Improving aged care quality protections

Options for a Serious Incident Response Scheme (SIRS) in home and community aged care

Department of Health

Final Report

July 2021

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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-funded 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.
Commonwealth Home Support Programme (CHSP)	The Commonwealth Home Support Programme is an entry-level home support program that helps older Australians to live independently in their homes and communities. It also provides respite services to give carers a break.
Elder abuse	Physical, psychological or emotional, sexual or financial abuse of older Australians or intentional or unintentional neglect.
Flexible Care	Flexible Care is Commonwealth-funded care provided in a residential or community setting that addresses care needs in alternative ways to the care provided in residential aged care and home aged care. This report only refers to flexible care delivered in the community setting. Flexible Care includes Short Term Restorative Care (STRC), Multi-Purpose Services (MPS), the Transition Care Program (TCP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).
Home and community aged care	This report refers to aged care services accessed in the home and community setting. This includes services delivered through the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) and Flexible Care delivered in home and community settings.
Home Care Package (HCP)	A Home Care Package is a Commonwealth-funded, co-ordinated package of services tailored to meet the person's specific care needs, with eligibility determined by an Aged Care Assessment Team. There are four levels of packages.
Participating provider	An aged care provider that submitted six months of data for inclusion in the prevalence study.
Participation rate	The rate of participation of providers in the study out of the total number of providers in the broader provider population by program, jurisdiction and remoteness category (e.g. this sample captured a certain percentage of all CHSP providers nationally).
Prevalence study	A study that examines the relationship between serious incidents and variables of interest (e.g. program type, jurisdiction and remoteness

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Terms	Definition
	category) among home and community aged care providers between 1 November 2020 and 30 April 2021.
Service provider	An organisation that has either been approved by the Secretary of the Department of Health to provide residential care, home care or flexible care under the *Aged Care Act 1997* or has been funded to deliver aged care services under a contractual arrangement with the Department of Health.
Reportable incident	The current Serious Incident Response Scheme for residential aged care defines a 'reportable incident' as an incident (actual, alleged or suspected) committed to a care recipient in connection with the provision of services in a residential aged care setting. Providers are required to notify the Aged Care Quality and Safety Commission of reportable incidents.
Residential aged care	Residential aged care is Commonwealth-funded accommodation and personal care for older Australians. It operates 24 hours a day and includes access to nursing and general health services.
Royal Commission into Aged Care Quality and Safety (the Royal Commission)	The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018. The final report was published on 1 March 2021. The Government response was submitted on 11 May 2021.
Serious Incident Response Scheme (SIRS)	The SIRS refers to new regulatory requirements of residential aged care providers with regards to identifying, reporting and responding to incidents. The SIRS requires residential aged care providers to report certain serious incidents to the Aged Care Quality and Safety Commission (the Commission) and places additional obligations on residential aged care providers to identify, record, manage and resolve all incidents.
SIRS-type scheme	This report refers to reporting schemes similar to the SIRS for residential aged care as SIRS-type schemes. These schemes capture incidents related to the conduct of staff and incidents that are of a serious nature but may be related to provider systems, policies and processes.
Total provider population	All 2,078 home and community aged care providers across Australia.
Weighting	A method for weighting a sample to help ensure national estimates reflect the national provider population rather than the subset of services that submitted data.

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Executive summary

Elder abuse in Australia has become more visible with increased reporting, and the prevalence of this abuse appears to be growing. Estimates indicate that between two and 14 per cent of older Australians experience abuse.[1] The Serious Incident Response Scheme (SIRS) was introduced in residential aged care on 1 April 2021, however it does not currently apply to home and community care settings.

Recent reports and reviews[2] have highlighted the need to implement consistent safeguards for older Australians across all service settings, including for the more than 900,000 older Australians accessing aged care services in their home or community. This need was also acknowledged by the Royal Commission into Aged Care Quality and Safety (Royal Commission), which recommended the extension of the SIRS to home and community care settings (Recommendation 100). In the 2021-22 Budget, the Australian Government announced funding of an initial $14 million to expand the SIRS from residential aged care into home and community care from 1 July 2022. This will provide greater protections to consumers receiving home and community aged care services.

KPMG was engaged by the Commonwealth Department of Health (the Department) to undertake a study on the prevalence of serious incidents in home and community aged care settings (Prevalence Study), and to develop options for extending the SIRS to home and community aged care. This work aims to inform advice to Government on the design and implementation of a SIRS for home and community aged care, including further detailed design of options.

Findings from the Prevalence Study

The Prevalence Study was undertaken over a six-month period from 1 November 2020 to 30 April 2021 on the prevalence of serious incidents in home and community aged care settings. Data collection was completed by a sample of home and community aged care providers who voluntarily registered for the study in response to sector-wide communications or direct invitations. Key findings from the Prevalence Study included:

- Of the 2,078 home and community aged care providers in Australia, 151 (seven per cent) participated in the study.
- A total of 161 serious incidents were reported over the six month period.
- The majority of participating providers, 118 of 151 (78 per cent), reported zero incidents in the study period.
- The total number of serious incidents reported by participating providers was relatively consistent over the six-month period, averaging 27 serious incidents reported per month.
- Of the 161 reported serious incidents, a large number involved stealing or coercion (69, or 43 per cent), or neglect (50, or 31 per cent). The remaining 42 reported serious incidents comprised unreasonable use of force (14, or nine per cent), psychological or emotional abuse (10, or six per cent), unexpected death (nine, or six per cent) and unlawful or inappropriate sexual contact (eight, or five per cent). Please note one respondent did not record a serious

[1] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).
[2] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017); Aged Care Royal Commission, Final Report – Volume 1, (Royal Commission into Aged Care Quality and Safety, 2021).

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incident type. None (zero per cent) of the reported incidents involved inappropriate physical or chemical restraint.

Options for a SIRS for home and community care

Four options for a SIRS for home and community care have been developed. These options have been framed by their similarity or difference to the existing scheme (i.e. SIRS for residential care). The development of these options was informed by an environmental scan of schemes similar to a SIRS in both aged care and other related sectors, consideration of the existing landscape of quality and safeguarding mechanisms both within and external to the aged care system, as well as consideration of the unique characteristics associated with the delivery of aged care in home and community settings.

Option 1

No change to the current arrangements – no SIRS will be implemented for home and community aged care (noting, the Australian Government committed to implementing the Serious Incident Response Scheme in Home and Community Care from 1 July 2022 as part of the 2021-22 Budget).

Option 2

The SIRS for residential aged care will be implemented within the home and community setting, adapted to suit the home care environment. This includes two sub-options for the timing of reports about serious incidents:

- **Option 2a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.
- **Option 2b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours).

Option 3

The SIRS for residential aged care will be implemented within the home and community setting, adapted to suit the home care environment. However, incidents associated with low or no harm are not reported. One means of achieving this could be to only report incidents that meet the definition of a Priority 1 reportable incident.

Option 4

The SIRS for residential aged care will be implemented within the home and community setting but with an expanded scope of incidents including differentiated responsibilities for providers and the Commission for certain incident types. The scope of serious incidents captured under this option would be expanded to include serious incidents that the provider becomes aware of during the course of supports or services being provided and that have occurred between a person and a care recipient within a relationship where there is an expectation of trust. As with Option 2, this includes two sub-options for the timing of reports about serious incidents:

- **Option 4a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.

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- **Option 4b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours.

Implementation considerations

There are a range of matters that will need to be considered in implementing the preferred option for a SIRS for home and community aged care. These include the need for legislative change, the capacity and capability of the Commission to administer the scheme, support required for providers and the community, technology considerations, and options for implementation timeframes.

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2 Introduction

2.1 Project context

Elder abuse in Australia has become more visible with increased reporting, and the prevalence of this abuse appears to be growing. Estimates indicate that between two and 14 per cent of older Australians experience abuse.[3] Comparably, 5.4 per cent of Australians from the general population had experienced violence in the past 12 months in 2016.[4] Cognitive impairment or disability, social isolation or prior histories of traumatic life events are amongst common risk factors which may mean an older person is at higher risk of experiencing abuse.[5] The Australian Law Reform Commission (ALRC) Elder abuse – A national legal response report – highlighted the need to protect older Australians from abuse to support and promote their health, safety and wellbeing. The Royal Commission into Aged Care Quality and Safety (the Royal Commission) also made several recommendations to strengthen safeguards for older Australians.

The most recent development in safeguards for older Australians receiving Commonwealth-funded aged care was the implementation of a Serious Incident Response Scheme (SIRS) in residential aged care, which commenced on 1 April 2021. The SIRS introduced new regulatory requirements of residential aged care providers with regards to identifying, reporting and responding to incidents. The SIRS requires residential aged care providers to report certain serious incidents to the Aged Care Quality and Safety Commission (the Commission) and places additional obligations on residential aged care providers to identify, record, manage and resolve all incidents.

The SIRS also introduced requirements for all residential aged care providers to adopt a systematic approach to minimising the risk of, and responding to, serious incidents involving residents. The SIRS requires every residential aged care service to have in place an effective incident management system – a documented set of protocols, processes, and standard operating procedures – to manage all incidents, respond to incidents, and take steps to ensure they do not happen again. The incident management system covers a broader range of non-reportable incidents and includes incidents that involve staff or visitors. While the existing SIRS for residential aged care does not apply to home and community aged care settings, the SIRS sits alongside, and complements, other requirements that all aged care providers, including home and community care providers, must meet (detailed further in Section 2 of this report).

2.1.1 A SIRS for Home and Community Aged Care

Recent reports and reviews[6] have highlighted the need to implement consistent safeguards for older Australians across all service settings, including for over 900,000 older Australians accessing aged care services in their home or community. This was acknowledged by the Royal Commission, which recommended the extension of the SIRS to home and community care settings,

[3] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).
[4] Australian Bureau of Statistics. (2016). Personal Safety, Australia. https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release
[5] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, Elder abuse: Understanding issues, frameworks and responses, (Melbourne: Australian Institute of Family Studies 2015).
[6] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017); Aged Care Royal Commission, Final Report – Volume 1, (Royal Commission into Aged Care Quality and Safety, 2021).

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Recommendation 100. In the 2021-22 Budget, the Government announced funding of an initial $14 million to expand the SIRS from residential aged care into home and community care from 1 July 2022. This will provide greater protections to consumers receiving home and community aged care services.

While evidence of abuse and neglect within home and community aged care settings has emerged through the Royal Commission, there is limited data available on the prevalence of abuse and neglect in home and community aged care settings. As part of the 2019-20 Budget, the Australian Government committed to undertaking preparatory work on a SIRS for home and community aged care, including a prevalence study and development of options.

2.2 Project purpose and scope

KPMG was engaged by the Commonwealth Department of Health (the Department) to undertake this work, including a study on the prevalence of serious incidents in home and community aged care settings (Prevalence Study), and to develop options for extending the SIRS to home and community aged care. This project will inform advice to Government on the design and implementation of a SIRS for home and community aged care, including further detailed design of options.

2.2.1 Approach

KPMG undertook a series of activities to inform the development of options on extending a SIRS to home and community aged care. The activities included:

- **Prevalence Study** – A Prevalence Study was conducted over a six-month period (from 1 November 2020 to 30 April 2021) to determine the prevalence of serious incidents in home and community aged care settings.
- **Environmental scan** – An environmental scan was completed to gain an understanding of schemes similar to a SIRS, in both aged care and other related sectors locally and internationally, and their relative effectiveness. This included both desktop research of publicly available sources and consultations with a sample of representatives of other sectors in Australia. The desktop research focused on evidence that has emerged since the November 2019 KPMG report 'Strengthening protections for older Australians' (the 2019 Report) and explored how the design of other schemes has been adapted or changed for home and community care settings. Consultations were also undertaken with a sample of providers that deliver home and community aged care in order to understand the effectiveness and maturity of provider incident management systems and processes in the context of record keeping and reporting requirements under a SIRS.
- **Broad stakeholder engagement process** – Twenty-two co-design workshops with over 280 stakeholders were held from late March to mid-April 2021, to seek views from home and community aged care providers, government agencies including from other related sectors, care recipients and care recipient representatives on options for the design and implementation of a SIRS for home and community aged care.
- **Design workshops** – Five workshops were held with representatives from the Department and the Commission to refine draft options for a SIRS for home and community aged care and to identify the benefits, limitations, risks and implications of each option.

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2.2.2 Programs in scope

The aged care programs in scope for this project include the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) and Flexible Care delivered in home and community settings. Flexible Care includes Short Term Restorative Care (STRC), Multi-Purpose Services (MPS), the Transition Care Program (TCP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

2.3 Structure of the report

This report is structured in the following sections:

- Section 1 (this section): Provides an overview of the context, purpose and scope of the project.
- Section 2: Provides an overview of the SIRS for residential aged care and presents findings from the environmental scan.
- Section 3: Provides an overview of the Prevalence Study and its key findings.
- Section 4: Provides a statement of the options.
- Section 5: Provides an assessment of each option.
- Section 6: Details a number of implementation considerations to support a SIRS for home and community aged care.
- Appendices:
  - Appendix A: Provides detailed analysis from the Prevalence Study.
  - Appendix B: Provides the approach to modelling the Prevalence Study data.

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3 Background

This section provides an overview of the SIRS for residential aged care and presents findings from the environmental scan.

3.1 SIRS for residential aged care

The SIRS for residential aged care commenced on 1 April 2021, replacing the previous reportable assaults requirement for residential aged care providers and flexible care providers where care is delivered in a residential aged care setting under the *Aged Care Act 1997*. The purpose of the SIRS for residential aged care is to:

- Help prevent and reduce the risk and occurrence of incidents of abuse and neglect in Commonwealth-funded residential aged care services
- Promote an aged care system that supports care recipients to feel safe and confident about the quality of their care
- Ensure that the care and services that older Australians receive will continuously improve and that incidents will be prevented, managed and resolved, with enhanced outcomes for care recipients.

3.1.1 Definition and types of reportable incidents in the SIRS for residential aged care

The SIRS for residential aged care defines a 'reportable incident' as an incident (actual, alleged or suspected) committed to a care recipient in connection with the provision of services in a residential aged care setting. The types of reportable incidents under a SIRS include:

- Unreasonable use of force against a care recipient
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on a care recipient
- Psychological or emotional abuse of a care recipient
- Unexpected death of a care recipient
- Stealing from, or financial coercion of, a care recipient by a staff member of the provider
- Neglect of a care recipient
- Use of physical restraint or chemical restraint on a care recipient (other than in circumstances set out in the Quality of Care Principles)
- Unexplained absence of a care recipient from the service.

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3.1.2 Reporting requirements under the SIRS for residential aged care

Under the SIRS for residential aged care, the timeframe to notify the Commission of an incident is dependent on the degree of harm to the care recipient:

- **A 'Priority 1' incident** (reportable within 24 hours of the provider becoming aware of the incident) carries a higher degree of harm in that it "has caused, or could reasonably have been expected to have caused, a care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or where there are reasonable grounds to report the incident to police"[7]. Unexplained absences of a care recipient from care and unexpected deaths of a care recipient are always reportable as a 'Priority 1' incident under the SIRS for residential aged care.
- **A 'Priority 2' incident** (reportable within 30 days of the provider becoming aware of the incident) carries a lower degree of harm and includes all other reportable incidents that do not meet the criteria for a 'Priority 1' incident.

3.1.3 Responsibilities of the provider under the SIRS for residential aged care

Residential aged care providers have more responsibilities under the SIRS for residential aged care than previously under the reportable assaults requirements (which are no longer applicable). Under the SIRS for residential aged care, providers are responsible for more than just reporting to the Commission[8]. Under the SIRS for residential aged care, the responsibilities of a provider include to:

- Manage incidents and take reasonable steps to prevent incidents
- Assess the support and assistance required to ensure the safety, health and well-being of persons affected by the incident, and provide support and assistance to those persons
- Assess how to appropriately involve each person affected in the resolution of an incident
- Ensure staff member informants are not victimised or identified
- Use an open disclosure process
- Assess incidents in relation to whether the incident could have been prevented, the need for remedial action to prevent similar incidents occurring, how well the incident was managed and resolved, identifying whether actions could be taken to improve the management and resolution of similar incidents, and whether other parties should be notified of the incident
- Take any remedial actions determined or any actions to improve the provider's management and resolution of similar incidents, and notify the persons/bodies of the determination
- Identify and address systemic issues and provide feedback and training to staff
- If there are reasonable grounds on which to report the incident to police, notify a police officer of the incident within 24 hours of becoming aware
- Collect data relating to incidents that will enable the provider to continuously improve their management and prevention of incidents
- Regularly analyse and review information to assess effectiveness of management and prevention and what improvements should be made and implemented

[7] Aged Care Quality and Safety Commission. Serious Incident Response Scheme. Accessed 6 May 2021: https://www.agedcarequality.gov.au/sirs
[8] These responsibilities apply to a broader scope of incidents (see section 15K of the *Quality of Care Principles 2014*).

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- Manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system[9]
- Ensure that staff members who become aware of reportable incidents notify the provider
- Advise the Commission of reportable incidents about which they become aware
- Notify the Commission of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information
- If required by the Commission, provide a final report about a reportable incident.

3.1.4 Role of the Commission under the SIRS for residential aged care

Under the SIRS for residential aged care, the *Aged Care Quality and Safety Commission Act 2018* and the *Aged Care Quality and Safety Commission Rules 2018* were amended to give the Commission expanded legislative powers to[10]:

- Receive serious incident reports from providers
- Require providers to provide additional information or a final report in relation to a serious incident report
- Take actions (including requiring providers to do something) to deal with a reportable incident, such as:
  - Requiring the provider to complete remedial action in relation to the incident
  - Requiring the provider to undertake an internal investigation and report on the findings
  - Requiring the provider to appoint an external expert to undertake an investigation and report on the findings
- Authorise or carry out an inquiry in relation to a reportable incident
- Issue compliance notices where a provider is not complying, or something would suggest they are not complying, with requirements under the SIRS (failure to comply attracts a maximum civil penalty of 60 penalty units)
- Enforce the requirements under the SIRS through accepting enforceable undertakings, issuing injunctions, and infringement notices
- Use information given to the Commission about a reportable incident to inform risk profiling of providers, identification of trends about serious incidents, and conduct public reporting on the operation of a SIRS
- Supporting the sector in incident management, such as through:
  - Providing guidance and education to build the capacity of providers to develop effective systems to prevent and respond to incidents
  - Providing feedback to the sector to promote understanding of reportable incidents and effective responses, and to support continuous improvement by providers in the quality and safety of care

[9] Specific requirements related to incident management systems are included under Division 3 of Part 4B of the *Quality of Care Principles 2014*

[10] Some of the Commission's responsibilities presented are covered under existing legislative arrangements, rather than those specific to the SIRS.

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- Refer information about an incident to another body, if appropriate, for example, but not limited to, the police or the Coroner.

3.1.5 Implementation of the SIRS for residential aged care

The SIRS for residential aged care is being rolled out in two stages. From 1 April 2021, residential aged care providers are required to report all 'Priority 1' incidents to the Commission within 24 hours of becoming aware of the incident. Then from 1 October 2021, residential aged care providers will also be required to report all 'Priority 2' incidents to the Commission within 30 days of becoming aware of the incident.

The implementation of the SIRS for residential aged care has been supported by communications, online learning modules available in ALIS[11], a webinar series and a range of guidance materials and other resources accessible via the Commission's website (e.g. fact sheets, frequently asked questions, guidelines and posters) for providers to help them prepare for and implement the scheme.

3.2 Other quality and safeguarding mechanisms

The SIRS sits alongside a broader range of quality and safeguarding mechanisms, both within and external to the aged care system, as detailed below.

3.2.1 Requirements for aged care providers in relation to serious incidents

While the existing SIRS for residential aged care does not apply to home and community aged care settings, the SIRS sits alongside, and complements, other requirements that all aged care providers, including home and community care providers, must meet.

All providers must comply with the Aged Care Quality Standards which detail the standards of care a person can expect as an aged care consumer. For example:

- Standard 8: Organisational governance – requires approved providers to have in place effective risk management systems and practices that enable them (among other things) to manage high-impact risks associated with the care of consumers, to identify and respond to abuse and neglect of consumers and to manage and prevent incidents, including through the use of an incident management system. Standard 6: Feedback and complaints – requires approved providers to demonstrate that an open disclosure process is used when things go wrong in providing care for consumers.

A provider is also legally required to help consumers understand their rights under the Charter of Aged Care Rights.

3.2.2 Broader quality and safeguarding mechanisms within the aged care system

In addition to the SIRS, there are a range of other quality and safeguarding mechanisms in place within the aged care system which seek to prevent and respond to incidents. These are presented in the diagram below. Mechanisms are categorised against whether they are focused on preventing, detecting or responding to incidents, noting that actions and responses taken across all mechanisms, including continuous improvement actions taken in response to learnings from each stage, contribute to the prevention of incidents generally.

[11] ALIS is the Commission's online Learning Management System.

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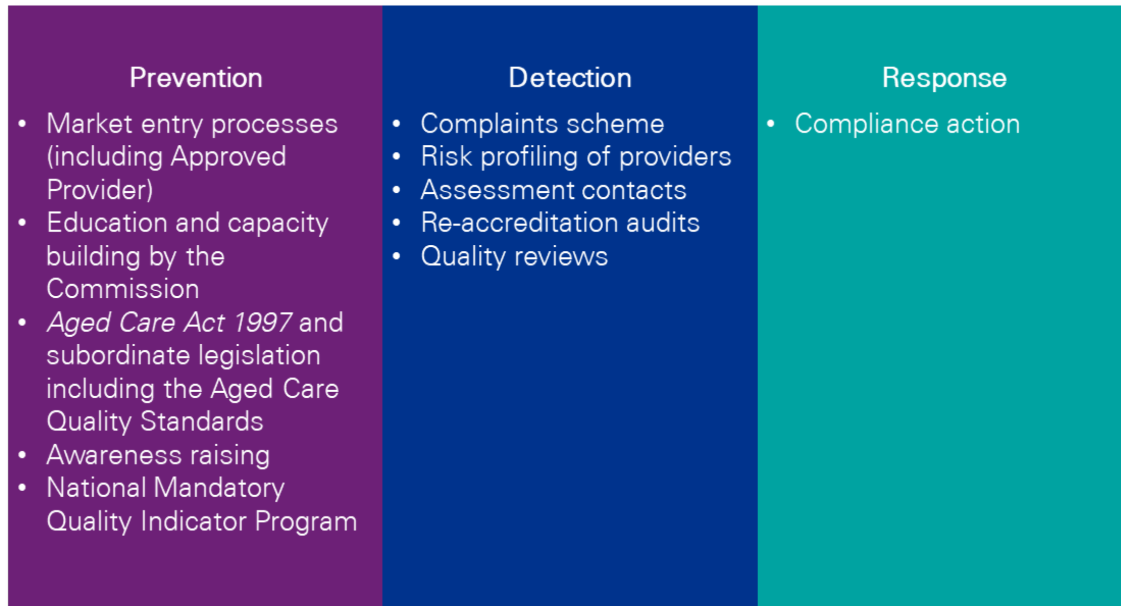
Figure 1: Broader quality and safeguarding mechanisms within the aged care system



Source: KPMG

Table 1 provides a description of each mechanism and how they contribute to prevention, detection and response to incidents.

