

Reportable incidents and Serious Incident Response Scheme (SIRS): Provider guidelines

AGED CARE QUALITY AND SAFETY COMMISSION

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1. Introduction

1.1 Context

All registered providers of funded aged care have a responsibility to provide safe and quality care services to support older people to live the best lives they can.

As part of this responsibility and under the *Aged Care Act 2024* (the Act), providers in all the registration categories have obligations relating to reportable incidents:

- Home and community services (category 1)
- Assistive technology and home modifications (category 2)
- Advisory and support services (category 3)
- Personal and care support in the home or community (category 4)
- Nursing and transition care (category 5)
- Residential care (category 6).

Throughout this guidance, where relevant, distinctions are made between category 6 providers of “residential care homes” and category 1-5 providers of “services delivered in home or community settings”.

This obligation, at s165A of the Aged Care Act, is that providers – also referred to as ‘you’ throughout this guidance – must give reports relating to reportable incidents to the Commissioner:

- (a) in the approved form, and
- (b) in accordance with requirements prescribed by the Aged Care Rules 2025 (Aged Care Rules).

Those requirements for reportable incidents are further detailed at Chapter 5, Part 2, Division 2 of the Aged Care Rules. There are also reportable incident requirements for:

- aged care workers, at s164-20(g) of the Aged Care Rules;
- a quality care advisory body of a provider, at s158-15(g) of the Aged Care Rules; and
- operators of aged care digital platforms, at s189 of the Aged Care Act as well as at s189-10, 189-15, and 189-20 of the Aged Care Rules.

The Aged Care Quality and Safety Commission (the Commission, also referred to as ‘we’, ‘us’ or ‘our’ throughout this guidance) is the national rights-based regulator of funded aged care services. The Commission, our Commissioner and Complaints Commissioner all have functions under the Aged Care Act that give the Commissioners the authority to regulate the provision of aged care services and deliver government’s strategic priorities for the aged care system.

For more information see [1.3 The role of the Commission](#) below.

1.2 Purpose of this guide

The purpose of this guide is to help you as a provider to understand your responsibilities and obligations related to reportable incidents and the Serious Incident Response Scheme (SIRS).

The SIRS was introduced during 2021 and expanded in 2022 with the aim of reducing the risk of abuse and neglect of older Australians receiving funded aged care services. It established responsibilities for all funded providers of aged care to:

- prevent and manage incidents, focusing on the safety, health and wellbeing of older people
- use incident data to drive quality improvement
- notify reportable incidents to the Commission.

Under the Aged Care Act and the Aged Care Rules, providers of aged care services continue to have reportable incident responsibilities, which complement other obligations and requirements including the [Statement of Rights](#), the [Aged Care Code of Conduct](#), the [Aged Care Quality Standards](#) (the Standards) and [open disclosure requirements](#). Together, these support providers to engage in risk management and continuous improvement activities to deliver safe, quality aged care services to older people.

Providers must report certain types of incidents (known as reportable incidents) to the Commission via the SIRS – these include witnessed, as well as alleged, and suspected events. Providers must also report incidents involving criminal or potentially criminal behaviour to the police, as it is the police's role to investigate crimes and prosecute offenders. Reporting an incident to the Commission does not replace this obligation.

For more information about the regulatory framework and broader provider obligations, please refer to the [For providers](#) page of our website.

1.3 The role of the Commission

The Commission is the national regulator of funded aged care services. The Commission's primary purpose is to uphold rights, protect and enhance the safety, health, wellbeing and quality of life of older people in Australia receiving funded aged care services.

The Commission also gives older people in Australia and their families a single point of contact when they want to raise a concern (through a complaint or feedback) about the performance of an aged care provider or worker in fulfilling their obligations under the Aged Care Act and the Aged Care Rules.

A range of functions and powers available under the Aged Care Act and the Aged Care Rules enable the Commission to protect and enhance the safety, health wellbeing and quality of life of older people accessing funded aged care services, including by managing sector-wide risks and issues.

As part of the Commissioner's safeguarding functions under s349 of the Act, there are four Commission functions that relate specifically to providers' incident management and reportable incidents. These include:

- support registered providers to develop and implement effective incident management systems
- build the capability of registered providers to prevent and manage reportable incidents
- oversee the notification and management of reportable incidents and respond where appropriate, and
- collect, correlate, analyse and disseminate information relating to reportable incidents to identify trends or systemic issues.

The Commission reviews all reportable incidents to assess the risk of harm to older people. If a provider has not appropriately addressed an incident or controlled ongoing risks that we identify the Commission will take action. Our response will depend on the provider's willingness and ability to comply with their responsibilities.

For more information about the Commission and its role, please refer to the [About us](#) page of our website.

If a provider has an enquiry about the SIRS, you 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 other enquiries, providers, workers, older people and supporters 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.

2. Key terms and concepts

2.1 What is an incident?

Before we consider reportable incidents via the SIRS, it is important to understand some terms and concepts about incidents generally.

Incidents (as indicated at s164-10(1) of the Aged Care Rules) consist of acts, omissions, events or circumstances:

- that occur, or are alleged to have occurred, or are suspected of having occurred in connection with the delivery of funded aged care services to an older person by a registered provider; and
- either:
 - have caused harm to the older person or another person; or
 - could reasonably have been expected to have caused harm to an older person or another person.

Providers in registration categories 1, 3, 4, 5, and 6 have incident management obligations for any incident meeting these requirements for the purposes of the Aged Care Act and the Aged Care Rules. Any acts, omissions, events or circumstances that have caused harm to the older person and that a registered provider subsequently becomes aware of in connection with the delivery of funded aged care services to an older person in a residential care home of the provider also trigger incident management obligations.

For more information about the incident management obligations for all incidents, please refer to the [SIRS Provider resources page](#) on the Commission's website, including the 'Effective incident management systems: Best practice guidance'.

If you are already familiar with these concepts from this definition of an incident (e.g. from the 'Effective incident management systems: Best practice guidance'), please proceed to [2.2 What is a reportable incident?](#)

2.1.1 'In connection with the delivery of...' in residential care home settings

For providers of **residential care homes** (and providers of flexible care delivered in residential care homes), the phrase 'in connection with the delivery of' aged care services in the context of an 'incident' is intended to be broad.

Arising out of the 24 hour/7 day responsibility for care services in those settings, it covers incidents occurring while the care services are being provided to an older person in the residential care setting, and incidents when the older person is outside the care home under supervision of one or more workers (e.g. when on a social outing or to attend a specialist appointment).

However, the phrase does not apply to incidents that occur when an older person is on leave from the residential care home, for example because they are in hospital or are visiting family without worker supervision. This is different from an older person leaving the residential care home without the provider's knowledge. An unexplained absence from the residential care home, where there are reasonable grounds to report the absence to police, is a reportable incident. See 3.8 Unexplained absence.

If you as a provider or your residential care home workers become aware of incidents occurring while the older person is away from the residential care home (not in connection with your delivery of care services), these do not trigger reportable incident obligations under the Aged Care Act or Rules. However you are still expected to act in the best interests of the older person to protect their wellbeing. Some actions you may take upon becoming aware of such incidents could be amending the older person's risk assessments, reporting matters to police or others as required, and if harm had been caused managing and resolving the incident via your incident management system.

2.1.2 'In connection with the delivery of...' in home or community settings

For providers of services in **home or community settings**, the phrase 'in connection with the delivery of' care services in the context of an 'incident' is more limited, referring to the relationship or association between an incident and the provider.

It covers incidents that occur during times while care services are being provided, or that arise out of a failure to provide those services. It also includes incidents that may not have occurred while the care services were being provided, but occurred later because harm (or potential harm) arose from the delivery (or non-delivery) of services.

For example, a grab rail is installed in an older person's shower area, but it later collapses due to poor quality installation or materials, causing the older person injury. The incident has occurred at a time care services were not being delivered but arose from the poor quality of the care service provided, and you should consider whether the incident triggers reportable incident obligations under the Act.

If you as provider or your workers in home or community settings become aware of incidents not in connection with the delivery of care services, these do not trigger incident management obligations under the Aged Care Act or the Aged Care Rules. For example, a worker may notice small injuries the older person appears to have sustained outside the hours they receive care services. You should first consider whether the injury may be connected to the delivery (or non-delivery) of your services, such as an older person falling as a result of defective equipment you installed or following a missed visit. If it is not connected, it does not trigger incident management obligations, but in such circumstances, they are still expected to act in the best interests of the older person to protect their wellbeing.

Workers may also have separate reporting obligations under their professional registration or state or territory laws. Where it is safe and appropriate, consider referring the older person to family and domestic violence support services, such as 1800RESPECT (1800 737 732).

If a worker in any setting does witness, suspect, become aware of or is told about instances of elder abuse, they should act in the best interests of the older person to protect their wellbeing. For example, they can connect them to a range of services such as:

- the Older Persons Advocacy Network (OPAN – <https://opan.org.au>),
- the free national elder abuse phone line 1800 ELDERHelp (1800 353 374)
- reporting matters to police or others as appropriate.

2.1.3 Harm

The concept of 'harm' in the definition of incidents is broad, and involves injury, illness or danger to an older person's health. It is not limited to serious harm or injury or only to physical harm – it also includes emotional and psychological harm. For example, where:

- an older person is taken on an outing by a family member or supporter, and upon return to the residential care home they seek medical attention due to a minor physical injury sustained (which may have been due to ongoing physical abuse by the family member or supporter)
- an older person seems emotionally distressed, and the worker becomes aware the older person's internet banking password was being used by a family member or supporter to steal their money.

In all cases harm was caused to the older person, and so when you as a provider or your workers become aware the incidents should be managed and resolved via your incident management system, and you should consider whether the incident triggers reportable incident obligations under the Act.

Please note, it is expected providers take a person-centred, culturally informed and trauma informed approach to assessing the physical or psychological injury and discomfort from an incident note, understanding that a person who can't communicate the impact of an incident may still have been affected.

2.1.4 'Could reasonably have been expected to cause' harm

The phrase 'could reasonably have been expected to have caused harm' in the context of an 'incident' (generally) applies when acts, omissions, events or circumstances do not result in harm (such as injury, illness or danger to health) to an older person or another person in that specific instance – but had potential to, and would ordinarily do so.

For example, when:

- an older person is walking in a common area of a residential care home and slips on a wet floor but luckily grabs hold of a nearby cupboard and doesn't suffer any injury
- there is poor lighting that results in a worker tripping and almost falling over an undetected extension cord, or
- equipment temporarily left at a blind spot in a corridor that could potentially have resulted in a collision involving older people, workers, or visitors.

Ordinarily, an injury or harm could (reasonably) have been expected to have been caused in all these circumstances – for instance, if the older person who slipped was not able to grab hold of anything and instead fell straight to the floor. These near misses meet the definition of an incident, trigger your incident management obligations and therefore should be managed and resolved through your incident management system (and you should consider whether the incident triggers reportable incident obligations under the Act).

The phrase also includes where an incident involves conduct that is not acceptable and would ordinarily cause harm, even though it may not have caused harm in that specific instance. For example:

- an older person is yelling at and threatening another older person, who does not show their distress because their level of cognitive functioning does not allow them to recognise what was happening. This conduct could reasonably have been expected to have caused harm even if it did not appear to do so for this older person.
- a worker takes photos of an older person while they are showering and shares those photos with other workers. This conduct could reasonably have been expected to have caused harm, even if that older person was unaware of the conduct or unable to communicate the impact it had on them.
- a worker assists an older person with limited mobility to the toilet but leaves them unattended for an extended period, where an older person might feel discomfort, anxiety, or vulnerability. This conduct could reasonably have been expected to have caused harm, even if when the worker returns the older person shows no visible signs of harm or distress.

These examples also meet the definition of an incident and should be managed in the same way. The provider is responsible for assessing whether an incident meets this threshold, given the older person's individual vulnerabilities and the nature of the incident. When making such assessments

about incidents, you should consider the older person's unique physical and psychological conditions, limitations, vulnerabilities, and past experiences, even if no actual harm (physical, emotional, or psychological) appears to have occurred. Record the outcome of this assessment, and your reasons, in your incident management system.

Providers should also consider whether a reasonable person (with knowledge of the older person's needs) would expect this incident to cause harm. To guide your decision-making as a provider about harm, reflect on how you would feel if the incident happened to you or someone you care about.

