



# Strengthening protections for older Australians

**Development of models and options for a Serious Incident Response Scheme (SIRS) for Commonwealth funded aged care service providers**

Commonwealth Department of Health

February 2019



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### **Inherent Limitations**

This report has been prepared as outlined in the Scope Section. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the Commonwealth Department of Health or stakeholders consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

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## Scope of this report

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The Commonwealth Department of Health engaged KPMG to support development of models and options for a Serious Incident Response Scheme (SIRS) for Commonwealth funded aged care services providers.

This report presents policy options for the regulatory components of a SIRS.

This report has been prepared based on a rapid review of the relevant literature, analysis of the current arrangements in place in aged care, and stakeholder consultation to understand the likely impact of options for a SIRS.

A range of regulatory and non-regulatory options were canvassed in a consultation paper and through a consultation process with stakeholders. Consultation took place between 1 November and 6 December 2018 and included meetings and workshops with approximately 130 people who participated in the consultation process including representatives from aged care peak bodies, consumer representatives, state and territory ombudsman and regulatory authorities, aged care service providers including rural and remote providers, and a range of other government and non-government stakeholders. Appendix 6 outlines the stakeholder consultation process.

The policy options presented in this report take into account the views expressed by stakeholders and recommendations from a number of inquiries into the aged care system.

## Structure of this document

This paper has been organised into a number of parts:

- Part 1 provides an executive summary.
- Part 2 states some of the problems with the current arrangements and outlines the emerging evidence to support a new approach to serious incidents.
- Part 3 outlines the policy objectives for a SIRS.
- Part 4 provides a summary statement of the options.
- Part 5 discusses each option and its component parts.
- Part 6 covers a number of implementation, compliance, enforcement and evaluation strategies to support a SIRS.
- Part 7 outlines a high-level operating model for a SIRS.
- Appendix 1 provides a comparison of a SIRS with other serious incident reporting and response schemes and their enabling legislation and regulation.
- Appendix 2 outlines a number of case studies to show how aged care service providers can respond to familial abuse.
- Appendices 3-5 provide a cross-jurisdictional view of criminal laws that intersect with issues of abuse and neglect against consumers of aged care services.
- Appendix 6 describes the stakeholder consultation process to develop options.
- Appendix 7 includes a glossary of key terms.
- Appendix 8 outlines a number of recent inquiries and reports that were considered as part of developing options.

## Part 1: Executive summary

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Elder abuse in Australia has become more visible and its prevalence appears to be growing with estimates indicating that between two and 14 per cent of older people experience abuse.<sup>1</sup> A number of inquiries and reviews have highlighted examples of elder abuse, neglect and exploitation, particularly in residential aged care settings, and have made recommendations that have shaped the reform agenda in relation to the quality and safety of aged care services.

Existing provisions in the *Aged Care Act 1997* (the Act) require approved providers of residential aged care to report an allegation, or a suspicion, of a 'reportable assault' on a care recipient.<sup>2</sup> However, the Australian Law Reform Commission (ALRC) 2017 report, *Elder Abuse – a National Legal Response* (ALRC report) concluded that these current arrangements are ineffective and do not promote safe, quality care. In particular:

- The definition of 'reportable assault' may exclude certain serious incidents of abuse and neglect occurring in residential aged care.
- The exemption of resident-on-resident violence may not be effective in ensuring a violence and abuse-free environment for residents.
- The reportable assault obligations only apply to approved providers of residential aged care.
- There are no specific legislative requirements for the way providers need to respond to reportable assaults.
- Provider responses to reportable assaults are not adequately overseen.

Both the ALRC report and the Review of National Aged Care Quality Regulation Processes Report (the Carnell-Paterson Review) recommended that a new SIRS be implemented.<sup>3</sup> In response to this recommendation, the Australian Government announced in the 2018-19 Budget that it would develop options for a SIRS, in consultation with the aged care sector.

A number of policy options for the regulatory components of the proposed SIRS have been developed. The development of options has been informed by the following activities:

- Review of literature and other sources to identify models used in similar service systems, best practice models, and principles of effective schemes.
- Development of possible approaches and options for a SIRS, informed by the review of literature and work undertaken to date in recent reviews and inquiries.
- Consultation on options with key stakeholders in the aged care sector, and other stakeholders to identify benefits, risks and costs to consumers, providers, regulators and others.

In the consultation process, high level options for a SIRS were presented which have subsequently been further developed through policy and legal analysis.

### Proposal

The policy options developed for a SIRS are summarised below:

- **Option 1:** involves no change to the current arrangements.
- **Option 2:** involves developing guidance material to better enforce the current arrangements.
- **Option 3:** involves introducing a reportable conduct scheme which would require all aged care service providers to report abuse or neglect by a staff member against a consumer to the Aged Care Quality and Safety Commission (the Commission).
- **Option 4:** involves expanding Option 3 to include unexplained serious injury in residential aged care as a serious incident.

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<sup>1</sup> Australian Law Reform Commission, *Elder Abuse – A National Legal Response* (Commonwealth of Australia, Sydney, 2017).

<sup>2</sup> Section 63-1AA (2) and section 53 of the Accountability Principles 2014 (Cth).

<sup>3</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, October 2017, p 125; and Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, 14 June 2017, page 101.

- **Option 5:** involves expanding Option 3 to include aggression and abuse between consumers in residential aged care settings as a serious incident.

## Rationale

Despite there being a plethora of interventions designed to address elder abuse, there is limited research on elder abuse prevention and therefore evidence as to the efficacy of specific interventions.<sup>4</sup> However, there are a range of schemes within the health, aged care and human services sectors, covering a breadth and depth of incidents and abuse, which have been considered in developing the options in this paper. A summary of the benefits and risks for each option, including a summary of the evidence and stakeholder views on each option is summarised in Table 1 below.

*Table 1: Summary of evidence and consultation support for each option*

Key benefits and risks	
<b>Option 1</b>	Recent reviews have identified limitations with the current reportable assault arrangements. This option will not involve additional cost to government or regulatory burden to providers, however, this option does not address the limitations identified by these reviews. The vast majority of stakeholders through the consultation process did not support maintaining the status quo and supported changing the current arrangements.
<b>Option 2</b>	The introduction of guidance alone will not involve significant new cost to government or regulatory burden. Guidance is likely to support providers to identify and respond to serious incidents. However, this option does not address the limitations identified by recent reviews. Stakeholders through the consultation process to develop options did not support maintaining the status quo.
<b>Option 3</b>	Recent reviews supported the implementation of a SIRS that captures reportable conduct by staff members in all aged care settings. A review of other service systems shows that a number of reportable conduct schemes are in operation, including in the child protection and disability sectors. It does not appear there has been a systematic evaluation on the effectiveness of reportable conduct schemes, but emerging evidence indicates these schemes show some promise. The NSW Ombudsman's reportable conduct scheme for disability services reported that 91 per cent of matters notified had led to action to improve the support and circumstances of the person with a disability. Stakeholders through the consultation process widely supported this option. This option would also address a number of issues raised in recent inquiries and reviews, including shifting the emphasis from requiring providers to report an incident, to requiring an investigation and response.
<b>Option 4</b>	The ALRC report recommended the inclusion of unexplained serious injury in a SIRS. The ALRC report drew heavily on the NSW disability reportable incident scheme in defining the scope of incidents. The experience of NSW shows that a significant volume of incidents relating to clinical care and practice would likely be captured under this option. There is limited evidence to show that a regulatory scheme is the most effective way to respond to issues involving poor clinical practice and care, compared with other initiatives that are underway or that have been recommended to improve clinical care and practice in aged care. This is a complex issue and warrants further consideration and consultation with experts. Stakeholders through the consultation process also recognised this is a complex issue.
<b>Option 5</b>	The ALRC report recommended the inclusion of aggression and abuse between consumers in residential aged care as part of a SIRS. The ALRC report considered that, by reporting this type of abuse, it would ensure that the underlying cause was identified and that appropriate solutions were put in place. Relatively little is known about the nature and prevalence of this type of abuse in residential aged care. This issue is a complex one and warrants further consideration and consultation with experts. Stakeholders through the consultation process recognised this is a complex issue.

<sup>4</sup> Baker PRA et al, *Interventions for preventing abuse in the elderly*. (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.

## Timeframes

Due to the complexity of implementing substantial changes to the current arrangements (Options 3-5) and the reform context in which a SIRS will be implemented, it is proposed that a phased approach to implementation be taken. The timeframes for implementation are detailed at Table 6:

- **Set-up phase for a SIRS** (January 2019 – current): Develop policy proposal, including cost and regulatory burden and seek decision from Government.
- **Detailed analysis** (July – December 2020): Recruit a core establishment team, undertake detailed policy and legal analysis, and undertake consultations with the sector.
- **Implementation** (January 2020 to June 2021): Develop a detailed business and operating model, expand the core establishment team and undertake sector engagement and change management activities, including training and education.
- **Go live** (July to December 2022): ‘Go live’ date of 1 July 2022 for a SIRS and test, monitor and improve systems.

## Risks and sensitivities

There are a number of issues that will be important to consider in implementing the preferred option for a SIRS. Consultations were limited in their consideration of the regulatory burden of options on various stakeholders and the implementation requirements. Further policy and legal analysis, and consultation with key sector stakeholders is required in order to fully consider each of the below issues prior to implementation. Performance of a SIRS should be monitored throughout implementation to improve its effectiveness. A SIRS should also be evaluated at an appropriate point in time to assess its efficacy and build the available evidence base for such types of schemes.

Risk or sensitivity	Who is affected
Any substantial change to the current arrangements (Options 3 to 5) will require significant resourcing and investment to support the oversight function of the Commission. This includes costs to recruit the workforce to support the new functions within the Commission and build the capacity of providers to implement a scheme effectively.	Government, Providers
Options 3 to 5 will substantially increase the regulatory burden on providers to report and respond to serious incidents.	Providers
Legislative amendments will be required and will need to be considered in the context of existing Commonwealth and state and territory legislation.	Government
It is important to consider how a SIRS may be implemented within the broader reform context of the aged care system, including within the Commission.	Government
Appropriate IT infrastructure will be required to support reporting by providers, data collection by the Department or the Commission, and data analysis to identify patterns and trends. The IT infrastructure for a SIRS should be considered within the context of work underway to define IT for the Commission’s broader functions.	Government

## Part 2: Statement of the problem and emerging evidence

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Elder abuse in Australia has become more visible and its prevalence appears to be growing with estimates indicating that between two and 14 per cent of older people experience abuse.<sup>5</sup> A number of inquiries and reviews have highlighted examples of elder abuse, neglect and exploitation, particularly in residential aged care settings, and have made recommendations that have shaped the reform agenda in relation to the quality and safety of aged care services.

### Elder Abuse – a National Legal Response

The Australian Law Reform Commission (ALRC) 2017 report, *Elder Abuse – a National Legal Response* considered the current provisions of the Act in relation to elder abuse. It noted that under the current definitions, the definition of reportable assaults which are subject to mandatory reporting is limited and, in turn, many incidences of elder abuse are not reported as they do not come under the assault definition in the Act. Further, when an assault is reported to the Department of Health (the Department), there is no obligation on a provider to report actions it has taken or to ensure the person who has been assaulted receives appropriate care, counselling and support.

The ALRC report concluded that the current mandatory reporting arrangements are ineffective and do not promote safe, quality care.<sup>6</sup> As a result, it recommended:

- The introduction of a SIRS to address concerns regarding the abuse of elders in residential aged care and to extend the SIRS to cover all types of aged care including home care and flexible care.
- The Act be amended to require mandatory reporting of any serious incident, expanding the current definition of what constitutes a serious incident.
- Aged care providers be required to report the outcome of the investigation and any action taken in response.<sup>7</sup>

### Review of National Aged Care Quality Regulatory Processes (Carnell-Paterson Review)

The Review of National Aged Care Quality Regulatory Processes (the Carnell-Paterson Review) suggests that the primary purpose of quality regulation is consumer protection.<sup>8</sup> In turn, it highlights that as part of its safety oversight role, the Commonwealth can help protect consumers of aged care services through requiring reporting of serious incidents. While acknowledging the role that accreditation plays in setting expectations of providers that there are systems in place for the identification, recording and reporting of incidents, the Review also identified limitations in the current approach. These include, but are not limited to, the narrow definitions of a serious incident and that there is no responsibility placed on the provider other than to report the assault. This in turn leaves a gap in relation to whether a response is made as a consequence of the incident, and whether the response is adequate to ensure the safety of the older person and ensure similar incidents do not occur.

Ultimately, the ALRC report and the Carnell-Paterson Review both recommended that a SIRS be implemented, and that replacing the current statutory scheme with a new reportable incidents scheme would contribute to a strengthened legal framework and allow the provider to take a proportionate, considered response to the incident.<sup>9</sup>

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<sup>5</sup> Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, (Commonwealth of Australia, Sydney, 2017).

<sup>6</sup> *ibid.*

<sup>7</sup> *ibid.*

<sup>8</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulatory Processes Report*, October 2017.

<sup>9</sup> *ibid.*



## 2.1 Statement of the problem

### **The scope of the current arrangements is narrow in comparison to the range of Commonwealth funded aged care services available.**

Current arrangements apply to reportable assaults within a residential aged care setting. However, this only represents 21 per cent of older people who currently receive Commonwealth funded aged care.<sup>10</sup> A range of other Commonwealth funded aged care services are not included in these arrangements. This means there may be serious incidents occurring in other care settings that are not visible to an oversight body.

With the increased emphasis on providing care in the home, it is appropriate for incidents that occur outside of residential aged care and in connection with the delivery of care services by aged care providers to be reportable and for providers to demonstrate they have responded to an incident. Introducing a SIRS for home and flexible care would strengthen the legal obligation of providers in these programs to take a considered response to serious incidents. It would also provide greater visibility over the prevalence of serious incidents across the entire aged care system, which will assist with identifying systemic risk and designing whole-of-system prevention strategies. This also aligns with the Government's commitment to create a single aged care quality framework for all aged care services.

### **The scope of incidents reportable under current arrangements may exclude certain serious incidents from being reported.**

Under the Act, an approved provider of residential aged care is required to report an allegation, or a suspicion, of a 'reportable assault' on a consumer. However this may exclude certain serious incidents of abuse and neglect occurring in residential aged care, including physical or financial abuse, sexual abuse (noting that sexual assault is currently reportable), cruel treatment, unexplained serious injury, or an incident that is part of a pattern of abuse. Violence between care recipients in residential care is also exempt from being reported in certain circumstances. This means there may be serious incidents occurring in residential aged care that are not being reported through current arrangements and therefore over which the Department does not have visibility.

Expanding the scope of what constitutes a serious incident under a SIRS would ensure all incidents of a serious nature are reported and therefore visible by an oversight body. It would also strengthen the legislative obligations on providers to take an appropriate and considered response to all incidents of a serious nature, and therefore reduce risk for all consumers receiving Commonwealth funded aged care.

### **The level of reporting required under current arrangements is limited to information gathered and actions taken within 24 hours of a serious incident occurring.**

Providers are currently required to notify the Department of a reportable assault within 24 hours of an incident occurring. While these arrangements provide the Department with timely notification of a serious incident, there is no reporting requirement that captures the subsequent actions taken. This means there is limited visibility of the entirety of a response or the outcomes of that response.

Extending reporting requirements to a subsequent report following initial notification would allow providers to demonstrate that a considered response to an allegation was taken. It would also enable an oversight body to sufficiently assess whether an appropriate response was taken.

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<sup>10</sup> Australian Institute of Health and Welfare (AIHW), *2017-2018 Report on the Operation of the Aged Care Act 1997* (Commonwealth of Australia as represented by the Department of Health 2018).

**There is lack of clarity around pathways for all key stakeholders to report concerns about incidents affecting older people.**

An effective quality and safety scheme has appropriate channels to report concerns by all key stakeholders involved in the delivery of aged care services. While there were channels available through the Aged Care Complaints Commissioner and the Australian Aged Care Quality Agency (now transitioned to the Commission), there is a lack of clarity around pathways for all key stakeholders to report concerns about incidents affecting older people.

In the context of introducing a SIRS and the introduction of the Commission, there is an opportunity to strengthen the visibility and accessibility of these channels so that all key stakeholders have an appropriate avenue to raise concerns.

**There is a lack of clarity amongst some providers about how to respond to serious incidents.**

Residential aged care providers are required to report an allegation, or a suspicion, of a ‘reportable assault’ on a consumer. Under the Aged Care Quality Standards, providers are also required to have effective risk management systems and practices for identifying and responding to abuse and neglect of consumers.<sup>11</sup> However, stakeholders consulted stated there is a lack of clarity amongst some providers about the nature and scope of responses required to serious incidents beyond reporting to an oversight body, including when it is appropriate to engage other stakeholders such as the police, adult safeguarding bodies and professional registration authorities. This may mean not all consumers receive a consistent, appropriate or adequate response when a serious incident occurs.

A SIRS could provide further guidance to providers in relation to responses that are guided by best practice. This would improve the overall capability of providers to respond effectively and consistently to serious incidents.

**There is limited opportunity under current oversight arrangements to assess the adequacy of responses and identify risks in the system.**

The Department receives notifications from residential aged care providers on reportable assaults and publishes data on the number of notifications made. The Department is able to consider information received about reportable assaults as part of its regulatory functions, for example in managing provider compliance. However, the information received by the Department is limited to information gathered and actions taken within 24 hours of a serious incident occurring. This means the Department does not have adequate oversight of the entirety of responses by providers and the outcomes of those responses. This limits the ability of the Department to adequately identify risks across the system and publicly report on serious incidents.

The oversight arrangements of a SIRS could be strengthened to ensure providers report and respond to serious incidents in certain ways, for example by overseeing the way in which providers manage and respond to serious incidents. There are also opportunities with other quality and safety functions transitioning to a new Commission to analyse serious incident reports and data to identify patterns and trends across the system, and to better target capacity building efforts to increase compliance.

## **2.2 Evidence of established practice in other service systems**

The information contained in this report draws on existing and proposed schemes in other health, ageing and human services systems and the evidence-base about what is known to be effective in responding to serious incidents.

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<sup>11</sup> Standard 8.3(d)(ii).

In the health, aged care and human services sectors, a serious incident – also called a ‘critical incident’ in some systems and jurisdictions – refers to an event which threatens the safety of people or property.

In the aged care system, one of the most important relationships is that between consumers and providers of aged care services. The capacity and capability of providers is therefore a critical safeguard.

A quality provider will have strong governance, policies and procedures, and a corporate culture that fosters respect and openness. Providers should respect and value feedback from consumers of aged care services and others and use this feedback to improve and innovate.

Planning for and managing serious incidents is an important element in managing the quality and safety for services within the health, aged care and human services sectors. Serious incident response systems are critical where providers of aged care services are offering services where such incidents could injure or harm consumers, staff, family, carers, the community or the provider. Providers should have appropriate procedures for managing serious incidents, including reporting, as required.

## 2.3 Emerging evidence from the literature

The information contained in this report draws on emerging evidence related to best practice models of SIRS (or similar schemes) in aged care and other related settings.

A rapid review of the literature was undertaken to identify the types of models used in aged care and other related settings, as well as to understand the relative effectiveness of these models. It also identified best practice models of SIRS, and principles of effective schemes that may form the basis of a scheme in aged care.

A series of research questions were identified to guide the research. Search tools used include PubMed, Google, Google Scholar and JSTOR. The review considered both peer reviewed and grey literature from the last five years within Australia and international jurisdictions and within the sectors of aged care, health, disability and child protection.

### 2.3.1 Results of the literature review

There are a range of systems and schemes that are used to identify and respond to abuse or serious incidents in health and human services. These schemes sit within a broader safeguarding framework that is designed to ensure the safety of a specific cohort of the population. The effectiveness of any of these schemes is dependent on their interface with other quality and safety functions of these systems. The ALRC report recommended a system of safeguards to improve the quality and safety of aged care services. The intersection of these recommendations will be important to consider in implementing any of the options proposed in this paper.

Table 2 compares some of the key components of the current reportable assaults scheme with a number of comparable schemes in other jurisdictions.

Table 2: Key components of comparable schemes

Key component of a SIRS	Aged Care reportable assaults scheme	NDIS Commission reportable incidents scheme	NSW Ombudsman Part 3A reportable conduct scheme	NSW Ombudsman Part 3C reportable incidents scheme	NSW Health Clinical Incident Management	UK Care Quality Commission
<b>Definition of reportable incidents</b>	<b>Yes</b> The definition is clearly defined in the Act. Some resident-on-resident assaults are reported. The current scheme is for consumers in residential aged care facilities only.	<b>Yes</b> The National Disability Insurance Scheme (NDIS) has clearly defined the matters which must be reported under the NDIS Act and Rules. A SIRS requires that any incident which occurs 'in connection with' a NDIS service be reported. It is anticipated that this would be broader than incidents committed by staff. A SIRS requires that any incident which occurs 'in connection with' a NDIS service be reported. It is anticipated that this will not be restricted to residential aged care facilities.	<b>Yes</b> The definition is clearly defined in the Ombudsman Act NSW. The NSW Ombudsman's child protections jurisdiction, is limited to incidents and convictions related to employees of in-scope agencies. A SIRS is not restricted to a certain kind of setting.	<b>Yes</b> The definition is clearly defined in the Ombudsman Act NSW. The NSW Ombudsman Disability jurisdiction also covers resident- on-resident incidents. The NSW Ombudsman disability scheme is restricted to consumers in supported group accommodation.	<b>Yes</b> All incidents must be reported and then are rated under the Severity Assessment Code (SAC) rating system. The Clinical Excellence Commission reviews a wide range of incidents, and these are not restricted to matters involving staff. The Clinical Excellence Commission reviews incidents that have occurred in health and hospital settings.	<b>Yes</b> There is a wide variety of reportable incidents. The Commission reviews a wide range of incidents, and these are not restricted to matters involving staff. The Commission's jurisdiction is wide ranging.
<b>Independent Oversight</b>	<b>No</b> The Department does not oversee or monitor provider's handling of serious incidents, although matters may be referred.	<b>Yes</b> The NDIS Commission has an independent oversight role.	<b>Yes</b> The NSW Ombudsman has an independent oversight role.	<b>Yes</b> The NSW Ombudsman has an independent oversight role.	<b>Yes</b> The Clinical Excellence Commission reviews clinical incidents and investigation reports for SAC 1s.	<b>Yes</b> The Commission conducts a number of oversight activities, such as monitoring.
<b>Conducting investigations</b>	<b>No</b> The Department does not conduct their own investigations into serious incidents, although matters may be referred.	<b>Yes</b> The NDIS Commission conducts investigations into reportable incidents.	<b>Yes</b> The NSW Ombudsman has the ability to conduct own motion investigations.	<b>Yes</b> The NSW Ombudsman has the ability to conduct own motion investigations.	<b>Yes</b> The Clinical Excellence Commission reviews clinical incidents and investigation reports, and may conduct their own investigative activities.	<b>Partial</b> The Commission conducts inspections of providers, and can then take enforcement action from this.
<b>Enforcement Powers (such as the ability to issue compliance notices and sanctions)</b>	<b>Yes</b> The Department currently has the ability to take enforcement action under the Act.	<b>Yes</b> The NDIS Commission has a variety of enforcement powers available.	<b>No</b> The NSW Ombudsman has an advisory and educative role.	<b>No</b> The NSW Ombudsman has an advisory and educative role.	<b>No</b> The Clinical Excellence Commission has an advisory and educative role.	<b>Yes</b> The UK Commission has a variety of enforcement powers available.

Specifically, for protections for older people, a conceptual overview of the system is shown in the diagram below (refer Figure 1). A SIRS for aged care would be an element within a broader system of safeguards to increase the detection rate of abuse through legislative reporting.

Figure 1: Conceptual overview of a system to prevent elder abuse

Education programs	Aimed at increasing professional awareness of elder abuse and how to recognise and respond to it
Legislation	Includes mandatory reporting legislation and adult protection statutes
Programs to increase detection rate	This may include monitoring or screening programs and hotlines to report abuse
Programs for victims	Includes services such as protective services, counselling, emergency shelters and other programs designed to support victims of abuse
Programs to reduce factors influencing elder abuse	This includes a broad range of programs that address key risk-factors for elder abuse, such as initiatives to reduce poverty and social exclusion
Specific policies for older people	These policies are intended to strengthen and improve elderly welfare and decrease dependency, such as through welfare assistance, employment policies or financial policies
Rehabilitation programs	This incorporates a range of programs for the perpetrator including counselling, psychiatric intervention and legal assistance

Source: Adapted from Baker, Philip RA, Francis, Daniel P, Hairi, Noran N, Othman, Sajaratulnisah, & Choo, Wan Yuen, *Interventions for preventing abuse in the elderly (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.*

Despite there being a plethora of interventions designed to address elder abuse as shown above, there is limited research on elder abuse prevention and therefore evidence as to the efficacy of specific interventions.<sup>12</sup> This means that while some interventions are being implemented, there is limited high quality evidence to support decision making on a scheme or a system to implement. The *National Plan to Respond to the Abuse of Older Australians [Elder Abuse] 2019-2023* being developed by the Attorney-General's Department in consultation with states and territories and key stakeholders will set the strategic direction for a national response to prevent and respond to elder abuse, as well as setting the research agenda for building an evidence base.

A review of the evidence and current schemes in health and human services showed that these schemes are wide-ranging in nature. They cover a breadth and depth of incidents and abuse that is reportable and who is able to report into these schemes. These schemes can be broadly categorised into the following types:

- Reportable conduct schemes.
- Serious incident management schemes.

<sup>12</sup> Baker PRA et al, *Interventions for preventing abuse in the elderly.* (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.

- Mandatory reporting schemes.

Each of these types of schemes are discussed below.

### 2.3.2 Reportable conduct schemes

Reportable conduct schemes are concerned with the conduct of staff in relation to the services they deliver. They generally have a focus on incidents of abuse directed toward the service's consumers. In practice, identification of reportable conduct requires an identifier to notify appropriate regulatory bodies. Thorough investigation and inquiry into the substance of the claim follows, at which point appropriate service/governing bodies are consulted and subsequent action taken.

Within disability and child protection sectors, a number of reportable conduct schemes across state and territory jurisdictions are in operation. An established history in implementing schemes is illustrated in NSW by the NSW Ombudsman through the Disability Reportable Incidents Scheme and a reportable allegations and convictions child protection scheme. On a national level, in the early childhood sector, the Education and Care Services National Law obliges relevant institutions to report complaints and serious incidents to the relevant regulatory authority.

#### 2.3.2.1 Definition of a serious incident

The definition of a serious incident is a critical factor in a SIRS, as setting parameters and scope for what constitutes a serious incident determines what is required to be reported. Lack of clarity on the definition of a reportable incident has a number of impacts. This includes difficulty for staff in identifying an incident of abuse and correctly categorising the incident for reporting purposes, which can result in under-reporting.<sup>13,14</sup> For example, in a report undertaken by the Victorian Ombudsman, the meaning of 'neglect' was found to be the most poorly understood type of incident, particularly consequences of neglect on consumers.<sup>15</sup>

Further, where the threshold for a reportable incident is set too low (e.g. it captures routine matters that reflect complex client needs and service delivery contexts rather than only the most serious incidents), a disproportionate amount of time is consumed, both for providers in reporting and in the administration of a reportable conduct scheme.<sup>16</sup> A reportable conduct scheme should reflect primary emphasis on significant harm or risk of harm.<sup>17,18</sup>

#### 2.3.2.2 Effectiveness of reportable conduct schemes

Although a number of reviews<sup>19</sup> examining quality and safety aspects of reportable conduct schemes have been published, evidence as to the effectiveness of schemes is limited. This highlights a need for further research into the effectiveness of reportable conduct schemes and what therefore constitutes best practice in a SIRS or similar scheme.

Effectiveness of a reporting scheme within a home care service context, e.g. Home Care Packages (HCP) or Commonwealth Home Support Programme (CHSP), was questioned in recent reviews. In a

<sup>13</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>14</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final report* (Parliament of Victoria, May 2016).

<sup>15</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>16</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight* (Victorian government, June 2015) P.P. No. 49.

<sup>17</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final report* (Parliament of Victoria, May 2016).

<sup>18</sup> Care Quality Commission, *Learning from Serious Incidents in NHS Acute Hospitals* (Care Quality Commission, June 2016).

<sup>19</sup> See for example: Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.; Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight* (Victorian government, June 2015) P.P. No. 49.; Professor Leanne Dowse *Issues in recognising, reporting and responding to client to client reportable incidents under the NSW Ombudsman Disability Reportable Incidents Scheme* (Ombudsman NSW, November 2016).

home environment, consumers are likely to be alone with support workers. If abuse was to occur by the worker, the consumer may be hesitant make a report to their provider for a range of reasons and the worker in question is unlikely to report the allegation of abuse for which they are the subject.<sup>20</sup> An important enabler in this context will be the empowerment of consumers (and their families/carers) to report abuse to their provider.

Notwithstanding the limited evidence as to the effectiveness of reportable conduct schemes, reviews highlighted a range of issues and learnings that are relevant for consideration when developing a SIRS for Commonwealth funded aged care services. These are discussed in the following section.

### 2.3.2.3 Reporting, responses and oversight of reportable conduct

Understanding the foundations upon which reporting processes are built is fundamental to developing an effective reportable conduct scheme. Key learnings and criticisms of these processes include:

- Failure of paper-based reporting schemes to capture information beyond a point-in-time. Paper-based schemes requiring handwritten notes and manual input into a central system are resource intensive and are at risk of misinterpretation errors.<sup>21</sup>
- Any form or system used for reporting needs to be able capture a two-way flow of information in order to record subsequent actions in response to an incident and any recommendations or follow-up actions the oversight body sends to the provider.<sup>22</sup>
- Reporting forms need to capture contextual information and allow for adequate explanation of the incident, as opposed to a series of standard tick boxes, and for the voice of the client to be highlighted.<sup>23</sup>
- The quality of reports received within a scheme can be variable. Variation in reporting quality can be reflective of provider organisational capacity (including their ability to access and provide relevant data and to undertake an investigation), the ability of an organisation/reporting staff member to be objective (noting there is a risk of conflict of interest), staff awareness of procedures and information required, and the literacy of staff to make reports.<sup>24,25</sup> The quality of reports is critical to ensuring the right response and level of scrutiny is applied by the oversight body.<sup>26</sup>
- Structured guidance on how and when to make a report according to the relevant threshold is valued by potential reporters to ensure that reports are only made when required, reduce false positives and reduce excess demand on the oversight body.<sup>27</sup> It also provides a common language for users to discuss and understand risks to the vulnerable person.<sup>28</sup>
- Use of an online portal was recommended to address many of the short-comings highlighted above.<sup>29,30</sup>
- An immediate or within one-day reporting timeframe was noted to be appropriate given the seriousness of incidents reported, however, it was highlighted that this timeframe does not allow sufficient time for the provider to confirm what actions have been/will be taken in immediate

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<sup>20</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>21</sup> *ibid.*

<sup>22</sup> *ibid.*

<sup>23</sup> *ibid.*

<sup>24</sup> Professor Leanne Dowse *Issues in recognising, reporting and responding to client to client reportable incidents under the NSW Ombudsman Disability Reportable Incidents Scheme* (Ombudsman NSW, November 2016).

<sup>25</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>26</sup> *ibid.*

<sup>27</sup> UNSW Social Policy Research Centre (2014) *Keep Them Safe Outcomes Evaluation Final Report*, p 51.

<sup>28</sup> UNSW Social Policy Research Centre (2014) *Keep Them Safe Outcomes Evaluation Final Report*, p 83.

<sup>29</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>30</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

response and what further follow-up actions may be taken.<sup>31</sup> The value of this information is important in relation to on-going client needs and lessons for the future.

Oversight bodies play a multifaceted role in a reporting scheme, in overseeing individual reports and responses and also in playing a broader leadership role in identifying trends and lessons at a sector-wide level. An oversight body needs to have clear jurisdiction, powers and independence to effectively manage a reportable incident scheme.<sup>32</sup>

Lessons identified in other schemes in relation to the functions of an oversight body include the following:

- A single oversight body is preferable that includes, in addition to incident reporting, functions related to complaints management to streamline systems for consumers and providers and to better address issues related to quality and safety.<sup>33</sup>
- A key role for an oversight body is to undertake data analysis to inform the sector and policy and promote transparency. Limited reporting to the oversight body does not allow for analysis of data to be undertaken to inform education and prevention strategies.<sup>34</sup>
- A core function of the oversight body is to ensure timely and effective responses are taken to address client safety and wellbeing. This means that the oversight body should also provide constructive feedback to service providers on their response to incidents to enable learning.<sup>35,36,37</sup> This may also include providing specific recommendations to be implemented in response to an incident.<sup>38</sup>
- In order to reduce workload for the oversight body, as providers increase in competency in responding to incidents, the oversight body can enter into agreements which exempt the provider from notifying incidents deemed less serious. This allows a greater focus on supporting providers in the most serious cases.<sup>39</sup>
- Where oversight bodies provide guidance about reporting thresholds, guidance should be provided to reporters on how to support and assist vulnerable people who do not meet the reporting threshold, but for whom the reporter nevertheless has concerns about the safety or wellbeing.<sup>40</sup> Providers would still be required to meet their obligations under the Aged Care Quality Standards in relation to the incident.
- Where investigation by the oversight body may be considered there needs to be a clear framework that articulates the purpose and process of the investigation, who undertakes it and how a client is supported through the process.<sup>41</sup>
- Reporting to an oversight body should not replace reporting to police or other agencies who should be informed of specific incidents so they can take appropriate action. Rather, reporting to

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<sup>31</sup> *ibid.*

<sup>32</sup> *ibid.*

<sup>33</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>34</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight* (Victorian government, June 2015) P.P. No. 49.

