



Australian Government
Department of Health

REPORT ON THE OUTCOME OF PUBLIC CONSULTATION ON THE SERIOUS INCIDENT RESPONSE SCHEME FOR COMMONWEALTH FUNDED RESIDENTIAL AGED CARE

November 2019

Acknowledgement

The Department of Health (the department) would like to sincerely thank the carers, consumer representatives and peaks, aged care workers, health professionals, aged care providers and provider peaks, government colleagues as well as the other individuals and groups who contributed comments on the finer details of operation of a Serious Incident Response Scheme (SIRS) for Commonwealth funded residential aged care. The feedback provided as part of the public consultation will support the development of the SIRS model.

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PART 1 – BACKGROUND

Purpose of this report

The purpose of this report is to summarise the key themes and outcomes of the Department of Health's (the department) consultation paper, *Serious Incident Response Scheme for Commonwealth funded residential aged care: Finer details of operation*. The outcomes of this consultation will further inform advice to Government on the development of the Serious Incident Response Scheme (SIRS) for aged care, including the structure and operation of the scheme, legislative requirements and resourcing implications.

Context

On 30 August 2019, the department released an online consultation paper seeking public comment on the details of a SIRS for Commonwealth funded residential care.

The consultation paper described the proposed model for the SIRS and sought stakeholder views on a range of details regarding the scheme including:

- proposed serious incidents, including how each of the proposed serious incidents should be defined;
- what should not be considered a serious incident;
- who should be required to report a serious incident;
- the timeframes for making a serious incident report and the information to be provided as part of the report;
- record keeping requirements;
- the powers of the Aged Care Quality and Safety Commission (the Commission) in relation to a serious incident;
- public reporting on the SIRS.

The online consultation was open from 30 August to 11 October 2019.

Profile of respondents

In total, 45 responses to the consultation paper were received. Of these:

- 28 respondents provided answers to questions in the online survey format;
- 17 respondents completed only introductory information relating to their organisation (type, location, etc.) in the online survey and addressed the substance of the consultation paper through detailed submissions.

Stakeholders who provided information identified as:

- Carer or other consumer representatives (3);
- Consumer advocacy organisations and peak bodies (3);
- Approved providers of residential care (19);
- Approved providers of home care (2);
- Aged care provider peak bodies (3);
- Aged Care Assessment Team/Service (1);
- Aged Care workers and health professionals (6);
- Workforce association or union (1);
- State and territory government (4);
- Other (3).

No submissions were received from consumers.

Respondents came from all states and territories (with the exception of the Northern Territory), with 40 out of 45 stakeholders residing in (or working in an organisation that was based in) a metropolitan area or major city. Many stakeholders based in a metropolitan area also operated in (or represented consumers based in) remote areas (12), rural areas (17) or regional areas (23).

Responses were received from approved providers of all sizes, including those that operated: a single aged care home (5), 2 to 6 aged care homes (5), 7 to 19 aged care homes (6) and 20 or more aged care homes (5).

[Attachment A](#) provides further information about the profile of stakeholders that responded to the survey.

Establishing a SIRS for aged care

Existing compulsory reporting requirements

Under the [Aged Care Act 1997](#) (the Act), approved providers of residential care are currently required to report incidents of alleged or suspected reportable assaults, including unreasonable use of force or unlawful sexual contact inflicted on an aged care consumer that would constitute an offence against a law of the Commonwealth, or a State or Territory. Providers are required to report these incidents to the police and the department within 24 hours of receiving an allegation or suspecting on reasonable grounds a reportable assault has occurred.

Approved providers are not required to make a report when, in the limited circumstances described in the aged care law:

- the alleged assault is perpetrated by an aged care consumer with an assessed cognitive or mental impairment, and care arrangements are put in place to manage the behaviour within 24 hours; or
- previous reports of the same or substantially the same incidents have already been made to the police and the department.

Preparing for SIRS

The Commonwealth Government provided \$1.5 million in funding in the 2019-20 Budget, to undertake preparatory work for the introduction of a SIRS in residential care. The activities included undertaking consultation on the finer details of the SIRS for residential care and the department engaged with individuals and organisations including:

- consumers, their families and carers;
- key sector groups;
- aged care providers;
- staff of aged care providers, health and disability services providers;
- advocacy groups;
- other government stakeholders.

In addition to the online consultation described in this report, the Department undertook three targeted stakeholder workshops to discuss the proposed details of the SIRS with consumers, aged care providers and other government officials with experience developing and administering like reporting schemes.

The Budget measure followed a range of reviews and recommendations dating from 2017 to 2019, which support the establishment of a SIRS for residential care and were used to develop the consultation paper containing the parameters and finer details of the SIRS.

PART 2 – KEY THEMES EMERGING FROM CONSULTATION

Key themes

Across all submissions, stakeholders expressed a keen interest in improving the safety and quality of care for older Australians (particularly those living in residential care) and supported the idea of a strong framework for reporting and responding to serious incidents involving older Australians. It was strongly held that aged care consumers have the same rights as members of the general community to be protected from the criminal conduct of others.

Overall, a number of key themes emerged regarding the purpose and detail of the SIRS, including:

- Stakeholders strongly agreed that serious incidents should not be distinguished on the basis of who the 'perpetrator' is (i.e. whether it was a staff member or another consumer). Any serious incident inflicted on a consumer regardless of who the alleged or suspected perpetrator is should be reported and responded to. This would include, for example, serious incidents inflicted by staff members, family, visitors to the service, volunteers, other consumers, etc.
- There was support for removing the exception to reporting for consumers with cognitive impairment. This would expand current reporting requirements to include alleged or suspected serious incidents perpetrated by consumers with assessed cognitive or mental impairment, thereby providing a more comprehensive picture as to the type, number and nature of serious incidents within the aged care sector, and an opportunity to better identify, monitor, prevent and act upon incidents.
- Submissions highlighted the need for clearly defined serious incidents that:
 - are consistent with like schemes that include the same or similar incidents (the NDIS Quality and Safeguarding Framework was noted as an example of robust quality and safeguarding arrangements);
 - set a clear threshold for reporting (and are not subjective, broad or open to interpretation in different contexts);
 - account for broader aged care reform (including the reforms being driven in the elder abuse space by the Attorney General);
 - are well supported with examples and guidance to assist providers and staff to comply with the requirements.
- The importance of clearly identifying the objective or purpose of the SIRS, including to support a shift in focus from reporting to response, where providers are responsible for the effective response, management and prevention of serious incidents.
- The need for governance measures that encourage continuous improvement and capacity building across the aged care sector, with a number of stakeholders identifying the potential for more detailed and transparent public reporting about serious incidents in residential care to drive greater accountability in the sector.