Please note, following commencement of the Aged Care Act and the Aged Care Rules from November 2025 the 'could reasonably have been expected to have caused harm' phrase no longer appears in the [definition of a Priority 1 reportable incident](#). This means that providers don't have to predict 'potential' or 'worst-case' impacts of incidents when deciding if within 24 hours of becoming aware is the appropriate timeframe for notifying the Commission of the reportable incident. However, your notice to the Commission must still describe the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected (s165A-25(4)(b)(ii) and s165A-30(2)(b)(ii) of the Aged Care Rules).

2.1.5 Near misses

While not a legislative term, often these incidents that could reasonably have been expected to have caused harm are informally referred to as 'near misses'.

Near misses in connection with the delivery of care services trigger your incident management obligations, and should be captured by – and managed and resolved through – your incident management system (and you should consider whether the incident triggers reportable incident obligations under the Act). You may see some references to “incidents (and near misses)” throughout this guidance and other resources produced by the Commission, but remember that near misses are considered incidents wherever the term “incidents” alone is used.

You should consider the effect the near miss could reasonably have been expected to have had on an older person, and as a result what steps you could put in place to reduce the risk of future harm. You should support your workers to recognise and report near misses, and to be part of the learning and quality improvements that come out of incidents including near misses.

Being proactive about reporting near misses is an opportunity for your organisation to build a safety culture and assess and learn from events so that you can understand risks and prevent incidents from occurring.

Case study: Near miss

While visiting his father in a residential care home, an older person's son noticed the packaging colour of the insulin medication that his father was about to be given by the Registered Nurse was not the usual colour of the medication. On mentioning this difference in colour, the Registered Nurse realised that the medication was not the correct insulin medication prescribed for the older person.

Even though no harm was caused on this occasion, the Registered Nurse recognised that this event was a near miss that could reasonably have been expected to have caused harm, if the older person's father not been present and observant (or hadn't spoken up). They recorded this incident (near miss) in the provider's incident management system to enable assessment, investigation and/or further analysis. Systemic changes to improve practice and to prevent a similar event from happening in future were implemented and discussed with the older person and his family or supporters.

2.2 What is a reportable incident?

The Aged Care Act at s16 defines a reportable incident as 'incidents that have occurred, are alleged to have occurred, or are suspected of having occurred in connection with the delivery of funded aged care services to an older person by a registered provider'.

There are 8 types of incidents listed at s16(1) of the Aged Care Act which providers must report to the Commission. Definitions and explanations of these can be found below at [3. Types of reportable incidents](#).

In abbreviated form we refer to those reportable incident types as:

- [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](#)
- [Unexplained absence](#)

Please note, following commencement of the Aged Care Act and the Aged Care Rules from November 2025 the definition of the [Neglect](#) reportable incident type has changed.

The former 'missing consumer' reportable incident type for home services providers has also been included in a combined '[unexplained absence](#)' incident reportable type' covering both residential care homes and services delivered in home or community settings.

2.2.1 What is not a reportable incident?

The Aged Care Rules at s16-10 set out that the following acts, omissions or events are not reportable incidents:

1. In residential care homes, where the incident resulted from an older person deciding to refuse the delivery of care services

An incident is generally **not reportable** where the incident relates to a person's own decision about what services they want to receive, or how they want those services delivered, provided that:

- The incident would otherwise only be considered neglect.
- The provider informed the older person (or their representative) of the risks, so that they could make an informed choice.
- The person (or the representative) had the capacity to make the decision and communicated their choice before the incident occurred.
- The provider documented that communication and the older person's choice in writing.

Example: An older person chooses not to receive assistance with certain daily living activities, or not to eat food inconsistent with their dietary needs, after being informed of the risks, and this decision has been documented.

This itself is not reportable incident. However, if an incident does subsequently occur perhaps indirectly resulting from an older person's refusal of care, depending on the other circumstances it may still need to be reported to the Commission.

2. In home or community settings, where the incident resulted from a choice made by the older person about the care services to be delivered, or how they are to be delivered by the provider

For example, an older person refuses personal care, and a worker believes there is high risk that a poor outcome or incident may result.

Providers must take all reasonable steps to support the older person's decision-making process, including:

- Informing the older person, and where appropriate their family or supporters, about the potential risks or consequences of refusing care or services.
- Documenting the refusal in relevant care planning documents, including:
 - The circumstances of the refusal.
 - The reasons for the older person's decision, where understood.
 - The measures implemented to mitigate risks and support the older person's wellbeing.

An incident is generally **not reportable** under those circumstances – but only if before the incident occurred the older person communicated the choice to the provider and the provider recorded their choice in writing.

However, if an incident does subsequently occur perhaps indirectly resulting from an older person's refusal of care, depending on the other circumstances it may still need to be reported to the Commission.

Such documentation helps the Commission assess how the refusal contributed to the incident, the provider's efforts to assist the older person in understanding the risks, and any actions taken to minimise these risks.

2.2.2 Exemption from requirements to report an incident

The Aged Care Rules at s165A-35 also allow for the Commissioner to decide that a provider is not required to give a notice about a particular reportable incident.

This may only apply in situations where an older person has repeatedly alleged that an incident happened, and the Commission can be satisfied that the allegation is due to the person's delusion.

A provider may request the Commission to consider an exemption for a repeated alleged incident that meets the above criteria, providing supporting evidence for consideration. The Commissioner will seek and consider specialist clinical advice before deciding to grant any exemption from reporting an incident of that kind.

For more information, see [Process for seeking exemption for a reportable incident to no longer be notified](#).

2.3 Reporting timeframes and prioritising incidents

A provider must decide what timeframe they are required to report an incident (including suspicion or allegation) to the Commission, and apply the relevant priority categorisation.

2.3.1 Priority 1 reportable incidents

The Aged Care Rules at s165A-25 require a provider to notify the Commission about a **Priority 1 reportable incident within 24 hours** of becoming aware of it.

A Priority 1 reportable incident is any incident, included an alleged or suspected incident:

- that **has caused** an older person [physical or psychological injury or discomfort](#) that [requires medical or psychological treatment to resolve](#); or
- where there are [reasonable grounds to report the incident to police](#); or
- involving [unlawful sexual contact or inappropriate sexual conduct](#) inflicted on an older person; or
- involving [unexpected death](#) of the older person resulting from care services delivered (or a failure to be delivered) by the provider; or
- involving [unexplained absence](#) of the older person during the delivery of aged care services where there are reasonable grounds to call police.

Please note, from 1 November 2025 the 'could reasonably have been expected to have caused harm' phrase was removed from the definition of a Priority 1 reportable incident, and the Aged Care Rules now explain what is meant by 'medical or psychological treatment'.

This change only affects which incidents must be notified within 24 hours. It does not change what a notice must contain. Both priority 1 and priority 2 notices must still describe the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected (s165A-25(4)(b)(ii) and s165A-30(2)(b)(ii) of the Aged Care Rules). In addition to the initial reporting timeframe, the Aged Care Rules at s165-25(6) require that **within 5 days of**

becoming aware of the Priority 1 reportable incident (or within such other period as the Commission determines) a provider must give the Commission any required information that was:

- not available within the first 24 hours
- missing from the initial notification
- specified by the Commissioner as required to deal with the reportable incident.

2.3.2 Priority 2 reportable incidents

The Aged Care Rules at s165A-30 require providers to notify the Commission of a **Priority 2 reportable incident within 30 days** of becoming aware of it.

A Priority 2 reportable incident is one where a notification has not been required under any of the conditions requiring a priority 1 reporting timeframe. This includes any incident, allegation or suspicion that could reasonably have been expected to have caused harm to an older person receiving aged care services.

Please note, while the 'could reasonably have been expected to have caused harm' phrase is no longer a condition in the definition of a Priority 1 reportable incident, following commencement of the Aged Care Act and the Aged Care Rules on 1 November 2025 it still applies when considering your Priority 2 reportable incident requirements.

2.4 Physical or psychological injury or discomfort

Harm can take many forms, including physical injuries such as cuts, burns, fractures, or bruises that require medical treatment. Psychological impacts, such as anxiety, panic, distress, or trauma needing counselling or psychological support, are also considered harm. Serious incidents like head injuries, loss of consciousness, or hospital admissions must be reported, as well as any unexpected death of an older person. Keep in mind that some types of harm, such as emotional withdrawal or behavioural changes, may not be immediately visible but are equally significant.

When assessing incidents, use your judgement and knowledge of the older person's history and preferences and consider the older person's circumstances and vulnerabilities. When judging if an incident has caused physical or psychological injury, a provider must recognise and consider:

- that each older person's experience of an incident will be unique
- if the older person has an impairment that may affect their ability to recognise or communicate physical or psychological injury or discomfort.

When deciding on the priority and reporting timeframe for an incident, a provider must not let that impairment affect their judgement about whether (or the degree of) injury or discomfort was caused to an older person by a reportable incident.

When assessing if an incident has caused physical or psychological injury, providers need to understand that a person who can't communicate how a serious incident has affected them may still have been affected. You need to assess the impact on the person even if they can't communicate it.

For example, where a worker strikes an older person with an object but the older person did not display psychological or emotional distress – because their level of cognitive function did not enable

them to later remember the incident or to communicate the incident's impact – it doesn't mean there's been no psychological impact.

Your assessment should consider if the person's behaviour has changed. For example, have they become withdrawn, or fearful of certain types of care or people? You may have to do this assessment over a period of time, as not all impacts will be obvious straight away.

To help you assess the impact an incident has had on an older person, the Commission developed an [Impact Assessment Tool](#). This tool encourages you to think about the different impacts an incident could have on an older person by walking in their shoes. This approach ensures that all relevant incidents are properly identified, assessed, and reported to the Commission, protecting the safety and well-being of older people receiving your care services.

2.5 Requires medical or psychological treatment to resolve

Please note, the commencement of the Aged Care Act and the Aged Care Rules on 1 November 2025 explained what is meant by 'medical or psychological treatment' in the definition of a Priority 1 reportable incident.

The Aged Care Rules at s5-5 define medical or psychological treatment in relation to a Priority 1 reportable incident to mean "treatment that may only be provided by a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker".

For reportable incidents where a person needs general treatment that anyone can provide, you don't need to categorise them as Priority 1 and report within 24 hours of becoming aware, unless any of the other criteria apply.

When judging if a reportable incident required medical or psychological treatment to resolve, treatment therefore does not include:

- minor medical attention such as applying an ice pack or bandage
- emotional support after an incident, or treatment that could have been provided by a person who is not a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker.

There may be situations where a paramedic attends and provides treatment to an older person following an incident. While paramedics are not expressly included in the definition of "medical or psychological treatment" in the Aged Care Rules, providers should consider the seriousness of the incident and the nature of the treatment provided when determining the appropriate notification timeframe.

Where treatment provided by a paramedic indicates a level of injury or impact that is comparable to incidents that would ordinarily meet the Priority 1 threshold, providers are encouraged to notify the incident within the Priority 1 timeframe. This supports timely oversight of incidents involving potentially serious harm to older people.

If a provider is not clear if a reportable incident caused **physical or psychological injury or discomfort that requires medical or psychological treatment to resolve**, you should err on the side of caution and notify within a Priority 1 timeframe. This is to make sure you meet reportable incident obligations, and you should follow up with any missing information within five days of

becoming aware of the incident. The Commission will confirm following assessment if a provider is routinely notifying reportable incidents within incorrect timeframes.

It is important to note that if an older person needs medical or psychological treatment unrelated to an incident – such as for a pre-existing condition – those routine situations are not classified as Priority 1 reportable incidents unless another part of the definition applies.

2.6 Reasonable grounds to report the incident to police

The Aged Care Rules at s164-40(2) and (3) require that a provider must report an incident to a police officer within 24 hours if there are reasonable grounds to do so. Reporting to the police should occur regardless of whether the incident is witnessed, is alleged, or is suspected to have occurred.

Reasonable grounds to report an incident to police include where a provider is aware of facts or circumstances (alleged or known) that lead them to believe or suspect that:

- the incident is likely to be of a criminal nature, or
- unlawful activity has occurred.

For example, a provider might suspect an incident involves an assault or an indecent assault (or there is ongoing danger of such). This would be reasonable grounds for the provider to report the incident to the police.

If you are uncertain about whether or not an incident may be criminal in nature, it is your responsibility to report it to the police. The police are the appropriate authorities to investigate and determine whether an incident involves criminal conduct.

Reasonable grounds to report an incident to police also include a situation where there is a potential risk to the older person's health and safety.

For example, an older person goes missing who does not have sufficient cognition to care for themselves (or would miss a dose of essential medication while missing). This would be reasonable grounds for the provider to report the absence to the police.