<sup>35</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>36</sup> Brunsveld-Reinders, Anja H., et al. *Incident and error reporting systems in intensive care: a systematic review of the literature*, (International Journal for Quality in Health Care 2015) 28.1 pp 2-13.

<sup>37</sup> Christine Heron, *Hidden in plain sight: inquiry into disability-related harassment* (Local Government Information Unit Policy Briefing, September 2011) pp -5.

<sup>38</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>39</sup> NSW Ombudsman, *Strengthening the oversight of workplace child abuse allegations. A special report to Parliament under s. 31 of the Ombudsman Act 1974* (NSW Ombudsman, February 2016).

<sup>40</sup> UNSW Social Policy Research Centre (2014) *Keep Them Safe Outcomes Evaluation Final Report*, p 78.

<sup>41</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.



an oversight body should provide an additional level of security and safeguarding and should ensure that providers are fulfilling their obligations in this respect.<sup>42,43</sup>

#### 2.3.2.4 Enabling factors

In addition to the elements of a serious incident response scheme described above, there are a number of enabling factors that may improve the overall effectiveness of such schemes. Enablers include:

- A person-centred focus to ensure that processes and responses are in the best interests of the affected individual/s and focus on improving outcomes for consumers.<sup>44</sup> In addition, responses to an incident should be determined by the harm or risk of harm caused to the individual rather than determined by the nature of abuse or vulnerability of the victim.<sup>45</sup>
- Appropriate supports for affected individuals through investigations and legal processes.<sup>46,47</sup>
- Education and training for staff/providers in both identifying incidents of abuse and the correct procedures and processes to follow once suspected or identified.<sup>48,49,50</sup>
- A positive reporting culture that empowers staff (and consumers) to report incidents rather than a fear of consequences should they report on a staff member.<sup>51,52,53</sup>

#### 2.3.3 Serious incident management systems

Serious incident management systems are most commonly found in the health sector, with the introduction of mandatory incident management systems in all Australian hospitals in 2005.<sup>54</sup> Serious incident management systems aim to improve patient and/or consumer safety and in the aviation industry have been shown to produce long-term quality improvements. Serious incident management systems are often underpinned by principles such as a 'no blame' culture and open disclosure principles and emphasise learning.

Systems are well-structured and have clear guidelines which outline what action is required in response to a particular incident. Generally, the response required is determined by a rating of the incident. For example, in Victoria the rating of an incident is determined by an algorithm based on degree of impact, level of care and treatment required. Each rating then has a series of expected responses the health service must undertake, including timeframes. The most serious of incidents are expected to be investigated to determine the root cause analysis, with other varying levels of investigation required for less serious incidents.<sup>55</sup> For example, in NSW, the NSW Health clinical incident management system requires a root cause analysis and a mandatory report of SAC 1

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<sup>42</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>43</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>44</sup> *ibid.*

<sup>45</sup> *ibid.*

<sup>46</sup> *ibid.*

<sup>47</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>48</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>49</sup> Sengstock, M and Marshall, B, *Adult Protective Services Workers Assess the Effectiveness of Mandatory Reporting of Elder Maltreatment in Michigan* (Journal of Applied Social Sciences 2013). Vol 2, issue 2 pp 220-231.

<sup>50</sup> Care Quality Commission, *Sexual Safety on Mental Health Wards* (September 2018).

<sup>51</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>52</sup> Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting* (Victorian government, December 2015) P.P. No. 125.

<sup>53</sup> Cooper, Jennifer, et al. *Nature of blame in patient safety incident reports: mixed methods analysis of a national database* (15.5 The Annals of Family Medicine, 2017) pp 455-461.

<sup>54</sup> Milbank, Q., *How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review*, (December 2015).

<sup>55</sup> Victorian Department of Health and Human Services, *Client incident management guide* (Department of Health and Human Services, 2017).

incidents to the Ministry of Health within 24 hours of an incident being notified through the Incident Information Management System (IIMS).<sup>56</sup>

Evidence shows that the sheer volume of incidents reported in healthcare organisations means that most incidents receive only a superficial investigation with very few serious incidents subject to the gold standard root cause analysis.<sup>57</sup> Under-reporting of incidents was also identified as a limitation of these systems as they do not truly reflect the frequency of incidents.<sup>58, 59</sup> Evidence instead shows that the number of incidents reported through incident management systems can be more reflective of the willingness of staff to report, rather than the safety of a system.<sup>60</sup> Furthermore the intended learning and quality of care outcomes of reporting systems often fail to materialise due to the administrative burden.<sup>61</sup> In the United States, it was found that there was an unexpected large volume of incident reports and insufficient resources to deal with this volume, which led to inadequate triaging, analysis and action on reports.<sup>62</sup>

There is, however, evidence which suggests that a culture of reporting improves safety outcomes. Incident reporting is perceived to have a positive effect on safety, and can lead to an increased safety culture, and awareness of risks.<sup>63</sup> A positive reporting culture, which supports and encourages people to 'speak up', and where staff and management consider incident reporting an integral part of providing a quality service, is a key aspect of building broader 'protective' or 'safeguarding' cultures in service providers.<sup>64, 65, 66, 67, 68</sup> Incident reporting can lead to 'single-loop learning changes' such as corrections to policies and procedures or improvements to techniques.<sup>69</sup>

Effective feedback is essential to learn from errors, which includes feeding back to the reporter, rapid response, raising risk awareness among all staff, informing staff of actions taken, and improving work systems safety.<sup>70</sup>

A core outcome of these systems is that they provide a broader perspective on trends, incidents and learning beyond a provider level. For example, the Victorian Department of Health and Human Services undertakes state-wide analysis of incidents to share lessons across the state. Their analysis provides an opportunity to learn from patterns of client incidents to maintain client safety and improve service quality. Data captured includes trends in the volume and type of clinical incidents, key risk

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<sup>56</sup> Clinical Excellence Commission, *Incident Management Policy* (NSW Health, 2014).

<sup>57</sup> Thomas, Matthew, et al., *Mapping the limits of safety reporting systems in health care-what lessons can we actually learn?* (194 Medical Journal of Australia, 2011) pp 635-639.

<sup>58</sup> Westbrook, Johanna, et. al., *What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system?* (*Int J Qual Health Care*, 2012) 27(1):1-9.

<sup>59</sup> Milbank, Q., *How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review*, (December 2015).

<sup>60</sup> *ibid.*

<sup>61</sup> Anya H. Brunsveld-Reinders et al, *Incident and error reporting systems in intensive care: a systematic review of the literature* (28.1 International Journal for Quality in Health Care 2015) pp 2-13.

<sup>62</sup> Mitchell, Imogen, et al. *Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human'*. (2016) 25.2 *BMJ Quality and Safety*, pp 92-99.

<sup>63</sup> Anderson et al *Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting* (International Journal for Quality in Health Care 2013), vol 25, issue 2.

<sup>64</sup> Disability Services Commissioner, *Safeguarding People's Rights to be Free from Abuse Learning from Complaints Occasional Paper No. 1*, (2012) p 14.

<sup>65</sup> Flemons, W. Ward, and Glenn McRae. *Reporting, learning and the culture of safety* (2012) 15 *Healthcare Quarterly* pp 12-17.

<sup>66</sup> Brunsveld-Reinders, Anja H., et al. *Incident and error reporting systems in intensive care: a systematic review of the literature.* (28.1 International Journal for Quality in Health Care 2015) pp 2-13.

<sup>67</sup> Cooper, Jennifer, et al. *Nature of blame in patient safety incident reports: mixed methods analysis of a national database*, (15.5 *The Annals of Family Medicine* 2017) pp 455-461.

<sup>68</sup> W. Ward Flemons and Glenn McRae, *'Reporting, learning and the culture of safety'* (2012) 15 *Healthcare Quarterly* pp 12-17.

<sup>69</sup> Milbank, Q. (*How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review*, (December 2015).

<sup>70</sup> Brunsveld-Reinders, Anja H., et al. *Incident and error reporting systems in intensive care: a systematic review of the literature* (28.1 International Journal for Quality in Health Care 2015) pp 2-13.

areas, and how this information can be used to impact policy, practice, case management, improve service quality and prevent future incidents.<sup>71</sup>

A number of studies have identified that incident management systems are more effective when combined with other quality and safety improvement initiatives and should therefore complement, rather than replace, other practices used to review and improve practice.<sup>72</sup>

### 2.3.4 Mandatory reporting schemes

Mandatory reporting schemes refer to a system that requires individuals (or organisations) to make a report (usually to a government agency) where abuse is suspected to have occurred against someone in a specified cohort of the population; for example mandatory reporting of child abuse is common in Australian states and territories. These schemes are the broadest in nature as they encompass a large range of people who are 'mandated notifiers' (usually based on a person's occupation or contact with the cohort covered by scheme) and require reporting of all abuse for any perpetrator of that abuse (e.g. parent/guardian, family, teacher, worker who delivers a service, etc.). For example, in Victoria if a mandated notifier suspects abuse of a child, this must be reported to Victorian Child Protection. Further, all adults in Victoria are required to report any 'reasonable belief that a sexual offence has been committed in Victoria by an adult against a child under 16 years of age' to the police or face a criminal offence.<sup>73</sup>

Mandatory reporting was found to be a common theme across the sectors examined. Evidence as to the efficacy of mandatory reporting is mixed, however mandatory reporting in areas such as health, child safety and disability are well-established within Australian and international law.

In the Australian health sector, all registered practitioners, education providers and employers that form a reasonable belief that a registered practitioner has engaged in notifiable conduct has a mandatory reporting obligation under the Health Practitioner Regulation National Law to the Australian Health Practitioner Regulation Agency. The threshold for reporting to the regulatory agency is a reasonable belief and the report must be made as soon as practicable. Any practitioner who fails to report may be subject to performance action.<sup>74</sup>

Evidence shows that the introduction of mandatory reporting has increased the level of reporting and identification of at-risk persons in the child safety sector, which has in turn increased the number of investigations conducted into abuse.<sup>75,76</sup> Mandatory reporting of elder abuse is based on the strategies of the child safety system. However, in practice, (would be) reporters of elder abuse do not always have the skills, knowledge and education to be able to recognise, identify and report elder abuse.<sup>77,78,79</sup> Furthermore, there is evidence of additional barriers faced by mandatory reporters, such

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<sup>71</sup> Victorian Department of Health and Human Services, *Client incident management guide* (Department of Health and Human Services, 2017).

<sup>72</sup> Milbank, Q. *How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review*, (December 2015).

<sup>73</sup> Department of Health and Human Services Victoria (2018), [Reporting Child Abuse](#), (accessed 19 November 2018).

<sup>74</sup> Health Practitioner Regulation National Law Act 2009.

<sup>75</sup> Mathews et al, *Impact of a new mandatory reporting law on reporting and identification of child sexual abuse: A seven year time trend analysis* (Child Abuse & Neglect 2016) Vol 56, pp 62-79.

<sup>76</sup> Ben Mathews, Xing Ju Lee, and Rosana E. Norman, *Impact of a new mandatory reporting law on reporting and identification of child sexual abuse: a seven year time trend analysis* (Child abuse & neglect 2016), Vol. 56, pp 62.

<sup>77</sup> Sengstock, M and Marshall, B, 'Adult Protective Services Workers Assess the Effectiveness of Mandatory Reporting of Elder Maltreatment in Michigan' (2013) Journal of Applied Social Sciences. Vol 2, issue 2 pp 220-231.

<sup>78</sup> Care Quality Commission, *Sexual Safety on Mental Health Wards* (September 2018).

<sup>79</sup> Mary C. Sengstock and Brenda I. Marshall, *Adult Protective Services workers assess the effectiveness of mandatory reporting of elder maltreatment in Michigan* (Journal of Applied Social Science 2013) vol. 7.2 p 220.

as confidentiality concerns, and the possible paradox of perverse outcomes for the elder involved that hinder reporting.<sup>80,81</sup>

Historically, when discussing the topic of mandatory reporting for elder abuse, consumers of aged care services have indicated that they want to be able to make decisions for themselves in cases of abuse, and are not wholly supportive of the idea of mandatory reporting.<sup>82,83</sup> This is similar to the discussion surrounding mandatory reporting of abuse broadly within the adult disability sector, where again there is tension around an individual's right to choose whether to take action in response to abuse.<sup>84</sup> Mandatory reporting is also common internationally. For example, in the US, a broad range of people (based on their occupation and contact with older people) are mandated notifiers for elder abuse.<sup>85</sup> It is also worth noting that many states in the US have an Adult Protective Service that responds to elder abuse in the community. Even though mandatory reporting is common and longstanding in the US, there is still a large question mark as to the efficacy of mandatory reporting.<sup>86</sup>

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<sup>80</sup> *ibid.*

<sup>81</sup> Michael A. Rodríguez et al, *Mandatory reporting of elder abuse: Between a rock and a hard place* (The Annals of Family Medicine 2006) Vol. 4.5 pp 403-409.

<sup>82</sup> Kurrle, Susan, and Gerard Naughtin. *An overview of elder abuse and neglect in Australia*, (Journal of elder abuse & neglect 2008): 20, no. 2 pp 108-125.

<sup>83</sup> Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses*, (Melbourne: Australian Institute of Family Studies.2015).

<sup>84</sup> Family and Community Development Committee, *Inquiry into abuse in disability services: Final Report* (Parliament of Victoria, May 2016).

<sup>85</sup> Baker PRA et al,) *Interventions for preventing abuse in the elderly*. (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.

<sup>86</sup> *ibid.*

## Part 3: Policy objectives

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The Australian Government is committed to high quality care for older Australians and considers the health, safety and welfare of aged care recipients a high priority. As part of reforms to the aged care system, the government is developing an end-to-end, market-based system with the sector where the consumer drives quality.<sup>87</sup>

The policy objectives of the options outlined in this report are to:

- Help protect and safeguard older people from the risk of abuse and neglect by providers of aged care services in a way that promotes the autonomy of older people.
- Strengthen provider accountability for their responses to serious incidents to address the safety, health and well-being of consumers of aged care services.
- Respond to serious incidents in a proportionate and transparent manner.
- Promote the psychological wellbeing of consumers by ensuring a prompt apology is enacted as soon as practical in line with the open disclosure policy.
- Promote the use of open disclosure as one means of responding to serious incidents.
- Complement, not duplicate, existing reporting and response requirements, for example options outlined in this report are not intended to replace reporting criminal matters to police who are best placed to investigate matters of a criminal nature.
- Improve the ability of the Commission to identify and respond to failures in delivering quality aged care to older Australians.
- Improve the ability of providers and the Commission to understand the causes of serious incidents and prevent them from occurring in the future.
- Enhance the continuous improvement of providers through identifying opportunities to improve quality and safety of care.
- Support risk-profiling of aged care service providers to inform monitoring and compliance functions of the Commission.
- Replace the current responsibilities in relation to reportable assaults in the Act.

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<sup>87</sup> Australian Government, Department of Health, Ageing and Aged Care, *Single quality framework: focus on consumers*, visited at <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers>.

## Part 4: Statement of options

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Five policy options for the regulatory components of the proposed SIRS have been developed. The development of options has been informed by the following activities:

- Review of literature and other sources to identify models used in similar service systems, best practice models, and principles of effective schemes.
- Development of possible approaches and options for a SIRS, informed by the review of literature and work undertaken to date in recent reviews and inquiries.
- Consultation on options with key stakeholders in the aged care sector, and other stakeholders to identify benefits, risks and costs to consumers, providers, regulators and others.

In developing the options proposed, the following key areas of a SIRS were considered:

- Whose conduct should be reportable and who should provide reports.
- What conduct should be reportable.
- What reports should be provided and when and what responses should be required to reportable conduct by staff members.
- What roles and functions should the Commission have.

An outline of the options developed is provided below.

Option 1 involves no change to the current arrangements.

Option 2 involves developing guidance material to better enforce the current arrangements.

Option 3 involves introducing a new reportable conduct scheme for aged care services.

*Whose conduct should be reportable and who should provide reports?*

- The Commission should independently oversee how service providers notify, investigate and respond to reportable conduct.
- The reportable conduct scheme should apply to all Commonwealth funded aged care service providers to ensure that abuse or neglect by a staff member against a consumer is reported no matter the type of aged care service being provided.
- Definition of a 'staff member' should mean any individual who is employed, hired, retained or contracted by the service provider directly or indirectly to provide care or other services.
- Service providers should notify the Commission of any reportable allegation, suspicion, conduct or conviction involving a staff member against a consumer of which the service provider becomes aware.
- Service providers should notify appropriate police, adult safeguarding and professional registration authorities of relevant reportable conduct by a staff member.
- Service providers should be able to disclose information about a staff member involved in reportable conduct to safeguard a consumer.
- Service providers should encourage staff members to make notifications of reportable conduct and there should be protections such as whistle-blower provisions for staff members who make reports in good faith.
- Any person who becomes aware of reportable conduct should be able to make a notification to the relevant service provider or the Commission.
- Failure to report penalties have not been included as part of this option as it is not known whether this measure will persuade or dissuade service providers from making reports. However, it is noted that the regulator will still have discretion to progress serious non-compliance.
- Public reporting requirements by service providers have not been included as part of this option as it is not known whether this measure will persuade or dissuade service providers from making reports.

- Mandatory reporting by service providers of broader incidents of elder abuse has not been included as part of this option as this issue is complex and requires further consideration.

*What conduct should be reportable?*

- Reportable conduct should be defined to mean abuse and neglect by a staff member against a consumer.
- Reporting exemptions to release service providers from notifying the Commission of 'trivial or negligible' incidents have not been included as part of this option as abuse and neglect by staff members against consumers is always a serious matter.
- Abuse by consumers against staff members should not be defined as reportable conduct but should be dealt with by providers as a work health and safety (WHS) issue through compliance with existing WHS laws.

*What reports should be provided and when and what responses should be required to reportable conduct by staff members?*

- Service providers should make an incident notification to the Commission as soon as practicable after becoming aware of reportable conduct by a staff member.
- Service providers should make an incident report to the Commission within 28 days of the incident notification. Alternatively, this could be determined by the Commission based on the risk the incident has or continues to pose to care recipients.
- Service providers should collect data and keep appropriate records to enable administration of the reportable conduct scheme.
- Service providers should identify, manage and resolve serious incidents, including reportable conduct by a staff member, in line with specific guidance which the Commission should be required to develop.
- Express legislative requirements for service providers to investigate every instance of reportable conduct has not been included as part of this option as the nature and type of any investigation will depend on the circumstances of each case.

*What roles and functions should the Commission have?*

- The appropriate powers to keep under scrutiny<sup>88</sup> the systems providers have in place to prevent staff members from engaging in reportable conduct, including by auditing service providers.
- The appropriate powers to oversee and monitor how providers investigate and handle reportable conduct.
- The appropriate powers to, on its own initiative, conduct an investigation of reportable conduct.
- The appropriate powers to make recommendations to a service provider for action to be taken.
- The appropriate powers to exempt certain conduct from being reportable by agreement with services providers if the Commission is satisfied the exemption would not increase the risk of harm to consumers.
- The appropriate powers to undertake capacity building and practice development in relation to responses by service providers to reportable conduct.
- The appropriate powers for information sharing to enable the prevention and early detection of abuse and the safety of consumers.
- The appropriate powers to support interaction with the criminal justice system and police.
- The appropriate powers to make public reports and be required to publicly report on an annual basis on the operation and effectiveness of the reportable conduct scheme.
- The appropriate powers to cause a periodic independent review of the operation of the reportable conduct scheme at least every five years or more frequently.

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<sup>88</sup> The NSW Ombudsman has an oversight function – in relation to the NSW reportable conduct scheme for child protection services – to 'keep under scrutiny' the systems that providers have in place for preventing staff members from engaging in reportable conduct. One way the NSW Ombudsman fulfils this responsibility is by auditing providers of children's services procedures and providing recommendations to help providers improve their systems and practices.

- The Commission should consult on the establishment of a Register to provide a centralised record of persons involved in reportable conduct and consider how the Register could interact with other registration and pre-employment screening systems.

Option 4 involves expanding Option 3 to include unexplained serious injury in residential aged care as a serious incident that should be reported to the Commission.

Option 5 involves expanding Option 3 to include aggression and abuse between consumers in residential aged care settings as a serious incident that should be reported to the Commission.



## Part 5: Impact assessment of options

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### 5.1 Option 1 – No change

#### 5.1.1 *Whose conduct should be reportable and who should provide reports?*

This option involves no change to the current arrangements. In terms of whose conduct should be reportable and who should provide reports, under the current system, only approved providers are required to report certain allegations of abuse with respect to residential aged care consumers. Non-residential aged care providers – home care, flexible care and other Commonwealth funded aged care services – are not in scope of the current reportable assaults scheme. The Department oversees reports under the current scheme. Providers are required to report abuse by staff members against consumers and abuse by a consumer against another consumer with an exemption from reporting outlined in section 5.5.2. The definition of ‘staff member’ includes any person engaged by the provider to deliver care or other services.

#### 5.1.2 *What conduct should be reportable?*

‘Reportable assaults’ are defined as ‘unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory’.

Incidents between aged care recipients in residential care are exempt from reporting, where the resident alleged to have committed the offending conduct has a pre-diagnosed cognitive impairment, provided the approved provider implements arrangements to manage the person’s behaviour within 24 hours.

#### 5.1.3 *What reports should be provided and when? And what responses should be required to reportable conduct by staff members?*

An approved provider must report an allegation, or a suspicion on reasonable grounds, of a ‘reportable assault’ on a consumer to police and the Department within 24 hours.

The reportable assault provision places no responsibility on the provider other than to report an allegation or suspicion of an assault. The *Records Principles 2014* (Cth) require providers to keep records of reportable assaults, containing:

- The date when the approved provider received the allegation, or started to suspect on reasonable grounds, that a reportable assault had occurred.
- A brief description of the allegation or the circumstances that gave rise to the suspicion.
- Information about whether a report has been made to a police officer and the Department; or whether no report has been made because the resident-on-resident exemption applies.

No obligation is placed on the provider to record any actions taken in response to an incident. There are no specific requirements under the current reportable assaults scheme arrangements for providers to identify, manage or resolve assaults in a particular way.

#### 5.1.4 *What roles and functions should the Commission have?*

The Commission will assume responsibility of the reportable assaults function and the regulatory functions within the Department, for example managing provider compliance, from 1 January 2020.

The Department’s submission to the ALRC Elder Abuse Inquiry stated that it ‘may take regulatory action if an approved provider does not ... have strategies in place to reduce the risk of the situation

from occurring again'.<sup>89</sup> However, current powers are limited to the broader regulatory avenues available through managing broader provider compliance, rather than specific to reportable assaults. For example, the Department does not have the power to investigate reportable assaults. In addition, the Department does not maintain a register of staff members who have been found to have been involved in reportable assaults and there is limited systematic oversight of how providers handle investigations into reportable assaults.

### 5.1.5 Benefits and impact

In 2017-2018, there were 4,013 notifications of 'reportable assaults'.<sup>90</sup> This represents an incidence of reports of suspected or alleged assaults of 1.6 per cent of people receiving permanent residential care during that period. Of the 3,773 required to be reported under the Act, 3,226 were recorded as alleged or suspected unreasonable use of force, 513 as alleged or suspected unlawful sexual contact, and 34 as both.<sup>91</sup> There is little publicly available information available beyond these figures. As Leading Age Services Australia (LASA) commented to the ALRC Elder Abuse Inquiry, little is known about the outcome of reports, whether the allegations were found to have had substance, what local actions were put in place, and if any convictions occurred as a result of police action.<sup>92</sup>

Most stakeholders that participated in the ALRC Elder Abuse Inquiry were critical of the existing scheme. Aged and Community Services Australia (ACSA) called for a review of the reportable assaults requirement, arguing that 'there is little evidence that the reporting requirement to the Australian Department of Health has been effective'. LASA echoed this criticism, submitting that 'it could be contended that those requirements have made little or no difference to the safety of residents ... [They] appear to only support red tape and bureaucratic processes, rather than promote safe quality care'.<sup>93</sup>

The ALRC heard conflicting reports about any subsequent actions taken by the provider or the Department following the making of a report. However, the ALRC Elder Abuse Inquiry found there is no further publicly available information regarding how the Department makes an assessment about the suitability of any strategies implemented by the provider.

UnitingCare Australia submitted to the ALRC Elder Abuse Inquiry that the 'process of making a report does not in itself trigger any actions and that it is up to providers to implement processes to address risks and negotiate solutions'.<sup>94</sup>

By contrast, LASA submitted to the ALRC Elder Abuse Inquiry that the Department did become involved in oversight of provider response to reportable assaults and stated that:

When an investigation occurs at the local level the Departmental Officers often require a full report on what actions are taken, and their outcome. This can lead to involvement by the [Australian Aged Care Quality Agency] and or the Complaints Commissioner and compliance action by the [Department of Health].<sup>95</sup>

The Carnell-Paterson Review acknowledged the existing legal requirements for quality and safety in aged care including the reportable assaults scheme but commented that the current safeguards are not sufficiently robust to provide adequate safeguards for residents who may have been subject to abuse and neglect. The Carnell-Paterson Review commented that the events at Oakden indicate the current system is not sufficient to safeguard residents who may be subject to abuse and neglect.<sup>96</sup>

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<sup>89</sup> ALRC, *Elder Abuse - Submission 113* (Department of Health August 2018).

<sup>90</sup> Department of Health, *2017-18 Report on the Operation of the Aged Care Act 1997* (Commonwealth of Australia, 2018).

<sup>91</sup> *ibid.*

<sup>92</sup> Australian Law Reform Commission, *Elder abuse – A National Legal Response*, (Commonwealth of Australia, Sydney, 2017).

<sup>93</sup> *ibid.*

<sup>94</sup> *ibid.*

<sup>95</sup> *ibid.*

<sup>96</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017) p 111.

The main benefit of this option is that it involves no regulatory burden or additional cost to government. However, this option is unlikely to address the concerns identified by recent inquiries and reports.

#### *5.1.6 Stakeholder support for this option*

The vast majority of stakeholders through the consultation process to develop options did not support maintaining the status quo. Stakeholders supported changing the current arrangements.

## 5.2 Option 2 – Development of guidance material to better enforce the current arrangements

This option involves better enforcement of the current arrangements but no new legislative or regulatory requirements in relation to provider reporting or responses to serious incidents. This would include development of best practice guidelines for all providers on managing incidents including internal risk management systems. This guidance should cover:

- Acts, omissions, events or circumstances that occur in connection with providing aged care services to a consumer and which have, or could have, caused harm to the consumer including clinical incidents.
- Acts by a consumer that occur in connection with providing aged care services to a consumer and which have caused serious harm, or a risk of serious harm, to another person.
- Abusive or neglectful conduct by staff members.

Specific guidelines should set out – in line with requirements under the Aged Care Quality Standards – the expected procedures to be followed by providers in identifying, managing and responding to incidents. This guidance could also cover effective responses to clinical incidents that cause, or are likely to cause, serious injury to aged consumers based on best practice. This would also involve some basic education activities to support providers to apply best practice.

### 5.2.1 Benefits and impact

Guidance could support providers to understand the different types of serious incidents, incident management, how to address any immediate safety issues affecting aged care consumers, reporting and liaison with police, and how providers should investigate serious incidents. Guidance could also increase awareness of what might constitute an effective response.

The main benefit of this option is that it involves modest additional cost to government and low regulatory burden on approved providers. However, this option is unlikely to address the concerns identified by recent inquiries and reports. This option provides flexibility to the oversight body on determining the thresholds for serious incidents and how providers should respond to serious incidents. The oversight body, namely the Commission, could then use its administration of the Aged Care Quality Standards as a regulatory lever in the event of unsatisfactory provider performance for this matter.<sup>97</sup>

### 5.2.2 Stakeholder support for this option

The vast majority of stakeholders consulted did not support maintaining the status quo with better enforcement of the current arrangements. Stakeholders supported introducing new legislative and regulatory requirements for responses to serious incidents.

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<sup>97</sup> That is, the Commission could publicly report the provider's non-compliance with Standard 3.3(b) and 8.3(d). Until July 2020, it could then be open to the Department to commence compliance action against the provider in relation to this non-compliance against these standards.

## 5.3 Option 3 – Reportable conduct scheme for aged care service providers

### 5.3.1 *The Aged Care Quality and Safety Commission should independently oversee how service providers notify, investigate and respond to reportable conduct*

The vast majority of stakeholders through the consultation process to develop options commented that the Commission should provide this oversight.

### 5.3.2 *Whose conduct should be reportable and who should provide reports?*

#### 5.3.2.1 *Reportable conduct scheme should apply to all Government-subsidised aged care service providers to ensure that abuse or neglect by a staff member against a consumer is reported no matter the type of aged care service being provided*

Regulation and oversight for the reportable conduct scheme should be consistent, balanced and proportionate to the risk to the consumer and avoid placing unnecessary or excessive regulatory burden on aged care providers and government.

The Aged Care Quality Standards will – as of 1 July 2019 – apply to all Commonwealth funded aged care providers, including providers of residential aged care, home care, care funded through the CHSP and flexible care.

The Aged Care Quality Standards focus on quality outcomes for consumers. This will make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. These quality and safety measures recognise the high degree of responsibility providers exercise in relation to aged care recipients. These measures place a high priority on the health, safety and well-being of aged care recipients.

The vast majority of stakeholders through the consultation process to develop options commented that the reportable conduct scheme should apply to all Commonwealth funded aged care service providers including non-residential aged care services including home care. This is consistent with the ALRC's recommendations to expand the scope of reporting to include non-residential aged care services. Stakeholder support for extending this oversight to home care was on the basis that abusive or neglectful conduct by a staff members against a consumer should be reportable no matter the type of aged care service being provided. Some stakeholders also raised the need to ensure that an equitable level of protection is provided to all consumers of aged care services, no matter the type of aged care service. Abuse or neglect by staff members in non-residential care services is not currently reported under the existing reportable assaults scheme and so the exact nature and type of incidents occurring are not known, nor is the scope of incidents across home care and flexible care. The inclusion of these non-residential care services in the scope of the reportable conduct scheme is likely to improve understanding about prevalence and help to inform prevention strategies. The new Aged Care Quality Standards will apply from 1 July 2019 across aged care services and the extension of the reportable conduct scheme to all service types would be consistent with the scope of the new standards.

Like the Aged Care Quality Standards, the reportable conduct scheme should apply to service providers through appropriate legislative or contractual arrangements. Further detailed policy and legal analysis is required to determine the exact nature of the most appropriate arrangements for the different types of aged care service providers. Table 3 below outlines the instruments that apply the Aged Care Quality Standards to different types of aged care service providers.

Table 3: Aged Care Quality Standards apply to all service providers through legislative and contractual instruments

Type of service provider	Instrument to apply the Aged Care Quality Standards
<b>Residential Aged Care and Short-term Restorative Care (STRC) in a residential care setting.</b>	Provisions of the Aged Care (Single Quality Framework) Reform Act 2018 (SQF Act), which commence on 1 July 2019, amend the responsibilities of providers of residential aged care and providers of STRC in a residential care setting under the <i>Aged Care Act 1997</i> (the Act) to require them to comply with the Aged Care Quality Standards (in place of the Accreditation Standards).
<b>Home Care and STRC in a home care setting.</b>	Provisions of the SQF Act also amend the responsibilities of providers of Home Care and providers of STRC in a home care setting under the Aged Care Act to require them to comply with the Aged Care Quality Standards (in place of the Home Care Standards).
<b>Commonwealth Home Support Programme (CHSP)</b>	The Commonwealth Home Support Programme Manual (2018) requires CHSP providers to comply with the new Aged Care Quality Standards and notes "New aged care quality standards and changes to the current quality assessment process are being developed and service providers will be required to meet the new Aged Care Quality Standards and participate in the new quality assessment process, once introduced." The Manual outlines the operational requirements of the CHSP and forms part of their CHSP Grant Agreement. The Commonwealth Home Support Programme Guidelines (April 2018) require CHSP providers to adhere to a set of quality standards, in accordance with their grant agreement with the Department. The Guidelines are designed to be read in conjunction with the CHSP service provider's grant agreement.
<b>National Aboriginal and Torres Strait Islanders Flexible Aged Care Program (NATSIFACP)</b>	Service providers funded under the NATSIFACP operate outside of the <i>Aged Care Act 1997</i> (Cth) and are required to enter into a Funding Agreement with the Commonwealth which sets out the conditions of funding. The conditions of funding include meeting operational requirements outlined in the NATSIFACP Program Manual 2018. This manual includes a statement that from 1 July 2019, service providers will be required to comply with the Aged Care Quality Standards (that will replace the National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework Standards).
<b>Transition Care</b>	Under the Transition Care Programme Guidelines 2015 (Guidelines), transition care service provision must comply with the Guidelines and Transition Care Program Quality Improvement Framework (that includes the Transition Care Programme Quality Standards) and external health or aged care accreditation standards and review processes. The Guidelines will be updated so that they are consistent with, or align with, the Aged Care Quality Standards, rather than just refer to them.
<b>Multi-Purpose Services (MPS)</b>	Under the National Quality Improvement Framework for MPS, that forms part of the payment agreement between the Commonwealth, State and Territory Governments and service providers, MPS have to provide a level of quality care consistent with community expectations, and in a manner consistent with the aged care standards where appropriate.

5.3.2.2 *Definition of a 'staff member' should mean any individual who is employed, hired, retained or contracted by the service provider, directly or indirectly, to provide care or other services*

The reportable conduct scheme should define a 'staff member' to mean any individual who is employed, hired, retained or contracted by the service provider, directly or indirectly, to provide care or other services.

