it is used, and whether these are consistent with requirements as described in Part 4A of the Quality of Care Principles).

The treatment of this reportable incident type differs between home services and residential care. This is because the requirements for use of restrictive practice set out in the Quality of Care Principles [43] are tailored to the residential care setting and do not currently apply to home service providers delivering care in a consumer's home.

For home services providers, the Quality of Care Principles set out that the use of a restrictive practice is **not** a reportable incident if:

- the restrictive practice is used in the course of providing home services, and
- before the restrictive practice is used, the following matters were set out in the consumer's care and services plan:
  - the circumstances in which the restrictive practice may be used, including the consumer's behaviours of concern that are relevant to the need for the use
  - the manner in which the restrictive practice is to be used, including its duration, frequency and intended outcome, and
- the restrictive practice is used:
  - in the circumstances set out in the plan, and
  - In the manner set out in the plan, and
  - in accordance with any other provisions of the plan that relate to the use, and
- details about the use of the restrictive practice are documented as soon as practicable after the restrictive practice is used. [44]

Use of a restrictive practice in an emergency situation will therefore be a reportable incident in home services, as emergency use will not meet all the requirements above (including matters that need be detailed in the consumer's care and services plan prior to its use).

42 See section 54-9(1) of the Aged Care Act.

43 See Part 4A of the Quality of Care Principles.

44 See section 15NB(2A) of the Quality of Care Principles.

Before the restrictive practice is used

It is important to carefully plan and manage the use of any non-emergency restrictive practice in partnership with consumers, their representatives and health practitioners.

Before a restrictive practice is used in relation to a consumer, you must document:

- the circumstances in which restrictive practices may be used, including the consumer's behaviours that may require the use of restrictive practice
- details regarding the way restrictive practice is to be used, including:
  - the type of restrictive practice and any specifics about how this is to be safely applied
  - the duration for which the restrictive practice is to be used
  - the frequency for which the restrictive practice is to be used, and
  - the intended outcomes of using the restrictive practice.

Where a consumer has a behaviour support plan that forms part of their care and services plan, these matters may be documented in the behaviour support plan. Where these matters have been documented by another health professional involved in the consumer's care, they should be included as part of the consumer's care and services plan.

Before using a restrictive practice in relation to a consumer, it is best practice to:

- document any alternative strategies that may be used
- engage with the consumer, their representative and others involved in their care (such as the consumer's GP) about the restrictive practice and the circumstances in which that practice might be or is required
- document this engagement and the consumer's informed consent in the consumer's care and services plan
- schedule regular reviews to reassess the need for a restrictive practice.

Care and services plans

Where restrictive practices are used, they must be in accordance with the consumer's documented care and services plan.

As required by Standard 2 of the Quality Standards, care and services plans must:

- consider the risks to the consumer's health and wellbeing to inform the delivery of safe and effective care and services
- address the consumer's current needs, goals and preferences
- developed in collaboration with the consumer and others involved in the consumer's care
- readily available to the consumer and where care and services are provided
- regularly reviewed for effectiveness and when circumstances change or incidents impact on the needs, goals or preferences of the consumer — this is particularly important where restrictive practices are used.

Behaviour support plans

While it is not a requirement for home service providers to develop a behaviour support plan for consumers, it is best practice to have a behaviour support plan for all consumers who require behaviour support. A behaviour support plan forms part of the individual care and services plan and does not replace it.

A behaviour support plan sets out information about the consumer's behaviours for which the consumer may require support, relevant assessments, alternative strategies for addressing behaviours and information about how the provider has consulted with the consumer and their relevant representatives and carers about the use of alternative strategies.

In preparing and reviewing a consumer's behaviour support plan, the provider should consult with:

- the consumer and any other person nominated by the consumer or, if the consumer has a legally appointed substitute decision-maker who, under who, under the relevant State or Territory law, can make decisions about that care, and
- health practitioners with expertise relevant to the consumer's behaviours.

See more information about behaviour support plans on the Commission's website [45].

While the restrictive practice is in use

Restrictive practices can only be used:

- in the circumstances set out in the consumer's care and services plan
- in the manner set out in the consumer's care and services plan
- in accordance with any other provisions of the consumer's care and services plan that relate to the use of restrictive practices.

While the restrictive practice is being used, you should remember to:

- monitor the consumer for signs of distress or harm, side effects and adverse events and changes in mood or behaviour, wellbeing or the consumer's ability to maintain independent function
- monitor, review and document the need for the restrictive practice in the consumer's care and services plan (in consultation with the consumer and relevant health practitioners)
- monitor the effectiveness of the restrictive practice and the effect of changes in the use of the restrictive practice
- support consumers to make changes (e.g. to their environment) to reduce or remove the need for the use of the restrictive practice
- if the restrictive practice used is chemical restraint, you should also provide information about the effects and use of the chemical restraint to the prescribing practitioner.

45 https://www.agedcarequality.gov.au/minimising-restrictive-practices

Following the use of the restrictive practice

You must record details of the use of the restrictive practice in relation to a consumer as soon as possible following that use.

The documentation must demonstrate the use of the restrictive practice was in accordance with the consumer's care and services plan. You should therefore document, at a minimum:

- the time and date of the use of the restrictive practice
- the manner in which the restrictive practice was used, including the duration and the outcome
- the consumer's response to the use of the restrictive practice
- any observations or concerns about the use of the restrictive practice on the consumer.

Depending on your organisation's systems and processes, this may be recorded in the consumer's care and services plan or progress notes, for example. It should be readily available to others involved in the consumer's care, such as workers, managers, coordinators, RNs, etc.

The inappropriate use of restrictive practices by a consumer's family member (for example, locking the consumer in a room or overmedicating a consumer) is not reportable under this incident type as it is not connected to the provision of care and services to the consumer. However, where workers witness or suspect a consumer is being subjected to inappropriate use of restrictive practices, this must be escalated and responded to accordingly (as per requirements to identify and respond to abuse and neglect of consumers under Quality Standard 8). This may include, for example, engaging with the consumer's representative, holding discussions with others involved in the consumer's care (such as their GP), referring the consumer to an advocacy service, or considering reassessment of the consumer's care and services. See incidents that did not occur in connection with the provision of care.

What is not inappropriate use of restrictive practices?	What is inappropriate use of restrictive practices?
• Where a provider uses the restrictive practice in line with the consumer's documented care and services plan, uses the restrictive practice in the course of providing aged care in a home or community setting, and records the use of the restrictive practice as soon as possible following the use.	• Restricting a consumer's movement where this is not in line with their documented care and services plan. For example, depending on what is documented in the consumer's care plan, this **may** include: — installing bed rails such that makes it difficult for a consumer to get out of bed — placing a table or something in front of a consumer in order to limit their ability to move — locking a consumer's door such that they can't exit a certain room or their house — 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. • 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 (in line with their documented care and services plan).

Missing consumers

Missing consumers is a reportable incident type specific to the provision of home services and differs from the related reportable incident type for residential care (unexplained absence).