If a provider becomes aware of reasonable grounds to report an incident to police after they had notified a reportable incident to the Commission, then the provider must:

- report the incident to police within 24 hours of becoming aware of the reasonable grounds
- also notify this as significant new information about the reportable incident to the Commission.

When deciding whether to report an incident to the police, consider how you would feel if the incident happened to you or a loved one, and think about whether a reasonable person would expect the police to be informed in such a situation.

It is acknowledged that in some cases older people or their supporters may not want an incident reported to the police. This may happen for example if the older person is experiencing coercive control by their partner, or their family or supporters have mistrust of government authorities because of past experiences (such as the families impacted by the Stolen Generations).

The older person's agreement is not required, and their wishes do not change your obligation to report an incident to police within 24 hours where there are reasonable grounds to do so. You should still explain to the older person, and their family or supporters, why you are making the report. Listen to their concerns and take reasonable steps to address them, for example by explaining how their safety and privacy will be protected. These conversations must not delay the report.

2.7 Other term

For an explanation of other significant terms found in this guidance, please refer to the Commission's [Glossary](#).

3. Types of reportable incidents

Section 16(1) of the Aged Care Act defines what constitutes a reportable incident and outlines the eight types of reportable incidents that providers must notify to the Commission via the SIRS. The Aged Care Rules further define and clarify the expressions set out in s 16 of the Act, at s 16-5.

Chapter 1, Part 7 of the Aged Care Rules defines and clarifies the reportable incident types as explained below.

3.1 Unreasonable use of force

The definition of “unreasonable use of force against the older person” as a reportable incident type is the same for both residential care homes and services delivered in home or community settings.

Unreasonable use of force:

- Includes actions like a violent physical attack or using unnecessary physical force.
- Does not include gentle touch used for purposes such as:
 - providing care
 - attracting the older person's attention
 - guiding the older person
 - comforting the older person when they are upset.

Unreasonable use of force covers actions like shoving, pushing, hitting, punching, kicking, or rough handling of an older person. It does not apply to kind, respectful care that includes gentle touch, as long as it is done with the older person's consent and in line with their preferences and is appropriate for the situation.

What is <u>not</u> reportable unreasonable use of force?	What is reportable unreasonable use of force?
• Gently touching an older person, for example, to attract their attention or guide them. • Comforting an older person by gently touching them when they are distressed (if this aligns with their preferences). • Physical contact that is legally justified, such as pushing an older person out of the way of an oncoming car or falling object to prevent harm. • Gently helping an older person into a transport vehicle or assisting them with their seatbelt. • Gently guiding or supporting an older person while walking around the shops.	• Any physical behaviour towards an older person that is illegal under state or territory law. • Unjustified or unwarranted physical force, including rough handling of the older person during aged care services. • Physical force such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects at older people, or threatening physical harm. • Deliberate physical attacks or assaults on an older person. • Non-consensual physical contact that might seem minor on its own but causes harm or discomfort when repeated over time.

Important consideration for workers

Some older people may feel uncomfortable with even gentle physical touch. Workers should focus on effective verbal communication to support aged care services. For example, instead of immediately touching an older person to help them stand, workers could first ask if they can rise from their chair independently.

If an older person does need help to stand, workers must:

- Seek consent first – always ask for the older person’s permission before assisting.
- Explain the action – clearly describe what you are about to do.
- Use the gentlest touch possible – minimise physical contact and proceed carefully.

3.2 Unlawful sexual contact or inappropriate sexual conduct

The definition of “unlawful sexual contact, or inappropriate sexual conduct, inflicted on the older person” as a reportable incident type is consistent across residential care homes and services delivered in home or community settings.

Unlawful sexual contact or inappropriate sexual conduct includes:

- if the contact or conduct is inflicted by a person who is a worker of the provider or a person who provides care or services for the provider and is providing such aged care services at the time of the incident (e.g. while volunteering):
 - any conduct or contact of a sexual nature inflicted on the older person, including but not limited to sexual assault, an act of indecency or the taking and/or sharing of an intimate image of the older person
 - any touching of the older person’s genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the older person

- 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 older person
- engaging in conduct relating to the older person with the intention of making it easier to procure the older person to engage in sexual contact or conduct.

The definition also ensures that any conduct or contact of a sexual nature inflicted on the older person by a worker is always a reportable incident (i.e. older person 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 2.6 (above) 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.

The SIRS notification requirements are designed to protect vulnerable older people, not to limit their sexual freedoms. Unlawful sexual contact or inappropriate sexual conduct refers to any non-consensual sexual activity involving older people. When a worker is involved, any sexual contact is considered a reportable incident, regardless of consent.

Older people have the right to make choices about their personal and social lives, including sexual freedom and the ability to give and receive affection. Furthermore, older people are able to engage in relationships of their choosing, including intimate relationships, unless a substitute decision-maker legally limits these rights.

Under the Statement of Rights and the Standards, providers must support older people to exercise choice and independence and maintain relationships of their choice.

Older people living in their own homes often have greater decision-making capacity than those in residential care homes, including the ability to engage in consensual sexual relationships.

Workers must respect the older person's privacy and choices, particularly regarding relationships and intimacy and be alert to any signs of non-consensual sexual contact or behaviour and act to protect the older person if needed.

Consent

The definition of consent varies across States and Territories under criminal law. However, it is generally understood as a person's free and voluntary agreement for something to happen or to do something.

Key points about consent:

- It can be withdrawn at any time.

- An older person's prior consent to an action does not mean they consent to it again in the future.

Always ensure you have the older person's current consent before providing care or engaging in physical contact. Even where the legislation allows or requires you to act without an older person's consent, you should inform them of the action being taken wherever possible. This helps them understand any issues, decisions, or outcomes that may arise afterwards.

What is <u>not</u> reportable unlawful sexual contact or inappropriate sexual conduct?	What is reportable unlawful sexual contact or inappropriate sexual contact?
• Consensual acts of affection such as greeting someone with a kiss on the cheek or a hug. • Consensual sexual relations between an older person and another person who is not a worker of the provider. • Consensual sexual relations between two older people receiving services from the provider. • Consensual gestures of comfort, for example a worker rubbing an older person's back or patting an older person on the knee where this aligns with the older person's personal preferences. • Helping an older person to wash and dry themselves, where the worker 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 older person by a worker 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 an older person (with a body part or an object) - touching an older person's genitals (or other private areas) without a care need - masturbating, showing their genitals to an older person or exposing themselves in the presence of an older person - undressing in front of an older person or watching older people undress in circumstances where supervision is not required - inappropriate exposure of older people to sexual behaviour of others - taking an intimate image of an older person - sexual innuendos, sexually explicit language or showing pornography to an older person or using an older person in pornography - grooming, stalking or making sexual threats to or in the presence of an older person - forcing, threatening, coercing or tricking an older person into sexual acts.

These points about consent relate to sexual contact or conduct and to the delivery of care. They do not affect your reporting obligations. The older person's consent is not required for you to notify the Commission or to report an incident to police.

Whether sexual contact or conduct is unlawful or inappropriate must be assessed on a case-by-case basis. For example, in the context of someone making a gesture of comfort, it is important to understand whether the older person perceives that gesture as comforting. Some older people are more comfortable with physical touch than others, so it is essential to consider cultural sensitivities, personal preferences, and your knowledge of the older person and their relationships with those offering comfort.

Unlawful sexual contact can result in a range of emotional, behavioural, and physiological responses. These may include symptoms related to post-traumatic stress, such as depression, withdrawal, agitation, distress, or confusion, which can sometimes resemble symptoms of cognitive impairment. In some cases, there may be no obvious response, but this does not mean the person has not experienced physical, emotional, or psychological trauma.

Important consideration for workers

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

3.3 Psychological or emotional abuse

The definition of “psychological or emotional abuse of the older person” as a reportable incident type is consistent for both residential care homes and services delivered in home or community settings.

Psychological or emotional abuse refers to conduct that has caused, or could reasonably be expected to cause, psychological or emotional distress to an older person. This includes actions such as taunting, bullying, harassment, intimidation, threats of maltreatment, and humiliation. It can also involve unreasonable refusal to interact with or acknowledge the older person, as well as unreasonably restricting their ability to engage socially or interact with others.

Repetitive actions or contact that do not involve physical force but cause, or could reasonably be expected to cause, psychological or emotional distress are also considered abuse.

Under the Statement of Rights and the Standards, older people must always be treated with dignity and respect and have the right to live without abuse or neglect. Providers are expected to have systems and processes in place to ensure older people feel accepted, valued, and safe, regardless of their needs, abilities, gender, age, religion, spirituality, mental health status, ethnicity, background, or sexual orientation.

Your systems and processes should support older people to report disrespectful care or discrimination. This includes providing ongoing education and training for workers, as well as giving feedback on how aged care services are delivered. Workers should ensure that their care is respectful, culturally appropriate, and makes older people feel valued and heard.

Patterns of abuse

Abuse can occur as a single event, such as a worker yelling at an older person, but it can also involve a pattern of repeated behaviour over time. While an isolated incident may not initially cause, or be expected to cause, psychological or emotional distress, repetitive behaviour can have a cumulative effect, increasing the potential harm to the older person.

Your incident management system must be able to record all incidents in a way that makes it easy to identify repeated minor instances of such behaviour. This ensures patterns of abuse can be recognized and reported as a single reportable incident through the SIRS, while also allowing you to take action to prevent it from happening again.

What is <u>not</u> reportable psychological or emotional abuse?	What is reportable psychological or emotional abuse
• Raising one's voice to get the attention of, or communicate with, an older person who has hearing difficulties. • Minor disagreements between older people, such as during activities at a day therapy centre. • Making reasonable requests to support the safe and effective delivery of aged care services, like asking an older person to cooperate or encouraging them to shower. • Situations where an older person is seen arguing with their family member or supporter.	• Yelling, name-calling, bullying, or harassing an older person. • Humiliating or intimidating an older person. • Making threatening or aggressive gestures or pretending to act violently toward an older person. • Ignoring an older person unreasonably, threatening to withhold care or services, or threatening mistreatment. • Refusing an older person access to care or services as a form of punishment. • Taunting, making disparaging remarks about an older person's gender, sexual orientation, cultural or religious identity, or other personal attributes, or constantly criticizing them. • Repeated actions like flicking, tapping, or bumping an older person. While these actions may not involve physical force, their repetitive nature can cause emotional or psychological distress. • Knowingly causing anguish or distress, such as calling an older person by the wrong name or ignoring their expressed, reasonable preferences. • Moving items around an older person's home or placing them out of reach without permission, deliberately causing confusion or irritation.

Important consideration for workers

Workers may witness others interacting with older people in a way they consider inappropriate or disrespectful. Examples include:

- A worker giving abrupt, terse, or brusque orders to older people,
- A visiting family member or supporter making inappropriate or cruel comments or jokes to an older person or within earshot of an older person.

Where this occurs, workers must be encouraged to:

- Raise it with the person directly, or
- Report it to service management.

Any incident or series of incidents that cause significant harm and/or discomfort to an older person should be considered a reportable incident.

Where multiple registered providers are delivering care to an older person such as services in home or community settings, workers may witness or become aware of incidents or allegations involving workers from another provider. Expectations in these situations are outlined under [Where multiple aged care providers are delivering care services](#).

By encouraging open communication and reporting, providers can address inappropriate interactions promptly and ensure the safety and wellbeing of older people.

3.4 Unexpected death

The definition of “unexpected death of the older person” as a reportable incident type differs between providers of residential care homes and services delivered in home or community settings, due to the limited oversight providers of services delivered in a person’s own home or community have over an older person’s daily life.

As such, the circumstances in which those providers are required to report unexpected deaths is more limited than for providers of residential care homes.

An unexpected death is reportable when it results from the provider's actions or mistakes, such as a clinical error, or from the provider's failure to act, such as not delivering care aligned with the older person’s assessed needs or best practice.

Providers are only required to report if they know of the death and have reasonable grounds to believe it was caused by their actions, inaction, or services. A death can occur immediately or later following care. Providers are not required to report deaths unrelated to their care or where the cause is unclear unless there is a reasonable belief it was linked to their care. Families are not obligated to inform providers about the death or its circumstances. Reporting is limited to cases where the provider becomes aware of the death and suspects their care was a contributing factor.

Providers must notify the Commission if they failed to take reasonable steps to prevent an incident that led to death. This includes situations where they did not adequately assess or respond to an older person’s condition or incident, resulting in death, or where mistakes in care or poorly managed care contributed to the death.