Table 1: How each quality and safeguarding mechanism contributes to the prevention, detection and response to incidents

Mechanism	Description	How it contributes to the prevention, detection and response to incidents
Market entry processes (including Approved Provider)	Prior to becoming a provider of Commonwealth-funded aged care, organisations must submit an application to the Commission to determine their eligibility to be an approved provider of aged care[12]. Providers that deliver care under a Commonwealth grant agreement[13] must also meet requirements when applying for grant funding.	Market entry processes ensure that only organisations that are suitably qualified and equipped to deliver quality and safe aged care, including that those that are able to effectively identify, respond to and manage incidents, are able to enter the market.
Education and capacity building by the Commission	The Commission is responsible for providing information and education to aged care providers, consumers and their representatives and the public related to any of its functions, including incident	Education and capability building by the Commission, including in relation to incident management, contributes to improving the capacity of providers to prevent, respond to and manage

[12] Amongst other things, the Commission approves providers when the organisation: has satisfied certain matters set out in Part 7A of the Commission Act; understands an approved provider's responsibilities established by the Aged Care Act; and can deliver care that aligns with the associated Principles made under section 96-1 of the Aged Care Act.
[13] Funding under the CHSP and NATSIFACP is delivered through grants.

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Mechanism	Description	How it contributes to the prevention, detection and response to incidents
	management and delivering quality and safe care.	incidents, and thereby preventing future incidents from occurring.
Aged Care Act 1997 and subordinate legislation including the Aged Care Quality Standards	The *Aged Care Act 1997* and its subordinate legislation is the legislative framework that outlines the obligations and responsibilities of aged care providers and governs the delivery of Commonwealth-funded aged care.	The legislative framework for aged care seeks to protect and enhance the health and wellbeing of care recipients by specifying obligations and responsibilities of providers that ensure the provision of safe and quality care, including related to incident management.
Awareness raising	Both the Commission and the Department are responsible for providing information and raising awareness with the public about Commonwealth-funded aged care.	Awareness raising activity contributes to care recipients and families being more informed about the quality of care they can expect from the aged care system and being better equipped and empowered to identify and raise an issue when something has gone wrong with their care.
National Mandatory Quality Indicator Program (QI Program)	The QI Program collects quality indicator data from residential aged care services to provide an evidence base that can be used to improve the quality of services provided to care recipients.	The QI Program collects quality indicator data, including certain incident data, which supports aged care providers to measure, monitor, compare and improve the quality of their services. This contributes to the prevention of future incidents.
Complaints scheme	The Commission is responsible for dealing with complaints in relation to Commonwealth-funded aged care.	The complaints function of the Commission is another channel by which incidents can be detected and therefore incidents to be responded to by providers.
Risk profiling of providers	The Commission assesses an individual provider's risk through its history, characteristics and compliance performance to inform decisions on assessment and monitoring.	Risk profiling supports the Commission in its regulatory responsibilities by identifying risk within the aged care system and ensuring targeted support and action is taken to address issues related to the quality and safety of care at a provider level, including those which may contribute to increase risk of incidents occurring.
Assessment contacts, re-accreditation audits and quality reviews	The Commission conducts assessment contacts to monitor the quality of care and services delivered by aged care providers. The Commission also completes re-accreditation audits and quality reviews to assess the quality of	Quality assessments, re-accreditation audits and quality reviews are mechanisms by which the Commission can monitor and review the quality of services being delivered by providers to ensure issues and risks at a provider level are detected and responded to,

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Mechanism	Description	How it contributes to the prevention, detection and response to incidents
	care and services delivered by aged care providers.	including those related to identifying, response and management of incidents.
Compliance action	Where there is evidence during a performance assessment that the care and services provided in a service do not meet the Aged Care Quality Standards, the Commission may take action in relation to non-compliance.	Compliance action may be taken by the Commission to respond to and manage non-compliance with the Quality Standards. This action seeks to ensure a provider returns to compliance and addresses any risks to the safety, health and wellbeing of consumers, including risks which may increase the probability of an incident occurring.

Source: KPMG

3.2.3 Other safeguarding mechanisms for older Australians

There is an existing landscape of protections available in Australia to respond to Elder Abuse. These relate to both incidents that occur within the context of care delivery and broader incidents of abuse, including those by family members and other persons. Specific mechanisms include (but are not limited to):

- **Safeguarding agencies** have been introduced in some states and territories (such as the NSW Ageing and Disability Commission, and the Adult Safeguarding Unit in South Australia) to protect vulnerable adults from abuse, neglect or exploitation. These agencies make available channels for any person to report an allegation of abuse, neglect and exploitation of an adult, including an older person. They provide support and information, raise community awareness on the reduction and prevention of abuse, neglect and exploitation, report and advise government on related systemic issues and have powers to investigate matters.
- All states and territories have **Elder Abuse support services** (funded by government) which provide information and advice to any person in the community about elder abuse. Some of these units are embedded within the safeguarding agencies described above. **Advocacy organisations** such as the Older Persons Advocacy Network (OPAN) also seek to address issues of elder abuse and provide additional support through advocacy, information and education.
- While **Australian state and territory laws** have not enacted specific criminal offences related to the abuse of older persons, a range of types of conduct which might be described as elder abuse are covered in all jurisdictions under offence provisions relating to personal violence and property offences[14]. These include assault, sexual offences, kidnap and detain offences, and fraud and theft offences. Some jurisdictions have offences for neglect, although these are rarely utilised in respect of older Australians. There are also family violence frameworks in all jurisdictions that provide for quasi-criminal protective responses, which may be relevant for older Australians experiencing elder abuse in domestic settings[15]. The **Police** in each jurisdiction are responsible for responding to allegations which constitute a criminal offence. Some states and territories have also employed dedicated Elder Abuse Prevention Officers in the Police.

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

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- Each state and territory has a tribunal or board that appoints a **guardian or financial administrator** for a person with diminished decision-making ability. Guardians or financial administrators, as well as Powers of Attorney administrators, can support older Australians with diminished decision-making ability to make health and lifestyle decisions, or make decisions about financial affairs, which can act as a preventative mechanism to abuse and neglect of an older person by another person.
- The Australian Government has also committed $18.3m over four years to support the **delivery of front-line services** to older Australians experiencing elder abuse, such as specialist elder abuse units, health-justice partnerships and case management and mediation services[16].

3.3 Unique characteristics of home and community aged care

There are a range of unique characteristics associated with the delivery of aged care in the home and community which may influence the design or implementation of a SIRS. These characteristics are explored below.

3.3.1 The care recipient base of home and community aged care is larger and more diverse

Significantly more older Australians access aged care services. Nationally, over 1.3 million older Australians accessed aged care services during 2019-20. Approximately 77 per cent of these older Australians receive support in their home or in a community-based setting[17]. This is compared to 244,363[18] older Australians who received permanent residential aged care. This means a SIRS for home and community aged care would cover a larger care recipient base than the current SIRS in residential aged care.

Home and community aged care providers have a more diverse care recipient base than residential aged care providers. The proportion of care recipients who identify as being from an Aboriginal and Torres Strait Islander background is higher in home care, transition care and home support (two per cent) than residential aged care (one per cent). The proportion of care recipients born in countries other than mainly-English speaking countries (e.g. United Kingdom, Ireland, New Zealand, Canada, South Africa, and the United States) is also higher in home care, transition care and home support (22 per cent) than residential aged care (20 per cent)[19]. Care recipients from diverse backgrounds may require specialised supports to help them understand their rights and be empowered to report incidents. This may include access to language services in languages other than English and easy-to-understand English, as well as support to access specialist organisations that advocate for specific diverse needs groups.

[16] Council of Attorneys-General, *Protecting the Rights of Older Australians*, (Attorney-General's Department).
[17] Department of Health (2020), '2019-20 Report on the Operation of the *Aged Care Act 1997*', available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%E2%80%932020-accessible.pdf.
[18] Ibid.
[19] GEN Aged Care Data. Aged Care Data Snapshot 2020 Release 3.

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3.3.2 There are more providers of home and community aged care, with a larger proportion based in regional and remote areas

There are significantly more providers delivering home and community aged care (1,452 CHSP providers and 920 Home Care Package providers as at July 2020) compared to residential aged care (845 residential aged care providers as at July 2020). As such, the scale of implementation of a SIRS for home and community aged care may be larger and more complex than the implementation of a SIRS for residential aged care. Home and community aged care providers may also require significant support in adopting a SIRS as they may have limited experience with SIRS-type schemes (unless they have operated in residential aged care, where there has been a reporting scheme).

The proportion of providers based in regional and remote areas out of the total population of providers is also higher in home and community aged care (42 per cent) than in residential aged care (37 per cent)[20]. In implementing a SIRS for home and community aged care, there may be a need to consider how geographic distribution and providers operating in rural and remote areas can implement a scheme and participate in implementation activities such as training.

3.3.3 The service delivery environment of home and community aged care is less controlled

Providers have less control over the care environment within a home and community setting than they do when delivering residential aged care[21]. For example, providers have limited knowledge or control over:

- The nature / set-up of the home
- Other places the care recipient goes outside of the home
- Who visits the care recipient, when the visit occurs and the duration of the visit.

Multiple providers may also enter a home to deliver services. These conditions can act as a barrier to prevention, early identification and response to incidents. For example, it may be difficult to identify the person(s) who has committed an incident. This is because multiple people (e.g. staff members from different providers, including subcontractors) may have been in contact with a care recipient at any time, and the provider is not always present at the care recipient's home (since home and community care is episodic or may be one-off, as is the case of home maintenance). Without identifying the actual or alleged perpetrator, the provider may not be able to prevent that person(s) from doing further harm to a care recipient.

The uncontrolled service delivery environment may contribute to certain types of incidents occurring frequently. For example, research has found there has been increasing demand from informal caregivers (e.g. a family member) to use restraints in a home care setting as a 'safety measure'[22].

3.3.4 There is a higher frequency of service delivery without supervision

Home and community aged care staff are more likely to deliver care in a one-on-one format and independently of supervision from other staff or informal carers. In one-on-one situations, staff may be less inclined to report an incident that they are directly involved in or may expect that incidents are reported by care recipients, their family members or carers, or another support

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[20] GEN Aged Care Data. Aged Care Data Snapshot 2020 Release 3.
[21] Lang, A., Edwards, N. & Fleiszer, A. (2007). Safety in home care: a broadened perspective of patient safety. International Journal for Quality in Health Care 2008. 20(2), 130-135.
[22] Scheepmans, K., Dierckx de Casterle, B., Paquay, L., Van Gansbeke, H. & Milisen, K. (2020). Reducing physical restraints by older adults in home care: development of an evidence-based guideline. BMC Geriatrics, 20(169).

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worker. This is especially problematic if the care recipient does not speak English and is not provided with an opportunity to report the incident in the language that they speak.

The workforce may require more structured guidance and training to help them understand the importance of reporting and build their capacity to recognise incidents on their own. Care recipients and their family / carers may also require support to understand their rights, recognise incidents and raise complaints through notifying providers and using existing complaints channels. Further, a role may be played by community members and advocates to help with identifying and reporting incidents.

3.3.5 Home and community aged care providers have varying incident management capabilities

All providers consulted as part of the environmental scan have systems to identify and respond to incidents, however the systems used vary across providers. Newer and smaller providers reported using paper-based systems or having extensive manual processes. Larger providers and providers who deliver a more extensive service mix described more established, electronic incident management systems. This variance in incident management capability may act as a barrier for some home and community aged care providers to effectively adopt the SIRS.

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3.4 New evidence from the literature

KPMG examined schemes similar to the SIRS for residential aged care to inform the design and implementation of a SIRS for home and community aged care. The review sought to understand the operation and effectiveness of other similar schemes, and how their design components may be impacted by the home and community care context. A summary of the findings from the environmental scan is presented below.

3.4.1 Understanding 'SIRS-type' schemes

Reporting schemes exist across a variety of sectors. This review narrowed the types of reporting schemes examined to those that are similar to the SIRS for residential aged care (referred to hereafter as 'SIRS-type schemes'). SIRS-type schemes capture incidents related to the conduct of staff (generally covered by 'reportable conduct schemes' in ageing and human services systems) and incidents that are of a serious nature but may be related to provider systems, policies and processes (generally covered by 'incident management schemes' in the health system). SIRS-type schemes are therefore comparable to both reportable conduct schemes and incident management systems. The environmental scan explored SIRS-type schemes in aged care in the following jurisdictions: Australia, New Zealand, England, Scotland, Singapore, Canada, Denmark, and Norway. It also explored how schemes in other sectors in Australia have adapted their approach to the home and community care setting. This included exploration of the National Disability Insurance Scheme (NDIS) and Out of Home Care.

3.4.2 SIRS-type schemes exist in aged care internationally

The environmental scan found examples of SIRS-type schemes that cover both residential and home and community aged care settings internationally. In most jurisdictions, a SIRS-type scheme is in place for aged care services delivered in a residential setting. Some schemes cover government-funded services in more than one sector, for example aged care, disability and health such as in New Zealand and England. No evidence was found of schemes specifically dedicated for the home and community care setting.

However, examples were found of SIRS-type schemes that cover both residential and the home and community care context, and that cover a similar scope of incidents such as in England and Scotland. Legislation in England for example specifies, in a similar manner to the SIRS for residential aged care, that reportable incidents are 'those that occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity'[23]. Like the SIRS for residential aged care, these schemes provide structure around notification and reporting, with requirements for providers to report an incident to a designated regulator within a specific timeframe. However, they do not appear to adapt the design elements of the scheme for the home and community care setting.

Not all jurisdictions appear to have a SIRS-type scheme in aged care (such as in Denmark, Singapore or Norway). In the absence of a SIRS-type scheme in these jurisdictions, there appears to be an increased focus on community involvement in making reports and complaints about aged care services as a safeguarding mechanism to protect the wellbeing of older Australians receiving care. In jurisdictions without a SIRS-type scheme, care recipient complaints mechanisms and / or adult protective mechanisms are made available for the reporting of a broad range of matters.

[23] Regulation 18: Notification of other incidents | Care Quality Commission (cqc.org.uk)

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Several jurisdictions, both those with a SIRS-type scheme and those without, have introduced regulatory requirements to identify, report and respond to incidents.

Despite there being SIRS-type schemes identified internationally, there remains limited evidence surrounding the effectiveness of SIRS-type schemes in aged care in general. This may be due to the limited number of reviews examining the quality and safety aspects of SIRS-type schemes, including schemes that involve home and community care. In addition, there have been recent changes to SIRS-type schemes, which have not yet been reviewed.

3.4.3 SIRS-type schemes in other sectors

While no specific adaptations appear to be made, different schemes have recognised similar challenges to those faced in home and community aged care. The challenges include the varying maturity of providers, the unsupervised nature of service delivery and possible under-reporting of incidents. Different measures are used across sectors to respond to these challenges, including:

- The regulator plays an active role in capacity building of providers. For example, the New South Wales (NSW) Office of the Children's Guardian has an enquiry line for providers to ask questions about the scheme, and training and resources on responding to reportable allegations.
- The regulator provides detailed guidance and fact sheets on how to identify, report and respond to incidents. For example, the NDIS Commission has published an Incident Management System Guidance to support registered NDIS providers to develop or improve their incident management systems. The Victorian Commission for Children and Young People has published a range of resources and support materials on various aspects of the scheme.
- The regulator makes available materials for care recipients to understand the scheme and how to engage with the scheme. For example, the NDIS Commission has published a fact sheet (in English and other languages) for NDIS participants and what they can expect of providers in responding to incidents.
- Additional measures are introduced for an independent organisation or a person to 'visit' the home and check on residents. For example, the NSW Official Community Visitors Scheme has a role in reporting matters that affect children and young people in out-of-home care, including incidents of abuse and neglect. However, it is important to note that out-of-home care providers are not subject to unannounced visits by the regulator.

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4 Prevalence Study for a SIRS

This section provides an overview of the Prevalence Study and its key findings. The detailed analysis of findings from the Prevalence Study can be found at Appendix A.

4.1 About the Prevalence Study

The Prevalence Study was undertaken over a six-month period from 1 November 2020 to 30 April 2021 on the prevalence of serious incidents in home and community aged care settings. The purpose of the Prevalence Study was to understand the volume and nature of serious incidents that occur in home and community aged care, and that may be reportable under a SIRS for home and community aged care. As such, data was captured at a provider level. The scope of home and community aged care for the Prevalence Study aligns to the scope as defined in the broader project and includes CHSP, HCP and Flexible Care delivered in home and community settings. Flexible Care is inclusive of STRC, MPS, TCP and NATSIFACP where they are delivered in home and community settings.

The Prevalence Study included serious incidents that have either occurred:

- Between a staff member and a care recipient / family member where the incident is committed by a staff member, or
- Between care recipients in community settings where the incident is committed by one of the care recipients.

The Prevalence Study defined 'community setting' as a location outside a person's home where two or more care recipients receive a service together, such as group activities (e.g. transport or social support groups), day centres or respite.

Data was captured on a range of types of serious incidents defined in consultation with the Department and the Commission:

- Unreasonable use of force
- Unlawful or inappropriate sexual contact[24]
- Psychological or emotional abuse
- Unexpected death
- Stealing or coercion[25]
- Neglect (committed by a staff member)
- Inappropriate physical or chemical restraint (committed by a staff member).

[24] The wording of this reportable incident type differs to the definition included under the SIRS for residential aged care as legislative amendments for the SIRS for residential aged care were still being drafted when the terms of the study were agreed.
[25] The definition of this incident type under the Prevalence Study was limited to incidents committed by a staff member.

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4.1.1 Data collection in the Prevalence Study

Data collection was completed by a sample of home and community aged care providers who voluntarily registered for the study in response to sector-wide communications or direct invitations. This study was advertised through aged care sector announcements, the aged care sector newsletter ('Information for the Aged Care Sector'), and an email to the Aged Care Sector Committee. Some providers were also directly approached and invited to participate, including through invitations distributed by the Department's Flexible Care Program Team to Flexible Care providers.

It is important to note that information collected under the Prevalence Study was not used for any other purpose than for this project. Incidents captured under the Prevalence Study were not referred to the Commission or to the police as part of the study. KPMG did not collect specific or identifying details about the incidents that occurred. Providers were advised of this prior to registering in order to encourage participation in the study.

4.1.2 Sample and study limitations of the Prevalence Study

The findings from the Prevalence Study should be considered in light of sample and study limitations, as follows:

- **Non-random sample** – The sample of home and community aged care providers that participated in the study was not randomly selected. Therefore, the Prevalence Study cannot specify the degree of statistical confidence over how representative the sample is of the broader population.
- **Data submission tool** – Participating providers were asked to submit data on serious incidents that occurred at their organisation between 1 November 2020 and 30 April 2021. Participating providers were asked to make selections from predetermined lists to indicate the 'type' of serious incident that occurred, the 'impact' of the incident and their 'response(s)' to the incident. Items on the lists were not exhaustive. For example, the response types available for selection were focused on actions involving the victim as opposed to continuous improvement related actions that may involve staff members. Some participating providers provided feedback that they had indicated "none" as the response type because their actual action taken (e.g. training) did not align with any other 'response' descriptions available for selection. Therefore, a "none" response (as indicated in the data submission) may not necessarily equate to no action taken.
- **Representativeness of the sample** – The representativeness of the sample of participating providers varied based on different characteristics. The sample was more representative by jurisdiction than it was by program or remoteness category. Over- or under-representation may bias sample results and must be considered when interpreting the study's findings.
- **Loss to follow up** – Providers were asked to submit data in two tranches, with the first tranche corresponding to the first three months and the second tranche corresponding to the last three months of the study period. One hundred and sixty-nine providers submitted data for the first tranche. Of these, 151 submitted data for the second tranche, equivalent to a loss to follow up rate of 11 per cent (18 providers). Of the 18 providers lost to follow up, two providers reported at least one incident between a staff member and care recipient / family member for a total of seven incidents between these two providers. None of the providers that were lost to follow up reported incidents between care recipients. Given that the providers lost to follow up did not provide six months-worth of incident data, they were excluded from the sample analysed.
- **Additional providers** – There were an additional 10 providers who submitted data in the second tranche that did not submit data in the first tranche. Of these, only one provider

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reported any incidents. This provider reported two incidents but did not include the date of either incident. Given that this subset of 'additional providers' did not provide six months-worth of incident data and the magnitude of not including this small subset of providers would be minimal, they were excluded from the sample analysed.

- **Alignment of the Prevalence Study scope to options presented in this report**: While the Prevalence Study offers some insights into the volume and nature of incidents that may occur in home and community aged care, the scope of the data collection does not directly align to any of the four options proposed in this report.

4.2 Nature of serious incidents in the Prevalence Study

KPMG analysed the serious incident data submitted by participating providers from 1 November 2020 to 30 April 2021 to understand the nature of serious incidents in home and community aged care settings. This study considered how representative the sample was by:

1. *Comparing the relative proportions.* This was determined by stratifying providers according to key characteristics (e.g. jurisdiction, remoteness, program type) and calculating the proportion of providers within each stratum. The strata across the sample population were then compared to the strata across the broader population of providers - e.g. comparing the proportion of providers in the sample that are CHSP providers with the proportion of providers in the broader population that are CHSP providers.
2. *Analysing participation rates.* This was determined by the rate of participation of providers in the study out of the total number of providers in the broader provider population by program, jurisdiction and remoteness category (e.g. this sample captured a certain percentage of all CHSP providers nationally).

A summary of the key findings is presented below.

4.2.1 Summary characteristics of participating approved providers

The study analysed key characteristics of providers who submitted data with respect to the programs they delivered, their jurisdiction and remoteness category.