Overarching concerns expressed by a number of stakeholders included:

- the lack of clarity in the consultation paper regarding words used in definitions (such as serious, unreasonable, reckless, serious injury, trivial, negligible impact, potential to cause serious harm or death), all of which needed better explanation;
- the degree of interpretation and judgement required by staff to determine whether an incident is 'serious', and the potential for variation in judgement which could result in both over and under reporting; and
- how the SIRS is intended to intersect with other Commonwealth, state and territory regulatory frameworks and processes (for example, reporting to the Coroner or to Australian Health Practitioner Regulation Agency (AHPRA)).

It was also noted that some of the concerns expressed by stakeholders would be addressed by the development of more detailed guidance and education for the sector, which would build the confidence and capacity of sector to support the implementation of the SIRS.

Some of the more specific issues highlighted in relation to examples included:

- the examples don't give any insight into the more challenging scenarios faced by providers and how an incident will be deemed to be serious (and therefore reportable);
- there are not enough examples, specifically it would be useful to have examples that:
 - are dementia-specific;
 - deal with behaviour that is more 'borderline';
 - differentiate between manual handling and physical abuse – clarifying if it is a serious incident when a staff member physically restrains a resident who is being physically aggressive, in order to defend others or themselves;
 - go to the intersections with other state-based safeguarding laws and Health Practitioner Regulation National Law;
 - better distinguish between incidents and serious incidents (noting that the development of case studies could help to draw out this nuance).

Clarification of the purpose of the SIRS

A number of stakeholders identified a need to clarify the purpose and objectives of the scheme, including to confirm that the SIRS is not intended to replace existing obligations to report suspected crimes to the police and other relevant authorities.

Suggestions regarding the purpose of the scheme included:

- To minimise the risk of harm to consumers.
- To improve the capability of the Commission to identify potentially under-performing providers.
- To reduce the number of serious incidents across the sector and protect consumers and staff from harm.
- To support continuous improvement in the aged care sector through analysis of trends and learning from serious incidents.
- To provide a tool to achieving a reduction in the number of 'serious incidents' through taking a learning approach that includes:
 - Monitoring the rate of serious incidents;
 - Collecting information on provider's actions to prevent further incidents;
 - Analysing information provided to inform systemic improvements;
 - Using the analysis to inform system-wide organisational learning.

- To support recognition of the rights of residential care consumers including that reporting and responses to serious incidents are in keeping with individual rights and preferences.

One stakeholder suggested that use of the term ‘response scheme’ carries expectations for consumers, as it implies there is a team of responders who will mobilise quickly and come to the location of the reported serious incident.

PART 3 – FEEDBACK REGARDING THE PROPOSED DEFINITIONS

General feedback on the approach to defining a serious incident

The consultation paper proposed the following serious incidents would be within the scope of the SIRS.

When by a staff member against a consumer:

- *physical, sexual, or financial abuse;*
- *seriously inappropriate, improper, inhumane or cruel treatment;*
- *inappropriate physical and chemical restraint;*
- *neglect.*

When by a consumer against another consumer:

- *sexual abuse;*
- *physical abuse causing serious injury;*
- *an incident that is part of a pattern of abuse.*

A serious incident also includes a death or serious injury that is unexplained, and/or where the perpetrator isn't known.

An act or omission that, in all circumstances, causes harm that is trivial or negligible should not be considered a ‘serious incident’.

Distinguishing between staff members, consumers and others

Many stakeholders felt that the definition of a serious incident should not be limited to whether the incident of concern was inflicted on a consumer by a staff member or another consumer. Rather, providers should be required to record and report any incidents of abuse or neglect that occur in the residential care service, irrespective of whether the perpetrator is an employee, health professional, visitor, family member, carer or volunteer.

For this reason, there was strong support for defining the incidents without reference to the alleged or suspected perpetrator (noting that this is how mandatory reporting requirements currently operate, and the SIRS should not narrow reportable incidents).

Incidents between consumers

Many responses raised the challenges associated with incidents occurring between consumers in a residential care setting, with some stakeholders noting that incidents causing injury are not uncommon and are often between consumers with cognitive impairment.

Recognising that this is a difficult dynamic to manage, stakeholders felt that:

- it is important to explicitly report on dementia and/or cognitive impairment in the context of incidents between consumers;
- consideration needs to be given to including reference to mitigating circumstances around serious incidents between consumers (e.g. provocation, protective or defensive actions);
- there should be further clarity and guidance on consent, capacity and cognitive impairment;
- the past social or family history of relationships, and any history of incidents between consumers is relevant in reporting incidents between consumers;
- it is essential that the SIRS not be used as a mechanism to criminalise, remove or discriminate against consumers who exhibit challenging behaviours due to dementia, disability, previous trauma and/or medical conditions.

Threshold for 'serious'

Numerous comments were made in relation to the threshold for determining whether an incident qualifies as 'serious' and 'reportable'. A number of stakeholders felt a clear threshold should be included in each of the definitions of incidents as this would assist accurate reporting.

It was variously noted that:

- failing to establish a threshold that distinguishes between 'incidents' versus 'serious incidents' weakens the SIRS, and risks the scheme being overwhelmed with reports of minor incidents because the definitions appear to encompass everything and do not set a reasonable bar;
- thresholds should be aligned with criminal offences, which already have established thresholds;
- cognitive assessment and intent of the behaviour should form part of the threshold;
- it is not clear whether the terms serious injury, medical attention and immediate medical treatment are intended to establish the threshold for reporting;
- there is significant risk that (without clear thresholds) reporting on incidents will be challenging and burdensome for providers, particularly given the number and breadth of incidents between consumers with cognitive impairment; and

- it is not clear what the terms trivial or negligible mean.
 - Some felt that not reporting an incident if the impact on the consumer is trivial or negligible is too subjective and difficult to properly assess, particularly within the proposed reporting period of 24 hours.

While some aspects of the proposed definitions for a serious incident set out in the consultation paper were supported, some modifications and clarifications were sought from a number of stakeholders. Following is a summary of the key issues that stakeholders raised in relation to each of the proposed definitions that would constitute a serious incident.