All reportable unexpected deaths are classified as Priority 1 incidents. Providers must notify the Commission within 24 hours of becoming aware of the death.

Unexpected death includes cases where the provider did not take reasonable steps to prevent death or where the death resulted from care provided or not provided by the provider. If unsure,

providers should assess whether there are reasonable grounds to believe their care was linked to the death. In such cases, notify the Commission promptly, even if the coroner has not determined the exact cause.

What is not a reportable unexpected death?	What is a reportable unexpected death?
- It results from an ongoing illness, disease, or condition that was appropriately assessed, monitored, and managed (including palliative care deaths with proper end-of-life care). - It occurs due to a disease outbreak (e.g., COVID-19), where separate reporting processes apply. - It follows an unrelated condition or illness after an incident. - An accident occurs, unconnected to the care or services provided.	- An older person is injured during care (e.g., a fall) and dies from those injuries. - A provider's equipment or supports fail (e.g., grab rails break), resulting in death. - Clinical care or services are poorly managed (e.g., an untreated wound becomes infected, leading to death). - A provider fails to monitor or assess an older person's condition, leading to avoidable death. - Regular care services are withheld or missed (e.g., workers repeatedly fail to attend, resulting in neglect and death).

Important consideration for workers

Unexpected deaths may occur even when workers have appropriately assessed and managed an older person's condition, including injuries sustained from an incident. If you are unsure whether a death was related to a specific incident, mistake, or poor care, you should report it. This includes cases where an older person is admitted to hospital following an incident and subsequently dies in hospital.

If you reasonably suspect that a death may be related to the care or services you provided—or failed to provide—you must report it to the Commission, even if the exact cause of death has not yet been confirmed by a coroner.

Deaths are often referred to a coroner for various reasons, such as when a person dies unexpectedly, from an accident or injury, or in unnatural or violent circumstances, or when a doctor cannot issue a death certificate because the cause of death is unknown. While waiting for the coroner's determination, providers must report to the Commission any death they reasonably begin suspect to be related to their aged care services.

Additional reporting responsibilities for deaths

Your responsibility to notify the Commission of an unexpected death is in addition to any legal obligations to notify the coroner or other authorities under state or territory requirements. Each jurisdiction has specific rules regarding the reporting of deaths to authorities such as the coroner or police.

Deaths may be referred to a coroner for various reasons, including when a person dies unexpectedly, from an accident or injury, in unnatural or violent circumstances, or when the cause

of death is unknown and a doctor cannot issue a death certificate. In such cases, it is the coroner's role to determine the date, place, circumstances, and medical cause of the death.

It is acknowledged that this process can take time. Consequently, you may not be able to provide all required details when initially reporting an unexpected death to the Commission. Providers should notify the Commission as significant new information becomes available, using the approved form (refer to [Making a notification](#) for details).

Given the potential for multiple reporting obligations, providers are strongly encouraged to establish clear policies and procedures. These should guide workers on how to respond to a death, including identifying responsibilities for notifying the Commission and other relevant bodies and adhering to reporting timeframes.

3.5 Stealing or financial coercion

The definition of "stealing from, or financial coercion of, the older person by an aged care worker of the provider" as a reportable incident type applies consistently across both residential care homes and services delivered in home or community settings.

Stealing or financial coercion refers to instances where a worker of the provider engages in theft or improper conduct related to an older person's financial affairs.

Stealing or financial coercion includes:

- A worker stealing from an older person.
- Conduct by a worker that is coercive, deceptive, or exerts unreasonable control over the older person's financial affairs.

For a reportable incident, the actions must involve a worker. This includes any person employed, hired, retained, volunteering for or contracted by the provider, whether directly or through an employment or recruiting agency, to provide aged care services.

You are required to notify the Commission if you have a reasonable belief that a worker is responsible for, or is alleged or suspected to be responsible for, an older person's missing or stolen items.

Missing items and unknown subject of the allegation

When an older person's money or valuables go missing without explanation, you should assist the older person in trying to locate the items. If the items cannot be found and there are circumstances supporting a suspicion that a worker may be responsible—such as a direct accusation from the older person—you must report the incident to the Commission.

If the missing item is later found, you should update the Commission with the new information (refer to procedures for notifying additional information).

It is understood that you may not always be able to identify the person responsible at the time of reporting. However, when an older person accuses a worker of theft, you are expected to make reasonable efforts to locate the missing item and/or identify who was responsible.

What is <u>not</u> reportable stealing or financial coercion?	What is reportable stealing or financial coercion?
• An older person with the cognitive capacity freely and voluntarily buys a worker a coffee while out in the community. • An older person, their family member or supporter gives a worker a gift as a gesture of gratitude for their services and support. • Items initially thought to be missing but are quickly found to have been misplaced. • An older person complains to a worker about feeling financially pressured by their family or supporter (this does not involve any worker's action).	• A worker coerces an older person to change their will in favour of the worker or another person. • A worker steals money or valuables from an older person. • A worker uses an older person's personal property for their own purposes, such as borrowing furniture without the older person's permission or consent. • A worker asks or coerces an older person to purchase something for them or another person. • A worker uses power of attorney to misappropriate an older person's funds. • An item goes missing from an older person's home, and the older person, their family or supporters allege or suspect a worker is involved.

Financial Coercion

Financial coercion involves the forced, deceptive, or fraudulent control of an older person's finances. Examples of this behaviour by a worker include:

- Encouraging an older person to give them a gift or money.
- Advising an older person to change their will.
- Using power of attorney to inappropriately control an older person's finances.
- Deceiving an older person to obtain financial advantage for themselves or another person.
- Pressuring, bullying, or threatening an older person to obtain a financial benefit.

An incident is considered reportable regardless of the nature or value of the theft or financial coercion. Whether the item is of significant financial worth, sentimental value, or low monetary value, the responsibility to report the worker's actual, suspected, or alleged conduct remains the same.

Important consideration for workers

If a worker is accompanying an older person to an appointment and the older person offers to buy them a coffee or lunch, this is not typically considered a reportable incident, although it may be discouraged by your organization's rules or professional code of conduct. However, if you witness or receive an allegation or suspicion that a worker specifically asks or coerces an older person to buy something for them, even if the item is of low value, this should be reported as a potential incident of financial coercion.

3.6 Neglect

Please note, following commencement of the Aged Care Act and the Aged Care Rules from November 2025 the definition of the Neglect reportable incident type has changed.

The definition of “neglect of the older person” as a reportable incident type applies across both residential care homes and services in home or community settings.

The definition of “neglect of the older person” as a reportable incident type is when, in connection with the delivery of funded aged care services by a registered provider, aged care worker or a responsible person has, or is alleged to have, or is suspected of having:

- delivered aged care services that exposes the older person to risk of serious injury or illness; or
- been reckless or intentionally negligent in delivering aged care services to the older person; or
- caused or contributed (including through reckless or intentional behaviour) to:
 - a significant failure to deliver aged care services to the older person, or
 - a systemic (repeated or ongoing) pattern of poor conduct; or
- delivered a grossly inadequate aged care service to the older person.

If an incident doesn’t meet the threshold (requirements) for reporting neglect, you need to understand if you should still record and respond to it as part of your incident management obligations.

What does putting the older person at risk of serious injury or illness mean?

Putting an older person at risk of serious injury or illness means putting them in a situation where they could have a serious injury or illness. Serious injury or illness doesn’t have to have happened. Under the Act, a serious injury or illness includes injuries requiring immediate treatment for serious harm, such as amputations, serious head, eye, burn or spinal injuries, loss of bodily function, serious lacerations, serious wounds or pressure injuries, or medical treatment within 48 hours of exposure to a substance. For example, leaving an older person (who needs help to move) in the sun without enough shade, sun protection, water or access to help.

What is a significant failure?

A significant failure is conduct or behaviour that’s significantly different from that which could reasonably be expected from a registered provider, or responsible person. Providers, responsible persons and workers have rules for their conduct under the Act.

What is a systematic pattern of conduct?

To work out if there is a systematic pattern of conduct, you must have regard to:

- the number of times the conduct has not complied with a provision of the Aged Care Act (the relevant contraventions);
- the period over which the contraventions occurred;
- the number of older people the relevant contraventions affected;
- how you as a provider responded to any complaints about the relevant contraventions.

What does reckless or intentionally negligent mean?

The Aged Care Act and the Aged Care Rules do not define 'reckless or intentionally negligent'. Generally, it describes a situation where a registered provider, aged care worker or responsible person has not given due regard to how care services are delivered to an older person.

For example, this could include:

- not giving an older person in a residential care home access to medical care or allied health services
- leaving wounds untreated
- not changing soiled continence aids in a timely manner
- failing to adequately supervise an older person.

Warning signs

Incidents of neglect aren't always witnessed. And not all older people will report that there has been an incident. Warning signs of neglect can include:

- unexplained weight loss
- unexplained or unusual hunger or thirst
- constant tiredness or falling asleep at unexpected times
- poor hygiene or grooming, like overgrown nails, dirty hair, body odour, or continence aids not being regularly changed
- wearing dirty and damaged clothes or clothing that doesn't suit the weather
- wounds that won't heal
- dirty dressings
- unexpected changes to behaviour
- hints or comments that seem to be about neglect.

If you suspect there has been a reportable incident, you must let us know. Don't wait for definite proof.

Responding to reportable neglect

When an incident happens or is alleged or suspected, a provider and care team's first priority is to make sure the older person is safe and well. For incidents of neglect, this could mean:

- reassuring them
- immediately attending to their needs
- organising further assessment and treatment
- offering to connect the person with confidential support
- acting to stop more harm from the neglect.

You can read about [open disclosure](#) on the Commission's website.

Reportable neglect doesn't include

- **Decline in the older person's health because of disease, when all care has been taken to meet the older person's needs.**

For example, weight loss during end-of-life care.

- **When an older person makes an informed choice not to receive care or services.**

Where an older person makes an informed choice not to receive certain aged care services (even when they are assessed as requiring these) and this results in an incident, it is not reportable.

For example, an older person with diabetes makes the informed decision not to follow a diabetic diet. Or an older person decides they don't want to be taken to the hospital for treatment, the provider informed the older person of any risks related to their choice, the older person confirmed and communicated this choice to the provider; and the provider documented the discussion and decision in writing.

- **Where an older person is awaiting a higher level of care**

When an older person is awaiting a higher level of care – such as transitioning from a CHSP (Commonwealth Home Support Programme) to a Support At Home package or from a lower-level Support At Home package to a higher one – it's important to manage their aged care services effectively while they wait. Providers should have a conversation with the older person (and their supporters or representative, where applicable) to explain the aged care services that are currently available within their existing package. You should explore options for accessing additional services that the older person requires while waiting for a higher level of care.

Providers need to assess any risks associated with the older person's current aged care services and implement strategies to manage those risks until more appropriate services become available. If certain care services (such as medical care) are not funded or within the scope of the provider's responsibilities, it is not considered reportable neglect if the provider does not offer those care services. For example, if a provider is funded for gardening but the older person requires wound care, it is the provider's (your) responsibility to ensure that the older person is encouraged or assisted to seek appropriate medical treatment for their needs.

In summary, while a provider's responsibility is to deliver care services within the scope of their funding, you must also support the older person's health and well-being by guiding them to the appropriate services and addressing any risks while awaiting a more suitable care package.

When should you report neglect to the police?

Under s164-40(2) of the Aged Care Rules, if there are reasonable grounds to report an incident to police, you must notify a police officer within 24 hours of becoming aware of it. This applies to all incident types, including neglect. Whether reasonable grounds exist will depend on the circumstances, for example where the neglect may be criminal in nature. See 2.6 Reasonable grounds to report the incident to police. **What if the neglect isn't from an aged care service?**

Providers and their teams may see neglect caused by the action or lack of action of an older person's family or supporters.

In these situations you should give the older person, and their supporters, information about:

- OPAN – the Older Persons Advocacy Network gives free, confidential and independent support to older people looking for or receiving care. Contact them on 1800 700 600 or opan.org.au.
- 1800 ELDERHelp (1800 353 374) – a free and confidential national elder abuse phone line. If the person is in immediate danger, or there is possible criminal conduct, contact emergency services.