Providers who participated in the study

- Of the 2,078 home and community aged care providers in Australia, 151 (seven per cent) participated in the study.
- The proportion of CHSP providers in the sample (76 per cent) was almost the same as the proportion of CHSP providers in the total provider population[26] (77 per cent). The proportion of Flexible Care providers in the sample (32 per cent) was slightly higher than its proportion in the

[26] A list of all providers in the home and community care setting was generated by integrating CHSP provider and non-CHSP services and provider datasets, removing duplicates and with some alterations and additions to match the information received by registered providers. A single home and community aged care provider may deliver more than one home and community aged care program. For example, many participating providers deliver and submitted data for both CHSP and HCP. For this reason, the percentages presented do not equal a total of 100 per cent.

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total provider population (19 per cent). The proportion of HCP providers in the sample (75 per cent) was relatively higher than its proportion in the total provider population (44 per cent).

- *CHSP:* A CHSP provider may deliver one or more of 17 CHSP service types. The majority of participating CHSP providers (85 of 115 (74 per cent)) deliver Domestic Assistance. It was least common for participating CHSP providers to deliver Assistance with Care and Housing, with only 16 (14 per cent) of the 115 participating CHSP providers delivering this CHSP service type. The CHSP service type with the highest rate of participation in this study was Cottage Respite with 29 (18 per cent) participating out of the total 163 Cottage Respite providers in the population.
- *HCP:* A HCP provider may deliver one or more HCP levels. All 113 participating HCP providers deliver all four levels of HCP. The participation rates of HCP providers in this study were similar across HCP levels, with 113 (averaging five per cent) HCP providers participating out of approximately 2,276 HCP providers in the population at each HCP level.
- *Flexible Care:* Of the 49 participating Flexible Care providers, 26 (53 per cent) deliver TCP, 20 (41 per cent) deliver STRC, and a small number at three (6 per cent), deliver NATSIACP. None (0 per cent) of the participating Flexible Care providers deliver MPS. Providers of STRC, MPS, NATSIACP and TCP varied significantly in their rate of participation in this study, ranging from none (0 per cent) participating out of 179 MPS providers in the population, to 26 (32 per cent) participating out of the 81 TCP providers in the population.

Participating providers by jurisdiction

- The proportions of providers by jurisdiction in the sample were relatively similar to the proportions of providers by jurisdiction in the broader provider population by jurisdiction. No greater than five per cent difference was recorded between the proportions of providers by jurisdiction in the sample and the corresponding proportions of providers by jurisdiction in the broader population.
- There was some variation in the participation rates of providers by jurisdiction. The participation rates ranged from six per cent of providers in Queensland participating, to 12 per cent of providers in Tasmania participating.

Participating providers by remoteness

- The proportions of providers in Remote and Very Remote remoteness categories were relatively similar to their respective proportions in the broader provider population by remoteness category. In the sample, two per cent of providers were from Very Remote Australia, nationally, three per cent were based in Very Remote Australia. Similarly, in the sample, two per cent of providers were from Remote Australia, nationally, three per cent were based in Remote Australia.
- The proportion of providers from Inner Regional and Outer Regional Australia were somewhat similar to their respective proportions in the broader provider population by remoteness category. In the sample, five per cent of providers were from Outer Regional Australia, nationally, 12 per cent were based in Outer Regional Australia. Similarly, in the sample, 19 per cent of providers were from Inner Regional Australia, nationally, 24 per cent were based in Remote Australia.
- However, for providers in Major Cities, a 14 per cent difference was recorded between the proportions of providers by remoteness categories in the sample and the corresponding proportions of providers by remoteness categories in the broader national population. In the sample, 72 per cent of providers were from Major Cities, nationally, and 58 per cent were based in Major Cities of Australia.

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- There was some variation in the participation rates of providers by remoteness categories. The participation rates ranged from three per cent of providers in Outer Regional Australia and four per cent of providers in Very Remote Australia participating, to nine per cent of providers in Major Cities participating.

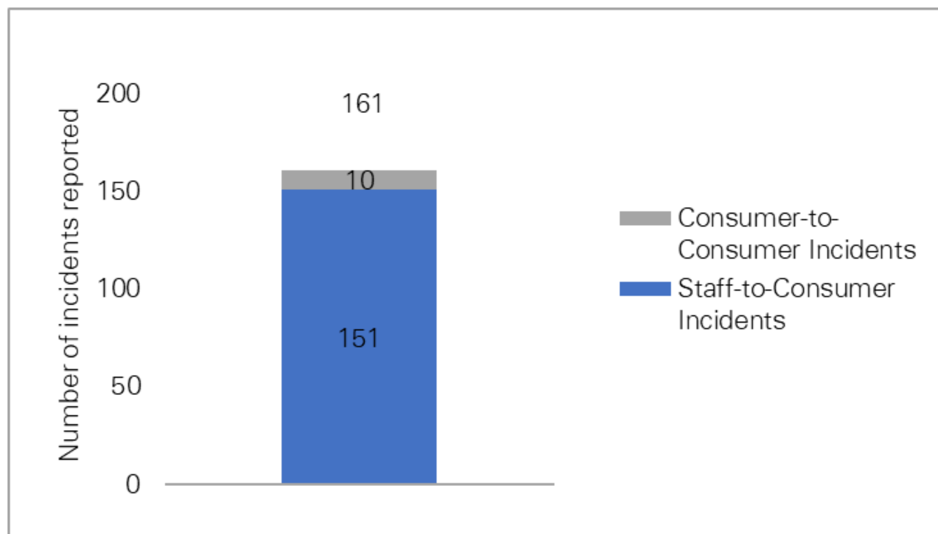
Summary descriptive analysis of serious incident data

The study analysed serious incident data including trends over the six months, the types of incidents reported, the impact of incidents on care recipients and the actions providers took in response to incidents.

Serious incidents reported by participating providers

- A total of 161 serious incidents were reported. Of that, nearly all were perpetrated by a staff member to a care recipient or their carer / family member, representing 151 of 161 (94 per cent) serious incidents as demonstrated in Figure 2 below.

Figure 2: Count of serious incidents reported by participating providers by perpetrator type



Source: KPMG analysis of Prevalence Study data

- The majority of participating providers, 118 of 151 (78 per cent), reported zero incidents in the study period. Twelve participating providers reported they had one incident and of the 21 participating providers who reported more than one serious incident, eight (38 per cent) reported more than five incidents. This distribution is demonstrated in Figure 3 below.

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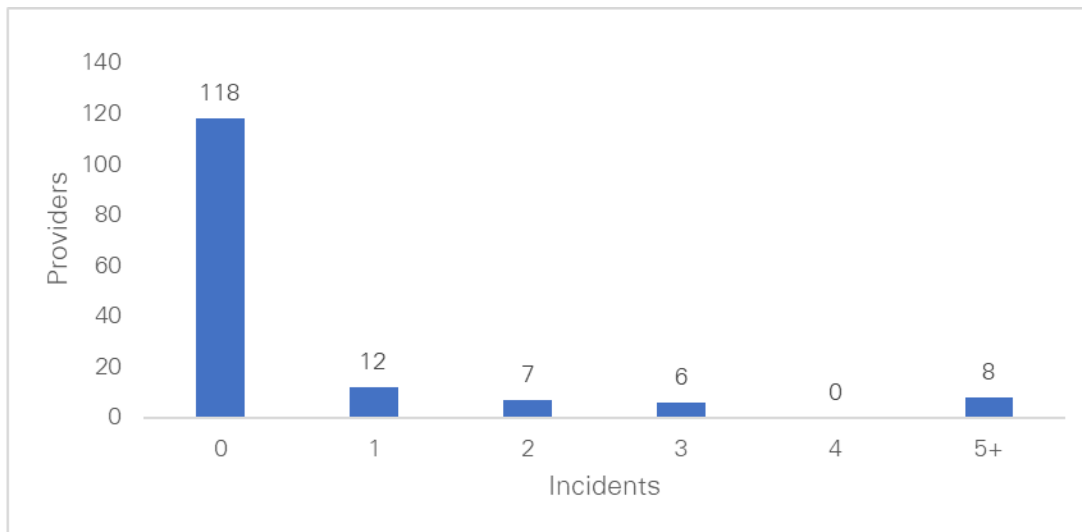
Figure 3: Count of providers who reported an incident by the number of incidents reported



Source: KPMG analysis of Prevalence Study data

- Eight out of the 151 providers (five per cent) reported five or more incidents. These providers reported 117 (73 per cent) of the 161 serious incidents. Of these providers:
  - One provider reported five incidents – all staff-to-care recipient incidents
  - One provider reported seven incidents – all staff-to-care recipient incidents
  - One provider reported seven incidents – six staff-to-care recipient incidents and one care recipient-to-care recipient incident
  - One provider reported nine incidents – seven staff-to-care recipient incidents and two care recipient-to-care recipient incidents
  - One provider reported 11 incidents – all staff-to-care recipient incidents
  - One provider reported 17 incidents – 14 staff-to-care recipient incidents and three care recipient-to-care recipient incidents
  - One provider reported 26 incidents – all staff-to-care recipient incidents
  - One provider reported 35 incidents – all staff-to-care recipient incidents.

Reported incidents involving the same perpetrator

- Of the 151 participating providers, 33 providers reported staff-to-care recipient incidents (22 per cent). Of these 33 providers,19 providers reported more than one staff-to-care recipient incident. Of these, 14 provided data on whether the same staff member was involved in more than one staff-to-care recipient incident. Of these 14 providers, three indicated that the same staff member was involved across their multiple incidents in the first reporting period and two indicated that the same staff member was involved across their multiple incidents in the second reporting period. However, the three providers that indicated the same perpetrator was involved during the first reporting period were different to the two providers that indicated the same perpetrator was involved during the second reporting period. This is demonstrated in Table 2 below.

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Table 2: Count of incidents reported by providers with more than one staff-to-care recipient incidents

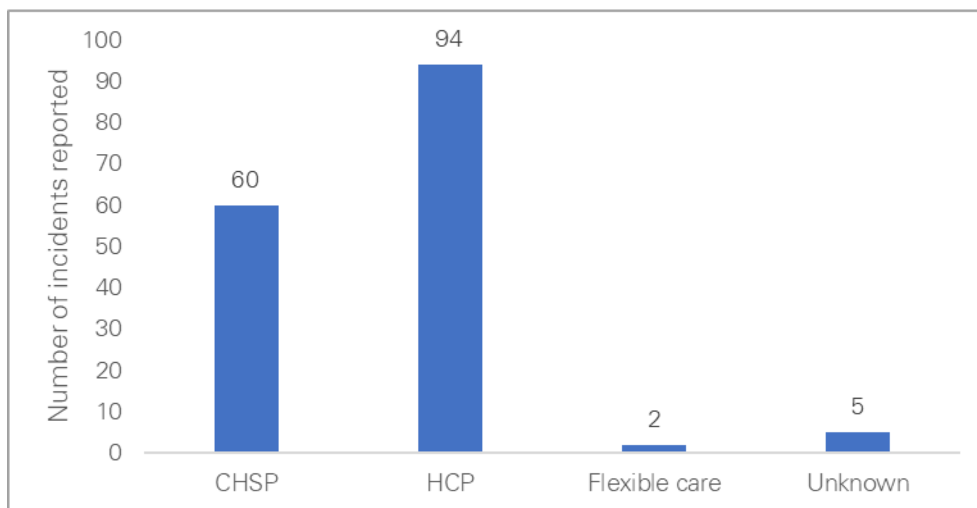
Provider type	Number of providers	Number of incidents reported
Providers reporting more than one staff-to-care recipient incident	19	137
Providers reporting more than one staff-to-care recipient incident that **provided information** on whether the same perpetrator was involved	14	127
Providers reporting more than one staff-to-care recipient incident **where they reported that the same perpetrator was involved during the first reporting period**	3	33
Providers reporting more than one staff-to-care recipient incident **where they reported that the same perpetrator was involved during the second reporting period**	2	19

Source: KPMG analysis of Prevalence Study data

Reported incidents by program

- The program where the highest number of serious incidents were reported was HCP, which made up 94 (58 per cent) of the total 161 reported serious incidents. CHSP recorded 60 incidents (37 per cent) of the total 161 incidents. The program where the lowest number of serious incidents was reported was Flexible Care, which made up two (one per cent) of the 161 reported serious incidents. This is demonstrated in Figure 4 below.

Figure 4: Count of serious incidents (by program) reported by participating providers[27]



Source: KPMG analysis of Prevalence Study data

- Put another way, given there were 113 participating HCP providers and 94 serious incidents in HCP, this is the equivalent to 0.83 incidents per HCP provider over the study period. Given there were 115 participating CHSP providers and 60 serious incidents in CHSP, this is the equivalent of 0.52 incidents per CHSP provider over the study period. Given there were

[27]For five incidents, respondents did not provide information on the program type, hence were designated as 'unknown'.

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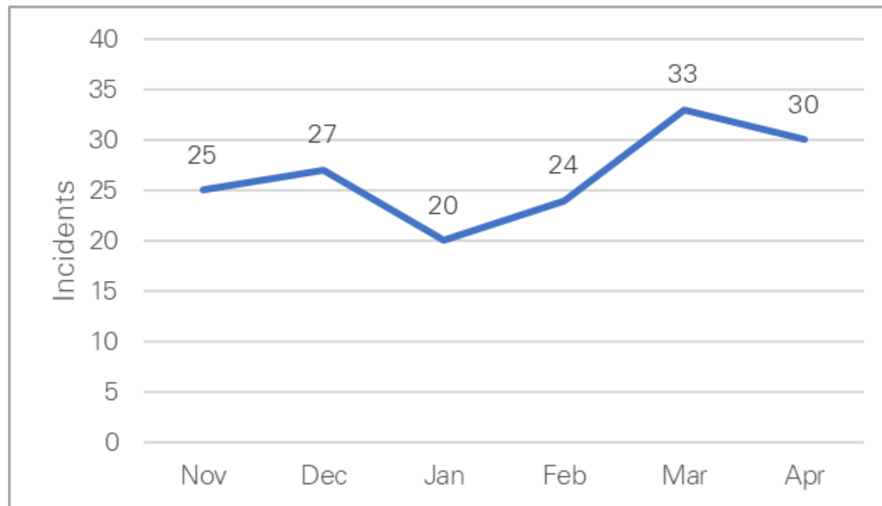
49 participating Flexible Care providers and two serious incidents in Flexible Care, this is the equivalent of 0.04 serious incidents per Flexible Care provider over the study period.

Reported incidents by month

- The total number of serious incidents reported by participating providers was relatively consistent over the six-month period, averaging 27 serious incidents reported per month as show in Figure 5 below.

Figure 5: Count of total serious incidents reported (by month) by participating providers[28]



Source: KPMG analysis of Prevalence Study data

Reported incidents by incident type

- A list of incident types was presented to participating providers, who were asked to select only one of seven incident types from the list that was perceived to most closely reflect the nature of each serious incident they reported. The incident types available for selection were "neglect", "inappropriate physical or chemical restraint", "stealing of coercion", "unexpected death", "psychological or emotional abuse", "unlawful or inappropriate sexual contact" and "unreasonable use of force".
- Of the 161 reported serious incidents, a large number involved stealing or coercion (69, or 43 per cent), or neglect (50, or 31 per cent). The remaining 42 reported serious incidents were comprised of unreasonable use of force (14, or nine per cent), psychological or emotional abuse (10, or six per cent), unexpected death (nine, or six per cent) and unlawful or inappropriate sexual contact (eight, or five per cent). Please note one respondent did not record a serious incident type. None (zero per cent) of the reported incidents involved inappropriate physical or chemical restraint. This is demonstrated in Figure 6 below.[29]

[28] N=159 because one respondent recorded that a serious incident occurred in December 2021 and one respondent did not provide a date

[29] N=160 because one respondent did not record a serious incident type

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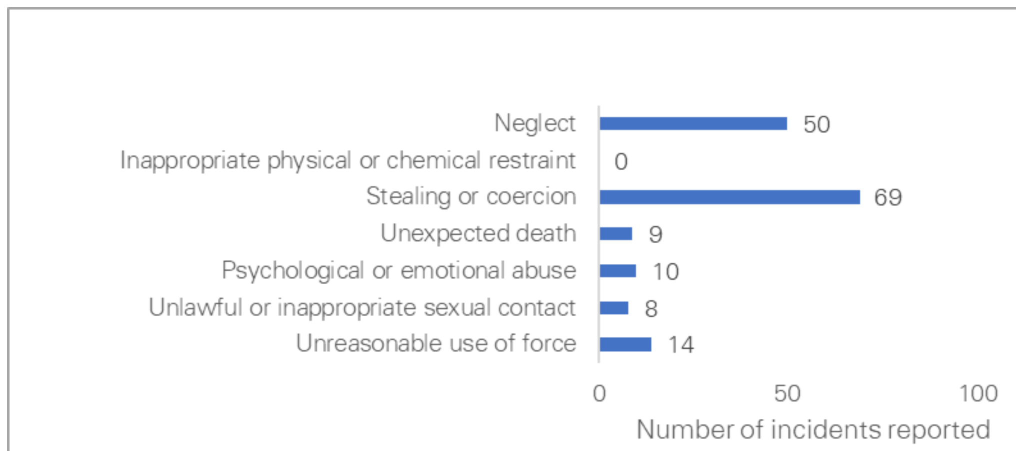
Figure 6: Count of total serious incidents (by types) reported by participating providers[30]



Source: KPMG analysis of Prevalence Study data

Reported incidents by impact type

- A list of impact types was presented to participating providers, who were asked to select only one of six impact types from the list that was perceived to most closely reflect the nature of each serious incident they reported. The impact types available for selection were "fatality or 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", "minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions" and "no impact". We note that one incident did not record the impact type.
- Around half of all reported incidents, 80 of 161 (50 per cent), were perceived to have no impact on the victim. Sixty six of the 161 incidents (41 per cent) were reported to result in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions.
- Three incidents (two per cent) resulted in physical or psychological injury or illness requiring onsite medical or psychological treatment and four (two per cent) resulted in physical or psychological injury or illness requiring a hospital admission (but not permanent).
- One (one per cent) resulted in permanent physical or psychological impairment and six (four per cent) in fatality or severe permanent physical or psychological impairment. One incident did not have the impact reported. It was noted that there is some disconnect between the number of incidents that were reported for unexpected death (9), and the number that providers reported to be associated with permanent physical and psychological impairment (1). The overall incident types are presented in Figure 7 below.[31]

[30] N=160 because one respondent did not record a serious incident type
[31] N=160 because one respondent did not record a serious incident impact

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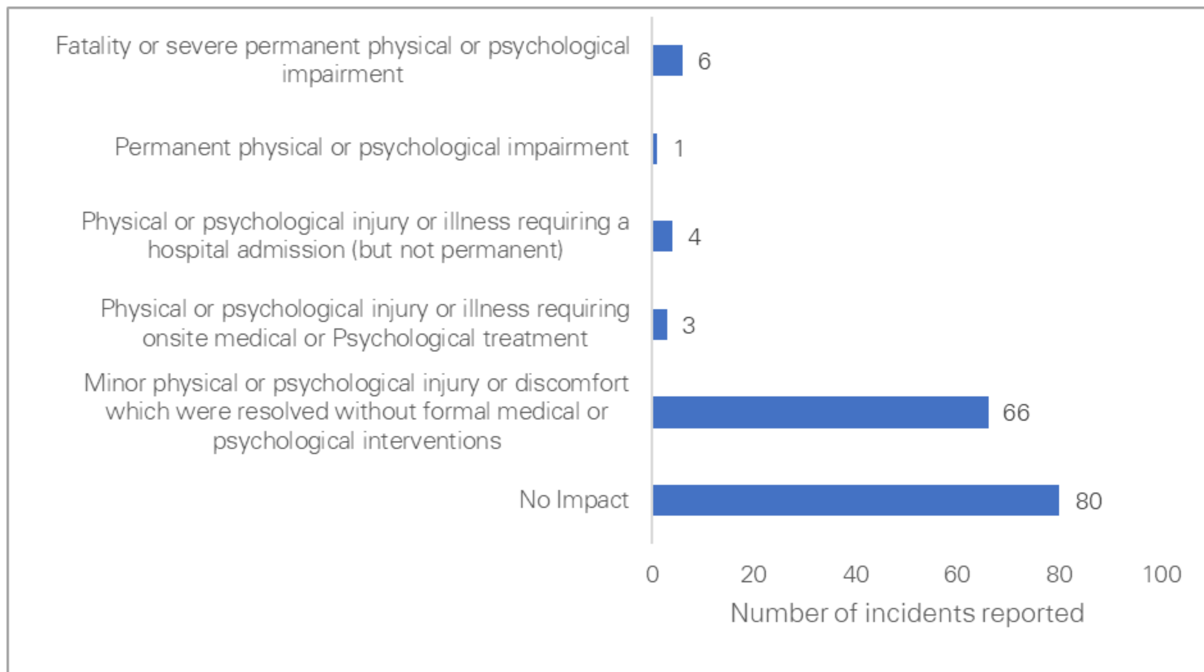
Figure 7: Count of serious incidents (by impact) reported by participating providers[32]



Source: KPMG analysis of Prevalence Study data

Reported incidents by response type

- A list of response types was presented to participating providers, who were asked to select all response types from the list that reflected the actual action(s) taken in response to a serious incident they reported. The response types available for selection were "hospital admission for the victim", "onsite medical treatment provided to the victim", "referral made to a general practitioner (GP) (or other health professional)", "report made to the police", "update made to the victim's care plan", "referral made to the Dementia Behaviour Management Advisory service" and "none". Providers were able to select more than one response per incident. Hence, there were 175 counts for responses recorded across the 161 incidents.
- The "none" category of response was the most common type of response reported by participating providers. Eighty serious incidents (50 per cent) resulted in no response. A small amount of unsolicited feedback, documented from two providers, suggested that potentially, there may be some instances where providers selected "none" as their response type even though they had taken some form of action. This may have occurred, for example, if the provider perceived that their actual action taken did not to align with the response types available for selection.
- Sixty-eight serious incidents resulted in only one action being taken. No serious incident resulted in five or more actions being taken. The number of actions taken in response to serious incidents is summarised in Table 3 below.