Physical abuse

Adapted from both the NDIS Quality and Safeguards Commission definition and the NSW Ombudsman's definition, the following definition of physical abuse was proposed in the consultation paper, as it relates to alleged serious incidents by staff against consumers.

Unlawful contact with, or assault of, an aged care consumer, including the unreasonable use of physical force, injury, or physical coercion of an aged care consumer.

The same definition was proposed in relation to serious incidents between consumers, with the addition that the physical abuse cause serious injury.

The following specific concerns were expressed about the proposed definition of physical abuse:

- It moves away from the currently used and understood definition (based on unreasonableness).
- It introduces the concept of 'unlawful' contact which presupposes familiarity of aged care staff with provisions of criminal and civil law as to what constitutes lawful or unlawful.
 - For some it was not clear why the definition requires a legal basis as well as descriptors of specific forms of physical abuse (assault and unreasonable use of force, injury, physical coercion).
 - Others felt that removing the threshold of physical assault by reference to established law introduces a grey area that is open to interpretation.
- It may make it difficult to capture 'low level' physical abuse that is consistently inflicted over time (weeks and months), such as a pattern of rough handling during care delivery.
- It could be expanded to also encompass the impact or outcome on the consumer (e.g. transfer to hospital, assessment by medical doctor or nurse practitioner, change in care plan).

Some stakeholders indicated general support for the definition of 'physical abuse causing serious injury' between aged care consumers but noted that it is unclear how this would operate in practice. It was stated that "...aged care consumers have a right to feel safe in their place of residence, free from the risk of abuse, including from other residents and any assault to an older person has the potential to cause serious injury due to physical frailty."

Various comments were made in relation to what could be meant by serious injury, for example:

- physical abuse should only be reported if it causes serious injury that requires immediate medical attention (noting that even 'requiring medical attention' is problematic in that it varies from examination, to support, to counselling, to treatment, to hospitalisation);
- attendance at or admission to hospital or evaluation by a medical doctor/nurse practitioner is a good indicator of seriousness;
- it is about the extent of medical treatment required to deal with the injury / severity of injury;
- 'serious injury' should be defined to include bruising or any injury requiring medical assessment or treatment;
- a threshold based on whether serious injury is caused does not take into account the dynamics and types of abuse;
- it should include the consequences of the injury on the consumer, and impact it had on their life (for example, extensive and/or ongoing bruising, skin damage and choking, through to irreversible damage or harm);
- it should be based on wording in the Commonwealth Government's Guide to the assessment of the degree of permanent impairment – "*medically determined injury or impairment preventing the person from performing usual daily activities, including physical and psychological effects, for example, loss of body function*".

In relation to physical or verbal behaviour one stakeholder noted that development of a matrix on seriousness would be useful, factoring in offensiveness to consumer, consent of consumer, and calibrated by the context in which it occurred (for example, a known perpetrator or particular living conditions).

Sexual abuse

Sexual abuse was defined in two ways in the consultation paper. For alleged, suspected or actual serious incidents by a staff member against a consumer the proposed definition was:

Any sexual activity inflicted on, with, or in the presence of an aged care consumer.

For alleged, suspected or actual serious incidents between aged care consumers the proposed definition was:

Any sexual activity inflicted on, with, or in the presence of an aged care consumer without their consent.

Overarching feedback was that all allegations of sexual abuse (by anybody) must be covered in the SIRS.

With regards to the proposed definitions of sexual abuse the following comments were made:

- it is important for the definition to:
 - cover threats or intimidation;
 - be clear that sexual abuse by a person with cognitive impairment is still sexual abuse;
 - include detailed guidance about what specific behaviours do or do not constitute sexual abuse;
 - clarify that it is never okay for sexual activity to take place between aged care consumers and staff members;
- it is unclear whether it prohibits intimacy for couples or those consumers who consent. Given that partners of consumers often work as volunteers at facilities, a delineation may be required to permit intimate contact (out of work hours);
- the example, that a staff member giving a distressed consumer a hug is not sexual abuse, is good.

While one stakeholder noted that use of 'in the presence of' is an important change as it captures non-contact sexual activity, another felt that it needed to incorporate actual abuse, because some non-contact behaviour of a sexual nature (e.g. touching yourself in the presence of others) by consumers with dementia is more accurately captured as unacceptable, offensive behaviour than sexual abuse. On this point it was noted that *"...over-reporting of sexual acts that are not abusive in nature is likely to cause unnecessary distress and possible harm to residents and their families."*

The following issues were raised in relation to inclusion of 'consent' in the definition as it applied to incidents between aged care consumers:

- the term consent should be included in the definition because it constitutes the recognition of aged care consumers' rights to sexual freedom and to give and receive affection, and is contained in the Charter of Aged Care Rights;
- consumers with cognitive impairment may be unable to provide a clear verbal indication of consent, therefore any sexual activity engaged in by these consumers could be defined as sexual abuse if there is reference to consent in the definition;
- the definition could be expanded to include the wording 'or does not have the capacity to consent' (stated to be consistent with section 348 of the Criminal Code);
- the department should seek specialist expertise to better understand the complex matter of consent in relation to sexual intimacy where one or both participants have cognitive impairment.

It was also noted that sexual abuse can be difficult to monitor unless it is a pattern of behaviour, and this is particularly problematic for consumers with dementia (given that behaviours can change unpredictably, and uncharacteristically as the condition changes).

Financial abuse

The definition of financial abuse proposed in the consultation paper was adapted from Section 6 of the Victorian Family Violence Protection Act 2008, as follows:

Behaviour that is coercive, deceptive, or unreasonably controls the finances of an aged care consumer.

Opinions differed about whether financial abuse should be included in the SIRS at all, or if financial abuse should only be considered a serious incident if it involved a certain dollar value. Some felt that there should be a monetary threshold (but did not specify what that threshold should be), while most felt that if an incident involves theft or fraud, it is irrelevant how much money is involved – any action that involves criminal conduct should be acted on and reported, and have consequences. It was also noted that any suspected criminal offences should be reported to police for them (not the provider) to make a determination about the extent of criminality.

