



Final Report

Prevalence Study for a Serious Incident Response Scheme (SIRS)

November 2019

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Glossary

Terms	Definition
Aged Care Quality and Safety Commission (the Commission)	The Commission independently accredit, assess and monitor aged care services subsidised by the Commonwealth Government.
Aged Care Quality Standards (the Standards)	Organisations providing Commonwealth subsidised aged care services are required to comply with the Standards. Organisations are assessed and must be able to provide evidence of their compliance with and performance against the Standards.
Aged Care Act 1997 (the Act)	Outlines the responsibilities of approved providers and the standards they must meet when delivering aged care services.
Aged care service (service)	A care facility that provides residential aged care.
Approved provider	An approved provider receives subsidies for the delivery of aged care to care recipients and is responsible for making decisions about the delivery of quality care to care recipients, the financial management of subsidies and for managing care recipients' fees and payments.
GEN Aged Care	Comprehensive platform for data and information about aged care services in Australia. It reports on capacity and activity in the aged care system focusing on the people, their care assessments and the services they use.
Organisation or service	This report refers to organisations (or services) providing residential aged care.
Reportable assaults	Defined as unlawful sexual contact and unreasonable use of force.
Resident	Resident is a person to whom an organisation provides or is to provide care through an aged care service.
Unlawful sexual contact	Non-consensual sexual contact involving residents in residential aged care facilities. Where the contact involves residents with an assessed cognitive or mental impairment, the resident may not have the ability to provide informed consent.
Unreasonable use of force	Assaults ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force on a resident. This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising.

Executive Summary

Project context

Elder abuse in Australia has become more visible and its prevalence appears to be growing. Estimates indicate that between two and 14 per cent of older people experience abuse.¹ There is limited research on the incidence of elder abuse in Commonwealth-funded aged care. However, older people in residential aged care settings are particularly vulnerable to abuse as they tend to be frailer and dependent on others to provide care.²

Safeguards are currently in place to protect older people in residential aged care from abuse. 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 resident.³ However, a number of inquiries and reviews have highlighted issues related to the current reportable assaults arrangements, including that the exemptions relating to the reporting of resident on resident violence when the resident has cognitive impairment, may not be effective in ensuring a violence and abuse-free environment for residents. Both the Australian Law Reform Commission (ALRC) 2017 report, *Elder Abuse – a National Legal Response* (ALRC report), and the Review of National Aged Care Quality Regulation Report (Carnell-Paterson Review) recommended that a new Serious Incident Response Scheme (SIRS or Scheme) be implemented.⁴

In response to this recommendation, the Commonwealth Government announced in the 2018-19 Budget that it would develop options for a SIRS, in consultation with the aged care sector.

During 2018, options for a SIRS were developed by KPMG in consultation with the aged care sector to resolve the issues presented in the ALRC report, including one to introduce a SIRS that includes aggression and abuse between residents in residential aged care and removes current exemptions that apply to residents with cognitive impairment.

The 2018 report recommended that the Department investigate the prevalence of such incidents, including the nature and severity of these incidents, to assist in the establishment of a SIRS and setting of a threshold which will support safeguarding of older Australians in residential aged care.⁵

Scope

KPMG was engaged by the Commonwealth Department of Health (the Department) to undertake research on the prevalence of resident on resident incidents in residential aged care nationally (the study). The purpose of this study was to understand resident on resident incidents that are exempt from reporting, including to:

¹ Australian Law Reform Commission, *Elder abuse – A national legal response*, (Commonwealth of Australia, Sydney, 2017).

² Lynn McDonald et al, 'Institutional Abuse of Older Adults: What We Know, What We Need to Know' (2012) 24(2) *Journal of Elder Abuse & Neglect* 138, 139.

³ Section 63-1AA (2) and section 53 of the *Accountability Principles 2014* (Cth).

⁴ 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, p 101.

⁵ KPMG on behalf of the Commonwealth Department of Health (2018), *Strengthening protections for older Australians*, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch_.pdf.



- Collect data on the volume and nature of resident on resident incidents that are exempt from reporting in residential aged care
- Using the data collected, model the national prevalence of resident on resident incidents that are exempt from being reported to the Department
- On the basis of this modelling, provide information and findings to the Department to inform the scope of resident on resident incidents that are captured in a SIRS.

Due to the complexity of the study and constrained timeframes in gathering data, a number of data points on resident on resident incidents were out of scope for this study (identified in Section 1.2.1). Other design aspects of a SIRS were also out of scope for this project, such as:

- The roles and responsibilities of Aged Care Quality and Safety Commission (the Commission) and providers
- The threshold set for other types of incidents
- Other policy levers that could be used to respond to or prevent resident on resident incidents from occurring
- How the broader quality and safety framework will complement or interface with a SIRS.

Prevalence study methodology

The project ran from July 2019 to November 2019. The key stages of the study and the associated timeframes of these stages are summarised in Table 1 below.

Table 1: Summary of key stages for the prevalence study

Stage	Detail	Timeframe
Development of an approach to data collection	An approach to data collection was designed in consultation with the Department to ensure data collected could be used to inform the design of a SIRS. Components of the approach that were developed with the Department included the scope of the data collection, questions and data fields to be captured, and the time period for data collection. This stage also involved the development of the data submission tool, the recruitment of residential aged care services, and the provision of guidance and resources to support services to participate.	August 2019
Data collection and modelling	Data collection and modelling involved the following key activities: <ul style="list-style-type: none"> • The collection and submission of data by services • Validation of submissions • Modelling of data. 	September to October 2019
Analysis and final reporting	Data modelled during the project was analysed and synthesised to develop a final report (this report) for the Department. This included the validation of findings with the Department and the Commission to inform recommendations presented in this report.	October to November 2019

Source: KPMG



Development of the data collection approach

The data collection approach, including the scope and the data collection period, was developed in consultation with the Department. The study collected information about incidents between residents that are not currently reported to the Department. Two types of incidents were captured:

- **Type 1 incidents:** Resident on resident incidents that meet the Act's definition of a reportable assault but which are exempt from being reported to the Department⁶
- **Type 2 incidents:** Other resident on resident incidents which do not meet the definition of a reportable assault but are recorded by the approved provider.

The data collection period was a six month period from 1 February 2019 to 31 July 2019. The amount of detail collected about each incident differed depending on the incident type:

- For Type 1 incidents, the study collected information about the total number of incidents that occurred at a service during the data collection period and specific information about each incident that is already recorded by services
- For Type 2 incidents, only the number of incidents that occurred during the data collection period was captured.

Participation in the study was voluntary. Recruitment of residential aged care services occurred through direct email invitations sent to all aged care services listed on the Australian Aged Care Service List (AACSL) dated 30 June 2019, an announcement about the prevalence study via the Department's Bulk Information Distribution service to aged care providers and an invitation to the Aged Care Sector Committee to promote the study within their networks. Services had approximately four weeks to register. A total of 175 services registered to participate.

Aged care services were supported to participate in the study through:

- An online training webinar to prepare for the study
- Written guidance materials, including a resource manual and Frequently Asked Questions (FAQs)
- A dedicated toll-free hotline and functional mailbox that was available throughout the project period.

Data submission

Data submission occurred over a three week period from 16 September 2019 to 4 October 2019. Registered aged care services submitted data through an online submission tool. Three services withdrew from the study during the data submission period. Additional data was obtained from the Department and publically available sources to validate and further analyse the data submissions made by aged care services.

Data modelling and analysis

A total of 196 submissions were received during the data collection period. Of these submissions, 179 were used for data analysis and modelling. 17 submissions were excluded during the data validation process. Data analysis involved three different types of analysis:

⁶ 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 resident. An exemption under subsection 63-1AA(3) applies when a reportable assault is perpetrated by a resident with an assessed cognitive or mental impairment, and care arrangements are put in place within 24 hours to manage the behaviour, or when an allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion of a reportable assault, and that earlier allegation or suspicion was reported to the Department.



- Descriptive analysis of participating services and providers to understand whether the sample of services was representative of the national population of residential aged care services, noting it is not possible for a sample to perfectly represent the population from which it is drawn
- Descriptive analysis of Type 1 and Type 2 incidents to understand the number and nature of incidents that were reported
- Modelling of incidents to generate national estimates.

Findings

178 aged care services participated in the study: The sample of participating services was not “representative” from a jurisdiction point of view. Several jurisdictions were under-represented (ACT, SA and WA) and the NT was not represented at all. The sample did, however, appear to be “representative” of all services from a remoteness perspective. In terms of size, smaller services were under-represented but when considering occupancy, rather than number of bed licenses per service, the sample was more representative of services nationally. As with any study with voluntary participation, it is subject to voluntary response bias, and it is not known whether non-participating services would have reported more or less incidents. Regardless, the study still provides the best available data on resident on resident incidents in residential aged care. The resulting national estimates need to be considered in light of the sample and study limitations.

There were key characteristics in the incident data: The number of Type 1 and Type 2 incidents reported varied across services. Notably, 28 services reported zero Type 1 incidents and 81 services reported zero Type 2 incidents. In addition, 18 services reported 15 or more Type 1 incidents, i.e. some services averaged zero incidents over a six month period and other services averaged more than two Type 1 incidents per month. When it came to the characteristics of Type 1 incidents, there were stand out categories in terms of incident type, perpetrator behaviours, victim impact and service response. For incident type, 95 per cent of Type 1 incidents were classified as *unreasonable use of force*. When it came to perpetrator behaviours, the vast majority of Type 1 incidents were classified as pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning. This aligns with the fact that the majority of incidents were classified as *unreasonable use of force*. The impact on the victim was classified as *no impact* in the majority of incidents. The majority of services reported two or more service responses to an incident (e.g. *referral made to GP, update made to the victim’s care plan*). National estimates are likely to be influenced by the variation in the number of incidents reported across services (i.e. zero incident services and 10+ incident services). If, for example, the 28 services that reported zero Type 1 incidents were the only services to participate in the study then the national estimate would be zero. There was also a provider that reported a large number of incidents.

At a national level, over a 12 month period, there may be tens of thousands of incidents: For a six month window, 178 services reported 1,259 Type 1 incidents and 455 Type 2 incidents. This means that the total number of Type 1 and Type 2 incidents at a national level (i.e. all 2,717 services) for a 12 month period are estimated to be in the tens of thousands, specifically 38,898 Type 1 incidents and 13,757 Type 2 incidents (detailed further in Table 8 of this report). The sample ratios can be combined with the national total estimates to provide an estimate of specific incident types. For example, the 4.4 per cent of incidents that were classified as being unlawful sexual contact can be combined with the total estimate of 38,898 incidents to provide an estimate at the national level of resident on resident incidents involving unlawful sexual contact (1,730 incidents).

Options for reporting thresholds

Based on the study findings, there are a number of future options which can be considered for the reporting additional resident on resident incidents in a SIRS. A number of principles were identified to guide the assessment of the benefits and limitations of each option. These include:



- **Ease of application**, i.e. the extent to which the new threshold is straightforward and easy to apply for services. The ease of application is significantly influenced by the number of criteria that need to be considered by services in order to determine whether an incident must be reported.
- **Level of reporting by services**, i.e. the additional time that will be required to make reports for that option. The level of reporting required by services is proportionate to the volume of additional incidents that will be reported. The greater the volume of incidents, the more resources required to make the reports. Note that time spent reporting may displace time spent in other activities which could have a greater impact on the quality of care and experiences of residents.
- **Regulatory response by the Commission**, i.e. the additional time that will be required to analyse incident data and respond for that option. The response taken by the Commission is proportionate to the volume of additional incidents that will be reported. Greater data volumes will drive the resources required for the Commission to operate the SIRS.
- **The capture of additional information about incidents which result in harm**, i.e. the extent to which the option provides information which was not otherwise available about resident on resident incidents (i.e. addresses the gap identified by the ALRC report). This principle also considers the extent to which this additional information focuses on those incidents which are associated with greater harm to the resident who was the victim.

Eight options for the future reporting of resident on resident incidents in a SIRS were presented, and analysed. These include:

- Option 1: Report all Type 1 and Type 2 incidents
- Option 2.1: Report All Type 1 incidents only
- Option 2.2: Report all Type 1 unreasonable use of force only
- Option 2.3: Report Type 1 unlawful sexual contact only
- Option 2.4: Report Type 1 incidents of a 'higher' level of impact only
- Option 2.5: Report all Type 1 incidents triggering particular types of provider responses only
- Option 2.6: Report all Type 1 unlawful sexual contact and all Type 1 unreasonable use of force associated with a higher level of impact only
- Option 3: No change to the reporting requirements.

Each option was analysed, using the assessment principles of ease of application, level of reporting by services, regulatory response by the Commission, and the extent to which the option supported the capture of additional information on those incidents associated with the most harm. Based on this assessment, two preferred options were identified. These were Option 2.4 and Option 2.6. Benefits associated with both these options include:

- They both collect additional information about serious resident on resident incidents which is not currently available.
- Both options target reporting to those incidents that are associated with the greatest impact on the resident who is the victim; this may facilitate the collection of data which can, in a more targeted way, inform system level and service specific interventions by the Commission and, in turn, enable services to deliver better quality care that enhances the experience and wellbeing of residents.
- Both options present a lower volume of incidents for the Commission to analyse and respond to when compared to most of the other options
- Both options present a lower volume of incidents for services to report when compared to most of the other options to expand the threshold and, as such, are associated with a lesser need for resources which are focused on making reports. This may free up resources to focus on local or service-specific efforts to improve the quality of care.



The key challenge with both options relates to the ease of application of these thresholds. Both options would require services to be clear as to which specific incidents are in scope for reporting. As such, there will be a need for clear and simple tools and resources to help services understand new requirements, and education to embed the new practices should either of these options be implemented.

In making a decision about the future threshold for reporting of resident on resident incidents, the level of maturity of this data collection should be considered. As further data is collected, more information will become available to guide ongoing reporting.

Other considerations

There are other aspects of a SIRS and the broader regulatory framework of aged care that are important to consider in setting the threshold of resident on resident incident reporting under a SIRS. These include:

- Other design aspects of a SIRS, such as roles and responsibilities of the Commission and providers, as well as the threshold set for other types of incidents
- Other policy levers that are in place or that could be implemented to respond to or prevent resident on resident incidents from occurring, or mitigating the harm associated with these incidents
- The broader quality and safety framework that is in place and how this complements or interfaces with a SIRS, such as the Aged Care Quality Standards, the Charter of Aged Care Rights, quality compliance, and open disclosure.

Information gaps still remain regarding resident on resident incidents that are not currently reported. There is a need for further research into these areas to better support future decision making for regulatory and policy responses.



1 Introduction

This section provides some background and context to the project. The project's objectives and scope are also outlined.

1.1 Project context

Elder abuse in Australia has become more visible and its prevalence appears to be growing. Estimates indicate that between two and 14 per cent of older people experience abuse.⁷ There is limited research on the incidence of elder abuse in Commonwealth-funded aged care. However, older people in residential aged care settings are particularly vulnerable to abuse as they tend to be frailer and dependent on others to provide care.⁸

Existing safeguards

Safeguards are currently in place to protect older people in residential aged care from abuse. Existing provisions in the Act require approved providers of residential aged care to report an allegation, or a suspicion, of a 'reportable assault' on a resident.⁹ 'Reportable assaults' are defined as:

- *Unlawful sexual contact*, which refers to non-consensual sexual contact involving residents in residential aged care facilities. Where the contact involves residents with an assessed cognitive or mental impairment, the resident may not have the ability to provide informed consent
- *Unreasonable use of force*, which is intended to capture assaults ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force on a resident. This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising.

An approved provider must report an allegation, or a suspicion on reasonable grounds, of a 'reportable assault' on a resident to police and the Department within 24 hours. Not all reportable assaults are required to be reported to the Department. Exemptions for reporting include:

- When the alleged assault is perpetrated by a resident with an assessed cognitive or mental impairment and care arrangements are put in place to manage the behaviour within 24 hours
- When an allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion of a reportable assault, and that earlier allegation or suspicion was reported to the Department.

Recommendations from recent inquiries and reviews

A number of inquiries and reviews have highlighted issues related to the current reportable assaults arrangements and have made recommendations to improve safeguards for older people. The ALRC report, concluded that the current reportable assault arrangements are ineffective and do not promote safe, quality care.¹⁰ In particular:

⁷ Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).

⁸ Lynn McDonald et al, 'Institutional Abuse of Older Adults: What We Know, What We Need to Know' (2012) 24(2) Journal of Elder Abuse & Neglect 138, 139.

⁹ Section 63-1AA (2) and section 53 of the Accountability Principles 2014 (Cth).

¹⁰ Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).



- The definition of 'reportable assault' may exclude certain serious incidents of abuse and neglect occurring in residential aged care
- The exemptions relating to the reporting of certain 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 approved providers need to respond to reportable assaults
- Provider responses to reportable assaults are not adequately overseen.

The Carnell-Paterson Review also identified limitations in the current approach, including that the current definition of a serious incident is narrow and no responsibility is placed on the approved provider other than to report the assault. This 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 prevent the occurrence of similar incidents.

Both the ALRC report and the Carnell-Paterson Review recommended that a new SIRS be implemented.¹¹ In response to this recommendation, the Commonwealth Government announced in the 2018-19 Budget that it would develop options for a SIRS, in consultation with the aged care sector.

Preparatory work for a SIRS

The Commonwealth Government announced in the 2019-20 Budget that it would fund preparatory work to introduce a SIRS for residential aged care as part of the *More Choices for a Longer Life* Budget measure. The Department is currently undertaking this preparatory work focusing on the development and definition of the finer details of operation of a SIRS for residential aged care. This includes understanding the prevalence of resident on resident incidents to inform decision making.

Broader quality and safety framework of aged care

A SIRS sits within the broader safeguarding framework of aged care that ensures the safety of residents. The effectiveness of a SIRS is dependent on its interface with other quality and safety functions of the aged care system. Other regulatory settings relevant to a SIRS include the Aged Care Quality Standards, the Charter of Aged Care Rights, quality compliance, and open disclosure. These settings support approved providers to engage in risk management and continuous improvement activities to deliver safe, quality care to residents of residential aged care. In addition, there are a range of other interventions – other than regulatory oversight – that have been identified in recent research to address this issue, including existing programs such as:

- Mandatory training for residential aged care staff and advice (such as through the Dementia Training Program)
- Services that respond to behavioural and psychological symptoms of dementia such as the Dementia Behaviour Management Advisory Service (DBMAS) or Severe Behaviour Response Teams (SBRT).

It will be important to consider the intersection of a SIRS (and its relevant design components) with the current and future quality and safety functions of the aged care system and these other interventions.

¹¹ 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.



Options proposed for a SIRS

During 2018, options for a SIRS were developed by KPMG in consultation with the aged care sector in order to seek to resolve the issues presented in the ALRC report.¹² Several options were outlined, including one to introduce a SIRS that includes aggression and abuse between residents in residential aged care and removes current exemptions that apply to residents with cognitive impairment. This option recommended that a reportable incident between residents in residential aged care should be defined to mean:

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

This would remove the exemption for incidents between residents with cognitive impairment and is consistent with the ALRC Report recommendation.

A key feature of introducing this option was noted to be the 'threshold' definition for when an incident must be reported and, therefore, when the provider's response will be visible to the Commission. Setting a new threshold requires detailed consideration. The threshold set will have an impact on providers, the Commission and, most importantly, residents. For example, a lower threshold may support the Commission in its role to detect systemic issues related to the quality and safety of care and to ensure a violence and abuse-free environment for residents, but will increase the regulatory requirements for providers and may result in a volume of reports being made that is unmanageable for the Commission to appropriately investigate and respond to.

In the absence of data regarding these incidents, decision making regarding a SIRS is complex. As such, the 2018 report recommended that the Department investigate the prevalence of such incidents, including the nature and severity of these incidents, to assist in the establishment of a SIRS and setting a threshold which will support safeguarding of older Australians in residential aged care.

1.2 Project objectives and scope

KPMG was engaged by the Department to undertake research on the prevalence of resident on resident incidents in residential aged care nationally (the study). The information collected will be used to inform advice to Government on the design of the definitions and threshold for a SIRS, to ensure that reporting is appropriate and the Government's regulatory resources and efforts are targeted to the highest risks.