[32] N=160 because one respondent did not record a serious incident impact

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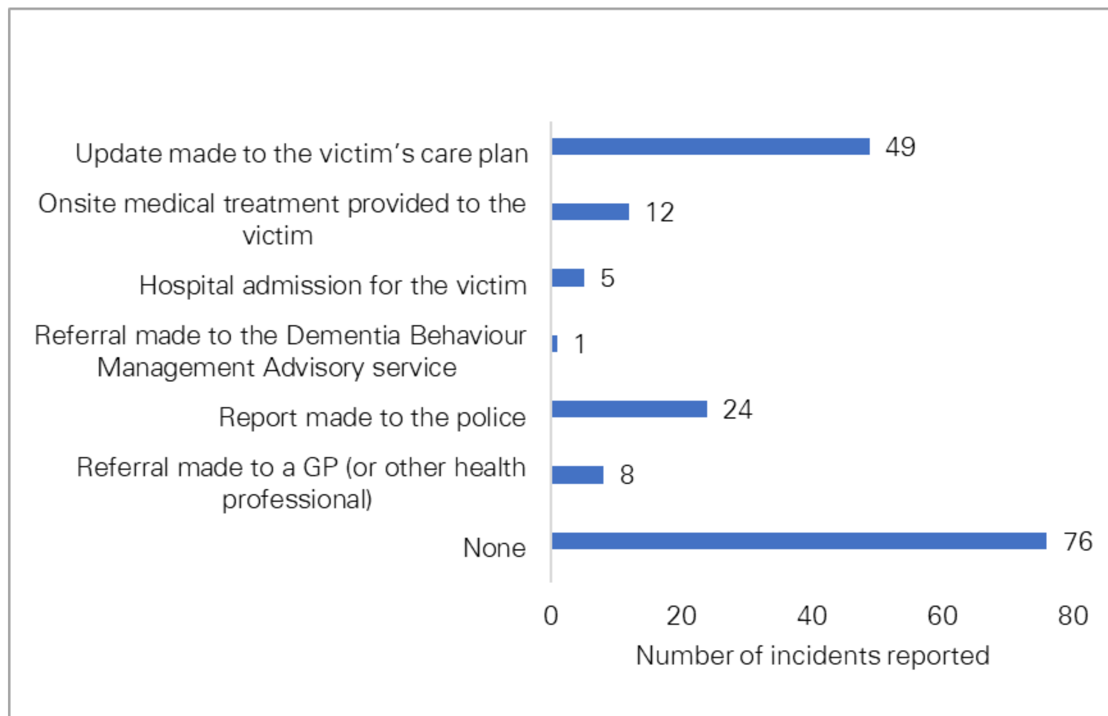
Table 3: Count of response to reported serious incidents (by number of actions)

Number of responses to a reported serious incident	Number of reported serious incidents	Percentage of total reported serious incidents
No response	80	50%
One action	68	42%
Two actions	9	6%
Three actions	3	2%
Four actions	1	1%
Five or more actions	0	0%
Total	**161**	**100%**

Source: KPMG analysis of Prevalence Study data

- When action was taken, an update made to the victim's care plan was the most common type of action taken, comprising 49 counts of responses (28 per cent). There were 24 counts (14 per cent) of reports made to police – of these 24, 19 were in response to incidents of stealing or coercion. The 175 counts for responses recorded across the 161 incidents are summarised in Figure 8 below.

Figure 8: Count of serious incidents (by response) by participating providers



Source: KPMG analysis of Prevalence Study data

Impact and response to different types of reported incidents

- *Incidents involving stealing or coercion:* Of the 69 incidents of stealing or coercion, 37 (54 per cent) resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions, the remaining 32 incidents (46 per cent)

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reported no impact on care recipients. While the most common response to stealing or coercion was no action (33 per cent), 26 per cent of responses to stealing or coercion involved making a report to the police and 24 per cent involved updating the victim's care plan.

- *Neglect:* Of the 50 incidents of neglect, 35 (70 per cent) reported no impact while 13 (26 per cent) reported minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions. The remaining two incidents were reported to result in physical or psychological injury or illness that was neither permanent nor fatal. The most common response to incidents of neglect was no action (64 per cent), but 22 per cent of responses involved updating the victim's care plan.
- *Unreasonable use of force:* Of the 14 incidents involving unreasonable use of force, six (43 per cent) were care recipient-to-care recipient incidents. Put another way, six of the 10 care recipient-to-care recipient incidents (60 per cent) related to unreasonable use of force. The most common response to incidents of unreasonable use of force was to update the victim's care plan (56 per cent).
- *Psychological and emotional abuse:* Of the 10 incidents of psychological and emotional abuse, nine resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions, and one resulted in physical or psychological injury or illness requiring onsite medical or psychological treatment.
- *Incidents involving unexpected death:* Of the 161 reported incidents, nine were reported as unexpected deaths (six per cent). Among these nine incidents involving unexpected deaths, the most common reported response was onsite medical treatment provided to the victim.
- *Incidents involving unlawful or inappropriate sexual contact:* Reported serious incidents involving unlawful or inappropriate sexual contact were most commonly perceived either to have no impact to the victim (three incidents, 38 per cent) or to have resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions (three incidents, 38 per cent). The most common response was to either update the victim's care plan (31 per cent of actions taken), make a referral to a GP or other health professional (23 per cent) or make a report to police (15 per cent).

4.3 National estimates of incidents

Data was received from a sample of services. One of the main objectives of the study was to estimate the prevalence of serious incidents in home and community aged care settings over a six-month period. To estimate (or model) the prevalence of serious incidents at a national level "weighting" the sample estimates was required, i.e. to use the incident data from the 151 providers surveyed to estimate how many incidents occur in all 2,078 providers.

Four methods were used to weight the data and calculate national level estimates. All four were based on the linear, unbiased estimator described in Appendix B. The four methods are briefly described below.

- Method One simply assumes that all participating providers have equal weight, i.e. no adjustments are made for any characteristic of the provider. In this method, all participating providers have equal weight. The weight is calculated by dividing the population of providers by the participating providers (2,078 providers in the population / 151 in the sample = 13.76). This means each incident reported within the sample represents 13.76 incidents at a population level.

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- Method Two weights the services by program type. The estimator is determined based on program (CHSP, HCP or Flexible Care). It assumes, for example, that CHSP providers in the sample are likely to have a similar number of incidents as CHSP providers in the population. The weight accounts for the representation of each program within the sample and adjusts for the representation of these service type nationally.
- Method Three repeats Method Two, but the estimator is determined based on jurisdiction.
- Method Four repeats Method Two, but the estimator is determined based on remoteness category.

The total number of estimated serious incidents across home and community care at a national level (i.e. all 2,078 service providers) over 12 months is outlined in Table 4. The figures shown underneath each estimate is one standard error either side of the estimated mean.

Table 4: National estimates of serious incidents in home and community care

Method	Population estimate of serious incidents each year
1. Assume all providers in the sample have equal weight	4,395 (3,093 to 5,697)
2. Stratify by program	2,931 (1,325 to 4,537)
3. Stratify by jurisdiction	4,729 (3,298 to 6,161)
4. Stratify by remoteness	4,488 (3,257 to 5,720)

Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

At a national level, there may be thousands of serious incidents, as demonstrated in the table above. However, we note there is a range of estimates possible for the national estimate, and a wider range when allowing for the estimation uncertainty inherent in generalising results from a small sample of providers over a limited time period to a broader national population. We also note that serious incident data may have been impacted due to COVID-19, particularly for jurisdictions or providers managing COVID-19 outbreaks – that is, the data was collected over a period that may not represent a 'standard' six-month period of data collection.

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5 Statement of options

Four options for a SIRS for home and community care have been developed. In developing the options, the following key areas of a SIRS were considered for each option:

- The definition of a reportable incident, including the types of incidents that should be reported
- Timing of when incidents should be reported
- Associated provider responsibilities
- The role of the Commission.

These options have been framed by their similarity or difference to the existing scheme (i.e. SIRS for residential care). This framing was chosen because co-design with stakeholders highlighted the need to reduce complexity wherever possible in the design of a SIRS for home and community aged care, and stakeholders demonstrated a desire to align a potential future SIRS with existing schemes where possible (e.g. SIRS for residential care or the NDIS reportable incidents).

The four options developed are outlined in Figure 9 below and discussed in further detail in the following sub-sections.

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Figure 9: Options for a SIRS for home and community aged care

Option 1

No change to the current arrangements – no SIRS will be implemented for home and community aged care (noting, the Australian Government committed to implementing the Serious Incident Response Scheme in Home and Community Care from 1 July 2022 as part of the 2021-22 Budget).

Option 2

The SIRS for residential aged care will be implemented within the home and community setting, adapted to suit the home care environment. This includes two sub-options for the timing of reports about serious incidents:

- **Option 2a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.
- **Option 2b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours).

Option 3

The SIRS for residential aged care will be implemented within the home and community setting, adapted to suit the home care environment. However, incidents associated with low or no harm are not reported. One means of achieving this could be to only report incidents that meet the definition of a Priority 1 reportable incidents.

Option 4

The SIRS for residential aged care will be implemented within the home and community setting but with an expanded scope of incidents including differentiated responsibilities for providers and the Commission for certain incident types. The scope of serious incidents captured under this option would be expanded to include serious incidents that the provider becomes aware of during the course of supports or services being provided and that have occurred between a person and a care recipient within a relationship where there is an expectation of trust. As with Option 2, this includes two sub-options for the timing of reports about serious incidents:

- **Option 4a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.
- **Option 4b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours.

Source: KPMG

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5.2 Option 1: No change

Option 1 involves no change to the current arrangements. Option 1 means that no SIRS for home and community care will be introduced (noting, the Australian Government committed to implementing the Serious Incident Response Scheme in Home and Community Care from 1 July 2022 as part of the 2021-22 Budget).

5.2.1 What is a reportable incident?

Providers of aged care services in the home and community setting would not be required to report any incidents to the Commission. This would be a continuation of the current arrangements.

5.2.2 Timing of reporting

As there are no incidents that are reportable, there are no requirements about the timing of these reports.

5.2.3 Responsibilities of providers

Providers would not be required to report serious incidents to the Commission.

Providers would still be required to meet their existing obligations to manage incidents. These include, but are not limited to, their obligations set out in the Aged Care Quality Standards[33], such as Standard 8, which requires providers to have effective risk management systems and practice to:[34]

- Manage high impact or high prevalence risks associated with the care of care recipients
- Identify and respond to abuse and neglect of care recipients
- Manage and prevent incidents, including the use of an incident management system.

Role of the Commission

The Commission would have no additional role in relation to serious incidents in home and community aged care. However, the Commission would continue to monitor provider complaints against the Aged Care Quality Standards.

[33] The Aged Care Quality Standards are in legislation (Schedule 2 of the *Quality of Care Principles 2014*).
[34] *Aged Care Act 1997 (Cth)*

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5.3 Option 2: SIRS for residential aged care is implemented in the home and community care setting

Under Option 2, the SIRS for residential aged care will be implemented in the home and community care setting, adapted to suit the home and community care environment. A high level process map of how Option 2 may work in practice is presented in Figure 10.

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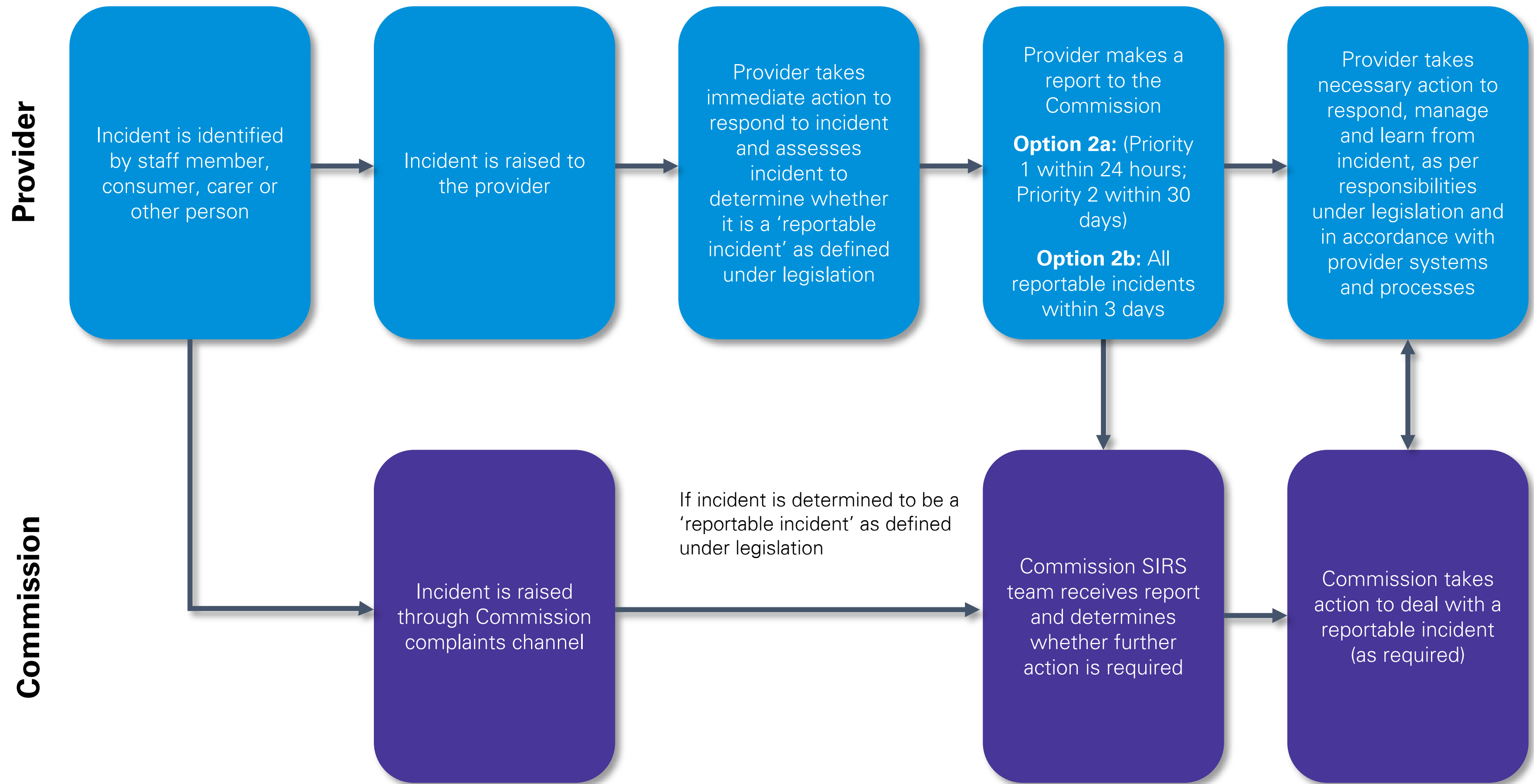
Figure 10: High-level process map for Option 2



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5.3.1 What is a reportable incident?

A reportable incident for Option 2 will be aligned to that in the existing scheme. This means that a reportable incident will be any of the following incident types that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of services:[35]

- Unreasonable use of force against the aged care recipient[36]
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the aged care recipient
- Psychological or emotional abuse of the aged care recipient
- Unexpected death of the aged care recipient
- Stealing from, or financial coercion of, the aged care recipient by a staff member of the provider
- Neglect of the aged care recipient
- Use of physical restraint or chemical restraint in relation to the aged care recipient (other than in circumstances set out in the Quality of Care Principles)
- Unexplained absence of the aged care recipient from the aged care services of the provider.

'In connection with'

There is no clear reference point within the aged care sector that can be used to define what 'in connection with' means within the home and community care context as the existing guidance is specific to the residential setting. As such, the meaning of 'in connection with' for the SIRS for residential aged care has been adapted for application in the home and community care setting for this option. In making these adaptations, this option draws from the meaning of 'in connection with' used in the NDIS Reportable Incidents Detailed Guidance 2019.[37] For this option, the phrase 'in connection with' refers to serious incidents that are directly linked to, or caused by the service. This means it includes serious incidents that:

- May have occurred during the course of supports or services being provided
- Arise out of the provision, alteration or withdrawal of supports or services, and/or
- May not have occurred during the provision of supports or services but are connected because it arose out of the provision of supports or services.

Incidents that are coincidental to service delivery will not be considered reportable incidents.

Reportable incidents between care recipients

In Option 2, incidents between care recipients that occur in community settings are also in scope. A 'community setting' means a location outside of a person's home where two or more care recipients receive a service together, such as through group activities (e.g. transport or social support groups), day centres, or respite. The incidents in scope for these community settings are

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[35] Drawn from the *Aged Care Act 1997 (Cth).* Wording changed to remove the word 'residential' before the phrase 'aged care recipient'.

[36] The term 'aged care recipient' and 'care recipient' have both been used in this options paper to refer to care recipients of home and community aged care services. 'Aged care recipient' has generally been the term applied in the context of referring to existing incident types or definitions that are set out in legislation, where the term 'residential aged care' recipient is currently used. In most other instances, the term 'care recipient' has been used.

[37] NDIS Quality and Safeguards Commission. Reportable incidents. Detailed Guidance for Registered NDIS Providers. June 2019.

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those involving two or more care recipients where the incident is committed by one of the care recipients. The incident types in scope where two or more care recipients are involved are:

- Unreasonable use of force against the aged care recipient
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the aged care recipient
- Psychological or emotional abuse of the aged care recipient
- Unexpected death of the aged care recipient.

Incidents that occur between the care recipient and other individuals or parties – i.e. where the perpetrator is not the provider, a staff member, or another care recipient in the community setting – are not reportable incidents under this option.

Definitions of reportable incidents in the home and community setting

Option 2 aims to maintain consistency with the current SIRS for residential aged care wherever possible. Detailed definitions for each of the incident types that exist for the SIRS for residential care are provided within the *Quality of Care Principles 2014* and therefore Option 2 will draw directly from these. For this option, it is proposed that these definitions remain aligned, but with consideration given to making the following adjustments to their current form:

- All incident types

  Wording should be updated to reflect that the incidents apply to aged care recipients in home and community care, not just 'residential' aged care recipients.

- Restraint

  The current definition refers to restraint guidance in legislation that has been specifically crafted for the residential aged care setting. Consideration will need to be given to how these principles should be applied to providers of aged care in the home and community care setting.

Table 5 below lists each of the reportable incident types for Option 2 and the corresponding definition of that incident type from the *Quality of Care Principles 2014*, noting that the language has been adjusted to remove reference to the 'residential' aged care recipient.

Table 5: Types and definitions of reportable incidents for Option 2

Type of incident	Definition – aligned to the *Quality of Care Principles 2014*
Unreasonable use of force against the aged care recipient	Unreasonable use of force on a care recipient, ranging from deliberate and violent physical attacks on care recipients, to the use of unwarranted physical force.
Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the aged care recipient	• If the contact or conduct is inflicted by a person who is a staff member of the provider or a person while the person is providing care or services for the provider (such as while volunteering)—the following applies: - Any conduct or contact of a sexual nature inflicted on the aged care recipient, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the aged care recipient - Any touching of the aged care recipient's genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the aged care recipient • Any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the aged care recipient

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Type of incident	Definition – aligned to the *Quality of Care Principles 2014*
	• Engaging in conduct relating to the aged care recipient with the intention of making it easier to procure the aged care recipient to engage in sexual contact or conduct.
Psychological or emotional abuse of the aged care recipient	Verbal or non-verbal acts that cause, or could reasonably have caused, significant emotional or psychological anguish, pain or distress. This includes: • Taunting, bullying, harassment or intimidation • Threats of maltreatment • Humiliation • Unreasonable refusal to interact with the care recipient or acknowledge the recipient's presence • Unreasonable restriction of the aged care recipient's ability to engage socially or otherwise interact with people • Repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which has caused or could reasonably have expected to have caused the aged care recipient psychological or emotional distress.

Unexpected death of the aged care recipient	Death in circumstances where:
	• Reasonable steps were not taken by the provider to prevent the death, or
	• The death is a result of:
	  - care or services provided by the provider
	  - a failure of the provider to provide care or service.

Stealing from, or financial coercion of, the aged care recipient by a staff member of the provider	• Stealing from the care recipient by a staff member of the provider, or
	• Conduct by a staff member of the provider that:
	  - Is coercive or deceptive in relation to the care recipient's financial affairs; or
	  - Unreasonably controls the financial affairs of the aged care recipient.

Neglect of the aged care recipient	• A breach of the duty of care owed by the provider, or a staff member of the provider, to the aged care recipient • A gross breach of professional standards by a staff member of the provider in providing care or services to the aged care recipient.
Use of physical restraint or chemical restraint in relation to the aged care recipient (other than in circumstances set out in the Quality of Care Principles)	The use of physical or chemical restraint that does not meet the requirements of the *Quality of Care Principles 2014*.
Unexplained absence of the aged care recipient from the aged care services of the provider	An absence of the aged care recipient from the services in circumstances where there are reasonable grounds to report the absence to police.

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Source: Adapted from the *Quality of Care Principles 2014*

5.3.2 Timing of Reporting – Priority 1 and 2 incidents

Under the current scheme, reporting is separated into two tiers: Priority 1 and Priority 2 incidents. For this option, two sub-options are proposed, each considering a different approach to the timing requirements for reporting of serious incidents.

Option 2a – report timing is aligned to the current scheme and Priority 1 and Priority 2 incidents remain

Option 2a directly aligns with the current reporting requirements for the SIRS for residential aged care. As such, Option 2a will retain the tiered reporting arrangements.

A Priority 1 reportable incident will need to be reported to the Commission within 24 hours of the provider becoming aware of the incident. A Priority 1 incident will be a reportable incident:

- That has caused, or could reasonably have been expected to have caused, an aged care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or
- Where there are reasonable grounds to report the incident to police, or
- Where there has been an unexpected death of the aged care recipient or unexplained absence of the aged care recipient.

All other incidents that meet the definition of a serious incident will be Priority 2 incidents, which are required to be reported to the Commission within 30 days of the provider becoming aware of the incident.

Option 2b – removal of the reporting prioritisation

Option 2b removes the tiered reporting arrangements in the current scheme. All incidents will be reported to the Commission within three business days following the provider becoming aware of the incident.

The rationale for Option 2b is as follows:

- All reportable incidents are serious and should be treated equally

  If an incident meets the definition of a reportable incident then it is by nature serious and should be reported promptly to the Commission. Allowing a 30-day period for reporting may indicate that some incidents are less serious.

- It is difficult to assess harm to aged care recipients and therefore harm assessments should not drive reporting requirements

  The current definition of a Priority 1 incident includes criteria that relies on the provider accurately assessing the degree of harm the incident incurred on the aged care recipient. Consultations undertaken to inform the development of these options highlighted the challenges in accurately assessing harm to older Australians, particularly in short timeframes:

  - Assessing impact or harm on an older person is innately complex and requires skills, knowledge and experience
  - The current capability of aged care staff in assessing harm is limited
  - In the home and community care setting, staff generally have less contact and familiarity with individual aged care recipients compared to that in the residential aged setting. As such, picking up on cues associated with harm may be even more difficult.