Those who did not support the inclusion of financial abuse noted:

- there are existing requirements and processes to deal with stealing and financial coercion committed by staff, including that they be reported to police for investigation and/or be reported to APRA, while also being addressed through professional conduct expectations;
- providers are very concerned about, but have limited or no authority over, financial abuse perpetrated by family members and others, noting, for example, that “...*when such cases come to light, it would be more appropriate for the approved provider to engage with the relevant elder abuse arrangements in each state/territory.*”

Stakeholders who supported the inclusion of financial abuse in SIRS noted that:

- it should explicitly include ‘theft’;
- it should include abuse and misuse of a consumer’s property and/or assets;
- theft is an absolute (not relative) concept, and it constitutes a serious incident regardless of the amount/value of the item stolen;
- the proposed definition rightly focuses on behaviour that is coercive, deceptive or unreasonably controls the finances of a consumer and examples of actions it should cover include: coercion to give an enduring power of attorney; coercion of a consumer to make amendments to a will, or any other action which would result in inappropriate financial or material benefit to the coercer or other.

Some clarity was sought with regards to how lower level matters (that may not appropriately be defined as serious incidents) are handled through the approved provider’s policies and procedures, noting that there must be significant consequences for lower-level misconduct (to act as a deterrent and ensure that there is not systemic low-level theft and fraud).

Seriously inappropriate, improper, inhumane or cruel treatment

The definition of seriously inappropriate, improper, inhumane or cruel treatment proposed in the consultation paper draws on elements from the NSW Ombudsman reportable incidents scheme.

Unreasonable behaviours against a consumer that constitutes a serious breach of the duty of care, and/or any relevant code of conduct or professional standard that applies(ied) to the staff member.

In relation to this definition, the consultation paper emphasised that the focus would be on alleged conduct rather than the actual effect of the conduct, and could include:

- emotional/psychological abuse;
- making excessive and/or degrading demands;
- a pattern of hostile or unreasonable and seriously inappropriate, degrading comments or behaviour;
- threats, insults or taunting.

Stakeholders felt strongly about this category and gave detailed feedback in relation to what it should cover, and the appropriateness of the definition.

While some stakeholders agreed with the focus on the alleged conduct rather than the actual effect of the conduct, noting that “[i]t is a way of ensuring that consumers who may not recognise that behaviours exhibited towards them are abuse or inappropriate are protected”, others felt that focusing on the alleged conduct:

- makes the definition so far reaching as to be impractical for providers to manage on a day-to-day basis;
- is inconsistent with a rights-based approach – which would focus on the individual person, and the impact upon the person’s rights, autonomy and independence.

Aspects of the definition that were supported included:

- the inclusion of emotional abuse;
- the coverage of a wide range of inappropriate, demeaning behaviours potentially including:
 - inappropriate removal of clothes;
 - verbal abuse (swearing, taunts, abusiveness, sexual jokes, unsolicited asking for sex, intrusive questions);
 - seclusion/exclusion;
 - advanced pressure sores caused by failures in wound management (noting that just as many stakeholders did not want this captured by the SIRS, including because wound deterioration is caused by range of factors, including palliation and interference by consumers themselves, and it is better to look at wound care trend data);

- intentional or reckless behaviour by staff.

Criticisms of the definition and what it covered included:

- the words in the definition are inherently subjective and open to interpretation in different contexts (“...so open-ended that it may prove impractical and confusing to implement”). For example:
 - what is deemed cruel to one is not cruel to someone else;
 - cultural differences impact how these terms are understood and enacted;
- there is no clarity in relation to non-physical harms (i.e. what constitutes serious psychological distress), with one stakeholder noting: “*Verbal assault is not clearly articulated and therefore could pick up low level minor incidents, creating unnecessary reporting. Once defined, only serious instances of this nature should be included in the definition of a ‘serious incident’;*”
- reference to the breaching of ‘relevant codes of conduct or professional standards’ would only be meaningful if all categories of staff (including volunteers) were covered by such codes and standards;
- assessment and analysis by a provider as to whether particular conduct or behaviour is a breach of duty, or a serious breach of duty, incorporates a legal aspect which will:
 - require a proper investigation of the circumstances leading to events, and this would take longer than allowed for in the proposed reporting period;
 - lead to uncertainty and confusion with respect to reporting.

While it was acknowledged that this definition is intended to be flexible enough to capture a range of serious, abusive behaviours by staff, stakeholders sought further clarification around the terms:

- unreasonable behaviours;
- serious breach of duty of care;
- relevant code of conduct (noting that personal care workers do not have one);
- the degree of inappropriateness, injury or neglect that constitutes a ‘serious incident’;
- cruel and improper treatment, neglect and trivial or negligible insult;
- severity of injury (such as fracture, subdural bleed);
- the impact of exclusion on emotional/social abuse based on religion, ethnicity, culture, sexual or gender identity.

Neglect

The definition of neglect in the consultation paper was adapted from the NSW Ombudsman’s disability reportable incidents scheme, as follows:

Intentional or reckless failure in the duty of care for an aged care consumer that may also be a gross breach of professional standards.

The consultation paper noted that behaviour that would be categorised as neglect would be that which: has the potential to result in death or significant harm; and/or involves depriving a consumer of the basic necessities of life.

Some specific issues stakeholders had with the way neglect was proposed to be defined were:

- it refers to the concept of 'duty of care', and establishing whether or not a breach of duty of care has taken place is a matter for courts, not the SIRS;
 - It was suggested that instead of using the term 'duty of care', it should read:
intentional or reckless failure in the care of an aged care consumer that may also be a gross breach of professional standards;
- neglect can be difficult to pin down in residential care – the worsening condition of a wound may not result from lack of care (neglect) but the presence of comorbidities;
- if a key element in identifying neglect is the concept of whether harm was suffered as a consequence – would this cover the full continuum, from minimal harm of no lasting consequence, through to serious harm resulting in lasting adverse outcomes;
- that care is often compromised due to unsafe staffing levels and the inability of staff to provide effective, evidence-based care and a safe place for people to live;
- there is an issue of degree in considering neglect, for example:
 - when the call button is not situated close enough for the consumer to access;
 - not changing a dressing strictly within the prescribed times;
 - malnutrition caused by inadequate provision of nutritious enjoyable food and/or assistance to eat and drink;
 - medication mismanagement (off-label prescribing or excessive administration of medication or withholding medications for no clinical reason);
- there are issues around consumer choice, for example:
 - supporting a consumer who does not wish to shower, shave, or attend any activities;
 - a consumer with diabetes refusing to eat a diabetic diet who, as a result, has a wound with poor healing prognosis.