1.2.1 Scope

The project ran from July 2019 to November 2019. The purpose of this study was to understand resident on resident incidents that are exempt from reporting, including to:

- Collect data on the volume and nature of resident on resident incidents that are exempt from reporting in residential aged care
- Using the data collected, model the national prevalence of resident on resident incidents that are exempt from being reported to the Department
- On the basis of this modelling, provide information and findings to the Department to inform the scope of resident on resident incidents that are captured in a SIRS.

¹² KPMG on behalf of the Commonwealth Department of Health (2018), *Strengthening protections for older Australians*, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch_.pdf.



Out of scope

Due to the complexity of the study and constrained timeframes in gathering data, a number of data points on resident on resident incidents were out of scope for this study:

- The nature of Type 2¹³ incidents including the type, impact or response taken
- The experiences of aged care services in collating and submitting the data for this study
- The experiences and behaviours of aged care services generally in collecting data about resident on resident incidents, including how information is recorded and where it is recorded
- Information on where data was recorded and by whom it was able to be accessed
- Incidents that were part of a pattern of abuse.

The following aspects of the design of a SIRS were also out of scope for this project:

- The roles and responsibilities of the Commission and providers
- The threshold set for other types of incidents
- Other policy levers that could be used to respond to or prevent resident on resident incidents from occurring
- How the broader quality and safety framework will complement or interface with a SIRS.

While these areas were out of scope for this project, section 4.2 of this report describes how some of these areas might be considered by the Department in designing a SIRS and setting a threshold for incidents captured by a SIRS.

1.3 Purpose and structure of the report

The purpose of this report is to provide a summary of the project methodology and findings, including the design of the data collection approach, data collection by aged care services, analysis and modelling completed, findings from the data collection, and high level considerations on which resident on resident incidents should be reported under a SIRS.

The report is structured in the following key sections:

- Section 1 (this section): provides an overview of the project, including the background, context and objectives
- Section 2: provides an overview of the study methodology, including the design of the data collection approach, development of the data submission tool, recruitment of residential aged care services, data collection and submission and data modelling and analysis
- Section 3: provides findings of the data analysis
- Section 4: provides key considerations for a SIRS.
- Appendices: includes:

¹³ For the purpose of this project, Type 2 incidents were defined as other resident on resident incidents which do not meet the definition of a reportable assault but are recorded by the approved provider (outlined further in Section 3.1.1 of this report).



- Appendix A: Questions and data fields captured in this study
- Appendix B: Prevalence study resource manual
- Appendix C: Field validation in the data submission tool
- Appendix D: Guidance and resources to support aged care services to participate in the study
- Appendix E: Approach to modelling data.

2 Prevalence study methodology

This section provides an overview of the prevalence study methodology and activities. It outlines the details of the development of the data collection approach, data collection and submission by residential aged care services, and the validation, modelling and analysis process. The key stages of the study and the associated timeframes of these stages are summarised in Table 2 below.

Table 2: Summary of key stages for the prevalence study

Stage	Detail	Timeframe
Development of an approach to data collection	An approach to data collection was designed in consultation with the Department to ensure data collected could be used to inform the design of a SIRS. Components of the approach that were developed with the Department included the scope of the data collection, questions and data fields to be captured, and the time period for data collection. This stage also involved the development of the data submission tool, the recruitment of residential aged care services, and the provision of guidance and resources to support services to participate.	August 2019
Data collection and modelling	Data collection and modelling involved the following key activities: <ul style="list-style-type: none"> • The collection and submission of data by services • Validation of submissions • Modelling of data. 	September to October 2019
Analysis and final reporting	Data modelled during the project was analysed and synthesised to develop a final report (this report) for the Department. This included the validation of findings with the Department and the Commission to inform recommendations presented in this report.	October to November 2019

Source: KPMG

2.1 Development of the data collection approach

The development of the data collection approach involved the following key steps:

- Designing the scope of the data collection
- Development of the data submission tool
- Recruitment of residential aged care services
- Provision of guidance and resources to support aged care services to participate.

Each of these steps is detailed further below.

2.1.1 Designing the scope of the data collection

A half-day workshop was conducted with the Department's project team to design the data collection approach. This involved the design of questions and data fields for the data submission tool, and agreeing the time period for data collection.



Types of resident on resident incidents in scope for the study

Under the current arrangements, approved providers of residential aged care are required to report an allegation, or a suspicion, of a 'reportable assault' on a resident.¹⁴ 'Reportable assaults' are defined as 'unlawful sexual contact' and 'unreasonable use of force' (as defined in section 1.1). However, the scope of incidents that meet the definition of a reportable assault is narrower than the breadth of incidents that could occur in residential aged care.

Incidents between residents in residential aged care can present in many different forms,¹⁵ including:

- Physical aggression (e.g. pushing another resident)
- Verbal aggression (e.g. yelling and shouting)
- Sexual aggression (e.g. inappropriate touching)
- Material aggression (e.g. taking other residents' property).

Current arrangements for reporting exclude certain serious incidents of abuse between residents, such as emotional or psychological abuse. Similarly, not all incidents that meet the definition of a reportable assault are required to be reported to the Department. Exemptions from current reporting include:

- When the alleged assault is perpetrated by a resident with an assessed cognitive or mental impairment and care arrangements are put in place to manage the behaviour within 24 hours
- When an allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion of a reportable assault, and that earlier allegation or suspicion was reported to the Department.

This means that 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.

This study aimed to collect information about incidents between residents that are not currently reported to the Department. These include:

- Resident on resident incidents that meet the Act's definition of a reportable assault but are exempt from being reported to the Department (referred to as 'Type 1 incidents' for the purpose of this study)
- Other incidents between residents, which do not meet the definition of a reportable assault but are recorded by the approved provider (for example, in an incident log) (referred to as 'Type 2 incidents', for the purpose of this study).

Type 1 incidents: Resident on resident incidents that meet the Act's definition of a reportable assault but which are exempt from being reported to the Department

If a reportable assault meets the exemption criteria of the current reportable assaults arrangements (as described above), and is not reported to the Department, approved providers are still required to record information about the incident.¹⁶ The Accountability Principles require that each consolidated record of a resident on resident incident includes:

- The date when the approved provider received the allegation, or started to suspect on reasonable grounds, that a reportable assault had occurred

¹⁴ Section 63-1AA (2) and section 53 of the Accountability Principles 2014 (Cth).

¹⁵ KPMG on behalf of the Commonwealth Department of Health (2018), *Strengthening protections for older Australians*, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch_.pdf.

¹⁶ *Records Principles 2014* s. 8. Retrieved from, <https://www.legislation.gov.au/Details/F2019C00610>



- A brief description of the allegation or the circumstances that gave rise to the suspicion
- Information about whether a report of the allegation or suspicion has been made to a police officer and the Department; or whether the allegation or suspicion has not been reported to a police officer or the Department because the exemption under subsection 63-1AA(3) of the Act applies.¹⁷

This study collected information about these incidents – i.e. resident on resident incidents that meet the definition of a reportable assault and are recorded, but not reported.

Type 2 incidents: Other resident on resident incidents which do not meet the definition of a reportable assault but are recorded by the approved provider

In addition to the incidents that meet the Act's definition of a reportable assault, other incidents that do not meet the definition of a reportable assault may occur in residential aged care, such as but not limited to emotional or psychological abuse. These incidents may be recorded by an aged care service in a central place, such as a risk register or incident log. The study collected data on these incidents.

Data collection period

The data collection period chosen was a six month period of 1 February 2019 to 31 July 2019. The design of the data collection period and data fields was guided by a number of principles:

- The national prevalence of incidents can be estimated using the data collected
- Only information that aligns to the purpose of the project is collected
- The burden on aged care providers (and their services) is limited
- Providers are able to make an accurate assessment of the impact of an incident.

Data fields

The amount of detail collected about each incident differed depending on the incident type.

For Type 1 incidents, providers are currently required to record information about incidents. The study collected information about the total number of these incidents that occurred at a service during the data collection period, as well as specific information about each incident that is already recorded by aged care services. This included:

- The date a service first became aware or started to suspect that the reportable assault had occurred
- The type of reportable assault that occurred (i.e. unlawful sexual contact or unreasonable use of force)
- The behaviours that were displayed by the resident who was the alleged perpetrator
- The impact of the incident on the resident who was the victim
- Actions taken by a service in response to the incident.

For Type 2 incidents, aged care services are not currently required to record information on these incidents in a specific location or in a particular way. Therefore for the purpose of this study, only the quantum of incidents that occurred during the data collection period was captured.

The specific questions and data fields captured are provided in Appendix A of this report.

¹⁷ The exemption relates to reportable assaults that have occurred when the alleged assault is perpetrated by a resident with an assessed cognitive or mental impairment, and care arrangements are put in place to manage the behaviour within 24 hours or when an allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion of a reportable assault, and that earlier allegation or suspicion was reported to the Department.



2.1.2 Recruitment of residential aged care services

Participation in the study was voluntary. Recruitment of residential aged care services for the study was undertaken over approximately four weeks, beginning 21 August 2019 and closing 13 October 2019. The recruitment process included the following activities:

- An invitation was sent to all aged care services listed on the AACS List, dated 30 June 2019, to participate in the study
- An announcement was made about the prevalence study via the Department's Bulk Information Distribution service to aged care providers
- An invitation was sent to members of the Aged Care Sector Committee asking them to promote the study within their networks.

If services wished to participate, they registered their interest using a link provided in the invitation. A total of 175 aged care services registered to participate in the study.

A number of challenges were experienced with recruitment. These included:

- The recruitment process was required to be completed within a short period of time (two weeks). The KPMG project team promoted the study through a range of communication channels to increase participation in the study. However, the time available to complete the study was limited. This may have impacted the number of services that were able to participate in the study.
- The contact details used to invite aged care services to participate were gathered from the AACS List, dated 30 June 2019. However, not all contact details in this document were directed to the most appropriate contact for this study.
- The study ran concurrently with a range of changes occurring in the sector, including the Royal Commission into Aged Care Quality and Safety and the commencement of the Aged Care Quality Standards. A number of aged care services advised that they were unable to participate in the study due to resourcing constraints associated with these changes.
- The study sought to attract participation from a sample of services that would be representative of the population of residential aged care services nationally. However, the study was undertaken on a voluntary basis. Not all services agreed to participate. As with any sample, the aged care services that registered to participate through the general recruitment process did not necessarily reflect the characteristics of aged care services nationally.
- There is potential for aggregate results to be influenced by services with a larger number of incidents. These services may not be representative of services that did not participate.

2.1.3 Development of the data submission tool

An online data submission tool was developed to provide a mechanism through which providers could submit data. The data fields collected were designed in consultation with the Department. The data fields collected for each type of incident were:

- For Type 1 incidents:
 - The total number of Type 1 incidents during the data collection period
 - Whether or not any of the incidents involved the same resident
 - For each incident, the date when the service first became aware or started to suspect that the reportable assault had occurred
 - For each incident, the type of reportable assault that occurred (i.e. unlawful sexual contact or unreasonable use of force)
 - For each incident, the behaviours that were displayed by the resident that was the alleged perpetrator
 - For each incident, the impact of the incident on the resident who was the victim
 - For each incident, actions taken by the service in response.



- For Type 2 incidents:
 - The number of incidents that occurred during the data collection period.¹⁸

The Resource Manual developed for aged care services during the project can be found at Appendix B of this report. The data submission tool was accessible by any desktop, laptop or mobile phone with an internet connection.

Field validation

The data submission tool was built using a series of field validations. Field validations can be used to ensure answers are given in a particular format or within a logical range, or to prevent respondents from progressing to the next page of questions until all or particular questions on the preceding page have been answered. This serves to encourage response completeness and to ensure the correct type of information is given. An overview of the field validations used in the data submission tool is provided in Appendix C of this report.

2.1.4 Provision of guidance and resources to support aged care services to participate

Aged care services were supported to participate in the study through:

- An online training webinar to prepare for the study
- Written guidance materials, including a resource manual (included at Appendix B) and FAQs
- A dedicated toll-free hotline and functional mailbox throughout the project period.

Further detail regarding these activities is provided in Appendix D.

Summary of key findings

- The data collection approach, including scope and data collection period, was developed in consultation with the Department.
- The study collected information about incidents between residents that are not currently reported to the Department. Two types of incidents were captured:
 - Type 1 incidents: Resident on resident incidents that meet the Act's definition of a reportable assault but which are exempt from being reported to the Department
 - Type 2 incidents: Other resident on resident incidents which do not meet the definition of a reportable assault but are recorded by the approved provider.
- The data collection period was a six month period of 1 February 2019 to 31 July 2019.
- The amount of detail collected about each incident differed depending on the incident type:
 - For Type 1 incidents, the study collected information about the total number of incidents that occurred at a service during the data collection period and specific information about each incident that is already recorded by providers.
 - For Type 2 incidents, only the number of incidents that occurred during the data collection period was captured.
- Participation in the study was voluntary. Recruitment of residential aged care services occurred through direct email invitations sent to all aged care services listed on the AACS List, dated 30 June 2019, an announcement about the prevalence study via the Department's Bulk Information

¹⁸ For Type 2 incidents, aged care services are not currently required to record information on these incidents in a specific location or in a particular way. Therefore for the purpose of this study, only the quantum of incidents that occurred during the data collection period was captured.



Distribution Service to aged care providers and an invitation to the Aged Care Sector Committee to promote the study within their networks. Services had approximately four weeks to register. A total of 175 services registered to participate.

- Aged care services were supported to participate in the study through:
 - An online training webinar to prepare for the study
 - Written guidance materials, including a resource manual and FAQs
 - A dedicated toll-free hotline and functional mailbox throughout the project period.

2.2 Data submission

2.2.1 Data submission by services

Data submission occurred over a three week period from 16 September 2019 to 4 October 2019. This stage involved aged care services submitting data via the online submission portal.

Registrations remained open throughout the data submission period. A small number of services contacted the KPMG project team to request an amendment to their response. The KPMG project team kept a log of any amendments requested and made changes to submissions prior to data analysis.

There were also some challenges that arose during the data submission period. These included:

- There was some level of confusion regarding the definition of Type 2 incidents. The KPMG project team clarified queries as they arose through the functional mailbox and hotline.
- The contact person assigned by some aged care services at the point of registration was unavailable during the data submission period.
- The KPMG project team was unable to get in contact with some aged care services to validate submissions.

A total of three services withdrew from the study during the data submission period. Withdrawn services did not provide a reason for dropping out of the study and were not contacted further.

2.2.2 Additional data

Additional data was obtained from the Department to validate and further analyse the data submissions made by aged care services. This included both publically available data and data obtained directly from the Department. The data sources used in the study are summarised in Table 3 below.

Table 3: Administrative data sources

Source	Data	Fields	Availability	How the data was used
GEN Aged Care website ¹⁹	AACS List, 30 June 2019	<ul style="list-style-type: none"> • Service name • Address and location fields • Aged Care Planning Region • Care type • Number of residential places 	Publically available	<ul style="list-style-type: none"> • Reconciled list of services that submitted data (the sample) with the list of approved service providers to ensure all submissions were eligible. Eligibility was restricted to residential aged care services operating under an approved provider in Australia.

¹⁹ Australian Institute of Health and Welfare. (2019). GEN Aged Care Data. Retrieved from, <https://www.gen-agedcaredata.gov.au/>.



Source	Data	Fields	Availability	How the data was used
		<ul style="list-style-type: none"> Number of home care places Number of restorative care places Provider name Organisation type Remoteness (ABS) 2018-19 Australian Government funding 		<ul style="list-style-type: none"> Analysed how the characteristics of the sample compared to the characteristics of the complete list of services in Australia. Characteristics included size, location and remoteness of the service. Analysed any potential correlation between service characteristics and incident number.
Department of Health	Australian Aged Care Services Residential Occupancy Rates, February to July 2019, by month	<ul style="list-style-type: none"> Provider name Service name Service ID Occupancy percentage (claim days) for February, March, April, May, June and July 2019 	Provided on request	<ul style="list-style-type: none"> Analysed any potential correlation between occupancy rate and incident number.

Source: KPMG

Summary of key findings

- Data submission occurred over a three week period from 16 September 2019 to 4 October 2019. Registered services submitted data through an online submission tool.
- Three services withdrew from the study during the data submission period.
- Additional data was obtained from the Department and publically available sources to validate and further analyse the data submissions made by aged care services.



2.3 Data modelling and analysis

The process to model and analyse data collected by aged care services is detailed below.

2.3.1 Data validation

A total of 196 submissions were received through the online tool.²⁰ The submissions were reviewed at a submission and incident level. As a result of the submission review, 17 submissions were excluded due to:

- 15 submissions were classified as incomplete. For example, a service commencing data entry and then stopping part way through
- There was one duplicate submission
- There was one submission where the specific name of the service was unable to be determined.

A total of 179 submissions remained for analysis after the data validation process. Once the submission validation was complete, high level incident validation was undertaken. There were nine Type 1 incidents with dates outside of the reporting period (1 February 2019 to 31 July 2019). These incidents were excluded. One service was only able to report Type 1 incidents and not Type 2 incidents.

2.3.2 Modelling

Data was received from a sample of services (the sample). One of the main objectives of the study was to estimate the total number and type of Type 1 and Type 2 incidents that take place in residential aged care. To estimate (or model) the prevalence of Type 1 and Type 2 incidents at a national level, sample estimates were required to be “weighted”. This ensured that national estimates reflected the national population of services, rather than the subset of services that submitted data (e.g. services from a particular jurisdiction). Five methods were used to weight the data and calculate national level estimates. The approach for modelling data is included in Appendix E of this report.

2.3.3 Analysis

Three main pieces of analysis were undertaken as part of the study:

1. Descriptive analysis of the participating services and providers
2. Descriptive analysis of the Type 1 and Type 2 incidents
3. Modelling the incidents from the sample to present a national estimate of incidents.

The purpose of the descriptive analysis was to understand whether the sample of services was representative of the national population of residential aged care services.

It is not possible for a sample to perfectly represent the population from which it is drawn. This is the case with the sample of services that participated in the study. Section 3 outlines some of the limitations of the sample in terms of providers and services, jurisdiction, remoteness, size (number of residential places) and occupancy. **These limitations need to be considered when interpreting the modelled estimates.**

²⁰ The number of services that submitted data was higher than the number of services that registered as some services submitted data without registering to participate.



Descriptive analysis of the Type 1 and Type 2 incidents reported by aged care services was used to understand the number and nature of incidents. Type 1 incident analysis focused on the characteristics of the incidents, namely:

- When (by month)
- Reportable assault type (unreasonable use of force or unlawful sexual contact)
- Perpetrator behaviours
- Victim impact
- Service response.

Some detailed incident level analysis was undertaken. This included analysing reportable assault types by perpetrator behaviour, victim impact and service response. However, undertaking detailed incident breakdowns (or cross-tabulations) by reportable assault type, perpetrator behaviour, victim impact and by service response simultaneously did not provide additional insights due to the distributions inherent within each individual variable. Distributions within each variable were often dominated by a particular response category e.g. unreasonable use of force was selected in 95 per cent of incidents and update made to the perpetrator's care plan was selected as a service response for 82 per cent of incidents.

Summary of key findings

- A total of 196 submissions were received during the data collection period. 179 submissions were used for data analysis and modelling. 17 submissions were excluded during the data validation process.
- Data analysis involved three different types of analysis:
 - Descriptive analysis of participating services and providers to understand whether the sample of services was representative of the national population of residential aged care services, noting it is not possible for a sample to perfectly represent the population from which it is drawn.
 - Descriptive analysis of Type 1 and Type 2 incidents to understand the number and nature of incidents that were reported.
 - Modelling of incidents to generate national estimates.