What is <u>not</u> reportable neglect?	What is reportable neglect?
• An isolated incident of late or missed medications in a residential care home (or home and community settings, when the provider is responsible for assisting the older person to administer medications) where there is no harm and/or discomfort caused to the older person. • Rapid weight loss as a result of disease in a residential care home (or home and community settings, when the provider is responsible for delivering meals) where all reasonable efforts are made to ensure the older person is receiving adequate nutrition. • Where an older person has made an informed choice not to receive care and services in line with their assessed care need, for example: ○ where an older person with diabetes chooses not to eat a diabetic diet ○ where an older person with dysphagia chooses not to eat a liquified diet but is appropriately supervised when eating ○ where an older person chooses not to shower or be showered, or brush their teeth or hair (or have them brushed) ○ where an older person with liver disease chooses to drink alcohol ○ where an older person chooses to smoke despite having a chronic respiratory condition or other condition exacerbated by smoking ○ where an older person with a chronic disease chooses not to undergo clinical treatment	• Depriving an older person of basic necessities, including food, drink or clothing. • Withholding personal care, such as showering, toileting or oral care. • Frequent or regular late or missed administration of medications (or assistance with administration of medications), or failure to assist an older person to administer correct or time critical medications (where this is the responsibility of the worker). • Failing to monitor an older person's nutrition and hydration, resulting in rapid weight loss and clinical complications. • Failing to seek appropriate medical assessment and treatment for an older person where they appear unwell or are injured. For example: ○ failure to treat injuries or wounds ○ failure to assess and manage pain ○ failure to seek medical diagnosis or treatment when a consumer shows signs of illness ○ failure to call an ambulance when the consumer's injuries or illness require treatment in hospital. • Failing to ensure an older person is reviewed regularly by a health professional or specialist in line with their documented care needs.

What is <u>not</u> reportable neglect?	What is reportable neglect?
○ where the provider is responsible for delivering clinical care and an older person chooses not to have their wound cleaned and dressed ○ where the provider is responsible for delivering garden maintenance and an older person chooses not to have their lawn mowed.	• Failing to supervise an older person in an environment that leaves them susceptible to injury. For example: ○ leaving an older person outside unprotected in the sun resulting in significant burns ○ leaving an older person 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 older person ○ failing to supervise older people where they may wander into unsafe environments such as busy roads, construction sites or bodies of water ○ failing to appropriately monitor/support an older person at risk of falls when taking them shopping resulting in the older person falling over. • Where a worker does not arrive to provide care and services, resulting in harm and/or discomfort to the consumer, e.g. where: ○ a worker does not arrive to assist an older person into bed, so the older person remains in their wheelchair all night ○ a provider fails to deliver meals to the older person, resulting in the older person going hungry ○ a worker providing assistance with hygiene and toileting does not arrive to change an older person's continence aids resulting in emotional distress to the older person ○ a worker does not arrive to change an older person's dressing and their wound worsens as a result. • Frequent or regular missed instances of care without the older person's prior agreement. • Failing to consistently deliver or withholding personal care (such as showering, toileting

What is <u>not</u> reportable neglect?	What is reportable neglect?
	or oral care) or agreed outings to community settings (such as not taking the consumer shopping). • Failing to recognise and respond appropriately when an older person experiences acute deterioration while services are being delivered. • Failing to appropriately modify an older person's meals (including prepared meals) to account for specific directions from an assessment and as recorded in their care plan (e.g. difficulty of swallowing) or failure to give sufficient assistance to a consumer to eat their food, resulting in the older person not being able to eat meals or choking. • Failing to change soiled continence aids in a timely manner. • Lack of consistent clinical oversight exacerbating conditions requiring acute care, such as, lymphedema, contractures, catheter care and infections.

These examples are illustrative only and each case will need to be assessed individually. There may be incidents of neglect that are minor and do not necessarily need to be reported to the Commission. In these instances, the incident may be best addressed through the provider's continuous improvement process and should be clearly documented in the provider's records.

3.7 Inappropriate use of restrictive practices

Inappropriate use of restrictive practices

The inappropriate use of restrictive practices is a serious reportable incident. Restrictive practices refer to actions or interventions that restrict the rights or freedom of movement of an older person, with or without their consent. Whether such practices are deemed inappropriate depends on compliance with the requirements outlined in the Aged Care Act and Aged Care Rules.

These requirements specify the circumstances in which restrictive practices may lawfully be used and apply differently in residential care homes and services in home or community settings. Providers must ensure restrictive practices are used only as a last resort, in compliance with relevant legislation, and as part of a person-centred approach to care.

Restrictive practices in residential care homes

In residential aged care, restrictive practices include chemical, environmental, mechanical, and physical restraints, as well as seclusion. These measures may only be used when necessary to prevent harm and after all alternative strategies have been exhausted. Providers are required to adhere to strict preconditions, including:

- **Informed consent:** Consent must be obtained from the older person or their substitute decision-maker, who must understand the nature, purpose, and risks of the practice.
- **Behaviour support plan:** The restrictive practice must be documented in a behaviour support plan tailored to the older person's older person needs.
- **Compliance with State/Territory laws:** Providers must ensure their actions align with local legislative requirements concerning restrictive practices.

In emergency situations where immediate action is necessary to prevent harm, restrictive practices may be used without prior consent, provided the incident is documented and communicated to the substitute decision-maker as soon as practicable. Importantly, chemical restraints, such as sedative medications, can only be prescribed and used after a clinical assessment by a qualified medical or nurse practitioner. Providers must document the administration of these medications and report their use to the prescribing practitioner for monitoring purposes.

Restrictive Practices in services in home or community settings

In home or community settings, the use of restrictive practices must align with the older person's care plan, which should detail the type of restrictive practice permitted, the specific circumstances in which it may be applied, and the duration of use. Unlike residential care homes, services in home or community settings are not required to implement behaviour support plans, but doing so is strongly encouraged as best practice.

The emergency use of restrictive practices in services in home or community settings is a reportable incident because such situations inherently do not meet the preconditions for lawful application. Providers must document and report these incidents to the Commission, ensuring transparency and accountability. If restrictive practices are deemed necessary in non-emergency situations, the provider must work collaboratively with the older person or their substitute decision-maker to ensure informed consent is obtained and documented.

Documentation and monitoring

Regardless of the care setting, the use of restrictive practices must be accompanied by robust documentation and active monitoring. Providers are expected to record:

- The date, time, and duration of the restrictive practice.
- The type of restrictive practice used and the reasons for its application.
- Observations on the older person's response, including signs of distress or adverse outcomes.

For chemical restraints, additional documentation must include the prescribed dosage, the frequency of administration, and any side effects observed. Providers are required to report these details to the prescribing practitioner to ensure ongoing clinical oversight. Documentation must also demonstrate compliance with the older person's care plan and facilitate regular reviews to evaluate the necessity and effectiveness of the restrictive practice.

Addressing restrictive practices by family or supporters

In home or community settings, there are instances where family members or supporters may implement restrictive practices. While these actions are not classified as reportable incidents to the Commission, providers still have a responsibility to address them under their broader obligations, including the Statement of Rights and, for providers in registration categories 4, 5 and 6, Standard 2 - The organisation. Providers must assess and respond appropriately to potential older person abuse or neglect, which may include engaging advocacy services, offering family or supporters education or revising care arrangements.

Following the use of restrictive practices

After using restrictive practices, providers must conduct a thorough review to assess the ongoing necessity and appropriateness of the intervention. This involves collaborating with the older person, their family or supporters, and other care professionals to evaluate the outcomes and explore alternative strategies to manage behaviour or risk. Post-use actions include updating the care plan and providing debriefings for older people involved to ensure they are supported and understand the implications of their actions.

The overarching goal is to minimise the use of restrictive practices while safeguarding the rights, dignity, and well-being of older people, consistent with regulatory frameworks and best practice principles.

The use of an approved restrictive practice as planned is not reportable if:

- It is used in a home or community care setting.
- The restrictive practice is included in the person's care and services plan.
- The plan clearly describes:
 - when it may be used,
 - why it may be needed,
 - how it will be used,
 - its duration and frequency.
- The practice is used exactly as outlined in the plan.
- The use is documented as soon as practicable afterwards.

Example: A restrictive practice documented in an older persons care and services plan, used appropriately in accordance with all requirements and that plan, and each instance of its usage then recorded is likely not reportable.

What is <u>not</u> reportable inappropriate use of restrictive practice	What is reportable inappropriate use of restrictive practice
• Restrictive practices used in line with the older person's documented aged care services plan, ensuring proportionality and necessity, and recorded promptly after use. • Restrictive practices applied in emergency situations to prevent imminent harm, with the older person's representative informed as soon as practicable.	• Restricting an older person's movement without alignment to their documented aged care services plan, such as using bed rails, barriers, locked doors, or restraints. • Physically restraining an older person by blocking their path, holding onto them, or forcibly preventing their movement. • Removing or tampering with an older person's mobility aids, such as disabling

Administration of prescribed medication for treating a diagnosed health condition, documented in the care plan, and with prior notification to the older person's representative.	- electric wheelchairs or placing aids out of reach. - Confining or secluding an older person without facilitating voluntary exit. - Administering drugs to control, sedate, or restrict behaviour instead of treating a diagnosed health condition.
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3.8 Unexplained absence in the course of delivery of aged care services

Please note, following commencement of the Aged Care Act and the Aged Care Rules from November 2025 the 'missing consumer' reportable incident type for home services providers has been included in a combined 'unexplained absence' incident reportable type', covering both residential care homes and services delivered in home or community settings.

The definition of "unexplained absence of the older person in the course of the delivery of funded aged care services to the older person" as a reportable incident type is similar for providers of residential care homes and services delivered in home or community settings – although providers who deliver care services in the home or community settings have limited control over the older person's movement, living environment and safety outside of when care services are being delivered.

Reportable unexplained absence means:

- an absence of an older person from a residential care home where there are reasonable grounds to report the absence to police
- an absence of an older person from the home or community setting during the delivery of care services where there are reasonable grounds to report the absence to police.

Providers are expected to report the unexplained absence to the police within a reasonable timeframe to enable appropriate actions to locate the older person.

All reportable unexplained absences (that is, absences where there are reasonable grounds to report the absence to police) are classified as Priority 1 reportable incidents, and such cases must be notified as soon as practicable and within 24 hours of the provider becoming aware of the incident. This classification ensures that such incidents receive immediate attention and appropriate follow-up. This notification is required whether the absence has been or is yet to be reported to the police.

In residential care homes, an older person's absence is not unexplained just because it is not authorised by the provider. There must also be reasonable grounds to report the absence to the police.

For example, if an older person can't be located and does not have sufficient cognition to care for themselves (or would miss a dose of essential medication), that may be reasonable grounds for the provider to report the absence to the police, given the potential risk to the person's health and

safety. You should take reasonable steps to find the older person, including considering whether there may be cultural or other reasons for their absence. These steps can happen at the same time as reporting to police, and must not delay a report where there are reasonable grounds to make one.

For home or community settings, 'during the delivery of funded aged care services' captures situations where a provider has the older person in their physical care immediately before their unexplained absence. For example, where an older person goes missing while a worker is delivering care service in their home and there is reason for concern (older person could be harmed if they were wandering alone), or during a scheduled outing with a worker, while receiving transport services, while at a day therapy centre, or in overnight respite.

A provider delivering care services in the home or community is not required to report incidents through the SIRS where their worker arrives for a scheduled visit and the older person is not present, or where they capably leave their home while for example home maintenance services are provided. These are not unexpected absences **during the delivery of funded aged care services**. These non-reportable absences should be managed through the provider's incident management system.

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

Absent older people who return

If an older person returns to the residential care home (or the home or community service setting) before their absence is noticed, there is no requirement to notify the Commission of the incident as an unexplained absence. However, if a residential care home provider becomes aware that an older person is in the hospital without prior knowledge that they were missing, that circumstance may signify reasonable grounds and qualify the absence to be reported to the Commission as an unexplained absence.

All incidents of unexplained absence should be documented in a provider's incident management system and the older person's care and services plan. This documentation helps in understanding behaviours or wandering patterns of the older person (including wandering patterns in community settings) and enables providers to implement appropriate management strategies.

Providers should also assess whether the incident meets the criteria for another type of reportable incident. For example, if an older person with cognitive impairment left the residential care home (or the home or community service setting) due to a breach of duty of care and returned with an injury, this could be reported as an incident of neglect.

4. Expectations and obligations of providers

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 the loved ones, engaging with an older person's advocacy service, contacting the Australian Human Rights Commission or reporting it to the police.

As part of your broader duty of to protect older person's safety, health, and wellbeing, you must take appropriate action regarding any abuse or neglect of older people including (allegations or suspicions) that you become aware of.