Where a consumer goes missing in the course of a home services provider delivering care and services to the consumer and there are reasonable grounds to report that fact to police, this is a reportable incident.[46]

This definition is intended to capture situations where a provider has the consumer in their physical care immediately prior to their absence. For example:

- a staff member has taken a consumer to the shops and the consumer has gone missing during the outing
- a consumer goes missing while in overnight respite, receiving care at a day therapy centre, receiving transport services or on a scheduled outing with the provider
- a consumer goes missing while a staff member is delivering care and services in the consumer's home and there is reason for concern (e.g. the consumer could be harmed if they were wandering alone).

This definition is **not** intended to require you to notify the Commission of incidents where a staff member arrives for a scheduled visit and the consumer is not present, or where a consumer leaves their home while, for example, home maintenance services are being provided.

However, it is important to acknowledge that if a consumer is not present when service delivery has been scheduled and there is reason for concern (or no reasonable explanation for their absence), staff members would be responsible for alerting the provider to the consumer's unexpected absence and the provider would be expected to follow this up (as per existing procedures agreed with each consumer).

It is expected that you will report a missing consumer 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 reportable incidences of missing consumers are Priority 1 reportable incidents for the purposes of notifying the Commission (see Chapter 6).

All unexpected absences of a home services consumer should be recorded in your IMS, and the consumer's care plan, so that consumer behaviours (including wandering patterns in community settings) can be understood and appropriately managed.

46 See section 15NAA of the Quality of Care Principles.

Assessing and classifying incidents

Overview

- You are required to notify all actual, alleged or suspected reportable incidents to the Commission, and indicate in your SIRS notification whether you are reporting a Priority 1 or Priority 2 reportable incident.
- Some reportable incidents will need to be reported within a Priority 1 timeframe based on the type of incident (for example, unlawful sexual contact or inappropriate sexual conduct, unexpected death, missing consumers) and where there are reasonable grounds to report the incident to police.
- For other categories of reportable incidents, you will need to classify the incident priority based on whether it caused (or could reasonably have been expected to have caused) the consumer physical or psychological injury or discomfort.
- The classification of an incident will determine the period of time for notifying a reportable incident to the Commission.
  - All Priority 1 reportable incidents must be notified to the Commission within 24 hours of you becoming aware of the reportable incident.
  - All Priority 2 reportable incidents must be notified to the Commission within 30 calendar days of you becoming aware of the reportable incident.

Classifying reportable incidents as Priority 1 or Priority 2

You are required to notify all actual, suspected or alleged reportable incidents (as described in Chapter 4) to the Commission.

The Commission has developed a SIRS decision support tool [47] to help providers determine whether an incident should be reported and to classify the incident's priority, i.e. the timeframe for notifying the incident to the Commission.

You are required to classify a reportable incident as either:

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

Some reportable incidents must always be classified a Priority 1 reportable incident based on the incident type or if there are reasonable grounds to report the incident to police. For other types of reportable incidents, you will need to classify the incident priority based on whether the incident caused (or could reasonably have been expected to have caused) physical or psychological injury or discomfort to a consumer requiring medical or psychological treatment to resolve.

47 https://www.agedcarequality.gov.au/sirs/decision-support-tool

Classification of the incident as Priority 1 or Priority 2 determines the relevant timeframe for notifying the incident to the Commission and the information required to be included in your notification.
Your actions to respond to and/or manage the reportable incident and its impacts should be taken as soon as appropriate to the situation and circumstances, without regard to the timeframes for initially notifying the incident to the Commission.

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

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

A Priority 1 reportable incident is a reportable incident:

- that caused, 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
- where there are reasonable grounds to report the incident to police
- involving unlawful sexual contact or inappropriate sexual conduct inflicted on a consumer
- that is an unexpected death of a consumer, or
- where a consumer goes missing in the course of provision of home services [48].

Could reasonably have been expected to have caused harm

For priority 1 reportable incidents, the phrase 'could reasonably have been expected to have caused harm' includes circumstances where an incident (including a suspected or alleged incident) involves conduct that would ordinarily cause physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, even though the conduct may not have had such an effect in the circumstances of that specific incident.

Establishing whether harm might be reasonably expected will require you to consider the particular physical and psychological conditions, limitations, vulnerabilities and past experiences of consumers. For example, a consumer with a cognitive impairment may be more vulnerable and therefore an incident might be considered more likely to cause them harm, where for a more independent individual the same incident (e.g. leaving them on their own near a potentially hazardous environment) may not be as likely to be expected to cause harm.

When considering whether an incident could reasonably have been 'expected to have caused' discomfort or physical or psychological injury, it is important to think about the general vulnerability of aged care consumers. You should also be aware (and record in relevant care plans) that some consumers may be unable to express or display pain and/or discomfort (whether distress or injury, etc.) in the same way as other consumers.

48 See section 15NE(2) of the Quality of Care Principles.

Consider how you might feel if the incident happened to you or a loved one.

This ensures incidents that could have caused a consumer injury or discomfort are also captured by the provider, particularly where a consumer has a cognitive impairment, memory deficit or such other condition that prevents them from articulating or displaying evidence of harm and/or discomfort.

When reporting the incident to the Commission, include information not only about actual harm, but also harm that could have reasonably have been expected to have caused discomfort or physical or psychological injury. To assist the Commission's assessment of your notification, provide details about how you came to the conclusion that the incident caused, did not cause, or could reasonably have been expected to have caused, physical or psychological injury or discomfort. That is, include your reasoning to support your assessment of the level of harm that you've selected, whether or not you have assessed that the incident caused, did not cause, or could reasonably have been expected to have caused injury or discomfort.

Physical or psychological injury or discomfort

Reportable incidents that caused, 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 will be Priority 1 reportable incidents regardless of whether:

- the injury or discomfort caused to the consumer is temporary or permanent
- the required medical or psychological treatment is, or can be, provided to the consumer in their home or elsewhere.

Physical or psychological injury or discomfort includes but is not limited to:

- consumer distress requiring support or counselling
- consumer pain
- consumer panic or anxiety
- 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 that requires medical treatment to resolve
- consumer trauma associated with an incident requiring psychological treatment
- 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.

When assessing the physical or psychological injury and/or discomfort that was caused (or that could reasonably have been expected to have been caused) to a consumer by a reportable incident, it is important to remember that the injury and/or discomfort does not have to include visible physical harm and/or discomfort (such as bruising or scratches). Psychological and emotional effects are also types of injury and/or discomfort. Some incidents may cause a consumer to become withdrawn, deter a consumer from providing feedback on their care and services, cause a consumer to try to avoid a certain staff member, or have no discernible effect on the consumer at all (particularly where a consumer has a cognitive impairment, memory deficit or such other condition that prevents them from articulating or displaying evidence of harm and/or discomfort.

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 harm and/or discomfort a reportable incident has caused, or could reasonably have been expected to have caused, to a consumer.

Medical or psychological treatment

'Medical or psychological treatment' is the application of medical treatment or psychological treatment to cure a disease or condition or, in the context of the SIRS, to treat and resolve physical or psychological injury or discomfort.

Treatment is the application of medicines, surgery, psychotherapy or other forms of therapy to resolve the physical or psychological injury or discomfort. The need for treatment should be assessed by suitably qualified personnel.