3 Findings

3.1 Characteristics of participating approved providers and services

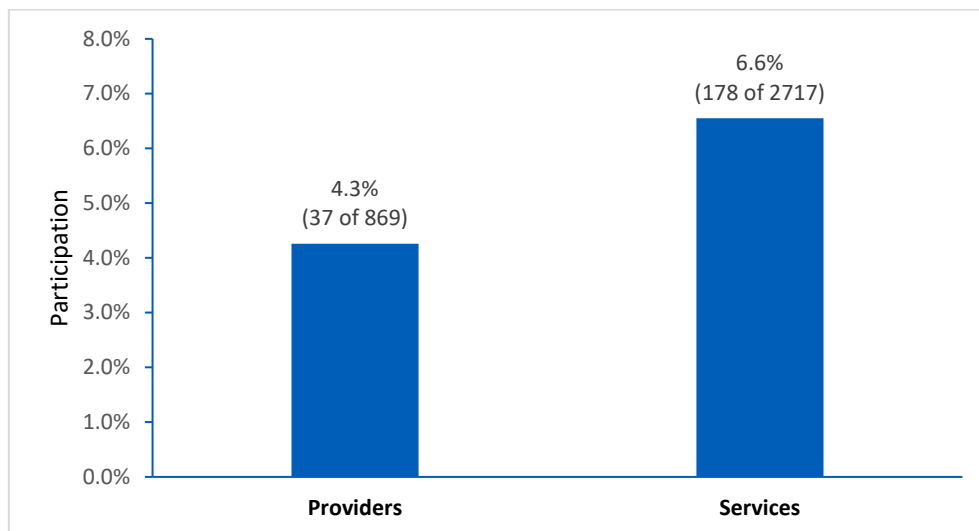
KPMG analysed the characteristics of the services that submitted data to understand whether these services were representative of the national population of residential aged care services. This involved comparing the number of approved providers and services in the sample with the numbers of approved providers and services in the population of services delivering residential aged care nationally. Service level characteristics, including jurisdiction, remoteness, size (places) and occupancy, were the main characteristics of the sample which were compared to the population of services.

The following sub-sections describe the results of this analysis. Data used to support this analysis was obtained from the GEN Aged Care website.²¹

3.1.1 Total number of services and approved providers in the sample

In Australia, there are 869 approved providers operating 2,717 services (as at 30 June 2019). On average, each approved provider operates 3.1 services (2,717 services / 869 approved providers). In total, 178 of 2,717 approved services (6.6 per cent) and 37 of 869 approved providers (4.3 per cent) participated in the study. This distribution is illustrated in Figure 1. On average, each participating approved provider submitted data on 4.8 services. A higher percentage of services than approved providers participated due to a number of approved providers submitting data for many services, e.g. two approved providers submitted data for over 20 services.

Figure 1: Percentage of approved providers and services that participated in the study



Source: KPMG analysis of resident on resident incident study data and Aged Care Service List June 2019

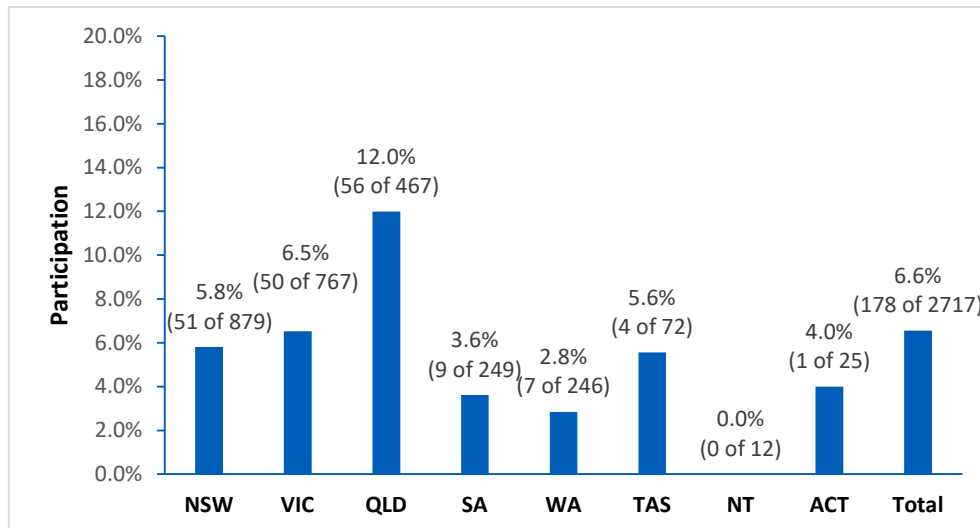
²¹ Gen Aged Care Data (2019). Aged Care Service List - Australia - as at 30 June 2019. AIHW, Canberra.



3.1.2 Participating services by jurisdiction and remoteness

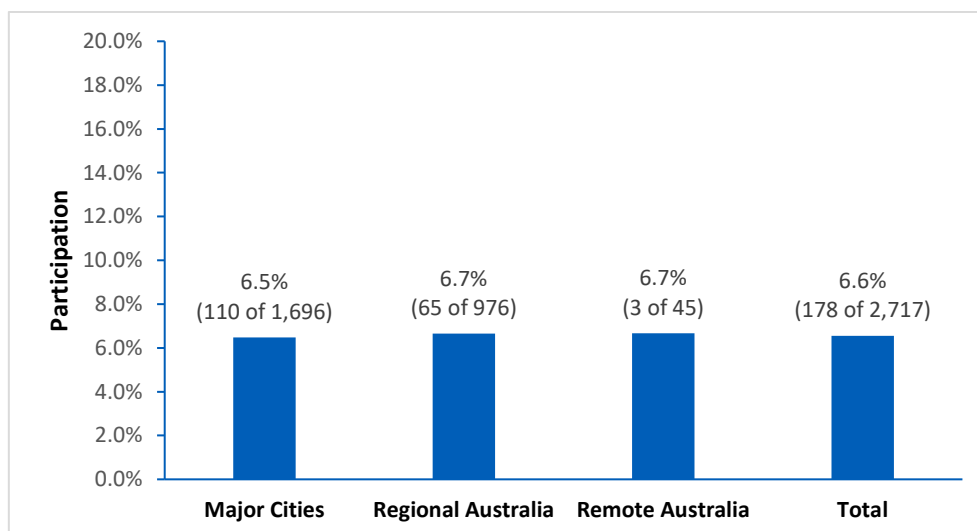
There was variation in participation by jurisdiction. Notably, no services from the Northern Territory (NT) participated and almost one in eight services (12.0 per cent) from Queensland participated. New South Wales (NSW) (5.8 per cent), Victoria (6.5 per cent) and Tasmania (5.6 per cent) were one percentage point below the national participation level of 6.6 per cent. Participation by services in the Australian Capital Territory (ACT) (4.0 per cent), South Australia (SA) (3.6 per cent) and Western Australia (WA) (2.8 per cent) was lower still and these jurisdictions, along with NT, may be considered under-represented compared to the national figure. This distribution is illustrated in Figure 2.

Figure 2: Percentage of services that participated by jurisdiction



Source: KPMG analysis of resident on resident incident study data and Aged Care Service List June 2019

There was no variation in participation by remoteness categories of Major Cities (6.5 per cent), Regional (6.7 per cent), and Remote Australia (6.7 per cent). In relation to the participating services and their remoteness, the sample can be considered “representative” as, across the three remoteness categories, a similar percentage of services participated. This distribution is illustrated in Figure 3.

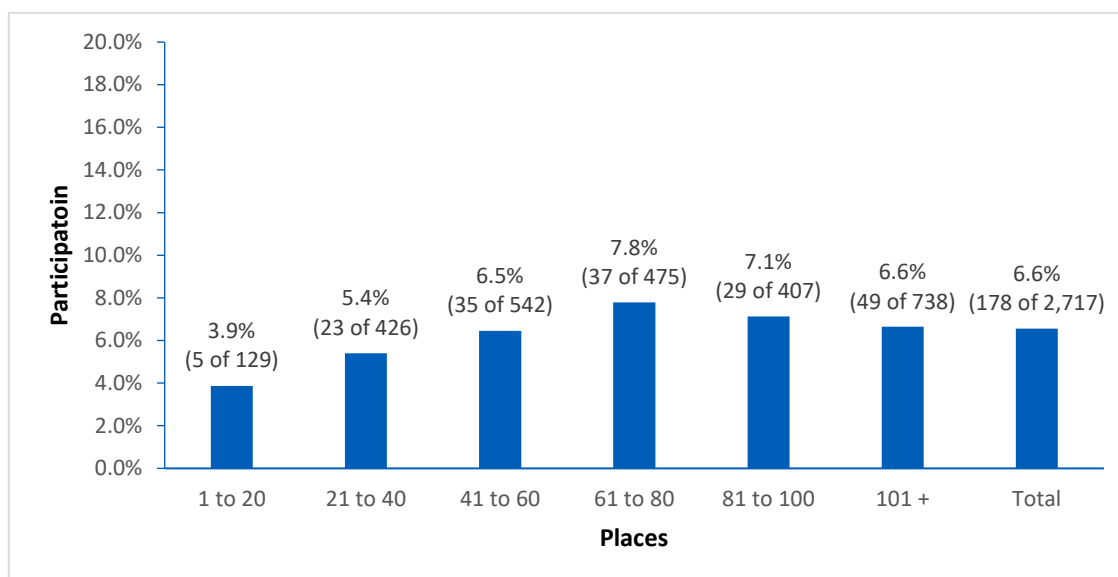
Figure 3: Percentage of services that participated by remoteness²²

Source: KPMG analysis of resident on resident incident study data and Aged Care Service List June 2019

3.1.3 Participating services by size and occupancy

There was some variation in participation by size (number of places) of service. Generally, smaller services were “under-represented” compared to larger services, which were “over-represented”. For example, 3.9 per cent of services that have one to 20 places participated, and 5.4 per cent of services that have 21 to 40 places participated compared to the national figure of 6.6 per cent. In comparison, services of 61 to 80 places were over-represented (7.8 per cent), when compared to the national figure of 6.6 per cent. This distribution is illustrated in Figure 4.

Figure 4: Percentage of services that participated by size

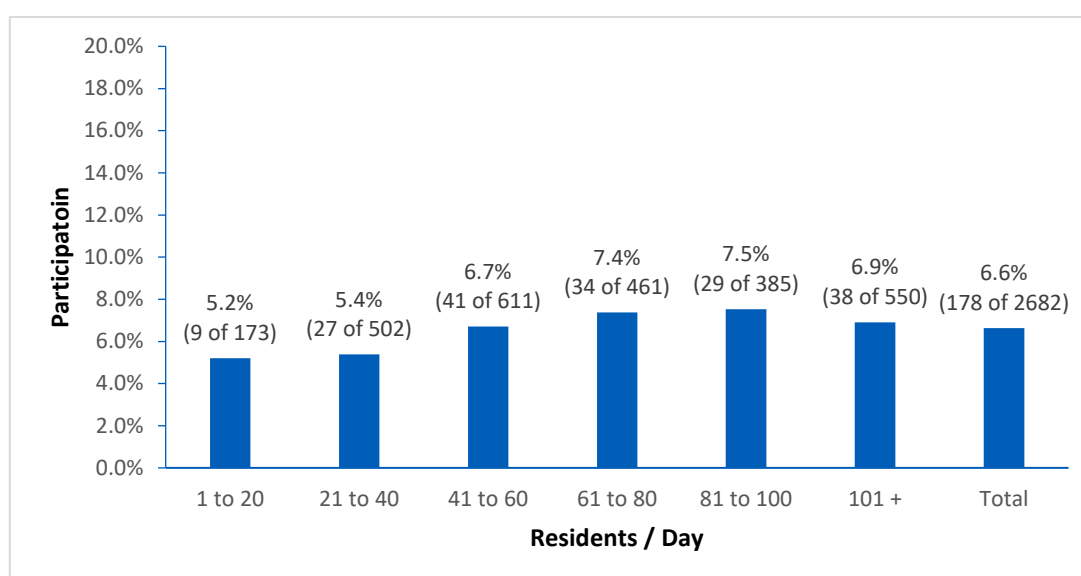


Source: KPMG analysis of resident on resident incident study data and Aged Care Service List June 2019

The Department provided KPMG with information on the occupancy of 2,724 services for the six month period of 1 February 2019 to 31 July 2019. Only 2,682 of these services could be matched to the aged care service list (as at 30 June 2019) to incorporate places (e.g. 20 places) with occupancy data (e.g. 90 per cent). The places and occupancy data was combined to calculate the average number of residents per day for the six month period. For example, a service with 20 places and 90 per cent occupancy over the six month window equates to there being 18 residents per day (Residents / Day). These residents per day calculations were grouped into the same bands as the size bands developed (e.g. 1 to 20 places and 1 to 20 Residents / Day).

Generally, services with a lower occupancy (1 to 20 Residents / Day, 21 to 40 Residents / Day) were under-represented. However, the distribution by occupancy ranges is quite even, with the lowest participation rate being for services with 1 to 20 residents (5.2 per cent), and the highest being for services with 81 to 100 Residents / Day (7.5 per cent). This distribution is outlined in Figure 5.

Figure 5: Percentage of services that participated by occupancy²³



Source: KPMG analysis of resident on resident incident study data and occupancy data supplied by the Department

3.1.4 Sample of participating services

Any sample of residential aged care services selected will, across a range of factors such as location (jurisdiction and remoteness), size and occupancy be deficient in one of these factors. In this instance, the sample of participating services is not “representative” from a jurisdiction point of view. Several jurisdictions were under-represented (ACT, SA and WA), and NT was not represented at all. The sample did however, appear to be “representative” of all services from a remoteness point of view. In terms of size, smaller services were under-represented but when considering occupancy, rather than just size, the sample was more “representative” of services nationally.

There was a total of 178 services that participated in the SIRS prevalence study. Noting some of the limitations with participating service “representativeness” above, the study sample still provides the only available data on resident on resident incidents that are not reported to enable the estimation of the volume of incidents that may occur at a national level. These issues with “representativeness” should be taken into consideration alongside the national estimates presented in Section 3.3. The focus

²³ Note: the occupancy data was supplied for 2,682 services.

of the estimates is at a national level as more detailed breakdowns will be less reliable (e.g. national estimates of incidents for smaller services) or not possible to calculate (e.g. for particular jurisdictions).

3.2 Descriptive analysis of incident data

Descriptive analysis was performed on the Type 1 and Type 2 incident data in the sample. For the Type 1 incident data, analysis was undertaken on the characteristics of the Type 1 incidents, i.e. the total number of incidents, whether the same resident was involved, when the incident occurred (by month), reportable assault type (Unreasonable use of force or Unlawful sexual contact), perpetrator behaviour, victim impact and service response.

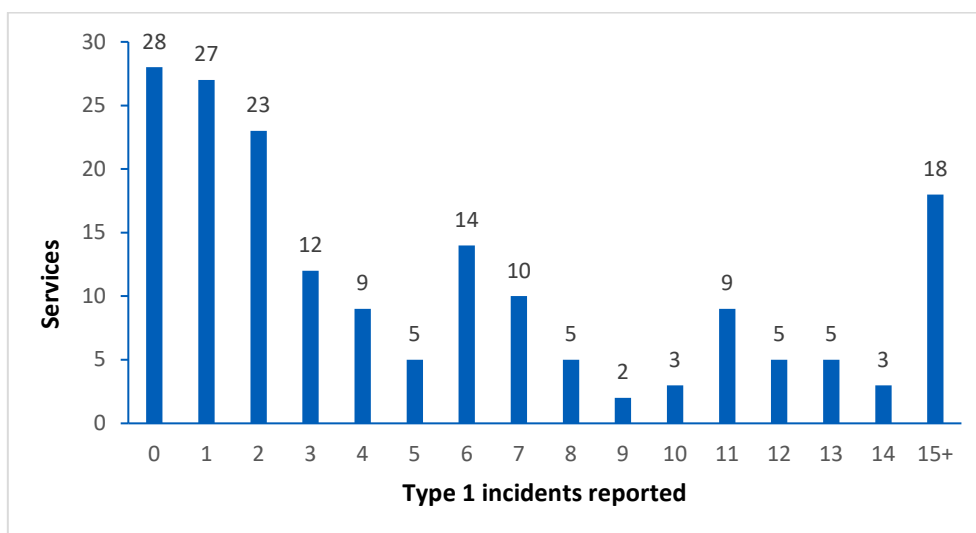
The following sub-sections describe the results of the descriptive analysis of Type 1 incidents followed by Type 2 Incidents.

3.2.1 Type 1 Incidents reported per service

In total, there was a total of 1,259 Type 1 incidents reported for the six month period from the 178 services in the sample. Notably, 28 services reported zero Type 1 incidents, and 18 services reported 15 or more Type 1 incidents. This distribution is illustrated in Figure 8.

This distribution, i.e. services reporting zero incidents and services reporting many incidents, is important to keep in mind when reading section 3.3 of this report. The main reason is that this sample data is used to infer estimates of incidents for all 2,717 services for a 12 month window. The sample has some services reporting zero incidents for a six month window and some services reporting more than one incident per month for the six month window. If, for example, the study had by chance only collected data from the 28 services that reported zero Type 1 incidents then the estimate of total incidents at a national level for a 12 month window would be zero.

Figure 6: Count of services by total Type 1 incidents reported

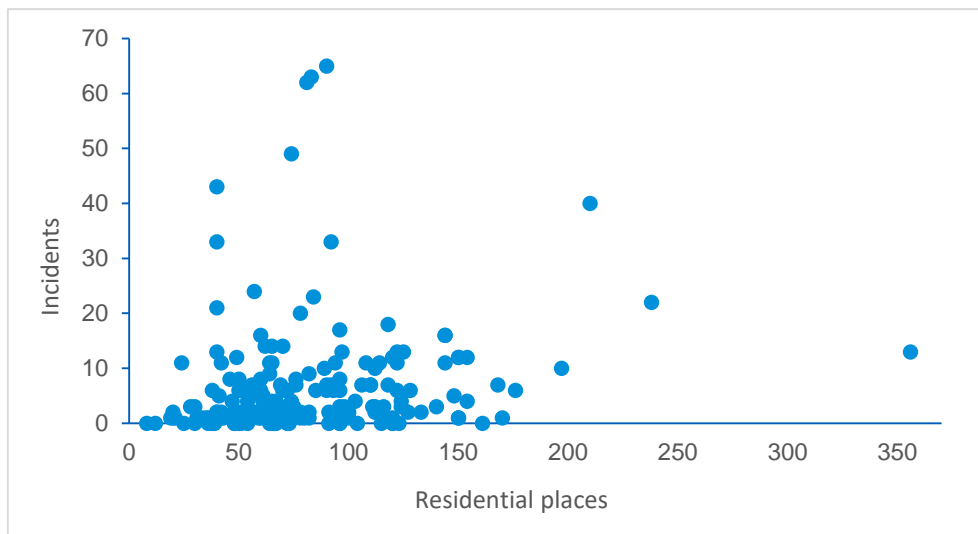


Source: KPMG analysis of resident on resident incident study data

The total number of incidents reported generally increased with service size. This is outlined in Table 4. A weak positive relationship between places and Type 1 incidents at a service level was also observed, i.e. as the size of the service increases, the number of Type 1 incidents also increases. This relationship was heavily influenced by outliers (those services reporting large numbers of incidents despite having less than 60 places), and some larger services reporting zero incidents (services with over 100 places but no incidents). This is illustrated in Figure 7.



Figure 7: Total incidents reported by size of service



Source: KPMG analysis of resident on resident incident study data

Table 4: Count of Type 1 incidents and services by residential aged care place size groupings

Service size	Incidents	Services participating	Average Incidents per service
1-20 places	4	5	0.8
21-40 places	144	23	6.3
41-60 places	158	35	4.5
61-80 places	224	37	6.1
81-100 places	369	29	12.7
101+ places	360	49	7.3
Total	1,259	178	7.1

Source: KPMG analysis of resident on resident incident study data

3.2.2 Type 1 Incidents involving the same resident

There was a total of 123 services that reported two or more incidents. These 123 services were also asked whether these incidents involved the same resident. This was asked about all incidents at an aggregate level and was not captured at an individual incident level. For example, if a service reported five incidents, the data collected cannot discern whether the same resident was involved in all five incidents or that the same resident was involved in two incidents and the remaining three incidents involved different residents. For those 123 services, the majority (78.9 per cent or 97 of 123) indicated that the same resident(s) was involved. These 97 services also reported 1,163 incidents. This distribution is outlined in Table 5.