Incident management obligations and requirements

Registered providers have specific obligations and requirements under the Aged Care Act and the Aged Care Rules to manage and prevent incidents that occur in connection with the delivery of care services. Effective management of incidents is critical for good governance, helping you manage risks to older people and improve the quality of aged care services you provide.

Incident management responsibilities apply to all incidents; however, additional provider responsibilities also apply to a subset of reportable incident types that must be notified to the Commission via the SIRS.

Aged Care Quality Standards

The Standards contain specified outcomes and accompanying actions relevant to incident management, which complement the provider obligations and requirements. For more information see [4.3.3 The Aged Care Quality Standards below](#).

Reportable incidents (including allegations and suspicions) are a subset of all incidents

When thinking about your obligations as a provider regarding incident management and reportable incidents, it is useful to understand that reportable incidents are a subset of all incidents.

That is, the specific obligations and expectations for reportable incidents could be said to exist 'within' your broader provider obligations and expectations for incident management (that must be followed for all incidents). Further, expectations for notifying Priority 1 reportable incidents could be said to be a specific subset of the obligations and expectations that apply to all (Priority 2) reportable incidents.

Your obligations and requirements			Definition or scope of incident
Incidents	Reportable incidents	Priority 1 reportable incident As per your incident management responsibilities, plus the incident and your response to it must be notified to the Commission via the SIRS within 24 hours of becoming aware – with any information not known at that time to be provided within the first 5 days since becoming aware of the incident.	All incidents involving: • unlawful sexual contact or inappropriate sexual conduct • unexpected death, or • unexplained absence during the course of delivery of care services And any incidents of other types: • that cause an older person 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.
		Priority 2 reportable incident As per your incident management responsibilities, plus the incident and your response to it must be notified to the Commission via the SIRS within 30 calendar days of becoming aware of the incident	Incidents where harm is caused to the older person , and the following types of incidents (where a condition for Priority 1 classification and timeframe has not been triggered): • unreasonable use of force • psychological or emotional abuse • stealing or financial coercion • neglect • inappropriate use of restrictive practices.
	Incident management	• 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 incident management system. • Must use your incident management system to inform continuous improvement of aged care services	For all acts, omissions, events or circumstances that: • occur (or are suspected to have occurred) in connection with the delivery of care services to an older person, and • have caused harm (or could reasonably have been expected to have caused harm) to an older person, worker or another person. There must be a relationship between the incident and the provider, worker or services.

Figure 1: Summary of incident management and reporting responsibilities

4.1 Reportable incident obligations under the Act

The Aged Care Act at s165A outlines reportable incident obligations.

They apply to registered providers in **all** registration categories 1-6.

Put simply, the Aged Care Act requires providers to report to the Commission any reportable incidents (including suspected or alleged incidents) of the eight reportable incident types, and to prepare and submit the report in the Commission approved form in accordance with any requirements in the Aged Care Rules.

A civil penalty or offence may also apply if the provider fails to report a reportable incident to the Commission or gives false or misleading information or documents as part of their incident report.

N.B. There are also reportable incident obligations for operators of aged care digital platforms in the Aged Care Act at s189(1)(e), which are to manage reportable incidents raised with them to the requirements of the Aged Care Rules, as described below at [Requirements of others under the Aged Rules](#).

4.2 Reportable incident requirements under the Aged Rules

4.2.1 Requirements of providers under the Aged Care Rules

Providers have reportable incident requirements in s165A of the Aged Care Rules.

They apply to registered providers in **all** registration categories 1-6.

Ensuring aged care workers internally notify about reportable incidents

The Aged Care Rules at s165A-20 require that a provider must ensure that an aged care worker who becomes aware of a reportable incident notifies one of the following as soon as possible:

1. a responsible person of the provider
2. their supervisor or a manager
3. someone within their organisation responsible for managing and responding to incidents, and for notifying reportable incidents to the Commission.

Giving a priority 1 notice within 24 hours

The Aged Care Rules at s165A-25 require that a provider must give the Commissioner a priority 1 notice **within 24 hours** of becoming aware of a reportable incident.

The priority 1 notice must include:

1. the provider's name and contact details
2. a description of the reportable incident including the:
 1. kind of reportable incident; and
 2. harm that was (or could reasonably have been expected to have been caused) to each person affected; and
 3. consequences of that harm, if known
3. the immediate actions taken in response to the incident, including:
 1. actions taken to ensure the safety, health and wellbeing of each older person (or their supporter) affected; and
 2. whether the incident has been reported to police or any other body
4. any further actions proposed in response to the incident
5. the name, position and contact details of the person giving the notice
6. the time, date and place at which the incident occurred (or was alleged or suspected to have occurred), if known
7. the names of the people directly involved in the incident, and
8. the level of cognition of affected older people directly involved in the reportable incident, if known.

If the above information is not available to a provider within the first 24 hours, you are not required to include the information in the initial priority 1 notice – but as per below you must give this information within 5 days.

Giving required (missing) or further information about a priority 1 incident

The Aged Care Rules at s165A-25 require that a provider must give the Commissioner **within 5 days** of becoming aware of the reportable incident:

1. any information that was required but not available within the first 24 hours to be able to include in the priority 1 notice
2. any further information specified by the Commissioner required to deal with the reportable incident.

For any reportable incident the Commission may determine this information is required within a different period, or not required at all.

The information must be given in writing in the Commission approved form.

Giving a priority 2 notice within 30 days

The Aged Care Rules at s165A-30 require that a provider must give the Commissioner a priority 2 notice **within 30 days** of becoming aware of a reportable incident. The priority 2 notice must include:

1. the provider's name and contact details
2. a description of the reportable incident, including the:
 1. kind of reportable incident; and
 2. harm that was (or could reasonably have been expected to have been caused) to each person affected; and
 3. consequences of that harm, if known
3. the actions already taken in response to the incident, including:
 1. actions taken to ensure the safety, health and wellbeing of each older person (or their supporter) affected; and
 2. whether the incident has been reported to police or any other body
4. any further actions proposed in response to the incident
5. the name, position and contact details of the person giving the notice
6. the time, date and place at which the incident occurred (or was alleged or suspected to have occurred), if known
7. the names of the people directly involved in the incident, and
8. the level of cognition of affected older people directly involved in the reportable incident, if known.

Giving further information about a priority 2 incident

The Aged Care Rules at s165A-30 state that, if required by the Commissioner, a provider must give any specified further information about the reportable incident within the requested time.

The information must be given in writing in the Commission approved form.

Notifying significant new information about any reportable incident

The Aged Care Rules at s165A-40 require that a provider must notify the Commissioner of significant new information relating to a reportable incident that has already been notified as soon as reasonably practicable after becoming aware of that new information.

The information must be given in writing in the Commission approved form.

Giving a final report about a reportable incident

The Aged Care Rules at s165A-45 state that, if required by the Commissioner, a provider must give a final report that includes specified further information about a reportable incident.

The report must be given **within 84 days** (or within a different period the Commissioner may determine) of the reportable incident being notified to the Commissioner.

The final report must be given in writing in the Commission approved form and contain the information specified by the Commissioner.

4.2.2 Requirements of others under the Aged Care Rules

Workers notifying a reportable incident as soon as possible

The Aged Care Rules at s164-20(g) require that as soon as an aged care worker becomes aware of a reportable incident, they are required to notify as soon as possible:

1. a responsible person of the provider,
2. their supervisor or a manager, or
3. someone within their organisation who is responsible for managing and responding to incidents, and for notifying reportable incidents to the Commission.

Quality care advisory body of a provider regularly report reportable incident concerns

The Aged Care Rules at s158-15(g) require that a quality care advisory body of a provider must regularly report to the governing body of the provider in writing any quality concerns it has (if any) about reportable incidents in connection with delivery of care services, and the actions taken in response to them.

Digital platform providers managing, referring and reporting quarterly on reportable incidents

The Aged Care Rules at s189-10, s189-15, and s189-20 require operators of aged care digital platforms also have obligations for recording, managing and referring reportable incidents to the responsible providers, and providing a quarterly report of the number and type of reportable incidents handled to the Commissioner.

4.3 Other obligations and requirements

Registered providers operate in the context of the aged care regulatory framework, to ensure that older people have the right to safe and quality care services that support their health and wellbeing and promote their quality of life.

Obligations and requirements about incident management are one element of an integrated framework, and complement and support other expectations to support providers to engage in risk management and continuous improvement activities around their delivery of

4.3.1 The Statement of Rights

The Aged Care Act includes a Statement of Rights, outlining the rights that older people have when accessing aged care services.

It promotes quality and safe care for older persons accessing, or seeking to access, to funded aged care services. The Statement of Rights empowers users of the aged care system by placing older people and their needs at the centre of the legislative framework. It is also a reference for providers and workers so they can take steps to act in a way that promotes older people's rights when delivering care.

Registered providers must:

Under s144(1) of the Act, it is a condition of registration that registered providers of a kind prescribed by the Aged Care Rules must:

- demonstrate that they understand the rights of older people under the Statement of Rights, and
- have practices in place to ensure they act compatibly with the Statement of Rights, in accordance with s24(2) of the Act.

Section 24(2) sets out Parliament's intention that registered providers take all reasonable and proportionate steps to act compatibly with the Statement of Rights when delivering funded aged care services. It also recognises that limits on rights may be necessary to balance:

- competing or conflicting rights
- the rights and freedoms of other people, including aged care workers and other older people accessing funded aged care services
- compliance with other Commonwealth, state or territory laws, including the *Work Health and Safety Act 2011*.

If an older person believes a provider is acting in a way that is incompatible with the Statement of Rights, they can make a complaint to the Complaints Commissioner (s358 of the Aged Care Act).

For more information please refer to the [Statement of Rights](#) page on the Commission's website.

4.3.2 The Aged Care Code of Conduct

The Aged Care Code of Conduct describes how registered providers (providers), their responsible persons (for example, board members and Chief Executive Officers), and aged care workers (including volunteers) must behave and treat people accessing funded aged care services.

The Aged Care Code of Conduct is aimed at promoting safe and quality delivery of aged care services, and consistent standards of behaviour across the sector. Providers must act in a way that's respectful, kind and consistent with the Code. You must also support, equip and prepare your workers and responsible persons to comply with the Code.

Providers must take reasonable steps to make sure all workers (including volunteers) and responsible persons you employ or otherwise engage, comply with the Code. This includes those workers employed or otherwise engaged (including as a volunteer) by an associated provider of the registered provider or engaged by the registered provider via an employment service.

The Aged Care Code of Conduct is set out in Part 5 of Chapter 1 of the Aged Care Rules. For more information, please refer to the [Aged Care Code of Conduct](#) page on the Commission's website.

4.3.3 The Aged Care Quality Standards

Under s15-15 of the Aged Care Rules, providers in registration categories 4, 5 and 6 must meet the requirements of relevant Standards, which detail outcomes providers are required to demonstrate in the care that older people receive.

The Standards are set out in Part 6 of Chapter 1 of the Aged Care Rules, and include '**Standard 2 - The organisation**' which makes the governing body responsible for meeting requirements to provide quality funded aged care services. Under this Standard, among other specified outcomes providers must:

- be accountable (responsible)
- have quality systems and processes
- use a risk management system
- use an incident management system to safeguard individuals (i.e. older people) and acknowledge, respond to, effectively manage and learn from incidents
- encourage and support workers and older people to make complaints and give feedback, and
- manage older people's information in the right way.

These outcomes (including for incident management) are just one aspect of the 7 Standards. The structure of each Standard includes:

- Intent – which describes the intended overall purpose of the Standard.
- Expectation statement – which describes what the older person can expect from their aged care provider related to that Standard.
- Outcomes – which describe what providers will be assessed against.

Actions – which describe what providers can do to meet the outcome. For more information, please refer to the [Standards](#) page on the Commission's website.

4.3.4 Open disclosure requirements

As outlined under the Aged Care Rules, providers must use an open disclosure process when care services do not go to plan or when something goes wrong that has either harmed or had the potential to cause harm to an older person.

Providers are expected to practise open disclosure in their prevention and management of any incidents affecting older people. Open disclosure requires providers to:

- use open and timely communication with older people (and their supporters)
- acknowledge and explain what went wrong
- apologise to those affected by an incident and address their immediate needs
- continue to support the older person, and
- facilitate discussion to determine the steps you will take for continuous improvement and to prevent any similar incidents from occurring again.

Open disclosure, expressions of compassion and offering an apology are important elements of communication, helping older people, their families and supporters and your workers in healing and in restoring trusting relationships.