This definition of 'staff member' is consistent with the current definition under the existing reportable assaults scheme and the ALRC Elder Abuse Inquiry recommendations.<sup>98</sup> Similar to the Police Certificate Guidelines, where approved providers are required to ensure volunteers undergo police

<sup>98</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, Recommendation 4-6, page 125, para 4.108. (Commonwealth of Australia 2017).

checks, the scope of whose conduct is reportable should include volunteers as well.<sup>99</sup> This definition is consistent with evidence that reportable conduct schemes should include conduct by any individual engaged by a provider to deliver services, whether or not they are a paid employee.<sup>100</sup>

Stakeholders through the consultation process to develop options commented on the need for a broad definition of a staff member.

### 5.3.2.3 *Service providers should notify the Commission of any reportable allegation, suspicion, conduct or conviction involving a staff member against a consumer of which the service provider becomes aware*

The reportable conduct scheme should require service providers to notify the Commission of any reportable allegation, suspicion, conduct or conviction involving a staff member against a consumer of which the service provider becomes aware. This is consistent with recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse (Child Abuse Royal Commission) that service providers should be required to notify the relevant oversight body of allegations, actual conduct and convictions.<sup>101</sup> The scope of reportable conduct is proposed to be abuse and neglect by a staff member against a consumer. This is discussed further at section 5.3.3 of this paper.

In comparing this to other schemes, the NSW reportable conduct scheme for child protection services defines a reportable allegation as ‘an allegation of reportable conduct against a person or an allegation of misconduct that may involve reportable conduct.’<sup>102</sup> The equivalent scheme in the ACT defines a reportable allegation as ‘an express assertion that reportable conduct has happened.’<sup>103</sup> The equivalent scheme in Victoria defines a reportable allegation as ‘any information that leads a person to form a reasonable belief’ that a staff member has committed reportable conduct or committed misconduct that may involve reportable conduct’.<sup>104</sup> The Child Abuse Royal Commission commented that ‘a reasonable belief requirement’ – such as in the Victorian scheme – may unnecessarily imply that a service provider needs to conduct its own inquiries before the obligation to report arises.<sup>105</sup>

Service providers may become aware of reportable conduct that is happening now, has occurred very recently or has occurred in the past. The requirement for service providers to notify the Commission of reportable conduct should be based on the point in time when the service provider actually becomes aware of a suspicion, allegation, conduct or conviction not based on the time the reportable conduct event occurred. If a service provider is aware of reportable conduct then it must report the conduct to the Commission. This is consistent with findings from the Child Abuse Royal Commission which recommended that state and territory reportable conduct schemes require service providers to make a notification about all reportable conduct by staff members irrespective of the point in time the reportable conduct event occurred. This is also consistent with the NSW reportable conduct scheme for child protection services where there is no time limit on when the relevant conduct occurred by a staff member. Service providers are required to make a notification about any reportable conduct involving a staff member of which the service provider becomes aware.<sup>106</sup>

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<sup>99</sup> Department of Health, Police Certificate Guidelines (March 2017), [https://agedcare.health.gov.au/sites/default/files/documents/04\\_2017/police\\_certificate\\_guidelines\\_april\\_2017.pdf](https://agedcare.health.gov.au/sites/default/files/documents/04_2017/police_certificate_guidelines_april_2017.pdf).

<sup>100</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* (Commonwealth of Australia 2017). Volume 7, p 270.

<sup>101</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* Recommendation 7.9. (Commonwealth of Australia 2017). Volume 7, p 24.

<sup>102</sup> *Ombudsman Act 1974* (NSW) s 25A(1), see definition of ‘reportable allegation’.

<sup>103</sup> *Ombudsman Act 1989* (ACT) s 17D(1), see definition of ‘reportable allegation’.

<sup>104</sup> *Child Wellbeing and Safety Act 2005* (Vic) s 3(1).

<sup>105</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* Volume 7 p 268 (Commonwealth of Australia 2017).

<sup>106</sup> *Ombudsman Act 1974* (NSW) s 25C(1)(a).

Stakeholders commented that service providers should be required to notify the Commission if the service provider receives an allegation or suspects that a staff member has been involved in reportable conduct.

#### 5.3.2.4 *Service providers should notify appropriate police, adult safeguarding and professional registration authorities of relevant reportable conduct by a staff member*

Service providers should notify state and territory police authorities of any reportable conduct that involves a criminal aspect. The rationale is that where it involves a crime, the police should be advised as they are the entity responsible for responding to crime. This is consistent with the current requirement to report conduct to police under the existing reportable assaults scheme. The Commission should provide clear policy guidance about reporting to police authorities and how service providers should work with police including when there are police investigations.

The ALRC did not recommend that service providers be required to notify police of all reportable conduct. In part, this was due to the expanded scope of the definition of reportable conduct proposed by the ALRC. It also reflects an approach that requires a service provider to turn its mind to the response required in the circumstances. Some criminal laws already require service providers to report suspicions of offences to police.<sup>107</sup> The reportable conduct scheme will not affect police reporting obligations by service providers under state and territory criminal laws. The requirement for service providers to notify police if and when conduct involves a criminal aspect is consistent with the intent of ALRC recommendations to require a service provider to consider the most appropriate response on a case-by-case basis.

Service providers should notify state and territory adult safeguarding authorities of any reportable conduct that involves an aspect of elder abuse and neglect that could be dealt with by those authorities. The rationale is that reportable conduct is serious and may involve an elder abuse and neglect aspect that should be reported to, and considered by, adult safeguarding authorities. The Commission should provide clear policy guidance about reporting to adult safeguarding authorities and how service providers should work with these authorities. Implementation of this component would also require consultation with the relevant state and territory safeguarding authorities to define pathways and roles and responsibilities.

On 14 November 2018, new laws to establish Australia's first Adult Safeguarding Unit were passed in South Australia. The NSW Government also recently announced that it will introduce a new Ageing and Disability Commissioner<sup>108</sup>, following the NSW Ombudsman's recommendation to establish an adult safeguarding authority in NSW.<sup>109</sup> Other state and territory jurisdictions are considering options to establish similar agencies to protect vulnerable adults, who, despite having full decision-making capacity, are experiencing abuse or neglect.

Service providers should notify any applicable professional registration authorities of reportable conduct that involves an aspect of professional misconduct by the staff member involved. The rationale is that reportable conduct is serious and may involve an aspect of professional misconduct that should be reported to and considered by an applicable professional registration authority.

Stakeholders through the consultation process commented that information about the conduct of a staff member should be shared with relevant authorities.

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<sup>107</sup> For example *Crimes Act 1900* (NSW), s 316.

<sup>108</sup> Family & Community Services, 'Ageing and Disability Commissioner', <https://www.facs.nsw.gov.au/inclusion/disability/ageing-and-disability-commissioner>, accessed 16 January 2019.

<sup>109</sup> NSW Ombudsman, *Abuse and neglect of vulnerable adults in NSW – the need for action* (State of New South Wales, 2018).



#### 5.3.2.5 *Service providers should be able to disclose information about a staff member involved in reportable conduct to safeguard a consumer*

The reportable conduct scheme should allow service providers to disclose information about a staff member involved in reportable conduct to safeguard a consumer, including to the Commission, police, adult safeguarding authorities, professional registration authorities and other authorities. This is consistent with the ALRC Elder Abuse Inquiry recommendations.<sup>110</sup>

The rationale is that service providers should have a clear basis for disclosing information to relevant authorities in relation to reportable conduct by a staff member in a way that is lawful.

Stakeholders through the consultation process commented on the need to ensure that service providers are able to disclose information to safeguard consumers.

#### 5.3.2.6 *Service providers should encourage staff members to make notifications of reportable conduct and there should be protections such as whistle-blower provisions for staff members who make reports in good faith*

The reportable conduct scheme should require service providers to encourage staff members to make notifications of reportable conduct and there should be protections such as whistle-blower provisions for staff members who make reports in good faith.

Protections should ensure that staff members are not victimised, informants' identities are protected, and that people who make notifications are shielded from civil and criminal liability and from reprisals or other detrimental action as a result of making the notification. For example, the NSW reportable conduct scheme for child protection services protects staff members who disclose information to the NSW Ombudsman from civil liability.<sup>111</sup> Under the NSW scheme, it is also an offence for an employer to dismiss or prejudice any staff member on account of the staff member assisting the NSW Ombudsman.<sup>112</sup> Similar provisions exist in the equivalent Victorian and ACT schemes.<sup>113</sup>

It is important to note that some protections exist already, for example Parts 3-1 of Chapter 3 of the *Fair Work Australia Act 2009* (Cth) allows a person to seek relief from injury and/or discrimination in employment or dismissal arising out of an employer's breach of a workplace right under a workplace law or instrument. A person has a workplace right if they are entitled to make a complaint or inquiry to a person having the capacity under a workplace law or instrument to seek compliance with that law.

The rationale is to encourage reporting and a culture committed to the reportable conduct scheme. These provisions are likely to encourage staff members to come forward and report information.

A staff member will, in most cases, notify their employing service provider of a reportable conduct allegation, however, there may be cases where a staff member makes a report directly to the Commission. For example, a staff member may not want to make a report using a provider's incident management system if the key personnel is the subject of the reportable conduct allegation. Similarly, if the key personnel of the provider has a close personal relationship with the subject of the reportable conduct allegation or the staff member has a close personal relationship with the subject of the reportable conduct allegation or the subject of the reportable conduct allegation holds some other position of authority in the service provider organisation<sup>114</sup> then a staff member should notify the Commission directly. This is consistent with the ALRC Elder Abuse Inquiry recommendations.<sup>115</sup>

<sup>110</sup> Australian Law Reform Commission, *Elder abuse – A National Legal Response*, (Commonwealth of Australia, Sydney, 2017).

<sup>111</sup> *Ombudsman Act 1974* (NSW), s 25H.

<sup>112</sup> *Ombudsman Act 1974* (NSW), s 37(5).

<sup>113</sup> *Child Safety and Wellbeing Act 2005* (Vic) s 16Y; and *Child Safety and Wellbeing Act 2005* (Vic) s 16ZE; *Ombudsman Act 1989* (ACT) s 17O(2); *Children and Young People Act 2008* (ACT) Div 25.3.3, s 863E.

<sup>114</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* Volume 7, p 266. (Commonwealth of Australia 2017).

<sup>115</sup> ALRC *Elder Abuse – A National Legal Response: Final Report*, Recommendation 4-6, (Commonwealth of Australia 2017) p 125.

Stakeholders through the consultation process commented on the need to provide support and protections to staff members who make a notification of a reportable conduct allegation.

*5.3.2.7 Any person who becomes aware of reportable conduct should be able to make a notification to the relevant service provider or the Commission*

Consumers, family members and any other concerned person should have opportunities to make a notification to the service provider or the Commission.

Under the Victorian reportable conduct scheme for child protection services, any person may disclose a reportable conduct allegation to the independent oversight body – the Commission for Children and Young People.<sup>116</sup>

Stakeholders commented on the need for mechanisms to allow any person with a reportable conduct allegation to make a notification.

*5.3.2.8 Failure to report penalties have not been included as part of this option as it is not known whether this measure will persuade or dissuade service providers from making reports*

Stakeholders commented on the need to avoid punitive measures as they may dissuade service providers from notifying the Commission of reportable conduct. Some stakeholders commented that the reportable conduct scheme should encourage service providers to comply with reporting requirements, for example by sharing best practice and building sector commitment to a SIRS. Nevertheless, the Commission will continue to hold the provider accountable against the Aged Care Quality Standards. Where there is a failure in governance systems to ensure compliance with the reporting requirements<sup>117</sup> or there is inadequate risk management systems in relation to identifying and responding to abuse, then it would be open to the Commission to find the provider non-compliant against the relevant standard.

The Aged Care Quality Standards require all service providers to have in place effective organisation wide governance systems relating to regulatory compliance.<sup>118</sup> Accordingly, service providers will have a responsibility to have appropriate systems in place to ensure a provider is meeting its legislative obligations and may face sanctions if they fail to do so, but it is not proposed that specific penalties associated with a failure to report by a service provider be introduced initially.

It is not known how failure to report penalties will influence service providers. This issue should be considered as part of an independent review of a SIRS. Failures to report would also likely result in compliance action under existing regulatory functions.

*5.3.2.9 Public reporting requirements by service providers have not been included as part of this option as it is not known whether this measure will persuade or dissuade service providers from making reports*

Public reporting requirements by service providers have not been included as part of this option as it is not known whether this measure will persuade or dissuade service providers from making reports.

The Carnell-Paterson Review commented that consideration should be given to requiring service providers to report the number of alleged or suspected incidents of reportable conduct that have occurred in their service on a monthly or quarterly basis and to make the information publicly available.<sup>119</sup>

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<sup>116</sup> *Child Wellbeing and Safety Act 2005 (Vic)* s 16L.

<sup>117</sup> Aged Care Quality Standard 8.3(c)(v) and 8.3(d)(ii).

<sup>118</sup> *Quality and Care Principles 2014*.

<sup>119</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 113.

Stakeholders supported some level of public reporting by the Commission but generally did not support individual service providers having to report publicly on reportable conduct at a service-by-service level.

Public reporting requirements could result in perverse outcomes. Providers should be incentivised to notify the Commission of reportable conduct by a staff member. The requirement to publicly report may act as a disincentive to service providers notifying the Commission in the first place. Higher levels of reportable conduct may be an indicator of effective internal incident management systems rather than poor quality service provision.

It is not known how public reporting requirements will influence service providers. This issue should be considered as part of an independent review of a SIRS. However, the Commission could report publically on a SIRS's operation as part of the Commission's new annual reporting requirements. This issue is considered further at section 5.3.5.9.

#### *5.3.2.10 Mandatory reporting by service providers of broader incidents of elder abuse has not been included as part of this option as this issue is complex and requires further consideration*

Mandatory reporting by service providers of broader suspicions or known cases of elder abuse, for example familial abuse, is a different regulatory measure to requiring providers to notify the Commission of reportable conduct by a staff member against a consumer. The issue of mandatory reporting of elder abuse by certain reporter groups – for example aged care service providers, police, doctors, nurses, registered psychologists – has been explicitly considered by the ALRC Elder Abuse Inquiry.

The ALRC Elder Abuse Inquiry stated that it does not recommend mandatory reporting of elder abuse within the Commonwealth aged care regulatory framework.<sup>120</sup> The ALRC Elder Abuse Inquiry recommended that adult safeguarding laws in each state and territory should provide for the safeguarding and support of at-risk adults.<sup>121</sup> The ALRC Elder Abuse Inquiry also recommended that guidance and protocols should be developed for when prescribed professionals should report suspected abuse of at-risk adults to adult safeguarding agencies.<sup>122</sup> The ALRC Elder Abuse Inquiry acknowledged that mandatory reporting – such as in child protection systems – could identify instances of abuse and neglect that occurs in private and which, without mandatory reporting, may not be brought to the attention of assisting agencies.<sup>123</sup>

The ALRC Elder Abuse Inquiry stated that abuse of older people must not be treated the same as for children and that professionals should not be required to report all types of elder abuse. It noted that older people should generally be free to decide whether to report abuse they have suffered to the police or a safeguarding authority, or to not report the abuse at all. However, the ALRC Elder Abuse Inquiry accepted there was a case for requiring professionals to report serious abuse of particularly vulnerable adults. The ALRC Elder Abuse Inquiry reported that many stakeholders were opposed to mandatory reporting of elder abuse, including concerns that too many reports of trivial cases would make a mandatory reporting scheme counterproductive.

The vast majority of stakeholders raised concerns about the level of abuse or mistreatment experienced by older people receiving aged care services, in particular the level of abuse by family members. The vast majority of elder abuse is by family members.<sup>124</sup> Elder abuse concerns should be reported to relevant authorities, for example police or to adult safeguarding authorities, where

<sup>120</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, page 122, para 4.96. (Commonwealth of Australia 2017).

<sup>121</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, Recommendation 14-8 (Commonwealth of Australia 2017).

<sup>122</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, Recommendation 14-8 (Commonwealth of Australia 2017).

<sup>123</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, page 415, para 14.187. (Commonwealth of Australia 2017).

<sup>124</sup> Australian Institute of Family Studies, 'Elder Abuse', <https://aifs.gov.au/publications/elder-abuse/export>.

appropriate.<sup>125</sup> Appendix 2 contains a series of case studies outlining how providers of aged care services have and can respond to elder abuse issues not related to reportable conduct by staff.

One way to address the concerns of stakeholders – supported by the ALRC Elder Abuse Inquiry – would be for the Commission to create clear reporting guidelines and protocols setting out when it might be appropriate for professionals, including those working in aged care, to report different types of elder abuse to safeguarding agencies.

It is important to note that service providers are already required to notify relevant authorities of abuse and neglect under certain legislative and regulatory requirements, for example state and territory criminal laws and adult safeguarding laws.

It is also important to note that anyone – including consumers of aged care services – can contact state and territory elder abuse services to raise concerns. A national elder abuse peak body (Elder Abuse Action Australia) has also been established to support the national coordination and advocacy of issues relating to the prevention of elder abuse. The Older Persons Advocacy Network (OPAN) also seeks to address issues of elder abuse and provide additional support for people facing this problem through advocacy, information and education.

The issue of mandatory reporting of elder abuse is complex, is a community-wide and not aged-care specific issue, and warrants further consideration and possibly consultation with the sector as well as expert authorities and state and territory governments. For these reasons, mandatory reporting of elder abuse suspected to be occurring by family or friends, reported by service providers has not been included as part of this option.

### 5.3.3 What conduct should be reportable?

#### 5.3.3.1 Reportable conduct should be defined to mean abuse and neglect by a staff member against a consumer

Reportable conduct should be defined to mean abuse and neglect by a staff member against a consumer, including:

- Physical, sexual or financial abuse.
- Seriously inappropriate, improper, inhumane or cruel treatment.
- Neglect.

Specific guidance should be developed in relation to the meaning of reportable conduct by staff members, including the development of explicit definitions, examples of acts and practices by staff members that are in scope, and case studies.<sup>126</sup>

The rationale for including physical, sexual and financial abuse is to capture a broad range of conduct by staff members. Some abuse may constitute a criminal offence. It is not expected that providers engage in technical legal analysis of whether conduct amounts to a criminal offence. It is expected that providers respond to abuse, support consumers, notify the Commission and – where appropriate – notify other authorities including police.

The rationale for including seriously inappropriate, improper, inhumane or cruel treatment is to capture a range of serious abuse by staff members, for example failure to provide an appropriate form of communication for someone who is communication impaired or the practice of staff members leaving a consumer on the floor in considerable distress if staff formed a view that intervening to assist was not needed immediately, as identified in the Oakden Report. This is in line with the

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<sup>125</sup> For an example of an approved provider responding to such an incident, refer to case study of Mr and Mrs C in Resthaven, Submission 114.

<sup>126</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 114.

recommendations of the ALRC Elder Abuse Inquiry,<sup>127</sup> although the ALRC Elder Abuse Inquiry only recommended inclusion of this type of abuse for residential aged care settings.

It is also possible for particular types of conduct or incidents to meet a combination of the above definitions.

The rationale for including neglect is to capture conduct by staff that involves intentional or reckless failure to adequately supervise or support a consumer where there is a gross breach of professional standards and there is potential to result in death or significant harm. The inclusion of neglect also aims to capture grossly inadequate care by staff members that involves depriving a consumer of the basic necessities of life. Advanced pressure sores said to be caused by failures in wound care, for example, should be reportable conduct by staff under the meaning of neglect. This is in line with the recommendations of the ALRC Elder Abuse Inquiry.<sup>128</sup>

Reportable conduct should not be defined so broadly that it unduly consumes time and resources in reporting. A narrow but clear definition will ensure the Commission is not overloaded with reports and that the most serious conduct by staff members is reported and investigated.

Concerns have been expressed around the precise definitions of reportable conduct. Legislation should clearly define key terms by describing the included behaviours or acts and also providing examples of excluded behaviour or acts that are not intended to be reported as part of a SIRS.<sup>129</sup> For example, legislation for the ACT reportable conduct scheme for child protection services provides that reportable conduct does not include ‘the reasonable discipline, management or care of a child taking into account the characteristics of the child, and any relevant code of conduct or professional standard that at the time applied to the discipline, management or care of the child.’<sup>130</sup>

#### *5.3.3.2 Reporting exemptions to release service providers from notifying the Commission of ‘trivial or negligible’ incidents have not been included as part of this option as abuse and neglect by staff members against consumers is always a serious matter*

Reporting exemptions to release service providers from notifying the Commission of ‘trivial or negligible’ incidents have not been included as part of this option as abuse and neglect by staff members against consumers is always a serious matter.

The ALRC Elder Abuse Inquiry’s proposed definition of reportable conduct by staff members includes a broad exemption that excludes the need to report acts or omissions when the harm caused to a consumer is ‘trivial or negligible’. The aim of this recommendation by the ALRC Elder Abuse Inquiry is to balance the need to capture conduct by staff members against the risk of over-burdening the aged care system with investigating and overseeing responses to ‘non-serious’ conduct.

The current state and territory criminal law systems that give rise to the assault and sexual assault offences summarised in Appendices 3-5 also provide, albeit in different forms, for ‘trivial and negligible’ exemptions to such offences.

It is acknowledged that to reduce over-burdening the reporting system, it may be appropriate to set a reporting threshold, however, providers should not be expected to make technical decisions about what type of abuse by staff is ‘trivial’ versus ‘serious’. The Commission should have broad discretion in how it handles reportable conduct so that proportionate action is taken based on the actual harm or potential risk of harm to a consumer. Furthermore, by reporting the full range of abusive or neglectful behaviour to the Commission, even where the actual harm was low, the Commission may be able to

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<sup>127</sup> Australian Law Reform Commission, *Elder abuse – A National Legal Response*, (Commonwealth of Australia, Sydney, 2017).

<sup>128</sup> *ibid.*

<sup>129</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* Volume 7, p 269 (Commonwealth of Australia 2017).

<sup>130</sup> *Ombudsman Act 1989* (ACT) s 17E(2).

detect trends such as inadequate supervision by providers or patterns of abusive behaviour by staff members.

Stakeholders consulted were generally not supportive of a 'trivial or negligible' exemption on the basis that if the incident involved abuse or neglect by a staff member to a consumer then it should be reported and handled as reportable conduct.

#### *5.3.3.3 Abuse by consumers against staff members should not be defined as reportable conduct but should be dealt with by providers as a work health and safety issue through compliance with existing WHS laws*

Staff should be able to attend work free from fear of violence. Being a victim of violence can have dire mental and physical health consequences for residents, staff and visitors. This may include emotional and psychological trauma from being a victim or witnessing violence, physical injuries or even death. Violence at work is a work health and safety issue. Employers are obligated to provide a safe and healthy work environment for their employees. Violence in the workplace can lead to negative outcomes for the aged care system from staff losses due to injuries or a lack of staff retention. The issue of violence against staff is best addressed by:

- Providers managing the behaviours of consumers with aggressive tendencies in line with best practice and person-centred supports.
- Providers conducting risk assessments to identify hazards and risks and possible ways to control or mitigate them.
- Providers introducing and enforcing policies aimed at reducing risks and encouraging reporting of incidents and a zero tolerance culture.
- Staff reporting all instances of violence against staff members to providers to encourage a zero tolerance culture.<sup>131</sup>

There are limitations with this approach including that not all risks and hazards leading to violence can be prevented and violence may always occur to some extent. Staff may be reluctant to change as reporting all forms of violence may mean more paper work for already time poor staff. To be effective, zero tolerance policies need to be supported by clear consequences that condemn violent acts. This means developing policies which define clear consequences if an incident occurs. These will be difficult to implement in a residential aged care setting as it is the resident's home and they cannot be removed or refused service. Further, many residents have cognitive impairment and may not comprehend the consequences of their actions. However, zero tolerance policies are an important first step towards creating organisational culture and community expectations that consider violence among residents as preventable and not an accepted occurrence in residential aged care services.<sup>132</sup>

Some stakeholders through the consultation process to develop options queried whether conduct by consumers to staff members should be included in the reportable conduct scheme. For the reasons outlined, the proposed reportable conduct scheme does not include conduct by consumers.

#### *5.3.4 What reports should be provided and when and what responses should be required to reportable conduct by staff members?*

##### *5.3.4.1 Service providers should make an incident notification to the Commission as soon as practicable after becoming aware of reportable conduct by a staff member*

The requirement to notify as soon as practicable means to notify as soon as is possible. In most cases, it should be possible for providers to both address the immediate safety needs of a consumer

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<sup>131</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017) p 184.

<sup>132</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017) p 185.

and take the immediate steps necessary to respond to a serious incident, as well as to notify the Commission of the reportable conduct within 24 hours of the provider becoming aware of the conduct.

The incident notification to the Commission should be made in writing and include, if known:

- The name and contact details of the provider.
- A description of the reportable conduct, including the impact on, or harm caused to, the consumer.
- The time, date and place at which the reportable conduct occurred.
- The names and contact details of the persons involved in the reportable conduct.
- The names and contact details of any witnesses to the reportable conduct.
- The immediate actions taken in response to the reportable conduct, including actions taken to ensure the health, safety and wellbeing of affected consumers.
- Whether the conduct has been reported to police or any adult safeguarding (if available in the relevant state or territory) or professional registration authority or any other body.
- Any further actions proposed to be taken in response to the conduct.
- The name and contact details of the person making the notification.
- Any other information required by the Commission.

The Commission should be required to develop and approve a specific form for the purposes of providers giving the Commission this information in a way that minimises unnecessary burden on providers.

A SIRS should require the Commission to acknowledge receipt of the incident notification as soon as practicable.

The rationale for this notification requirement is that while appropriate responses by providers will vary according to each specific case, a process of information gathering will be required in all cases to enable informed decisions by the provider and Commission about what further actions should be taken. Adjusting the notification timeframe from the current 24 hours under the existing reportable assaults scheme to as soon as practicable will allow providers to demonstrate a considered response to an allegation or suspicion of reportable conduct. This is consistent with the ALRC Elder Abuse Inquiry recommendations.<sup>133 134</sup>

Many stakeholders in the consultation process to develop options – as well as recent reviews and reports – have considered the question of appropriate notification timeframes. There was broad consensus in the stakeholder consultations process that as soon as practicable would enable a considered response and would be appropriate. The NSW reportable conduct scheme for child protection services provides for a 30-day notification period within which providers must notify the oversight body of any reportable conduct. The notification period does not prioritise allegations of imminent harm or more serious alleged conduct. In practice, many providers notify as soon as they become aware of a reportable allegation, however, this does not occur in every case.<sup>135</sup> This notification timeframe may be problematic in more serious matters – for example sexual offences or sexual misconduct – because there may be no oversight of how the provider handles the conduct in the critical early stages where poor provider handling practices can have profound, negative impacts on victims and their families.<sup>136</sup>

A 30-day notification period may not be consistent with the objectives of a reportable conduct scheme to ensure adequate oversight of provider handling of reportable conduct. For these reasons, the Royal Commission into Institutional Responses to Child Sexual Abuse called on state and territory

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<sup>133</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, (Commonwealth of Australia 2017) page 115, para 4.61-4.62.

<sup>134</sup> ALRC *Elder Abuse – A National Legal Response: Final Report*, (Commonwealth of Australia 2017) page 116, para 4.66.

<sup>135</sup> Transcript of S Kinmond, Case Study 38, 24 March 2016 at 18358:35–7.

<sup>136</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* (Commonwealth of Australia 2017) Volume 7, p 267.

governments to consider legislating for a three-day initial notification period, similar to the Victorian approach, in order to improve reporting of, and responses to, abuse or neglect by staff members.<sup>137</sup>

The Department has commented on the need to ensure that providers respond immediately to reportable conduct. The benefit of a 24 hour notification requirement would be that providers would be required to notify the Commission of action taken and providers would be required to respond promptly to incidents that occur. The issue of immediate notification timeframes should be further considered as part of the detailed policy analysis to be undertaken prior to implementation.

#### 5.3.4.2 *Service providers should make an incident report to the Commission within 28 days of the incident notification*

Alternatively, this could be determined by the Commission based on the risk the incident has or continues to pose to care recipients. The incident report to the Commission should be made in writing and include, if known:

- Details of any internal or external investigation or assessment that has been undertaken in relation to the reportable conduct including:
  - The name and position of the person who undertook the investigation.
  - When the investigation was undertaken.
  - Details of any findings made.
  - Details of any corrective or other action taken since the incident notification.
- A copy of any report of the investigation or assessment.
- Whether consumers affected (or their representative) have been kept informed of the progress, findings and actions relating to the investigation or assessment in line with open disclosure requirements.
- Any other information required by the Commission.

A SIRS should require the Commission to develop and approve a specific form for the purposes of providers giving the Commission this information in a way that minimises unnecessary burden on providers.

A SIRS should require the Commission to acknowledge receipt of the incident report as soon as practicable. This is consistent with the ALRC Elder Abuse Inquiry recommendations.<sup>138</sup>

The rationale for this notification requirement is that additional information about any findings or actions taken by the provider in response to reportable conduct will allow the Commission to decide what further oversight action, if any, should be taken. This is consistent with the ALRC Elder Abuse Inquiry recommendations.<sup>139</sup>

The Carnell-Paterson Review recommended that providers should inform the Commission of the outcome of an investigation, including findings and action taken.<sup>140</sup> The Carnell-Paterson Review also commented that it was problematic that there is no legislative obligation on the provider to record any actions taken in response to an incident under the current reportable assaults scheme.<sup>141</sup>

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<sup>137</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Improving institutional responding and reporting* Volume 7, p 267 (Commonwealth of Australia 2017).

<sup>138</sup> ALRC *Elder Abuse – A National Legal Response: Final Report*, (Commonwealth of Australia 2017 page 116, para 4.66.

<sup>139</sup> ALRC *Elder Abuse – A National Legal Response: Final Report*, (Commonwealth of Australia 2017 page 115, para 4.61-4.62.

<sup>140</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, Recommendation 6(i)(b) (October 2017)

<sup>141</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 112.



#### *5.3.4.3 Service providers should collect data and keep appropriate records to enable administration of the reportable conduct scheme*

The proposed incident notification and incident report requirements outline the main information that providers should record. There should also be a clear recordkeeping requirement for providers to record and maintain appropriate records in line with the requirements of the reportable conduct scheme. Record keeping requirements, including retention periods, should align with existing requirements under the Act and Records Principles 2014.

#### *5.3.4.4 Service providers should identify, manage and resolve serious incidents, including reportable conduct by a staff member, in line with specific guidance which the Commission should be required to develop*

Providers have a responsibility to comply with the requirements of the Aged Care Quality Standards, including the requirement that providers have effective risk management systems and practices for identifying and responding to abuse and neglect aged consumers.

Guidance previously published by the (then) Australian Aged Care Quality Agency in relation to the Aged Care Quality Standards sets out expectations for how providers should respond to incidents. This includes that risks to consumers be monitored; steps be taken to stop abuse and report abuse as required by law; and systems be strengthened for the prevention of abuse and neglect.

In addition to existing requirements, the Commission should be required to publish specific guidelines in relation to how providers should identify, manage and resolve serious incidents including reportable conduct by a staff member. This will help providers to develop and improve their risk management systems, meet the general requirements of the Aged Care Quality Standards and provide clear guidance about how providers should respond to reportable conduct by staff members.

Specific guidelines published by the Commission on risk management systems, including incident management systems, should be developed based on best-practice and consultation with the sector and experts – and be periodically updated – and cover the following incidents:

- Acts, omissions, events or circumstances that occur in connection with providing aged care services to a consumer and which have, or could have, caused harm to the consumer including clinical incidents.
- Acts by a consumer that occur in connection with providing aged care services and which have caused serious harm, or a risk of serious harm, to another person.
- Reportable conduct by staff members.

These guidelines should also set out the expected procedures to be followed by providers in identifying, managing and responding to incidents including clinical incidents and set out:

- How incidents are identified and recorded including the method and manner of recording an incident, the timeframes for internal reports and how incidents should be reported internally, and the minimum requirements concerning the records that must be kept about incidents.
- To whom incidents must be reported including the need for providers to establish clear reporting lines when incidents occur; specify who must be notified when an incident occurs; when police or emergency services should be notified; when guardians, family members or carers should be notified; who must be notified internally when an incident occurs; and who is responsible for notifying the Commission about any reportable serious incidents.
- How providers will provide support and assistance to a consumer affected by an incident to ensure the consumer's health, safety and wellbeing.
- How a consumer and others affected by an incident will be involved in the management and resolution of the incident, in line with open disclosure requirements. Open disclosure is recognised as an important practice in the provision of aged care services when things go wrong and is a requirement under the Aged Care Quality Standards. Service providers should be required to ensure consumers affected by serious incidents (or their representative) are kept informed of the

progress, findings and actions relating to an investigation or assessment in line with these open disclosure requirements.

- When an investigation into an incident is required by the provider to establish the cause of a particular incident, its effect and any operational issues that may have contributed to the incident occurring; why if police are involved an internal investigation by providers should not commence until the police have completed their inquiries; and what training should be provided to workers involved in conducting and responding to incidents. Training for workers should include the capacity to apologise and to show empathy without admitting guilt.
- When corrective action should be taken by providers in response to an incident and the nature of such action, for example, but not limited to re-training or further training of workers; practice improvements including developing or enhancing policies and procedures; changes to the environment in which the services are provided; and changes to the way in which services are provided.

The vast majority of stakeholders commented on the need to develop clear guidance on best practice risk management systems and how providers should identify, manage and resolve incidents. An alternative approach would be to put the onus on providers to comply with requirements, including by developing and implementing appropriate risk management systems.