Table 5: Count of services and incidents by whether the same resident was involved

Incidents involved the same resident	Count of services	Percentage of services	Sum of incidents	Percentage of incidents
No	26	21.1%	69	5.6%
Yes	97	78.9%	1,163	94.4%
Total	123	100.0%	1,232	100.0%

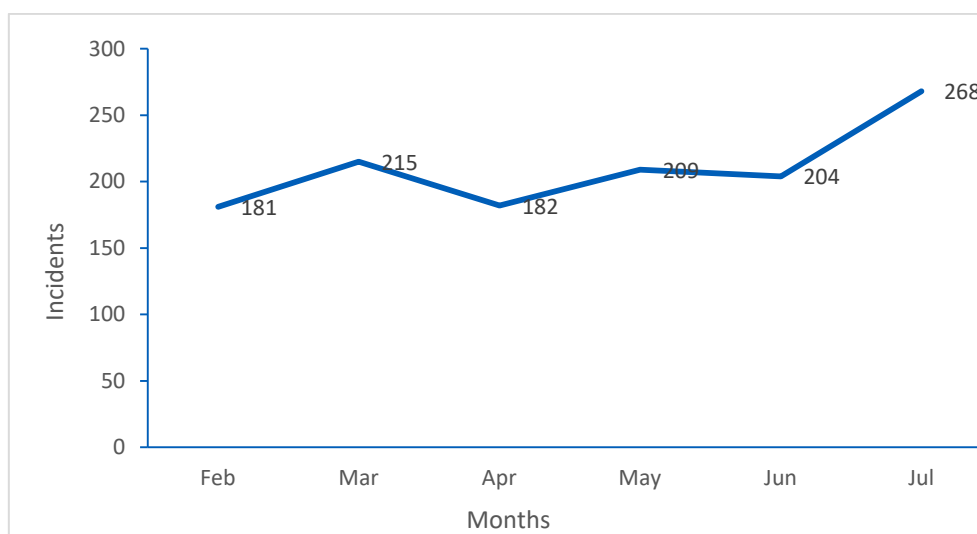
Source: KPMG analysis of resident on resident incident study data

There was a total of 60 services that reported seven or more Type 1 incidents for the six month window. All 60 services indicated that the same resident(s) was involved. As described above, if there were seven incidents, the data collected does not discern whether the same resident was involved in all seven incidents or if one resident was involved in three incidents and another resident in four incidents.

3.2.3 Type 1 Incidents by month

Services provided data about the date of the incident (dd/mm/yyyy). The distribution of Type 1 incidents was similar across each month. Notably, there was a slightly higher number of incidents reported in July but, generally, there was limited variation across the total number of incidents reported for each individual month. This distribution is illustrated in Figure 9. On average, 1.2 Type 1 incidents were reported per month per service, i.e. 1,259 incidents divided by 178 services = 7.1 incidents per service. 7.1 incidents per service divided by six months = 1.2 Type 1 incidents per month.

Figure 8: Count of total incidents reported by month from participating services, Type 1 incidents

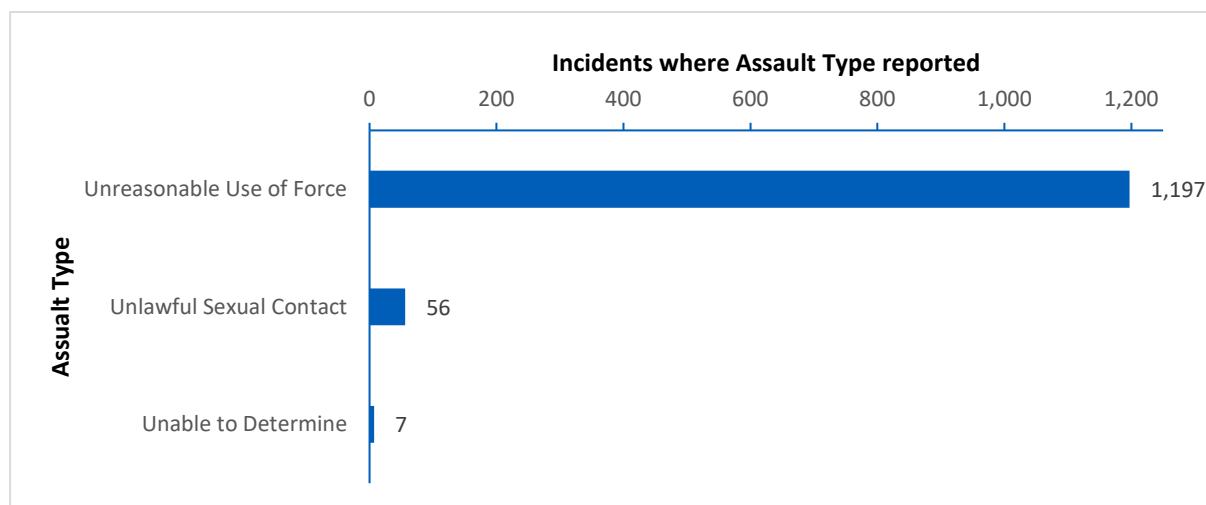


Source: KPMG analysis of resident on resident incident study data

3.2.4 Type 1 Incidents by reportable assault type

For each Type 1 incident, the service was asked to select all reportable assault types that applied (i.e. Unreasonable use of force, Unlawful sexual contact, or Unable to determine). All respondents selected one reportable assault type for each incident, except for one incident that involved both unlawful sexual contact and unreasonable use of force. The reportable assault type was unable to be determined in only seven of 1,259 (0.6 per cent) incidents. Notably, unreasonable use of force was reported in the majority of incidents (95.0 per cent) and unlawful sexual contact in a minority of incidents (4.4 per cent). This distribution is illustrated in Figure 9.

Figure 9: Count of reportable assault types, Type 1 incidents



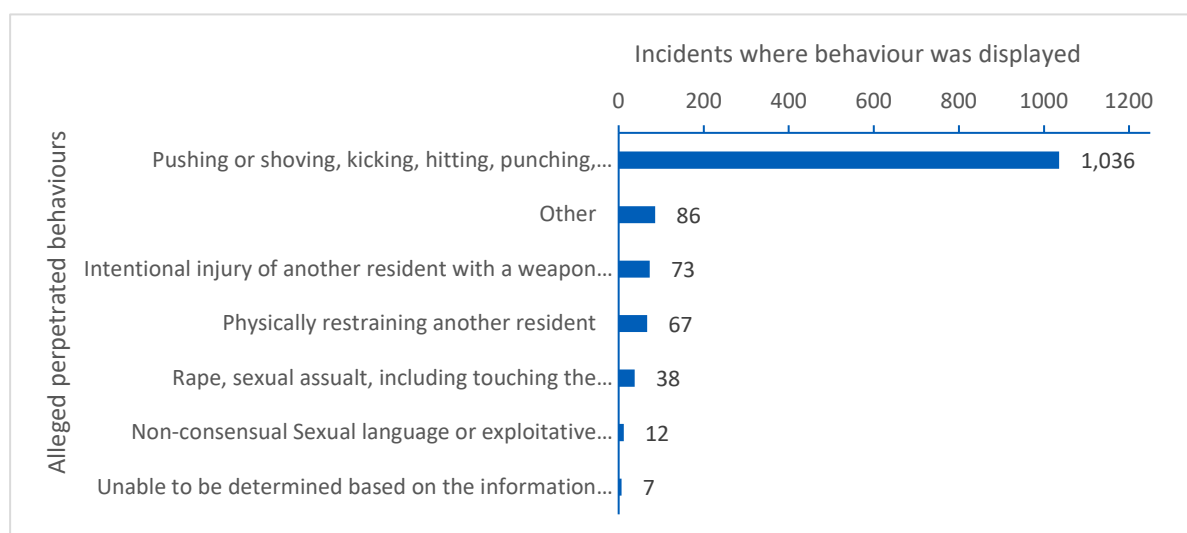
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Source: KPMG analysis of resident on resident incident study data

3.2.5 Type 1 Incidents by perpetrator behaviours

For each Type 1 incident, the respondent was also asked to select all behaviours that were displayed by the alleged perpetrator. One behaviour type was selected in 1,206 of the 1,259 (95.8 per cent) Type 1 incidents and two behaviour types or more were selected in 55 incidents (4.4 per cent). Pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning behaviour was the most common behaviour type, being reported in 1,038 (82.3 per cent) of Type 1 incidents. This distribution is illustrated in Figure 10.

Figure 10: Count of alleged perpetrator behaviours, Type 1 incidents



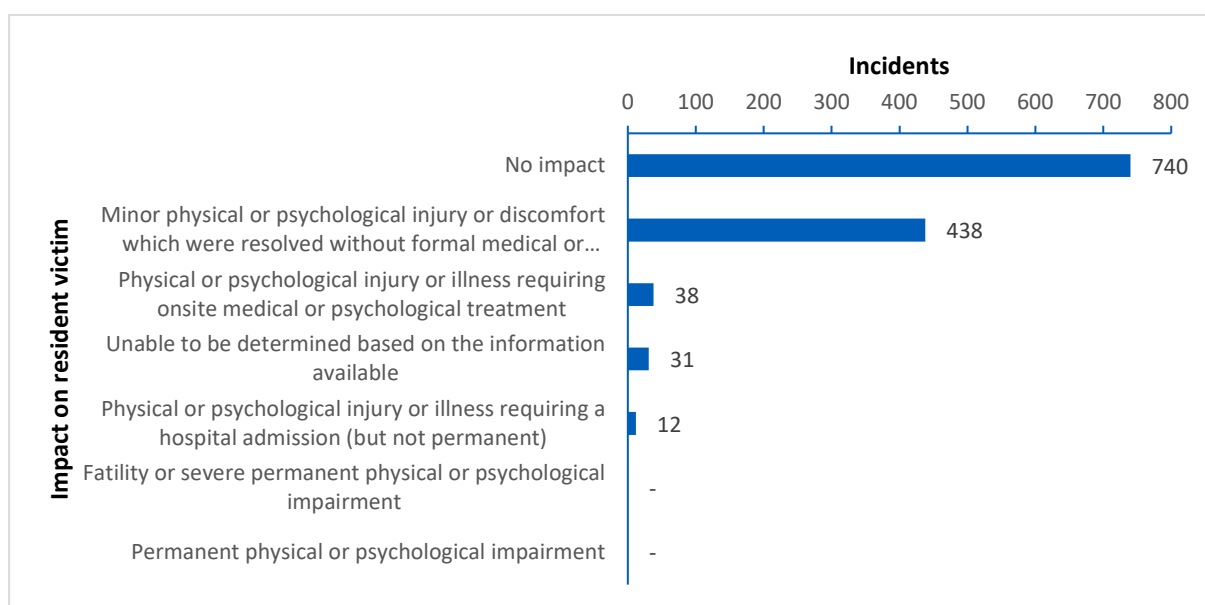
Source: KPMG analysis of resident on resident incident study data

²⁴ Respondents could select more than one perpetrator behaviour for an individual incident.

3.2.6 Type 1 Incidents by victim impact

For each Type 1 incident, the respondent was asked to select the impact of the reportable assault that most closely aligned with the impact on the resident.²⁵ The most common impact was that the incident had no impact on the victim, which was reported in 740 incidents (58.8 per cent). Notably, physical or psychological injury or illness requiring a hospital admission (but not permanent) occurred in only 12 incidents (1.0 per cent) and physical or psychological injury or illness requiring onsite medical or psychological treatment occurred in only 38 (3.0 per cent) of incidents. This distribution is illustrated in Figure 11.

Figure 11: Count of impact of the reportable assault on the victim, Type 1 incidents



Source: KPMG analysis of resident on resident incident study data

This distribution is important as there is an order to these impact options. This order ranges from no impact to fatality or severe permanent physical or psychological impairment and is outlined below:

- No impact (or least harm)
- Minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions
- Physical or psychological injury or illness requiring onsite medical or psychological treatment
- Physical or psychological injury or illness requiring a hospital admission (but not permanent)
- Permanent physical or psychological impairment
- Fatality or severe permanent physical or psychological impairment (or most harm).

No incidents were reported against the last two options (most harmful options). The “mid-level” impact options of physical or psychological injury or illness requiring onsite medical or psychological treatment

²⁵ Respondents could only select one value for victim impact.

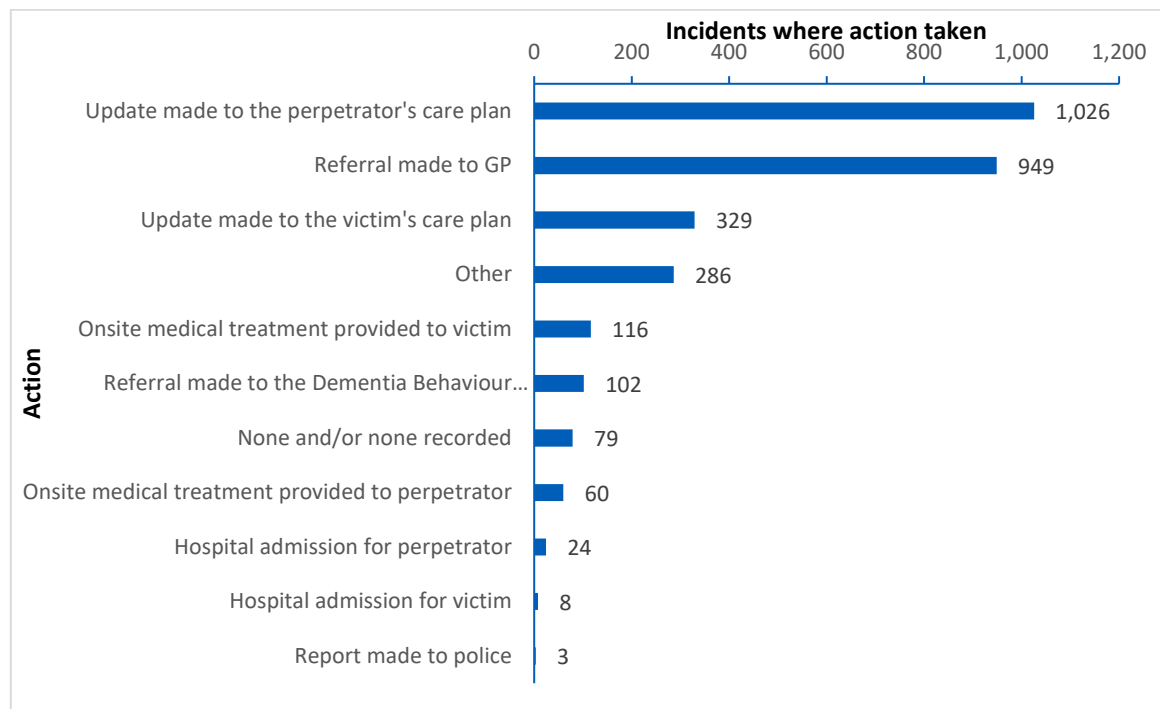


(38 incidents) and physical or psychological injury or illness requiring a hospital admission (but not permanent) (12 incidents) were selected in a total of 50 Type 1 incidents (4.0 per cent).

3.2.7 Type 1 Incidents by service response

For each Type 1 incident, the service was asked to select all actions that were taken in response to the incident.²⁶ The most common response by a respondent was to take two actions in response to a Type 1 incident, which occurred in 512 of the 1,259 reported Type 1 incidents (40.7 per cent). The top three actions were update to the perpetrator's care plan, referral to GP and update to victim's care plan. This is outlined in Table 6 and illustrated in Figure 12.

Figure 12: Count of provider actions taken for Type 1 incidents



Source: KPMG analysis of resident on resident incident study data

Table 6: Count of provider actions taken by provider in response, Type 1 incidents

Service size	Incidents	Percentage
One action	283	22.5%
Two actions	511	40.6%
Three actions	247	19.6%
Four actions	173	13.7%
Five or more actions	45	3.6%
Total	1,259	100%

Source: KPMG analysis of resident on resident incident study data

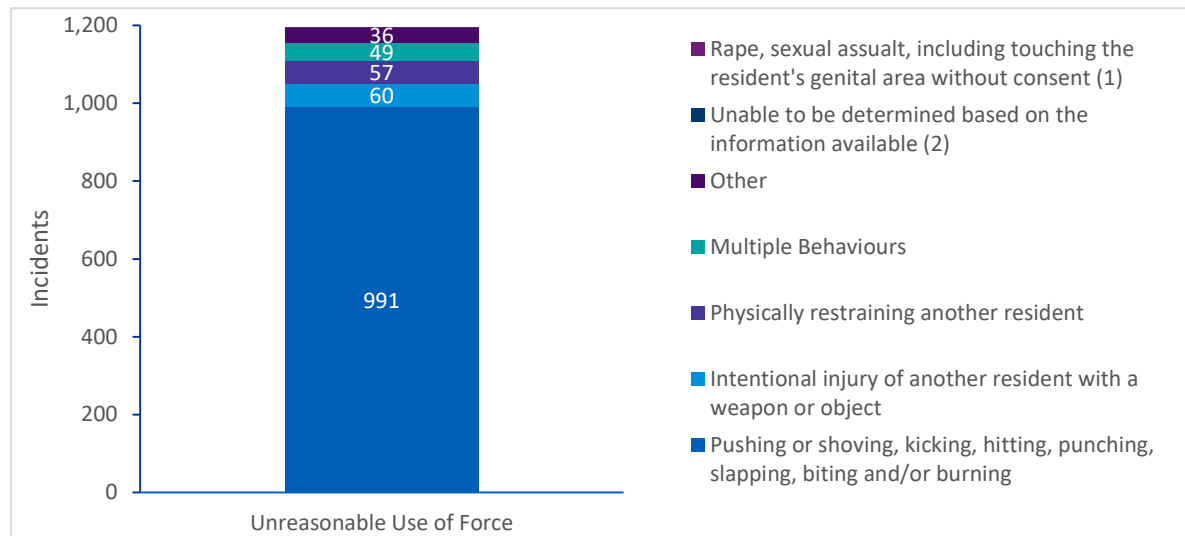
²⁶ Respondents could select more than one service response for an individual incident.



3.2.8 Type 1 Incident Type by perpetrator behaviour and victim impact

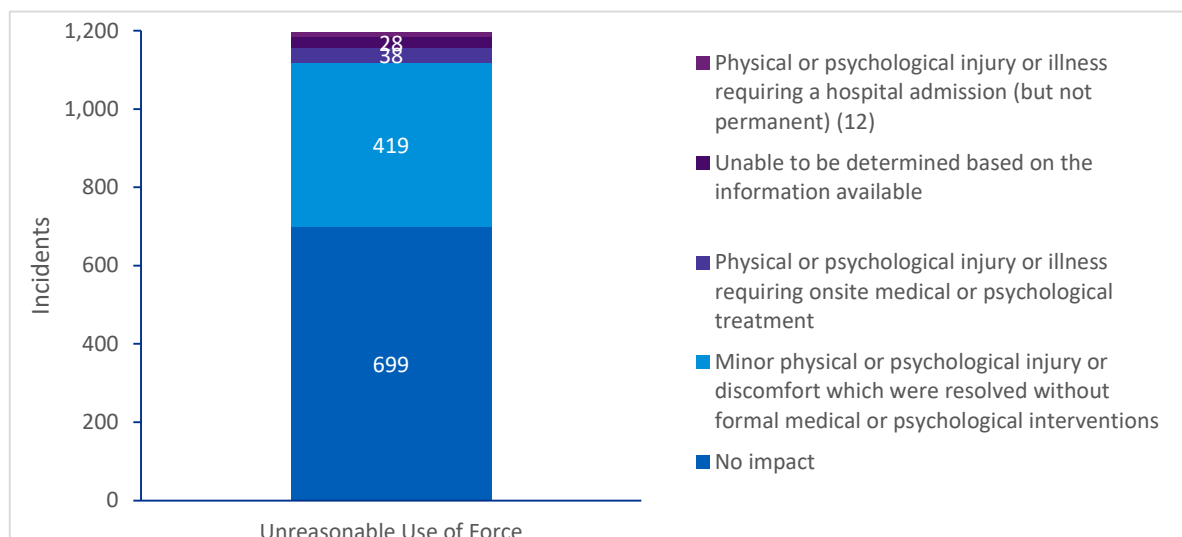
The next step in the analysis of data submitted involved breaking down the Type 1 incident type by perpetrator behaviours and victim impact. A total of 1,196 Type 1 incidents were classified as unreasonable use of force. The majority of the incidents that were reported as unreasonable use of force displayed perpetrator behaviours of pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning and resulted in no impact on the victim. The distribution of perpetrator behaviours reported for incidents involving unreasonable use of force is illustrated in Figure 13, while the distribution of victim impact is illustrated in Figure 14.