Some (non-exhaustive) examples of actions which may constitute medical or psychological treatment include:

- applying an ice pack
- elevating a limb
- applying salves, antiseptic, bandages or dressings to a wound
- escalating to a medical officer or RN for review
- offering a consumer specific emotional support or onsite or offsite counselling
- taking a consumer to see a GP or allied health professional
- taking a consumer to hospital — this includes presentation or admission to an emergency or other ward within a hospital facility (including short-stay admissions).

There will be instances in which consumers require medical or psychological treatment for reasons unrelated to injury or harm resulting from an incident (e.g. due to a pre-existing health condition) and these instances are not reportable incidents.

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

A Priority 2 reportable incident includes any reportable incident that does not meet the Priority 1 criteria as outlined above.

Examples of a Priority 2 reportable incident may include where the consumer is momentarily shaken or upset because of the incident or where the consumer experiences temporary redness or marks that do not bruise (or could not reasonably have been expected to cause an injury), and which do not (or could not reasonably have been expected to) require medical or psychological treatment to resolve. In these cases, the reportable incident will be a Priority 2.

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

Notifying reportable incidents

Overview

- All reportable incidents are to be notified to the Commission by providers via the My Aged Care Service and Support portal.
- You are required to indicate in your SIRS notification whether you are reporting a Priority 1 or Priority 2 reportable incident.
- Incident notifications must be sufficiently detailed to enable the Commission to assess and respond to risk. Where insufficient information is provided, the Commission will seek further information or may choose to investigate the incident.
- The Commission may decide that multiple allegations of the same reportable incident do not need to be notified.
- You must also report an incident to the police when there are reasonable grounds to do so, and report to other relevant authorities when required.
- Protections for people who disclose reportable incidents are strengthened under the SIRS.
- As part of your responsibility to maintain an IMS, you are required to keep a record in relation to each incident that occurs in the service, regardless of whether or not it is a reportable incident.

Notifying reportable incidents to the Commission

Recording reportable incidents in an IMS can help you to identify trends and issues and pursue continuous improvement in the quality of care and services you deliver. Notifying reportable incidents through the SIRS also supports the Commission to assess and respond to risk at a provider level (to identify trends within a service/outlet or across multiple services/outlets), and to identify where improvements are needed across the sector.

It is critical that notifications of reportable incidents to the Commission through the SIRS are clearly and comprehensively described and include sufficient detail to enable the Commission to:

- **understand the context of the reportable incident**
  - To support this, you should describe the incident, those involved in the incident, what led to the incident's occurrence, how the incident was identified, what occurred before/after the incident, etc.
- **assess the appropriateness of the provider's response to the incident**, including to ensure sufficient actions have been undertaken to ensure the safety, health and wellbeing of the consumer(s) involved.

- You should consider the consumer's safety, health and wellbeing in terms of both current and ongoing physical and psychological harm and/or discomfort and ensure that consumers (and other relevant people) are involved in determining a response to the incident.
- You should also consider if there are other parties that the incident should be reported to, including whether there are reasonable grounds to report to the police.
- Explain the specific actions taken to treat and support the consumer(s) involved and what you have done to ensure the safety, health and wellbeing of the consumer(s).

- **determine the level of harm and/or discomfort caused (or that could reasonably have been expected to have caused) to the consumer(s) involved**
  - Include details of the physical or psychological injury and/or discomfort caused to the consumer and describe the consumer's response (for example, observed behaviour such as crying, not speaking, not wanting to do usual activities). Consider the views of the consumer and also people who know them well such as their loved ones or staff that regularly care for the consumer.
  - Regardless of whether you have assessed the incident as causing harm to the consumer, include your reasoning to support your assessment of the level of harm that you've selected. This includes where your assessment was that no harm was caused or could reasonably have been expected to have caused.
  - Describe any medical and/or psychological treatment provided to (and/or proposed or scheduled for) the consumer in response to the incident. Also consider also other mechanisms used to comfort or calm the consumer outside of medical or psychological treatment (e.g. separating the consumer from the distressing space, talking with the consumer to calm or distract them, etc).
- **assess the appropriateness of the provider's actions taken to manage the incident and minimise the risk of reoccurrence**
  - Describe how you undertook assessment of the incident, including details of any investigations and whether it was identified that actions could have been taken to prevent the incident or to cause less harm and/or discomfort (considering all the factors that may have contributed to the incident occurring).
  - You should include clear and detailed descriptions of the actions taken (or that you plan to take) to prevent similar incidents occurring in the future or to manage similar risks. This could include, for example, changes to processes and procedures, assessment and/or care planning, risk assessments, staff duties or training, clinical governance, etc.
  - Describe the expected/desired impact of any changes and how you will measure their effectiveness.

- **assess the effectiveness of the provider's IMS**
  - The Commission will consider how well the provider's IMS supports it to effectively manage, prevent, assess, report and resolve incidents.
  - Your ability to provide timely and adequately detailed reports and respond to incidents in a way that demonstrates continuous improvement will enable the Commission to consider whether your IMS procedures meet the requirements.

Rather than providing summary statements, dot points or extracts from care documentation, include detailed information such that someone who is unfamiliar with the consumer and who was not present, can understand what happened. It is important that the person making the notification is familiar with the incident and was involved in the assessment of the incident so they can accurately describe the relevant factors contributing to the incident's occurrence, the factors informing their assessment of harm and/or discomfort caused to the consumer, reasoning behind the management of the incident and the status of any changes being made to reduce the risk of reoccurrence.

This will enable the Commission to assess the adequacy of your risk and incident management approaches and determine whether further investigation or intervention is required to mitigate risks to consumers.

The Commission has developed guidance to:

- enable providers to adopt a problem-solving approach to assessing incidents [49] to better understand the cause of an incident and develop solutions to prevent incidents from reoccurring
- support providers to complete notifications [50], including a range of example responses [51] to assist providers in understanding the level of detail of information to be included in notifications to the Commission.

You should also attach relevant records to the notification which demonstrate the steps you've already taken. If the Commission decides to further assess an incident or conduct an investigation, it will look for evidence of the actions taken by providers to manage the incident and prevent similar incidents from reoccurring (particularly where there is an identified trend in incidents).

49 https://www.agedcarequality.gov.au/sites/default/files/media/sirs-reporting-using-problem-solving-approach-enhance-effective-incident-management.pdf

50 https://www.agedcarequality.gov.au/sites/default/files/media/sirs-reporting-practical-tips-for-providers-making-notification.pdf

51 https://www.agedcarequality.gov.au/sirs/submit-notifications

Who must notify a reportable incident?

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, or
- that staff member's supervisor or manager, or
- the person in your organisation who is responsible for notifying reportable incidents to the Commission.[52]

You are responsible for ensuring that staff at your service alert 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 IMS and processes, which encompasses all incidents (and not just reportable incidents) to ensure that staff understand and can respond appropriately to incidents that occur (or are alleged or suspected of occurring) 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 or incidents 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.

Escalation processes

It is acknowledged that, in the home services context, not all staff will necessarily have the skills to adequately assess an incident and its effect on the consumer. For example, where staff are providing gardening services or other domestic assistance and typically have limited interaction with the consumer.