In relation to reportable conduct, specific guidance on responding to reportable conduct should be developed and set out the expected procedures to be followed by providers in identifying, managing and responding to reportable conduct by staff specifically, including:

- What reportable conduct is; a description of the different categories of a reportable conduct and what they mean; when conduct must be reported to the Commission; who needs to notify the Commission of reportable conduct; timeframes for notifying reportable conduct to the Commission; how notifications to the Commission should be made; what information must be provided to the Commission.
- How providers should respond to reportable conduct to ensure immediate safety and support of the consumer and staff members who are the subject of allegations.
- How providers are required to investigate reportable conduct by staff members, including to determine whether the conduct could have been prevented; how well the conduct was managed and resolved; what, if any, remedial action needs to be undertaken to prevent further similar conduct from occurring; whether other persons or bodies need to be notified of the conduct.
- How providers should obtain clearance from police before taking any action that might compromise any police investigation and how providers should work with police.
- When corrective action should be taken by providers and the Commission; for example the Commission requiring a provider to give information about reportable conduct to police; refer reportable conduct to other authorities with responsibilities in relation to the conduct; undertake specific remedial action to ensure the health, safety and wellbeing of a consumer; carry out an internal investigation; engage an appropriately qualified and independent expert at the expense of the provider to carry out an investigation; conduct an inquiry; or take other action as considered appropriate.
- How providers should inform consumers, guardians, representatives, family members and/or other support people about reportable conduct in line with open disclosure requirements.

The vast majority of stakeholders commented on the need to develop clear guidance on best practice responses to reportable conduct and how providers should identify, manage and resolve reportable conduct allegations and events.

#### 5.3.4.5 *Express legislative requirements for service providers to investigate every instance of reportable conduct has not been included as part of this option as the nature and type of any investigation will depend on the circumstances of each case*

Express legislative requirements for service providers to investigate every instance of reportable conduct has not been included as part of this option as the nature and type of any investigation will depend on the circumstances of each case.

The NSW reportable conduct scheme for child protection services does not include an express legislative requirement for providers to investigate every reportable conduct allegation, but it is a matter of practice that providers do investigate each allegation. The NSW Deputy Ombudsman told the Royal Commission into Institutional Responses to Child Sexual Abuse that he had ‘yet to see a matter where an agency has told us in relation to a matter of substance that they are not going to investigate it.’<sup>142</sup>

The rationale for not introducing an explicit requirement for providers to conduct investigations is that:

- The Aged Care Quality Standards already require providers to have effective risk management practices for identifying and responding to abuse and neglect of consumers.
- Good working relationships between the Commission and aged care providers are likely to be effective in persuading providers to conduct appropriate action where required.
- The development of clear guidelines in relation to provider responses to serious incidents and reportable conduct by staff members is likely to be effective in supporting providers to respond effectively.
- It may not be appropriate to require providers to investigate reportable conduct if police are conducting their own investigations.

The risk that a provider does not undertake appropriate investigations can be managed by requiring providers to give the Commission information about how they intend to investigate and respond and by giving the Commission an oversight function to require providers to take action in response to reportable conduct. This is discussed in the section below covering the roles and functions of the Commission.

### 5.3.5 *What roles and functions should the Commission have?*

The Commission should have a core range of powers to operate the reportable conduct scheme as set out below.

#### 5.3.5.1 *The Commission should have appropriate powers to keep under scrutiny the systems providers have in place to prevent staff members from engaging in reportable conduct including by auditing service providers*

The NSW Ombudsman has an oversight function – in relation to the NSW reportable conduct scheme for child protection services – to ‘keep under scrutiny’ the systems that providers have in place for preventing staff members from engaging in reportable conduct.<sup>143</sup> One way the NSW Ombudsman fulfils this responsibility is by auditing providers of children’s services and providing recommendations to help providers improve their systems and practices. Providers are given feedback, including on areas of good practice and areas for improvement. The equivalent ACT scheme has similar provisions.<sup>144</sup>

Recognising there are risk management requirements in aged care as part of the Aged Care Quality Standards, the proposed reportable conduct scheme should strengthen the role of the Commission in relation to reportable conduct by staff members by requiring the Commission to ‘keep under scrutiny’ provider systems to prevent reportable conduct. This will help to ensure a SIRS has an enduring

<sup>142</sup> Transcript of S Kinmond, Case Study 38, 24 March 2016 at 18360:36–8.

<sup>143</sup> *Ombudsman Act 1974* (NSW) s 25B(1).

<sup>144</sup> *Ombudsman Act 1989* (ACT) s 17F.

focus on quality improvement and preventing abuse and neglect by staff members against consumers.

This function will allow the Commission to engage with providers in a way that is not linked to any particular instance of reportable conduct. Legislation establishing the Commission as a SIRS oversight body should set out as an objective the prevention of reportable conduct from occurring. This will ensure there is balance between how the Commission exercises its oversight and monitoring functions as well as its functions to prevent reportable conduct from occurring. The Commission should develop clear guidelines and advice about how it will work with providers and other bodies to prevent reportable conduct from occurring and scrutinise provider systems to handle reportable conduct.

It may be the case that many providers do not have the internal capability to conduct an effective investigation. This is especially the case for providers with a smaller or lower risk consumer or staff base where reportable incidents occur infrequently, where internal staff are unlikely to gain experience in conducting investigations, and the volume of incidents does not warrant the appointment of dedicated internal staff.

In such cases, it may be more appropriate for the Commission to administer a panel of external investigation service providers to assist aged care providers discharge their obligations under this regime. This carries the advantage of more consistent investigations with the Commission able to educate and influence a smaller but more experienced cohort of investigative persons.

#### *5.3.5.2 The Commission should have appropriate powers to oversee and monitor how providers investigate and handle reportable conduct*

These powers should allow the Commission to monitor the progress of provider investigations, be present as an observer during interviews conducted by or on behalf of a provider for the purpose of the investigation, confer with persons conducting the investigation about the conduct, seek information about the progress of an investigation, require providers to give documentary and other information including records of interviews with respect to investigations and require the provider to defer its investigation if the Commission believes it is necessary for an independent person or body to investigate the matter. These powers are consistent with the NSW, Victorian and ACT reportable conduct schemes for child protection services.<sup>145</sup>

#### *5.3.5.3 The Commission should have appropriate powers to, on its own initiative, conduct an investigation of reportable conduct*

These powers should allow the Commission to conduct an investigation into a provider's response to reportable conduct. If the Commission becomes aware of reportable conduct allegations, the Commission should be able to investigate with or without a notification of the reportable conduct from a service provider. These powers should allow the Commission to conduct an investigation on its own initiative or in response to a complaint. These powers are consistent with the NSW, Victorian and ACT reportable conduct schemes for child protection services.<sup>146</sup>

The Commission should develop and disseminate clear guidance and advice about roles and responsibilities when the Commission conducts its own investigation or is heavily involved in monitoring a provider's investigation into reportable conduct. For example, when conducting investigations on its own initiative, the Commission should be clear as to whether the Commission or the provider will keep consumers and family members informed about progress and findings of any investigation and any action taken in response to those outcomes.

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<sup>145</sup> *Ombudsman Act 1974* (NSW) s 25E(1); 203 *Ombudsman Act 1974* (NSW) s 25E(2); 204 *Ombudsman Act 1974* (NSW) s 25E(3); *Child Wellbeing and Safety Act 2005* (Vic) ss 16G(c), 16H, 16K(2),(3), 16W; *Ombudsman Act 1989* (ACT) s 171.

<sup>146</sup> *Ombudsman Act 1974* (NSW) s 25G(1); *Ombudsman Act 1974* (NSW) s 25G(2); *Child Wellbeing and Safety Act 2005* (Vic) ss 16G(d), 16H; *Ombudsman Act 1989* (ACT) s 17K(1).

#### *5.3.5.4 The Commission should have appropriate powers to make recommendations to a service provider for action to be taken*

These powers are consistent with the NSW, Victorian and ACT reportable conduct schemes for child protection services.<sup>147</sup> The non-binding nature of recommendations mean the Commission will be reliant on building strong relationships with providers and the aged care sector to ensure its recommendations are implemented. There may be limitations with the non-binding nature of recommendations in cases where providers are reluctant or unwilling to change<sup>148</sup> and where abuse or neglect by a staff member against a consumer is being actively covered up.

There may be merit in considering whether the Commission should have powers to make binding recommendations to providers in exceptional circumstances, for example where it is in the public interest to do so. The capacity of the Commission to issue binding orders in some circumstances would enable it to enforce the reportable conduct scheme where a provider refuses to improve its practices in handling reportable conduct. The capacity of the Commission to issue binding orders may also serve as motivation for provider compliance, as well as being a deterrent to bad practice.

It is not known whether powers to make binding recommendations are necessary, and this issue should be considered as part of an independent review of a SIRS.

#### *5.3.5.5 The Commission should have appropriate powers to exempt certain conduct from being reportable by agreement with services providers if the Commission is satisfied the exemption would not increase the risk of harm to consumers*

The Commission should have appropriate powers to exempt certain conduct from being reportable by agreement with services providers if the Commission is satisfied the exemption would not increase the risk of harm to consumers. These powers are consistent with the NSW, Victorian and ACT reportable conduct schemes for child protection services.<sup>149</sup>

This will allow providers that have demonstrated a satisfactory level of competence in responding to reportable conduct to carry out investigations into certain exempted conduct without being required to notify the Commission. This will allow the Commission to focus its efforts on serious matters and on providers that have not demonstrated a satisfactory level of competence in handling reportable conduct. Providers should be required to show growth and maturity in handling reportable conduct to enter into such agreements. Class or kind agreements should be tailored to the expertise and experience of the provider and applied. The Commission should be required to publicly publish a list of exemptions that are in place, including an explanatory statement and the time period for the exemption. The Commission should be able to vary or revoke an exemption and withdraw an exemption from a particular provider if it is satisfied the exemption would likely result in a risk of harm to consumers.

There will be some administrative burden on the Commission on administering class exemptions and exempted conduct that would not be reported which would affect prevalence data on the number of incidents occurring.

#### *5.3.5.6 The Commission should have appropriate powers to undertake capacity building and practice development in relation to responses by service providers to reportable conduct*

This could be conducted as part of the Commission's broad education function contained in section 20 of the *Aged Care Quality and Safety Commission Act 2018*. For example, training, education and guidance to build the capacity and develop the practice of providers in relation to handling reportable conduct and preventing abuse or neglect by staff members against consumers.

<sup>147</sup> *Ombudsman Act 1974* (NSW) s 25G(5); *Child Wellbeing and Safety Act 2005* (Vic) s 16G(f); *Ombudsman Act 1989* (ACT) s 17K(3)(b).

<sup>148</sup> *Final Report: Improving institutional responding and reporting* Volume 7, p 273 (Commonwealth of Australia 2017).

<sup>149</sup> *Ombudsman Act 1974* (NSW) s 25CA; *Child Wellbeing and Safety Act 2005* (Vic) s 16I; *Ombudsman Act 1989* (ACT) s 17G(3).

These powers are consistent with the Victorian reportable conduct scheme for child protection services.<sup>150</sup> The equivalent NSW and ACT reportable conduct schemes do not expressly legislate for a capacity building and practice development role. However, in practice, the oversight bodies provide training, education and guidance to providers on how to identify, report, handle and investigate reportable conduct. The *Aged Care Quality and Safety Commission Act 2018* describes a general education function for the Commissioner.<sup>151</sup>

This power will ensure the Commission balances its oversight and capacity building roles so there is adequate training, education and guidance, for example on:

- Interpreting the meaning and definition of reportable conduct.
- Using reportable conduct notification forms.
- Developing mature processes to handle and respond to reportable conduct.
- Avoiding under-reporting and mishandling of reportable conduct.
- Improving processes around human resources issues.
- Driving practice improvement.
- Establishing a panel of investigators so that smaller providers do not have to maintain this capability in-house.
- Working with rural and remote providers to support the operation of a SIRS and engagement by providers.

#### 5.3.5.7 *The Commission should have appropriate powers for information sharing to enable the prevention and early detection of abuse and the safety of consumers*

A major strength of the NSW reportable conduct scheme for child protection services is that it enables prevention and early detection of child abuse by enabling information gathering and sharing between police, child protection services, the NSW Carers Register and any other relevant body.<sup>152</sup> Benefits from the proposed reportable conduct scheme for aged care services will be enhanced if the operation of a SIRS is supported by efficient and comprehensive information sharing between the Commission and other relevant agencies.<sup>153</sup> Given the convergence of care and of the care workforce across disability, aged care, child protection and health services, benefits from a SIRS are likely to be further enhanced through comprehensive information sharing between agencies responsible for other reportable conduct-type schemes. For example, a disability support worker may be involved in a very serious incident of abuse against a NDIS participant that falls below the criminal threshold. This incident will not be captured through a police check. The same worker may also be providing aged care services and present a serious risk to consumers but this information – without interoperability and information sharing mechanisms – may not be shared between oversight bodies and captured in the aged care system.

Comprehensive information sharing provisions will enable the Commission to work in a complementary way with other oversight bodies and reportable conduct schemes, where the disclosure of information will safeguard a consumer. Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) – which takes precedence over privacy laws – provides a model for how oversight bodies can share information about persons subject to reportable conduct investigations with providers and public authorities including police.<sup>154</sup> Importantly, the NSW Ombudsman has access to the NSW Police Force Computerised Operational Police System and the NSW FACS Key Information and Directory System database. This gives the NSW Ombudsman a ‘helicopter’ view of relevant information and makes it the only government agency in NSW with

<sup>150</sup> *Child Wellbeing and Safety Act 2005* (Vic) s 16G(a).

<sup>151</sup> *Aged Care Quality and Safety Commission Act 2018*, s 20.

<sup>152</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report into improving institutional responding and reporting*, (Commonwealth of Australia 2017) Volume 7, p 257.

<sup>153</sup> *ibid.*

<sup>154</sup> *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 245C(1), 248(6)(a).

access to all key sources of child protection information in a way that can enable proactive risk identification and information sharing.<sup>155</sup> One organisation has observed that:

One of the risks in child protection is that perpetrators can move from an area or jurisdiction of high scrutiny to an area of lower scrutiny. The NSW Ombudsman's ability to share information with the Children's Guardian assists in reducing this opportunity in NSW ... The access that the NSW Ombudsman has to both policing matters and employment matters is significant. The capacity of the Ombudsman to collate and link information about people against whom findings have been made leads to a [sic] much safer outcomes for children in NSW.<sup>156</sup>

The Commission should – with enabling legislation – develop comprehensive standard operating procedures with relevant oversight bodies and authorities to share information to safeguard consumers.

The Commission has limited powers to share protected information as set out in sections 60 and 61 of the *Aged Care Quality and Safety Commission Act 2018*. These provisions generally provide for the circumstances outlined above for the purposes of sharing information for a reportable conduct scheme, and can be expanded by Rules issued by the Minister for the purposes of paragraph 61(1)(j) of that Act.

#### *5.3.5.8 The Commission should have appropriate powers to support interaction with the criminal justice system and police*

The Commission should have appropriate powers to support interaction with the criminal justice system and police. The NSW Ombudsman's reportable conduct scheme for child protection services allows the NSW Ombudsman and NSW Police Force to develop standard operating procedures that specify steps for police to follow when responding to matters that fall under the reportable conduct scheme to ensure that providers are given the information they require to manage the allegation.

The NSW Ombudsman has commented that these standard operating procedures give providers a 'guarantee of service in relation to the ongoing support and advice police should provide'.<sup>157</sup> For example, if the matter is to be investigated by the police, the standard operating procedures state the provider should be given:

- The contact details of the investigating officer.
- Expected timeframes for updates.
- Advice as to whether the employee can be advised of the nature of the allegations.
- Advice as to whether the employee can be informed of the police investigation.
- Any known information relating to the safety, welfare or wellbeing of a particular child or young person if the investigating office believes that supplying the information would assist the employing agency to manage any risk to such persons.

Further, if a reportable conduct notification involves a criminal aspect, the NSW Ombudsman will usually assign a principal investigator to the matter. This investigator is responsible for liaising with the NSW Police Force and other agencies.

The NSW Ombudsman advises providers to apply a balance of probabilities threshold to investigations into reportable conduct.<sup>158</sup> This threshold is lower than the 'beyond reasonable doubt' threshold which is applied by the criminal justice system. The lower threshold allows providers to take action against employees on the basis of a sustained finding made under a SIRS even where the

<sup>155</sup> A Scipione, *16 years of Reportable Conduct Forum 2016* (speech delivered at the NSW Reportable Conduct Scheme Forum, Sydney, 2016), (Viewed 28 July 2017).

<sup>156</sup> Truth, Justice and Healing Council, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation paper: Best practice principles in responding to complaints of child sexual abuse in institutional contexts, 2016, p 22.

<sup>157</sup> New South Wales Ombudsman, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse*, Issues paper No 8: Experiences of police and prosecution responses, 2015, p 8.

<sup>158</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report into improving institutional responding and reporting*, (Commonwealth of Australia 2017) Volume 7.

reportable conduct does not result in a criminal conviction. When the police do not take action in response to a report, the NSW Ombudsman can record and share information relevant to the reportable conduct with those in a position to act to promote the safety of children, including the provider. This is – in part – how the reportable conduct scheme in NSW helps to identify individuals who pose a risk but do not have a criminal record.

The Commission should – with enabling legislation – develop comprehensive standard operating procedures with state and territory police authorities to ensure the Commission, providers and police interact appropriately to safeguard consumers.

#### *5.3.5.9 The Commission should have appropriate powers to make public reports and be required to publicly report on an annual basis on the operation and effectiveness of the reportable conduct scheme*

The Commission should have appropriate powers to make public reports and be required to publicly report on an annual basis on the operation and effectiveness of the reportable conduct scheme. This could be through the new Commission's annual report and the *Report on the Operation of the Aged Care Act 1997*. For example, this could include reporting on trends in the reports received from providers. The Commission should be able to report to Parliament on any matter arising in connection with the reportable conduct scheme. The Victorian reportable conduct scheme for child protection services expressly provides that annual reports by the oversight body include a statement about trends observed in relation to the reportable conduct scheme.<sup>159</sup> The equivalent NSW and ACT schemes also provide powers for the oversight body to report to Parliament.<sup>160</sup>

This will ensure data about the operation of a SIRS is reported and there is discussion of trends in reportable conduct. These powers will also ensure the Commission has the ability to report publicly through the Parliament on any other relevant matter related to the operation of a SIRS. The Commission's annual report to Parliament on the effectiveness of the reportable conduct scheme should include consideration as to whether legislative and policy changes would enhance the effectiveness of a SIRS.

Public reporting will also help to ensure the Commission operates independently of the Department and the aged care providers whose operations it monitors.<sup>161</sup> Public reporting will also ensure the Commission is directly accountable to the public for the administration of the reportable conduct scheme through the Australian Parliament – this will help promote transparency and accountability.<sup>162</sup>

It should be noted that sections 59 and 59A of the *Aged Care Quality and Safety Commission Act 2018* enable the Commissioner to release certain specified information about providers to the public. These may be suitable provisions for the purposes of releasing information to the public for a reportable conduct scheme, and can be expanded by Rules issued by the Minister for the purposes of paragraphs 59(1)(j) and 59A(1)(i) of that Act.

#### *5.3.5.10 The Commission should have appropriate powers to cause a periodic independent review of the operation of the reportable conduct scheme at least every five years or more frequently*

The reportable conduct scheme needs to be able to adapt to changing dynamics and new challenges relevant to abuse and neglect by staff members against consumers. Legislative changes to a SIRS and policy changes by the Commission should be made in response to any shortcomings that may be identified, the need for better responses by providers to handling reportable conduct, new and evolving risks to consumers, research and policy developments around best practice, and regulatory

<sup>159</sup> *Child Wellbeing and Safety Act 2005* (Vic) s 16ZL(3).

<sup>160</sup> *Ombudsman Act 1974* (NSW) s 31; *Ombudsman Act 1989* (ACT) s 21.

<sup>161</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report into improving institutional responding and reporting*, (Commonwealth of Australia 2017) Volume 7 p 263.

<sup>162</sup> *ibid.*



and policy developments in other sectors and service systems. Consideration would need to be given to who performs the independent review (i.e. the Commissioner, someone appointed by the Commissioner or someone appointed by the Minister) and who they report to (the Commissioner, the Department or the Minister).

*5.3.5.11 The Commission should consult on the establishment of a Register to provide a centralised record of persons involved in reportable conduct and consider how the Register could interact with other registration and pre-employment screening systems.*

The aim of a Register would be to promote the safety and wellbeing of consumers by requiring providers to check a prospective employee's record of reportable conduct as part of pre-employment screening. Establishment of a Register could have a substantial regulatory burden on providers. There are a number of implementation considerations and key issues outlined which would require significant sector consultation, including with the relevant unions, and further detailed policy and legal analysis.

The ALRC Elder Abuse Inquiry considered the issue of pre-employment screening and recommended that an assessment be made of a person's suitability to work in aged care based on any relevant reportable conduct.<sup>163</sup> The ALRC Elder Abuse Inquiry considered that checking against a Register would enhance safeguards for older people receiving aged care by ensuring that people delivering aged care are screened for relevant prior history that may affect their suitability to work with older people.<sup>164</sup>

The ALRC Elder Abuse Inquiry considered that pre-employment screening be strengthened generally to not only consider any adverse findings made about a prospective employee that resulted from reportable conduct<sup>165</sup> but to also consider findings from disciplinary or complaint action taken by relevant professional registration or complaint handling bodies.<sup>166</sup>

The ALRC Elder Abuse Inquiry commented that only screening criminal history through a police check – which is currently required by the Act – has limitations because it does not allow non-criminal information about adverse findings arising out of the reportable conduct scheme to be assessed to determine a person's suitability to work in aged care. Conduct must meet a very high evidentiary threshold before it will be recorded on a police check. Capturing conduct that meets a lower threshold would allow a more comprehensive risk assessment of a person's prior history. Stakeholders have noted through the consultation process that, as regulatory controls have tightened in adjacent human services sectors, for example child protection and disability, workers of concern have moved to less regulated markets including aged care where there is a lower chance that non-criminal information about misconduct will be detected by pre-employment screening and checks.

In its submission to the ALRC Elder Abuse Inquiry, the ACT Disability Aged and Carer Advocacy Services noted that providers would – as part of pre-employment screening – need access to the reportable incident register so that allegations of abuse or neglect could be considered by a provider in determining whether a person is fit to work in the sector.<sup>167</sup> The ACT Disability Aged and Carer Advocacy Service further noted that 'Criminal charges are rarely progressed in elder abuse cases, therefore the employment screening process would also need access to the reportable incident register so that past allegations of abuse or neglect can be considered in determining whether a

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<sup>163</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, Recommendation 4-9, (Commonwealth of Australia 2017) p 135.

<sup>164</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017).

<sup>165</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.169.

<sup>166</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.150.

<sup>167</sup> ALRC, *Elder Abuse - Submission 269*. ACT Disability Aged and Carer Advocacy Service (ADACAS), (February 2017).

person is fit to work in the sector.<sup>168</sup> A number of submissions to the ALRC Elder Abuse Inquiry supported reportable conduct being considered in pre-employment screening.<sup>169</sup>

The ALRC Elder Abuse Inquiry recommended the establishment of a Register of staff members involved in reportable conduct as part of establishing a national employment screening process for government-subsidised aged care.<sup>170</sup> The benefits of maintaining a Register of reportable conduct would likely be enhanced if other reforms recommended by the ALRC Elder Abuse Inquiry to the pre-employment screening process in aged care were implemented. Submissions to the ALRC Elder Abuse Inquiry were supportive of including non-criminal information in the pre-employment screening process, for example through a reportable conduct register.<sup>171</sup>

The Register would need to complement – not replace or duplicate – systems and processes that providers already have in place to assess the suitability of a person to work in aged care, for example other minimum probity and suitability checks in aged care such as police checks and any checks against a person’s professional registration. Providers would be required to check the Register as part of pre-employment screening to determine whether a person has been involved in prior reportable conduct. Providers would be required to make a declaration that all their staff members with a reportable conduct allegation or finding have been entered.

The Register would operate as an independently administered system – operated by the Commission – for all staff members in aged care services. Administration of the Register would need to ensure its integrity and include quality assurance measures. The Register would need to include information about staff members, including a flag to record reportable conduct allegations in relation to a staff member and a flag for findings from reportable conduct allegations. A flag could also be included for a provider to make a general note of concern or to flag when a person’s employment has been terminated because of safety concerns. Providers would need to exercise due diligence when entering and retrieving information using the Register.

The Register would enable providers to access a common source of information about staff members in aged care, including:

- Each individual person’s identification information where they have been involved in a current or finalised reportable conduct matter.
- History of work in aged care and relationship with aged care providers.
- Movements into and out of aged care providers.

The Register would:

- Operate to reduce the risk of inappropriate people working in aged care.
- Act as a tool to track individual workers with reportable conduct allegations and findings.
- Require providers to check the Register as part of pre-employment screening.
- Record essential information only.
- Operate as a restricted site, subject to strict privacy controls.
- Provide triggers for providers to seek further information from other providers.

The Register would not:

- Record details of consumers.
- ‘Authorise’ or ‘licence’ staff members to work in aged care.

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<sup>168</sup> *ibid.*

<sup>169</sup> ALRC, *Elder Abuse - Submission 351*, (Law Council of Australia 2017), ALRC, *Elder Abuse - Submission 361* Office of the Public Advocate (Qld).

<sup>170</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017), Recommendation 4-9, p 135.

<sup>171</sup> AnglicareSA, Submission 299; Holman Webb Lawyers, Submission 297; Mecwacare, Submission 289; ADA Australia, Submission 283; Churches of Christ Care, Submission 254; Legal Aid NSW, Submission 352; Institute of Legal Executives (Vic), Submission 320; Seniors Rights Service, Submission 296; Lutheran Church of Australia, Submission 244.

- Replace providers' more detailed processes and systems for assessment and authorisation of staff members to work in aged care.

The Register would include a process for review and appeals that affords procedural fairness to people who are subject to screening against the Register. This process could include, for example:

- Notifying a person of a finding of reportable conduct recorded on the Register and inviting them to submit information which may affect the finding.
- The opportunity to appeal having a record of reportable conduct being placed on the Register.

Information about a person's involvement in reportable conduct could be assessed as part of an overall consideration of risk rather than acting to automatically exclude a person from aged care work.<sup>172</sup> The ALRC Elder Abuse Inquiry considered that reference checks by providers would operate as an additional safeguard to stronger pre-employment screening to safeguard against providers employing unsuitable applicants. The ALRC Elder Abuse Inquiry considered that benefits would accrue from screening a person against a Register of reportable conduct as part of pre-employment screening, alongside police checks and referee checks.<sup>173</sup>

It is important to note that some members of the health professions working in aged care are subject to registration requirements, which include an assessment of criminal history.<sup>174</sup> Registered health professionals through AHPRA are required to declare their criminal history and AHPRA conducts criminal history checks on behalf of applicants before they become registered. For health professionals, consideration should be given to whether professional registration is sufficient in order to not require additional checks.<sup>175</sup> The ALRC Elder Abuse Inquiry considered that providers should assess information from professional registration bodies as part of the pre-employment screening process.<sup>176</sup> For example, information relating to a health practitioner's registration should be considered, such as previous cancellation of registration, suspension or conditions of registration. A register of reportable conduct by staff members could be integrated into existing registration systems, for example AHPRA. A Register of reportable conduct could also be integrated with complimentary reforms, for example the NDIS has signalled that a nationally consistent employment screening process will be developed for workers who have significant contact with people with disability as part of their work, and that this process will take into account workplace misconduct which comes to light through serious incident reporting.<sup>177</sup> The Commonwealth, states and territories have committed to implementing nationally consistent worker screening as part of the NDIS from 1 July 2019.<sup>178</sup>

Most stakeholders through the ALRC Elder Abuse Inquiry supported enhancing the pre-employment screening process for aged care.<sup>179</sup> ACSA expressed caution about introducing new pre-employment screening processes without clear evidence that demonstrates such a check provides additional protection for older people and employers without infringing on the rights of employees.<sup>180</sup> It may not be appropriate in every case for a reportable conduct allegation, or indeed prior criminal history, to

<sup>172</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.175.

<sup>173</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.174.

<sup>174</sup> Australian Health Practitioner Registration Agency, *Registration Standard: Criminal History* (1 July 2015). The standard is made under the Health Practitioner Regulation National Law s 38.

<sup>175</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.168.

<sup>176</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.175.

<sup>177</sup> Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 62

<sup>178</sup> NDIS Quality and Safeguards Commission, *Worker screening (workers)*, at <https://www.ndiscommission.gov.au/workers/worker-screening-workers>.

<sup>179</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.159.

<sup>180</sup> Aged and Community Services Australia, Submission 102. See also Leading Age Services Australia, Submission 377; Carroll & O'Dea, Submission 335; Australian Association of Gerontology (AAG) and the National Ageing Research Institute (NARI), Submission 291; Brotherhood of St Laurence, Submission 232.

'bar' a person from working in aged care.<sup>181</sup> Any system to record reportable conduct would need a procedure for review and discretion to avoid leading to 'unfair and perhaps unintended outcomes of prohibiting people who do not pose a risk.'<sup>182</sup> This is particularly the case should the Register record mere 'flags' or unsubstantiated findings, which may create a perception of unsuitability for future employment.

Providers need to have confidence in the integrity of the findings recorded on the Register about a person's involvement in reportable conduct. A key safeguard to ensure confidence is oversight by the Commission of a provider's investigation and findings in relation to misconduct by staff members.<sup>183</sup> The new Commission will ensure a quality investigation is undertaken by providers into alleged reportable conduct and ensure the validity of any related findings so they can be recorded on the Register accurately and used to inform a provider's overall risk assessment of a person's suitability to work in aged care.

One of the key components of the Register of reportable conduct in child protection in NSW is the information sharing and exchange legislation which enables a provider to share information with the oversight body and other providers to support assessment of a person's suitability.<sup>184</sup> This information sharing legislation enables what is called a 'designated agency check' in NSW, in recognition of the fact that the carer workforce – like in aged care – is highly mobile. The designated agency check could require a provider to check the Register and if they identify concerns then consult with the person's previous employer to seek further information. Legislation in NSW allows for the protection of providers who give information as part of these checks but also protects against circumstances in which information should not be shared, for example when it would prejudice a criminal investigation or coronial inquest.

All Australian jurisdictions require people who work with children to hold a 'working with children' check.<sup>185</sup> In NSW, the working with children check also considers adverse findings in relation to reportable conduct.<sup>186</sup> A 2015 report evaluating working with children check schemes concluded that it shared 'the view held by the majority of government and non-government stakeholders whom we consulted ... they deliver unquestionable benefits to the safeguarding of children.'<sup>187</sup> Some states and territories, for example the ACT and Tasmania, also have a Working with Vulnerable Adults Check.

Stakeholders through the ALRC Elder Abuse Inquiry made broader calls to integrate – as far as practicable – worker screening in aged care, disability and child care sectors.<sup>188</sup> The ALRC Elder Abuse Inquiry commented – more broadly – that it would be beneficial to have an independent body in aged care responsible for administering all pre-employment screening including against the Register of reportable conduct and be responsible for making a decision about a person's suitability to

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<sup>181</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.167.

<sup>182</sup> Legal Aid NSW, Submission 352. See also, eg, Leading Age Services Australia, Submission 377; National LGBTI Health Alliance, Submission 373.

<sup>183</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.173.

<sup>184</sup> Chapter 16A of the *Children and Young Person (Care and Protection) Act 1998*.

<sup>185</sup> Working with Vulnerable People (Background Checking) Act 2011 (ACT); Child Protection (Working with Children) Act 2012 (NSW); Care and Protection of Children Act 2007 (NT); Working with Children (Risk Management and Screening) Act 2000 (Qld); Children's Protection Act 1993 (SA); Registration to Work with Vulnerable People Act 2013 (Tas); Working With Children Act 2005 (Vic); Working with Children (Criminal Record Checking) Act 2004 (WA).

<sup>186</sup> Child Protection (Working with Children) Act 2012 (NSW) s 35; sch 1. The NSW Ombudsman may disclose information to the Office of the Children's Guardian, including information about reports of investigations into reportable conduct by the Ombudsman or a designated government or non-government agency: Ombudsman Act 1974 (NSW) s 25DA.

<sup>187</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks Report* (2015) 5.

<sup>188</sup> See, e.g., Office of the Public Guardian (Qld), Submission 384; Victorian Multicultural Commission, Submission 364; Disabled People's Organisations Australia, Submission 360; Office of the Public Advocate (Qld), Submission 361; COTA, Submission 354; Law Council of Australia, Submission 351; NSW Ombudsman, Submission 341; AnglicareSA, Submission 299; Mecwacare, Submission 289. Some stakeholders suggested that information from past conduct in all three sectors should be used to screen aged care workers: see, e.g. *ibid*.

work in the aged care sector.<sup>189</sup> The ALRC Elder Abuse Inquiry commented that this independent body – not individual providers – should make a determination about whether a person should be granted clearance to work in aged care.<sup>190</sup>

There are a number of implementation considerations and key issues in establishing a Register that – to resolve – will require significant sector consultation including with the relevant unions and further detailed policy and legal analysis. Table 4 below outlines the implementation considerations identified by stakeholders as part of the consultation process to develop options.