Figure 13: Perpetrator behaviours in unreasonable use of force assaults, Type 1 incidents



Source: KPMG analysis of resident on resident incident study data

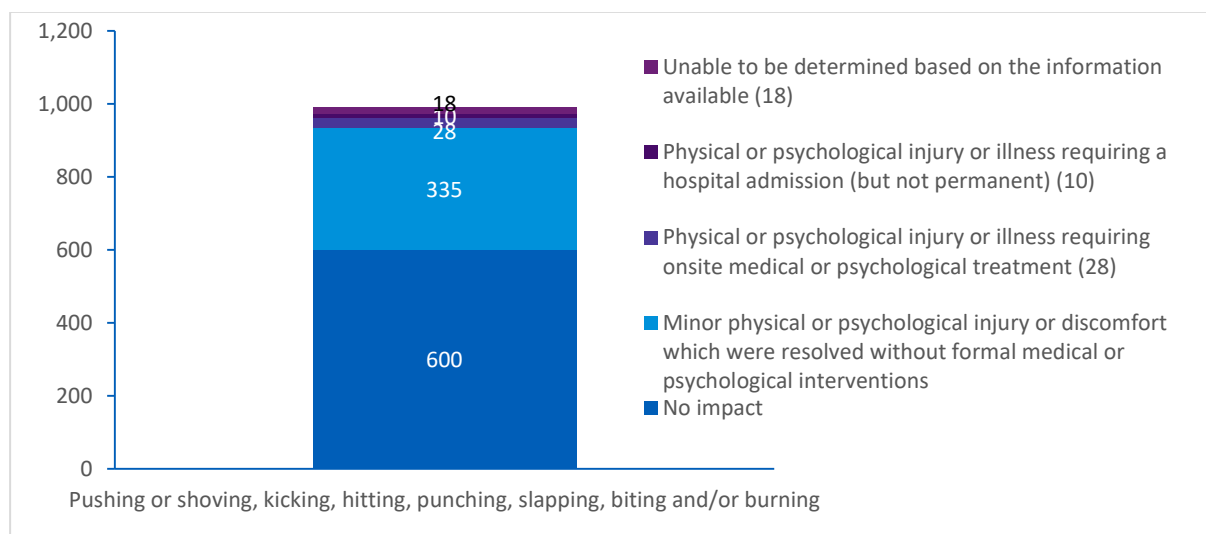
Figure 14: Victim impact in unreasonable use of force assaults, Type 1 incidents



Source: KPMG analysis of resident on resident incident study data

Further analysis was undertaken on the 991 incidents that were categorised as displaying perpetrator behaviours of pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning. This further analysis looked at the victim impact for these incidents. The majority of these incidents (60.5 per cent) resulted in "no impact" on the victim. The distribution is outlined in Figure 15.

Figure 15: Victim impact for incidents involving pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning



Source: KPMG analysis of resident on resident incident study data

A total of 56 Type 1 incidents were classified as unlawful sexual contact. The majority of the incidents that were reported as unlawful sexual contact displayed perpetrator behaviours of rape, sexual assault, including touching the resident's genital area without consent (54.4 per cent). The distribution of perpetrator behaviours for incidents that were reported as unlawful sexual contact is illustrated in Figure 16, while the distribution of victim impact is illustrated in Figure 17.

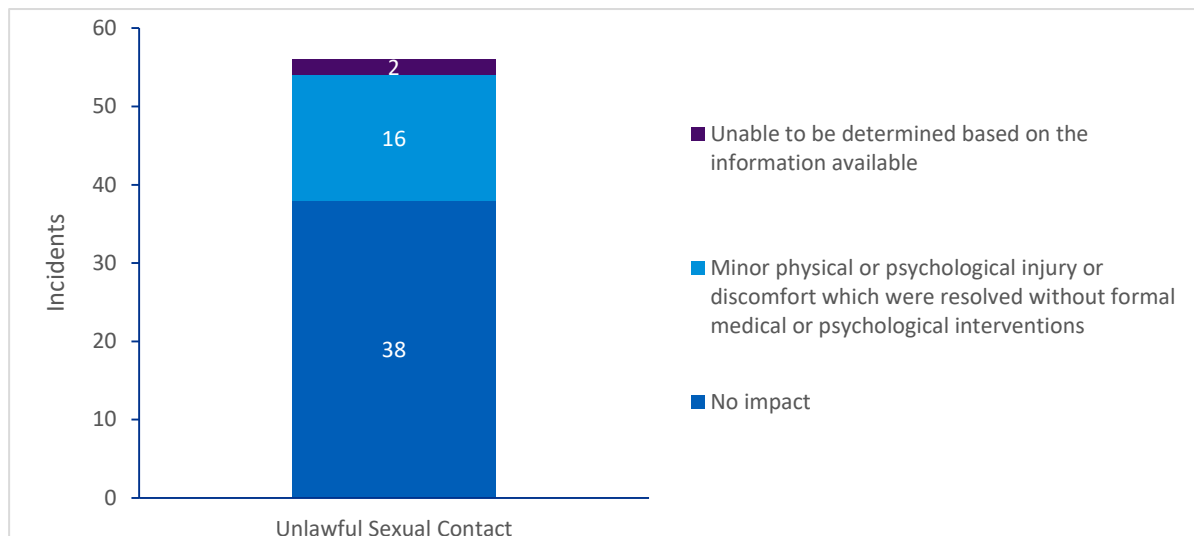
Figure 16: Perpetrator behaviours in unlawful sexual contact assaults, Type 1 incidents



Source: KPMG analysis of resident on resident incident study data



Figure 17: Victim impact in unlawful sexual contact assaults, Type 1 incidents

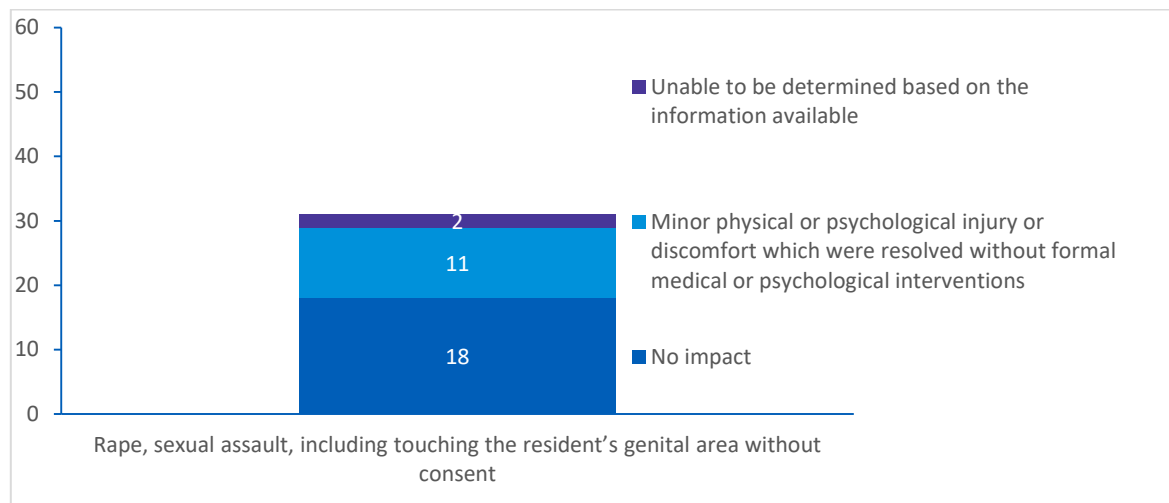


Source: KPMG analysis of resident on resident incident study data

Further analysis was undertaken on the 31 incidents that were categorised as displaying perpetrator behaviours of rape, sexual assault, including touching the resident's genital area without consent. This further analysis looked at the victim impact for these incidents. The majority of these incidents (58.1 per cent) resulted in "no impact" on the victim.

This result does appear somewhat anomalous. It might be expected that the perpetrator behaviour categorisation of "Rape, sexual assault etc." may result a more "substantial" impact on the victim. Without further information on these particular incidents (e.g. through case notes) it is difficult to understand why these incidents were classified in this manner. The distribution is outlined in Figure 18.

Figure 18: Victim impact for incidents involving rape, sexual assault, including touching the resident's genital area without consent



Source: KPMG analysis of resident on resident incident study data

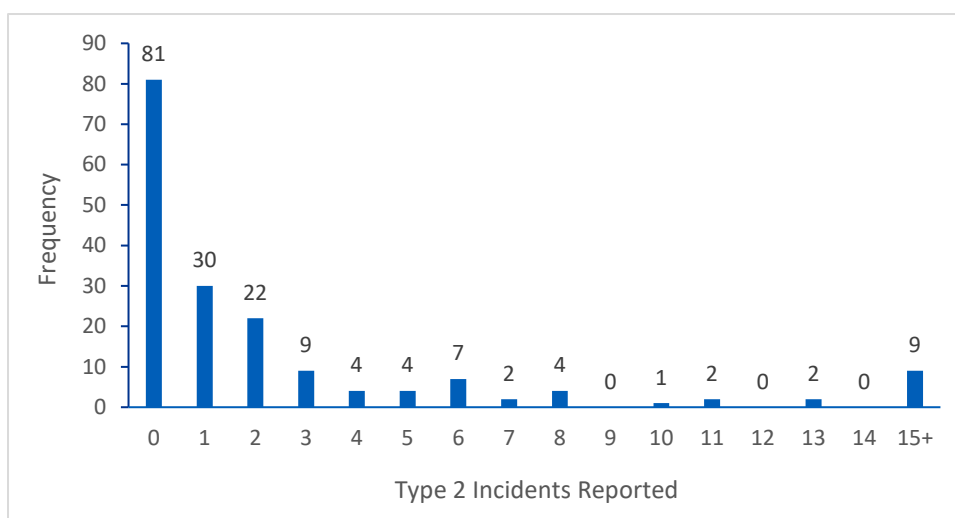
3.2.9 Type 2 Incidents

KPMG analysed the frequency of type 2 incidents. Only the quantum of type 2 incidents that occurred during the data collection period was captured. Detailed incident level analysis was not undertaken, i.e. looking at reportable assault types by perpetrator behaviours, victim impact and service response, as this was not collected for Type 2 incidents.

A total of 455 Type 2 incidents were reported by the 178 services that provided Type 2 incident data for the six month period. Notably, 81 services reported zero Type 2 incidents and 80 per cent of services reported three or fewer Type 2 incidents. This distribution is illustrated in Figure 19.

This distribution, i.e. services reporting zero, is important to keep in mind when reading section 3.3. The main reason is that this sample data is used to infer estimates of incidents for all 2,717 services for a 12 month window. The sample has 81 services reporting zero Type 2 incidents for a six month window. If, for example, the study had by chance only collected data from the 81 services that reported zero Type 2 incidents then the estimate of total incidents at a national level for a 12 month window would also be zero.

Figure 19: Count of services by total incidents reported, Type 2 incidents



Source: KPMG analysis of resident on resident incident study data

3.3 National estimates of incidents

Data was received from a sample of services. One of the main objectives of the study was to estimate the total number and type of Type 1 and Type 2 incidents that take place in residential aged care from this sample. To estimate (or model) the prevalence of Type 1 and Type 2 incidents at a national level required “weighting” the sample estimates to a national level, i.e. to use the incident data from 178 services to estimate how many incidents occur in all 2,717 services.

Five methods were used to weight the data and calculate national level estimates. All five were based on the linear, unbiased estimator described in Appendix E. The five methods are briefly described below followed by the benefits and limitations of each method. Method Three is the same as Method Two except that the incident data provided by one provider’s services has been excluded. This is included to highlight the effect of sampling error i.e. if this provider and their services had not submitted data the national estimate of total incidents would have been in the order of 10,000 incidents less.

- Method One simply assumes that all participating services have equal weight, i.e. no adjustments are made for any characteristic of the service. In this method all participating services have equal weight. The weight is calculated by dividing the population of services by the participating services (2,717 services in the population / 178 in the sample = 15.3). This means each service from the sample represents 15.3 services in the population.
- Method Two weights the services by size ranges. For example, services with 1 to 20 places have a weight of 25.8 (129 services in the population / 5 in the sample) and services of 61 to 80 places have a weight of 12.8 (475 services in the population / 37 in the sample). This translates to services of different sizes having weights that reflect their size strata. As the example shows due to the fact

that only five services of size 1 to 20 places participated they have a larger weight than the services of 61 to 80 places which had more services participate in the prevalence study.

- Method Three repeats Method Two but excludes one approved provider that reported a large number of incidents. The reason for doing this was to demonstrate how influential this approved provider and their services were on the national estimate. There were 16 services from this particular approved provider that reported a total of 446 incidents for the six month period. This made up 35.4 per cent of the 1,259 incidents reported.
- Methods Four and Five repeat methods Two and Three respectively. However, weights are calculated by occupancy instead of size. The reason for post-stratifying the data in this way was that for an incident to occur between residents, it requires there to be residents in a service.

The benefits and limitations of each of these five methods is briefly described below.

Table 7: Estimation methods and benefits and limitations of each approach

Method	Benefits	Limitations
1. Assume all services in the sample have equal weight	Simple method to implement. Does not assume that there is a relationship between size and occupancy and the number of incidents.	Does not take into account size or occupancy of services.
2. Stratify services by size	Takes into account the service size when weighting estimates. Assumes, for example, that large services in the sample are likely to have a similar number of incidents as large services in the population. A specific example being that a service with between 81 to 100 places in the sample can represent services with 81 to 100 places in the population.	Services can have low or high occupancy (e.g. 100 place service with 50 per cent occupancy in a month may only have 50 residents per day on average). Sample was under-representative in terms of smaller services.
3. Stratify services by size and exclude an approved provider	Excludes a provider that had 16 services report a large number of incidents. A large number of incidents being 446 for the six month period, which equated to 35 per cent of all incidents reported.	Excludes the provider described in the adjacent cell that reported a large number of incidents.
4. Stratify services by occupancy	Takes into account the service occupancy when weighting estimates. Assumes, for example, that services with similar residents per day over the period in the sample are likely to have a similar number of incidents as other services with the same number of residents per day in the population. For example a service that had 50 residents per day on average in the sample represents the services with 41 to 60 residents per day in the population.	Sample was slightly under-representative in terms of smaller, less occupied services.
5. Stratify services by occupancy and exclude an approved provider	Excludes a provider that had 16 services who reported a large number of incidents, being 446 for the six month period, which equated to 35 per cent of all incidents reported.	Excludes the provider described in the adjacent cell that reported a large number of incidents.

Source: KPMG

The total number of Type 1 and Type 2 incidents at a national level (i.e. all 2,717 services) for a 12 month period are outlined in Table 8. The estimates from Method Four have been used in the options for

reporting thresholds (outlined in section 4). This is not because the national estimates from Method Four are “superior” in a statistical sense. As outlined in Table 8 the national estimates from Methods One, Two and Four are quite similar. The results from Method Four have been selected as:

- it uses the data from the entire sample of services, i.e. the data from the provider that reported a large number of incidents is not excluded as there may well be other providers and services that could report a similar numbers of incidents; and
- stratifying by occupancy has some basic logic, i.e. there needs to be residents in a service in order to have incidents between residents.

Table 8: National estimates of Type 1 and Type 2 incidents

Method	Population Type 1 incidents	Population Type 2 incidents
1. Assume all services in sample have equal weight	38,753 (34,518 to 42,989)	13,930 (12,121 to 15,738)
2. Stratify services by size	37,697 (33,670 to 41,724)	13,777 (11,951 to 15,603)
3. Stratify services by size and exclude an approved provider	26,960 (24,208 to 29,712)	9,128 (7,778 to 10,478)
4. Stratify services by occupancy	38,898 (34,824 to 42,972)	13,757 (11,952 to 15,561)
5. Stratify services by occupancy and exclude an approved provider	28,279 (25,586 to 30,971)	9,341 (8,025 to 10,658)

Source: KPMG analysis on resident incident study data

Summary of key findings

Findings and implications relating to the services that participated, the incident data reported and the national estimates for a 12 month period are outlined below.

- **178 aged care services participated in the study:** The sample of participating services was not “representative” from a jurisdiction point of view. Several jurisdictions were under-represented (ACT, SA and WA) and NT was not represented at all. The sample did however, appear to be “representative” of all services from a remoteness perspective. In terms of size, smaller services were under-represented but when considering occupancy, rather than just size, the sample was more representative of services nationally. As with any study with voluntary participation, it is subject to voluntary response bias, although it is not known whether non-participating services would have reported more or less incidents. Regardless, the study still provides the best available data on resident on resident incidents in residential aged care. The resulting national estimates need to be considered in light of the sample and study limitations.
- **There were key characteristics in the incident data:** The number of Type 1 and Type 2 incidents reported varied across services. Notably, 28 services reported zero Type 1 incidents and 81 services reported zero Type 2 incidents. In addition, 18 services reported 15 or more Type 1 incidents, i.e. some services averaged zero incidents over a six month period and other services averaged more than two Type 1 incidents per month. When it came to the characteristics of Type 1 incidents, there were stand-out categories in terms of incident type, perpetrator behaviours, victim impact and service response. For incident type, 95 per cent of Type 1 incidents were classified as unreasonable use of force. When it came to perpetrator behaviours, the vast majority of Type 1 incidents were classified as pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning. This aligns with the fact that the majority of incidents were classified as unreasonable use of force. The impact on the victim was classified

as *no impact* in the majority of incidents. The majority of services reported two or more service responses to an incident (e.g. *Referral made to GP, Update made to the victim's care plan*). National estimates are likely to be influenced by the variation in the number of incidents reported across services (i.e. zero incident services and 10+ incident services). If, for example, the 28 services that reported zero Type 1 incidents were the only services to participate in the study then the national estimate would be zero. There was also a provider that reported a large number of incidents.

- At a national level, over a 12 month period, there may be tens of thousands of incidents:**
For a six month window, 178 services reported 1,259 Type 1 incidents and 455 Type 2 incidents. This means that the total number of Type 1 and Type 2 incidents at a national level (i.e. all 2,717 services) for a 12 month period are estimated to be in the tens of thousands, specifically 38,898 Type 1 incidents and 13,757 Type 2 incidents. These estimates are based on Method 4 outlined in Table 8. The sample ratios can be combined with the national total estimates to provide an estimate of specific incident types. For example, the 4.4 per cent of incidents that were classified as being unlawful sexual contact can be combined with the total estimate of 38,898 incidents to provide an estimate at the national level of resident on resident incidents involving unlawful sexual contact (1,730 incidents).

4 Study implications for the design of a SIRS

This section discusses the implications of the study findings for the design of a SIRS. Options for the reporting of resident on resident incidents are described and assessed, considering the benefits and limitations of each. Other considerations for the Department, in relation to the reporting of resident on resident incidents in the future, are also discussed.

4.1 Options for reporting thresholds

Through providing insight in relation to the number and nature of resident on resident incidents which are not currently reported to the Department, the study provides new information to help government determine which of these other resident on resident incidents, if any, should be reported in a future SIRS.

This section discusses a number of options for the scope of resident on resident incidents to be reported under a SIRS. Before doing so, it first sets out some key considerations to guide the assessment of these options.²⁷

4.1.1 Principles for options assessment

Four principles were identified to guide the assessment of the benefits and limitations of each option. These principles are discussed below.

Ease of application by aged care services

One of the challenges of any reporting scheme is collecting high quality data. High quality data underpins better analysis, and in turn enables more informed decision making. In the context of a SIRS, some of the key contributors for high quality data include ensuring that the data submitted by services is accurate, complete and timely. For services to do so, the threshold for reporting must be easily applied, i.e. determining which incidents must be reported, and what information about the incident must be submitted needs to be clear and straightforward. Where there is complexity, or a lack of clarity, there is an increased risk of inaccurate reporting. For example, if there are multiple criteria which must be considered by services to identify incidents that meet the threshold, this increases the chance that the incorrect incidents are reported.

Implementation may also be more challenging if services have not previously captured information about a particular type of incident. For example, it is currently unknown how services document and collate information about Type 2 incidents. It was not in scope for the study to gather information about challenges in collecting incident data, however several enquiries were received from study participants about Type 2 incidents indicating that while this information was captured, it was not collated or stored centrally.

²⁷ In the commentary within this section, there is reference to the oversight body for serious incidents. For current reporting, it refers to the Department, however future reporting oversight is assumed to be under the remit of the Aged Care Quality and Safety Commission.