Suggestions regarding the definition of neglect included:

- building in “gross breach of organisational policy, procedure, processes or professional standards”;

- that the definition (or the guidance) acknowledge that neglect would be more strongly demonstrated where there is more than one type of measurement;
 - For example, if it was suspected that a consumer had suffered neglect through inadequate provision of nutritious food, a series of observations would have to be made based on gathered information, such as, unplanned weight loss documented through weight measurements over time; the sequential results of calculations of a food chart noting the intake of a resident; and a series of observations by staff or visitors of the food offered to the resident.
- that it be expanded to include acts or omissions that lead to an ‘avoidable decline in a consumer’s health and wellbeing’.

Inappropriate physical or chemical restraint

The consultation paper proposed a definition in relation to inappropriate physical and chemical restraint as follows:

The use of physical or chemical restraint that does not meet the requirements of the Quality of Care Amendment (Minimising the Use of Restraint) Principles 2019.

Stakeholders acknowledged the importance of minimising the use of physical and chemical restraint but raised a number of issues, including:

- the definition of restrictive practices should be consistent with the definition already established for the NDIS and Queensland’s disability sector models, which references ‘unauthorised use of a restrictive practice’ (including the elements of physical restraint, chemical restraint, mechanical restraint, environmental restraint and seclusion), with any additional clarification needed to apply these concepts in aged care;
- there needs to be a clear understanding of what equates to restraint;
- the consequences (for example, physical harm or injury) resulting from physical/chemical restraint should be captured by the SIRS;
- more guidance is required on the inappropriate use of restraint, particularly chemical restraint, given that:
 - providers are not the prescribers of the medication or chemical restraint;
 - the list of drugs deemed to be chemical restraint is continually changed and expanded by the Commission and includes some drugs which have therapeutic and/or mental health benefits.
- inappropriate physical and chemical restraint is now more strongly regulated by the department and the Commission, such that the purpose for further including it in the SIRS is not clear.

Some concerns were expressed regarding the proposed definition of inappropriate physical and chemical restraint, which is based on the *Quality of Care Amendment (Minimising the Use of Restraint) Principles 2019*, including:

- the Quality of Care Principles amendment is wholly inadequate to protect aged care consumers from the misuse of physical and chemical restraint;
- the new requirements under these Principles have caused significant confusion within the aged care sector (for example, lack of clarity around circumstances under which physical and chemical restraints are ‘non-compliant’, ambiguity of terms ‘as soon as practicable’, ‘minimum time necessary’ and ‘regularly monitor’);
- the Commonwealth Parliamentary Joint Committee on Human Rights is currently conducting an inquiry into the Principles and it may compromise the SIRS to use this definition before an appropriate legal framework around decisions to apply restrictive practices is introduced by the Commonwealth.;
- One stakeholder noted that the amendments to the Principles drastically regress the protections of the human rights of people living in residential care – and give no consideration to a person’s right to decision-making support, or choice and control.
- The current definition does not come from a rights-based perspective:
“Unauthorised’ use of restrictive practices should be clearly tied to ‘consent’ to the use of such practices, and authorisation being provided by the consumer, or (where authorised under a legal instrument such as an enduring power of attorney, or court order) by their appointed decision-maker in accordance with state or territory law.

Stakeholders also questioned the likelihood of providers self-reporting inappropriate use of physical and chemical restraint, suggesting that this is unlikely to be the best method of monitoring inappropriate use of restraint.

Unexplained death or serious injury

The proposed definition for unexplained death or serious injury is based on the NSW Ombudsman’s disability reportable incident scheme:

A serious incident also includes a death or serious injury that is unexplained, and/or where the perpetrator isn’t known.

A number of stakeholders supported the inclusion of unexplained death in the definition of a serious incident, and felt that all serious injuries, explained or unexplained, should be reported and investigated to identify case specific and systemic issues that need to be managed.

Stakeholders who felt that unexplained death should be included in SIRS noted:

- unexplained deaths have been covered up in aged care and this needs to be addressed;

- deaths in aged care often occur due to poor management and clinical mistakes, and the death may occur sometime after the ‘mistake’ was made, therefore it is not attributed to poor care (i.e. falls, injuries or wounds that are not treated);
- the definition should be expanded to encompass premature/unexpected/avoidable deaths where steps may not have been taken to prevent death or injury;
- by reporting this information to the Commission, there is an early ‘alert’ of potential problems at a specific service that may require further investigation from a quality standards or incident perspective;
- while acknowledging the role of the Coroner, including unexplained death in the SIRS is not duplicative because:
 - the coroner’s process is too long (can take months or years), whereas reporting under the SIRS would give more scope for a full, and more immediate investigation process;
 - providers are not given findings from the Coroner, so they are unable to link critical information to drive service improvements for consumers in the future;
- it is particularly important to include if there appears to be issues surrounding staff practices and level/type of care provided leading up to the death.

Noting some challenges with the term ‘unexplained’, additional words were suggested: *A serious incident also includes an unexplained death or serious injury resulting in moderate to serious temporary or permanent harm or death; a premature or unexpected death (where steps may not have been taken to prevent death); and/or where the perpetrator isn’t known.*

In addition, clarification was sought on how the definition would intersect with the withdrawal of life sustaining measures and or the commencement of end of life measures outside of protocol or care plan.

Those who felt unexplained death should not be included suggested that:

- there is an established process whereby the appropriate medical officer refers unexplained deaths to the Coroner for investigation (and the Coroner has sufficient powers to deal with these matters);
- adding unexplained death to the SIRS would duplicate an existing investigative process – adding an unreasonable burden to doctors, family and providers by having to liaise with two competing agencies.

Class and kind exemptions – Commission or Minister

The consultation paper proposed that certain classes or kinds of serious incidents could be exempted from mandatory reporting, and that while these matters would still be defined as serious incidents (and be subject to approved provider internal governance and reporting arrangements), exemptions could enable government to better target regulatory resources and efforts to the highest risk incidents.

A number of stakeholders felt it may be appropriate to exempt acts or omissions that cause trivial or negligible harm to consumers (noting that there were questions raised about how trivial or negligible harm would be defined). However, stakeholders were most commonly emphatic about what should not be excluded under proportionate reporting arrangements, rather than specifying what types of 'trivial or negligible' incidents might be exempted.

The stakeholders who did not support class and kind exemptions noted that:

- the proposed definitions of serious incidents allow a distinction to be made between serious and non-serious or trivial incidents. All serious incidents must be covered by SIRS and included in reporting;
- applying exemptions could contribute to a pattern of behaviour or abuse that escalates over time;
- the SIRS should be well established before thought is given to the possibility of exemptions from mandatory reporting.