*Table 4: Implementation considerations and key issues in establishing a Register*

Implementation considerations	Key issues
<p><b>Scope of the Register and integration with other registration systems</b></p>	<p>The appropriate scope of a Register is a key issue that requires further analysis and consultation. The Register could record all people working in aged care and ‘flag’ people with reportable conduct allegations and findings; or the Register could record only the people who are subject to a reportable conduct allegation or finding. This should include consideration of who may make ‘findings’ that will appear on the Register, with a preference that these be findings of statutory office holders, including the Commissioner, and judicial officers, not findings of service providers. Beyond the scope of the Register, there are also questions as to whether the Register should be a standalone record or be integrated with other registration systems.</p> <p>The ALRC Elder Abuse Inquiry recommended a range of changes to the aged care workforce including that unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers. It is important to note that the National Code of Conduct for Health Care Workers is subject to implementation and progression by states and territories and therefore variation in applicability within the aged care context.</p> <p>The ALRC Elder Abuse Inquiry also commented there should be an independent body to ‘clear’ or ‘authorise’ a person to work in aged care.</p> <p>The NDIS Commission is also in the process of establishing its worker screening arrangements, including to screen for staff involved in serious incidents against NDIS participants. A worker screening system in aged care could be integrated with NDIS arrangements given that the workforce may move between these sectors.</p> <p>There are also professional registration requirements for some people who work in aged care, for example through AHPRA.</p> <p>Design of the Register must address these questions of scope and integration. Consideration should be given to the different criteria of these registration and screening regimes. For example, the focus of professional registration is on compliance with a code of conduct and professionalism which may not completely cover concepts of abuse and neglect.</p>
<p><b>Enabling legislation and powers</b></p>	<p>Enabling legislation and powers would be required to operate the Register, for example to allow providers to disclose and enter information about individual workers on the Register as well as to share information of concern with the Commission and other providers. It is important to note that the disclosure of protected information is currently an offence and there may be a need to consider whether an expressive legislative exemption would be required to enable providers to enter information into the Register. The legal or administrative threshold of evidence that would be required to include someone on a Register would also need to be further considered.</p> <p>It is also important to note that the rule making power under the new Commission’s legislation does not allow for sanctions or offences to be placed in the rules. This means that any sanctions to compel providers to use and administer the Register in a particular way would need to be contained in the primary legislation.</p>

<sup>189</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) para 4.151.

<sup>190</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report Elder Abuse Inquiry*, (Commonwealth of Australia 2017) paras 4.178-4.180.

Implementation considerations	Key issues
<b>Independent administration of the Register</b>	<p>Administration of the Register will need to be supported by clear business rules to set out the roles and responsibilities of providers and the Commission in relation to maintaining and using the Register.</p> <p>Administration will include maintaining the integrity of the Register, for example conducting some unannounced audits of a provider's employee records against the records of the Register.</p>
<b>Procedural fairness for workers</b>	<p>The Register must afford procedural fairness to people who are subject to screening against the Register and ensure that workers are not treated unfairly.</p> <p>A person working in aged care would need to have the ability to correct or challenge an entry on the Register and consideration needs to be given to how information on the Register will influence a provider's decision about employment.</p> <p>Alternatively, the Register may leave the matters of investigation, sanction and procedural fairness to the existing health practitioner code of conduct framework, and simply refer information to existing bodies for their consideration, and record the findings from those bodies into the Register. This should include internal reconsideration, administrative review and judicial review rights.</p>
<b>Authorisation of aged care workers</b>	<p>The Register could be extended to 'authorise' individuals to work in aged care – or ban certain individuals. This issue requires further detailed policy and legal analysis and sector consultation including with the relevant unions.</p> <p>Consideration needs to be given to whether a finding of reportable conduct should automatically exclude a person from working in aged care and how this should be recorded and identified in the Register.</p> <p>Consideration should also be given to state based health care complaints commissions that have the power to investigate misconduct by unregistered health care workers and to issue prohibition orders. Furthermore, boards under APHRA may impose banning or conditions of a registered practitioner's registration or scope of practice.</p>
<b>Access to information recorded on the Register</b>	<p>A centralised register would need to be established and key personnel in provider organisations would need to be authorised to access the Register as part of pre-employment screening checks. Consideration needs to be given to the most appropriate platform to house the Register.</p>
<b>Complementarity and mutual recognition</b>	<p>There are a range of pre-employment screening checks in aged care and the Register should complement and recognise these checks, not duplicate them.</p>
<b>Assisting providers to navigate the functions within the Register and develop internal procedures to adhere to best practice administrative principles</b>	<p>Design of a Register would need to consider:</p> <ul style="list-style-type: none"> <li>• How providers should register their organisation against the Register (what email address to receive system alerts, the structure of the provider, which staff within the provider's organisation will be given access to the Register).</li> <li>• Provider roles and responsibilities in relation to the Register (enter information about staff members on the Register, check prospective employees against the Register, update or correct information in the Register, exchange information with the Commission and other providers for the purposes of assessing a person's suitability to work in aged care).</li> <li>• Business rules to administer the Register (whose information will be recorded on the Register, the level of information required of providers to uniquely identify an employee, whether consent is required, who has access to the Register information, data integrity, timeframes for data entry, exchange of information, recording of reportable allegations on the Register, appeals and reviews).</li> </ul> <p>Education programs and guides, for example e-learning modules, would be needed to train providers in how to access and use the Register.</p>
<b>Back capture requirements and timeframes</b>	<p>Depending on the design of a Register, providers may need a period of time to complete the back capture process to enter information about staff members within a period of time of the Register commencing.</p>
<b>Flags and information recorder on the Register</b>	<p>Flags against individual workers on the Register will need to identify potential concerns including reportable conduct allegations and findings as well as other flags that may be appropriate to include on the Register, for example a flag of concern by a provider in cases where a reportable allegation has not been made</p>

**Implementation considerations****Key issues**

but the provider has another significant concern they would like to include on the Register.

### *Interaction with AHPRA and the National Code of Conduct for Health Care Workers*

Stakeholders through the consultation process to develop options commented on the need for any Register to interact in a complementary, not duplicative, way with existing registers and professional accreditation bodies.

The aged care workforce comprises approximately 366,000 employees<sup>191</sup>. Of these over 240,000<sup>192</sup> are employed in direct care roles such as nurses (Registered Nurses, Enrolled Nurses and Nurse Practitioners), Personal Care Workers (Personal Care Assistants and Community Care Workers) and Allied Health Professionals (and Allied Health Assistants). The other 126,000<sup>193</sup> are employed in indirect care roles, such as management, operations, hotel services and admissions. Of the direct care workforce, nurses account for approximately 20 per cent<sup>194</sup> and allied health professionals account for approximately 2 per cent.<sup>195</sup> These health professionals are regulated under the National Registration and Accreditation Scheme (NRAS). The NRAS is administered by the Australian Health Practitioner Regulation Agency (AHPRA). Some of the unregistered workers – Personal Care Workers – are also covered under the National Code of Conduct for Health Care Workers (NCC) in some state and territory jurisdictions. Further detailed policy and legal analysis and consultation is needed to understand how the Register could interact with AHPRA and the NCC.

The purpose of the NCC is to protect the public by setting minimum standards of conduct and practice for all unregistered health care workers who provide a health service. It sets national standards against which disciplinary action can be taken and, if necessary, a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety.

The final report to the Council of Australian Governments (COAG) on the establishment of the NCC recommended that the definition of 'health service' include aged care services.<sup>196</sup> However, the definition of a 'health service' is a matter for each state and territory's health complaints legislation, and there are differences across jurisdictions in how a 'health service' is defined and whether aged care services are specifically captured.<sup>197</sup> Analysis from 2015 shows, for example that:

- Queensland's health complaints legislation has the broadest definition, capturing services for 'maintaining, improving, restoring or managing peoples' health and wellbeing'.
- The South Australian definition is framed to include a service designed to 'promote human health' and the Commissioner deals with complaints about both health and community services.
- The NSW and Victorian definitions are narrow compared with other jurisdictions. These definitions state that 'a health service includes...', followed by examples. There is considerable overlap in the list of examples between NSW and Victoria. Use of the word 'includes' means that the list of examples is not exhaustive in that there may be other services that the responsible health complaints entity determines to be health services that are not listed.

<sup>191</sup> Department of Health, *The Aged Care Workforce 2016*, (Commonwealth of Australia, 2017).

<sup>192</sup> *ibid.*

<sup>193</sup> *ibid.*

<sup>194</sup> *ibid.*

<sup>195</sup> *ibid.*

<sup>196</sup> Victorian Department of Health, *Final Report: A National Code of Conduct for Health Care Workers* (Australian Health Ministers' Advisory Council 2014 2015), Recommendation 4.

<sup>197</sup> Victorian Department of Health, *Final Report: A National Code of Conduct for Health Care Workers* (Australian Health Ministers' Advisory Council 2014 2015), p 52.

- The Tasmanian definition refers to services that are provided ‘for the benefit of human health’ and includes ‘a service provided for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction’.
- The Western Australian definition does not list specific types of service, rather it refers to ‘any service provided by way of diagnosis or treatment of a disorder, preventative care, palliative care’ etc. In Western Australia, the scope of the regime covers complaints about both health and disability services.
- The ACT definition also includes a reference to ‘maintaining or improving...comfort or wellbeing’.
- The Northern Territory definition refers to a service provided ‘for, or purportedly for, the benefit of the health of a person’.<sup>198</sup>

These differences mean that the inclusion of aged care services and workers varies depending on the scope of powers of state and territory health complaints entities. Each jurisdiction determines the scope of application of the NCC and determines its own definition of what constitutes a health service<sup>199</sup> and therefore whether aged care services and aged care workers are in scope.

Figure 2 below indicates for each state and territory jurisdiction whether the health complaints legislation expressly includes aged care services and aged care workers in scope. In states and territories where the NCC includes unregistered aged care workers then service providers should notify the relevant health complaints body about reportable conduct involving staff members.

Figure 2: Key features of the definition of 'health service' in state and territory health complaints legislation

TABLE 3: Key features of the definition of 'health service' in state and territory health complaints legislation								
	Maintaining wellbeing, benefit health	Disability services	Community services	Accom services aged, physical disability, mental dysfunction	Volunteers	Ancillary health service	Services prescribed by regulation	Geographic limitation
ACT	YES	Diagnosing or treating disability	NO	NO	Not specified	NO	NO	YES
NSW	NO	OT, physio, speech pathology etc	'Community health services'	NO	Not specified	YES	YES	NO
NT	If 'for benefit of health of person'	If 'for benefit of health of person'	If 'for benefit of health of person'	If 'for benefit of health of person'	Not specified	YES	YES	YES
Qld	YES	Maybe	Maybe	Maybe	Not specified	YES	YES	NO
SA	If 'to benefit or promote human health	If provided in association with accom services	Maybe	YES	NO	YES	YES	NO
Tas	If 'for benefit of human health'	Accom services	Maybe	YES	Not specified	YES	NO	NO
Vic	NO	OT, physio, speech pathology etc	NO	NO	Not specified	YES	YES	NO
WA	NO	Diagnosis or treatment of physical or mental disorder	NO	NO	Not specified	YES	YES	NO

Source: Final Report: A National Code of Conduct for Health Care Workers (2015), p 53.

### 5.3.6 Benefits and impact

The main benefit of the proposed reportable conduct scheme is the introduction of a new approach to abusive and neglectful conduct by staff members delivering aged care services. The reportable conduct scheme changes the emphasis from requiring providers to report the occurrence of an

<sup>198</sup> *ibid.*

<sup>199</sup> COAG Communique, 17 April 2015, Attachment 1: National Code of Conduct for Health Care Workers, Definitions.



alleged or suspected assault to requiring an investigation and response to reportable conduct by providers.

The vast majority of stakeholders through the consultation process to develop options supported the development of a reportable conduct scheme if it meant that 'something' would be done in response to reports. The reportable conduct scheme will help to ensure that provider investigations and responses are independently overseen by the Commission.

The ALRC Elder Abuse Inquiry and Carnell-Paterson Review recommended establishment of the reportable conduct scheme with independent oversight as a key element of a more effective quality regulatory system. The Carnell-Paterson Review commented the reportable conduct scheme should be overseen by the Commission<sup>200</sup> and that a SIRS would contribute to a strengthened legal framework and allow providers to take proportionate, considered responses to serious incidents committed by staff members against consumers.<sup>201</sup>

The NSW Ombudsman has commented that in 91 per cent of matters notified through the reportable conduct scheme for disability services, action has been taken to improve the support and circumstances of the person with a disability affected by the conduct.<sup>202</sup>

Some stakeholders noted that compliance with accreditation standards may be evidence enough to demonstrate that appropriate responses to reportable conduct by providers will occur. The new Aged Care Quality Standards and guidelines set clear expectations that all aged care service providers should have appropriate systems in place to identify and respond to abuse and neglect of consumers. This would include reportable conduct by staff members, however, it is important to note there are currently no specific guidelines under the Aged Care Quality Standards in relation to reporting and responding to abusive or neglectful conduct by staff members. Periodic accreditation on its own is insufficient to guarantee that all reportable conduct by staff members – in the intervening period between accreditation processes – will be recorded and appropriately responded to on an incident-by-incident basis.

There are a range of systems in place to ensure consumers receive safe and quality aged care services. Additional scrutiny and oversight of the particular responses by providers to reportable conduct by staff will strengthen the framework of safeguards to ensure safety and quality for consumers. The reportable conduct scheme should be designed in a way that integrates with providers' existing internal processes for responding to abuse and neglect including reportable conduct by staff members. This will help to minimise additional administrative burden and increase the effectiveness of a SIRS.

As commented by the NSW Ombudsman, a reporting and independent oversight system for reportable conduct by staff members is an important and necessary component of a comprehensive framework for preventing and effectively responding to abuse, neglect and exploitation of more vulnerable members of the community and is fundamental to enabling a genuinely person-centred approach to supports.<sup>203</sup>

The ALRC Elder Abuse Inquiry found there was significant support for a new and expanded reportable conduct scheme to capture abuse and neglect by staff members against consumers.<sup>204</sup>

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<sup>200</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 112.

<sup>201</sup> *ibid.*

<sup>202</sup> ALRC, *Elder Abuse - Submission 341* (NSW Ombudsman March 2017).

<sup>203</sup> ALRC, *Elder Abuse - Submission 160: Submission to the Australian Reform Commission's inquiry on Protecting the Rights of Older Australians from Abuse* (NSW Ombudsman, August 2016).

<sup>204</sup> See, e.g., Office of the Public Guardian (Qld), Submission 384; Seniors Rights Victoria, Submission 383; National Legal Aid, Submission 370; Victorian Multicultural Commission, Submission 364; National Older Persons Legal Services Network, Submission 363; Office of the Public Advocate (Qld), Submission 361; Eastern Community Legal Centre, Submission 357; M Berry, Submission 355; Legal Aid NSW, Submission 352; Law Council of Australia, Submission 351; NSW Ombudsman, Submission 341; CPA Australia, Submission 338; ACT Human Rights Commission, Submission 337; Elder Care Watch, Submission 326; L Barratt, Submission 325; Speech Pathology Australia, Submission 309; P Greenwood, Submission 304; Seniors Rights Service, Submission 296; ADA Australia, Submission 283; ACT Disability Aged and Carer Advocacy Service

The National Older Persons Legal Services Network, for example, supported a scheme that could provide a response to conduct by staff members on both a systemic and individual basis:

A SIRS needs to balance and address two important interests. Firstly, the interests of the individual user. Secondly the interests of the aged care system ... Accountability to each through the reporting process is crucial to its success. For example, a reported incident must provide a critical response to those involved (victim and perpetrator), it must translate into accountability outcomes through systemic accountability including service standards, accreditation etc.<sup>205</sup>

A SIRS will trigger new levels of oversight in relation to how providers respond to ensure that providers address the wellbeing and immediate safety of the people involved. A SIRS will provide an opportunity to review and improve operational practices as appropriate to reduce the risk of further harm. Providers should respond to reportable conduct by staff members in a way that addresses the impact of the conduct on the consumer and any remedial action needed to ensure the wellbeing of the consumer.

Oversight of reportable conduct will 'lift the lid' on providers and help the Commission to identify abusive and neglectful staff members' quality of care issues. This additional surveillance and intelligence will itself enable the Commission to better exercise its regulatory efforts, for example through risk identification and scheduling unannounced visits to aged care services.<sup>206</sup> Reporting by providers, oversight of provider responses, and the register of staff members involved in reportable conduct will be important new sources of information to enable the Commission to identify the risk profile of aged care services and target accreditation and quality of care reviews. In particular, this information could be used by the Commission to better review residential aged care service providers' performance alongside the current aged care data sets. A SIRS may improve risk-profiling through new information about abuse and neglect being collected. The ability to fully realise this benefit will depend on the future architecture of the broader risk-profiling system for the Commission.

When the Commission receives a reportable conduct notification, it should consider whether the provider's investigation into the conduct has been adequate and whether an appropriate response and action has been taken to manage the risks involved. The Commission should also, where appropriate, monitor the investigation and, when an incident is the subject of monitoring, require the provider to report the results of investigation and risk management action taken. Stakeholders have commented more broadly that this type of independent oversight of reportable conduct by staff members will promote cultural change:

... if we're talking about cultural change, to put the responsibility on the organisation to be vigilant in terms of identifying this type of behaviour and for there to be some openness and transparency ... then for an external player to have a look at how those matters are dealt with, is essential in this area.<sup>207</sup>

One of the main benefits from a SIRS relates to collecting information about abusive and neglectful staff conduct that falls below the criminal threshold. While police may not pursue some reportable conduct by staff members, police not pursuing a matter should not be the end of a provider's responsibilities. A SIRS will ensure that providers do not misinterpret police taking no action on reportable conduct as meaning the provider has no further responsibilities in responding to the matter. Police taking no further action may simply mean the evidence gathered does not meet the threshold

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(ADACAS), Submission 269; Churches of Christ Care, Submission 254; NSW Nurses and Midwives' Association, Submission 248; Office of the Public Advocate (Vic), Submission 246; Lutheran Church of Australia, Submission 244; Advocare, Submission 213; COTA, Submission 354; Alzheimer's Australia, Submission 282; Combined Pensioners and Superannuants Associates, Submission 281; Elder Care Watch, Submission 326.

<sup>205</sup> ALRC, *Elder Abuse - Submission 363: Submission to Australian Law Reform Commission Elder Abuse Discussion Paper 83* National Older Persons Legal Services Network, March 2017).

<sup>206</sup> Australian Government Department of Health, *A Matter of Care Australia's Aged Care Workforce Strategy* (Aged Care Workforce Strategy Taskforce, June 2018), p 93.

<sup>207</sup> Transcript of S Kinmond, Case Study 24, 3 July 2015 at 15049:19–27.

for a criminal prosecution. Reportable conduct, while not necessarily criminal in nature, may reflect more subtle forms of abuse that are caused by mistakes, poor staff practice, poorly designed organisational systems or even insufficient resourcing. A SIRS will ensure there is oversight of provider reporting and responses to reportable conduct by staff members. Maintenance of a Register of staff members who have been found to have been involved in reportable conduct and the requirement to make providers check the Register as part of pre-employment screening is a key measure to realise these benefits. Importantly, a SIRS is likely to enable prevention and early detection of abuse by staff members against consumers by assisting providers to identify high-risk employees through information gathering and pre-employment screening against the Register of staff members involved in reportable conduct.<sup>208</sup>

The NSW Ombudsman has commented that even where there may not be a remedy available through the criminal justice system, the reportable conduct scheme can still be effective and help to ensure appropriate responses. The NSW Ombudsman commented that in one-third of all matters involving an allegation or suspicion of abuse by a staff member towards a client, there has been a finding of unacceptable behaviour on the part of the involved employee, and a range of management action has been taken.<sup>209</sup>

The introduction of independent oversight by the Commission will assist providers to better identify and manage risks to consumers. It is likely to improve providers' competency, transparency and accountability in handling reportable conduct by staff members. The reportable conduct scheme is also likely to help to create a nationally consistent standard of practice across the aged care sector in relation to preventing and handling abusive and neglectful conduct by staff members against consumers. A strengthened legal framework to require providers to notify the Commission of any reportable allegation, suspicion, conduct or conviction involving any of the provider's staff members – and for the Commission to monitor providers' investigation and handling of the allegation – is likely to result in providers taking a proportionate, considered response in a way that protects and safeguards older people directly impacted by the conduct.

The proposed reportable conduct scheme builds on the existing requirements for reporting allegations of abuse in the Act and draws on existing and proposed schemes for responding to abuse and neglect by staff members in other health and human services sectors.

The ALRC Elder Abuse Inquiry referred to four main schemes in developing recommendations about introducing reportable conduct requirements for abuse and neglect by staff members against consumers. The four schemes were the disability and child protection reportable conduct schemes administered by the NSW Ombudsman, the serious incident scheme administered by the NDIS Commission, and the serious incident scheme administered by the UK Care Quality Commission. At the time of this analysis, no publicly available research had been undertaken to fully evaluate any of these schemes. However, there is some research into the NSW child protection reportable conduct scheme to indicate that it is 'nominally robust' and that 'data indicates promising implementation capacity' based on the numbers of reports being made to the NSW Ombudsman.<sup>210</sup> In July 2017, reportable conduct schemes began in Victoria and the ACT for child protection services. In the context of child abuse, it has been noted that, without further research, it is not possible to know the efficacy of reportable conduct schemes or if all relevant conduct by staff members that should have been reported has been notified to the oversight body.<sup>211</sup>

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<sup>208</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report into improving institutional responding and reporting*, (Commonwealth of Australia 2017) Volume 7 p 257.

<sup>209</sup> ALRC, *Elder Abuse – Submission 341* (NSW Ombudsman, March 2017).

<sup>210</sup> B Mathews, *Oversight and regulatory mechanisms aimed at protecting children from sexual abuse: Understanding current evidence of efficacy*, (Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 12).

<sup>211</sup> *ibid.*

### 5.3.7 Stakeholder support for this option

The vast majority of stakeholders supported the introduction of a reportable conduct scheme to capture abusive and neglectful conduct by staff members against consumers and the introduction of independent oversight through the Commission of how providers handle and respond to reportable conduct.

## 5.4 Option 4 – Reportable incidents scheme for unexplained serious injury in residential aged care services

The ALRC Elder Abuse Inquiry recommended that a reportable incident in residential aged care should be defined to include unexplained serious injury experienced by consumers.<sup>212</sup> This would require an independent body – the Commission – to independently oversee how service providers notify, investigate and handle these incidents. The ALRC Elder Abuse Inquiry intended – by including unexplained serious injury as a reportable incident – to ensure that there is appropriate investigation of the circumstances leading to such an injury, appropriate clinical care provided, and appropriate communication with the injured person and their family members or representatives.

In formulating this recommendation, the ALRC Elder Abuse Inquiry drew heavily on the definition of a reportable incident from the NSW disability reportable incident scheme.<sup>213</sup> Experience from the NSW scheme – and commentary from stakeholders through the consultation process to develop options – suggests that including unexplained serious injury as a reportable incident in residential aged care settings is likely to capture a significant volume of clinical incidents related to clinical care and practice.

The meaning of unexplained serious injury is ambiguous, and further analysis and consultation would be needed to identify what should be reported – if anything – as part of a reportable incidents scheme. For example, it should identify whether temporary harm to consumers, unexpected hospitalisation, serious adverse events due to practice issues, premature deaths, oral and dental care issues, aspiration pneumonia, malnutrition and sepsis, suicide, under-diagnosed residents with depression and mental health needs, resident-to-resident aggression and behaviour management, restrictive practices, choking, falls, injuries from the use of mobility devices, pressure-injuries, infectious outbreaks and unexplained absences occurring in residential aged care services should be reported.

The Aged Care Quality Standards require delivery of safe and effective personal and clinical care, and consumers and the community expect this will occur. The question is whether the introduction of a regulatory scheme to make providers report every incident involving an unexplained serious injury is the most effective way to respond to issues involving poor clinical practice and care given the likely cost to government, regulatory burden on providers and limited evidence that this regulatory intervention will lead to significant improvements to clinical care relative to other interventions. This is a complex issue and warrants further consideration and consultation with experts.

Further analysis is required on the extent to which existing quality and safety provisions, including the new Aged Care Quality Standards, support the effective investigation and response to clinical matters and unexplained serious injury in residential aged care. Additionally, further consideration is needed as to whether the scope of such a scheme should be broader, and include home care and other

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<sup>212</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, Recommendation 4-3(c). (Commonwealth of Australia 2017).

<sup>213</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report* Footnote 123: The recommendation draws on the definition of ‘reportable incident’ in the DRIS, as well as the proposed scope of serious incident reporting for the NDIS: *Ombudsman Act 1974* (NSW) s 25P; Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 52. See also the requirements for notification of certain incidents in health and social care in the UK to the Care Quality Commission: broadly, incidents including injury, abuse or allegations of abuse (where abuse is defined as sexual abuse, physical or psychological ill-treatment, theft, misuse or misappropriation of money or property, or neglect and acts of omission which cause harm or place at risk of harm): *Care Quality Commission (Registration) Regulations 2009* (UK) reg 18. (Commonwealth of Australia 2017).

flexible care types. Any new regulatory scheme should also be considered in the context of other recommendations made from recent reviews and initiatives that are underway to improve the quality and safety of aged care.

#### 5.4.1 *Unexplained serious injury is likely to capture clinical incidents involving poor clinical practice and care*

The NSW disability reportable incident scheme commenced on 3 December 2014 and requires certain disability services to notify the NSW Ombudsman of allegations of serious incidents involving people with disability living in supported group accommodation. Under a SIRS, the NSW Ombudsman oversees how service providers prevent, handle and respond to specific reportable incidents including unexplained serious injury; employee to client incidents, which is covered by Option 3; and client-to-client incidents, which is covered by Option 5.

The NSW Ombudsman has published specific guidance on identifying and responding to an unexplained serious injury.<sup>214</sup> This guidance identifies that a serious injury is unexplained if it is not known how the injury occurred, and that this typically arises when a client is unable to provide an account of how the injury occurred or when the circumstances that caused the injury were not witnessed by another person. Part 3C of the *Ombudsman Act 1974* (NSW) sets out that a serious injury includes – but is not limited to – a fracture, burns, deep cuts, extensive bruising or concussion.

In its 2015-16 Annual Report, the NSW Ombudsman reported on one case study relating to unexplained serious injury which related to managing falls.<sup>215</sup> The NSW Ombudsman reported that the service provider involved made a reportable incident notification about a client with disability after the person was diagnosed with a fractured shoulder. The client was known to have epilepsy and frequent falls. The information the NSW Ombudsman received from the service provider indicated there had been delays in obtaining medical assistance for the client after previous falls. It was not clear how or when the fracture occurred or what had caused it, although it was suspected to be the result of an unwitnessed fall.

In this case study, the NSW Ombudsman identified a range of concerns with the service's management of the client's risk of falling, including:

- A lack of appropriate assessments.
- Inconsistent and inadequate medical intervention.
- Gaps in the available guidance for staff.
- Inadequate consideration of pain management.

The NSW Ombudsman raised these issues with the service provider and made suggestions to address them. This included ensuring the client had access to medical and other assessments, reviewing the client's support plans to ensure that they included current information about his falls, risks and strategies to manage those risks, and delivering training to staff to provide appropriate support. The NSW Ombudsman followed up with the service provider to make sure the feedback had been accepted and implemented.

In its subsequent annual reports, the NSW Ombudsman has reported on several case studies relating to unexplained serious injury. All of the reported case studies relate to clinical incidents, poor clinical practice and the need to deliver better quality, person-centred supports.<sup>216</sup>

The nature and prevalence of unexplained serious injury in aged care is not known. Stakeholders through the consultation process to develop options commented that there is likely to be a relatively high volume of unexplained serious injury incidents affecting consumers related to clinical care and

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<sup>214</sup> NSW Ombudsman, *Disability Reportable Incidents Fact Sheet, Identifying and responding to an unexplained serious injury* (NSW Ombudsman, June 2017).

<sup>215</sup> NSW Ombudsman, *Annual Report 2015-16*, (NSW Ombudsman, October 2016) p 109.

<sup>216</sup> NSW Ombudsman, *Annual Report 2016-17* (NSW Ombudsman, October 2017) p 130; NSW Ombudsman Annual Report 2017-18, (NSW Ombudsman, October 2018) p 97.

practice due to the frailty of consumers and high prevalence of dementia. Given there is no reliable prevalence data, there is a risk that a high volume of reportable incidents involving clinical care and practice could 'break' the Commission and create a flood of reports which are better dealt with through quality improvement responses rather than regulatory oversight. In 2015-16, the NSW Ombudsman received 686 disability reportable incidents involving people with disability living in supported group accommodation.<sup>217</sup> The NSW Government reported that in 2015-16, approximately 10,200 people with disability accessed supported accommodation services.<sup>218</sup> The number of notifications of reportable incidents in the first year of operation far exceeded the NSW Ombudsman's expectations and additional funding was needed to manage the volume of work.<sup>219</sup> In 2015-16, around 45 per cent of reported incidents related to employee to client incidents; around 37 per cent related to client-to-client incidents; and around 16.5 per cent related to unexplained serious injury. Unexplained serious injury accounted for 17.1 per cent of all reported incidents in 2016-17;<sup>220</sup> and 22.2 per cent of all reported incidents in 2017-18.<sup>221</sup> If it was assumed that between six and nine per cent of consumers in residential aged care were the subject of a reportable incident involving an unexplained serious injury related to clinical care and practice, there could be at least 20,000 reportable incidents each year. Based on the same assumptions, if the reporting of unexplained serious injury was expanded to include consumers in home care and other care types, the number of reports would increase substantially, and could account for at least 55,000 additional reports (not including the number of reports from residential care).

#### *5.4.2 Older people in residential aged care may be at a higher risk of unexplained serious injury because of their frailty*

While it may be appropriate for unexplained serious injury to be reported in the disability service system, further consideration is needed as to whether reporting of these incidents through an oversight and regulatory scheme is appropriate in aged care. The cohort of older people in residential aged care differs to the cohort of people with disability in supported group accommodation.

Older persons in residential aged care are at significant risk of harm as a consequence of their physical frailty, cognitive impairment, multiple co-morbidities and complex drug regimes.<sup>222</sup>

It is also important to note that the total number of older people in a residential aged care setting compared to the number of people with disability in group accommodation is also much higher.

##### *5.4.2.1 Clinical care and practice may be better dealt with through quality improvement and policy initiatives*

There are a range of mechanisms in place within the quality and safety framework for aged care to manage clinical incidents. Recent reviews have made extensive recommendations to improve clinical care and practice in aged care. Arguably, these recommendations should be considered alongside an option to introduce new regulatory oversight in relation to unexplained serious injury.

Recent research into the prevention of injury in residential aged care has recommended that a national program for improving the quality of care and safety for residents and staff should be developed to promote organisational leadership, a culture of continuous learning and national data collection to enable providers to have high performing systems to evaluate their service and reduce the possibility of any residents suffering adverse events.<sup>223</sup>

<sup>217</sup> NSW Ombudsman, *Annual Report 2015-16*, (NSW Ombudsman, October 2016) p 105.

<sup>218</sup> NSW Family and Community Services, *2015-16 Annual Report*, Volume 1, Part 2, p 26.

<sup>219</sup> NSW Ombudsman, *Annual Report, 2015-16*, (NSW Ombudsman, October 2016) p 16.

<sup>220</sup> NSW Ombudsman, *Annual Report, 2016-17* (NSW Ombudsman, October 2017) p 129.

<sup>221</sup> NSW Ombudsman, *Annual Report, 2017-18* (NSW Ombudsman, October 2018) p 124.

<sup>222</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017), p 30.

<sup>223</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017) p 13.

The Carnell-Paterson Review also recognised that clinical care and clinical leadership is a vital component of services delivered in residential aged care<sup>224</sup> and proposed that a Chief Clinical Advisor be appointed in the new Commission. The Carnell-Paterson Review commented that the new Chief Clinical Advisor should provide clinical leadership, support the Commission to adapt its processes to better align with changes in clinical practice in residential aged care, provide guidance on the development of clinical outcome measures as part of accreditation, champion development of a clinical governance framework for residential aged care services, provide information to the sector and aged care workers on best practice in clinical care, and support the review of facilities found to be delivering ineffective or unsafe clinical care.

The Carnell-Paterson Review commented that the serious incidents at Oakden illustrate the risks posed by ineffective clinical governance arrangements where warning signs were not heeded by the service provider, responsibility for clinical outcomes was not owned, leadership was poor, education, training and professional development were seriously deficient, there were no systems of continuous improvement, and important data was not used to drive change.<sup>225</sup>

The Carnell-Paterson Review recommended that a clinical governance framework be developed for residential aged care – as well as other aged care providers delivering clinical care – to address the roles, responsibilities and scope of clinical care delivered in these settings. Recommendation 9 of the Carnell-Paterson Review explicitly identified the need to more clearly define clinical outcome measures in standards and guidance material and the need to strengthen the capability of assessment teams to work with providers and improve clinical care and practice.

There have been recent calls for a national study to investigate the standards and quality of aged care.<sup>226</sup> A national study could support government to better understand the extent to which clinical incidents in aged care are leading to premature deaths and causing greater levels of injury-related morbidity. A national study could examine a wide range of clinical incidents.

The Carnell-Paterson Review recommended that all government-subsidised aged care services participate in the National Quality Indicators Program and adopt mandatory reporting of provider performance against quality indicators, and that the three quality indicators be expanded beyond pressure injuries, use of physical restraint and unplanned weight loss.<sup>227</sup>

The Carnell-Paterson Review and other reviews have identified the need for further work to improve clinical care and practice in aged care services, including the need for instructions on ‘how to’ deliver different aspects of care to avoid the clinical incidents and poor clinical practice causing unexplained serious injury to aged consumers.

In endorsing the ALRC Elder Abuse Inquiry’s recommendation that unexplained serious injury be reported on an incident-by-incident basis as part of a reportable incidents scheme, the Carnell-Paterson Review cited evidence from a draft report by Monash University’s Health, Law and Ageing Research Unit in relation to extending the current reportable assaults scheme.<sup>228</sup> It is important to note that after the Carnell-Paterson Review completed its final report, the report from Monash

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<sup>224</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, Recommendation 3-5 to establish a prevalence study of elder abuse to build the evidence base to inform policy responses; The ‘Recommendations for prevention of injury-related deaths in residential aged care services’ report also recommends a national study be undertaken. (Commonwealth of Australia 2017).