Level of reporting by services

Based on the findings of this study, any substantial change to the threshold of incidents that must be reported will increase the overall volume of incidents required to be reported by services. This additional reporting will need to be resourced by services. There may also be costs associated with building the capacity of aged care services to understand the new arrangements. While there are potential benefits of reporting incidents, consideration needs to be given to the benefit of reporting against the resourcing required to report; for example, time spent reporting may displace a different service or provider level activity which may contribute more to the safety and quality of care than any benefit associated with reporting more incidents.

In addition, findings from this study indicate that the impact of a change to the threshold of incidents that must be reported may not be distributed equally. For example:

- There was a wide variance in the volume of Type 1 and Type 2 incidents reported by services (see Section 3). Services with higher volumes of incidents would need to spend more time reporting than those with lower incident volumes. Higher numbers of incidents may not mean lower service quality. While further research is required to better understand the nature and factors influencing the number of resident on resident incidents, it is possible that factors such as resident mix (e.g. high proportion of residents with severe dementia) may increase the likelihood of incidents.
- The study did not collect information about how services recorded and collated information about Type 1 or Type 2 incidents. Therefore, it is unclear how difficult and / or time consuming this process was, and whether or not it occurred at an approved provider or service level. It is possible that local data and information collection practices vary between services and / or approved providers, and the impact of additional reporting requirements may also vary. This may particularly be the case for Type 2 incidents.

Regulatory response by the Commission

If reports are made, the Commission will be obliged to consider and respond to these, both individually and in an aggregated form. Any substantial change to the current threshold of incidents captured will increase the volume of incidents which need to be analysed and for which a response may be required.

The greater the volume of reports, the greater the level of analysis and response that will be required by the Commission. This will need to be accompanied by a corresponding level of resourcing and investment to support the oversight function.

The analysis of incidents may trigger a range of responses by the Commission. For example, should there be a spike or trend in a particular type of incident, this may warrant the release of guidance material or education to services, i.e. a collective response to incidents. Other responses may involve commencement of service-specific actions such as a tailored response to a specific incident.

The level of analysis and response required by the Commission should be considered in the context of the SIRS more broadly. In considering options and the impact of these on the Commission, it will be important to ensure that resident on resident incidents are viewed in the context of all potential future incident reporting; resident on residents incidents are only one subset of incidents in residential aged care.

Capturing additional information about incidents which result in harm

As outlined in Section 1, the ALRC report raised concerns about the current reportable assault reporting requirements, including resident on resident incidents.²⁸ The definition of reportable assaults was considered too narrow, and in the context of resident on resident incidents, the exemption criteria further narrows the range of incidents which must be reported. With this narrow reporting requirement,

²⁸ Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).



the report raised concerns that incidents of a serious nature are not being captured by the current system.

One of the ways in which options for a new threshold for reporting resident on resident incidents can therefore be assessed is the extent to which the new reporting requirements address this gap, i.e. whether or not they capture additional information about incidents which are of a serious nature.

The additional information about serious incidents may provide a range of secondary benefits to expanding the threshold for reporting. Key amongst these are:

- For residents, improved quality of care, better experiences, and living and receiving care and services in an environment free from harm
- For the Australian public, greater confidence in aged care services, in that there is oversight of, and effective responses to, incidents which may harm residents in aged care
- For the Commission, data to inform specific service or approved provider level interventions where particular risks are identified, or to provide the evidence base (currently not available) to inform tailored regulatory, policy or educational initiatives to support good practice and improve the quality of care in response to more systemic risks
- For services and approved providers, through access to evidence-based resources and support to manage resident on resident incidents, support to deliver safety, higher quality care and services to residents.

Capturing additional information about incidents however, must take a balanced approach. One of the risks associated with broadening the threshold for reporting of resident on resident incidents is the potentially large volume of reports that may result. If the threshold for a reportable incident is set too low, it may capture routine matters that reflect complex resident needs and service delivery contexts rather than the most serious incidents. A SIRS should therefore reflect a primary emphasis on significant harm or risk of harm and one way of assessing the need to report information about an incident is to determine whether or not the incident resulted in harm to a resident.^{29,30}

In this study, data was collected in relation to the nature of the 'impact' on the resident who was the victim. Using this particular data collection, it could be assumed that where there was a greater level of impact, there was also greater harm. As such, options for a threshold for the reporting of additional resident on resident incidents could be assessed not only by determining whether or not it captures additional information about incidents, but also by determining whether or not the additional incidents are those which are associated with higher levels of impact.

For the purposes of this data collection, higher levels of impact relate to the selection of the following response options:

- Fatality of severe permanent physical or psychological impairment (zero Type 1 incidents in the sample)
- Permanent physical or psychological impairment (zero Type 1 incidents in the sample).
- Physical or psychological injury or illness requiring a hospital admission (but not permanent) (12 Type 1 incidents in the sample).
- Physical or psychological injury or illness requiring onsite medical or psychological treatment (38 Type 1 incidents in the sample).

²⁹ 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.

³⁰ Family and Community Development Committee, Inquiry into abuse in disability services: Final report (Parliament of Victoria, May 2016).

While in some cases the nature of the service's response may be associated with the harm incurred by the incident, using this as a proxy was not considered reliable as it assumes the service's response is always proportional (and appropriate) to harm.

It should also be noted that there are a range of ways in which harm could be identified and future data collections could be undertaken using a different tool or approach to harm identification. Whatever approach is chosen however, it should be valid and easy to apply (see Ease of application by aged care services, above).

Impact measures were not collected for Type 2 incidents. It is unknown what levels of harm are associated with Type 2 incidents.

Summary of key findings

A number of principles were identified to guide the assessment of the benefits and limitations of each option. These include:

- **Ease of application**, i.e. the extent to which the new threshold is straightforward and easy to apply for services. The ease of application is significantly influenced by the number of criteria that need to be considered by services in order to determine whether an incident must be reported.
- **Level of reporting by services**, i.e. the additional time that will be required to make reports for that option. The level of reporting required by services is proportionate to the volume of additional incidents that will be reported. The greater the volume of incidents, the more resources required to make the reports. Note that time spent reporting may displace time spent on other activities which could have a greater impact on the quality of care and experiences of residents.
- **Regulatory response by the Commission**, i.e. the additional time that will be required to analyse incident data and respond for that option. The response taken by the Commission is proportionate to the volume of additional incidents that will be reported. Greater data volumes will drive the resources required for the Commission to operate the SIRS.
- **The capture of additional information about incidents which result in harm**, i.e. the extent to which the option provides information which was not otherwise available about resident on resident incidents (i.e. addresses the gap identified by the ALRC report). This principle also considers the extent to which this additional information focuses on those incidents which are associated with greater harm to the resident who was the victim.

4.1.2 Options for reporting and option assessment

Based on the study findings, there are a number of future options which can be considered for the reporting of additional resident on resident incidents in a SIRS. This section provides an overview of these options, considering the key benefits and limitations of each. It should be noted that these options represent only those which can be informed by the study, i.e. there may be other factors which could be used to inform a threshold for reporting (such as, but not limited to, the risk profile of an individual service) but that were not considered in the study.

Drawing on the findings of the study, there are three options which could be considered. These include:

























1. Reporting all Type 1 and Type 2 incidents
2. Reporting a subset of Type 1 and Type 2 incidents (of which there are many different sub-options)
3. Making no changes to the current reporting threshold for resident on resident incidents.

Discussion about each of these three options (and sub-options for Option 2) is provided below. Each option is described, noting the benefits and limitations of the option. Each option is also assessed in relation to the four principles outlined in Section 4.1.1 above, and are given a red, amber or green (RAG) rating. For each of these principles, the ratings can be understood as follows:

- **Ease of application:** Green ratings indicate application of the threshold is likely to be easier for services, red ratings indicate it may be more complex.
- **Level of reporting by services:** Green ratings indicate a lower volume of reporting, red ratings indicate a higher volume of reporting.
- **Regulatory response by the Commission:** Green ratings indicate a lower volume of incidents to analyse and respond to, red ratings indicate a higher volume of incidents to analyse and respond to.
- **Captures additional information about incidents which cause harm:** Green ratings indicate the option helps focus on incidents which cause harm, red ratings indicate that incidents are captured which may not be associated with much harm

Table 9 summarises these findings. Estimates of the total numbers of incidents that may be reported annually for each of the option types are included in the table and in the sections which follow. These are based on Method 4 in section 3.3. Note that the confidence intervals associated with the total Type 1 and Type 2 incident estimates can be found in section 3.3.

Table 9: Summary of reporting options assessment against key principles

Option (Modelled annual volume)		Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
Option 1 – all Type 1 and Type 2 incidents (38,898 Type 1 incidents and 13,757 Type 2 incidents)					
Option 2 – some Type 1 incidents	2.1 All Type 1 incidents only (38,898 incidents)				
	2.2 Type 1, unreasonable use of force only (36,892 Incidents)				
	2.3 Type 1, unlawful sexual contact only (1,730 incidents)				
	2.4 Type 1, incidents of 'higher' level of impact only (1,545 incidents)				
	2.5 Type 1, incidents triggering particular types of service responses only				



Option (Modelled annual volume)		Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
	7,539 incidents)				
	2.6 – All Type 1 incidents involving unlawful sexual contact and Type 1 incidents involving unreasonable use of force that result in higher levels of harm to the victim only (3,191 incidents)				
Option 3 – no change to the current reporting requirements (Zero Type 1 incidents and zero Type 2 incidents)					

Source: KPMG

Option 1: Report all Type 1 and Type 2 incidents

Incidents covered by this option

Under this option, all incidents which meet the definitions of Type 1 and Type 2 incidents would be reported as part of the SIRS. This would be an expansion of the current reportable assaults definition. Based on modelling undertaken as part of this study, this could result in 38,898 Type 1 incidents and 13,757 Type 2 incidents being reported each year.

Benefits of this option

This option could support the Commission to gain a greater understanding of the number and nature of resident on resident incidents in residential aged care. Note however, the level of insight gained would depend on the specific data fields which are collected about these incidents. Given the number of incidents that may be reported, it is likely that fewer data fields and data fields that are more structured would need to be captured.

There are potential secondary benefits to be realised through the availability of additional information about Type 1 and Type 2 resident on resident incidents. This includes for the Commission, access to new data to drive service or system level interventions in response to service specific or systemic risks, and an evidence base to inform the development of guidance or education for services. Services, in turn, may be able to deliver better quality care and services through application of this guidance, resulting in improved care for residents, and better resident experiences. Through stronger oversight, and the establishment of processes to effectively use the reported data, the public confidence in residential aged care services may also improve.

Limitations of this option

This option would result in services being required to report a higher volume of incidents. Where more reports are to be made, there are subsequent costs for resources required to make the reports. Further,

time taken to report may displace a different service or provider level activity which may have a larger safety and quality impact than any benefit associated with reporting more incidents.





The impact of this change would likely be distributed unequally across services. Services with higher volumes of incidents would need to spend more time reporting than those with lower incident volumes. As outlined in section 2.2, as service size increased, generally, the number of Type 1 and Type 2 incidents reported increased. Services with less mature or less automated incident management reporting systems may also experience greater difficulties reporting incidents than those services with automated systems.

This option would also increase the volume of incidents that the Commission would need to analyse and respond to, due to the large additional volume of incidents that would be reported. The greater the level of analysis and response required, the more resources the Commission may need in order to complete this work.

While this option would capture incidents which cause higher levels of harm, it would likely also capture a large volume of incidents associated with lower levels of harm.

This study only collected information about the total number of Type 2 incidents. The ease of collecting this information from services is unknown.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
Option 1 – all Type 1 and Type 2 incidents (38,898 Type 1 incidents and 13,757 Type 2 incidents)				

Option 2: Report a subset of Type 1 incidents

This option involves the reporting of a subset of Type 1 incidents. There are a range of different sub-options which are outlined below.

Option 2.1: Report all Type 1 incidents only

Incidents covered by this option

Under this option, all incidents which meet the definition of a Type 1 incident would be reported as part of the SIRS. This would be an expansion of the current reportable assaults definition. Based on modelling undertaken as part of this study, this could result in 38,898 Type 1 incidents being reported annually.

Benefits of this option

This option could support the Commission to gain a greater understanding of the number and nature of resident on resident incidents in residential aged care. However, the level of insight would depend on the specific data fields which are collected about these incidents. Given the number of incidents that may be reported, it is likely that fewer data fields and data fields that are more structured would need to be captured.

There are potential secondary benefits to be realised through the availability of additional information about Type 1 incidents. This includes, for the Commission, access to new data to drive service or system level interventions in response to service specific or systemic risks, and an evidence base to inform the development of guidance or education for services. Services, in turn, may be able to deliver

better quality care through application of this guidance, resulting in improved care for residents and better resident experiences. Through stronger oversight, and the establishment of processes to use the reported data effectively, the public confidence in residential aged care services may also improve.

Implementing this reporting should not be complex. Services are already required to record these incidents and therefore should be able to easily identify them.

Limitations of this option





This option would result in services being required to report a higher volume of incidents. Where more reports are to be made, there are subsequent costs to services for the resources required to make the reports. Time taken to report may displace a different service or provider level activity which may have a larger safety and quality impact than any benefit associated with reporting more incidents.

The impact of this change would likely be distributed unequally across services. Services with higher volumes of incidents would need to spend more time reporting than those with lower incident volumes. Services with less mature or less automated incident management reporting systems may also experience greater difficulties reporting incidents than those services with automated systems.

Also, this option would still increase the volume of incidents that the Commission would need to analyse and respond to, due to the large additional volume of incidents that would be reported. The greater the level of analysis and response required, the more resources the Commission may need in order to complete this work.

While this option would capture incidents which cause higher levels of harm, it would also capture other incidents.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.1 All Type 1 incidents only (38,898 incidents)				

Option 2.2: Report all Type 1 incidents involving unreasonable use of force only

Incidents covered by this option

Under this option, incidents which meet the definition of a Type 1 incident **and** which involve unreasonable use of force would be reported as part of the SIRS. This would be an expansion of the current reportable assaults definition. Based on modelling undertaken as part of this study, this option could result in an additional 36,892 incidents being reported annually.

The study identified one incident which involved both unlawful sexual contact and unreasonable use of force. While this finding suggests these incidents are uncommon, a decision would need to be made as to whether incidents covering both incident categories would be included under this option.

Benefits of this option

The benefit of this option is that it would direct focus on the most common type of resident on resident incident identified in the study. This means that the data collected could be used to help the Commission understand more about these incidents.

There are potential secondary benefits to be realised through the availability of additional information about Type 1 incidents involving unreasonable use of force. This includes, for the Commission, access to new data to drive service or system level interventions in response to service specific or systemic risks, and an evidence base to inform the development of guidance or education for services. Services,

in turn, may be able to deliver better quality care and services through application of this guidance, resulting in improved care for residents and better resident experiences. Through stronger oversight, and the establishment of processes to effectively use the reported data, the public confidence in residential aged care services may also improve.

There is a marginal benefit in this option when compared to collecting information about all Type 1 incidents (Option 2.1) in that there would be a reduction in the volume of incidents and, in turn, the level of reporting required by services and the response required by the Commission. However, given that unreasonable use of force constitutes 95 per cent of all Type 1 incidents, this benefit is small.

Implementation of this option should be straightforward. Services are already familiar with these incidents, as they are already required to record information about them.

Limitations of this option





Because these incidents constitute the vast majority of resident on resident incidents, the volume of incidents reported under this option would still be high. As such, this option would still result in services being required to report a higher volume of incidents. Where more reports are to be made, there are subsequent costs to services for the resources required to make the reports. Furthermore, time taken to report may displace a different service or provider level activity which may have a larger safety and quality impact than any benefit associated with reporting more incidents. The impact of this change would likely be distributed unequally across services. Services with higher volumes of incidents would need to spend more time reporting than those with lower incident volumes. Services with less mature or less automated incident management reporting systems may also experience greater difficulties reporting incidents than those services with automated systems.

Also, this option would still increase the volume of incidents that the Commission would need to analyse and respond to, due to the large additional volume of incidents that would be reported. The greater the level of analysis and response required, the more resources the Commission may need in order to complete this work.

Further, by collecting information about unreasonable use of force only, it excludes instances of unlawful sexual contact. While the study findings indicate that these constitute only a small percentage of resident on resident incidents, these are still serious incidents (i.e. they meet the definition of a reportable assault). Without their inclusion in the dataset, the Commission will not only be unable to keep sight of the prevalence of these, but their absence may contribute to less insight about the nature of these incidents, and therefore less information, which may help inform strategies to reduce the incidence of unlawful sexual contact in resident on resident incidents in the future. This may have a negative impact on the quality of care and experiences of residents.

While this option would likely capture incidents causing harm, it would also capture incidents associated with lower levels or no harm to the victim.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.2 Type 1, unreasonable use of force only (36,892 Incidents)				

*Option 2.3: Report all Type 1 incidents involving unlawful sexual contact only***Incidents covered by this option**

Under this option, incidents which meet the definition of a Type 1 incident **and** which involve unlawful sexual contact would be reported as part of the SIRS. This would be an expansion of the current reportable assaults definition. Based on modelling undertaken as part of this study, this could result in 1,730 additional incidents being reported.

The study identified one incident which involved both unlawful sexual contact and unreasonable use of force. Similar to Option 2.2, while this finding suggests these incidents are uncommon, a decision would need to be made to determine whether incidents covering both incident categories would be included under this option.

Benefits of this option

As outlined in Section 3.2.4, Type 1 incidents involving unlawful sexual contact comprise only 4.4 per cent of Type 1 incidents. As such, one of the key benefits of this option is that the additional volume of incidents that would be reported would be comparatively small. In turn, the additional level of reporting by services and the volume of incidents that the Commission would need to analyse and respond to would be much lower than if the threshold was set to collect all Type 1 incidents (Option 2.1), or Type 1 incidents involving unreasonable use of force (Option 2.2).

Collecting information about Type 1 incidents which involve unlawful sexual contact would support better understanding of the nature and prevalence of these types of serious incidents. This could contribute to helping the Commission take effective action in reducing their prevalence in the future such as through regulatory, guidance and education measures. In turn, services may be able to use this guidance to improve their care and services, resulting in the receipt of higher quality care for residents and better resident experiences.





Implementation of this option should be straightforward. Services are already familiar with these incidents, as they are already required to record information about them.

Limitations of this option

Excluding Type 1 incidents involving unreasonable use of force means that information about most incidents that meet the definition of a reportable assault, but are currently not reported, is not shared with the Commission. Without information about these incidents, the Commission will have less information to inform targeted action, such as education, guidance material, or to conduct investigations if required.

Given the volume of Type 1 incidents of the category of unreasonable use of force, it is likely that at least some of these incidents which are excluded are those which cause harm to the victim. Therefore, excluding all incidents involving unreasonable use of force from the data collection may mean that important information about these incidents will be missed.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.3 Type 1, unlawful sexual contact only (1,730 incidents)				



Option 2.4: Report all Type 1 incidents resulting in higher levels of impact

Incidents covered by this option

Under this option, incidents which meet the definition of a Type 1 incident **and** which are associated with higher levels of harm to the victim would be reported as part of the SIRS. The volume of incidents that would be reported would depend on how the threshold for 'higher levels of harm' is set.

This would be an expansion of the current reportable assaults definition. Based on modelling undertaken as part of this study, this could result in 1,545 additional incidents being reported, if incidents meeting any of the following victim impact thresholds were included:

- Fatality of severe permanent physical or psychological impairment
- Permanent physical or psychological impairment
- Physical or psychological injury or illness requiring a hospital admission (but not permanent)
- Physical or psychological injury or illness requiring onsite medical or psychological treatment.

Benefits of this option

The key benefit of this option is that it may assist in focusing the reporting of incidents on those incidents which are associated with the greatest level of impact (harm) to the victim. This, in turn, may assist the Commission in taking action to support the reduction of serious incidents in the future. In turn, services may be able to use this guidance to improve their care and services, resulting in the receipt of higher quality care for residents and better resident experiences.

This option is associated with a much lower volume of incidents for services to report and a lower volume of incidents for the Commission to analyse and respond to when compared to collecting all Type 1 incidents (Option 2.1) or all Type 1 incidents involving the use of unreasonable force (Option 2.2).