In such circumstances, there must be processes in place to enable such staff to escalate an incident to an appropriate manager who is skilled to assess whether an incident has caused harm, or could reasonably have been expected to have caused harm, to the affected person.

Information about these escalation processes should be part of the provider's IMS and addressed through regular staff training.

52 See section 15ND of the Quality of Care Principles.

Important information

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, identifying signs of possible harm (whether distress, discomfort or injury, etc.), disclosure by a consumer or receiving information from another person.

Staff must know who to speak to within the organisation so that an appropriate response can be initiated without delay, including a notification to the Commission. Information about these escalation processes should be part of the provider's IMS and addressed through regular staff training.

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 incidents (including suspicions or allegations of reportable incidents) in good faith (see Protections for those providing information or reports).

Anyone can raise concerns about an incident

You should encourage any person who is concerned about an incident or a consumer's safety, health or 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 to attract the protections afforded to a reportable incident notification). Information about how people may give feedback or lodge a complaint is available on the Commission's website [53].

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

Notifying Priority 1 reportable incidents

Priority 1 reportable incidents involve a staged reporting process. Stages beyond the initial notification of a Priority 1 reportable incident will depend on the information available to you at the time of reporting and the appropriateness of your response to the incident.

Initial notification to Commission

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

If you are unable to complete all the required information in this initial notification as some details are not available within the 24 hours, then the missing information is to be provided to the Commission through an additional notification (see below).

Notifying additional information to Commission (if required)

All information required in the initial notification may not always be available within the required timeframe for submitting the notification. Any required information not submitted in the initial report must be provided to the Commission within 5 calendar days of the provider becoming aware of the reportable incident, or within a period notified by the Commission.

If the Commission sets a shorter or longer period than 5 calendar days in which the information is to be provided, the Commission will notify you of the period in writing.

It is your responsibility to ensure the required information missing from your initial notification is provided within the 5 calendar days or within a different period if requested to do by the Commission.

The Commission will also determine on a case-by-case basis whether further information is required from you, for example, more detailed information on actions taken in response to an incident. This information must be provided to the Commission within 5 calendar days of becoming aware of the reportable incident or within a period notified by the Commission. If further information is required, the Commission will issue you with a notice detailing the specified further information you are required to provide and the period in which you are required to provide the information.

If you are required to notify the Commission of additional information, whether that is required information missing from your initial notification and/or further information, you must use the Commission-approved form [54].

54 https://www.agedcarequality.gov.au/sirs#resources

Significant new information

If, after you have submitted your initial notification, you become aware of significant new information in relation to the reportable incident, you are required to notify the Commission as soon as possible using the Commission-approved form [55].

An example is where a consumer has had a fall due to a failure by care staff to follow standard procedures. The provider has submitted a SIRS notification as the incident is a reportable incident which details that the consumer has been hospitalised. If the consumer dies, this is considered significant new information and must be notified to the Commission.

Notifying Priority 2 reportable incidents

Providers must notify the Commission of Priority 2 reportable incidents **within 30 calendar days** of 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 [56].

Making a notification

Notifications of reportable incidents must be lodged electronically using the form available to providers through the My Aged Care Service and Support portal [57].

Once a notification has been submitted, you will receive an email confirming receipt of your submission. This email is automatically issued and will include a SIRS notification number (e.g. NF23/012345). If the Commission is in contact to request any further information that may be required, the Commission will refer to the notification number to which the request for further information relates. In submitting missing, further or significant new information, you are required to submit this information to the Commission using the Commission-approved forms [58].

The Department of Health and Aged Care provides information and support to access [59] and log in [60] to the provider portal. Facts sheets and guidance documents (which include advice about functionality to bulk upload P2 notifications) are also available on My Aged Care [61] and the Department's website.

55 https://www.agedcarequality.gov.au/media/89701
56 https://www.agedcarequality.gov.au/media/89701
57 https://www.health.gov.au/resources/apps-and-tools/my-aged-care-service-provider-portal
58 https://www.agedcarequality.gov.au/sirs#resources
59 https://www.health.gov.au/initiatives-and-programs/my-aged-care/using-my-aged-care/set-up-access-to-my- aged-care
60 https://www.health.gov.au/resources/publications/my-aged-care-logging-in-to-the-my-aged-care-provider-portal-using-mygovid
61 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

The questions you will be required to answer when notifying the Commission of a reportable incident electronically through the My Aged Care Service and Support portal [62] cover information that provider must include in the incident notice [63].

If you are providing an initial notification to the Commission 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. As noted above, where the required information is not available when submitting the initial notification, you must submit the missing information within 5 calendar days of becoming aware of the reportable incident (or within the period notified by the Commission).

You should ensure your notification includes as much detailed information as possible about the circumstances around the incident, its effect on the consumer and your response. See Notifying reportable incidents to the Commission.

Final report (if required)

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

The final report must be submitted to the Commission in writing using the Commission-approved form [64] and include details of matters specified by the Commissioner, such as a summary of your assessment and/or investigation of the incident, your findings, and any corrective action taken as a result.

Investigation report (if required)

Where the Commission has required you to undertake an internal or external investigation of an incident, a report of the investigation may also be required to be provided to the Commission within a specified period.

The Effective serious incident investigations guidance for providers [65] is designed to assist providers to conduct investigations into serious incidents.

The guidance promotes best practice approaches associated with conducting an investigation and outlines steps to take when responding to actual, alleged and suspected incidents.

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

63 See sections 15NE and 15NF of the Quality of Care Principles.

64 https://www.agedcarequality.gov.au/media/89702

65 https://www.agedcarequality.gov.au/sites/default/files/media/effective-serious-incident-investigations-guidance.pdf

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

A reportable incident is not required to be notified to the Commission if the Commission has made a determination under section 95D of the *Aged Care Quality and Safety Commission Rules 2018* (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 found to be based on delusions, you may contact the Commission regarding a determination that 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.

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.

In determining whether it is appropriate that any future repeat incidents involving the same consumer(s) in those precise circumstances would not be notified to the Commission, the Commission will consider (among other things):

- the nature and seriousness of the allegation
- the frequency of the allegation that is being made
- the clinical evidence submitted to support the claim that the allegation is a result of a delusion (including the role of the health professional and their knowledge of the consumer)
- the subject of the allegation
- the actions the provider has taken to ensure the consumer is supported and not distressed
- how the provider has involved the consumer's representative in the management and resolution of the incident

You can seek a determination by emailing sirs@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 IMS to ensure the consumer's wellbeing is protected and that the incident is appropriately assessed, managed and recorded.

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 safety, health and wellbeing of consumers.

The aged care legislation describes protections for those making disclosures. These will also be reflected in the funding agreements and program manuals for CHSP and NATSIFACP service providers.

When is a disclosure of information protected?

Sections 54-4 to 54-6 of the Aged Care Act afford protections against detriment, threat, victimisation and protection of identity for people who disclose reportable incidents. This also extends 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, disclosures relating to reportable incidents must meet the following requirements:

- the disclosure must be 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
  - 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 [66].

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.

66 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.

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, you and your managers have a responsibility to ensure, as far as reasonably practicable, that other staff or contractors do not victimise the person who made the disclosure.