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Providers should report promptly, but additional time may be required to gather basic facts about the incident in the home and community setting. Giving the provider a short period of time (e.g. 24-72 hours) after becoming aware of the incident to make the report would allow for additional time to gather the information about the incident, given the incident will not have occurred 'on site' as it would have within the residential aged care setting. Additional time would allow for basic fact gathering, however the retention of a short time period (three days) would ensure serious incidents are still reported promptly, in recognition of their serious nature.

5.3.3 Responsibilities of providers

The responsibilities of providers under Option 2 should align directly to the responsibilities of providers in the SIRS for residential aged care. Responsibilities of providers relate to both reportable incidents as well as those aimed at strengthening existing incident management of all incidents (i.e. not just those that are reportable). All of these responsibilities will apply to providers of home and community care, as part of Option 2.

Detail about the specific responsibilities for providers are set out in the Aged Care Act 1997 (Cth), in particular within the Quality of Care Principles 2014. In summary, this means that the providers' responsibilities will include the following:

- Manage incidents and take reasonable steps to prevent incidents
- Assess the support and assistance required to ensure the safety, health and well-being of persons affected by the incident, and provide support and assistance to those persons
- Assess how to appropriately involve each person affected in the resolution of an incident
- Ensure staff member informants are not victimised or identified
- Use an open disclosure process
- Assess incidents in relation to whether the incident could have been prevented, the need for remedial action to prevent similar incidents occurring, how well the incident was managed and resolved, identify whether actions could be taken to improve the management and resolution of similar incidents, and whether other parties should be notified of the incident
- Take any remedial actions determined or any actions to improve the provider's management and resolution of similar incidents, and notify the persons/bodies of the determination
- Identify and address systemic issues and provide feedback and training to staff
- If there are reasonable grounds on which to report the incident to police, notify a police officer of the incident within 24 hours of becoming aware
- Collect data relating to incidents that will enable the provider to continuously improve their management and prevention of incidents
- Regularly analyse and review information to assess effectiveness of management and prevention and what improvements should be made and implemented
- Manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system[38]
- Ensure that staff members who become aware of reportable incidents notify the provider
- Advise the Commission of reportable incidents about which they become aware

[38] Specific requirements related to incident management systems are included under Division 3 of Part 4B of the *Quality of Care Principles 2014*

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- Notify the Commission of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information
- If required by the Commission, provide a final report about a reportable incident.

5.3.4 The role of the Commission

The role of the Commission for Option 2 will align to their existing role for the SIRS for residential aged care. In summary, this means that under this option, the Commission's responsibilities will include:

- Receive serious incident reports from providers
- Require providers to provide additional information or a final report in relation to a serious incident report
- Take actions (including requiring providers to do something) to deal with a reportable incident such as:
  - Requiring the provider to complete remedial action in relation to the incident
  - Requiring the provider to undertake an internal investigation and report on the findings
  - Requiring the provider to appoint an external expert to undertake an investigation and report on the findings
- Authorise or carry out an inquiry in relation to a reportable incident
- Issue compliance notices where a provider is not complying, or something would suggest they are not complying, with requirements under the SIRS (failure to comply attracts a maximum civil penalty of 60 penalty units)
- Enforce the requirements under the SIRS through accepting enforceable undertakings, issuing injunctions, and infringement notices
- Use information given to the Commission about a reportable incident to inform risk profiling of providers, identification of trends about serious incidents, and conduct public reporting on the operation of a SIRS
- Supporting the sector in incident management, such as through:
  - Providing guidance and education to build the capacity of providers to develop effective systems to prevent and respond to incidents
  - Providing feedback to the sector to promote understanding of reportable incidents and effective responses, and to support continuous improvement by providers in the quality and safety of care
- Refer information about an incident to another body, if appropriate, for example but not limited to the police or the Coroner.

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5.4 Option 3: SIRS for residential aged care is implemented in the home and community care setting but incidents associated with low or no harm are not reported

Under Option 3, the SIRS for residential aged care will be implemented in the home and community care setting, adapted to the home and community care environment. However, incidents which are associated with low or no harm are not reported. A high level process map of how Option 3 may work in practice is presented in Figure 11.

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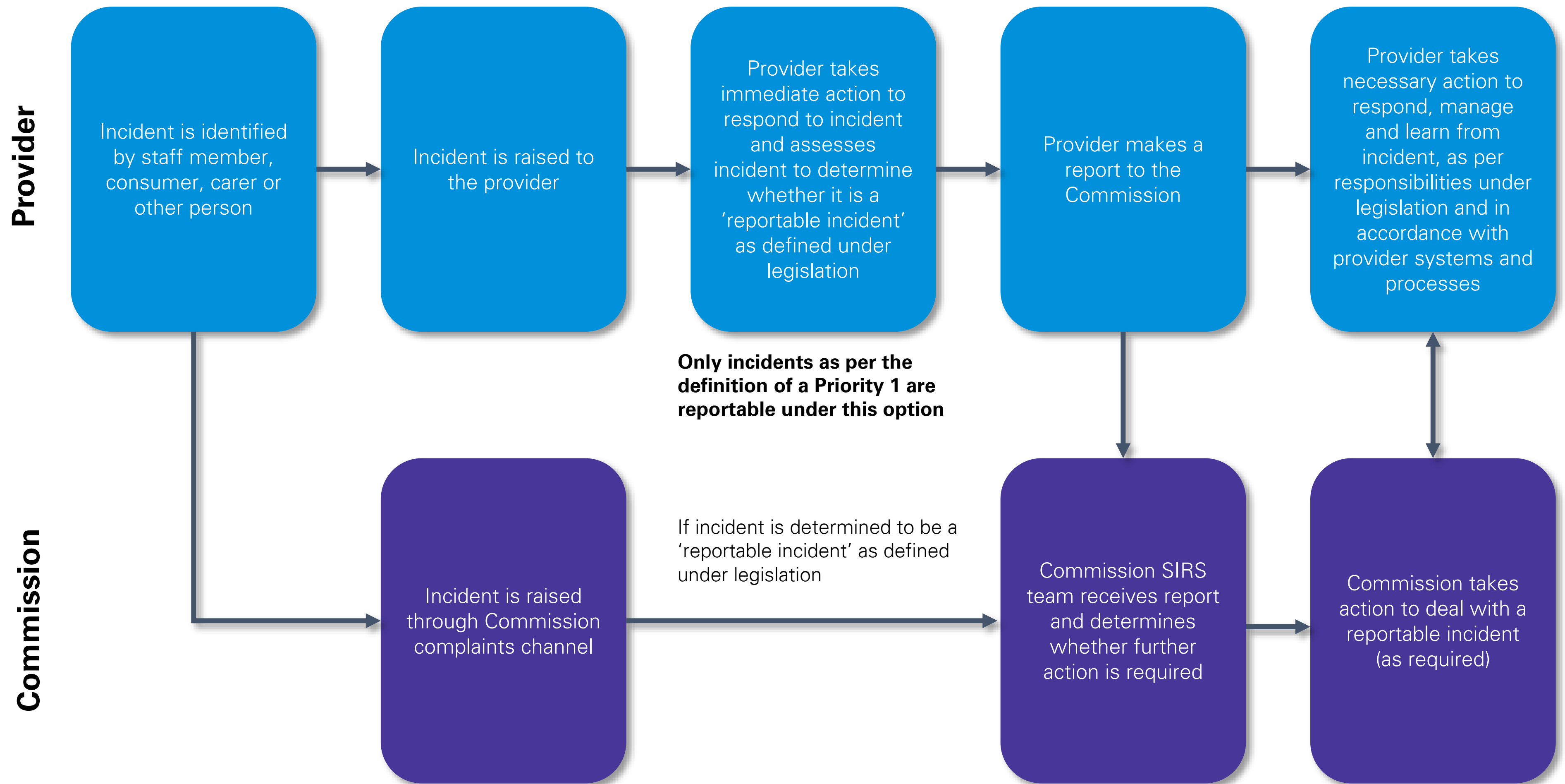
Figure 11: High-level process map for Option 3



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5.4.1 What is a reportable incident?

A reportable incident for Option 3 will be a narrower group of those that are reportable under Option 2. A reportable incident will therefore be any of the following incident types that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of services: [39]

- Unreasonable use of force against the aged care recipient[40]
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the aged care recipient
- Psychological or emotional abuse of the aged care recipient
- Unexpected death of the aged care recipient
- Stealing from, or financial coercion of, the aged care recipient by a staff member of the provider
- Neglect of the aged care recipient
- Use of physical restraint or chemical restraint in relation to the aged care recipient (other than in circumstances set out in the Quality of Care Principles)
- Unexplained absence of the aged care recipient from the aged care services of the provider.

However, of these incidents, those that are associated with low or no harm are not reported. One means of achieving this could be to only report incidents that meet the definition of a Priority 1 reportable incident, should be reported. A Priority 1 reportable incident is a reportable incident:[41]

- That has caused, or could reasonably have been expected to have caused, a care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or
- Where there are reasonable grounds to report the incident to police, or
- Incidents involving unexpected death, or unexplained absence.

The definition of 'in connection with' as outlined in Option 2, remains the same. Incidents involving other care recipients that occur in the community setting, also outlined in Option 2, also remain in scope. The definitions of reportable incidents in the home and community setting will also remain consistent with those for Option 2.

[39] Drawn from the *Aged Care Act 1997 (Cth).* Wording changed to remove the word 'residential' before the phrase 'aged care recipient'.

[40] The term 'aged care recipient' and 'care recipient' have both been used in this options paper to refer to care recipients of home and community aged care services. 'Aged care recipient' has generally been the term applied in the context of referring to existing incident types or definitions that are set out in legislation, where the term 'residential aged care' recipient is currently used. In most other instances, the term 'care recipient' has been used.

[41] *Quality of Care Principles 2014 (Cth)*

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5.4.2 Timing of Reporting

Given that incidents associated with no or low harm are excluded from Option 3, there will be no tiered reporting system. All incidents that meet the definition of a reportable incident should be reported to the Commission within an agreed short timeframe (e.g. 24 – 72 hours) of the provider becoming aware of the incident.

5.4.3 Responsibilities of providers

The responsibilities of providers under Option 3 should align directly to the responsibilities of providers in Option 2.

5.4.4 The role of the Commission

The role of the Commission for Option 3 will align to their responsibilities outlined within Option 2.

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5.5 Option 4: SIRS for residential aged care is implemented in the home and community setting but with an expanded scope

During the course of co-design, stakeholders raised concerns about the broader safeguarding of older Australians within the community. Stakeholders commented that serious incidents, including those involving elder abuse, are often observed or identified during the course of delivering care. Some stakeholders supported the inclusion of such incidents under a SIRS. This option seeks to address these views by presenting how elder abuse, in addition to incidents captured by Option 2, might be considered under a SIRS.

Option 4 includes a regulatory requirement for providers to make a report to the Commission on these incidents and the provider to make a report to a relevant state or territory authority. It is important to note that Option 4 requires providers to obtain the consent of a care recipient prior to making a report to the Commission or a relevant state or territory authority. This is in recognition of care recipient perspectives shared in previous reports and reviews which reflect that care recipients want to be able to make decisions for themselves in cases of abuse, and are not wholly supportive of the idea of mandatory reporting.[42,43] The issue of mandatory reporting of elder abuse by certain reporter groups, including aged care service providers, was also explicitly considered by the ALRC Elder Abuse Inquiry. The ALRC Elder Abuse Inquiry stated that abuse of older Australians must not be treated the same as for children and that professionals should not be required to report all types of elder abuse. It noted that older Australians should generally be free to decide whether to report abuse they have suffered to the police or a safeguarding authority, or to not report the abuse at all. However, the ALRC Report also noted that, while it did not recommend mandatory reporting, there is a case for requiring professionals to report serious abuse of particularly vulnerable adults. The issue of whether consent should be sought prior to a report being made is complex (specific risks and issues are identified in Section 5.4 of this report) and warrants further consideration and consultation with the sector, consumers and experts in elder abuse if this option is to be chosen.

It is also important to note that Option 4 does not require the Commission to take specific action or responses around each serious incident that does not involve the provider or a staff member, outside of receiving a report. This is because the Commonwealth aged care regulatory framework defined within the *Aged Care Act 1997* and its subordinate legislation governs the provision of Commonwealth-funded aged care services. The Commission acts as the national regulator of Commonwealth-funded aged care services and is responsible for ensuring that aged care providers meet their responsibilities in relation to quality of care. Taking broader safeguarding actions to respond to incidents that do not involve a provider or a staff member, such as dealing with an allegation, conducting investigations, making an application to a court or tribunal or raising awareness about such incidents, would require powers which the Commission does not currently

[42] Kurrle, Susan, and Gerard Naughtin. An overview of elder abuse and neglect in Australia, (Journal of elder abuse & neglect 2008): 20, no. 2, pp 108-125.
[43] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).

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have, nor are they the Commission's primary role. Requiring the Commission to refer an incident to a state or territory authority, rather than the provider, may also extend timeframes for a referral to be made and therefore extend the timeframe in which action is able to be taken by a state or territory authority.

In addition, if the Commission were to be tasked with a broader role surrounding these incidents, there would be a need to explore to what extent the *Australian Constitution* supports Commonwealth legislation to enable this role. The Commonwealth's power to legislate is limited to those powers specifically listed in the *Australian Constitution*. For example, the Commonwealth makes laws relating to financial institutions, social security and superannuation.[44] It has no enumerated power to legislate with respect to the welfare of adults generally.[45] As such, this option does not propose to legislate a specific responsibility of the Commission to respond to broader incidents involving elder abuse. Instead, it proposes that the Commission may receive reports and use data captured through reports to further understand the nature and prevalence of incidents.

A high level process map of how Option 4 may work in practice for incidents not in connection with the provision of services is presented in Figure 12. The process for incidents in connection with the provision of services for Option 4 is the same as Option 2 and is depicted at Figure 10.

[44] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017).
[45] Australian Law Reform Commission, Elder abuse – A national legal response, (Commonwealth of Australia, Sydney, 2017). The ALRC Report noted that there is some suggestion that the external affairs power (s 51(xxix)) or the executive power of the Commonwealth (s 61) might support Commonwealth legislation on elder abuse generally. However, the extent to which these powers might support general elder abuse legislation is not settled: Wendy Lacey, 'Neglectful to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' (2014) 36 Sydney Law Review 99.

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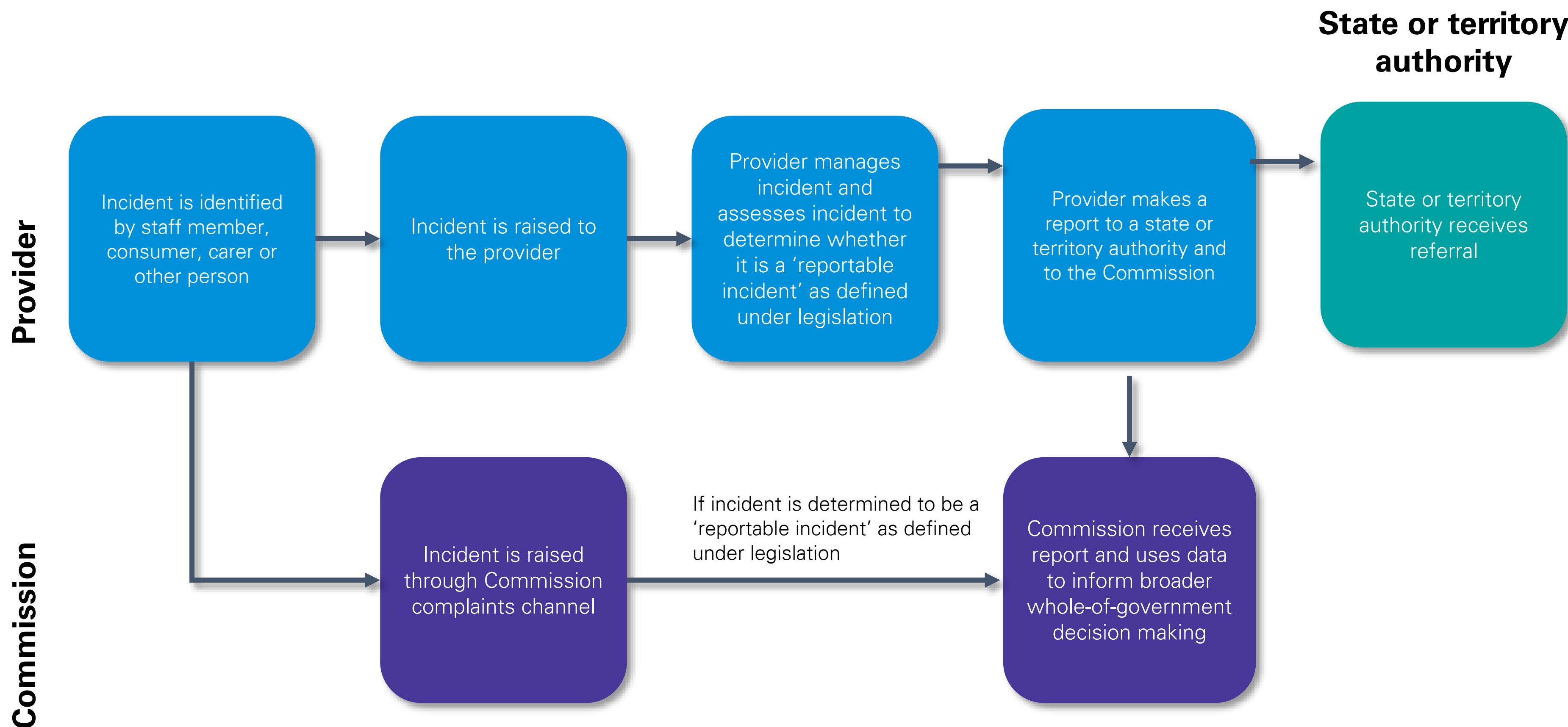
Figure 12: High-level process map for Option 4



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5.5.1 What is a reportable incident?

A reportable incident is any of the following incident types that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of services, or that have occurred within any relationship where there is an expectation of trust[46] between the care recipient and the person and for which the provider becomes aware of during the course of supports or services being provided:[47]

- Unreasonable use of force against the aged care recipient
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the aged care recipient
- Psychological or emotional abuse of the aged care recipient
- Unexpected death of the aged care recipient
- Stealing from, or financial coercion of, the aged care recipient
- Neglect of the aged care recipient
- Use of physical restraint or chemical restraint in relation to the aged care recipient (other than in circumstances set out in the Quality of Care Principles)
- Unexplained absence of the aged care recipient from the aged care services of the provider.

'In connection with'

Consistent with Option 2, the phrase 'in connection with' refers to incidents that:

- May have occurred during the course of supports or services being provided
- Arise out of the provision, alteration or withdrawal of supports or services, and/or
- May not have occurred during the provision of supports but are connected because it arose out of the provision of supports or services.

Within the context of incidents that have occurred in connection with the provision of services, incidents that are coincidental to service delivery are not reportable incidents.

Reportable incidents between care recipients

Consistent with Option 2, incidents between care recipients that occur in community settings are also in scope (refer to analysis under Option 2).

Under this definition, Option 4 will also capture a broader range of incidents, both incidents that have occurred as result of care being delivered by a provider as well as incidents of elder abuse which a provider may observe or become aware of that have occurred outside of service delivery. This may include incidents between care recipients within a home setting where there is an expectation of trust between the two care recipients.

Definitions of reportable incidents in the home and community

Option 4 also aims to maintain consistency of definitions with the current SIRS for residential aged care wherever possible. Definitions for each of the incident types that exist for the SIRS for residential care are provided within the *Quality of Care Principles 2014*, and therefore Option 4 will draw directly from these (as per Table 5). However, for Option 4, there are a number of amendments required to the definitions of each incident type in order to capture the broader range

[46] This could include but is not limited to family members, informal carers or other care providers.
[47] Drawn from the *Aged Care Act 1997 (Cth).* Wording changed to remove the word 'residential' before the phrase 'aged care recipient'

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of incidents which are in scope for this option. The following amendments are proposed under Option 4:

- All incident types

  Wording should be updated to reflect that the incidents apply to aged care recipients in home and community care, not only to 'residential' aged care recipients.

- Unexpected death of the aged care recipient

  The current definition of unexpected death is limited to incidents involving a staff member or an approved provider. Adjustments will need to be made to this definition to capture death in circumstances where reasonable steps were not taken to prevent the death or the death was a result of actions taken by a person where there is an expectation of trust between the care recipient and the person. Possible wording that could be used for this definition is presented below, noting all definitions and legislative amendments under the SIRS generally will need to be subject to detailed legal analysis prior to finalisation:

  Death in circumstances where:

  - *Reasonable steps were not taken to prevent the death, or*
  - *The death is a result of:*
    - *(i) care or services provided by the approved provider*
    - *(ii) actions taken by a person where there is an expectation of trust between the care recipient and the person*
    - *(iii) a failure of the approved provider to provide care or services.*

- Stealing from, or financial coercion of, the aged care recipient by a staff member of the provider

  Given the broader scope of this option, the definition of this incident type will need to be amended to broaden the scope of the incident type to capture stealing or financial coercion of a care recipient by a person where there is an expectation of trust between the care recipient and the person. Possible wording that could be used for this definition is presented below:

  Stealing from the care recipient, or conduct that:

  - *Is coercive or deceptive in relation to the care recipient's financial affairs; or*
  - *Unreasonably controls the financial affairs of the care recipient.*

- Neglect of the aged care recipient

  Given the broader scope of this option, the definition of this incident type will also need to be amended to broaden the scope of the incident type to incidents beyond those committed by a staff member of an approved provider to a breach of the duty of care owed by a person where there is an expectation of trust between the care recipient and the person. Possible wording that could be used for this definition is presented below:

  - *A breach of the duty of care owed by the approved provider, a staff member of the provider or a by a person where there is an expectation of trust between the care recipient and the person, to the care recipient*
  - *A gross breach of professional standards by a staff member of the approved provider in providing care or services to the care recipient.*

- Use of physical restraint or chemical restraint in relation to the aged care recipient (other than in circumstances set out in the Quality of Care Principles)

  As with Option 2, the current definition refers to restraint guidance in legislation that has been specifically crafted for the residential aged care setting. Consideration will need to be given to

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how these principles could be applied to providers of aged care in the home and community care setting.