Further, this option does not exclude incidents based on their category (i.e. unreasonable use of force or unlawful sexual contact, i.e. Options 2.2 and 2.3). Excluding incidents based on their category may mean that incidents which have a significant impact or cause harm to a resident are not captured.

Limitations of this option

The main limitation of this option is that it assumes that the service is able to accurately assess the harm incurred by a resident. This may be particularly challenging in relation to the assessment of psychological injuries and the assessment of the impact of an incident on residents with cognitive impairment. Having a valid tool for services to use to identify and report on harm would be an important consideration for this option.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.4 Type 1, incidents of 'higher' level of impact only (1,545 incidents)				

*Option 2.5: Report all Type 1 incidents triggering particular types of service responses only***Incidents covered by this option**

Under this option, incidents which meet the definition of a Type 1 incident **and** which are associated with particular types of service responses would be reported as part of the SIRS. The volume of incidents that would be reported would depend on which responses were of interest to the Commission. If the Commission is interested in those incidents which trigger more 'significant' responses by the service then examples of potential responses which could be in scope include the following:

- Onsite medical treatment provided to the victim OR perpetrator
- Hospital admission for the victim OR perpetrator
- Referral made to the DBMAS
- Report made to the police.

Regardless of the specific responses which are of interest, this would be an expansion of the current reportable assaults definition. There were 244 of the 1,259 Type 1 incidents that undertook at least one of the above actions (19.4 per cent). Based on modelling undertaken as part of this study, this could result in 7,539 additional incidents being reported per annum, if incidents triggering any of the above criteria were included. If 'referral made to GP' was included, the volume of incidents would be similar to Option 2.1 (all Type 1 incidents).

Benefits of this option





This option would be associated with a lower volume of incidents for services to report and a lower volume of incidents for the Commission to analyse and respond to when compared to collecting all Type 1 incidents (Option 2.1) or all Type 1 incidents involving the use of unreasonable force (Option 2.2). However the volume of incidents is still more significant than some other options, such as Options 2.4 or 2.6 and therefore, particularly for the Commission, will still be associated with a greater response option.

Limitations of this option

The key limitation of this option is that it is unclear whether or not incidents which trigger particular types of responses from services are those which are associated with more harm. Using provider response as a proxy for the level of harm incurred by an incident relies on both:

- Identifying which responses are positively associated with greater harm
- Services being consistent in their responses to a given level of harm.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.5 Type 1, incidents triggering particular types of service responses only (7,539 incidents)				



Option 2.6: Report all Type 1 incidents involving unlawful sexual contact and Type 1 incidents involving unreasonable use of force and higher levels of harm to the victim only

Incidents covered by this option

This option refers to reporting a specific subset of incidents. Under this option, the following incidents would be reported:

- Type 1 incidents of the category unlawful sexual contact
- Type 1 incidents of the category unreasonable use of force and which result in a higher level of victim impact.

This would be an expansion of the current reportable assaults definition. The number of additional incidents reported would be 3,191 incidents, if incidents meeting any of the following victim impact thresholds were included:

- Fatality of severe permanent physical or psychological impairment
- Permanent physical or psychological impairment
- Physical or psychological injury or illness requiring a hospital admission (but not permanent)
- Physical or psychological injury or illness requiring onsite medical or psychological treatment.

Benefits of this option

A key benefit of this option is a lower level of reporting for services and a lower level of analysis and response for the Commission when compared to collecting other types of incidents.

This option would also focus on collecting data which is focused on incidents associated with the most significant impact or harm to the victim. This, in turn, may assist the Commission in taking action to support the reduction of serious incidents in the future. In turn, services may be able to use this guidance to improve their care and services, resulting in the receipt of higher quality care for residents and better resident experiences.

Limitations of this option

This option would be associated with greater complexity for implementation. To support the submission of accurate data, services need to understand which incidents must be reported. Where incidents must meet multiple criteria in order to be considered 'reportable', this increases the complexity of identifying in scope incidents and, in turn, the likelihood that the wrong incidents are inadvertently reported as part of the SIRS. This may lead to a reduction in the ability of the Commission to use the dataset to inform service specific and system level interventions, and enable services to use this to deliver higher quality care and better experiences for residents.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
2.6 – All Type 1 incidents involving unlawful sexual contact and Type 1 incidents involving unreasonable use of force that result in higher levels of harm to the victim only (3,191 incidents)				

Option 3: Make no change to the current reporting arrangements**Incidents covered by this option**

Under this option, incidents which would be reported would be only those which meet the current criteria for a reportable assault, and are not subject to the existing exclusion criteria for reporting.

Benefits of this option





The key benefit of this option is that there would be no additional reporting required by services and additional regulatory responses (both analysis and response) required by the Commission, compared to the current arrangements.

Limitations of this option

The limitations of this option are that no additional reports about resident on resident incidents would be available. This would limit the Commission's understanding of the prevalence of these incidents and, in turn, their ability to intervene at a system or individual service level to support improvements in the quality of care and services. Without service specific and system level interventions, services will not be able to access the guidance which could assist in improving the quality of their services for residents and improving resident experiences.

This option does not have a specific focus on incidents which cause harm. Impact or harm incurred to the resident who is the victim is not a consideration in the current reporting threshold.

Summary assessment using principles

Option (Modelled annual volume)	Ease of application	Level of reporting by services	Regulatory response by the Commission	Captures additional information about incidents which cause harm
Option 3 – no change to the current reporting requirements (Zero Type 1 incidents and zero Type 2 incidents)				

4.1.3 Outcomes of the option assessment

Based on the option assessment described in section 3.1, two options were rated most positively. These are:

- Option 2.4: Reporting all Type 1 incidents resulting in higher levels of impact
- Option 2.6: Reporting all Type 1 incidents involving unlawful sexual contact and Type 1 incidents involving unreasonable use of force and higher levels of harm to the victim only.

Benefits associated with both these options include:

- They both collect additional information about serious resident on resident incidents which is not currently available, in turn contributing to addressing the gaps identified in the ALRC report.
- Both target reporting to those incidents which are associated with greater impact on the residents who were the victim. This facilitates the collection of data which can, in a more targeted way, inform system level and service specific interventions by the Commission and, in turn, enables services to deliver better quality care and services that enhances the experience and wellbeing of residents.



- Both options present a lower volume of incidents for the Commission to respond and analyse to when compared to most of the other options requiring a broader set of incidents to be reported, in turn, limiting the resources required to administer the SIRS.
- Both present a lower volume of incidents for services to report when compared to most of the other options to expand the threshold and, as such, are associated with a lesser need for resources which are focused on making reports. This may free up resources to focus on local or service-specific efforts to improve the quality of care.

The key challenge with both options relates to the ease of application of these thresholds. Both options would require services to be clear as to which specific incidents are in scope for reporting. As such, there will be a need for clear and simple tools and resources to help services understand new requirements, and education to embed the new practices should either of these options be implemented.

In making a decision about the future threshold for reporting of resident on resident incidents, the level of maturity of this data collection should be considered. This report outlines the findings from the first prevalence study for resident on resident incidents in Australia and, as such, is the first step in both understanding how frequently such incidents occur as well as the nature of these incidents. As further data is collected, more information will become available to guide ongoing reporting. In turn, this will assist in refining both reporting thresholds and the data fields for the future, in turn ensuring that the SIRS remains fit for purpose in its aim to strengthen the quality of care for older Australians.

Summary of key findings

- Eight options for the future reporting of resident on resident incidents in a SIRS were presented, and analysed, including:
 - Option 1: Report all Type 1 and Type 2 incidents
 - Option 2.1: Report All Type 1 incidents only
 - Option 2.2: Report all Type1 unreasonable use of force only
 - Option 2.3: Report Type 1, unlawful sexual contact only
 - Option 2.4: Report Type 1, incidents of a 'higher' level of impact only
 - Option 2.5: Report all Type 1, incidents triggering particular types of provider responses only
 - Option 2.6: Report all Type 1 unlawful sexual contact and all Type 1 unreasonable use of force associated with a higher level of impact only
 - Option 3: No change to the reporting requirements.
- Each option was analysed, using the assessment principles of ease of application, level of reporting by services, regulatory response by the Commission, and the extent to which the option supported the capture of additional information on those incidents associated with the most harm.
- Based on this assessment, two preferred options were identified. These were Option 2.4 and Option 2.6. Benefits associated with both of these options include:
 - They both collect additional information about serious resident on resident incidents which is not currently available
 - Both options target reporting to those incidents that are associated with the greatest impact on the resident who is the victim; this may facilitate the collection of data which can, in a more targeted way, inform system level and service-specific interventions by the Commission and, in turn, enable services to deliver better quality care that enhances the experience and wellbeing of residents
 - Both options present a lower volume of incidents for the Commission to analyse and respond to when compared to most of the other options
 - Both options present a lower volume of incidents for services to report when compared to most of the other options to expand the threshold and, as such, are associated with a lesser

need for resources which are focused on making reports. This may free up resources to focus on local or service-specific efforts to improve the quality of care.

- The key challenge with both of these options relates to the ease of application of these thresholds. Both options would require services to be clear as to which specific incidents are in scope for reporting. As such, there will be a need for clear and simple tools and resources to help services understand new requirements, and education to embed the new practices should either of these options be implemented.
- In making a decision about the future threshold for reporting of resident on resident incidents, the level of maturity of this data collection should be considered. As further data is collected, more information will become available to guide ongoing reporting.

4.2 Other considerations

This study focused on understanding the prevalence of resident on resident incidents nationally. This included gathering data related to the type and frequency of resident on resident incidents that occur in residential aged care. However, there are a range of other aspects of a SIRS and the broader regulatory framework of aged care that are important to consider in setting the threshold of resident on resident reporting under a SIRS, including:

- Other design aspects of a SIRS, such as roles and responsibilities of the Commission and providers, as well as the threshold set for other types of incidents
- Other policy levers that are in place or that could be implemented to respond to or prevent resident on resident incidents from occurring, or mitigating the harm associated with these incidents
- The broader quality and safety framework that is in place and how this complements or interfaces with a SIRS, including the Aged Care Quality Standards, the Charter of Aged Care Rights, quality compliance, and open disclosure.

While this study has gathered information about the type and frequency of resident on resident incidents that are not currently reported to the Department for the first time, information gaps still remain regarding these incidents. Specifically, there are gaps regarding:

- The nature of resident on resident incidents, particularly Type 2 incidents
- Provider behaviour with regards to responding to these incidents and record keeping
- The efficacy of different interventions in responding to incidents and preventing them from occurring.

There is a need for further research into these areas to better support future decision making for regulatory and policy responses to resident on resident incidents. In the absence of detailed data across these areas, the introduction of a SIRS offers the Department an opportunity to collect data and better understand certain resident on resident incidents. In addition, performance of a SIRS can be monitored and evaluated throughout implementation to refine the threshold of resident on resident incidents that are captured and to improve its effectiveness.

This section further details these considerations.

4.2.1 Design aspects of a SIRS

As noted above, the purpose of this study was to understand the prevalence of resident on resident incidents nationally. It did not consider the other design aspects of a SIRS which would influence decision making regarding the threshold of resident on resident incidents which should be reported. These other aspects include, but are not necessarily limited to:

- **The threshold set for the reporting of other incidents of abuse and aggression:** Setting a lower threshold for the reporting of other incidents of abuse and aggression will increase the number of incidents reported to the Commission and the ability of the Commission to resource and respond to resident on resident incidents.
- **The role and response by the Commission:** One of the main issues identified by recent reviews and reports was the oversight arrangements in place to assess the adequacy of responses by aged care services and to identify risks in the system. The impact of a threshold set for resident on resident incidents will be dependent on the roles and functions given to the Commission, including the response taken by the Commission and the response a Commission may require a service to take when an incident is reported.
- **Level of detail required to be reported for each incident:** The level of information required to be reported to the Commission about resident on resident incidents will impact the time and resources required by services to make reports. This will also impact the volume of information which the Commission must analyse and respond to.

Each of these design aspects of a SIRS influence the regulatory impact on providers and the Commission and how easily a SIRS could be introduced.

Other arrangements could also be introduced by the Commission (outside of setting a threshold) to reduce the volume of incidents that are to be reported and increase the ability of the Commission to receive and respond to reports of resident on resident incidents. For example, the 2018 report, 'Strengthening protections for older Australians', noted that reporting exemptions could be introduced to 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 residents.³¹ If such a power is introduced, it would provide flexibility for the Commission to decide which incidents are reportable, or indeed which providers are required to report to the Commission based on the level of risk.

It will be important to consider each of these design aspects of a SIRS holistically in setting the threshold of resident on resident incidents captured by a SIRS and indeed the breadth of other incidents that may be captured.

4.2.2 Other policy levers that could be used to address the issue of resident on resident incidents

Recent research has identified a number of recommendations – other than regulatory oversight – to address the issue of resident on resident incidents, and that should be considered in setting the threshold for reporting,³² including that:

- 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. The ALRC report considered education and advice to be important in managing and preventing resident on resident incidents, and that a report to a SIRS may prompt access to such education and advice.³³

³¹ KPMG on behalf of the Commonwealth Department of Health (2018), Strengthening protections for older Australians, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch._.pdf.

³² KPMG on behalf of the Commonwealth Department of Health (2018), Strengthening protections for older Australians, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch._.pdf.

³³ Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).



- Aged care providers introduce zero tolerance policies in residential aged care settings for violence against staff, residents 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.³⁴

It is important to note that existing support services are in place to respond to behavioural and psychological symptoms of dementia, such as the DBMAS or SBRT. It will be important to consider how different types of responses may be employed to tackle the issue of resident on resident incidents in aged care.

There may also be broader implications for introducing a SIRS on these other support services. For example, the Commission may choose to introduce requirements relating to how providers respond to resident on resident incidents that are reportable, such as requirements to access DBMAS or SBRT when an incident occurs. It will be important to consider what flow-on effects such requirements have on demand for other support services. It may be the case that, regardless of the reporting threshold set by the Commission, further consideration of investment in these services is warranted to respond to the estimated volume of resident on resident incidents that are occurring nationally.

4.2.3 The broader quality and safety framework of aged care

A SIRS sits within the broader safeguarding framework of aged care that support the safety of residents. As noted in the 2018 report, the effectiveness of a scheme similar to a SIRS is dependent on its interface with other quality and safety functions.³⁵ The effectiveness of a SIRS is dependent on how it complements and interfaces with other quality and safety functions of the aged care system. Other regulatory settings relevant to a SIRS include the Aged Care Quality Standards, the Charter of Aged Care Rights, quality compliance and open disclosure. These settings support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to residential aged care residents. It will be important to consider the intersection of a SIRS (and its relevant design components) with the current and future quality and safety functions of the aged care system. For example, the Commission may review and assess responses to resident on resident incidents by providers through accreditation or compliance processes, or may use information gathered through a SIRS to identify risk across the system.

4.2.4 Need for further research and evidence

There has been limited research to date on the incidence of resident on resident incidents in Commonwealth-funded aged care. This study has collected information on certain resident on resident incidents for the first time. This information is critical to setting a baseline of the prevalence of resident

³⁴ Prof. Joseph E Ibrahim, Recommendations for prevention of injury-related deaths in residential aged care services, (Monash University: Southbank 2017).

³⁵ KPMG on behalf of the Commonwealth Department of Health (2018), Strengthening protections for older Australians, accessed on 20 October 2019, available at https://agedcare.health.gov.au/sites/default/files/documents/04_2019/23012019_proposal_for_a_national_aged_care_serious_incident_response_sch_.pdf.

on resident incidents nationally. However, the level of information captured by this study was limited in terms of the level of detail captured on incidents and provider responses to incidents. The study was also unable to ascertain to what extent the same residents were involved in an incident. As such, information gaps remain regarding the nature and prevalence of all resident on resident incidents in residential aged care, particularly those incidents which met the definition of a Type 2 incident. There is also limited information available generally regarding provider behaviour in responding to resident on resident incidents and how these incidents are documented by providers in clinical systems (and therefore the impact of any change to the current scheme would present).

In addition, despite there being many interventions designed to address elder abuse, there is limited research on elder abuse prevention and therefore evidence as to the efficacy of specific interventions, including a SIRS.³⁶ 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.

There is a need for further research into these areas to better support future decision making for regulatory and policy responses. In the absence of detailed data across these areas, the introduction of a SIRS offers this opportunity. The ALRC report noted that a new scheme could improve information available on incidents. This could contribute to the evidence base for future interventions.

Regardless of the threshold taken, the performance of a SIRS should be monitored and evaluated throughout implementation to refine the threshold of resident on resident incidents that are captured and to improve its effectiveness.

4.2.5 Evaluate findings from this prevalence study

The Department could also consider evaluating the findings from this prevalence study to better understand the results and the distribution in volume of incidents across different aged care services and providers, such as:

- To understand why some aged care services reported zero incidents compared to others that reported a high number of incidents. It may be the case that some aged care services that reported a small number of incidents already reported the majority of resident on resident incidents that occur at their service to the Department.
- To understand why some aged care services reported a high number of Type 1 and Type 2 incidents. It may be the case that these aged care services support a high proportion of residents who have complex co-morbidities or experience severe behavioural and psychological symptoms of dementia.

Summary of key findings

- There are other aspects of a SIRS and the broader regulatory framework of aged care that are important to consider in setting the threshold of resident on resident incident reporting under a SIRS. These include:
 - Other design aspects of a SIRS, such as roles and responsibilities of the Commission and providers, as well as the threshold set for other types of incidents
 - Other policy levers that are in place or that could be implemented to respond to or prevent resident on resident incidents from occurring, or mitigating the harm associated with these incidents
 - The broader quality and safety framework that is in place and how this complements or interfaces with a SIRS, such as the Aged Care Quality Standards, the Charter of Aged Care Rights, quality compliance, and open disclosure..

³⁶ Baker PRA et al, Interventions for preventing abuse in the elderly. (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.

- Information gaps still remain regarding resident on resident incidents that are not currently reported. There is a need for further research into these areas to better support future decision making for regulatory and policy responses.
- The introduction of a SIRS offers the Department an opportunity to collect data and better understand certain incidents.
- Performance of a SIRS can be monitored and evaluated throughout implementation to refine the threshold and to improve its effectiveness.



Appendices

Appendix A: Questions and data fields captured in this study

This appendix outlines the specific questions and data fields that were captured during this study.

Type 1 Incidents – Reportable assaults between residents that have not been reported to the Department because they are exempt from being reported

Question	Data fields
How many incidents of this nature (Type 1) occurred during the six month period 1 February 2019 to 31 July 2019? If there are no incidents, please enter '0'.	n/a

Completed once for each Type 1 Incident:

Question	Details
When did the service first become aware or start to suspect that the reportable assault had occurred?	__ / __ / __ (DD/MM/YYYY)
Who was involved in the incident? Please enter the first name and first letter of the last name for each of the residents involved. e.g. JOHNS for John Smith	n/a

Question	Details
What type of reportable assault occurred? Select all that apply	<input type="checkbox"/> Unlawful sexual contact – non-consensual sexual activity towards residents in aged care facilities. <input type="checkbox"/> Unreasonable use of force – deliberate and violent physical attacks on residents and the use of unwarranted physical force on a resident. This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising. <input type="checkbox"/> Unable to be determined based on the information available
What behaviours were displayed by the resident who was the alleged perpetrator? Select all that apply	<input type="checkbox"/> Pushing or shoving, kicking, hitting, punching, slapping, and / or biting <input type="checkbox"/> Physically restraining another resident <input type="checkbox"/> Intentional injury of another resident with a weapon or object, including burning <input type="checkbox"/> Non-consensual sexual language or exploitative behaviour <input type="checkbox"/> Rape, sexual assault, including touching the resident’s genital area without consent <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Unable to be determined based on the information available
What was the impact of the reportable assault on the resident who was the victim? Please check the option which most closely aligns with the impact on the resident (select one only).	<input type="checkbox"/> Fatality or severe permanent physical or psychological impairment <input type="checkbox"/> Permanent physical or psychological impairment <input type="checkbox"/> Physical or psychological injury or illness requiring a hospital admission (but not permanent) <input type="checkbox"/> Physical or psychological injury or illness requiring onsite medical or psychological treatment <input type="checkbox"/> Minor physical or psychological injury or discomfort which resolved without formal medical or psychological interventions.