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 one or more of the Commission, another of your key personnel, the police or as required by law). You are also responsible for ensuring that a staff member who receives the notification of the reportable incident does not disclose the identity of the person.

Record keeping requirements

Information to be recorded

As part of your responsibility to maintain an IMS, you are required to keep a record in relation to each incident that occurs, regardless of whether it is a reportable incident (see documentation and record keeping).

Your IMS must also allow the collection of data that enables you to provide information to the Commission and other authorities as appropriate.

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 seven years after the incident was identified.

Privacy and confidentiality

You are legally required, as part of your online notification of a reportable incident, to confirm that you have provided a notice of collection (where appropriate)[67] 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).

67 https://www.oaic.gov.au/privacy/your-privacy-rights/your-personal-information/collection-of-personal-information

Common scenarios or issues providers may encounter

Overview

- This Chapter explores some common scenarios or issues that providers may encounter in seeking to meet their SIRS responsibilities.

Where providers and consumers (or their representatives) hold differing views about whether an incident should be notified

There may be scenarios where providers believe an incident should be notified to the Commission (as it meets the definition of a reportable incident) but the consumer (and/or their representative or family) does not want it to be notified.

In these circumstances, you should explain the purpose of the SIRS and your responsibilities to report certain incidents to the Commission and explain why reporting is an important part of protecting consumers from abuse and neglect and improving the delivery of care and services. At the same time, wherever possible throughout this process, you must also meet your responsibilities to support consumers to have control over, and make choices about, their own lives, care and services as per the *User Rights Principles 2014*. You should also seek to understand the consumer's concerns and attempt to alleviate any concerns they may have.

The absence of consumer consent is not a barrier to mandatory reporting and all reportable incidents must be notified to the Commission. Where the consumer has concerns for their safety or fears repercussions in relation to you making the notification, you may need to take appropriate steps to make them feel safe and protected from any further harm. Where the consumer is concerned about the management of sensitive or personal information in relation to your notification, you may need to explain the controls your organisation has in place to protect the privacy and confidentiality of all incident information.

In a scenario where a consumer or their representative believes that an incident should be notified and the provider holds a different view, consumers and their representatives may inform the Commission of an incident including by making a complaint. The Commission will review and work to resolve the complaint, which may include discussions with the provider regarding its responsibility to notify the Commission of reportable incidents (and/or consideration of regulatory actions for non-compliance where appropriate).

Where multiple aged care providers are delivering care and services to a consumer

Where you are one of multiple providers delivering aged care services to a consumer, you (or your staff) may become aware that an incident may have occurred, be alleged or suspected of having occurred in connection with the care and services delivered by another provider.

Examples include where you (Provider A) and another provider (Provider B) are delivering care and services to the same consumer and:

- the consumer tells a staff member of Provider A that a staff member of Provider B hurt them while delivering care and services, or
- the consumer shows signs of being involved in a reportable incident related to the care and services being delivered by Provider B but does not tell a staff member of Provider A what happened, or
- a staff member of Provider A witnesses a staff member of Provider B verbally abusing the consumer while delivering services in the consumer's home.

As Provider A, you are **not** required to notify the Commission of such incidents through the SIRS, given you are unlikely to know the details and have limited ability to investigate such incidents further.

In such circumstances, you are expected to raise your concerns directly with Provider B so that Provider B can assess the incident, submit a SIRS notification where required and manage the incident. This will ensure that Provider B can act to prevent similar incidents from occurring in connection with their provision of care and services into the future.

In providing quality care and services, you should also provide support to the consumer to ensure their safety, health and wellbeing. You may also consider engaging with the consumer's representative/s, a consumer advocacy service and/or making a complaint to the Commission, particularly where you have concerns about Provider B's management of the incident.

Where another provider contacts you with concerns about a suspected or alleged incident occurring in connection with the care and services you are providing to a consumer, you should take all steps to assess the incident, submit a SIRS notification where the incident meets the definition of a reportable incident, and manage the incident in accordance with your IMS.

Where you have engaged another organisation or worker to deliver services

Where you, the provider have contracted or engaged another organisation or worker to deliver services on your behalf, this is not considered 'multiple providers'. Where you have engaged another organisation or worker to deliver some, or all, of a consumer's care and services, **you** remain responsible for the delivery of safe and quality care and services and meeting your provider responsibilities.

It is your responsibility to ensure those delivering care understand their SIRS responsibilities, are trained to respond to incidents and can escalate incidents (so that they can be appropriately managed and documented in your IMS), and reportable incidents can be notified to the Commission.

Where consumers choose not to receive certain care and services

Consumers have the right to autonomy and to make choices about their lives, care and services, even where these choices involve risk. You must respect and uphold these rights in your delivery of services to support each person's right to the dignity of risk. While different levels and types of care and services are provided in home and community settings, it is acknowledged that many home service providers have limited visibility or influence over the consumer's living situation (as distinct from residential aged care settings).

Where a consumer chooses not to accept certain care or services, you must assist the person to understand the risks associated with their choice to ensure they are informed. Following this, you should record your discussions and the person's choice to refuse care or services in relevant care planning documents. The record should include the circumstances in which the consumer has made the decision 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. You should also review this decision with the consumer as appropriate.

The word 'choice' is broad and includes directions, requests or instructions given by consumers.

While incidents resulting from a consumer's choice would not be considered reportable incidents, providers are expected to support consumers to understand the risks associated with their choices and, where possible, to put measures in place to mitigate any risks to consumer safety, health and wellbeing. 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 effects of that refusal on the consumer's wellbeing and measures for mitigating the risk to the consumer.

Under the SIRS, you are not required to report an incident or inaction that would otherwise be considered 'neglect' where the incident results from informed choices made by the consumer about their care and services, property or living environment [68]. Such an incident would not be considered reportable where:

- a consumer has chosen not to receive certain care and services (even when they are assessed as requiring these), and
- the provider has discussed this choice with the consumer, including the potential risks, and
- the provider has documented this choice and the outcomes of this discussion, and
- an incident then results from the absence of these care and services.

For example, where the provider has discussed the risks with the consumer and recorded the choice in writing in advance, and it does not fall within another category of reportable incident, the following incidents would **not** be reportable:

- where you have assessed a consumer as requiring support to administer certain medications or treatments, but the consumer wishes to self-administer these and is harmed as a result
- where a consumer does not wish to receive certain care or services or partake in activities of daily living (such as showering) and this causes harm to the consumer
- where a consumer with diabetes chooses not to eat a diabetic diet and, as a result, has a wound with poor healing prognosis
- where a consumer chooses to live in a cluttered home or squalor, preventing adequate cleaning services from being provided and this causes harm to the consumer
- where a consumer chooses not to follow a health professional's recommendations or instructions and, as a result, their condition worsens.

68 This is described in section 15NB(4) of the Quality of Care Principles and applies to service providers under relevant funding agreements and program manuals.

Example

A provider is delivering personal care and clinical care to a consumer with a range of health conditions for which they require medications and support. The consumer is partially blind but is familiar with their medications and says they do not need help taking these. The provider discusses this choice with the consumer, including the potential consequences of taking the wrong medications if they cannot read the labels effectively. The provider suggests the consumer has their pharmacist package their medications in a Webster-pak to reduce the risk of the consumer taking the wrong medications. The consumer says they don't want to do this and the provider records this in the consumer's care planning documentation.