The majority of stakeholders felt that in the event that there were exemptions, the power to exempt certain classes or kinds of incidents should rest with the Commission (rather than with the Minister). Those who indicated that the Commission was best placed to make exemptions felt that:

- the Commission had the appropriate capacity, skills and knowledge to hold the decision-making power;
- there is a higher turnover of Ministers, whereas the Commission has a longer-term workforce with a working knowledge of the industry;
- in dealing with a broad range of issues, the Commission is well placed to investigate and inform the Minister if necessary.

Those who did not support decision-making resting with the Commission noted that there is the potential for the Commission to be put in a position of conflict. For example, it may enter into an agreement with a provider to exempt certain classes of incidents based on the provider demonstrating a satisfactory level of competence in responding to such incidents, but then be required to deal with complaints about that provider, involving that class of incident, which may influence the management of the complaint.

Others suggested that neither the Commission nor the Minister should have such power. There should be clear guidelines as to what is a serious incident and these incidents should be reported. The potential for a review process to be established was also raised, whereby a panel determines if 'other' incidents are serious, or if there is a pattern developing.

PART 4 – REPORTING, RECORD KEEPING AND ENFORCEMENT

General feedback on reporting

Some of the general comments that stakeholders made in relation to reporting included:

- There is a lack of coordination in the complaints process, and lack of understanding on part of providers about how to use the existing mandatory reporting system correctly.
- Providers do not have proper complaints systems, nor do they have adequate processes for investigating incidents that may indicate problems in their service.
- There is 'buck passing' when the Commission says the issues are police issues, but the police say the incident is too trivial to pursue or there is a lack of evidence.
- If the reporting process is too complex or there are severe repercussions resulting from a report, this may act as a deterrent to reporting.
- The challenge of the new scheme is in shifting to a culture in which providers are empowered, rather than fearful of reporting. The SIRS needs to encourage the proactive participation of providers.

Who should make the serious incident report?

The consultation paper noted that that any person, including staff members who are concerned that the care of a consumer is being compromised can (and should) report alleged, suspected or actual serious incidents to the approved provider, who then reports/escalates serious incidents to the Commission.

Stakeholders were asked whether there is a need to define the 'key personnel' that could report an incident on the approved provider's behalf. A number of stakeholders responded that the approved provider should determine the appropriate key personnel responsible for reporting and managing incidents under the SIRS, as they have management and governance arrangements in place to do this, and key personnel can vary considerably based on portfolio size and geographic distribution of services.

Stakeholders who did have suggestions about which key personnel should have responsibility for reporting and managing incidents under SIRS suggested it should be the responsibility of:

- Site Manager/Facility Manager/CEO;
- Director of Care;
- Registered Nurse/Senior Registered Nurse/Registered Nurse 1 designated as in-charge;
- anyone in a senior leadership management position of the organisation;
- organisation managers who are registered with AHPRA;
- key personnel as defined in the Act.

While some specifically stated that only one person in the service should carry the responsibility for external reporting of serious incidents, others felt that having more than one person in charge of the reporting role may provide a more balanced, impartial approach to reporting.

Timeframes for reporting

While the timeframes for incident notification (24 hours), provision of incident status report (5 business days), and final report (60 business days) were generally considered reasonable and appropriate, a number of stakeholders were critical and felt that the timeframes were inadequate, and insufficient to enable providers to report meaningful information.

The following specific issues with the reporting timeframes were raised:

- providing up to three reports for each incident will be burdensome for the regulator and for providers if the reporting threshold is set too low. An alternative approach would be a two-step process: Part A incident notification (72 hours) and Part B Incident Status Report (14 days);
- the 24-hour timeframe for providers to report information on all alleged, suspected and actual serious incidents:
 - is particularly difficult for rural and remote providers over a weekend when key personnel are not on-site (noting that there will still be a timely response to the incident);
 - is counterintuitive to the goals and the intent of the SIRS (to build provider capacity and strengthen the governance of risk and harm) because it encourages tick-box behaviour and does not give providers enough time to properly investigate the incident (particularly if the allegation is made by a consumer with a cognitive impairment, where the details are non-specific and there is no corroborating evidence). Five business days would be a more appropriate period for initial reporting;
 - should only apply to the most serious incidents. Lower level alleged or suspected incidents can require initial investigation to determine if they are reportable, and should therefore have a longer reporting timeframe;
- up to 10 business days is required to investigate and prepare a status report on an incident (the opportunity for a comprehensive process is limited if the timeframe is only five business days);
- the 60-business day reporting period for the final report is too long (two to four weeks is more appropriate).

On the issue of extending reporting timeframes, one stakeholder commented:

More time should be allowed for the circumstances of the incident and the impact on the consumer to be properly investigated and assessed and an appropriate management plan to be put in place. All of these details could then be provided in a single report within 30 days of the incident.

Others suggested that if the proposed reporting timeframes were not extended, some specific exemptions/mechanisms could be established such that an investigation could not be concluded within five business days (for example, if staff or witnesses not available or if consumer is not available due to hospitalisation), extra days could be granted.

Information that should be reported

The consultation paper included proposed information to be reported at each of the three reporting stages: incident notification, incident status report and final report. Stakeholders were asked if the proposed level of information requested was appropriate, and if it adequately covered incidents between consumers.

With regards to the type of information that should be reported if the incident occurs between consumers, stakeholders specifically wanted details related to cognitive function to be included, such as:

- diagnosis of cognitive impairment as assessed by a health professional (long or short term, sudden onset, etc.);
- information regarding the cognition of both consumers (suggesting that both are likely to have contributed to the incident, such that there won't always be one perpetrator and one victim);
- details of behavioural intervention strategies/support plan referral to support services.

Other suggestions included:

- information to clarify if the incident was part of a pattern of behaviour;
- description of any mitigating circumstances (e.g. provocation, antecedent events, past social and family history, previous relationships between the consumers);
- the impact the incident has had on both consumers, not just the victim, and this should be updated throughout subsequent reports;
- medical history beyond cognitive impairment, for example:
 - if a consumer has epilepsy and unexpectedly had a fit and injured another consumer, there is no cognitive impairment, however there is a relevant medical reason for the incident;
 - current medical conditions that may impact cognitive impairment such as infection leading to delirium for a person who is usually cognitively intact;
- where relevant, confirmation that the incident has been reported to the entity responsible for managing complaints about registered and unregistered health service practitioners;
- confirmation in the initial report as to whether the incident has been reported to police, and what action police may have taken (if any). This should also include a justification from providers as to why they deemed it necessary to involve law enforcement for an incident between consumers. It was suggested that this would allow the Commission to monitor any frequent police callouts, and to ensure providers are not exposing consumers to police unnecessarily.