Question	Details
	<input type="checkbox"/> No impact <input type="checkbox"/> Unable to be determined based on the information available
In addition to recording the reportable assault, what other actions were taken by the service in response to the incident? Select all that apply.	<input type="checkbox"/> Update made to the victim's care plan <input type="checkbox"/> Update made to the perpetrator's care plan <input type="checkbox"/> Onsite medical treatment provided to the victim <input type="checkbox"/> Onsite medical treatment provided to the perpetrator <input type="checkbox"/> Hospital admission for the victim <input type="checkbox"/> Hospital admission for perpetrator <input type="checkbox"/> Referral made to the Dementia Behaviour Management Advisory Service (DBMAS) <input type="checkbox"/> Report made to police <input type="checkbox"/> Referral made to GP <input type="checkbox"/> None and / or none recorded <input type="checkbox"/> Other, please specify _____

Type 2 Incidents – Other resident on resident incidents that have occurred and have been documented

Question	Answer
Approved providers may record information about resident on resident incidents in addition to those reported to the Department, and those covered in Type 1. How many of these other resident on resident incidents has your service documented within the in scope time period (e.g. in your incident log or risk management system)?	_____ (Insert number, number could be 0)

Appendix B: Prevalence study resource manual



SIRS Prevalence Study Resource Manual



Disclaimer

Inherent Limitations

This resource manual has been prepared as outlined in Section 1. 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 consulted as part of the process.

KPMG have indicated within this resource manual 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 resource manual in either oral or written form, for events occurring after the resource manual has been issued in final form.

Third Party Reliance

This resource manual is solely for the purpose set out in the Section 1 and has been prepared at the request of the Commonwealth Department of Health in accordance with the terms of KPMG's contract dated 31 July 2019. Other than our responsibility to the Commonwealth Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

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1 Overview of prevalence study

Background

The Government announced in the 2019-20 Budget that it would fund preparatory work to introduce a Serious Incident Response Scheme (SIRS, or Scheme) for residential aged care as part of the *More Choices for a Longer Life* Budget measure. The Department of Health (the Department) has commenced this preparatory work and will focus on the development and definition of the finer details of operation of a SIRS for residential aged care.

The intent of a SIRS is to strengthen the governance of the risk of harm arising from abuse and neglect of older people in residential aged care, by building provider capacity to better respond to incidents if and when they occur, and ensure consumers are supported appropriately.

The proposed SIRS, together with other regulatory settings including the Aged Care Quality Standards, the Charter of Aged Care Rights, and open disclosure, will support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to residential aged care consumers.

Purpose of the prevalence study

KPMG has been engaged by the Department to undertake research on the prevalence of resident on resident incidents in residential aged care nationally to support the preparatory work for a SIRS.

The purpose of this study is to help the Department understand what type of and how frequently resident on resident incidents occur. The information collected will be used to inform advice to Government, particularly on the design of the Scheme's definitions and threshold settings, to ensure that reporting is appropriate and the Government's regulatory resources and efforts are targeted to the highest risks.

Please note, information collected will not be used for any other purpose than this prevalence study. For example, it will not be used for compliance purposes.

What information is being collected?

We are collecting information about the type and frequency of resident on resident incidents (including allegations and suspicions of incidents) that have occurred in residential aged care services between the six month period of 1 February 2019 to 31 July 2019. Services which have had no incidents during this period should also submit data.

This study will collect information about two types of resident on resident incidents. These are:

- Resident on resident incidents that meet the *Aged Care Act 1997* (the Act) definition of a reportable assault but are exempt from being reported to the Department
- Other incidents between residents, which do not meet the definition of a reportable assault but are recorded by the approved provider (for example, in an incident log).

Further information on data to be collected by the study is provided in Section 2 of this Resource Manual.

What if I need help completing the submission?

Please call the KPMG team on 1800 789 576 between 9am and 5pm or email us on SIRSpresvalencestudy@kpmg.com.au if you require assistance with any aspect of the submission process.

2 What data is the study collecting?

The prevalence study is collecting information about the type and frequency of resident on resident incidents (including allegations and suspicions of incidents) that have occurred in residential aged care services between the six month period of 1 February 2019 to 31 July 2019.

Types of resident on resident incidents in scope for the prevalence study

The prevalence study will collect information about two types of resident on resident incidents. These are:

1. Resident on resident incidents that meet the *Aged Care Act 1997*'s definition of a reportable assault but are exempt from being reported to the Department
2. Other incidents between residents, which do not meet the definition of a reportable assault but are recorded by the approved provider (for example, in an incident log).

Information about each of these incident types is provided below. If services have had no incidents during this period, they should still submit data.

Incident type 1: Resident on resident incidents that meet the *Aged Care Act 1997*'s definition of a reportable assault but which are exempt from being reported to the Department

Under the *Aged Care Act 1997*¹, approved providers are required to report to the Department allegations or suspicions of reportable assaults. A reportable assault is:

- *Unlawful sexual contact*, which refers to non-consensual sexual contact involving residents in aged care facilities. Where the contact involves residents with an assessed cognitive or mental impairment, the resident may not have the ability to provide informed consent.
- *Unreasonable use of force*, which is intended to capture assaults ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force on a resident. This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising.

Not all reportable assaults are required to be reported to the Department. Exemptions for reporting include:

- When the alleged assault is perpetrated by a resident with an assessed cognitive or mental impairment and care arrangements are put in place to manage the behaviour within 24 hours
- When previous reports of the same or similar incidents have been made to the police or Department.

If a reportable assault meets these exemption criteria, and is not reported to the Department, approved providers are still required to record information about the incident². This study is collecting information about these incidents – i.e. resident on resident incidents that meet the definition of a reportable assault and are recorded, but not reported.

¹ *Aged Care Act 1997* Cth. 63-1AA. Retrieved from, <https://www.legislation.gov.au/Details/C2017C00241>

² *Records Principles 2014* s. 8. Retrieved from, <https://www.legislation.gov.au/Details/F2019C00610>

Incident type 2: Other resident on resident incidents which do not meet the definition of a reportable assault but are recorded by the approved provider

In addition to the incidents that meet the Act's definition of a reportable assault, approved providers may document information about other resident on resident incidents. These incidents may be recorded by the provider in a central place, such as a risk register or incident log. We are interested in the quantum of these incidents.

What information about these incidents is being collected?

The amount of detail which is being collected about these incidents differs, depending on the incident type. **For incident type 1**, we will ask for the total number of incidents that occurred at your service during the six month period 1 February 2019 to 31 July 2019. We will also be capturing information about each incident that occurred during this period. This includes:

- The date when your service first became aware or started to suspect that the reportable assault had occurred
- The residents involved in the incident (de-identified)
- The type of reportable assault that occurred (i.e. unlawful sexual contact or unreasonable use of force)
- The behaviours that were displayed by the resident that was the alleged perpetrator
- The impact of the incident on the resident that was the victim
- Actions taken by your service in response to the incident.

For incident type 2 only summary information is required. This includes:

- The number of incidents that occurred during the six month period 1 February 2019 to 31 July 2019.

Data dictionary

To ensure the data collected is suitable for collation and analysis, it is important that all services that participate submit information consistently so that it is comparable. To assist participants to identify and submit the right information, a 'data dictionary' is in Appendix A. This data dictionary lists each of the response fields to be completed in the data submission tool, and provides a definition. While some of the definitions provided may be consistent with definitions you use in your everyday work, others may differ. As such, please refer to this dictionary when identifying, preparing and collating information from your service, and before you submit it.

3 Participating in the prevalence study

The following sections provide information about how to prepare, collect and submit data for the study.

Summary of activities and timeframes

The prevalence study will run from September to October 2019. Following a registration period, an online training webinar will be delivered which will outline the data to be collated and how to submit this information into the data submission tool. The window for submitting data will be four weeks and you will be able to submit data at any point during this period. Key activities and timeframes are outlined in the table below.

Key activity	Timeframe
Services register interest to participate in the study	Registrations close on Friday 13 September
Online training webinar	Monday 16 September 9 to 11am
Data submission opens	Monday 16 September
Data submission closes	Friday 4 October
Data analysis and reporting by KPMG	October and November

The data collected during this prevalence study will be analysed by KPMG and a report developed to present a national picture of the prevalence of resident on resident incidents in residential aged care.

Preparing for the data submission

We suggest you take the following steps to prepare for data submission:

Attend the online training webinar

- An online training webinar will be held prior to the commencement of the study. The webinar will be held on 16 September from 9 to 11am. You will receive information via email about how to register for the webinar.
- The online training webinar will also be recorded and accessible throughout the data submission period, should you be unable to attend the training webinar, or wish to refer back to the training at any stage.

Conduct internal set up

- You may wish to consider the following steps to set up your service to collect data, noting that these are suggestions only:
 - Inform staff that will assist in collating and submitting data for the study
 - Identify a key contact who will collate data from your incident log or risk management system and submit the data into the online system.

Submitting data

This section outlines the process for submitting your service's data. We would suggest collating your data prior to starting the submission in the data submission tool. You will be unable to exit the form once you have begun your submission. A template has been provided in Appendix B that can be used to collate the relevant data required for this study.

Approaches

The suggested approach to collating and submitting data is to collate the data first and access the data submission tool to submit the data at a later point. We have provided a template (Appendix A) to assist you in collating the information ahead of time. We will also provide you with an editable word version of this template.

Preparing for the data submission prior to entering the information in the data submission tool is important as partially completed data submissions cannot be saved. The data submission must be completed in a single setting. If you have collated your service's data to submit, completing the data submission tool should take approximately 10 minutes, but may vary depending on the number of incidents that occurred during the data collection period. If you need to step away from your computer when completing the submission, you will be able to return to the survey at a later point in the day as long as the survey is left open on the same internet browser and on the same computer. The steps for submitting data are outlined below.

Step 1: Click on the link to the data submission tool

You will have received a link to the website to submit data via an email from KPMG. Click on the link contained in the email to open the data submission tool.

Step 2: Introductory page

The main screen provides some background information about the prevalence study and will guide you to start the data submission tool. The main screen will appear like this:

Prevalence research for a Serious Incident Response Scheme data submission tool

This online data submission tool has been developed to capture data from residential aged care services about resident on resident incidents. The focus is on incidents that have already occurred. This information will be used to estimate the national prevalence of resident on resident incidents in residential aged care that are not reported through the current reportable assaults arrangements.

Your participation in this study is important. It will assist the Department of Health (the Department) understand what type of and how frequently resident on resident incidents occur. The information collected will be used to inform advice to Government, particularly on the design of the Serious Incident Response Scheme including its definitions and threshold settings, to ensure that reporting is appropriate and the Government's regulatory resources and efforts are targeted to the highest risks. Please note, this information will not be used for any other purpose than this prevalence study, for example, not for compliance purposes.

Click on the arrow button at the bottom of the page to begin the data submission.

What if I need help completing the submission or would like further information?

Please call the KPMG team on 1800 789 576 or email us on SIRSpvalencestudy@kpmg.com.au if you require assistance or would like further information (including obtaining a copy of the SIRS Prevalence Study Resource Manual).



Step 3: Provider/submitter details

Once you have read the introductory information and clicked the arrow on the bottom right of the screen, this will take you to the first part of the tool. Part one will ask you to enter:

- The name of the approved provider
- The name of the service
- Your contact details.

You will only have to enter this data **once**.

What is the name of the approved provider?

What is the name of the service?

Please enter your full name.

After you have completed this page, press the arrow on the bottom right of the screen.

Step 4: Information about reportable assaults between residents that have not been reported to the Department because they are exempt from being reported.

From this point, the questions will match those on the paper-based tool. In part two you will be asked questions about Type 1 incidents. You will be asked to enter the total number of incidents that have occurred in the period 1 February 2019 to 31 July 2019. You will only have to enter this data **once**.

This section refers to reportable assaults between residents that have not been reported to the Department because they are exempt from being reported.

How many incidents of this nature occurred during the six month period 1 February 2019 to 31 July 2019? Please enter a number (e.g. 0, 1, 2, 3). If no incidents of this nature occurred, please type "0".

If the answer to this question is two or more incidents, the following question will also appear. The purpose of gathering this information is to understand whether residents are involved in more than one Type 1 incident during the period 1 February to 31 July 2019.

Note, please do not count any incidents other than Type 1 incidents (e.g. do not count incidents already reported to the Department, or Type 2 incidents).

Did any of these incidents involve the same resident?

- ☐ Yes
- ☐ No
- ☐ Unable to be determined based on the information available

You will then be asked to provide information about each individual incident. The information that will be collected for each incident is outlined in Section 2 and Appendix B of this document.

For incident 1:

When did the service first become aware or start to suspect that reportable assault had occurred?

Please enter your response in the format DD/MM/YYYY.

Following the completion of this page you will be directed to part three.

Step 5: Other resident on resident incidents that have occurred and have been documented

In part three you will be asked one question about Type 2 incidents. This refers to the number of Type 2 incidents that occurred during the six month period 1 February 2019 to 31 July 2019. Once you have entered a number, click the arrow located at the bottom right corner of the screen.

This section refers to other resident on resident incidents that have occurred and have been documented.

Approved providers may record information about resident on resident incidents in addition to those reported to the Department, and those covered in the previous section.

How many of these other resident on resident incidents has your service documented within the in-scope time period (e.g. in your incident log or risk management system)? Please enter a number (e.g. 0, 1, 2, 3). If no incidents of this nature occurred, please type "0".

**Step 6: Submit your data**

If you need to alter a response, navigate back to your response by clicking the arrow at the bottom left hand corner of the screen.

To finalise your submission, click the arrow on the bottom right of the screen.

Confirmation

Please click the arrow button below to finalise your response.



The screen below will appear once the data has been submitted.

We thank you for your time spent taking this survey.
Your response has been recorded.

We will email you at (your email address) with a copy of your responses. If you need to correct any information that you have submitted, you will be able to respond directly to the email.

What if I need assistance

Please call the KPMG team on 1800 789 576 between 9am and 5pm or email us on SIRSpvalencestudy@kpmg.com.au if you require assistance with any aspect of the submission process.

Appendix C: Field validation in the data submission tool

This appendix provides an overview of the field validations used in the data submission tool (in Table 10).

Table 10: Field validations in the data submission tool

Question	Validation
<ul style="list-style-type: none"> “This section refers to reportable assaults between residents that have not been reported to the Department because they are exempt from being reported. How many incidents of this nature occurred during the six month period 1 February 2019 to 31 July 2019? Please enter a number (e.g. 0, 1, 2, 3). If no incidents of this nature occurred, please type “0”.” “This section refers to other resident on resident incidents that have occurred and have been documented. Approved providers may record information about resident on resident incidents in addition to those reported to the Department, and those covered in the previous section. How many of these other resident on resident incidents has your service documented within the in-scope time period (e.g. in your incident log or risk management system)? Please enter a number (e.g. 0, 1, 2, 3). If no incidents of this nature occurred, please type “0”.” 	Response must be a whole number (e.g. 0, 1, 2, 3).
<ul style="list-style-type: none"> “When did the service first become aware or start to suspect that the reportable assault had occurred? Please enter your response in the format DD/MM/YYYY.” 	Response must be a date in the format DD/MM/YYYY.
<ul style="list-style-type: none"> All questions.³⁷ 	Forced response, i.e. respondents could not progress through the tool until they had answered each question on the page. Questions that required the respondent to select from a list of options always included an option to select “unable to be determined based on the information available”, “none and/or none recorded” or “other, please specify: ____”.

Source: KPMG

³⁷ With the exception of “Did any of these incidents involve the same resident?”. This question was only displayed to respondents who entered a Type 1 incident number of two or higher. Errors can result when forcing responses for a question that is only displayed to some respondents, hence, forcing responses was avoided for this question.

Appendix D: Guidance and resources to support aged care services to participate

This Appendix outlines the guidance and resources that were provided to aged care services to support them to participate in the study.

Online training webinar

KPMG ran an online training webinar (the webinar) to support study participants to prepare for the study. The webinar was held on Monday, 16 September 2019, via an online platform and was two hours in duration. A total of 22 individuals representing 19 services attended the webinar.

The webinar was facilitated by two senior KPMG project team members. The training webinar provided an overview of the study, including background information on the development of the SIRS and the purpose of the study. The webinar also provided an overview of the data collection process, including how to prepare for the study and how to submit data.

Slides and a recording of the webinar were made available to all study participants following the live session.

Guidance material

Guidance material was developed to support aged care services to prepare for the study. All resources were emailed to aged care services and were approved by the Department prior to distribution.

A summary of the materials developed for the study is provided in Table 11.

Table 11: Training and resources developed for the study

Resource	Overview	Format
Resource manual	An overview of the study and participation instructions. The manual provided specific data collection and submission instructions.	PDF
Data collection template	A template mirroring the online data submission tool for providers to complete prior to submitting data online.	Editable word document
Online data submission tool	An online tool for submitting data, which included a login portal. Discussed further in sections 3.1.2 and 3.1.3.	Online Tool
Frequently asked questions (FAQs) document	A document outlining frequently asked questions from participants at the training webinar session and their answers. This document was made available to all study participants.	PDF

Source: KPMG



Hotline and functional mailbox

A dedicated toll-free hotline and functional mailbox were available for study participants to contact when they had queries. Table 12 details the hotline and functional mailbox activities, their purpose, the availability of the support, and any other key issues or information.

Towards the end of the data submission period, the KPMG project team conducted follow-up calls to registered services that had not yet submitted data. The purpose of these calls was to provide an avenue to answer any queries or address any concerns that the service may have had, and also served as a reminder to submit data prior to the end of the data submission period. Between 26 September and 4 October 2019, 89 calls were made. Where the team was unable to reach the relevant service contact, a follow-up email was sent.

Table 12: Hotline and functional mailbox supports provided by KPMG

Support activity	Function	Timing/availability	Key outcomes
Mass outbound emails	Emails were sent to contacts as a reminder to collate and submit data, and to provide other study information.	<ul style="list-style-type: none"> Reminder emails were sent mid-way through the data submission period. 	<ul style="list-style-type: none"> Enabled the mass dissemination of key study information. Increase in submission rates.
Hotline	A toll-free telephone number was available for study participants to call and speak to a KPMG project team member. Outside of hours, a voice mail facility was available.	<ul style="list-style-type: none"> 9am to 6pm (AEST), Monday to Friday. Voice mails were responded to within one working day. 	<ul style="list-style-type: none"> Peak hotlines times were during the online data submission period. Aged care services were able to rapidly seek assistance with registration and online data submission, and to discuss the purpose of the study.
Mailbox	An email address was made available to study participants to contact the KPMG project team with any queries or issues.	<ul style="list-style-type: none"> Actioned within one working day. 	<ul style="list-style-type: none"> Respond to requests for registration information, pilot resources and help with data submission.

Source: KPMG

Appendix E: Approach to modelling data

The Horvitz Thompson (or linear unbiased estimator) can be used for any probability sample design.³⁸ Key statistics, formula and brief descriptions of this approach are outlined in Table 13.

Table 13: Statistics to estimate, formulae and descriptions

Statistic to estimate	Formula	Description
Estimate of total incidents	$\hat{Y} = \sum_{i \in s} \frac{N}{n} y_i$	In this situation, we assume that all services have equal weight (N= 2,717 and n=178) and sum the incidents at each service (e.g. 5 Type 1 incidents) are (y_i)
Variance of the total incidents	$Var(\hat{Y}) = \frac{N^2}{n} (1 - f) S_y^2$	The variance estimate of total incidents has N = 2,717, n = 178. The sampling fraction f = 178/2,717 and the sample variance S_y^2 is calculated from the total incident data for each service.
Standard error of the total incidents	$\sqrt{Var(\hat{Y})}$	The standard error is used for calculating confidence intervals and Relative Standard Errors, which provide an indication of the reliability of our estimates.

Five methods were used to weight the data and calculate national level estimates. All five were based on the linear unbiased estimator. Method One assumed that all services had equal weight, Method Two post-stratified services into size strata (e.g. one to twenty places), Method Three also post-stratified the services into size strata but excluded the services from an “influential³⁹” provider, Method Four post-stratified services into occupancy strata and Method Five also post-stratified the services into occupancy data and excluded the same influential provider.

³⁸ Australian Bureau of Statistics (ABS) 2003. Survey Methods 1 (Internal Publication). ABS, Canberra.

³⁹ This provider had 16 services participate and contributed 35.4 per cent of all Type 1 incidents in the sample.



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