Where the consumer is later involved in an incident caused by them self-administering the wrong medication, the provider would not be required to report this through the SIRS. However, the provider should use this as a prompt to talk to the consumer about the future management of their medications, the risks associated with this and check if the consumer still elects to make the same choice. While it is not a reportable incident under the SIRS, the provider must still capture this incident in their IMS and respond to it in line with incident management requirements.

As part of Standard 1 of the Quality Standards ('Consumer dignity and choice'), consumers must be supported to exercise choice and independence, including to make decisions about their care and services. Providers must uphold the rights of consumers, including their autonomy and choice; however, providers and their staff remain responsible for ensuring choices made by consumers are informed, that any tension between refusal of care and services and professional or legal responsibilities is managed, and that any relevant discussions and considerations are appropriately documented.

Although incidents resulting from a consumer's decision not to accept certain care and services may not be reportable under the SIRS, providers are expected to record and manage any incidents in accordance with the incident management requirements described in Chapter 3.

Where consumers who are also participants of the National Disability Insurance Scheme are involved in incidents

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 an incident that is reportable under the SIRS involves a consumer who is also an NDIS participant [69], you will be required to notify both the Aged Care Commission and the NDIS Commission.

Please note 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 [70].

69 A scenario in which a person is both an NDIS participant and an aged care consumer is more likely to arise in respect of CHSP or flexible care consumers. This is because a person who is 65 years or older who is accessing services and supports under the NDIS will cease to be a NDIS participant if they start to receive a home care package.

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

Role of the Commission

Overview

- The Commission is responsible for administering the SIRS and receiving notifications about reportable incidents from aged care providers.
- Following the assessment of a reportable incident, the Commission may respond by taking a number of actions, including (but not limited to):
  - requiring you to give information, further reports or documents
  - requiring you to complete remedial action(s) in relation to the incident
  - requiring you to undertake an investigation into the incident
  - undertaking an investigation of a reportable incident, including to understand your degree of compliance with your provider responsibilities.
- The Commission may also receive information about a reportable incident through feedback or via a complaint. This information may be examined to determine whether you are meeting your incident management and reportable incident notification responsibilities.
- Information obtained about an incident may be used by the Commission in relation to its other functions.
- The Commission has the power to use, share or refer information provided through the SIRS in accordance with legislative authority (and subject to privacy responsibilities and arrangements for the protection of information).
- The Commission has the power to take regulatory action(s) where appropriate to address non-compliance with provider responsibilities, including SIRS responsibilities.
- The Commission collects, correlates, analyses and disseminates information relating to incidents, including reportable incidents, to identify trends or systemic issues.

Role of the Commission

The Commission is responsible for overseeing the SIRS and receiving notifications about reportable incidents from aged care providers. The Commission will monitor and enforce compliance with provider responsibilities, including 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 in dealing with SIRS notifications and to address non-compliance with provider responsibilities. Information notified through the SIRS also gives the Commission valuable regulatory intelligence, informs risk profiling of providers and enables trends to be identified over time.

The Commission's role in relation to the SIRS includes:

- holding providers to account for having effective systems for recording, reporting, preventing, managing and responding to incidents that have occurred, or are alleged or suspected to have occurred
- providing guidance and resources for providers to develop and implement an effective IMS and build their capabilities to prevent and manage incidents
- taking intelligence-led, risk-based and proportionate regulatory action in dealing with SIRS notifications as well as in response to non-compliance by providers with their legal responsibilities, including compliance with the Quality Standards
- collecting, correlating, analysing and disseminating information relating to incidents, including reportable incidents, to identify trends or systemic issues.

Commission's regulatory response and actions

In dealing with SIRS notifications, as well as in response to non-compliance, the Commission takes an intelligence-led, risk-based and proportionate approach to regulation, 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
- providing feedback to the sector to promote understanding of reportable incidents and effective responses, and to support the continuous improvement of providers in the quality and safety of care and services
- use of monitoring and performance assessment activities, campaigns and targeted regulatory approaches on particular SIRS or incident management issues
- application of regulatory powers to enforce compliance with provider requirements, as appropriate.

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

For more information about the Commission's approach to regulation and to explain what is meant by responsive, risk-based regulation, refer to the Commission's Regulatory Strategy[71].

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

Assessment of a reportable incident notification

When the Commission receives a notification of a reportable incident, the Commission undertakes an assessment to:

- **determine whether the provider has correctly identified reportable incidents, categorised by the type of incident and classified by priority**
  - Where an incident is not required to be reported or is incorrectly categorised or classified, the Commission will give this feedback to the provider.
- **determine whether the notification is complete and includes all of the required and relevant information**
  - Where a notification is incomplete or insufficiently detailed to inform the Commission's assessment, the Commission will contact the provider to request further information (and, in some cases, seek copies of supporting documents).
  - If an approved provider does not provide sufficiently detailed information, the Commission may give the provider a notice of decision[72] requiring the provider to submit the identified information within a set timeframe.
  - The Commission will also contact the provider where it has not completed the notice of collection statement on the My Aged Care Service and Support Portal.
- **determine the level of risk**
  - The Commission will review the notification (and other relevant intelligence held by the Commission) and complete a risk assessment to assess: the risk to consumers; the adequacy of the actions being taken by the provider to manage and mitigate any such risk; other factors that may influence the Commission's confidence in the provider's ability to manage the risk and reduce the likelihood of reoccurrence.
  - Assessment of the notification will also take into consideration any information within the notice that may assist the Commission's other regulatory functions, including the provider's compliance with incident management and other responsibilities.
  - The risk assessment is reviewed each time new information is received by the Commission or following any Commission regulatory actions.

72 See section 95C of the Commission Rules in relation to approved provider and section 95L in relation to service providers.

Important information

The Commission is less likely to identify concerns when reviewing a provider's notification where a notification indicates that the provider:

- understands the issues and actions required to resolve them
- is focused on the safety, health and wellbeing of consumers
- has appropriate strategies (planned or in place) to prevent and manage risks to consumers
- has culture and systems to support incident and risk management
- has the capacity and capability to manage and monitor incidents and risks.

Where the notification is sufficiently detailed, there is a lower risk of harm to consumers, and the risk is being managed by the provider, the Commission's review of the notification may be complete at this point, noting that information informs the Commission's intelligence about incidents.

Where the Commission identifies risks or potential non-compliance with SIRS responsibilities in relation to an incident, the Commission may respond by undertaking further action, including:

- **contacting the provider**, including to:
  - seek further information, reports or documents
  - discuss actions that could be taken to support affected consumers, determine the underlying cause of an incident, reduce the risk of an incident reoccurring, notify or involve others in the resolution of an incident, etc.
  - discuss reporting the incident to police where the Commission considers the provider had reasonable grounds to notify the police of the incident and no notification occurred
  - provide information or guidance materials to help educate the provider about their incident management responsibilities.