It was also suggested that the final report should have a more strategic focus, demonstrating appreciation of broader implications of the incident in the context of the operations, and consumer composition and care needs within the service.

The need to consider confidentiality and privacy was also flagged, including that:

- the current reportable assault form does not allow consumers to refuse to have their personal details handed to the police (with a question around the right of the consumer to consent to the report being made);
- there is a need to ensure privacy and limited disclosure particularly when an incident is alleged and not proven;
- there are instances of the term 'alleged' being misused, which has consequences for staff (e.g. people being deemed guilty before investigation has occurred or charges have been made).

Proportionate reporting

The consultation paper sought feedback on proportionate reporting that could enable the Commission to apply a risk-based approach to regulation, whereby certain matters are exempt from being reported under the SIRS based on provider risk profile and performance (and if the Commission is satisfied the exemption will not increase the risk of harm to consumers). Stakeholders were asked if proportionate reporting should have time limits, and whether any incident types should be excluded from a proportionate reporting agreement.

Many stakeholders, including some providers, did not support proportionate reporting and felt that the SIRS should be well established before the possibility of exemptions from mandatory reporting is considered (for example, at a point when accumulated data from SIRS could assist decision making on proportionate reporting).

Stakeholders who did not support proportionate reporting felt that:

- The aged care sector has not yet reached a position where the public can be assured that providers have the skills and capability to self-govern in relation to serious incidents;
- Giving providers reporting exemptions is an inherently dangerous approach: *“There should be no outs for anybody... Aged care residents and their families would want reportable incidents reported by all providers.”*;
- The Commission will not have regular oversight of serious incidents as they occur at certain facilities deemed to have a low risk profile, and this creates an unacceptable level of risk;
- It is inconsistent with the intention to support analysis of trends and continuous improvement in the sector (as data will be incomplete);
- Government (and the public) will not: have accurate information about the rate of incident occurrence; or be able to monitor the nature, type and scope of incidents occurring year on year.

Whereas stakeholders who supported proportionate reporting felt that it was in line with the intent of SIRS, where a proven track record of documenting and responding to serious incidents evidences that the provider has strong frameworks to address systemic issues (and that this could be rewarded with exemptions from reporting certain matters).

Those in support of proportionate reporting felt it would need to be oversighted and periodically audited by the Commission to build the confidence of consumers that internal management of serious incidents was being handled appropriately.

The following suggestions were made for protections required if proportionate reporting is implemented:

- exclude certain incident types from proportionate reporting agreements (stakeholders variously suggested these include sexual, physical and verbal assault; serious unexplained injury; abuse resulting in death);
- exclude any abuse by staff, family, visitors, consumers;
- providers must report (as a minimum) the number and type of serious incidents occurring, along with strategies employed to address incidents and consequent impact;
- periodic/annual review of proportionate reporting based on an audit of serious incidents;
- proportionate reporting agreements that are reviewed every 12 months or on a case-by-case basis (e.g. if there are findings of concern during a Commission audit);
- Commission reviews should initially be three monthly and could be expanded to six months if it is working.

It was also noted that any serious incident involving potentially criminal conduct must continue to be reported to police, regardless of any proportionate reporting agreement in place with the Commission.

Public reporting by the Commission

It was noted that the current, broad level of categorisation and reporting of assaults by the Department does not enable government, the aged care sector or the general public to determine: the types of assaults that are occurring; if assaults involve staff and consumers, or are between consumers; whether they are in particular areas across Australia; or if systemic issues might be at play.

A number of stakeholders felt that public reporting by the Commission should include:

- the number of reports and actions taken by the provider and the Commission;
- data for analysis by various geographic locations (e.g. demographic data about victims and perpetrators);
- information as to whether the perpetrator or victim has a disability (including cognitive impairment).

Some stakeholders expressed that SIRS information should only be publicly reported if it is risk-adjusted for providers' consumer-mix, as consumer characteristics may affect the rate of SIRS reports (e.g. consumers with dementia or a mental health diagnosis or complex clinical care needs). Others were keen to ensure that the right balance in transparency is struck, noting that "...we would not want a scenario where providers are feeling that they need to seek to hide or not report serious incidents due to concerns as to how it will appear".

It was also suggested that data from the SIRS might not be published from the outset, as there may be benefit in testing that the system is fair and robust before making information public.

Record keeping

No change was proposed to the existing requirements for record keeping for approved providers as part of the proposed SIRS model. As such, most stakeholders felt that the proposed record keeping requirements were sufficient.

Some comments were made about the lack of standardisation of reporting and complaints systems between providers. To this end, some stakeholders suggested that a template or register for SIRS could be provided by the Commission to standardise procedures across services. Others commented that they would like to see record keeping requirements in residential care aligned with existing incident response schemes, such as those in the disability sector.

Compliance and enforcement

While some felt that the Commission should have the full range of compliance and enforcement tools (including civil penalties, sanctions and enforceable undertakings), others felt that the application of penalties should remain the province of other jurisdictions, including the courts and professional bodies.

In relation to the Commission's proposed powers to investigate and respond to reports, stakeholders felt that the:

- Commission should have the power to liaise with external agencies to protect consumers from abusive visitors and family members, and should be required to report health professionals who are alleged to have abused consumers to both AHPRA and the police;
- powers should align with existing incident response schemes, such as those in the disability sector;
- Commission's role to actively work alongside providers to protect and enhance the safety and quality of life of people receiving care could be enhanced under a new SIRS.

"We strongly recommend the SIRS is expanded to become a more collaborative model whereby the Commission actively works with providers to manage and respond to serious incidents, including strategies to improve outcomes, as well as sharing information on emerging themes, along with key learnings."