<sup>224</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 81.

<sup>225</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 145 commenting on Groves A., et al, 2017, *The Oakden Report*, South Australia Department for Health and Ageing, pp 89-90.

<sup>227</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, Recommendations 3 and 4 (October 2017).

<sup>228</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 113; citing Ibrahim, J., (ed.), , *Recommendations for prevention of injury-related deaths in residential aged care services [draft]*, Health Law and Ageing Research Unit, Department of Forensic Medicine, (Monash University 2017).

University was published and the full recommendations relating to reportable incidents are broader than the extracts commented on by the Carnell-Paterson Review. Specifically, the Monash University report recommended that the current reportable assaults scheme be extended but on the basis that a range of other improvements to clinical care and practice be made:

- Government, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage clinical incidents.
- All relevant data on incidents be centrally collected in a national database and reported publicly each year.
- Mandatory reporting requirements be extended to include all types of incidents.
- Mandatory training for staff be extended.
- Services adopt a person-centred care approach to aged care.<sup>229</sup>

The Monash University report is based on a public health approach and advocates for surveillance of all clinical incidents which cause harm or have the potential to result in harm to a consumer to inform effective prevention and response strategies.

#### *5.4.2.2 New Aged Care Quality Standards place explicit requirements on service providers to deliver safe and quality clinical care, personal care and services and supports for daily living*

The new Aged Care Quality Standards already require service providers to have effective systems to deliver safe and quality personal and clinical care and services and supports for daily living and to have effective risk management systems for identifying and responding to abuse and neglect of consumers. The Commission will also have a Chief Clinical Advisor to lead best practice clinical care in aged care. These new initiatives – along with other reforms – may be effective in reducing the risk of incidents causing unexplained serious injury. However, this will be unknown for some time until these initiatives are embedded within the sector.

The new Aged Care Quality Standards – in particular Standard 3 – set clear expectations about the standard of personal and clinical care that aged consumers and the community can expect. Under the standards, service providers must demonstrate safe and effective clinical care, including the effective management of high-impact and high-prevalence risks associated with the care of each consumer. This means that service providers need to do all they can to manage risks related to the personal and clinical care of each consumer. This includes following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer's independence to make their own choices, including to take some risks in life.

Effective management of risks must be underpinned by providers' clinical governance systems for safety and quality. This includes reviewing how personal and clinical care is delivered to apply new practices and responding appropriately and promptly to a consumer's changing needs.

For high-impact or high-prevalence risks related to personal and clinical care, for example falls, service providers are expected to use risk assessments to find ways to reduce these risks. Service providers should undertake these assessments in consultation with consumers. This can involve the provider's service environment, equipment, workforce training, systems, processes, or practices that affect any aspect of how they deliver personal and clinical care to consumers. For example, if there is a risk that a consumer may fall, the care and services plan should specify the assistance or mobility aids the service provider will deliver to help the consumer to move about safely. Providers must also educate and support their workforce to minimise risks to consumers.

Preventable harm can occur from a range of risks, including hydration and nutrition, swallowing difficulties and choking, managing multiple medications, pressure injuries and factors such as poor nutrition, poor skin health and lack of oxygen to tissues, restrictive practices, and delirium and hearing

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<sup>229</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017).



loss, where consumers may be at risk of developing depression or high levels of stress and frustration.

Resources have been developed to support service providers to deliver quality and safe clinical care in many areas, including clinical governance;<sup>230</sup> prevention and management of pressure injury;<sup>231</sup> pain and medication management;<sup>232</sup> best practice food and nutrition information including on swallowing;<sup>233</sup> preventing falls and harm from falls;<sup>234</sup> supporting a restraint-free environment and issues with the use of psychotropic medications;<sup>235</sup> good practice for aged consumers with deafness who need hearing assistance;<sup>236</sup> recognising and responding to dementia, delirium and cognitive and related functional decline and deterioration;<sup>237</sup> responding to the threat of antimicrobial resistance;<sup>238</sup> prevention and control of infection;<sup>239</sup> and end-of-life care.<sup>240</sup>

### 5.4.3 Benefits and impact

This option warrants further consideration and consultation with experts, including considering this option in other aged care settings such as home and other care types. Extending the scope of reporting unexplained serious injuries of consumers in home care and other care types has not been explored at length in this proposal, and should therefore be carefully considered in future analysis if this option is fully developed.

### 5.4.4 Stakeholder support for this option

Stakeholders commented that including unexplained serious injury as a reportable incident in residential aged care is likely to capture a significant volume of clinical incidents related to clinical care and practice and may unduly consume time and resources.

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<sup>230</sup> Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, (Sydney, ACSQHC, 2017); Department of Health and Ageing, *National Aged Care Quality Indicator Program | Resource manual for residential aged care facilities*, (Commonwealth of Australia, Canberra 2016).

<sup>231</sup> Australian Wound Management Association, *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury* (Cambridge Media Osborne Part, WA, 2012).

<sup>232</sup> The Australian Pain Society, *Pain in Residential Aged Care, Management Strategies*, 2nd Edition, (Australian Pain Society 2018); Department of Health and Ageing, *Guiding principles for medication management in residential aged care facilities* (Commonwealth of Australia 2012).

<sup>233</sup> Central Coast Local Health District (CCLHD), *Best Practice Food and Nutrition Manual for Aged Care Facilities*, 2nd Edition, (NSW Government 2015); Victorian Government, Department of Health, *Nutrition and Swallowing*.

<sup>234</sup> Australian Commission on Safety and Quality in Health Care, *Guidebook for Preventing Falls and Harm From Falls in Older People*, (Commonwealth of Australia 2009); National Ageing Research Institute, *Resources for Health Professionals – Falls and balance* (National Ageing Research Institute Limited 2018).

<sup>235</sup> Alzheimer's Australia, *The use of restraints and psychotropic medications in people with dementia*, (Alzheimer's Australia, Melbourne 2014); Department of Health and Ageing, *Decision-making tool: supporting a restraint-free environment in residential aged care*, (Commonwealth of Australia, Canberra 2012).

<sup>236</sup> Deafness Forum Australia, *Good Practice Guide, Reference Resources for Aged Care Hearing Assistance Programs* (Deafness Forum Ltd 2018).

<sup>237</sup> Guideline Adaptation Committee, *Clinical Practice Guidelines and Principles of Care for People with Dementia*, Sydney, Guideline Adaptation Committee NHMRC 2016; *National Framework for Action on Dementia 2015–2019 (2015)*; Australian Commission on Safety and Quality in Health Care, *Delirium Clinical Care Standard*, (Sydney: ACSQHC, 2016); National Health & Medical Research Council (NHMRC), Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People (Elsevier, 2018); Victorian Government, Department of Health, *Recognising and Responding to Clinical Deterioration*, (Victorian Department of Health 2014).

<sup>238</sup> Australian Government, Department of Health & Department of Agriculture, *Responding to the threat of antimicrobial resistance: Australia's first National Antimicrobial Resistance Strategy 2015-2019* (Commonwealth of Australia, Canberra 2015).

<sup>239</sup> National Health and Medical Research Council, *Australian guidelines for the prevention and control of infection in healthcare*, (Commonwealth of Australia, Canberra 2010).

<sup>240</sup> Australian Commission on Safety and Quality in Health Care, *National consensus statement: essential elements for safe and high-quality end-of-life care*, (Sydney, 2015).

## 5.5 Option 5 – Reportable incidents scheme for aggression and abuse between consumers in a residential aged care setting

### 5.5.1 Whose conduct should be reportable and who should provide reports?

This option would require the Commission to independently oversee how service providers notify, investigate and handle reportable incidents of abuse and aggression between consumers receiving Commonwealth funded aged care in a residential setting. The reportable incidents scheme should:

- Apply to all Commonwealth funded aged care services provided in a residential setting including respite and flexible care.
- Require service providers to notify the Commission of any reportable incident allegation, suspicion, conduct or conviction between consumers of which the service provider becomes aware.
- Require service providers to notify appropriate police, adult safeguarding and support services of relevant reportable incidents between consumers.
- Allow service providers to disclose information about a consumer involved in a reportable incident to safeguard other consumers.
- Require service providers to encourage staff members to make notifications of reportable incidents between consumers.
- Allow any person with a reportable incident allegation to be able to make a notification to the relevant service provider or the Commission.

### 5.5.2 What conduct should be reportable?

A reportable incident between consumers in residential care should be defined to mean:

- Sexual abuse.
- Physical abuse causing serious injury.
- An incident that is part of a pattern of abuse.

Reporting exemptions to release service providers from notifying the Commission of incidents involving a consumer with cognitive impairment should be removed because a reportable incident between consumers is always a serious matter. This is consistent with the ALRC Elder Abuse Inquiry recommendation.<sup>241</sup> No exemption is proposed in relation to incidents between consumers with cognitive impairment.

Specific guidance should be developed in relation to the meaning of reportable incidents including the development of explicit definitions and case studies.

### 5.5.3 What reports should be provided and when? And what responses should be required to aggression and abuse between consumers in residential settings?

Providers should be obliged to make:

- An incident notification to the Commission as soon as practicable after becoming aware of the reportable incident between consumers.
- An incident report to the Commission within 28 days of the incident notification.

A SIRS should require the Commission to develop and approve a specific form for the purposes of providers giving the Commission this information in a way that minimises unnecessary burden on providers.

A SIRS should require the Commission to acknowledge receipt of the incident notification and incident report as soon as practicable.

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<sup>241</sup> ALRC, *Elder Abuse – A National Legal Response: Final Report*, (Commonwealth of Australia 2017) page 123, para 4.98.

Providers should be required to collect data and keep appropriate records to enable administration of the reportable incidents scheme.

Providers should be obliged to identify, manage and resolve serious incidents, including reportable incidents between consumers, in line with comprehensive and specific guidance which the Commission must be required to publish. Specific guidance should be developed with the overarching aim to build organisational cultures that do not condone abusive conduct. This guidance – with appropriate definitions – should be developed in consultation with experts and stakeholders to assist providers of aged care services in residential settings to understand what constitutes abuse and how to implement solutions to prevent abuse between consumers.<sup>242</sup>

As part of a service provider's response to abuse and aggression between consumers in residential aged care settings, the service provider should review the circumstances as soon as possible, including:

- Immediate changes that may be needed to the care arrangements to protect all consumers.
- The need for a medical review of the victim and alleged offender.
- Use and effectiveness of behaviour supports including recommendations from dementia support services.
- Any need for a mental health review of the alleged offender.
- Whether the needs of the victim and alleged offender (and other consumers) are being met.
- Staffing and supervision arrangements.
- Open disclosure requirements.

The review by a service provider should include input from a range of different people, including the consumers involved; staff; representatives and family, where appropriate; and expert and clinical advice such as from clinical advisors.

The focus of a provider's response to a reportable incident between consumers in residential aged care services should be on the safety, health and wellbeing of the consumer impacted by the incident and on the behaviours and supports needed for the consumer who expressed abusive and aggressive behaviour.

Providers should not be obliged to conduct an investigation into the reportable incident in every case. However as a matter of practice, providers will conduct some investigation in many cases.

#### 5.5.4 What roles and functions should the Commission have?

The Commission should have – like in Option 3 – appropriate powers to:

- Keep under scrutiny the systems for preventing abuse and aggression between consumers in residential aged care, including by auditing service providers.
- Oversee and monitor how providers investigate and handle reportable incidents between consumers.
- Conduct an investigation of a reportable incident on its own initiative.
- Make a recommendation to a provider for action to be taken.
- Exempt certain incidents from being reportable by agreement with service providers if the Commission is satisfied the exemption would not increase the risk of harm to consumers.
- Undertake capacity building and practice development in relation to provider responses to reportable incidents between consumers.
- Share information to enable the prevention and early detection of abuse and aggression between consumers.
- Interact with the criminal justice system and police where appropriate.

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<sup>242</sup> Ms Kate Carnell and Professor Ron Patterson, *Review of National Aged Care Quality Regulation Report*, (October 2017), p 114.

- Make public reports and be required to publicly report on an annual basis on the operation and effectiveness of the reportable incidents scheme.
- Cause a periodic independent review of the operation of the reportable incidents scheme every five years.

One of the challenges for the new Commission in providing oversight of provider responses to abuse and aggression between consumers will be recruitment of specialist expertise to oversee these matters. Multi-disciplinary and skilled staff will be needed who bring expertise in aged care, dementia-related behaviour, abuse and aggression between residents and best practice supports to reduce aggressive behaviours.

### 5.5.5 Benefits and impact

The main benefit of a reportable incidents scheme for abuse and aggression between consumers in residential aged care is to ensure that providers have independent oversight on how they manage and reduce risks. Providers should focus on:

- The immediate safety and support needs of the impacted person and any other consumers.
- The cause of the incident.
- Action that should be taken, including behaviour supports, to prevent such incidents from happening again to the same or other consumers.

Stakeholders submitted to the ALRC Elder Abuse Inquiry that the focus of reporting and responding to reportable incidents between consumers should be on identifying the cause of the abuse, the action that needs to be taken and the supports that need to be provided to prevent recurrence.<sup>243</sup>

Responses to reportable incidents should address the underlying cause, seek appropriate solutions and monitor provider implementation of solutions and the effectiveness of these responses.<sup>244</sup>

The definition proposed by the ALRC Elder Abuse Inquiry of a reportable incident between consumers is broader than the definition in the current reportable assaults scheme. The definition proposed by the ALRC Elder Abuse Inquiry also removes the reporting exemption for incidents by consumers with cognitive impairment. A key feature of this option is the 'threshold' definition for when an incident must be reported and, therefore, when the provider's response will be overseen by the Commission. The definition proposed by the ALRC Elder Abuse Inquiry will capture very serious abuse, but these incidents may be the 'tip of the iceberg'. If less serious acts of abuse and aggression are not captured through the reportable incidents scheme then there may be limited opportunities for a SIRS to prevent or enable the early detection of serious harm to consumers. On the other hand, if all 'less serious' acts of abuse and aggression between consumers in a residential aged setting were reported then the Commission could be flooded with notifications and not be able to effectively triage and respond to serious incidents appropriately.

The issue is complex and warrants further consideration and consultation with experts as part of the detailed policy and legal analysis required.

#### 5.5.5.1 Definition of a reportable incident between consumers in residential care warrants further consideration

In considering what an appropriate reporting threshold should be, the nature and prevalence of consumer-to-consumer aggression in a residential aged care setting must be fully understood. Aggression between consumers in residential aged care can present in many different forms, including physical aggression (e.g. pushing another resident), verbal aggression (e.g. yelling and shouting), sexual aggression (e.g. inappropriate touching) and material aggression (e.g. taking other

<sup>243</sup> ALRC, *Elder Abuse - Submission 160: Submission to the Australian Reform Commission's inquiry on Protecting the Rights of Older Australians from Abuse* (NSW Ombudsman, August 2016).

<sup>244</sup> ALRC, *Elder Abuse – Submission 248: Elder Abuse Discussion Paper* (NSW Nurses and Midwives' Association February 2017).

residents' property). A number of fatal assaults on residents by other residents have been reported in recent times.<sup>245</sup>

Aggression between consumers in a residential aged care setting has been identified as an emergent public health concern.<sup>246</sup> It has been defined as 'negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient'.<sup>247</sup> Aggression between consumers in residential aged care settings can occur where one or more residents is living with dementia.<sup>248</sup> Due to the ageing population, the prevalence of dementia has risen considerably in recent years.<sup>249</sup> Approximately 50 per cent of consumers in residential aged care have a diagnosis of dementia.<sup>250</sup> The number of people requiring residential aged care services and specialised dementia support is likely to increase with the rapidly ageing population.<sup>251</sup> Aggression in a person living with dementia can arise from depression, psychotic symptoms, environmental stressors and/or unmet needs.<sup>252</sup> With appropriate behaviour and other supports, there is potential to reduce the severity and frequency of this behaviour.

In considering what the appropriate threshold or definition should be for a reportable incident between consumers, it is important to note that recent research has identified a number of recommendations – other than regulatory oversight – to address this issue, including that:

- All relevant data on incidents of aggression and assault in residential aged care settings be centrally collected in a national database and reported publicly each year.
- Mandatory reporting requirements be extended to include all types of aggressive incidents in a residential aged care setting, regardless of the cognitive status of resident involved.
- Mandatory training for residential aged care staff be extended to include training on the fundamentals of dementia and aggression and abuse between residents, potentially building on the training available through Dementia Training Australia.
- Aged care providers introduce zero tolerance policies in residential aged care settings for violence against staff, consumers and visitors.
- The physical environment of residential aged care be designed and used in a way that enables rather than disables residents with cognitive impairment.
- Clear user friendly definitions of the spectrum of aggressive behaviours be included in mandatory reporting legislation, policy and protocol documents.
- Government agencies, advocacy groups and aged care providers develop and implement a community awareness campaign to increase the general public's understanding of dementia; its behavioural and psychological symptoms; and knowledge about the preventability of aggressive incidents among older adults.
- Residential aged care service providers introduce policies aimed at supporting families to feel part of a comprehensive care team.<sup>253</sup>

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<sup>245</sup> See Angelique Donnellan and Nicola Gage, 'Oakden Nursing Home Murder Haunts Victim's Family' ABC News, 6 April 2017; Rebecca Opie, 'Nurse Hid as Elderly Patient Went on Rampage, SA Court Told' ABC News, 24 November 2016; Megan Gorrey, 'Jindalee Aged Care Nurse Left Bashed Man Unsupervised in the Same Room as Suspect' Canberra Times, 25 September 2015; Personal story recounted in Submission 189 to the ALRC Elder Abuse Inquiry.

<sup>246</sup> Recommendations for prevention of injury.

<sup>247</sup> McDonald L, Hitzig SL, Pillemer KA, Lachs MS, Beaulieu M, Brownell P, et al, 'Developing a research agenda on resident-to-resident aggression: recommendations from a consensus conference' *J Elder Abuse Negl* (2015) 27(2), pp 146-67.

<sup>248</sup> Op cit, Ferrah N, et al, 'Resident-to-resident physical aggression leading to injury in nursing homes' (2015).

<sup>249</sup> Australian Government: AIHW, Dementia in Australia, 2012.

<sup>250</sup> Australian Government, AIHW, Dementia among aged care residents: first information from the aged care funding instrument: aged care statistics serious number 32, 2011.

<sup>251</sup> Recommendations for prevention of injury, p 172.

<sup>252</sup> Dementia Collaborative Research Centre – Assessment and Better Care (DCRC-ABC), 2012, *Behaviour Management - A Guide to Good Practice: Managing Behavioural and Psychological Symptoms of Dementia (BPSD)*, University of New South Wales.

<sup>253</sup> Prof. Joseph E Ibrahim, *Recommendations for prevention of injury-related deaths in residential aged care services*, (Monash University: Southbank 2017).

There may also be opportunities for greater use of dementia support services, such as the Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Team (SBRT) delivered by Dementia Support Australia. These services assist carers when behavioural and psychological symptoms of dementia (BPSD) are affecting a person's care or quality of life. The Dementia Training Program also offers a national approach to accredited education, upskilling, and professional development in dementia care.

#### *5.5.6 Stakeholder support for this option*

Most stakeholders supported making abuse and aggression between consumers in residential aged care a reportable incident. Stakeholders commented that the main focus of this reportable incidents scheme should be on managing and reducing risks, the immediate safety and support needs of the impacted consumer, the cause of the incident, and what action should be taken, including behaviour supports, to prevent such incidents from happening again. Many stakeholders commented on the need for better guidance on handling abuse and aggression between consumers in residential aged care. All stakeholders acknowledged that this issue is complex, and stakeholders expressed a desire for further consultation in relation to how a reportable incidents scheme for abuse and aggression between consumers of residential aged care services should operate.

## Part 6: Implementation, compliance, enforcement and evaluation issues

There are a number of issues that will need to be considered in implementing the preferred option for a SIRS. Any substantial change to the current arrangements (Options 3 to 5) will require adequate funding and resourcing to operationalise. This includes costs to recruit the workforce to support the new functions within the Commission and build the capacity of providers to adopt a scheme effectively. Legislative amendments will be required and will need to be considered in the context of existing Commonwealth and state and territory legislation. It will also be important to consider how a SIRS may be implemented within the broader reform context of the aged care system.

These issues are discussed further in Table 5 below. Further policy and legal analysis of these issues, and consultation with key sector stakeholders is critical prior to implementation of a SIRS.

Table 5: Key issues to consider in implementing a SIRS

Implementation considerations	Key issues
<b>Legislative amendments and alignment</b>	<p>Detailed legal analysis is required to understand what legislative amendments are needed to implement a new SIRS and to identify the intersections of a SIRS with existing legislation.</p> <p>Enabling legislation and powers will be required to support the SIRS and its functions. It will be important to consider how this intersects with existing aged care legislation, including the <i>Aged Care Act 1997</i>, <i>Aged Care Quality and Safety Commission Act 2018</i> and the <i>Accountability Principles 2014</i>.</p> <p>Commonwealth, state and territory government collaboration will be required to consider any legislative gaps that need to be addressed, for example in criminal law, for a SIRS to operate smoothly including the need for any new information sharing provisions. There may be other laws that could be in conflict with a SIRS, for example certain aspects of industrial relations legislation may conflict with providers dismissing employees who have been found to have engaged in a serious incident affecting a consumer of aged care services.</p> <p>A SIRS and any supporting legislation also needs to be compatible with legislation regulating employment screening, carers registers, and mandatory and other reporting obligations so that providers do not have to duplicate reports to multiple government authorities. Greater use of technology may be one option to support providers to fulfil multiple reporting obligations and improve the interoperability between different government bodies that manage similar schemes or similar requirements.</p>
<b>Recruitment and resourcing</b>	<p>The Commission must be sufficiently resourced to perform its oversight role. Recruitment will take time and require significant investment by the Commission. The new workforce will need to be composed of a mix of resources that have the required skillset to support the different functions of a SIRS, including oversight of provider responses, investigation of incidents, provision of training and support to the sector and monitoring of the performance of a SIRS. The breadth of the types of serious incidents and the subsequent differences in the investigative response to these allegations requires the recruitment of investigators with varied skills and experience. The market for individuals with expertise in monitoring, compliance and investigations (with a focus on post-incident analysis, risk mitigation and client care) is limited. Overlaying this skill set with aged care knowledge and experience will be challenging for recruitment.</p> <p>The Commission will therefore need to consider recruiting staff with a mix of relevant skills and investing in upskilling staff so they can develop the required knowledge to provide quality oversight.</p> <p>The Commission will also need to monitor and adapt its resourcing during implementation to ensure the right resources are in place to support a SIRS. This will involve active monitoring of report data and caseloads to ensure appropriate and responsive levels of resourcing.</p> <p>Ensuring the SIRS Branch is resourced with appropriately skilled and experienced staff will be a key organisational risk.</p>

Implementation considerations	Key issues
<b>Location of SIRS Branch</b>	It is noted that the current team is located in Tasmania. Careful consideration will need to be taken as to the location of a SIRS Branch, in order to maximise quality recruitment. Regional decentralisation must be balanced with operational requirements, for example some stakeholders consulted have noted that placement of the NDIS Quality and Safeguards Commission in a regional NSW location has presented challenges in recruiting staff due to workforce gaps. There are also benefits with co-locating a SIRS with other functions of the Commission which should be considered in determining the location of a SIRS Branch.
<b>Integration</b>	It is important that the quality and complaints functions of the new Commission are appropriately integrated before the transition of the SIRS Branch into the Commission, as a number of functions of SIRS (for example the intake, investigations and compliance and enforcement functions) are intended to work in conjunction with (and gain efficiencies from) other areas within the Commission.
<b>ICT</b>	<p>Appropriate IT infrastructure will be required to support reporting by providers, data collection by the Department or the Commission, and data analysis to identify patterns and trends. As it is anticipated that the SIRS will generate a large number of reports, having a notification portal that allows online submission of a notification form would be ideal. This system would allow for the electronic flow of information between a provider and the Commission, and could allow for the case management system to be auto-populated to reduce the time and cost of the intake function. The portal could also have a dashboard for providers, which would allow them to more easily monitor the number of matters they have reported to the Commission, and allow them to easily analyse their own data.</p> <p>The Commission should also consider what information needs to be captured to support performance monitoring and evaluation of a SIRS in designing a new system or adapting current systems. This will allow for quality reporting on trends in reportable incidents (such as type of incident, status and outcomes etc.) as well as identification of systemic issues.</p> <p>However, introducing new IT systems will likely have significant cost and resourcing implications. Work is also already underway to define the IT infrastructure that is required to support a new Commission, including the systems to undertake risk profiling of providers. It will be important to consider how a SIRS might fit within this future IT infrastructure of a new Commission. The extent to which reporting functionality could be integrated into existing systems that service providers use, such as My Aged Care, could also be considered further as part of implementation.</p>
<b>Business process and procedure</b>	A systems-based approach to developing policy, process, risk matrices and decision guides is required. Policies, processes, risk matrices and decision guides should be refined on an ongoing basis to improve operational effectiveness.
<b>Strategic stakeholder engagement and information sharing</b>	<p>Early in the implementation process, the Commission should consider engaging proactively with key stakeholders such as Police and state and territory safeguarding and professional bodies to build relationships, and facilitate information sharing.</p> <p>This will ensure that any referrals or information sharing can be conducted in a timely way. For example, in high-risk matters, the SIRS Branch may benefit from engaging with police directly (as the Commission may be able to access information that will not be shared with providers), or co-ordinating with multiple agencies. Establishing relationships early will be critical to facilitating this work.</p>
<b>Sector capacity</b>	One of the key cost drivers for a SIRS will be building provider capacity to identify and respond to serious incidents. Not all service providers will have the same capacity and capability to respond to the new requirements of a SIRS. Service providers in rural and remote areas or smaller service providers may find the cost of hiring an external investigator prohibitive. Investment may be required to build the capacity of service providers to adopt a SIRS effectively.
<b>Engagement and education for providers.</b>	Stakeholder engagement is critical to ensure the successful implementation and operation of a SIRS. Engagement should be through a variety of channels, including forums, meetings, training, education strategies and other forms of dialogue and information exchange. It should also be flexible and inclusive to cater for the needs of different types of services providers, the services they deliver and the consumers they



**Implementation considerations****Key issues**

support. For example, the specific needs of smaller rural and remote providers and providers who support consumers from Aboriginal and Torres Strait Islander communities should be considered.

Early education and engagement with providers will be an integral step in the implementation of a SIRS. It is important that the Commission work early on building the capability of aged care providers in identifying, handling, and investigating serious incidents. The higher quality the handling of an incident by the provider, the less hands-on oversight and monitoring by the Commission. It is recommended that the education and engagement function be resourced six months before commencement, and be responsible for creating material such as, but not limited to, fact sheets, guidance material, training and workshops.

Meetings, presentations and attendance at events with providers will be a valuable tool for talking about a SIRS and answering questions to assist providers to gain an understanding of the regulatory system. Similarly, engagement with peak bodies, community representative groups and other organisations will help raise the profile of SIRS within the aged care community.

Any oversight body's relationships with providers is a key source of intelligence about potential risks to consumers of aged care services. If recommendations by an oversight body are non-binding, a strong working relationship that fosters goodwill and builds trust will be critical for ensuring that recommendations are respected and acted upon by providers. Good working relationships between any oversight body, providers, the Department and other government agencies through stakeholder engagement will ultimately support the effective implementation and operation of a SIRS.

## 6.1 Implementation timing

It will be important to consider how a SIRS fits within the broader reform context for aged care. The regulatory functions of the Department, including the existing compulsory reporting of assaults,<sup>254</sup> are intended to transition to the Commission in 2020.<sup>255</sup> A separate legislative amendment will be required to enable this transfer.<sup>256</sup>

Significant work is required to determine how each option will apply across each type of aged care service. Service providers will need time to understand what is required of a SIRS and how they can implement options in the context of the services they provide. It will also take time for the relevant Australian Government agencies to mobilise the necessary machinery for implementation, including recruitment of the necessary workforce to support the new oversight functions of a scheme.

Taking a phased approach to implementation will help to manage these complexities. High level implementation milestones have been developed in consultation with the Department. These are based on requirements from the Department around policy and legislative analysis, and consideration of other reform. The table below presents a high level timeline of how a SIRS could be implemented through a phased approach.

<sup>254</sup> The Senate Community Affairs Legislation Committee, *Inquiry into the Aged Care Quality and Safety Commission Bill 2018*, page 39, para 1.4.

<sup>255</sup> Commission bill EM, p. 1. It is intended the Commission will assume the Department of Health responsibilities of approval of providers of aged care, compliance and compulsory reporting of assaults from 1 January 2020. This will require a separate legislative amendment.

<sup>256</sup> The Senate Community Affairs Legislation Committee, *Inquiry into the Aged Care Quality and Safety Commission Bill 2018*, page 38, para 1.5.

Table 6: Possible implementation approach for a SIRS

January 2019 – July 2019	July 2019 - June 2020	July 2020 – June 2021	July 2021 – June 2022	July-Dec 2022
Set-up Phase		Implementation Phase		
<ul style="list-style-type: none"> <li>Develop policy proposal through targeted sector and expert consultation.</li> <li>Estimate cost and regulatory burden.</li> <li>Decision by Government on preferred SIRS option for further consultation and implementation.</li> <li>Recruitment of core establishment policy team in the Department.</li> </ul>	<ul style="list-style-type: none"> <li>Regulatory function of the Department to transfer to the Commission.</li> <li>Develop detailed implementation plan.</li> <li>Detailed policy, legal and legislative analysis including consideration of information sharing provisions.</li> <li>Develop discussion paper and sector consultation on finer policy details of SIRS.</li> <li>Draft legislation and subordinate legislation, update CHSP program guidelines etc.</li> <li>Sector engagement and change management to prepare providers for introduction of SIRS.</li> <li>Build My Aged Care ICT functions for approved providers to report through the portal.</li> <li>Build ITC for the Commission to review provider reports and run analysis/ reports operational from 1 July 2020.</li> </ul>	<ul style="list-style-type: none"> <li>Develop program guidelines for residential and other care settings.</li> <li>Continue sector engagement and change management for providers.</li> <li>Business and operating model analysis and change management to prepare for introduction of SIRS</li> <li>ICT testing for My Aged Care.</li> <li>ICT testing for Commission.</li> </ul>	<ul style="list-style-type: none"> <li>Develop communication materials for providers, give them time to modify /develop systems.</li> <li>Engage SDAP panel to assist remote and small providers.</li> <li>Communication and engagement with all affected stakeholders.</li> <li>Change leadership within the new Commission to enable SIRS function.</li> <li>Develop performance management tools and systems.</li> <li>Develop detailed business processes (including templates, decision guides, risk matrices etc.).</li> <li>Test core systems and business and operation model functions to deliver a SIRS and make necessary adjustments.</li> <li>Execute graduated recruitment and training plan in the Commission over final six months to meet staffing needs</li> <li>Upgrades to core systems (Resolve, My Aged Care).</li> </ul>	<ul style="list-style-type: none"> <li>1 July 2022 'go live' date for a SIRS.</li> <li>Test, monitor and improve systems.</li> <li>Business as usual.</li> </ul>

\* Dependent on decision by Government on the preferred option for a SIRS.

## 6.2 Compliance and enforcement

Monitoring, compliance and enforcement activities are central to the Commission's role as an oversight body. The Commission's regulatory powers and functions are set out in the *Aged Care Quality and Safety Commission Act 2018* and the associated Rules.

The regulatory functions are developmental, preventive and corrective and aim to:

- Strengthen and build capacity.
- Prevent harm and improve the quality of services.
- Resolve problems and provide oversight.

As part of the implementation of the SIRS, considerable work will need to be undertaken to develop and refine the Commission's compliance and enforcement strategy for serious incidents. The strategy should complement other functions of the Commission, such as handling and investigating complaints, and conducting quality reviews.

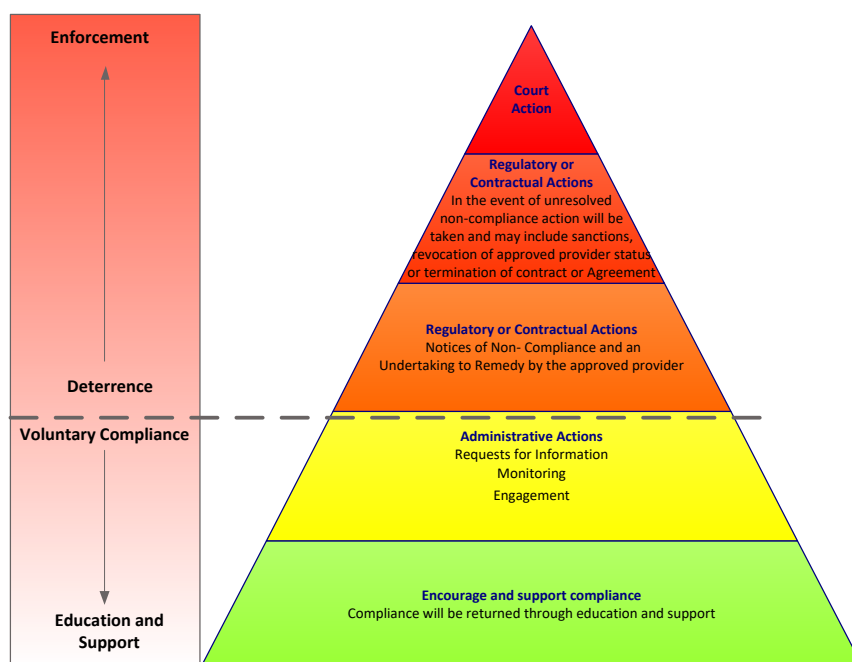
It is anticipated that whilst the Commission will work with providers to build capability to respond and investigate serious incidents, there will be a number of matters where compliance and enforcement action will need to be undertaken by the Commission.