- **requiring the provider to complete specified remedial action(s)**
  - The Commission may require a provider to undertake specified remedial action in relation to a reportable incident within a specified period, including to ensure the safety, health and wellbeing of consumers affected by the incident.
  - Actions may include for example, requiring the provider to engage an external provider to provide specified staff training, update certain policies and procedures, complete risk assessments to identify consumers who may be at risk of harm.
- **requiring the provider to conduct an internal investigation or an external investigation**
  - The Commission may require a provider to carry out an internal investigation into the incident. The Commission may also require an approved provider to engage an appropriately qualified and independent expert, at the expense of the provider, to carry out an investigation into the incident.
  - This may include where there is evidence that the incident may have been caused by a systemic issue, the cause of the incident is still unknown and/or risk mitigation actions have been put in place but there remain concerns that the incident could reoccur.
  - Investigations must occur in the manner and within the period specified by the Commission. The provider must report on the outcomes of the investigation to the Commission and may subsequently be required to take specified action(s) in relation to this.
- **undertaking investigations in relation to a particular reportable incident or series of reportable incidents**
  - For approved providers the Commission may undertake an investigation into a reportable incident, whether or not a notification was made, including to understand potential non compliance with provider responsibilities (including those related to SIRS, incident management and Quality Standards), and assist in determining whether regulatory action is required.
  - See more information regarding Commission investigations below.
- **requiring the provider to submit a final report at a specified time**
  - The Commission may request that a provider give a final report relating to a reportable incident. For example, where the provider has mitigated immediate risks but is undertaking longer-term analysis and/or improvements.
  - The report must include the information specified and be submitted within 84 calendar days (12 calendar weeks) from the initial notification (or another specified timeframe). The Commission will review the final report and consider any outstanding risks to determine whether further regulatory actions are required.
- **take any other action to deal with the reportable incident**
  - The Commission may take any other action to deal with the reportable incident that is reasonable in the circumstances.

- **referring the incident to another body with responsibility in relation to the incident**
  - The Commission may refer the incident to police or another body with responsibility in relation to the incident, such as a relevant State or Territory agency (e.g. the Coroner or state/territory complaints bodies).
  - Depending on the circumstances of the incident the Commission may also consider whether referral to another national body is appropriate (e.g. the NDIS Commission or Ahpra).

Where the Commission has concerns about an incident or a provider's compliance with its incident management responsibilities (or other responsibilities such as restrictive practices or Code of Conduct where relevant), the Commission will continue to monitor the provider's response to the incident and assess whether further action is required until it has been appropriately remedied. Where the Commission identifies evidence of non-compliance or information that may suggest non-compliance, the Commission may take compliance and enforcement action (see compliance and enforcement).

Providers will be notified where the Commission's review of the notification is complete or where the Commission is satisfied that the provider has taken appropriate action in relation to the incident.

Information obtained about the incident is valuable regulatory intelligence and may also be used by the Commission in relation to its other functions. This may result in:

- an assessment contact to monitor quality of care and services
- a performance assessment against the Quality Standards
- a new complaint or own initiative resolution process where the reportable incident may be more appropriately dealt with through these Commission processes
- a Code of Conduct investigation.

Commission investigation of a reportable incident

The Commission may investigate a reportable incident, including an approved provider's compliance with its responsibilities in relation to incident management, the Quality Standards, Code of Conduct or other related responsibilities such as those under the Quality of Care Principles (for example, regarding the use of restrictive practices).

Investigation is the planned and systemic gathering and analysis of all relevant facts. The purpose of an investigation is to:

- further inform/better determine the ongoing risk to consumers
- identify issues relating to the reportable incident or the effectiveness of the provider's IMS, which includes evidence of any non-compliance with provider responsibilities (and the nature of non-compliance)
- support and inform a regulatory response to the outcome of the SIRS investigation that is proportionate to the identified risk and non-compliance (if identified).

The Commission may also conduct an investigation to determine whether an approved provider is complying with its incident management responsibilities, for example, where there are a number of reportable incidents with similar circumstance.

Where an investigation into an incident (or number of incidents) is commenced, this may include a visit to the site by authorised officers of the Commission. Authorised officers may exercise certain powers [73] to investigate and collect evidence relating to a provider's compliance with its responsibilities under the Aged Care Act or the Aged Care Principles. Providers will be notified of the outcomes of any investigations undertaken by the Commission.

The Commission's authorised officer powers can be utilised regardless of whether there has been non-compliance, and may support, precede or follow other monitoring, compliance and enforcement actions.

Compliance and enforcement

In considering the appropriate regulatory response to a reportable incident notification, the Commission may take different actions where:

- a provider demonstrates they are willing and able to comply and will take all reasonable steps to do so
- a provider appears indifferent to providing quality of care and safety, or deliberately avoids compliance responsibilities.

Compliance and enforcement actions will also depend on whether the provider is an approved provider under the Aged Care Act or a service provider under a funding agreement with the Commonwealth (i.e. CHSP and NATSIFACP providers).

In situations where a reportable incident raises a compliance issue or raises concerns for the Commission that a provider is not complying with its responsibilities, the Commission can draw on a range of regulatory powers.

For example, the Commission may issue an Incident Management Compliance Notice where an approved provider fails to comply with, or the Commission is aware of information that suggests that an approved provider may not be complying with, incident management responsibilities. An Incident Management Compliance Notice will specify the action(s) the provider must take, or refrain from taking, within a reasonable period to address the identified or potential non compliance.

In relation to approved providers, the Commission may also:

- issue a Restrictive Practices Compliance Notice where a provider is not, or the Commission is aware of information that suggests that an approved provider may not be, complying with its responsibilities in relation to the use of restrictive practices as detailed in the Quality of Care Principles. This notice is to specify actions the provider must take, or refrain from taking, within a reasonable period to address the identified or possible non-compliance. [74]

73 For more information about the Commission's authorised officer powers, refer to Parts 8 and 8A of the Commission Act 2018 and Parts 2 and 3 of the Regulatory Powers Act.

74 The powers are only applicable to approved providers.

- impose sanctions (or prior to imposing sanctions, issue a Non-Compliance Notice and potentially a Notice to Remedy and, where satisfactory, accept an Undertaking to Remedy from a provider)
- require the provider 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
- issue an infringement notice in certain circumstances; for example, for causing detriment to a person who has made a disclosure regarding a reportable incident
- seek an injunction from a court to restrict a provider from engaging in conduct and/or, if necessary, require them to do a specific thing
- ask a court to impose a civil penalty for a contravention of the Commission Act or Aged Care Act
  - Under the SIRS, a civil penalty applies if the provider fails to comply with an Incident Management Compliance Notice.

The Commission may take one or more of these actions in order to address the non-compliance.

For more information on the Commission's approach to compliance and enforcement, including the use of its regulatory powers, refer to the Commission's Compliance and Enforcement Policy[75].

Intelligence and trend analysis

Information notified through the SIRS and other sources 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 and the prioritisation and scope of monitoring activities. It also supports the development of sector education, campaigns and targeted regulatory approaches on particular issues.

The Commission uses a number of processes, including consideration by officers and computer-based algorithms to assist with the identification of potential non-compliance with reporting responsibilities, as well as intelligence and trends arising from notifications.