- Unexplained absence of the aged care recipient from the aged care services of the provider

  Under this option, unexplained absence of the aged care recipient will only apply to incidents which have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of services. Given that the intent of this incident type is to capture incidents related to the absence of the care recipient from services, this incident type, by its nature, will only capture serious incidents that are in connection with the provision of services.

5.5.2 Timing of reporting

As noted under Option 2, under the current scheme, reporting is separated into two tiers: Priority 1 and Priority 2 incidents. As per Option 2, under Option 4, two sub-options are proposed, each considering a different approach to reporting (refer to Option 2 for detail):

- Option 4a – report timing is aligned to the current scheme and Priority 1 and Priority 2 incidents remain
- Option 4b – removal of the reporting prioritisation.

The rationale for aligning these two sub-options to Option 2 is that the persons involved in an incident or the circumstances in which an incident has taken place should not impact decision making around reporting timeframes for incidents.

5.5.3 Responsibilities of providers

For those incidents that have occurred, are alleged to have occurred, or are suspected of having occurred in connection with the provision of services, the responsibilities of providers under Option 4 will align directly to the responsibilities of providers in the SIRS for residential aged care (see Option 2 for the specific responsibilities described under the *Quality of Care Principles 2014*).

For incidents that have occurred, are alleged to have occurred, or are suspected to have occurred, that the provider becomes aware of during the course of supports or services being provided and that are not in connection with the provision of services (i.e. that have occurred within any relationship where there is an expectation of trust between the care recipient and the person), the responsibilities of providers will be different. For these incident types, providers will still be required to:

- Assess the support and assistance required to ensure the safety, health and well-being of persons affected by the incident, and provide support and assistance to those persons
- Ensure staff member informants are not victimised or identified
- Use an open disclosure process
- Collect data relating to incidents
- Implement and maintain an incident management system
- Ensure that staff members who become aware of reportable incidents notify the provider
- If there are reasonable grounds to report the incident to police, notify a police officer of the incident within 24 hours of becoming aware.

For incidents that have occurred within any relationship where there is an expectation of trust between the care recipient and the person, providers will also be responsible for the following, where consent has been provided by the care recipient to do so:

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- Make a referral to a relevant state or territory authority
- Advise the Commission of reportable incidents about which they become aware.

5.5.4 Role of the Commission

Under Option 4, the responsibilities of the Commission will align directly to the responsibilities of the Commission in the SIRS for residential aged care for those incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of services (see Option 2 for the specific responsibilities described under the *Quality of Care Principles 2014*).

For incidents that are not in connection with the provision of services (i.e. that have occurred within any relationship where there is an expectation of trust between the care recipient and the person), the responsibilities of the Commission will be different. The role of the Commission in relation to these incident types would be to receive serious incident reports from providers and use information gathered to inform whole-of-government decision making related to elder abuse.

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6 Impact assessment of options

This section examines each of the four options presented in the previous section, using a consistent set of assessment criteria. Criteria were developed in consultation with the Department and the Commission at workshops conducted over the course of the project.

6.1 Assessment criteria

Five assessment criteria have been used to inform the assessment of each option. These are listed below.

1. **Addresses the problem**

   The extent to which the option addresses the problem of abuse or neglect of older Australians receiving aged care services. This considers the nature and extent of the impact the option will have on care recipients, taking into account benefits for care recipients, and the extent to which the option upholds the rights of older Australians receiving aged care.

2. **Aligns with views of stakeholders**

   The extent to which the option aligns with the views of stakeholders captured through consultation activities conducted over the course of the project.

3. **Impact on providers**

   The nature and level of the impact the option has on providers, considering benefits for providers, as well as any additional administration, skill or resourcing requirements that will fall on providers.

4. **Impact on the Commission**

   The nature and level of the impact the option has on the Commission, considering the benefits for the Commission as well as any additional administration, skill or resourcing requirements that will fall on the Commission.

5. **Unintended consequences**

   Potential unintended consequences associated with the option.

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6.2 Option 1

Option 1

No change to the current arrangements – no SIRS will be implemented for home and community aged care (noting, the Australian Government committed to implementing the Serious Incident Response Scheme in Home and Community Care from 1 July 2022 as part of the 2021-22 Budget).

6.2.2 Addresses the problem

There has been increasing recognition of the need to take action to protect older Australians from abuse and neglect. If a SIRS for home and community care is not implemented, no requirement would remain for the reporting of serious incidents that occur in the home and community care setting to the Commission. This would mean that the volume and nature of these incidents would remain largely unknown. In turn, this would limit the efforts of system actors to take supportive or corrective action to address the problem.

Providers would retain their obligations to manage incidents in keeping with the Aged Care Quality Standards, however no new or enhanced incident management obligations would be put in place. This could limit the effectiveness and subsequent impact of local incident management practices, processes and systems in aged care providers in addressing cases of abuse and neglect of care recipients of aged care.

Under this option, no positive, additional action will be undertaken to minimise the risk to care recipients of abuse and neglect, or uphold the rights of older Australians to receive safe and high quality care. Therefore, there are no clear benefits to care recipients associated with this option.

6.2.3 Aligns to the views of stakeholders

There was very strong support for the introduction of a scheme to prevent and reduce incidents of abuse and neglect for older Australians receiving home and community aged care services. As such, Option 1 would not align with the views of the overwhelming majority of those consulted over the course of the project.

There was a very small number of stakeholders who suggested that a SIRS for home and community care should not be implemented. These stakeholders were not against implementing the SIRS in the home and community care per se; rather, they raised concerns about implementing the scheme in the near future. Specifically, it was suggested that a SIRS for home and community care not be implemented until the SIRS for residential aged care had been fully implemented and lessons learned were identified and understood to inform the design of the scheme. A small number of stakeholders questioned the efficacy of such schemes in preventing and reducing incidents of abuse and neglect of older Australians.

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6.2.4 Impact on providers

This option may have an overall net benefit to providers. Benefits to providers of not introducing a SIRS for home and community care centres on avoiding the effort and resourcing impost associated with the other options, in particular:

- Providers would not have to introduce new systems and processes in response to the introduction of a new reporting scheme
- Providers would not have to meet the resourcing / time burden associated with making reports when incidents occur
- Providers would not have to educate and upskill staff about the new scheme.

Despite these benefits, there are limitations associated with this option for providers. With the other options, the Commission would publish data and information about serious incidents, which could be used by providers to gain a better understanding of potential risks for their own care recipients and, in turn, improve the quality and safety of their services. With this option, the information would not be available to inform providers to take this improvement action. With this option, providers would also not have access to support from the Commission to support their response to incidents and their continuous improvement of their systems and processes.

6.2.5 Impact on the Commission

This option has both benefits and drawbacks for the Commission. Like providers, the benefits arise from avoiding the additional responsibilities which would sit with the Commission, similar to the other options. In particular, with this option, the Commission would not be required to establish the capacity, skills and resources for the overall administration of the SIRS for home and community care, including but not limited to receiving reports from providers about serious incidents; analysing data and information from providers; taking action in response to notifications of incidents; and publishing information about the operation of the SIRS. This would save effort, time and the direct costs of running the scheme.

Despite these potential benefits, there are drawbacks for the Commission associated with this option. The Commission's role is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. A SIRS for the home and community aged care setting offers a mechanism to contribute to this aim. Without the SIRS, the Commission will not have sight of the nature and frequency of reportable incidents in home and community care settings, which will in turn, limit their ability to use data to inform broader risk profiling activities and to take targeted and effective action, including compliance action, to support and protect older Australians and carry out their role and purpose.

6.2.6 Potential unintended consequences

If there is no definition of a serious incident in the home and community care setting, and if there is no reporting of these incidents, there is a risk that this could lead to a belief by government entities, providers or other parts of the community that either these incidents do not exist or that they are very rare. Such views could lead to poor awareness, and without awareness, incidents where abuse and neglect do occur, or a care recipient is at risk of harm, may not be recognised by those who could take action and / or provide support.

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6.3 Option 2

Option 2

The SIRS for residential aged care will be implemented within the home and community setting, adapted to the home and community setting. This includes two sub-options for the timing of reports about serious incidents:

- **Option 2a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.
- **Option 2b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours.

6.3.2 Addresses the problem

This option centres on taking specific and targeted action to understand, prevent and respond to incidents of abuse and neglect that occur in connection with the provision of aged care. In turn, Option 2 offers a positive contribution towards addressing the problem of abuse and neglect of older Australians receiving aged care services.

This option addresses the problem through:

- Formally recognising that serious incidents occur in connection with the provision of aged care services in the home and community care setting, and that a system must be in place to prevent and respond to these
- Capturing data and information about the problem of abuse and neglect that occur in connection with aged care service provision, to enable data-driven action by both those providing care as well as those with oversight responsibilities
- Requiring providers to implement enhanced incident management capabilities and systems more generally, which will support more effective responses and preventative action at the local level.

While this option takes positive action to address abuse and neglect of older Australians, its scope is limited to abuse and neglect that occurs in connection with aged care service provision. This means that this option will not take specific action to address incidents of abuse and neglect that occur outside of this context. To address broader instances of abuse and neglect, such as elder abuse, additional action will need to be taken by providers outside of the SIRS.

This option is also limited to capturing incidents which are aligned to the incident types and definitions already established for the SIRS for residential aged care. While some adjustments will need to be made to these definitions to ensure they are fit for purpose for the home and community care setting (and as outlined in Section 2), it is anticipated that these will be minor in nature. Given that there is limited information currently available about the nature and scope of serious incidents in the home and community care setting, particularly those in connection with

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service provision, it is possible that there are incidents that could occur that will not be captured through the scheme[48].

6.3.3 Aligns to the views of stakeholders

Option 2 aligns to the views of many stakeholders, however some stakeholders raised concerns about the limitations of this approach.

There was support from a range of stakeholders to introduce a SIRS for home and community care that aligned to the existing scheme in the residential setting. Some stakeholders thought limiting the scope of the SIRS for home and community care to those incidents that occur in connection with service provision was a strength of this option as it aligned closely with the existing role and remit of the Commission. In making this alignment, selecting Option 2 was considered to be setting the scheme up for success, with the existing oversight body (the Commission) having the necessary authority to take on this oversight function. Stakeholders also highlighted the need to reduce complexity wherever possible, and alignment of a new scheme for home and community care with the existing arrangements for residential care was strongly supported, particularly by those providers who delivered care across both residential and the home and community settings.

Not all stakeholder views however, aligned with various aspects of Option 2. A broad range of stakeholders highlighted concerns about the fact that incidents outside of those that occur in connection with service delivery would not be in scope. Specifically, there was a view that there were either limited, or an absence of, mechanisms to identify, respond to and prevent elder abuse more generally and that the introduction of a SIRS for home and community care provided an opportunity to address these gaps. In selecting Option 2, there was concern that these gaps would persist and that older Australians would continue to be at risk of abuse and neglect. In this context, stakeholders did not explicitly recognise that broader incidents of abuse and neglect could be addressed through their local incident management systems and processes, even if they were not reportable under a SIRS.

Other matters raised by stakeholders that would not be addressed by the adoption of Option 2 include:

- While the option would align to the residential SIRS, its definitions, nor the definitions of any other option, would not directly replicate the current NDIS definitions. While there would be some similarities between the definitions and Option 2, there would also be a range of differences. Hence while the option was supported by providers who worked across residential and home and community aged care settings, it was considered to be less positive by those providers who worked across aged care and disability settings as some of these providers recommended that alignment should be sought across both sectors[49].
- The phrase 'in connection with' was thought by some stakeholders to be complex, making it difficult for providers to apply the definition of a reportable incident in practice. There was concern that carrying over this phrase into the SIRS for home and community care would continue this complexity, and act as a barrier to providers and their staff having a clear understanding of what to report.

[48] Stakeholders were largely supportive of the definitions within the existing scheme. Should this option be chosen, refinements can be made to definitions as the scheme is implemented and lessons are learnt (described further in section 6).
[49] If this option is chosen, the Department could consider future exploration of amendments to the SIRS or advocate for amendments to the NDIS reportable incidents arrangements to seek harmonisation of requirements across both sectors. This work would align to direction of broader reforms occurring within the sector that seek to harmonise other requirements across sectors such as the Quality Standards and worker screening processes.

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6.3.4 Impact on providers

Option 2 is likely to have a significant impact on providers. At present, there is no requirement for the reporting of serious incidents and, as such, the introduction of a SIRS for home and community care would be a significant change for those providing aged care services in these settings. The introduction of a SIRS would be associated with new responsibilities and, as a consequence, providers would be required to meet these. These responsibilities would confer a new, additional time and resource burden for SIRS-related activities, in particular:

- Initial review of, and potential enhancement required for, incident management systems, capabilities and processes
- Ensuring staff understand the new requirements, and have the capabilities, capacity and knowledge required to identify, report and respond to serious incidents when they occur
- Making reports when incidents occur, in line with legislated requirements
- Taking action if directed to do so by the Commission.

In order to carry out these responsibilities, SIRS-related activities may either have to displace existing activities that are undertaken by staff, or additional resources may need to be recruited in order to ensure these responsibilities are appropriately met. Where providers are already at capacity and unable to acquire additional resources, direct care could be impacted if the administrative overhead of the scheme is significant (for example, through additional administrative charges placed under HCP by providers or reduced capacity to deliver the same units of care under grant agreements for CHSP).

It should be noted that the level of impact imposed by new requirements will be proportionate to the volume of incidents that occur. The Prevalence Study has offered some preliminary insights into the volume of incidents that may be captured under a SIRS for home and community aged care. While the scope of the data collection does not directly align to any of the four options proposed in this report, the national estimates indicate the prevalence of incidents may be lower compared to the volume captured by a SIRS for residential aged care. Some requirements (e.g. training or establishing new processes) will be required regardless of incident volume; other components, such as making reports when incidents occur, will be highly dependent on the number of incidents.

While there is an overall time and resource impost associated with the introduction of Option 2 for providers, this option may also confer some benefits. In particular, the collection of data and information about incidents of abuse and neglect, if published, will provide opportunities for providers to gain insight about potential risks facing their care recipients. Further, if the Commission is able to provide direct support to providers on their responses to incidents, and use information about incidents of abuse and neglect to develop and disseminate training and resourcing to address risks, this may further support providers in improving the quality and safety of their care.

6.3.5 Impact on the Commission

Option 2 will also have a significant impact on the Commission. As noted above, there is currently no requirement to report to the Commission serious incidents that occur in connection with the provision of home and community aged care services. As such, all responsibilities associated with the administration of the scheme would be new. Given that this option would align with the existing SIRS for residential care, it is possible that some efficiencies could be gained through building on existing processes and / or expanding the capacity of some existing functions at the Commission. However, very careful consideration would need to be given to ensuring that every part of the operating model for the administration of the scheme was tailored to respond to the

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specific context and needs of the home and community care setting, for example the level of support offered to providers to transition to the scheme (as detailed in Section 6).

The Commission would require capacity to deliver on its responsibilities, as well as the right systems, capabilities and skills to carry them out. Like providers, some responsibilities (such as establishing processes and a supporting system to capture and analyse incidents) would incur a 'fixed' time or resource burden, while others (such as reviewing individual reports or following up providers in response to concerns about serious incidents) would be directly proportionate to the volume and nature of incidents that are reported.

6.3.6 Potential unintended consequences

There is the potential that Option 2 could lead to a view (by any part of the system, or indeed the community) that there is a comprehensive system in place to address abuse and neglect for older Australians, when this option only intends to play a component part of a larger system that achieves this end. Additional action to understand, prevent and respond to broader incidents of abuse and neglect, such as elder abuse, will still be required, potentially requiring a whole-of-government and whole-of-community response. There is a risk that, if Option 2 is chosen and the remaining gap is not properly understood or addressed, awareness of the remaining risks for older Australians in the home and community could remain low. If Option 2 is chosen as the preferred option, this risk could be mitigated by clear communication about the purpose and scope of this option, including recognition that it will not be capturing broader incidents of elder abuse and that additional action would still be required to understand and respond to these broader incidents.

There is also a risk that providers may have challenges in determining what kind of incidents are reportable. This may mean they provide reports to the Commission on incidents that are not intended to be captured by the scheme. If more incidents are reported than required, this may be associated with an unnecessary reporting and response burden for both providers and the Commission.

Similarly, there may also be challenges for providers in determining the impact an incident has had on a consumer and therefore the priority level of an incident. As such, if Option 2a is chosen, the Commission may receive reports assessed by the provider as Priority 1 which are not in fact Priority 1 incidents. This challenge would not be associated however with Option 2b, as all incidents will need to be reported within the same timeframes.

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6.4 Option 3

Option 3

The SIRS for residential aged care will be implemented within the home and community setting, adapted to the home and community setting. Incidents which are associated with low or no harm are excluded. One means of achieving this could be to only report incidents that meet the definition of a Priority 1 reportable incident.

6.4.2 Addresses the problem

Like Option 2, Option 3 takes targeted action to understand, prevent and respond to incidents of abuse and neglect that occur in connection with the provision of aged care and, in doing so, also offers a positive contribution towards addressing the problem of abuse and neglect of older Australians receiving aged care services.

However, the scope of incidents that are reported through this option is narrower than Option 2. Incidents that are associated with low or no harm are excluded. This means that there will be instances of abuse and neglect of older Australians, including those who meet the definition of a serious incident, that do not sit within the scope of the SIRS. This includes those incidents that occur in connection with aged care service provision. This could limit this option's impact on addressing the problem of abuse and neglect in older Australians.

Option 3 would retain the requirement for providers to implement enhanced incident management capabilities and systems as outlined in Option 2. These requirements would help support more effective responses and preventative action at a local level for incidents generally, as well as for serious incidents associated with low or no harm. However, these 'low or no harm' incidents would not be reported to the Commission and, as such, the Commission would not be immediately aware of the nature or volume of these[50]. In turn, they would not be able to respond either to specific incidents of this nature, nor would they be able to identify trends or emerging issues when looking at data of serious incidents that are associated with low or no harm. It is possible that, as a consequence, the Commission's ability to respond to incidents of abuse and neglect of older Australians, and the effectiveness of their response, could be constrained, for example their ability to identify systemic risks associated with either a provider's or the sector's response to incidents to prevent future abuse and neglect from occurring.

6.4.3 Aligns to the views of stakeholders

As noted in the analysis for Option 2, Option 3 would retain the focus on capturing incidents that occurred in connection with service provision. Some stakeholders strongly supported limiting incidents in this way as it aligned closely with the existing remit of the Commission.

Despite this, there were a range of issues stakeholders raised that suggest this option would not be aligned with their preferences. These are outlined below.

- A key determinant of incident reporting for this option is a provider's assessment of the harm that occurred to the care recipient, i.e. this option relies on provider assessment of harm being accurate. As noted in section 4, assessing impact or harm on an older person is innately

[50] Noting the Commission would be or could become aware of incidents as part of an assessment contact.

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complex and requires skills, knowledge and experience. The current capability of aged care staff in assessing harm however, is limited.

- This option adds additional complexity to the SIRS overall. Stakeholders were strongly supportive of reducing complexity where possible, while maintaining alignment to the current scheme for residential care. Using a different approach to reporting, such as that involved in this option, would add additional complexity.
- This definition could call into question the definition of a serious incident. That is, if there are incidents that meet the definition of a serious incident yet are not reportable, this may cause confusion about which incidents are serious.
- There were strong views by some stakeholders that certain incidents would always be serious and should always be reported, regardless of a provider's assessment of harm. For example, for incidents of inappropriate sexual contact or conduct.

6.4.4 Impact on providers

The issues raised in the analysis of the impact of Option 2 on providers also applies to Option 3. The key difference is that, as the scope of reportable incidents is narrower, the additional time impost of reporting these incidents to the Commission will be lower. Importantly, many of the other requirements, for example training of staff and setting up systems to manage all incidents, will be similar between these options.

6.4.5 Impact on the Commission

The issues raised in the analysis of the impact of providers of Option 2 also applies to Option 3. The key difference is that, as the scope of reportable incidents is narrower, the time impost of receiving, analysing, reporting on, and when necessary responding to, these incidents will be lower.

Given that this option will have less alignment with the existing scheme for residential care than Option 2, there may also be some additional complexities in ensuring the systems, capabilities, skills and infrastructure are in place to manage this option should it be chosen.

6.4.6 Potential unintended consequences

Like Option 2, there is the potential that Option 3 could lead to a view that there is a comprehensive system in place to address abuse and neglect for older Australians, when this option only intends to play a component part of a larger system that achieves this end. Additional action to understand, prevent and respond to a broader suite of incidents of abuse and neglect, such as elder abuse, and incidents of abuse and neglect that occur in connection with service provision but that are associated with low or no harm, will still be required. Like Option 2, there is also the possibility that providers may have challenges in determining the impact an incident has had on a consumer and therefore what types of incidents are reportable. This may mean they provide reports to the Commission on incidents that are not intended to be captured by the scheme or do not report incidents that are intended to be captured by the scheme. If more incidents are reported than required, this may be associated with an unnecessary reporting and response burden for both providers and the Commission.

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6.5 Option 4

Option 4

The SIRS for residential aged care will be implemented within the home and community setting but with an expanded scope of incidents included and differentiated responsibilities for providers and the Commission for certain incident types. The scope of serious incidents captured under this option would be expanded to include serious incidents that the provider becomes aware of during the course of supports or services being provided and that have occurred between a person and a care recipient within a relationship where there is an expectation of trust. As with Option 2, this includes two sub-options for the timing of reports about serious incidents:

- **Option 4a:** timing requirements for reporting remain aligned with the current scheme for residential aged care, with some serious incidents (Priority 1 incidents) required to be reported within 24 hours and others (Priority 2 incidents) within 30 days.
- **Option 4b:** all serious incidents are treated the same (i.e. there is no tiered prioritisation system) and all are reported within 24 – 72 hours).

This option captures both the scope of incidents reportable under Option 2 as well as a broader subset of incidents: those that have occurred within any relationship where there is an expectation of trust between the care recipient and the person. The analysis presented under Section 5.3 for Option 2 is also relevant for incidents that have occurred in connection with the provision of services under Option 4. As such, the analysis presented in this section is focused on the implications of including the broader subset of incidents captured by Option 4.

6.5.2 Addresses the problem

There has been increasing recognition of the need to take action to protect older Australians from abuse and neglect within the home and community. Broader community concerns regarding the prevalence of elder abuse, not in connection with the provision of services within the community, have been highlighted in recent reports and reviews, including the ALRC Report. While evidence about the prevalence of elder abuse in Australia is currently lacking, it is likely that between two and 14 per cent of older Australians experience elder abuse in any given year.[51] Elder abuse has a range of impacts on older Australians, including physical, psychological and financial consequences. Responses to elder abuse are also complicated as they are contained in multiple layers of legislative and policy frameworks across sectors and levels of government.[52]

[51] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).
[52] Ibid.