In most matters, the role of the Commission will be to provide general oversight of a provider's response and investigation of a serious incident, but in other matters, the Commission will take a more active monitoring or investigatory role. When designing a compliance and enforcement strategy, the Commission will need to create risk-based decision matrices to prioritise monitoring and investigation activities.

It is recommended that the Commission, where possible, utilise a principle-based regulatory approach, which focuses on compliance outcomes, rather than strict processes. A flexible regulatory approach will minimise the need for enforcement by not only educating providers on better practice, but by building a shared understanding with providers of the objectives behind the regulation.

This approach is compliance oriented, and encourages providers to voluntarily comply. When a provider struggles to comply, the Commission should seek to support a provider to become compliant through persuasion and assistance. However, if this is not successful then the enforcement strategy should escalate. The wider the range of strategies (from persuasive to punitive) available, the more successful the regulation will be. Figure 3 below outlines a compliance and enforcement pyramid developed by the Department.

Figure 3: Compliance and enforcement pyramid



Source: Department of Health

The Commission will need to consider the following questions in determining what, if any, further actions are to be taken which include: whether the provider has an understanding of the problem; whether the provider demonstrates a willingness to act to address the problem; whether the provider has a history of non-compliance; and whether the non-compliance appears to be serious or systemic.

In exercising compliance, investigation and enforcement powers, the Commission must also adhere to the requirements of procedural fairness which means:

- The actions of the Commission and staff will be impartial.
- Any person directly and adversely affected by a decision will have an opportunity to respond.
- The Commission will provide reasons for any decision, findings or recommendation.

### 6.3 Evaluation

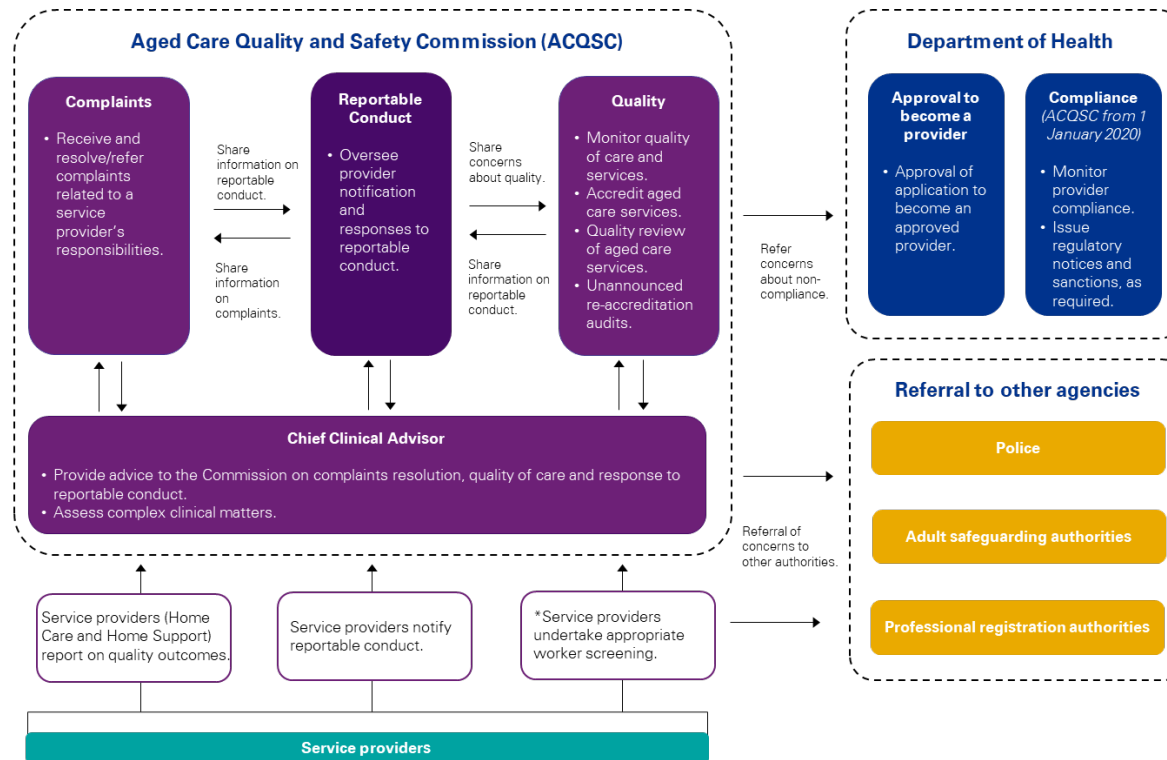
A SIRS should be evaluated as per the five-year evaluation requirements under the *Aged Care Quality and Safety Commission Act 2018*.

## Part 7: High-level operating model

### 7.5.1 High level operating model

Figure 4 below provides a high-level overview of how the reportable incident scheme (Option 3) could interact with other regulatory functions in the aged care system.

Figure 4: High-level operating model

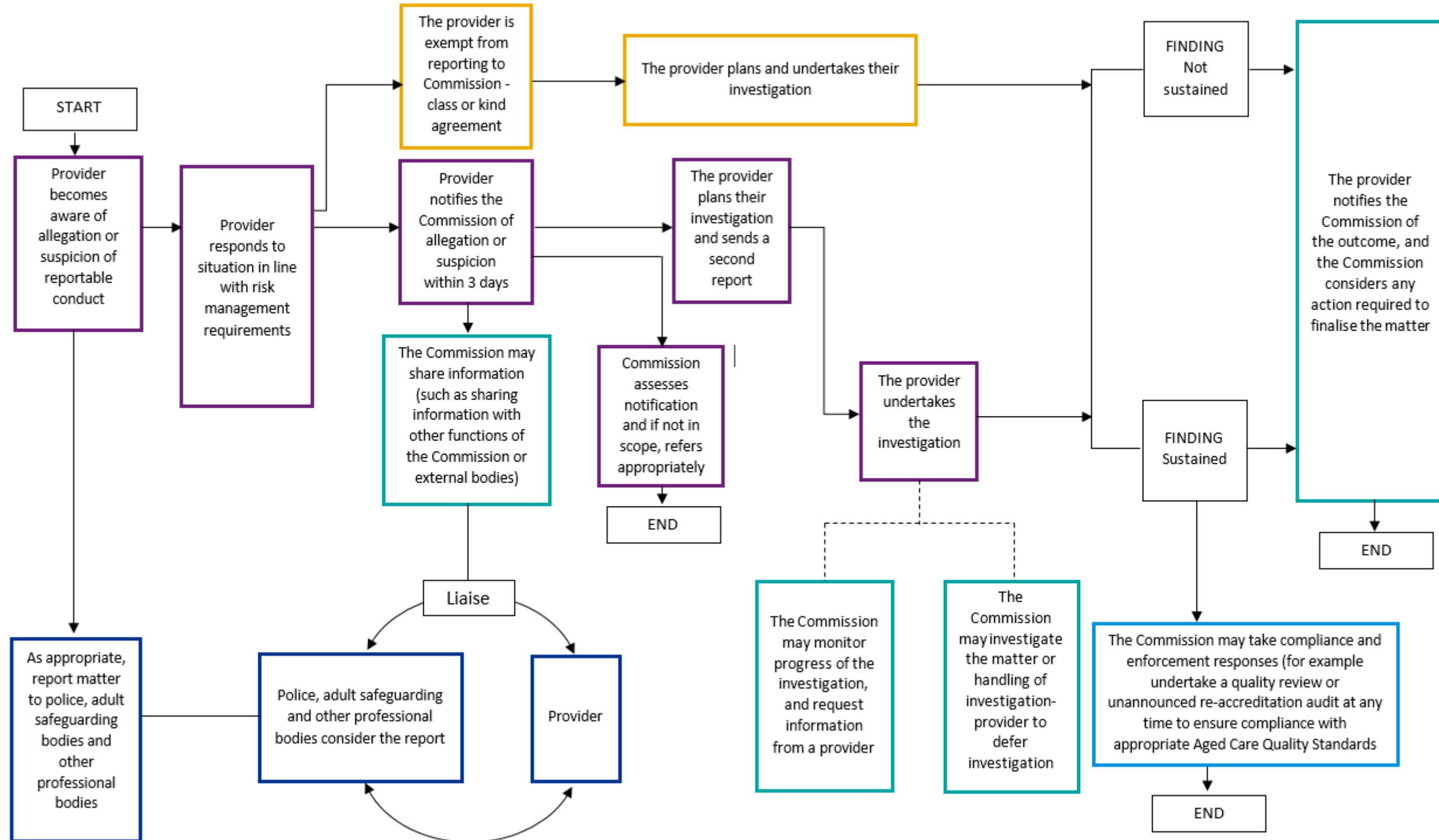


\*Worker screening process depends on outcome from consultation process and further policy and legal analysis.

7.5.2 High level end to end process

Figure 5 below provides a high-level overview of the end-to-end process of how a notification of reportable conduct could be handled by the Commission.

Figure 5: High-level end-to-end process



# Appendix 1: Alignment with other serious incident reporting and response schemes and enabling provisions

## Meaning and definition of serious or reportable incident

Table 7 below provides a jurisdictional comparison of the meaning and definition of select serious or reportable incident schemes. The ALRC report recommendations are also highlighted for comparison purposes.

It is important to note that the meaning, definition and scope of a serious or reportable incident varies across the options, and this is addressed below.

*Table 7: Jurisdictional comparison of meaning and definition of select serious or reportable incident schemes*

Element	Proposed SIRS	ALRC Recommendations	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme) Part 3A	Protection of people with disability in (NSW Ombudsman Scheme) Part 3C
<b>Serious or reportable incidents committed by staff</b>					
<b>Sexual contact / abuse / sexual offence</b>	Yes - all options	Yes <sup>257</sup>	Yes <sup>258</sup>	Yes <sup>259</sup>	Yes <sup>260</sup>
<b>Unreasonable use of force / physical abuse / physical assault</b>	Yes - all options	Yes <sup>261</sup>	Yes <sup>262</sup>	Yes <sup>263</sup>	Yes <sup>264</sup>
<b>Financial abuse</b>	Yes - Options 3-7	Yes <sup>265</sup>	Possible <sup>266</sup>	No	Possible <sup>267</sup>
<b>Seriously inappropriate, improper, inhumane or cruel treatment</b>	Yes - Options 3-7	Yes <sup>268</sup>	No	Possible <sup>269</sup>	No
<b>Serious injury</b>	Only for Options 4 and 6, the injury must be 'unexplained'	Yes <sup>270</sup>	Yes <sup>271</sup>	No- unless it relates directly to an assault	Yes <sup>272</sup>

<sup>257</sup> ALRC Recommendation 4-3(a).

<sup>258</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(d) & s 73Z(4)(e) includes sexual misconduct conducted against, or in the presence of a person with a disability, including grooming.

<sup>259</sup> *Ombudsman Act 1974* (NSW), s 25A (1) includes sexual misconduct conducted against, or in the presence of a child. This also includes child pornography and child exploitation material.

<sup>260</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(a)(i) and s 25P(1)(a)(ii) includes sexual offences, sexual misconduct and grooming.

<sup>261</sup> ALRC Recommendation 4-3(a).

<sup>262</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(c) refers to 'abuse' generally.

<sup>263</sup> *Ombudsman Act 1974* (NSW), s 25A(1).

<sup>264</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(a)(iii).

<sup>265</sup> ALRC Recommendation 4-3(a).

<sup>266</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z (4)(c) refers to 'abuse' generally. The NDIS will need to consider whether this definition extends to financial abuse.

<sup>267</sup> See however, offences under Part 4AA of the *Crimes Act 1900*.

<sup>268</sup> ALRC Recommendation 4-3(b).

<sup>269</sup> *Ombudsman Act 1974* (NSW), s 25A whilst seriously inappropriate, improper, inhumane or cruel treatment is not captured explicitly, the definition in section 25A is very broad, and this type of conduct may fall within that definition.

<sup>270</sup> The injury must be unexplained- ALRC Recommendation 4-3(c).

<sup>271</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(b).

<sup>272</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(d) please note that this is any unexplained serious injury. It does not need to involve a staff member.

	Proposed SIRS	ALRC Recommendations	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme) Part 3A	Protection of people with disability in (NSW Ombudsman Scheme) Part 3C
Element					
<b>Neglect</b>	Yes - Options 3-7	Yes <sup>273</sup>	Yes <sup>274</sup>	Yes <sup>275</sup>	Yes <sup>276</sup>
<b>Death</b>	No	No	Yes <sup>277</sup>	N/A <sup>278</sup>	N/A <sup>279</sup>
<b>Un-authorized use of restrictive practice</b>	No	No	Yes <sup>280</sup>	No	No
<b>Abuse</b>	Yes (as it relates to physical, sexual or financial abuse)	No	Yes <sup>281</sup>	Possible <sup>282</sup>	Possible <sup>283</sup>
<b>Ill-treatment</b>	No	No	No	Yes <sup>284</sup>	Yes <sup>285</sup>
<b>Offences under Part 4AA of the Crimes Act 1900 'Fraud'</b>	No	No	No	No	Yes <sup>286</sup>
<b>Reporting of reportable convictions</b>	No	No	No	Yes <sup>287</sup>	No
<b>Serious or reportable incidents committed by other residents</b>					
<b>Sexual offence / sexual abuse</b>	Yes - Options 5, 6 and 7	Yes <sup>288</sup>	Yes <sup>289</sup>	No	Yes <sup>290</sup>
<b>Physical abuse causing serious injury</b>	Yes- Options 5, 6 and 7	Yes <sup>291</sup>	Yes <sup>292</sup>	No	Yes <sup>293</sup>

<sup>273</sup> ALRC Recommendation 4-3 (d).

<sup>274</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(c).

<sup>275</sup> *Ombudsman Act 1974* (NSW), s 25A(1).

<sup>276</sup> *Ombudsman Act 1974* (NSW), s 25P(v).

<sup>277</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 73Z(4)(a).

<sup>278</sup> Note there is a separate jurisdiction for the review of child deaths.

<sup>279</sup> Note there is a separate jurisdiction for the review of deaths in disability (this is in transition between the NSW Ombudsman and the NDIS Commission).

<sup>280</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(f).

<sup>281</sup> *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(c) refers to 'abuse' generally.

<sup>282</sup> *Ombudsman Act 1974* (NSW), s 25A the definition could be interpreted quite broadly, and in that context, abuse would be included.

<sup>283</sup> *Ombudsman Act 1974* (NSW), s 25P the definition could be interpreted quite broadly, and in that context, abuse would be included.

<sup>284</sup> *Ombudsman Act 1974* (NSW), s 25A(b).

<sup>285</sup> *Ombudsman Act 1974* (NSW), s 25P.

<sup>286</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(a)(iv).

<sup>287</sup> *Ombudsman Act 1974* (NSW), s 25A(1).

<sup>288</sup> ALRC Recommendation 4-3 (e).

<sup>289</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. It is understood that this captures serious incidents committed by other residents.

<sup>290</sup> *Ombudsman Act 1974* (NSW), s 225P(1)(b)(i).

<sup>291</sup> ALRC Recommendation 4-3 (f).

<sup>292</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. It is understood that this captures serious incidents committed by other residents.

<sup>293</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(b)(ii) examples given include a fracture, burns, deep cuts, extensive bruising or concussion.



	Proposed SIRS	ALRC Recommendations	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme) Part 3A	Protection of people with disability in (NSW Ombudsman Scheme) Part 3C
Element					
<b>Assault with a weapon</b>	Only if it falls into the above definitions.	No	Yes <sup>294</sup>	No	Yes <sup>295</sup>
<b>Unexplained serious injury</b>	No	No	Possible <sup>296</sup>	No	Yes <sup>297</sup>
<b>Is part of a pattern of abuse</b>	Yes - Options 5,6 and 7	Yes <sup>298</sup>	Yes <sup>299</sup>	No	Yes <sup>300</sup>
<b>Serious or reportable incidents committed by other persons</b>					
<b>Contravention of an apprehended violence order (can be by any person)</b>	No	No	Possible <sup>301</sup>	No	Yes <sup>302</sup>
<b>Unexplained serious injury</b>	No	No	Possible <sup>303</sup>	No	Yes <sup>304</sup>
<b>Exemptions</b>					
<b>Exemption for 'trivial or negligible'</b>	No	Yes <sup>305</sup>	Yes <sup>306</sup>	Yes <sup>307</sup>	Yes <sup>308</sup>
<b>Other exemptions</b>	No	Yes-scope <sup>309</sup>	No	No	No

## Reporting and responding functions

Table 8 below provides a jurisdictional comparison of the reporting and responding functions of select serious or reportable incident schemes. The ALRC report recommendations are also highlighted for comparison purposes.

The reporting and responding functions of the reportable conduct scheme are consistent across all Options 3-5.

<sup>294</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. It is understood that this captures serious incidents committed by other residents.

<sup>295</sup> *Ombudsman Act 1974* (NSW), s 225P(1)(b)(iii).

<sup>296</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. The extent of this definition, and who it extends to, is yet to be tested

<sup>297</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(d).

<sup>298</sup> ALRC Recommendation 4-3 (g).

<sup>299</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. It is understood that this captures serious incidents committed by other residents.

<sup>300</sup> *Ombudsman Act 1974* (NSW), s 225P(1)(b)(iv).

<sup>301</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. The extent of this definition, and who it extends to, is yet to be tested.

<sup>302</sup> *Ombudsman Act 1974* (NSW), s 225P(1)(c).

<sup>303</sup> NDIS Providers are required to report any reportable incident that occurs 'in connection with' the provision of an NDIS service. The extent of this definition, and who it extends to, is yet to be tested.

<sup>304</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(d).

<sup>305</sup> ALRC Recommendation 4-5.

<sup>306</sup> *NDIS Incident Management and Reportable Incidents Rules*, s 16(2).

<sup>307</sup> *Ombudsman Act 1974* (NSW), s 25A (b) states that the use of physical force that, in all the circumstances, is trivial or negligible, does not need to be reported, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures.

<sup>308</sup> *Ombudsman Act 1974* (NSW), s 25P(1)(a)(iii).

<sup>309</sup> The ALRC recommended that in home or flexible care, 'serious incident' should mean physical, sexual or financial abuse only.

Table 8. High level reporting and responding jurisdictional comparison

		ALRC Recommendations	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme) Part 3A	Protection of people with disability in (NSW Ombudsman Scheme) Part 3C
Function	Application to a SIRS				
<b>Core Functions- Reporting</b>					
<b>Timeframes to make the initial report</b>	The initial notification is required to be made as soon as practicable, and no later than three days since the provider became aware of the incident.	As soon as practicable, but no more than 30 days.	24 hours/ 5 days. <sup>310</sup>	As soon as practicable, but no more than 30 days. <sup>311</sup>	As soon as practicable, but no more than 30 days. <sup>312</sup>
<b>Tiered approach to reporting</b>	It is recommended that the SIRS scheme utilise a two tiered reporting approach which would include an initial notification, followed by a secondary report which highlights the actions taken, and any corrections to the initial notification.	Yes <sup>313</sup>	Yes <sup>314</sup>	Yes <sup>315</sup>	Yes <sup>316</sup>
<b>Mechanism to report</b>	The initial process may need to be form based, but it is recommended that an electronic system be created in the future.	N/A*	Mixed <sup>317</sup>	Form <sup>318</sup>	Form <sup>319</sup>
<b>Responsibility for reporting</b>	The scope of reporting requirements under this option would be restricted to reports made by a provider. It is proposed that providers nominate 'key personnel' responsible for making a report within existing risk management systems (a requirement of Standard 8 of the Aged Care Quality Standards)	N/A	Key personnel <sup>320</sup>	Key personnel <sup>321</sup>	Key personnel <sup>322</sup>
<b>Requirement to report certain information</b>	A SIRS will outline the type of information that providers will need to report to the Commission.	Yes <sup>323</sup>	Yes <sup>324</sup>	Yes <sup>325</sup>	Yes <sup>326</sup>

<sup>310</sup> The NDIS requires that most serious incidents be notified within 24 hours, except for the unauthorised use of restrictive practice, which must be notified within five days.

<sup>311</sup> *Ombudsman Act 1974* (NSW), s 25C(2).

<sup>312</sup> *Ombudsman Act 1974* (NSW), s 25R(3).

<sup>313</sup> The ALRC recommended that a second report on the outcome of an investigation be provided to the oversight body.

<sup>314</sup> The NDIS has an initial notification, and then the NDIS Commissioner may then require a provider to provide a report within 60 days.

<sup>315</sup> *Ombudsman Act 1974* (NSW), s 25F.

<sup>316</sup> *Ombudsman Act 1974* (NSW), s 25V requires a provider to report the results of an investigation and the action taken.

<sup>317</sup> The NDIS is currently using a form system, with rural and remote providers able to telephone through reports. The NDIS is currently exploring building an electronic reporting system.

<sup>318</sup> See: <https://www.ombo.nsw.gov.au/what-we-do/our-work/employment-related-child-protection/information-for-agencies/employment-related-child-protection-notification-form2>

<sup>319</sup> See: <https://www.ombo.nsw.gov.au/what-we-do/our-work/community-and-disability-services/part-3c-reportable-incidents/disability-reportable-incidents-forms-and-guidelines>

<sup>320</sup> *NDIS Incident Management and Reportable Incident Rules*, s 18.

<sup>321</sup> *Ombudsman Act 1974* (NSW), s 25C(1).

<sup>322</sup> *Ombudsman Act 1974* (NSW), s 25R(1).

<sup>323</sup> The ALRC recommended that provider's be required to report the incident, and any findings or actions taken in response to it.

<sup>324</sup> *NDIS Incident Management and Reportable Incident Rules*, s 20(2).

<sup>325</sup> *Ombudsman Act 1974* (NSW), s 25C.

<sup>326</sup> *Ombudsman Act 1974* (NSW), s 25C.

		ALRC Recommendations	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme) Part 3A	Protection of people with disability in (NSW Ombudsman Scheme) Part 3C
Function	Application to a SIRS				
Core Functions- Responding					
<b>Requirement to notify the police</b>	Providers should notify police state and territory police authorities of any reportable conduct which has a criminal element.	No <sup>327</sup>	Partial <sup>328</sup>	Partial <sup>329</sup>	Partial <sup>330</sup>
<b>Requirement to notify any other party</b>	Providers should notify safeguarding bodies and professional registration bodies of reportable conduct where required.	N/A <sup>331</sup>	Partial <sup>332</sup>	Partial <sup>333</sup>	Partial <sup>334</sup>
<b>Requirement on providers to investigate</b>	Providers will be responsible for conducting their own investigations into reportable conduct, unless otherwise advised.	Yes <sup>335</sup>	Yes <sup>336</sup>	Yes <sup>337</sup>	Yes <sup>338</sup>
<b>Requirement to record certain information in relation to reportable incidents</b>	Providers should collect data and keep appropriate records to enable administration of reportable incident scheme.	N/A	Yes <sup>339</sup>	Yes <sup>340</sup>	Yes <sup>341</sup>

- N/A designates that the ALRC report was silent on this element.

<sup>327</sup> The ALRC has made a point to not recommend that providers be required to report an incident to police. They did recommend that it should be made clear to providers that disclosure of personal information to police in relation to serious incidents is lawful and appropriate. The ALRC does not recommend that all allegations or suspicions of serious incidents be reported to police, so this recommendation was intended to address concerns that such reporting would breach requirements relating to the protection of personal information without being 'required or authorised' by the *Aged Care Act*.

<sup>328</sup> The NDIS Commission has the ability to require a provider to refer a matter to police, but there does not appear to be a legislative requirement for a provider to do so in every matter.

<sup>329</sup> There is no express reference to this in the NSW Ombudsman legislation, but as part of good practice, the NSW Ombudsman would recommend that providers notify police. Please note that there are other laws which require mandatory reporting of child protection matters which may also be considered.

<sup>330</sup> There is no express reference to this in the NSW Ombudsman legislation, but as part of good practice, the NSW Ombudsman would recommend that providers notify police.

<sup>331</sup> Except for reporting requirements of other legislation, such as the *Crimes Act 1900* (NSW).

<sup>332</sup> The NDIS Commission has the ability to require a provider to refer a matter to another body, but there does not appear to be a legislative requirement for a provider to do so in every matter.

<sup>333</sup> Whilst the NSW Ombudsman does not have a legislative requirement that a provider must notify another party, providers are recommended to report where appropriate. Other legislation may also impose an obligation to notify other bodies.

<sup>334</sup> As above.

<sup>335</sup> The ALRC stated that the emphasis should change from requiring providers to report the occurrence of an alleged or suspected assault, to requiring an investigation and response to incidents by providers.

<sup>336</sup> Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 49–53; *National Disability Insurance Scheme Act 2013* (Cth), s 73Z(3)(a).

<sup>337</sup> It is the nature of Ombudsman systems, that the reporting body conduct the initial investigation, unless otherwise informed.

<sup>338</sup> As above.

<sup>339</sup> *NDIS Incident Management and Reportable Incident Rules*, s 25, *National Disability Insurance Scheme Act 2013* (Cth), s 73R.

<sup>340</sup> This is not an express legislative requirement in the Ombudsman Act, but other legislation applies in relation to record keeping.

<sup>341</sup> As above.

## Oversight functions and enabling provisions

Table 9 below provides a jurisdictional comparison of the oversight and enforcement powers of select serious or reportable incident schemes. The enabling provisions for the Commission are also referenced below.

The reporting and responding functions of the reportable conduct scheme are consistent across all Options 3-5.

Table 9: Oversight function jurisdictional comparison

		Enabling provision**	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme)	Protection of people with disability in (NSW Ombudsman Scheme)
Function	Application to a SIRS				
<b>Core Functions</b>					
<b>Refer an incident internally or to another body or person</b>	The Commission should be able to refer an incident to appropriate internal areas within the Commission and to other appropriate external bodies or people.	Internal referral can be enabled by internal policy. External referral can be facilitated through Part 7 of the <i>Aged Care Safety and Quality Commission Act 2018</i> (Cth) ('the Aged Care Commission Act')	Yes <sup>342</sup>	Yes <sup>343</sup>	Yes <sup>344</sup>
<b>Monitor provider investigations and handling of incidents</b>	The Commission should be able to monitor how providers are investigating and responding to incidents.	Section 19, Aged Care Commission Act. Part 6.4 of the <i>Aged Care Act 1997</i> (Cth) ('the Aged Care Act')	Yes <sup>345</sup>	Yes <sup>346</sup>	Yes <sup>347</sup>
<b>Provide non-binding recommendations</b>	The Commission should be able to make non-binding recommendations to providers about how to investigate or respond to incidents.	It is anticipated that this will be enabled by internal policy.	Yes <sup>348</sup>	Yes <sup>349</sup>	Yes <sup>350</sup>

<sup>342</sup> *NDIS Incident Management and Reportable Incident Rules*, s 26(1)(a).

<sup>343</sup> *Ombudsman Act 1974* (NSW), s 42.

<sup>344</sup> *ibid.*

<sup>345</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 73ZE.

<sup>346</sup> *Ombudsman Act 1974* (NSW), s 25E.

<sup>347</sup> *Ombudsman Act 1974* (NSW), s 25U.

<sup>348</sup> Whilst there is no specific provision to provide non-binding recommendations in the *National Disability Insurance Scheme Act 2013* (Cth) or the *NDIS Incident Management and Reportable Incident Rules*, this would be an internal procedure within the NDIS.

<sup>349</sup> *Ombudsman Act 1974* (NSW), s 26.

<sup>350</sup> *ibid.*

		Enabling provision**	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme)	Protection of people with disability in (NSW Ombudsman Scheme)
Function	Application to a SIRS				
<b>Commence an investigation</b>	The Commission should be able to commence its own investigation into an incident, a pattern of incidents or a provider's handling of a particular incident. Direct investigations by the Commission should not be routine. The Commission's focus should be on overseeing providers' own responses to incidents and building the capacity of providers in doing so.	Section 16 (2) and s 19, Aged Care Commission Act. The Commissioner may also chose to make rules in relation to investigations under s 21 of the Aged Care Commission Act.	Yes <sup>351</sup>	Yes <sup>352</sup>	Yes <sup>353</sup>
<b>Provide information on the progress or outcome of an investigation.</b>	The Commission should be able to share information on the progress or outcome of an investigation to a participants involved in an incident or another nominated person.	Part 7, Aged Care Commission Act.	Yes <sup>354</sup>	Yes <sup>355</sup>	Yes <sup>356</sup>
<b>Carry out an inquiry.</b>	The Commission should be able to carry out inquiries into systemic issues, including serious incidents.	Section 16 (2) and s 19, Aged Care Commission Act. The Commissioner may also chose to make rules in relation to inquiries under s 21 of the Aged Care Commission Act.	Yes <sup>357</sup>	Yes <sup>358</sup>	Yes <sup>359</sup>
<b>Make a recommendation or a report to the parliament and public.</b>	The Commission should be able to make recommendations and reports to the parliament and to the public to raise significant issues, drive change on quality and safety and report on its operations including in respect of particular incidents or providers.	Part 7, Aged Care Commission Act.	Yes <sup>360</sup>	Yes <sup>361</sup>	Yes <sup>362</sup>

*Functions to compel*

<sup>351</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 73ZF.

<sup>352</sup> *Ombudsman Act 1974* (NSW), s 13 and s 25G.

<sup>353</sup> *Ombudsman Act 1974* (NSW), s 13 and s 25W.

<sup>354</sup> *NDIS Incident Management and Reportable Incident Rules*, s 26(3).

<sup>355</sup> *Ombudsman Act 1974* (NSW), s 25GA.

<sup>356</sup> *Ombudsman Act 1974* (NSW), s 25WA.

<sup>357</sup> *NDIS Incident Management and Reportable Incident Rules*, s 27; *National Disability Insurance Scheme Act 2013* (Cth), s73Z (2)(d).

<sup>358</sup> *Ombudsman Act 1974* (NSW), s19.

<sup>359</sup> *ibid.*

<sup>360</sup> *NDIS Incident Management and Reportable Incident Rules*, s 27(7).

<sup>361</sup> *Ombudsman Act 1974* (NSW), s31.

<sup>362</sup> *ibid.*

		Enabling provision**	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme)	Protection of people with disability in (NSW Ombudsman Scheme)
Function	Application to a SIRS				
<b>Compel information from providers.</b>	The Commission should be able to compel information from providers and request updates and final investigation reports.	Sections 67 and 70, Aged Care Commission Act.	Yes <sup>363</sup>	Yes <sup>364</sup>	Yes <sup>365</sup>
<b>Compel information from other persons.</b>	The Commission should be able to request information the Commission needs to undertake its functions related to a SIRS.	This is unclear, the Commissioner may be able to make rules about this as per section 21 of the Aged Care Commission Act.	Yes <sup>366</sup>	Yes <sup>367</sup>	Yes <sup>368</sup>
<b>Powers of entry and inspection via consent or warrant</b>	The Commission should be able to enter or inspect premises either via consent or warrant, for example when investigating a serious incident and there is a risk of the destruction of evidence.	Broadly under Part 8 of the Aged Care Commission Act. See also part 6.4 of the <i>Aged Care Act 1997</i> (Cth).	Yes <sup>369</sup>	Yes <sup>370</sup>	Yes <sup>371</sup>
<b>Require a provider to give information on the progress or outcome of an investigation to a participant involved in an incident</b>	This power would enable the Commission to require a provider to give an update to the consumer, or their representative as to the progress of the investigation, or the findings/ outcome of an investigation.	The Commissioner may be able to make rules about this as per section 21 of the Aged Care Commission Act.	Yes <sup>372</sup>	No	No
<b>Require or request a provider take remedial or corrective action</b>	This power would enable the Commission to direct a provider to take a particular remedial or corrective action.	The Commissioner may be able to make rules about this as per section 21 of the Aged Care Commission Act.	Yes <sup>373</sup>	No	No
<b>Require a provider to conduct an</b>	The Commission should be able to direct a provider to undertake an internal investigation into a serious incident.	The Commissioner may be able to make rules about this as per section 21 of the	Yes <sup>374</sup>	No	No

<sup>363</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 55A and *NDIS Incident Management and Reportable Incident Rules*, s 20(2)(h).

<sup>364</sup> *Ombudsman Act 1974* (NSW), s 25E.

<sup>365</sup> *Ombudsman Act 1974* (NSW), s 25U.

<sup>366</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 55A.

<sup>367</sup> *Ombudsman Act 1974* (NSW), s 18 states that the NSW Ombudsman may require a public authority to provide information. This power is not as broad as the powers of the NDIS Commission.

<sup>368</sup> *Ombudsman Act 1974* (NSW), s 18.

<sup>369</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 73ZE (1) states that Part 2 of the *Regulatory Power Act* creates a framework for monitoring whether the provisions of this Part have been complied with, which includes powers of entry and inspection. *National Disability Insurance Scheme Act 2013* (Cth), s 73ZF (1) states that Part 3 of the *Regulatory Power Act* creates a framework for investigating whether a provision has been contravened, which includes powers of entry and inspection.

<sup>370</sup> *Ombudsman Act 1974* (NSW), s 25E.

<sup>371</sup> *Ombudsman Act 1974* (NSW), s 25U.

<sup>372</sup> *NDIS Incident Management and Reportable Incident Rules*, s 26(3).

<sup>373</sup> *NDIS Incident Management and Reportable Incident Rules*, s 26.