Notifications (or the absence of notifications) also enables 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 commonly notifies; areas in which providers are not making notifications; the influence of notifications on a positive safety culture; the nature of improvements in care and services and in incident management.

The Commission publicly reports information about the operation of the SIRS including via 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. Importantly, it also informs consumers and their families or representatives.

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

Glossary

The Commission has a full Glossary of terms on its website [76].

Aged Care Act 1997 (Aged Care Act)

The Aged Care Act is the overarching legislation which outlines the responsibilities and responsibilities that approved providers of aged care must comply with to receive subsidies from the Australian Government.

Aged care consumer/consumer

A person who is a recipient of Commonwealth funded aged care services or a care recipient under the Aged Care Act who has their care and services delivered in the home or community. This includes care and services delivered through home care packages, the Commonwealth Home Support Programme (CHSP) and flexible care delivered in a home or community setting (including Multi-Purpose Services, Short Term Restorative Care and the Transition Care Program) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

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; 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 of the Commission. It also outlines the Commissioner's powers, including those relevant to monitoring SIRS compliance and taking enforceable regulatory action in response to non-compliance.

Aged Care Quality and Safety Commission Rules 2018 (Commission Rules)

The Commission Rules set out the process for how the Commission performs its functions as defined in the Commission Act.

76 https://www.agedcarequality.gov.au/about-us/corporate-documents/aged-care-quality-and-safety-commission-glossary

Aged Care Quality and Safety Commissioner (Commissioner)

The Commissioner of the Aged Care Quality and Safety Commission as established by the Commission Act.

Aged Care Quality Standards (Quality Standards)

The Quality Standards with which aged care providers are legally required to comply.

Refer to the Commission's website for Quality Standards guidance and resources.

Approved provider

As defined in the Commission Act a person or body is an approved provider if:

- the person or body:
  - has been approved as a provider of aged care under section 63D of the Commission Act; or
  - is taken, under paragraph 63F(2)(a), to be an approved provider; and
- the approval of the person or body is in effect.

Approved providers may also be referred to as providers (see below) or aged care providers.

This term does **not** include providers that deliver Commonwealth Home Support Programme (CHSP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) services (see service provider below).

The Australian Health Practitioner Regulation Agency (Ahpra)

Ahpra works with the 15 National Boards to regulate Australia's registered health practitioners. Their primary role is to protect the public and set standards and policies that all registered health practitioners must meet.

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.

Cognitive impairment

A description of someone's condition which may include loss of some memory or thinking abilities. A person with cognitive impairment can find it difficult to learn new things, to concentrate, or make decisions.

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
- a person the consumer nominates to be told about matters affecting the consumer.

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.

Flexible care

The type of care provided in a residential or community setting through an aged care service that addresses the needs of people receiving care in alternative ways to the care provided through residential care services, as defined in section 49-3 of the Aged Care Act. This includes services provided through Multi-Purpose Services (MPS), Short Term Restorative Care (STRC) and the Transition Care Program (TCP).

Home care

Care consisting of a package of care and services provided in a non-residential care setting, as defined in section 45-3 of the Aged Care Act.

Home services

Commonwealth-funded aged care services delivered in the home or community. For the purposes of this guidance, home services includes care and services delivered through:

- home care packages
- home support under the Commonwealth Home Support Programme
- flexible care delivered in a home or community setting including flexible care under the Act (e.g. services provided through Multi-Purpose Services, Short Term Restorative Care and the Transition Care Program), and
- services provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Incident

An incident is any act, omission, event or circumstance that has occurred, is alleged to have occurred, or is suspected to have occurred in connection with the provision of care and services to a consumer and has (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, identify, respond to and manage incidents that occur during the course of delivering care and services to consumers. An IMS should be used in relation to all incidents, 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 about incidents that have caused harm or had the potential to cause harm to the consumer. Key components include an expression of regret, a factual explanation of what happened, the potential consequences and a description of the steps being taken to manage the harm associated with the incident and to prevent it from 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.

Priority 1 reportable incident

A reportable incident (for home service providers):

- that has caused, 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
- where there are reasonable grounds to report the incident to police;
- involving unlawful sexual contact or inappropriate sexual conduct inflicted on a consumer
- a consumer's expected death
- where a consumer goes missing in the course of provision of home service.

See section 15NE(2) of the Quality of Care Principles.

Priority 2 reportable incident

A reportable incident that does not meet the criteria for a Priority 1 incident.

Provider (also referred to as 'you' in this document)

A provider approved under the Aged Care Act (or funded through funding agreements) to provide Commonwealth-funded aged care services delivered in the home or community.

In many cases provider responsibilities will apply to management staff, although where approved providers have IMS and reportable incident responsibilities in relation to other staff this has been identified within this document.

Provider responsibilities

Responsibilities that providers have in relation to the aged care they provide through their services to aged care consumers. These responsibilities (set out under the Aged Care Act or specified in funding agreements) may relate to:

- the quality of care they provide
- user rights of the people to whom they provide services
- accountability for the services that are 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 administrative or regulatory action and enforcement action undertaken by the Commission in response to non-compliance with provider responsibilities, including SIRS requirements.

Reportable incident

An incident described in section 54-3 of the Aged Care Act (and section 15NA of the Quality of Care Principles).

For approved providers, a reportable incident has the meaning in the Aged Care Act. For service providers of Commonwealth-funded aged care services, the funding agreement that relates to the service will include the meaning of reportable incident (consistent with the meaning in the Aged Care Act).

Risk

The chance of something happening that will have a negative effect. It is measured by both 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 as well as the likelihood that they may occur.

In terms of the Commission's regulatory functions, risk also includes consideration of the current or future risk of a provider's non-compliance with their responsibilities, including the provision of quality care and services, and associated risks of harm to an aged care consumer or group of consumers.

Service

The business run by an approved provider through which Commonwealth funded aged care services and supports are provided. An approved provider may have multiple services.

An approved provider can also exist without a service however a service must be linked to an approved provider.

Serious Incident Response Scheme (SIRS)

The scheme established to prevent, and reduce the risk of, incidents of abuse and neglect in Australian Government-subsidised aged care. It requires providers to have an effective IMS in place, to manage and prevent incidents and to notify the Commission of all reportable incidents that occur or are alleged or suspected to have occurred.

Service provider

In this document, service providers refers to providers that deliver aged care under Commonwealth grant agreements (rather than as *approved providers* under the Aged Care Act).

Service providers include providers of Commonwealth Home Support Programme (CHSP) services and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) services.

Service providers may also be referred to as providers (see above) or aged care providers.

Staff member

An individual who is employed, hired, retained or contracted by a provider (whether directly or through an employment or recruiting agency) to provide care or other services.

Subject of an allegation

A staff member, consumer or any other person who has been accused of being involved in a reportable incident that has occurred or was alleged or suspected to have occurred.

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 the security of tenure for consumers, access for persons acting for consumers, and the information the provider must give consumers in particular situations.

The principles also describe 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 provider responsibilities will apply to management staff, although where approved providers have IMS and reportable incident responsibilities in relation to other staff this will be identified.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

November 2022

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city

ACR-SHS-003