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This option captures a broader subset of incidents, including incidents of elder abuse not involving a provider or a staff member. This option provides some benefits with regards to addressing the issue of elder abuse within the home and the community, including:

- Capturing incidents of this nature will deliver greater visibility of the nature and prevalence of serious incidents within the home and community. This information can be used to better understand elder abuse and inform broader whole-of-government responses to elder abuse.
- Introducing a regulatory responsibility of providers to report incidents to a state or territory authority may mean reports are made more frequently or earlier, and this may support care recipients to access relevant supports and services earlier, including state or territory safeguarding agencies, counselling and emergency shelters, thereby preventing future incidents of abuse from occurring. Similarly, facilitating referrals through a third party like the provider may remove some barriers that exist for care recipients in navigating reporting pathways and the existing service landscape.[53]

However, there are a range of issues or complexities which emerge as to whether this option contributes to addressing the problem of elder abuse:

- Even though reporting of elder abuse similar to that proposed under Option 4 is common in jurisdictions internationally, there is limited evidence as to the efficacy of this reporting in the adult context.[54]
- Providers and their staff may not have the skills, knowledge and education to be able to recognise, identify and report elder abuse.[55,56,57] The abuse of older Australians occurs within a complex interplay of individual, interpersonal, community and social factors.[58,59] This option requires providers to obtain the consent of a care recipient prior to making a report to the Commission or a relevant state or territory authority. Elder abuse is often difficult to detect and situations where an older person is dependent on an informal care giver can mean that a person may be reluctant to disclose abuse or consent to a report being made[60]. If such complex situations are not responded to appropriately, it may lead to adverse outcomes for care recipients, including being subject to further abuse and neglect, withdrawal of care or changes in living circumstances[61] as well as feelings of fear, embarrassment or shame.
- This option relies on an appropriate state and territory response being available to respond to reports made by the provider. Such is the case in the US, where mandatory reporting is common and longstanding, and Adult Protective Services are in place to respond to community reports. While states and territories make available different channels for anyone – including providers, staff members and care recipients of aged care – to raise concerns associated with elder abuse, the capacity of these organisations to respond to the number of reports that could be made under this option is unknown and, based on stakeholder reports, could be limited.

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[53] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).
[54] Baker PRA et al, Interventions for preventing abuse in the elderly. (Cochrane Database of Systematic Reviews, 2016) Issue 8. Art. No. CD10321.
[55] Sengstock, M and Marshall, B, 'A*dult Protective Services Workers Assess the Effectiveness of Mandatory Reporting of Elder Maltreatment in Michigan*' (2013) Journal of Applied Social Sciences. Vol 2, issue 2 pp 220-231.
[56] Care Quality Commission, *Sexual Safety on Mental Health Wards* (September 2018).
[57] Mary C. Sengstock and Brenda I. Marshall, *Adult Protective Services workers assess the effectiveness of mandatory reporting of elder maltreatment in Michigan'* (Journal of Applied Social Science 2013) vol. 7.2 p 220.
[58] Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023*, (Attorney-General's Department, 2019).
[59] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).
[60] Ibid.
[61] Ibid.

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Stakeholders reported during co-design for a SIRS for home and community care that existing agencies, both safeguarding agencies such as the NSW Ageing and Disability Commission and the Police, are already constrained in their ability to respond to the level of elder abuse prevalent within the community. Requiring the reporting of such incidents to state or territory authorities may overwhelm state or territory authorities and, once a report is made, lead to an expectation by the care recipient, provider and the community that a concern will be responded to.

- While capturing incidents of this nature will deliver greater visibility of the nature and prevalence of serious incidents within the home and community, the Australian Government, through the Attorney-General's Department, has already made investments in building the evidence base on the nature and prevalence of elder abuse in Australia through commissioning a national Prevalence Study of elder abuse, due for completion in 2021. This means that information captured through a SIRS may not add to the evidence base that is currently being built through the Prevalence Study being conducted by the Attorney-General's Department.
- Other strategies and interventions may achieve better outcomes for care recipients compared to a regulatory obligation under a SIRS. While there is a lack of research on the effectiveness of different prevention strategies related to elder abuse, case study examples included in the Australian Institute for Family Studies publication support the effectiveness of several strategies[62] including: using multidisciplinary teams where professionals pool expertise to resolve cases of alleged elder abuse; providing helplines and websites that provide information to potential victims; monitoring by financial institutions for suspicious patterns to identify older Australians at risk of financial abuse; and conducting public campaigns to raise awareness of elder abuse and enhance respect for older Australians.
- While complex, there is an existing landscape of protections available in Australia to respond to Elder Abuse (as outlined in Section 2). This includes safeguarding agencies in some states and territories (such as the NSW Ageing and Disability Commission, Adult Safeguarding Unit in SA), dedicated Elder Abuse Prevention Officers in the Police, and elder abuse support services in each state or territory, including a national helpline. The Australian Government has also committed $18.3m over four years to support the delivery of front-line services to older Australians experiencing elder abuse such as specialist elder abuse units, health-justice partnerships and case management and mediation services[63]. An alternative response by government to address concerns surrounding elder abuse witnessed or suspected by aged care providers is for the Commission to develop reporting guidelines and protocols (such as those available through the Health system[64]) that set out how providers and their workforce should report different types of elder abuse to safeguarding agencies and other support services. This could include, with support from safeguarding agencies and specialist support services, actively building the capacity and capability of providers and their workforce on elder abuse and how to respond where it is detected. This could also be complemented by additional investment in existing safeguarding responses to elder abuse such as those described above.

6.5.3 Aligns to the views of stakeholders

Stakeholders held varying views about whether or not the SIRS should capture a broader subset of incidents outside of those that occur in connection with the provision of services.

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[62] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).
[63] Council of Attorneys-General, *Protecting the Rights of Older Australians*, (Attorney-General's Department).
[64] Secretary NSW Health, *Identifying and responding to abuse of older people,* (January 2020).

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During the course of co-design, stakeholders raised concerns about the broader safeguarding of older Australians within the home and community. Stakeholders commented that serious incidents, including those involving elder abuse, are often observed or identified during the course of delivering care, however there is limited capacity within existing state and territory authorities, including the Police, to respond to such incidents. As such, some stakeholders, particularly aged care providers, supported the inclusion of such incidents under a SIRS in order to provide a channel for such incidents to be reported and responded to, and to reduce the overall risk of abuse and neglect for these care recipients.

Stakeholders who were not supportive of the inclusion of this broader subset of incidents raised concerns regarding various aspects of this option, including that:

- Reporting may lead to adverse outcomes for the older Australian, including withdrawal of care or changes in living circumstances[65] as well as feelings of fear, embarrassment or shame (as described under 'Addresses the problem')
- Incidents involving familial abuse are complex and providers may not be well equipped to identify and respond to such incidents (as described under 'Addresses the problem'). While aged care providers hold specific responsibilities under the Aged Care Quality Standards with respect to identifying and responding to abuse and neglect of care recipients, many stakeholders commented that the vast majority of the aged care workforce does not have the skills to navigate and respond to incidents of elder abuse
- Reporting of such incidents will represent a significant administrative burden on providers and could diminish their ability to focus on the delivery of quality and safe care
- Other strategies and responses, such as those described under 'Addresses the problem,' could be more effective in tackling the issue of elder abuse within the home and community setting.

6.5.4 Impact on providers

Given that the prevalence of this broader subset of elder abuse within the home and community in Australia remains largely unknown, the volume of incidents that may be captured under this option is unclear. However, Option 4 will have a more significant impact on providers than Option 2 due to the broader range of incidents in scope for reporting under this option.

Additional impacts on providers related to incidents that are not in connection with the provision of services include:

- Making additional reports related to the broader subset of incidents when they occur, in line with legislated requirements would be associated with an additional time and resource burden to do so. This would be in addition to any additional time and resource burden described in Option 2.
- Ensuring providers and their staff understand and are able to identify and respond appropriately and sensitively to these types of incidents. This would also be associated with a time and resource burden to provide training, resources and / or support. As outlined above, identifying and responding to these incidents can be complex and providers and staff will require the necessary skills to carry out these responsibilities. As described in Option 2, if providers are at capacity, there is a risk that reporting responsibilities may displace direct care or service provision.

[65] Kaspiew, Rae, Carson, Rachel and Helen Rhoades, *Elder abuse: Understanding issues, frameworks and responses,* (Melbourne: Australian Institute of Family Studies 2015).

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6.5.5 Impact on the Commission

Option 4 will also have a more significant impact on the Commission than Option 2 due to the broader range of incidents in scope for reporting under this option. Additional impacts will confer a time and resource burden on the Commission related to incidents that are not in connection with the provision of services include:

- Receiving additional reports related to the broader subset of incidents when they occur
- Needing to consider how it uses and reports on data surrounding these types of incidents for broader whole-of-government decision making.

The size of the additional time and resource burden will be proportionate to the number of incidents reported that are associated with the expanded definition of a reportable incident for Option 4.

6.5.6 Potential unintended consequences

There is the potential that Option 4 could lead to a view (by any part of the system, or indeed the community) that there is a comprehensive system in place to address abuse and neglect for older Australians, including incidents that are not in connection with the provision of services, when this option only intends to play a component part of a larger system that achieves this end.

If there is a requirement that providers make reports to relevant state or territory authorities, there may be an expectation by care recipients and the broader community that these reports are investigated and responded to as part of the scheme and relies on other state and territory authorities having the capacity to do so. Should there not be sufficient capacity within these authorities to respond, this may result in providers or the Commonwealth inadvertently holding risk associated with safeguarding older Australians.

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7 Implementation considerations

There are a range of matters that will need to be considered in implementing the preferred option for a SIRS for home and community aged care. These include the need for legislative change, the capacity and capability of the Commission to administer the scheme, support required for providers and the community, technology considerations, and options for implementation timeframes.

7.1 Legislative change

The implementation of a SIRS for home and community aged care will need to be supported by relevant legislative amendments. The nature of the change will need to align to the chosen option, however it is likely to require adjustments to the *Aged Care Act 1997*, the *Aged Care Quality and Safety Commission Act 2018*, the *Quality of Care Principles 2014* , and the *Aged Care Quality and Safety Commission Rules 2018* for its potential application to the home and community care setting (as noted in Section 4). Detailed legal analysis is required on the chosen option to understand what legislative amendments will be required, with particular consideration for:

- How to determine what should be considered 'unreasonable use of physical restraint and chemical restraint' given that the arrangements in the *Quality of Care Principles 2014* do not currently apply to providers of home and community aged care
- Enacting powers of the Commission to receive and refer reports associated with serious incidents not in connection with the provision of services (as per Option 4b).

7.2 Commission capacity and capability

The Commission will need to be adequately resourced to support any additional responsibilities. The level of resourcing required to support the new requirements will be proportionate to the volume of incidents that occur and the scope of incidents captured (i.e. option chosen). The Prevalence Study has offered some preliminary insights into the volume of incidents that may be captured under a SIRS for home and community aged care. While the scope of the data collection does not directly align to any of the four options proposed in this report, the national estimates indicate the prevalence of incidents may be lower compared to the volume captured by a SIRS for residential aged care.

Workforce planning will be required to ensure that there is an appropriate mix of knowledge, skills and experience of staff to undertake preparation for, and administration of, the SIRS for home and community aged care. Depending on the option chosen, staff may support one or more of the following functions:

- Receiving serious incident reports from home and community aged care providers
- Monitoring and investigating provider compliance with requirements under the SIRS
- Undertaking regulatory action(s) where appropriate to address non-compliance with provider responsibilities under the SIRS

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- Holding providers to account in relation to having an incident management system in place which is compliant with enhanced incident management responsibilities, and which can be used to record, report, prevent, manage and respond to serious incidents
- Collecting, correlating, analysing and disseminating information related to serious incidents to identify trends or systemic issues
- Direct and indirect engagement with providers to build their knowledge and capacity associated with identifying, reporting and responding to serious incidents.

It is likely these will align closely to the skills required to support the existing scheme for residential aged care. However, consideration will need to be given to:

- The likely volume of incidents to be reported
- Opportunities to expand existing functions and / or scale services provided through the SIRS for residential aged care
- The need for specific expertise about the service delivery context and risks that occur in the home and community care setting. For Option 4, specific expertise will be needed on how to handle matters related to broader elder abuse, including familial abuse.
- Potential additional resources required in the lead up to the introduction of the SIRS for home and community care as well as in its initial rollout, to support providers to make the transition.

In all workforce planning and recruitment decisions, the specific needs of the setting must be taken into account. There may be many areas of consistency between the schemes in terms of their administration, however, it is vital that there be no assumption that abuse and neglect in the home and community care context, its recognition, prevention and management, be a replica of that which occurs in residential aged care.

With implementation, the Commission's capacity and capability needs should be closely monitored over time, allowing for adequate flexibility in funding to ensure that adjustments can be made to ensure the workforce is fit for purpose for the new scheme. For example, while the Prevalence Study undertaken for the purposes of this project provides an initial picture of the likely nature and frequency of serious incidents in home and community care, this may not provide a full picture of the volume of incidents that will be reported in the future. This could arise from a range of factors, including because the final definitions chosen for a reportable incident may not align with that used for the Prevalence Study, or because reporting rates may change as the sector gains a better understanding of what a reportable incident is and how and when to report.

Wherever possible, opportunities to streamline resourcing across both the SIRS for residential and home and community care should be sought, however identifying efficiencies will be impacted by the nature of the final option chosen. Where there is strong alignment between the two schemes, the likely scale of efficiencies will be greater.

Where new roles are required, recruitment may be targeted at a specific skillset (e.g. in monitoring, compliance and investigations) to support the different functions of a SIRS. The workforce should also understand and / or have experience in the aged care context, specifically in home and community aged care. The COVID-19 pandemic has seen an increasing adoption of remote working, which may bridge geographic barriers and provide access to a previously untapped talent pool. At the same time, there may be unique challenges with remotely recruiting, onboarding and training the workforce.

If roles are expanded, consideration will need to be given to upskilling the workforce to recognise the differences between the two schemes and ensure that staff understand the specific nuances

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of the home and community care context, and how and when risks could occur and could be managed.

Engagement with an improvement lens

Fostering a sector-wide culture of continuous improvement, focused on the safety and wellbeing of care recipients, will support the implementation of a SIRS for home and community aged care. A key challenge for the Commission will be to ensure the scheme is framed in a way which avoids the view that the SIRS is primarily a punitive measure as this may create fear of repercussions amongst providers, and hinder providers' adoption of, and effective participation in, their new obligations.

In developing communications and support materials, key considerations for the Commission will include highlighting the importance of incident management as a way of maintaining the safety and wellbeing of the care recipient, and managing perceptions that reporting may be a risk to personal or organisational reputation or lead to other undesired consequences to the reporter. Placing value on providers learning from understanding the nature and frequency of incidents will be important in empowering the sector to take responsibility for their ongoing improvements in identifying, responding to and preventing abuse and neglect in older Australians.

7.3 Provider support

Provider support will be essential to ensuring the effective administration of a SIRS for home and community care. For there to be universal change by the home and community aged care sector, the workforce needs to internalise the behaviours and beliefs required for a SIRS. It is important that the Commission places ongoing emphasis on delivering activities, such as communication and training, with the sector to drive change. Support activities need to be varied and ongoing, and the nature of the support will need to take into account the varying characteristics, capability and capacity attributes of the provider population delivering home and community aged care.

New capabilities required for a diverse provider population

While the Commission may build on the supports and resources it has delivered for the existing residential scheme, new and / or additional considerations must influence the design of provider support materials for the home and community care sector. These considerations will need to take into account the differing nature of providers, services delivered, workforce characteristics, and different care recipients who access home and community care services (as detailed in Section 2). These include:

- Varying levels of maturity and sophistication in existing incident management systems, for example:
  - Smaller providers may not have an established, technology-based approach for identifying and reporting incidents, with many still using paper-based processes
  - Some providers of certain services (e.g. where there are minimal interactions with care recipients) may have more simplistic incident management systems as they may be exposed to a smaller range of types of incidents
  - The workforce may have an existing low level of knowledge in incident management overall, as well as identifying, responding to and reporting on serious incidents. In particular, results from the Prevalence Study indicate that there will be a need to build the

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capability of providers and their workforce to assess the impact of an incident on a care recipient and to determine what action should be taken after an incident has occurred

  - The workforce may not be equipped with the appropriate skills to respond to incidents in a culturally appropriate manner, for example when working with care recipients from culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities
  - Capacity constraints, which may be more acutely experienced by smaller providers and / or providers in rural areas, may make it more challenging to find time and / or resources for new systems, processes and reporting requirements. Where there are casual staff or in rural areas where travel times can be long, these pressures may be particularly significant.

- A workforce with varying levels of English literacy and technology literacy
- The need to tailor support materials to the home and community care setting, i.e. guidance and training materials that are developed specifically for that setting, using context-specific examples, case studies that cover the diversity of services delivered, and that acknowledge the unique risks that exist in this setting.

If Option 4 were chosen, the complexity of providing support would increase further. There was general consensus amongst stakeholders that providers are better placed to identify serious incidents committed by their own staff members (at the staff level) than they are to identify serious incidents committed by other types of people (e.g. care recipients, subcontractors and family members) or where there is no clear perpetrator.

Assessing and responding to harm

The current SIRS for residential aged care includes the requirement to assess the impact of an incident on the care recipient. If this is to be retained, the home and community care workforce will require a capability uplift to ensure they have the skills and knowledge to do so.

The Commission should ensure that supports and training materials developed to support the sector acquire knowledge in this area and are developed by those with the right expertise. These should take into account any specific challenges that providers may encounter because of the nature of interaction providers may have with care recipients of home and community care (for example but not limited to the intermittent nature of service delivery, in comparison to residential aged care), as well as the type of incident that has occurred (e.g. sexual assault versus unexplained absence). The Commission may also wish to explore the benefits of encouraging providers to seek additional support to respond to certain incidents. For example, whether there would be benefit in accessing additional support from community based sexual assault services, for care recipients who may have experienced an incident of this nature.

Support activities

Support activities will need to include provider engagement and education activities (e.g. factsheets, education videos and webinars) prior to the commencement of the scheme and throughout its administration. Engagement and education should be flexible and inclusive to cater for the needs of different types of providers, the services they deliver and the care recipients they support. Importantly, support activities and resources should be culturally appropriate, responsive to cultural sensitivities, distributed through a diverse set of channels to cater for different audiences, and tailored to a range of English literacy levels.

Early provider engagement and education will be critical to ensure the successful implementation and operation of a SIRS. This will allow providers the necessary time to understand the changes, consider the impact on their services, and plan for their new responsibilities. Support should be

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available to providers in a timely manner to build their capability in identifying, handling, and investigating serious incidents.

Different engagement and education activities for supporting providers will need to be used. This could include:

- Communications to introduce the sector to the scheme, what it will mean for providers, the timing of the rollout, and how and what support will be provided by the Commission. Subsequent communications should focus on directing providers to the available resources, webinars and training developed.
- Prescriptive guidance material on effective incident management, including, process steps in notification / reporting, investigation and response to incidents.
- Webinars, training, forums and presentations for providers and their workforce on the introduction of the SIRS, incident management systems, reporting requirements and the role of the Commission.
- Hotline / helpdesk that provides support to providers regarding specific issues, challenges or queries.
- Fact sheets on the purpose and scope of the SIRS; examples of incidents in scope under each incident type specific to home and community care; the differences between a Priority 1 and a Priority 2 incident (if applicable); whether the reporting 'timer' starts when an incident is identified by a staff member or when the incident is internally reported to a designated person within the provider organisation; whether there are exemptions to the reporting timeframe (e.g. for incidents that occur overnight, on weekends or public holidays); what the role of the Commission is and what actions they will take when a report is received; and how to respond to incidents which may not be reportable incidents (for example if Option 2 is chosen, how to respond to actual or suspected incidents of elder abuse).
- Readiness checklists of activities the providers should complete prior to the commencement of the scheme, e.g. becoming familiar with the SIRS. Each activity on the checklist could be linked to available support materials.

The ongoing needs of home and community aged care providers should be considered by the Commission. The engagement and educational material should be updated and tailored based on these changing needs.

7.4 Care recipient and community support

Support for care recipients, their families and carers will be essential to the successful implementation of a SIRS for home and community care. A core aim must be to empower care recipients to understand and recognise abuse and neglect, and to have the confidence to report it, without fear of retribution or negative impact on their access to services and / or the quality of care that they receive. Support should be given to enable care recipients to understand the responsibilities of their home and community aged care providers in relation to the SIRS, and how these responsibilities complement care recipients' rights to raise concerns with providers and the Commission through a complaints function.

To this end, key implementation considerations for a SIRS for home and community care include both developing tailored care recipient support materials, as well as implementing strategies to build community awareness more generally.

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Care recipient support materials

Care recipients will need access to materials that clearly explain the SIRS. This could include information about:

- Why the SIRS is important
- The benefits of the SIRS to care recipients
- Timing of the commencement of the SIRS
- How the SIRS is related to other requirements of aged care providers
- What an incident management system is
- Reportable incidents under the SIRS
- The role of the Commission
- How to make a complaint.

In developing care recipient-specific resources, consideration should be given to ensuring:

- Materials are available in a variety of languages and plain English to suit diverse communication requirements and preferences of care recipients
- Illustrations in resources that reflect the diversity of care recipients who are receiving aged care
- Resources are available in both digital and hard copy forms to accommodate where care recipients have low digital literacy or limited access to the internet
- That culturally appropriate examples are included, if examples of incidents are described within the resource
- That information is provided more than once (e.g. in 'welcome' packs, and again at various points during care planning and review activities)
- Providers offer care recipients the opportunity to discuss what the SIRS means, if they have difficulty understanding written material
- That information is also shared with other family members or informal carers who support the care recipient, or in some cases specialist organisations that support and / or advocate for specific community groups.

Wider community awareness and understanding of the SIRS

Care recipients' families and community networks are important to a care recipient's overall understanding and navigation of the aged care system, including the role of the SIRS. Community networks and services that older Australians access can be used to promote the scheme and may include hairdressers, GPs, pharmacists, neighbours, places of worship, and community leaders in Aboriginal and Torres Strait Islander communities.