A provider using open disclosure in the transparent resolution of an incident promotes and fosters an environment and culture of learning and continuous improvement of care services in partnership with older people and their supporters.

Refer to the Aged Care Rules at s164-15(a)(iii) and s164-40(1)(v) for open disclosure requirements regarding incidents, and at s165-10(a), s165-15(1)(n) and s165-35(2) for open disclosure requirements regarding complaints and feedback.

Further information relating to open disclosure can be found in the Commission's [Aged Care Open Disclosure Framework and Guidance](#) and [Open disclosure – rebuilding trust after something goes wrong](#) page on the Commission website.

5. Classifying and notifying reportable incidents

With an understanding of [Key terms and concepts](#) from Chapter 2, the [Types of reportable incidents](#) from Chapter 3, and [Expectations and obligations of providers](#) from Chapter 4, this chapter will walk you through key steps in assessing, classifying and notifying reportable incidents to the Commission via the SIRS.

5.1 Assessing and classifying reportable incidents

In following your reportable incident obligations, it is necessary for you as a provider to also be familiar with your incident management obligations, which include to record incident details and to manage and take reasonable steps to prevent incidents.

These obligations also apply to the subset of all incidents (and alleged or suspected incidents) that are reportable incidents. So, when you become aware of an incident, it is necessary for you to assess what happened (or appears might have happened) – not only to determine the necessary

support for those affected and to identify appropriate remedial actions, but also to determine whether the circumstances might qualify as a reportable incident to be notified to the Commission via the SIRS.

When **assessing an incident**, you must:

- consider the views of those affected to determine reasonable and proportionate remedial actions, and
- evaluate:
 - whether the incident could have been prevented
 - remedial actions needed to prevent similar incidents or minimise their harm
 - the effectiveness of your management and resolution of the incident
 - actions required to improve future management and resolution of similar incidents,
 - whether other persons or bodies should be notified of the incident.

As part of this process, you are responsible for:

- taking identified actions, including notifying relevant persons or bodies, minimizing risks, and preventing future incidents, and
- improving your incident management approach based on lessons learned from the assessment.

In some cases, you must decide whether to **conduct an internal investigation** to:

- determine the causes of the incident
- assess the harm caused by the incident, and
- identify operational issues that may have contributed to the incident.

You are also responsible for determining the nature and scope of any such investigation.

For further information about your incident management obligations – including how to analyse an incident, or investigate how and why an incident happened – please refer to the Commission's Effective incident management systems: Best practice guidance.

The Commission's Effective serious incident investigations guidance for providers is also 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.

To **ensure continuous improvement** in the prevention and management of incidents, you must collect and analyse data related to incidents. This data should be used to:

- identify and address systemic issues affecting the quality of care provided, and
- provide feedback and training to workers on preventing and managing incidents effectively.

You must also regularly review this information to:

- assess the effectiveness of your current prevention and management strategies, and
- identify opportunities for improvement.

Based on these reviews, you are responsible for taking the necessary actions to enhance your approach to incident management, ensuring a culture of ongoing improvement and accountability.

5.1.1 Distinguishing between incidents and reportable incidents

The period of time within which to notify a reportable incident to the Commission will depend on your categorisation of the incident as either an incident that:

- should be managed through your incident management system (all incidents)
- a Priority 2 reportable incident (a subset falling within the eight reportable incident types), or
- a Priority 1 reportable incident (a smaller subset of those incidents meeting relevant criteria).

Providers must assess whether an incident meets the criteria for a reportable incident. This means determining whether the incident (or alleged or suspected incident) meets the definitions of one or more of the eight reportable incident types, and then determining whether the incident fits within the criteria for Priority 1 or Priority 2 reportable incident.

Your priority classification determines the reporting timeframe. Priority 1 reportable incidents must be notified to the Commission within 24 hours of becoming aware of the incident. For Priority 2 reportable incidents, notification must be made to the Commission within 30 calendar days of becoming aware of the incident.

Providers must respond to and manage all incidents and their impacts as soon as appropriate to the circumstances through your incident management system, to ensure the wellbeing of the older person is prioritised. This includes incidents that you determine are Priority 1 or Priority 2 reportable incidents, as well as all other incidents (or alleged and suspected incidents).

5.1.2 Distinguishing between Priority 1 and Priority 2 incidents

As at section [2.3.1](#) above, a **Priority 1 reportable incident** is any incident, included an alleged or suspected incident:

- that **has caused** an older person [physical or psychological injury or discomfort](#) that [requires medical or psychological treatment to resolve](#); or
- where there are [reasonable grounds to report the incident to police](#); or
- involving [unlawful sexual contact or inappropriate sexual conduct](#) inflicted on an older person; or
- involving [unexpected death](#) of the older person resulting from care services delivered (or a failure to be delivered) by the provider; or
- involving [unexplained absence](#) of the older person during the delivery of aged care services where there are reasonable grounds to call police.

That is, three of the reportable incident types – unlawful sexual contact or inappropriate sexual conduct, unexpected death, and unexplained absence – are always Priority 1 incidents. You must consider the definitions of those incident types in the legislation and the advice in these guidelines.

Otherwise, you must determine whether or not there are reasonable grounds to report the incident (or allegation or suspicion) to police, and whether or not physical or psychological harm that required treatment to resolve was caused by the incident (or alleged or suspected incident). You must consider the definitions of these two criteria in the legislation and the advice in these guidelines.

If an incident meets the Priority 1 criteria, you must report it to the Commission within 24 hours of becoming aware of the incident (or alleged or suspected incident).

As at section [2.3.2](#) above, a **Priority 2 reportable incident** is one where a notification has not been required under any of the conditions requiring a priority 1 reporting timeframe. This includes any incident, allegation or suspicion that could reasonably have been expected to have caused harm to an older person receiving aged care services.

If an incident meets the Priority 2 criteria, you must report it to the Commission within 30 days of becoming aware of the incident (or alleged or suspected incident).

5.1.3 SIRS Decision Support Tool

It remains your responsibility as a provider to be aware of your obligations in the Aged Care Act and the Aged Care Rules about reportable incidents, and as explained in these guidelines. It is your responsibility to make your own assessment about the notification of each reportable incident, and if appropriate you should seek legal advice or other professional advice.

However, the Commission has developed a [SIRS Decision Support Tool](#) on our website that may help you work out what incidents you need to report to us and when.

Please note that the SIRS decision support tool is intended to provide you with general guidance only, and is not intended to be and should not be regarded as legal advice. While every effort is made by the Commission to ensure that information in the SIRS decision support tool is accurate and up to date, the Commission does not guarantee the accuracy, completeness, or currency of the information provided.

5.2 Notifying reportable incidents to the Commission

When notifying reportable incidents to the Commission, it is essential to provide a clear and comprehensive account. This should include detailed context about the incident, such as:

- who was involved
- the events leading up to the incident
- how it was identified, and
- what occurred before and after.

A thorough description of an incident allows the Commission to assess the appropriateness of your response to the incident (or allegation or suspicion) as a provider, including actions you've taken to ensure the immediate and ongoing safety, health, and wellbeing of the older person or older people involved. Your response should address any physical or psychological harm or discomfort experienced and demonstrate how the older person and relevant stakeholders (such as supporters or advocates) were involved in the process for resolving the incident.

Notifications must include sufficient detail to enable someone unfamiliar with the incident to fully understand what happened and why certain decisions were made. It is recommended that the person submitting the notification is directly involved in the incident assessment and familiar with all relevant contributing factors.

It is critical you assess and report the level of harm or discomfort caused by the incident—or that could reasonably have been expected to occur. Your notification should include specific details about the older person's response, such as observed behaviour (e.g., crying, withdrawal, or

avoidance). Input from workers familiar with the older person, including loved ones or regular workers, should also be considered. Where applicable, the reasoning behind your assessment of the harm level, even if you believe no harm occurred, must be clearly explained. Additionally, describe any medical or psychological treatment provided, proposed, or scheduled for the older person. Non-medical actions taken to comfort or reassure the older person, such as removing them from the distressing environment or engaging them in calming conversations, should also be documented.

Notifications must include details of how you as a provider managed the incident to minimise the risk of recurrence. This should encompass the steps taken to investigate the incident, identify contributing factors, and implement changes to reduce similar risks in the future. Examples of preventative actions might include revisions to care plans, updates to processes and procedures, additional training for workers, or adjustments to clinical governance practices. Clearly articulate the expected outcomes of these changes and describe how their effectiveness will be monitored over time.

Under the Standards, the Commission assesses the effectiveness of a provider's incident management system by evaluating how well it supports incident prevention, management, reporting, and resolution. Your ability as a provider to submit timely, comprehensive, and well-documented reportable incident notifications is an indicator of your system's adequacy.

5.2.1 Who must notify a reportable incident?

Anyone can raise concern about an incident

It is important to foster an environment where anyone with concerns about an incident or an older person's safety, health, or well-being feels encouraged to raise these concerns. In the first instance, older people should be directed to share their concerns directly with you as a provider. Creating a supportive and responsive culture ensures that issues are identified and addressed promptly.

Older people, their supporters, workers and others can raise concerns (either as feedback or complaints) to the Commission about a registered provider's, responsible person's or aged care worker's compliance with the Aged Care Act, or about a registered provider acting in a way that is incompatible with the Statement of Rights. Anyone can also give feedback or raise a concern with the Commission. However, it's important to note that for information to qualify for protections, the disclosure must meet specific requirements related to reportable incident notifications. See 5.3 Protections for those providing information or reports below.

Providers should ensure that clear information about how older people, their supporters, and workers to give feedback or lodge complaints to the Commission is readily available and accessible. Details about these processes can be found on the Commission's website, empowering older people to take action when needed while ensuring accountability and continuous improvement in care and service delivery.

Workers have responsibilities to internally notify incidents

Workers often play a critical role in identifying or suspecting that an older person has been involved in a reportable incident. They may become aware of an incident in various ways, such as witnessing an event, observing signs of potential abuse, harm, or discomfort, hearing a disclosure from an older person, or receiving information from another person.

Workers who become aware of a reportable incident must promptly notify one of the following:

- A responsible person of the organisation,
- Their supervisor or manager, or
- The designated person in the organisation responsible for notifying reportable incidents to the Commission.

It is your responsibility as a provider to ensure workers are trained to recognize, respond to, and report situations that may need notification to the Commission, the police, or both. Workers must understand the processes for identifying and escalating incidents, including their reportable incident responsibilities.

To achieve this, providers must educate workers on how to identify potential reportable incidents and the appropriate steps to take. This training should be part of a broader program covering the use of the provider's incident management system and all related processes. The program should ensure that workers can appropriately respond to all types of incidents, whether they are reportable or not, in compliance with aged care legislation.

Encouraging a culture where workers feel comfortable raising suspicions, concerns, or incidents is equally important. Such a culture fosters transparency and helps ensure prompt responses to incidents, which enables those affected to receive timely support and care.

Additionally, a well-trained workforce equipped to respond to incidents supports the ongoing review of processes and practices. This helps providers implement preventative strategies, maintain a safe and secure environment for both older people and workers, and continuously improve the quality and safety of aged care services delivered.

Providers have responsibilities to notify reportable incidents to the Commission

Providers must take all reasonable steps to ensure that reportable incidents are notified to the Commission. You must have responsible persons and workers who are registered users of any Departmental and Commission systems used to notify reportable incidents within the required timeframes.

It is essential for workers to understand who they should approach within the organisation to initiate any necessary notifications to the Commission without delay, and for a prompt and appropriate response.

Important considerations for your workers

Information about escalation processes should be integrated into the provider's incident management system and covered in regular training programs for workers. This ensures that all workers are equipped to handle incidents effectively, either by escalating them to the appropriate personnel or by directly reporting them to external authorities when necessary. A well-informed and supported workforce is vital for ensuring the safety and well-being of older people and maintaining a high standard of care and service delivery.

In the context of services in home or community settings, not all workers will have the skills to assess an incident's impact on an older person adequately. For example, workers providing gardening or domestic assistance often have limited interaction with the older person and may not

be equipped to determine the level of harm caused by an incident. To address this, providers must establish clear escalation processes. These processes should allow workers to escalate incidents to a manager or supervisor with the necessary skills to assess whether harm has occurred or could reasonably have been expected to occur.

Providers must also ensure that workers are aware of their right to report incidents directly to the police or the Commission if they feel uncomfortable reporting within the organisation. Workers should be assured that the law protects those who report suspicions or allegations of reportable incidents in good faith, shielding them from reprisal.