<sup>374</sup> *ibid.*

		Enabling provision**	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme)	Protection of people with disability in (NSW Ombudsman Scheme)
Function	Application to a SIRS				
internal investigation		Aged Care Commission Act.			
Require a provider to engage an independent expert to carry out an investigation	The Commission would be able to form the view that a provider needs to engage an expert, or needs to conduct an investigation into a serious incident.	The Commissioner may be able to make rules about this as per section 21 of the Aged Care Commission Act.	Yes <sup>375</sup>	No	No
<b>Compliance and enforcement functions</b>					
Enforce a civil penalty	This power would allow the Commission to enforce any civil penalty provisions in the legislation, by obtaining an order for a person to pay a pecuniary penalty for the contravention of a provision.	It is anticipated that this option will require legislative change.	Yes <sup>376</sup>	No	No
Issue an infringement notice	This power could allow for infringement notices to be issued when a civil penalty provision under the legislation is breached.	It is anticipated that this option may require legislative change.	Yes <sup>377</sup>	No	No
Issue a compliance notice	This power would enable the Commission to issue a written compliance notice if the Commissioner was satisfied or aware of information which suggests that a provider may not be compliant with the Act	It is anticipated that this option may require legislative change.	Yes <sup>378</sup>	No	No
Issue a banning orders	The Commission would be able to make a banning order prohibiting or restricting activities of a provider, or an individual person in certain circumstances such as when there is an immediate danger to the health, safety and wellbeing of a person.	It is anticipated that this option may require legislative change.	Yes <sup>379</sup>	No	No
Make an enforceable undertakings	The Commission would be able to accept and enforce an undertaking related to compliance. This may include an undertaking that a person will take or refrain from a certain action.	It is anticipated that this option may require legislative change.	Yes <sup>380</sup>	No	No
Issue a sanction	The Commission would be able to issue a sanction on a provider	Part 4.4 of the Aged Care Act	No	No	No
Use of injunctions	This power would allow the Commission to apply to a relevant court for an interim injunction, which would restrain a person from engaging in certain conduct, or require a person to do a specific action.	It is anticipated that this option may require legislative change.	Yes <sup>381</sup>	Yes <sup>382</sup>	Yes <sup>383</sup>

<sup>375</sup> *ibid.*

<sup>376</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s 73ZK.

<sup>377</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s 73ZL.

<sup>378</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s73ZN.

<sup>379</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s 73ZN.

<sup>380</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s 73ZP.

<sup>381</sup> *National Disability Insurance Scheme Act 2013 (Cth)*, s 73ZQ.

<sup>382</sup> *Ombudsman Act 1974 (NSW)*, s 21C.

<sup>383</sup> *ibid.*

		Enabling provision**	Protection of NDIS participants (NDIS Commission Scheme)	Child protection in NSW (NSW Ombudsman scheme)	Protection of people with disability in (NSW Ombudsman Scheme)
Function	Application to a SIRS				
<i>Supporting functions</i>					
<b>Assess systems for reporting and responding to serious incidents through auditing policies and procedures</b>	This function would enable the Commission to assess the systems that providers have in place for handling serious incidents, and recommend changes to policies and procedures so that they reflect better practice.	Sections 16-19 of the Aged Care Commission Act. The Commissioner may also make a rule about this under s 21 of the Act. May also rely on Aged Care Quality Standards.	Yes <sup>384</sup>	Yes <sup>385</sup>	Yes <sup>386</sup>
<b>Provide training, education and guidance to providers</b>	The Commission would provide a variety of education, training and guidance material to providers, on a range of topics, such as identifying, responding and investigation of serious incidents.	Section 20, Aged Care Commission Act.	Yes <sup>387</sup>	Yes <sup>388</sup>	Yes <sup>389</sup>
<b>Public reporting of trends in reported conduct</b>	The public reporting of trends, data and outcomes achieved in a SIRS is an important tool to drive change and continuous improvement in the sector.	Part 7, Aged Care Commission Act.	Yes <sup>390</sup>	Yes <sup>391</sup>	Yes <sup>392</sup>

\*\* This table is a guide only. Separate analysis will need to be conducted to establish whether the purpose of the *Aged Care Safety and Quality Commission Act 2018* (Cth) ('the Aged Care Commission Act') and the *Aged Care Act 1997* (Cth) (and certain provisions within these Acts) can be used to achieve the compliance and enforcement objectives of the Reportable Incidents Scheme. The Commissioner will have a rule making power under section 21 of the Aged Care Commission Act, and some of the functions listed in the above table may be enabled through the rule making power. However, certain powers will not be able to be enacted through a rule making power, and legislation change may be required.

<sup>384</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 73(2)(e) states that any provider that registers with the NDIS, needs to have an external audit conducted within 12-18 months of becoming a service provider. This audit covers all policies and procedures which relate to maintaining the NDIS practice standards (this includes that providers have an in-house management system for notifying the NDIS Commission of reportable incidents). It is anticipated that continuous improvement reviews in the future will be enabled to continue to building and enhance the capability of providers in handling and responding to serious incidents.

<sup>385</sup> *Ombudsman Act 1974* (NSW), s 25B.

<sup>386</sup> *ibid.*

<sup>387</sup> *National Disability Insurance Scheme Act 2013* (Cth), s 81E(c).

<sup>388</sup> This function of the NSW Ombudsman is enabled through policy.

<sup>389</sup> *ibid.*

<sup>390</sup> NDIS Compliance and Enforcement Policy.

<sup>391</sup> *Ombudsman Act 1974* (NSW), s 26 and s 31.

<sup>392</sup> *ibid.*



## Appendix 2: Case studies of provider responses to familial abuse

### Case study: home care provider response to suspected familial abuse

Mr A, an Aboriginal man, lives at home, in a multi-generational family environment. He is a recipient of an Aged Pension, however this money is accessed by the family leader, who has Mr A's PIN number and card, on pension day. Mr A has no access to his own funds, and is dependent on the family leader for shelter and food. Mr A receives a Home Care Package, the service provider recognises the practices within this household as abuse, however works cooperatively to negotiate solutions with respect given to cultural practices. Centrepay mechanisms are negotiated to pay Mr A's accounts at the local pharmacy, and for necessary services. At Mr A's request, a staff member takes him to the bank fortnightly, and then shopping, so he can make purchases to meet his needs.<sup>393</sup>

### Case study: residential care provider response to suspected familial abuse

Mrs B is 75 year old woman residing in a residential aged care home. She has right sided paralysis, and some subtle frontal and executive cognitive deficits. Mrs B has appointed her son as her EPOA, MPOA and EPOG prior to her condition deteriorating.

On admission to residential care, Mrs B's cognitive function was assessed and indicated she had minimal impairment but there was some short term memory loss. Her son had taken over management of all of her financial affairs and he viewed her as "dementing" despite being assessed by her doctor, and a geriatrician as having minimal deficit and was able to make her own decisions. Mrs B's son gradually ceased to consult with her and made decisions on her behalf, he removed all of her jewellery for "safe keeping" and was slow to bring in her personal items from her home. He provided her with regular spending money but then repeatedly questioned her about what she spent it on. She became very concerned at his overly controlling ways but she valued the relationship with her son as her only child and did not wish to challenge him as she was fearful the relationship may be placed in jeopardy.

In conversations with the residential manager, Mrs B disclosed the son's denial of her simple requests, the reducing amounts of funds he gave her for her personal use and the interrogative measures he took with her and his repeated derogatory comments about her cognitive impairment. With the support of the residential manager, Mrs B agreed to involve Aged Rights Advocacy Service and gradually felt more empowered to challenge her son. Her son refused to participate in any mediation meetings and Mrs B eventually took action in revoking her son's legal position in managing her affairs and appointed another person to this role. She has subsequently not had any interaction with her son.<sup>394</sup>

### Case study: rural and remote home care provider and mainstream services response to suspected familial abuse

The complexity of issues seen in the broader population are further exacerbated in rural and remote communities.

Mr and Mrs C reside 30km from the nearest town; Mrs C has a diagnosis of dementia. Mr C is sole family Carer for his wife, and denies there is any other family. He has Enduring Power of Attorney. Staff of the local health service, and previous aged care providers have concerns in relation to care provided to Mrs C by her husband, however this is not based on witnessed abuse, but a sense that "all is not right." Hospital staff insisted that a Home Care Package be in place prior to discharge from hospital, due to concerns for this client's welfare.

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<sup>393</sup> Submissions 114 to the ALRC Elder Abuse Inquiry.

<sup>394</sup> *ibid.*

Home care staff are present in the home for only one hour each day due to the need for two staff to effect transfers, and the distance to travel to the client each day. Over a period of months, a picture is established of a complex situation of abuse. Mrs C has been isolated from her family; a son and daughter contacted the in-home provider seeking information about their mother's wellbeing, as they are not able to gain information from Mr C. Mr C does not administer prescribed medications, the pharmacist is able to provide the data referencing prescriptions filled. Home care staff become aware of restrictions made to Mrs C's diet, by Mr C, which cause her adverse effects. In home staff are aware Mr C leaves his wife alone over extended periods, however he refuses all offers of respite.

Staff also witness rough treatment, and report this to their supervisor.

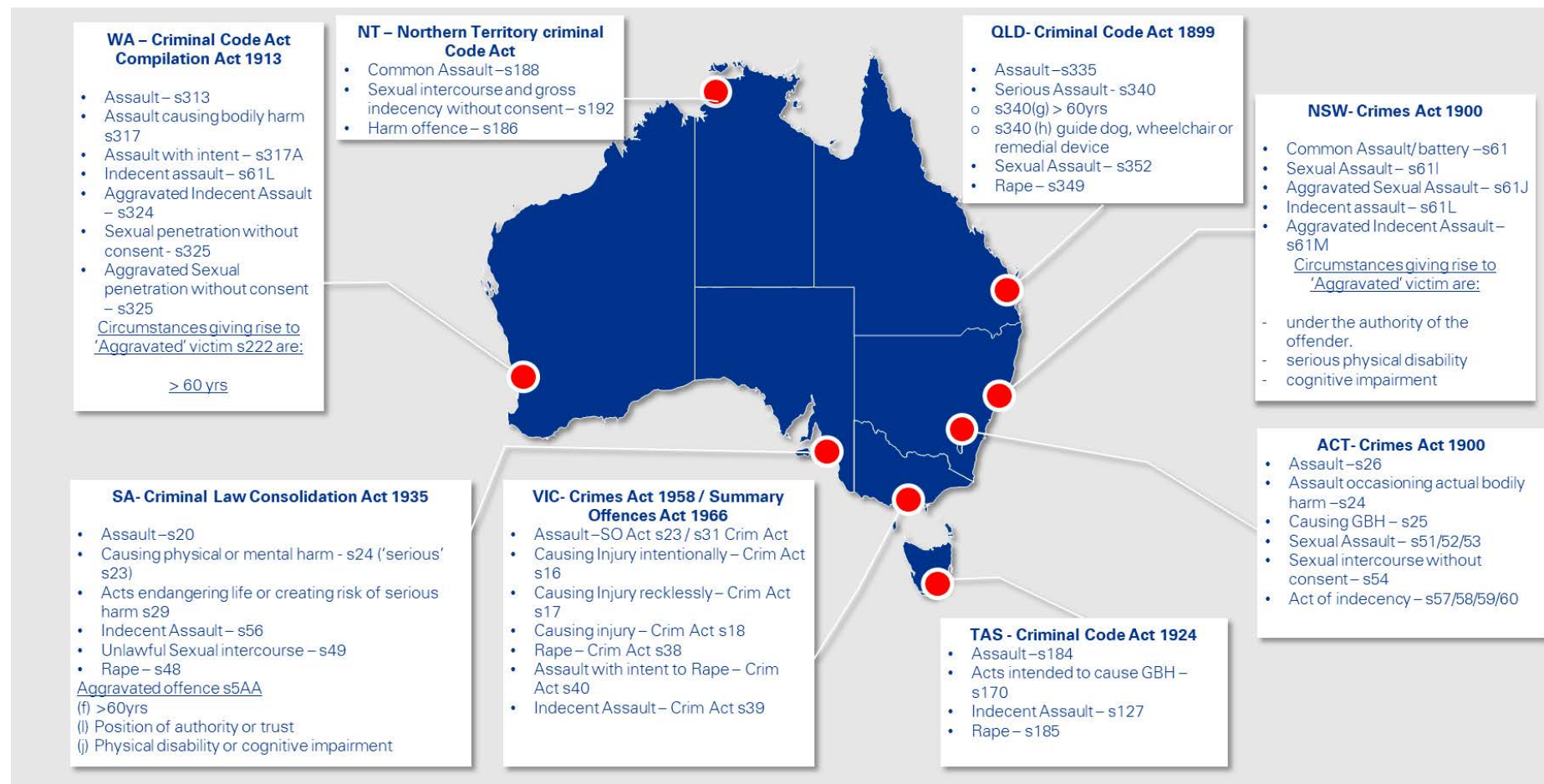
Home care staff sought advice from Office of the Public Advocate, and convened a meeting with Police, Health service staff and the client's GP. The GP sought advice from medical defence, and determined they would not be involved in submitting an application to the Guardianship Board. Once an opportunity for hospital admission arose, an ambulance was called by homecare staff, enabling application to be made to the Guardianship Board while Mrs C remained an inpatient. The Guardianship hearing resulted in appointment of a Guardian, and decisions made to admit to residential care.

### **Case study: rural home care provider response to suspected familial abuse**

Mrs D lives in a multi-generational home with her daughter and grandson, in a rural town. There is a strong history of mental illness evident in each family member in this home. Mrs D who is 80 years old and living with dementia, is the home owner, and mortgage holder. She receives a full DVA Pension, and the family needs this income to support the household. Mrs D's daughter has been renovating the home, and her mother, who is bed bound, remains in the home, while renovations occur, subjecting her to noise, dust, and intrusion, which exacerbates her agitation and distress. In the course of the renovations, Mrs D is moved to the back room of her house, which is not suitable for her needs, as the bathroom is not accessible, and heating and cooling is non-existent in this room. Home care staff work to negotiate solutions to these challenges. Extensive negotiation and commitment to case management is required to reach a positive outcome for this client.

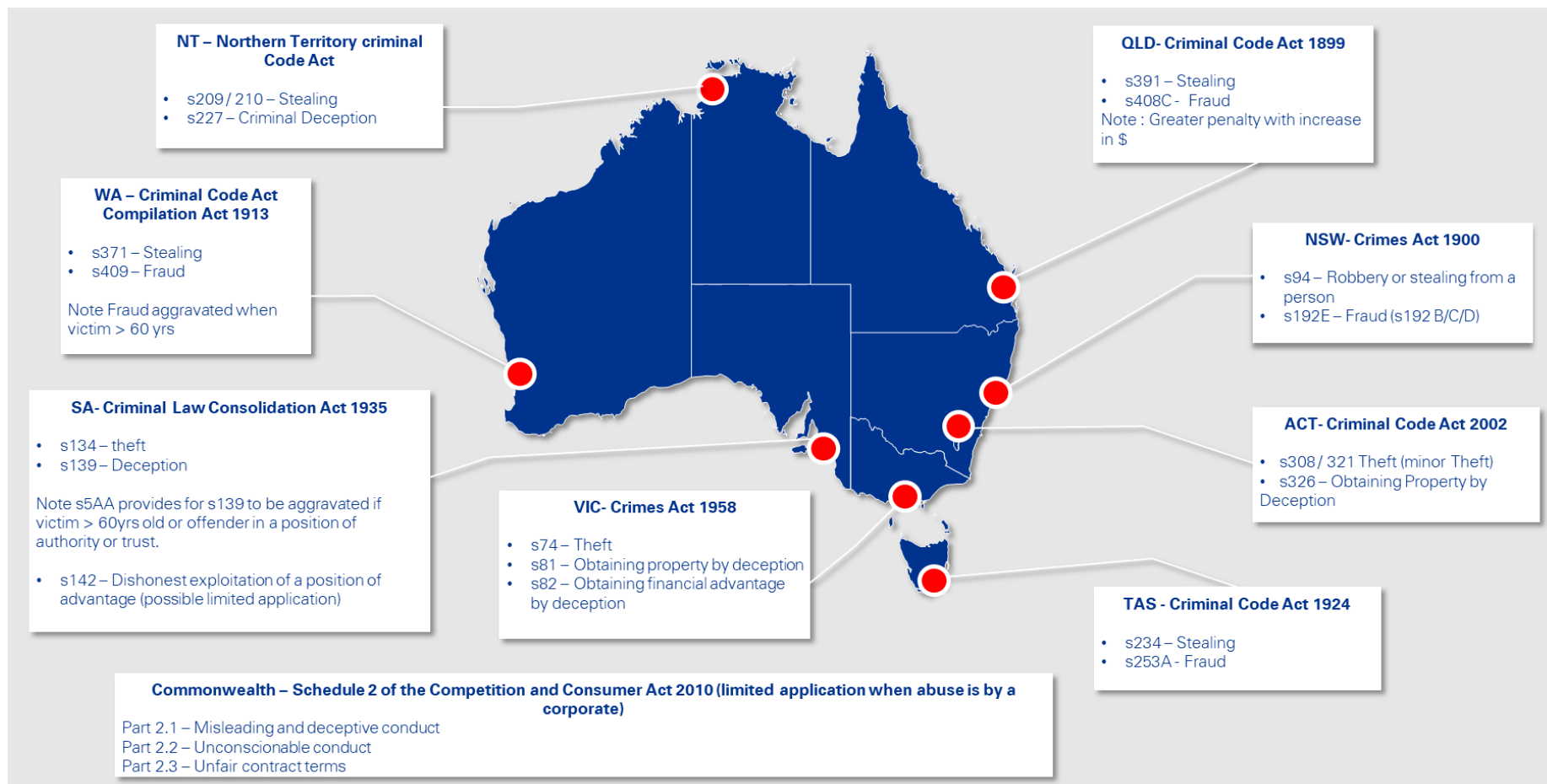
## Appendix 3: Cross-jurisdictional view of criminal laws on physical and sexual abuse

Figure 6: State and territory criminal laws on physical and sexual abuse



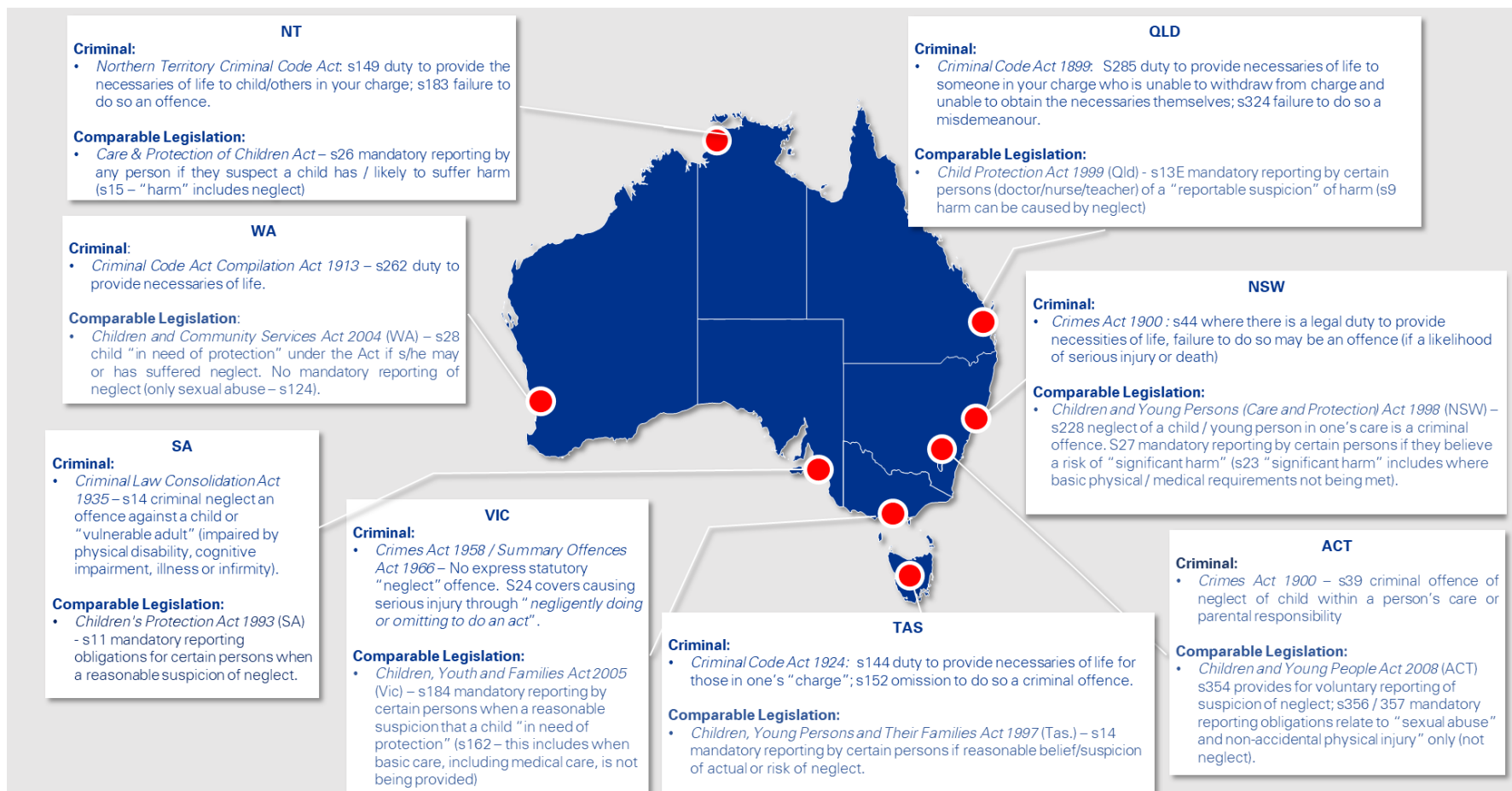
## Appendix 4: Cross-jurisdictional view of criminal laws on financial abuse

Figure 7: State and territory criminal laws on financial abuse



## Appendix 5: Cross-jurisdictional view of criminal laws on neglect

Figure 8: State and territory criminal laws on neglect



## Appendix 6: Description of stakeholder consultation process

Key stakeholders in the aged care sector and other stakeholders were consulted in November 2018, including:

- Aged care industry peaks
- Consumer representative organisations
- Aged care service providers
- Elder advocacy organisations
- Community Visitor Scheme providers
- State and Territory Ombudsmans and Complaints Commissions
- Aged Care Quality Advisory Council
- National Aged Care Alliance
- Australian Aged Care Quality Agency and Aged Care Complaints Commissioner
- Department of Health representatives.

The purpose of these consultations was to identify, discuss and further develop options for a scheme with the sector, including to identify potential impacts and costs on the broader aged care system, providers and consumers. In particular, consultations explored options and impact of the following key elements of a scheme:

- Scope and definition of a serious incident.
- Reporting and responding to serious incidents.
- Role of an oversight body in relation to responses to serious incident.

Consultations were conducted in person or by telephone in semi-structured format. Preliminary options were included in a presentation to inform discussion.

Stakeholder views have been incorporated into the analysis of options in this report.

A list of organisations that were consulted as part of this process is provided below:

- ACT Transition Care - University of Canberra Hospital
- Advocare
- Aged and Community Services Australia
- Aged Care Complaints Commissioner
- Aged Care Quality Advisory Group
- Amana Living
- Anglicare Australia
- Anglicare NT
- Association of Independent Retirees Limited
- Attendant Care Industry Association
- Audiology Australia
- Australasian Services Care Network
- Australian & New Zealand Society of Geriatric Medicine
- Australian Aged Care Quality Agency
- Australian Association of Gerontology
- Australian Association of Social Workers
- Australian College of Nursing
- Australian Community Transport Association Ltd
- Australian Dental Association
- Australian Healthcare and Hospitals Association
- Australian Medical Association

- Australian Nursing and Midwifery Federation
- Australian Physiotherapy Association
- Australian Psychological Society
- Australian Red Cross
- Baptist Care Australia
- Blue Care
- Bolton Clarke
- Brightwater Group
- Bundaleer
- Care Assessment Consultants Pty Ltd
- Carers Australia
- Catholic Health Australia
- Chair of the Aged Care Quality Advisory Council
- Chinese Community Social Services Centre Inc
- CHSALHN
- Commonwealth Department of Health
- COTA Australia
- Country Health South Australia LHN
- Darwin Community Legal Service
- Dementia Australia
- Dental Hygienists Association of Australia
- Department of Health and Human Services (Vic)
- Dietitians Association of Australia
- EACH
- Elder Abuse Prevention Unit
- Exercise & Sports Science Australia
- Federation of Ethnic Communities' Councils of Australia
- HammondCare
- Health Services Union
- Home Modifications Australia
- IntegratedLiving Limited Australia
- IRT Group
- Juniper
- Leading Age Services Australia
- Legacy Australia
- Lutheran Aged Care Australia
- Macular Disease Foundation Australia
- Matthew Flinders Care Services
- Midlands Multi-Purpose Health Centre, Tasmanian Health Services
- Multiple Sclerosis
- MYVISTA
- National Aboriginal Community-Controlled Health Organisation
- National Aged Care Alliance
- National LGBTI Health Alliance
- NDIS Quality and Safeguards Commission
- NSW Ministry of Health
- NSW Ombudsman
- NT Department of Health
- Occupational Therapy Australia
- Office of the Health Ombudsman
- Office of the Public Guardian (Qld)

- Older Persons Advocacy Network
- Ombudsman Western Australia
- Opal Aged Care
- Palliative Care Australia
- PHN Cooperative
- PICAC Alliance
- Presbyterian Care Australia
- PSRAC Leadership Committee
- Public Sector Residential Aged Care Leadership Committee
- Resthaven Inc
- Retirement Living Council
- Returned & Services League of Australia
- SA Health
- Seniors Rights Service
- Speech Pathology Australia
- Suncare Community Services Ltd
- Sydney Local Health District CVS
- Tasmanian Health Service
- The Pharmacy Guild of Australia
- The Royal Society for the Blind
- The Salvation Army
- Tonic Health Media
- United Voice
- UnitingCare Australia
- Vision Australia
- WA Country Health Service
- YMCA NSW



## Appendix 7: Glossary of key terms

Term	Definition
<b>Aged Care Act 1997 (the Act)</b>	The primary legislation governing the provision of aged care services.
<b>Aged Care Quality Standards</b>	A set of quality standards that apply to all Government-subsidised aged care service providers which aim to ensure quality outcomes are delivered for consumers.
<b>Australian Aged Care Quality Agency (AACQA or Quality Agency)</b>	The accreditation body for residential aged care homes. It conducts quality review of home care services, registers quality assessors; and provides information, education and training. The functions of the AACQA will transition to the new Commission from 1 January 2019.
<b>Aged Care Quality and Safety Commission (the Commission)</b>	The new independent regulatory body that will bring together the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner from 1 January 2019.
<b>Aged Care Complaints Commissioner (Complaints Commissioner)</b>	An independent statutory office holder responsible for providing a free complaints resolution service across Australia to anyone that wishes to raise a complaint or concern about an Australian Government-subsidised aged care service. The functions of the Complaints Commissioner will transition to the new Commission from 1 January 2019.
<b>Australian Health Practitioner Registration Agency (AHPRA)</b>	The agency responsible for administering the National Registration and Accreditation Scheme (NRAS) across Australia.
<b>Commonwealth Home Support Programme (CHSP)</b>	The program that provides entry-level support services designed to help frail older people stay in their homes. It was introduced on 1 July 2015, consolidating four former programs: Commonwealth Home and Community Care (HACC); the National Respite for Carers Program (NRCP); Day Therapy Centres (DTC); and Assistance with Care and Housing for the Aged (ACHA).
<b>Department of Health (the Department)</b>	The department that administers the <i>Aged Care Act 1997</i> and regulates the aged care industry on behalf of the Commonwealth.
<b>Elder abuse</b>	Physical, psychological or emotional, sexual or financial abuse of older people or intentional or unintentional neglect.
<b>Flexible care</b>	A type of aged care service designed for consumers that require a different care approach than that provided through mainstream residential and home care. Flexible care programs include Transition Care Program (TCP), Short Term Restorative Care (STRC), National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and Multi-Purpose Services (MPS).
<b>Home Care Packages</b>	Packages of care and supports designed to assist older people to remain living at home. The Home Care Packages Programme commenced on 1 August 2013.

Term	Definition
<b>Mandatory reporting</b>	Mandatory reporting of all abuse of a particular vulnerable cohort by any perpetrator. Mandatory of child abuse is common across states and territories in Australia.
<b>My Aged Care</b>	The main entry point to the aged care system in Australia designed to make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services.
<b>National Code of Conduct for Health Care Workers (NCC)</b>	The NCC is a minimum set of standards of conduct and practice for all unregistered health care workers who provide a health service.
<b>Open disclosure</b>	The open discussion of incidents that result in harm to a consumer while receiving aged care with the consumer, their family, carers and other support persons.
<b>Register</b>	A centralised record of persons who have a reportable conduct allegation and finding.
<b>Reportable assault</b>	Unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory (as defined under the Act).
<b>Reportable conduct</b>	A type of serious incident involving the conduct of staff when delivering services.
<b>Resident-on-resident or consumer-to-consumer</b>	A serious incident involving negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
<b>Residential aged care</b>	A programme that provides a range of care options and accommodation for older people who are unable to continue living independently in their own homes.
<b>Serious incident</b>	An event which threatens the safety of people or property.
<b>Serious incident management schemes</b>	A type of serious incident scheme designed to improve patient safety by capturing incidents
<b>Serious Incident Response Scheme (a SIRS or SIRS)</b>	A serious incident scheme for aged care designed to increase the detection of serious incidents by requiring reporting of serious incidents to an independent oversight body and responses to serious incidents.
<b>Service provider</b>	An organisation that has either been approved by the Secretary of the Department of Health to provide residential care, home care or flexible care under the Aged Care Act 1997 or has been funded to deliver aged care services under a contractual arrangement with the Department of Health.
<b>Staff member</b>	Any individual who is employed, hired, retained or contracted by an aged care service provider directly or indirectly to provide care or other services.

## Appendix 8: Recent inquiries and reports considered

A number of recent inquiries and reports have been considered as part of developing options. These inquiries and reports are outlined below:

1. Aged Care Financing Authority, 'Annual Report on the Funding and Financing of the Aged Care Sector' (2016).
2. Australian Law Reform Commission, 'Elder abuse – a national legal response, ALRC' (2017), report 131.
3. Carnell, Kate, Paterson, Ron, 'Review of National Aged Care Quality Regulatory Processes' (2017) <<https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes-report>>.
4. Department of Health (Cth), 'Report of the Operation of the Aged Care Act 1997' (2015-16) <[https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12\\_2016/2015-16\\_report-on-the-operation-of-the-aged-care-act-1997.pdf](https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2016/2015-16_report-on-the-operation-of-the-aged-care-act-1997.pdf)>.
5. Department of Health (Cth), 'Review of the Community Visitors Scheme', (2017). <<https://agedcare.health.gov.au/support-services/review-of-the-community-visitors-scheme-final-report>>.
6. Department of Health (Cth), 'Evaluation of the consumer-directed care initiative', (2015), <<https://agedcare.health.gov.au/ageing-and-aged-care-publications-and-articles-ageing-and-aged-care-reports/evaluation-of-the-consumer-directed-care-initiative-final-report>>.
7. Department of Health (Cth), 'Applicability of Consumer Directed Care principles in residential aged care homes – Final Report', (2015), <[https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09\\_2015/applicability-of-consumer-directed-care-principles-in-residential-aged-care-homes.pdf](https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2015/applicability-of-consumer-directed-care-principles-in-residential-aged-care-homes.pdf)>.
8. Department of Health (Cth), 'National Evaluation of the Transition Care Program Report', (2015), <<https://agedcare.health.gov.au/ageing-and-aged-care-publications-and-articles-ageing-and-aged-care-reports/national-evaluation-of-the-transition-care-program-full-report>>.
9. 'Senate inquiry into Violence and Abuse Against People with a Disability in Institutional Settings – Final Report', (2015), <[https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Violence\\_abuse\\_neglect](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect)>.
10. Groves A, Thomson D, McKellar D and Procter M. (201) The Oaken Report. Adelaide, South Australia: SA Health, Department for Health and Ageing. Department of Health (Cth), 'Review of the Aged Care Funding Instrument', (2017), <<https://agedcare.health.gov.au/reform/review-of-the-aged-care-funding-instrument-report>>.
11. Aged Care Financing Authority, 'Report on Funding and Financing of the Aged Care Sector', (2018), <<https://agedcare.health.gov.au/reform/aged-care-financing-authority/2018-acfa-annual-report-on-funding-and-financing-of-the-aged-care-sector>>.
12. 'Senate Economics References Committee: Inquiry into the financial and tax practices of for-profit aged care providers', (2018), <[https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Economics/Taxpractices-agedcare](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Taxpractices-agedcare)>.
13. 'The Aged Care Workforce Strategy Taskforce: A Matter of Care', (2018) <<https://agedcare.health.gov.au/aged-care-workforce-taskforce-strategy-report>>.
14. 'Senate Standing Committee on Community Affairs: Report on the Future of Australia's aged care sector workforce', (2018), <[https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/AgedCareWorkforce45](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45)>.
15. 'Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia Final Report', (2018), <[https://www.aph.gov.au/Parliamentary\\_Business/Committees/House/Health\\_Aged\\_Care\\_and\\_Sport/AgedCareFacilities](https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/AgedCareFacilities)>.

16. 'House of Representatives Standing Committee on Health and Ageing; Thinking Ahead – Report on the Inquiry into Dementia: early diagnosis and intervention', (2018), <<https://trove.nla.gov.au/work/183734765?selectedversion=NBD51843285>>.
17. Kaspiew, Rae, Carson, Rachel and Helen Rhoades, 'Elder abuse: Understanding issues, frameworks and responses', (2015), Melbourne: Australian Institute of Family Studies.
18. Tune, David, 'Legislated review of aged care' (2017) <<https://agedcare.health.gov.au/legislated-review-of-aged-care-2017-report>>.