Stakeholders expressed a preference for penalties to be applied to both individuals and approved providers. Comments included:

- those responsible for carrying out the serious incident should be held to account for their actions and face the reasonable consequences for those actions – with the focus being on safety and reducing the occurrence of serious incidents;
- a provider is the primary entity through which penalties might be applied, but an individual may be responsible for an act or omission that does not necessarily represent the views of the provider;
- individuals who are in a position of managing others could reasonably be held accountable for the actions of staff under their supervision;
- a provider with a history of repeated offences in their services should be penalised (because it goes to the culture and expectations of the organisation) but if it is an isolated incident, attributed to one individual, that has been managed appropriately, penalties should only apply to the individual:

“the nature of the penalties outlined in the consultation paper appear appropriate in relation to approved providers. It is difficult to understand how the Commission might implement such penalties against an individual, particularly if they are not a staff member of the approved provider”.

PART 5 - OTHER ISSUES RAISED BY STAKEHOLDERS

Abuse directed at staff

A number of stakeholders expressed concern about how the abuse of staff by consumers and family members was being captured and questioned the role of the SIRS in this scenario.

Specific references were made to:

- abuse by a family member towards staff, including visitors who are substance affected when on-site and who abuse staff:

“As a Former Manager of a dementia specific RACF, I was verbally abused and threatened by a relative, as were some of my staff, resulting in private security being employed for several weeks to safeguard myself and my staff. This type of incident (staff member verbally abused or physically threatened by a relative) is not mentioned in SIRS”

- consumers treating workers like slaves, resulting in high turnover of staff in many services (this situation could be improved with better education of consumers so that they have a better understanding of about the service provision);
- visitors targeting after hours staff thereby avoiding management (including phone calls and emails of an abusive nature).

SIRS and home care

Stakeholders felt that consideration should be given to expanding the SIRS to cover home-based care and services, noting there are no comprehensive protections for aged people living in the community who are at risk of elder abuse.

Resources and the economic impact of the SIRS

Some stakeholders commented that the SIRS is focused on a problem that wouldn't exist if there was a fair and equitable funding model for aged care, suggesting that all providers would deliver safe quality care if they had access to adequate funding and appropriately trained staff.

Other comments on this issue included:

- In the absence of mandating staff ratios, there will be no reduction in the instances of harm to elders.
- The economic impact on providers in regional and remote areas be carefully considered in the implementation of the SIRS.
- Preparatory work for the implementation of the SIRS must include consideration of:
 - a costed operating model (at the provider level) to account for the expected increase in the level of reporting responsibility on the part of providers;
 - appropriate support for the workforce (in the midst of significant and ongoing regulatory changes).

PART 6 – NEXT STEPS

Feedback from this consultation is being considered in detail by the department in consultation with key stakeholders to develop the final version of the SIRS model.

The department would again like to thank stakeholders for their submissions.

ATTACHMENT A – PROFILE OF STAKEHOLDERS RESPONDING TO THE SURVEY

In total, 45 submissions were received on the *Serious Incident Response Scheme for Commonwealth funded residential aged care – Finer details of operation*. The data in Attachment A relates to the 45 responses to the online survey.

Please note that the number of responses in some tables does not correlate with the number of surveys completed because stakeholders were able to select multiple responses to some questions.

Table 1 Role of stakeholders responding to the survey

Stakeholders were asked what stakeholder category they most identified with.

Category of stakeholder	Online survey responses
Carer or other consumer representative	3 (6.67%)
Consumer advocacy organisation	2 (4.44%)
Consumer peak body	1 (2.22%)
Approved provider of residential care	19 (42.22%)
Approved provider of home care	2 (4.44%)
Aged care provider peak body	3 (6.67%)
Aged Care Assessment Team/Service	1 (2.22%)
Aged Care worker	1 (2.22%)
Health professional	5 (11.11%)
Workforce association or union	1 (2.22%)
State and territory government	4 (8.89%)
Other	3 (6.67%)

Table 2 Groups that carers or other community representatives identify with

Consumers, carers and consumer representatives were asked if they, or the person/s they care for or represent, identify with or belong to one or more of the following groups. Stakeholders were able to select all categories that applied. Given that no consumers completed a survey, the information below is drawn only from responses from carers or other consumer representatives.

Group(s) carer or other consumer representative identify with	Online survey responses
People from Aboriginal and/or Torres Strait Islander communities	3 (6.67%)
People from culturally and linguistically diverse (CALD) backgrounds	4 (8.89%)
veterans	3 (6.67%)
People who live in rural or remote areas	3 (6.67%)
People who are financially or socially disadvantaged	4 (8.89%)
People who are homeless or at risk of becoming homeless	3 (6.67%)
People who are care leavers	1 (2.22%)
Parents separated from their children by forced adoption or removal	2 (4.44%)
lesbian, gay, bisexual, transgender and intersex people	3 (6.67%)
People with disabilities	4 (8.89%)
People with dementia	9 (20.0%)
Not applicable	13 (28.89%)
Not Answered	23 (51.11%)

Table 3 Approved provider type

Stakeholders completing the survey on behalf of an approved provider of residential care were asked to select whether their organisation was Nor-for-profit, For-profit, Government or other.

Type of service	Online survey responses
Not-for-profit	17 (37.78%)
For-profit	4 (8.89%)
Government	2 (4.44%)
Not Answered	22 (48.89%)

Table 4 Number of residential sites

Stakeholders completing the survey on behalf of an approved provider were asked to nominate the size of their organisation.

Type of service	Online survey responses
Operating a single aged care home only	5 (11.11%)
Operating 2 to 6 aged care homes	5 (11.11%)
Operating 7 to 19 aged care homes	6 (13.33%)
Operating 20 or more aged care homes	5 (11.11%)
Not Answered	24 (53.33%)

Table 5 Location of stakeholders responding to the survey (where the organisation operates, or where the individual lives)

Stakeholders where their organisation operated and were able to choose more than one location.

Location of stakeholder	Online survey responses
NSW	12 (26.67%)
ACT	3 (6.67%)
VIC	9 (20.0%)
QLD	10 (22.22%)
SA	4 (8.89%)
WA	5 (11.11%)
NT	0 (0%)
TAS	2 (4.44%)
All states and territories in Australia	10 (22.22%)
Not Answered	0 (0%)

Table 6 Location of stakeholders responding to the survey (categorised by metropolitan, regional or remote)

Stakeholders were also asked to specify whether they lived (or the organisation operated in) a metropolitan, regional or remote area.

Location of stakeholders	Online survey responses
In a remote area	12 (26.67%)
In a rural area	17 (37.78%)
In a regional area	23 (51.11%)
In a metropolitan area or major city	40 (88.89%)
Not Answered	0 (0%)