5.2.2 Making a notification

All notifications of reportable incidents must be lodged electronically using the designated approved form available to providers through the Department's My Aged Care Provider Portal.

Whenever the Portal is not available due to maintenance this will be advised on My Aged Care and providers must lodge reportable incident forms via a Commission SIRS Smartform that will be made available on our website at those times.

After submitting a reportable incident notification, you will receive an automatically generated email confirming receipt. This confirmation will include a reference number, which serves as a reference for any future communication regarding the incident.

If the Commission requests additional details about the incident, the notification number will be used to reference the specific case. When you provide missing, further, or significant new information after the initial notification, you must use the [Commission-approved forms](#) to ensure proper documentation and tracking.

By adhering to these submission processes and utilizing available resources, providers can ensure compliance with your reporting requirements while maintaining clear communication with the Commission.

The Department offers resources to assist providers in accessing and logging into the My Aged Care Provider Portal. These resources include fact sheets and guidance documents with instructions for portal functionality. This information can be found on both the My Aged Care website and the Department's website.

5.2.3 Information to be notified

When notifying the Commission of a reportable incident electronically through the My Aged Care Provider Portal or the Commission SIRS Smartform, you will be required to answer a range of specific questions about the incident. These questions cover all the essential details that must be included in your notification for the Commission to be assured that you are managing the incident and its impacts and controlling the risks effectively.

Make sure your reportable incident notification to the Commission includes as much detailed information as possible about:

- the circumstances of the incident
- how the incident affected the older person

- actions you have taken in response to the incident.

Providing clear and thorough information helps the Commission assess the situation effectively and ensures your response aligns with expectations and statutory requirements.

5.2.4 Notifying Priority 1 reportable incidents

Initial notification to the Commission

When you believe that a reportable incident qualifies as a Priority 1 reportable incident, you must notify the Aged Care Quality and Safety Commission within 24 hours of becoming aware of the incident. This initial notification is essential to assure us that your response to these incidents is prompt.

However, if all necessary information for the notification cannot be provided within the 24-hour timeframe, any missing required details must be submitted as soon as possible.

Submitting missing or further information

If submitting an initial notification for a Priority 1 reportable incident within the 24 hour timeframe, you can only provide the information available to you at the time.

In situations where required details are unavailable at the time of the initial notification, providers must supply the missing information to the Commission within **five (5) calendar days** of becoming aware of the incident. Alternatively, the Commission may set a different timeframe for submission of missing details and will notify you in writing if this occurs.

The Commission may request further details about your actions in response to the incident on a case-by-case basis. Such requests will specify the required information and the timeframe for submission.

It is your responsibility to ensure that all required information, whether missing from the initial notification or requested additionally by the Commission, is provided promptly.

If you are submitting additional information, whether it concerns missing details or further information requested by the Commission, you must use the [approved form](#) provided on the Commission's website.

5.2.5 Notifying Priority 2 reportable incidents

Notification requirements

Providers are required to notify the Aged Care Quality and Safety Commission of Priority 2 reportable incidents within 30 calendar days of becoming aware of the incident. This ensures sufficient time for you as a provider to gather all relevant information about a Priority 2 reportable incident before submitting a single, comprehensive notification.

Requests for further information

If the Commission requests additional information about a Priority 2 incident, you must respond promptly and provide the requested details. This process ensures the Commission has all the necessary data to assess the incident's impact and the adequacy of your response.

5.2.6 Significant new information

The Aged Care Rules at s165A-40 require that a provider must notify the Commission of any significant new information about a Priority 1 or Priority 2 reportable incident **as soon as reasonably practicable** after they become aware of it.

You should consider notifying the Commission of significant new information including where:

- the level of harm to an older person is more significant than your originally thought, such as:
 - an injury originally assessed to be minor bruising has now been determined to be a broken bone
 - the harassment of an older person that was originally reported to have caused no harm is later found to have caused a significant psychological injury
 - an older person later dies from injuries sustained from the incident.
- you later determined that the incident is also another kind of reportable incident, such as:
 - the incident was originally reported as neglect, although the neglect appears as though it may subsequently have led to the death of the older person, so it would now also be considered an unexpected death
 - the incident was originally reported as unreasonable use of force, although it is later found that there was also psychological or emotional abuse of the older person occurring at the same time.

In cases where significant new information regarding a Priority 1 or Priority 2 incident arises after the initial notification – for example, if an older person is hospitalized due to a reportable incident and later passes away, if the impact of the incident on the older person changes, or if any new relevant details come to light – these updates must be reported promptly using the [approved form on the Commission's website](#).

By adhering to these staged reporting processes, you ensure that the Commission has comprehensive and up-to-date information about how effectively you have managed the incident, controlled the risks, and made improvements to aid the prevention of future incidents.

5.2.7 Final report (if required)

Under s165A-45 of the Aged Care Rules, the Commission may require that you give a detailed report that includes specified information about a reportable incident.

If the Commission requires you to submit a final report for an incident, you must provide it within 84 calendar days (12 weeks) of when the initial notification about the incident was made, unless a different timeframe is specified by the Commission.

The report must be submitted in writing using the [Commission-approved form](#), and should include all details specified by the Commission in our request.

Your final report should as a minimum provide:

- a summary of your assessment and/or investigation of the incident
- your findings from the investigation
- any corrective actions taken in response to the incident.

This detailed final report ensures the Commission has a clear understanding of the incident and the steps you've taken to address it and prevent recurrence.

5.3 Protections for those providing information or reports

Registered providers must have a complaints and feedback system and also a whistleblower system. These critical systems support people to raise their concerns and provide information about suspected wrongdoing.

For the rights and protections available to a person making a qualifying disclosure, refer to [Managing Whistleblower Disclosures Policy](#).

5.4 Record keeping requirements

Under s154-150 of the Aged Care Rules, a provider must keep and retain the details recorded in relation to an incident in written or electronic form for 7 years starting on the day the record is made or received.

This refers to information within your incident management system about all incidents, and includes information about reportable incidents notified to the Commission via the SIRS.

5.5 Process for seeking exemption for a reportable incident to no longer be notified

As at section [2.2.2](#) above, under s165A-35 of the Aged Care Rules you may request that you are not required to give notice of a reportable incident (allegation), where the Commissioner can be satisfied that the same incident has been repeatedly alleged by an older person accessing care services to have occurred, and the allegation is the result of a delusion of the older person.

Below is information about the process for seeking such an exemption from reporting.

Criteria for exemption

The exemption applies when:

- The incident involves an older person diagnosed with dementia and experiencing delusions.
- The older person repeatedly reports the same event, which has been investigated and determined to be based on delusions.
- An initial notification of the incident has been submitted to the Commission.

Process for seeking determination

To request an exemption, you must provide sufficient evidence to the Commission that:

- A qualified health professional has assessed the older person.
- The professional has confirmed that the repeated allegations are due to a diagnosed cognitive impairment.

The Commission will consider:

- The nature and seriousness of the allegation.
- The frequency of the repeated allegations.

- Clinical evidence provided, including the qualifications and understanding of the health professional.
- The subject of the allegation.
- Actions taken to support the older person and prevent distress.
- Involvement of the older person's representative in managing and resolving the incident.

Requests for determination can be emailed to sirs@agedcarequality.gov.au with all necessary information.

Ongoing Obligations

Even if the Commission grants an exemption to not report future occurrences of the same incident (allegation):

- An initial notification must still be made.
- Any changes to the circumstances of the reportable incident in the initial notification must still be reported as a new incident (allegation).

Providers must always follow your incident management system obligations to protect the older person's wellbeing by assessing, managing, and recording the incident appropriately.

6. Common scenarios or issues providers may encounter

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

6.1 Situations that are not in the scope of the reportable incident types

Providers are not required to report to the Commission incidents which are not in the defined scope of one of the eight reportable incident types.

For example, **appropriate use of a restrictive practice** when documented in an older persons care plan, used in accordance with that plan and appropriately recorded all as per requirements is **not reportable** to the Commission via the SIRS. See [Inappropriate use of restrictive practices](#) reportable incident type above for further detail.

Also, it is not expected that providers report the following situations to the Commission via the SIRS:

- An older person discloses coercion by a family member or supporter to access their finances.
- An older person mentions their spouse's emotionally manipulative behaviour.
- An older person burns themselves preparing a meal.
- A worker notices bruises caused by an older person's fall while shopping with a family member or supporter.

- A worker observes rough handling or bullying of an older person by a family member or supporter.

These incidents should however be managed through a provider's incident management system.

6.2 Elder abuse

Workers in residential care homes and services delivered in home or community settings frequently develop close relationships with older people, enabling them to identify, suspect, or become aware of elder abuse. In some cases, older people may disclose incidents of abuse directly to workers.

The World Health Organization (WHO) defines elder abuse 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 may take various forms, including financial, physical, psychological, emotional, and sexual abuse, as well as neglect. Providers must recognise that no older person should experience abuse of any kind. Additionally, States and Territories may have specific legislation regarding elder abuse that providers need to comply with.

While reportable incident requirements ensure providers can prevent, manage, and report incidents that occur in connection with the aged care services they deliver, these do not extend to incidents of elder abuse that occur outside this scope.

Such incidents, while not reportable to the Commission, are unacceptable and must not be ignored. Providers have a duty to act in the best interests of the older person, offering support and connecting them with resources such as the Older Persons Advocacy Network (OPAN) or the free National Elder Abuse Helpline (1800 ELDERHelp or 1800 353 374).

If there is any suspicion of criminal activity, providers should immediately report the matter to the police, who are equipped to investigate such cases. Depending on the circumstances, incidents may also need to be reported to other authorities.

6.3 Work Health and Safety (WHS) Requirements

Providers have responsibilities under relevant State and Territory work health and safety (WHS) legislation to:

- Minimise risks and ensure a safe work environment for workers.
- Notify their WHS regulator of serious injuries, illnesses, and dangerous incidents that occur at work.

Additionally, an action under Quality Standard 2 Outcome 2 requires the governing body of registered providers to prioritise the safety, health and wellbeing of its aged care workers.

The requirements for incident notifications to state or territory bodies under WHS regulations differ from those for reportable incidents to the Commission via the SIRS. However, there may be situations where an incident in aged care must be reported to both the WHS regulator and the Commission.

While WHS reporting requirements vary between jurisdictions, the information required will be generally similar to the details needed for notifying reportable incidents to the Commission.

An effective incident management system supports continuous improvement in care delivery and helps maintain a safe and healthy workplace for workers. Maintaining an effective incident management system with detailed records of each incident connected to the provision of aged care services will assist you in meeting notification requirements for both WHS regulators and the Commission.

6.4 Where providers and older people (or their advocates) hold differing views

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 older person (and/or their supporters or representative) 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 older people from abuse and neglect and improving the delivery of aged care services. You should involve the older person in decisions about how the incident is managed and resolved, and respect their choices on matters that are theirs to decide. However, their wishes do not change whether an incident must be notified to the Commission. You should also seek to understand the older person's concerns and attempt to alleviate any concerns they may have.

The absence of an older person's consent is not a barrier to mandatory reporting and all reportable incidents must be notified to the Commission. Where the older person 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 older person 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 an older person or their representative believes that an incident should be notified and the provider holds a different view, older people and their advocates 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 noncompliance where appropriate).

6.5 Where multiple aged care providers are delivering care services

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

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

- the older person tells a worker of Provider A that a worker of Provider B hurt them while delivering care services, or
- the older person shows signs of being involved in a reportable incident related to the care services being delivered by Provider B but does not tell a worker of Provider A what happened, or
- a worker of Provider A witnesses a worker of Provider B verbally abusing the older person while delivering care services in the older person'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 that relate to care services delivered by the other provider 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 services into the future.

However, in providing quality care services you should also provide support to the older person to ensure their safety, health and wellbeing. You may also consider engaging with the older person's supporters, an older people's 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 services you are providing to an older person, 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 incident management system.

7. Resources

7.1 Legislation

This document is underpinned by:

- Latest [Aged Care Act 2024](#) and the [Originating Bill and Explanatory Memoranda](#)
- Latest [Aged Care Rules 2025](#) and the [Explanatory Statements](#)

7.2 Reference material

This guideline must be read in conjunction with and is supported by the following:

- Our [Regulatory Strategy](#)
- Our [Compliance and Enforcement Policy](#)
- The Commission's [Glossary](#)
- Relevant [resources for providers about reportable incidents](#) on the Commission's website
- [Open disclosure – rebuilding trust after something goes wrong](#) on the Commission's website



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