Care recipients' families and community networks will be influential to care recipients' awareness and understanding of the SIRS and can emphasise that care recipients should feel safe and encouraged to report a serious incident. This will require care recipients' families and community networks to not only have a sound understanding of the role of the SIRS and the Commission, but also to believe the SIRS is an effective tool in safeguarding older Australians who receive home and community aged care services. To this end, consideration should be given to the means to promote the SIRS and its purpose more broadly – potentially though community awareness building campaigns.

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7.5 Technology

Appropriate technology can offer support to providers to strengthen their incident management systems locally, as well as enable efficient and accurate reporting of serious incidents to the Commission. Current incident management systems in home and community care however are diverse in their maturity – ranging from sophisticated IT systems to simple, paper-based approaches. While legislation does not prescribe the use of technology for incident management systems, the introduction of a SIRS for home and community care means that providers will need to consider the extent to which their current systems (both technology and paper based) are fit for purpose. As such, ensuring there is adequate notice to providers about the scheme's requirements will be important to allow for planning and assessment to occur, particularly for smaller providers where such activity may represent a more significant change than for larger providers. The Commission may wish to consider developing guidance for providers regarding how they can assess their current systems and processes to support incident management. This should take into account the needs of smaller providers for whom technology-based options may appear to be too expensive for their service or where paper-based approaches are preferred.

Technology will also be a critical enabler for the Commission. The systems used by the Commission to administer the SIRS for residential aged care should be assessed to determine whether they are fit for purpose for the SIRS for home and community care. Where systems are working well, this will need to consider what would be required to increase the scale and capacity of the system to incorporate a greater volume of incidents. However, each component will need to be assessed to determine what changes would need to be made to ensure it is fit for purpose for incidents from home and community care. Opportunities to support efficiency should also be examined, including between the Commission and providers. For example, to examine ways to enable the direct flow of information from local incident management systems into a reporting portal to the Commission. Stakeholders were also supportive of designing the IT infrastructure for reporting in a way that would support providers to understand what is reportable and how to complete certain fields. For example, including instructions and guidance within the system and restricting certain fields from being completed where a particular response is chosen. It was also suggested that the IT system could be designed in a way to allow providers to update information captured into a report in recognition that not all information about an incident or the actions taken may be available at the time a report is made.

7.6 Alignment with ongoing aged care reforms

The SIRS for home and community aged care may need to evolve over time as changes are made to the broader aged care system. The Royal Commission Final Report recommended a series of changes in the aged care system, including but not limited to, recommendations to replace the *Aged Care Act 1997* and introduce a new aged care program that combines the CHSP, HCP Program and the Residential Aged Care Program, including Respite Care and Short-Term Restorative Care (STRC). Depending on the government's emerging reform agenda, further adjustments may be required to the SIRS for home and community aged care to take these into account.

The Department could also consider future exploration of amendments to the SIRS or advocate for amendments to the NDIS reportable incidents arrangements to seek harmonisation of

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requirements across both sectors. This work would align to direction of broader reforms occurring within the sector that seek to harmonise other requirements across sectors such as the quality standards and worker screening processes.

7.7 Existing aged care quality and safeguarding frameworks

There are a range of mechanisms in place to support the provision of safe and high quality care to older Australians and the prevention of abuse and neglect of older Australians (as described in Section 2). It is important that the introduction of any new regulatory instrument considers the existing quality and safeguarding framework and targets action and response to the highest areas of risk.

Figure 13 illustrates the existing quality and safeguarding framework for aged care and where a SIRS may fit. It is important that there is clarity about how the SIRS interacts and interfaces with these. Whatever option is chosen, the SIRS will not address all the safeguarding needs for older Australians; rather, it will need to operate as one of many effective components of an overall system that achieves that end. This means that, for its effective operation, there is a clear understanding of the SIRS' purpose and scope (i.e. what it will and will not achieve).

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Figure 13: Existing aged care quality and safeguarding framework

Source: KPMG

There will also need to be clear connection points or interfaces with other quality and safeguarding mechanisms in place. For example, incidents identified through other existing mechanisms (e.g. complaints processes) should be appropriately addressed through the SIRS if they meet the definition of a serious incident. This might include complaints made directly to a provider, making them aware that the serious incident occurred, or complaints made directly to the Commission, who determine that the complaint involves a serious incident and should also be reported to the SIRS for home and community care.

7.8 Implementation timeframes

Consultations undertaken for the development of SIRS options for home and community care indicated there was little enthusiasm for staged implementation based on the priority level of incidents, instead preferencing implementation as a single roll out approach.

Providers will require adequate notice of the implementation of the SIRS for home and community aged care. Adequate notice will give providers time to clearly understand their new responsibilities, adapt necessary internal system requirements, update relevant policies and processes to align to

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the SIRS, and deliver training to staff. A longer notice period may be required for Option 4 due to the complexity and scale of this option. During the initial stages of implementation, the Commission should focus on learning and development in the sector to ensure the sector is able to adequately adapt and change to adopt the scheme.

Table 6 presents a high-level timeline of how a SIRS could be implemented. This timeline will need to consider broader changes to the aged care system prior to implementation. For example, the potential merging of CHSP, HCP and the Residential Aged Care Program, including Respite Care and STRC, into a new aged care program could impact implementation timeframes.

Table 6: Potential implementation phases and activities for a SIRS for home and community aged care

Set-up	Pre-implementation	Implementation
• Confirm finer policy details of SIRS through development of a discussion paper and sector consultation • Develop relevant policy through consultation with experts and the aged care sector • Decision by government on the preferred option for a SIRS in home and community aged care • Estimate cost and regulatory burden • Draft legislation and subordinate legislation.	• Develop a detailed implementation plan and a detailed communications plan • Sector engagement and change management to prepare providers for introduction of the SIRS • Wider community engagement and promotion of the SIRS and its purpose.	• 'Go live' date for a SIRS in home and community aged care • Test, monitor and improve systems • Provide adequate communications and change support to the sector on the SIRS.

Source: KPMG

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Appendix A- Detailed analysis from the Prevalence Study

Introduction

Project context

KPMG has been engaged to undertake a study ('Prevalence Study') on the prevalence of serious incidents in home and community aged care settings over a six-month period from 1 November 2020 to 30 April 2021. The Prevalence Study is part of a project to provide advice to Government on the design and implementation of a Serious Incident Response Scheme (SIRS) for home and community aged care.

Data collection occurred over two periods. The first period included the first three months from 1 November 2020 to 31 January 2021, and the second for the three months from 1 February 2021 to 30 April 2021. The data captures a range of types of incidents defined in consultation with the Commonwealth Department of Health (the Department) and the Commission.

Data collection has been undertaken by a sample of home and community aged care providers who voluntarily signed up to the study in response to sector-wide communications or direct invitations. This study was advertised through aged care sector announcements and the aged care sector newsletter ('Information for the Aged Care Sector'), and an email to the Aged Care Sector Committee. The Flexible Care Program Team also distributed invitations directly to Flexible Care providers.

The scope of home and community aged care for the Prevalence Study includes the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) and Flexible Care. For the purpose of this study, Flexible Care includes the following programs where they are delivered in the home and community settings: Short Term Restorative Care (STRC), Multi-Purpose Services (MPS), the Transition Care Program (TCP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

Sample and study limitations

The findings in this document should be considered in light of sample and study limitations, as follows:

- **Non-random sample** – The sample of home and community aged care providers that participated in the study was not randomly selected. Therefore, the Prevalence Study cannot specify the degree of statistical confidence over how representative the sample is of the broader population.
- **Data submission tool** – Participating providers were asked to submit data on serious incidents that occurred at their organisation between 1 November 2020 and 30 April 2021. Participating

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providers were asked to make selections from predetermined lists to indicate the 'type' of serious incident that occurred, the 'impact' of the incident and their 'response(s)' to the incident. Items on the lists were not exhaustive. For example, the response types available for selection were focused on actions involving the victim as opposed to continuous improvement related actions that may involve staff members. Some participating providers provided feedback that they had indicated "none" as the response type because their actual action taken (e.g. training) did not align with any other 'response' descriptions available for selection. Therefore, a "none" response (as indicated in the data submission) may not necessarily equate to no action taken.

- **Representativeness of the sample** – The representativeness of the sample of participating providers varied based on different characteristics. The sample was more representative by jurisdiction than it was by program or remoteness category. Over- or under-representation may bias sample results and must be considered when interpreting the study's findings.
- **Loss to follow up** – Providers were asked to submit data in two tranches with the first tranche corresponding to the first three months and second tranche corresponding to the last three months of the study period. One hundred and sixty-nine providers submitted data for the first tranche. Of these, 151 submitted data for the second tranche, equivalent to a loss to follow up rate of 11 per cent (18 providers). Of the 18 providers lost to follow up, two providers reported at least one incident between a staff member and care recipient / family member for a total of seven incidents between these two providers. None of the providers lost to follow up reported incidents between care recipients. Given the providers lost to follow up did not provide six months' worth of incident data, they were excluded from the sample analysed.
- **Additional providers** – There were an additional ten providers who submitted data in the second tranche that did not submit data in the first tranche. Of these, only one provider reported any incidents. This provider reported two incidents but did not include the date of either incident. Given that this subset of 'additional providers' did not provide six months' worth of incident data and the magnitude of not including this small subset of providers would be minimal, they were excluded from the sample analysed.
- **Alignment of the Prevalence Study scope to options presented in this report**: While the Prevalence Study offers some insights into the volume and nature of incidents that may occur in home and community aged care, the scope of the data collection does not directly align to any of the four options proposed in this report.

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Characteristics of participating approved providers

KPMG analysed the characteristics of participating providers by jurisdiction and remoteness to understand at a high level, whether the sample was representative of the national population of approved home and community aged care providers. The analysis used data on the characteristics of provider organisations submitted by participating providers, and data on provider characteristics from the Commonwealth Department of Health and GEN Aged Care.

The sample of participating providers varied in its representativeness of the broader provider population. Representativeness was determined by analysing the proportion of providers in the study out of the proportion of providers in the total population by program, jurisdiction and remoteness category. Participation rates were also examined in the analysis. Participation rates were determined by the rate of participation of providers in the study out of the total number of providers in the broader provider population by program, jurisdiction and remoteness category.

Providers who participated in the study

In Australia, there are 2,078 approved home and community aged care providers operating 8,200 services (as at July 2020). Of the 2,078 approved home and community aged care providers in Australia, 151 (seven per cent) participated in the study. Table 7 assesses how representative the sample population was compared to the broader national population.

Table 7: Representativeness of the sample based on the relative proportions of providers stratified by program

Stratum (program)	There are a total 2,078 providers in the broader national population[66]	There were 151 providers in the sample population
CHSP	1,597 of 2,078 provide CHSP (**77 per cent**)	115 of 151 provide CHSP (**76 per cent**)
HCP	923 of 2,078 provide HCP (**44 per cent)**	113 of 151 provide HCP (**75 per cent**)
Flexible care programs	396 provide Flexible care programs (**19 per cent**)	49 provide Flexible care programs (**32 per cent**).

Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

It demonstrates that the sample represented a similar proportion of CHSP providers when compared with the broader national population (76 per cent compared with 77 per cent), but included relatively more HCP (75 per cent compared to 44 per cent) and Flexible Care (32 per cent to 19 per cent) providers.

In this study, the participation rate was:

- Highest for Flexible Care providers, with 49 of 396 (12 per cent) participating, and HCP providers, with 113 of 923 (12 per cent) participating.

[66] This includes individual providers and state health departments.

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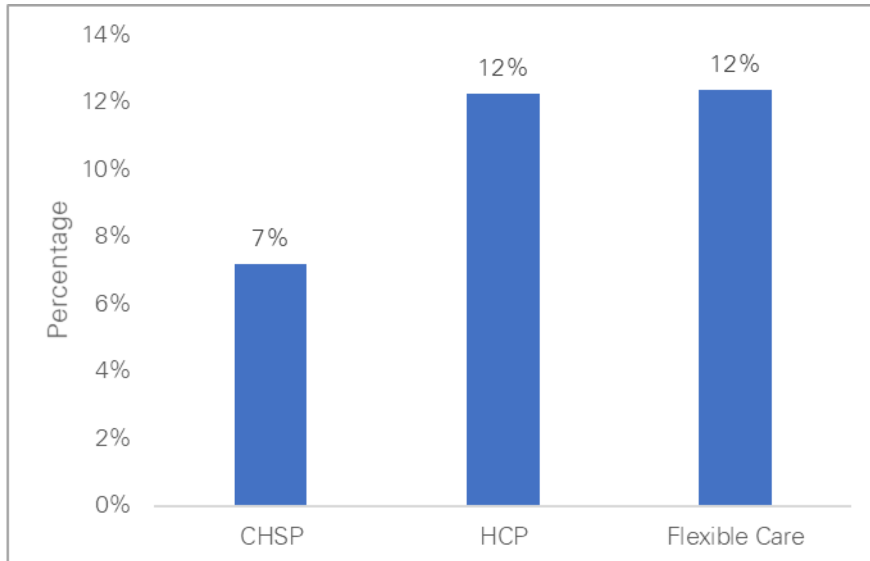
- The participation rate was lowest for CHSP providers, with 115 of 1,597 (seven per cent) participating. This distribution is illustrated in the figure below.

Figure 14: Percentage of participating providers out of national population of providers (by program)

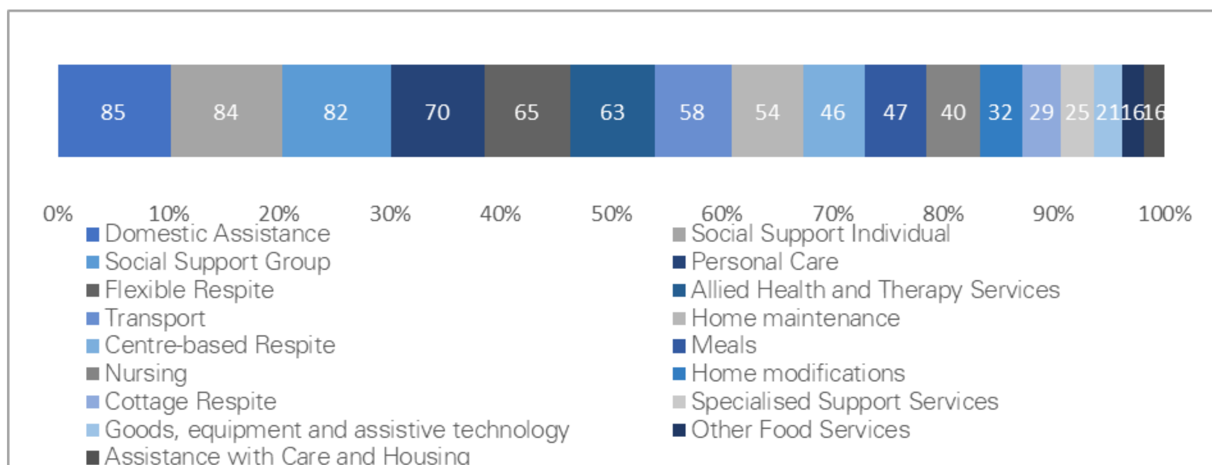


Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

Participating CHSP providers by CHSP service type

There are 17 different service types within the CHSP. A CHSP provider may deliver one or more CHSP service type. Of the 115 participating CHSP providers, 85 (74 per cent) deliver Domestic Assistance which was the most common CHSP service type. The distribution of CHSP services is illustrated in the figure below.

Figure 15: Distribution of participating CHSP providers (by CHSP service type)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

The participation rates of CHSP providers varied by CHSP service type. The participation rate was highest for CHSP providers of Cottage Respite, with 29 (18 per cent) participating CHSP providers submitting data on this service out of the total 163 Cottage Respite providers in the population.

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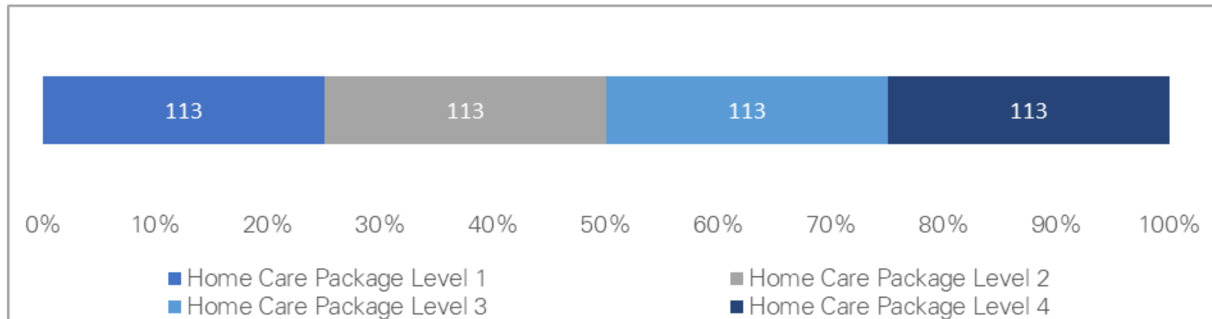
Participating HCP providers by HCP level

A HCP provider may deliver one or more HCP level. All 113 participating HCP providers delivered all four levels of HCP. The equal distribution of participating HCP providers by HCP levels is illustrated in the figure below.

Figure 16: Distribution of participating HCP providers (by HCP level)



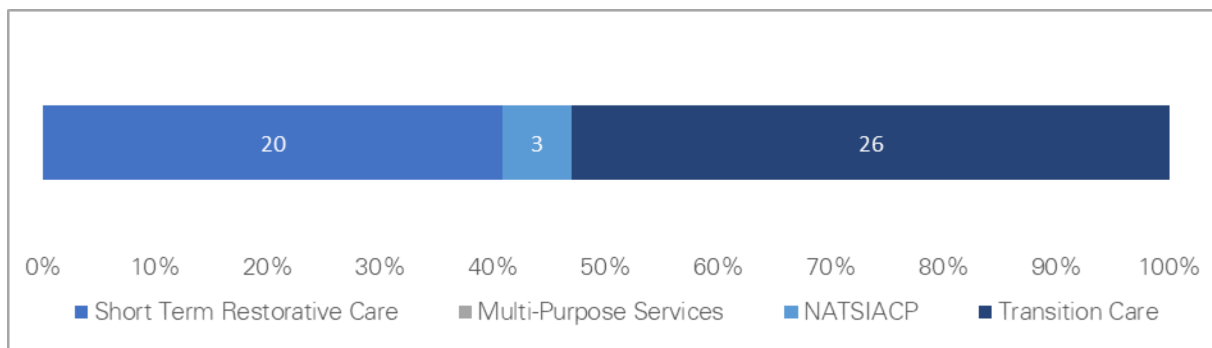
Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

The participation rates of HCP providers in this study were similar across HCP levels, with 113 participating HCP providers delivering each level of HCP (5 per cent) out of the total approximately 2,276 HCP providers in the population at each HCP level.

Participating Flexible Care providers by Flexible Care service type

STRC, MPS, TCP and the NATSIFACP are different types of Flexible Care. Of the 49 participating Flexible Care providers, 26 (53 per cent) deliver TCP, 20 (41 per cent) deliver STRC and three (6 per cent) deliver NATSIACP. None of the participating Flexible Care providers deliver MPS. This distribution is illustrated in the figure below.

Figure 17: Distribution of participating Flexible Care providers (by Flexible Care service type)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

The participation rates of Flexible Care providers in this study varied significantly by Flexible Care service type, with the largest representation from providers that deliver TCP. The participation rates ranged from none (0 per cent) participating out of 179 MPS providers in the population, to 26 (32 per cent) participating out of 81 TCP providers in the population.

Participating providers by jurisdiction

There was some variation across jurisdictions in the participation rates of providers. Tasmania and Western Australia had the highest rates of participating providers, with nine of 73 (12 per cent)

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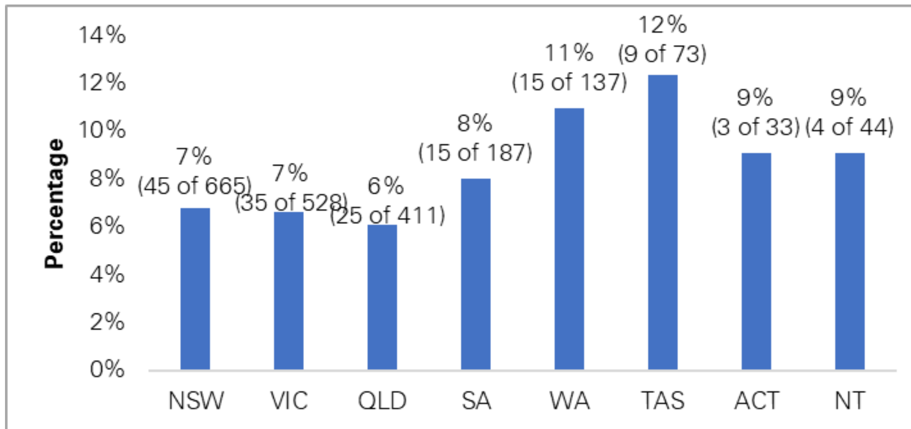
providers and 15 of 137 (11 per cent) providers participating respectively. Queensland had the lowest rate of participating providers, with 25 of 411 (6 per cent) providers participating. The participation rates of participating providers are illustrated in the figure below.

Figure 18: Percentage of participating providers out of population of providers (by jurisdiction)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

The table below (Table 8) assesses how representative the sample population was compared to the broader national population. No greater than five per cent difference was recorded between the proportions of providers by jurisdiction in the sample and the corresponding proportions of providers by jurisdiction in the broader population.

Table 8: Representativeness of the sample based on the relative proportions of providers stratified by jurisdiction

Stratum (jurisdiction)	There are a total 2,078 providers in the broader national population[67]	There were 151 providers in the sample population
NSW	665 of 2,078 are from NSW (**32 per cent**)	45 of 151 are from NSW (**30 per cent**)
VIC	528 of 2,078 are from VIC (**25 per cent**)	35 of 151 are from VIC (**23 per cent**)
QLD	411 of 2,078 are from QLD (**20 per cent**)	25 of 151 are from QLD (**17 per cent**)
SA	187 of 2,078 are from SA (**9 per cent**)	15 of 151 are from SA (**10 per cent**)
WA	137 of 2,078 are from WA (**7 per cent**)	15 of 151 are from WA (**10 per cent**)
TAS	73 of 2,078 are from TAS (**4 per cent**)	9 of 151 are from TAS (**6 per cent**)
ACT	33 of 2,078 are from the ACT (**2 per cent**)	3 of 151 are from the ACT (**2 per cent**)

[67] This includes individuals providers and state health departments.

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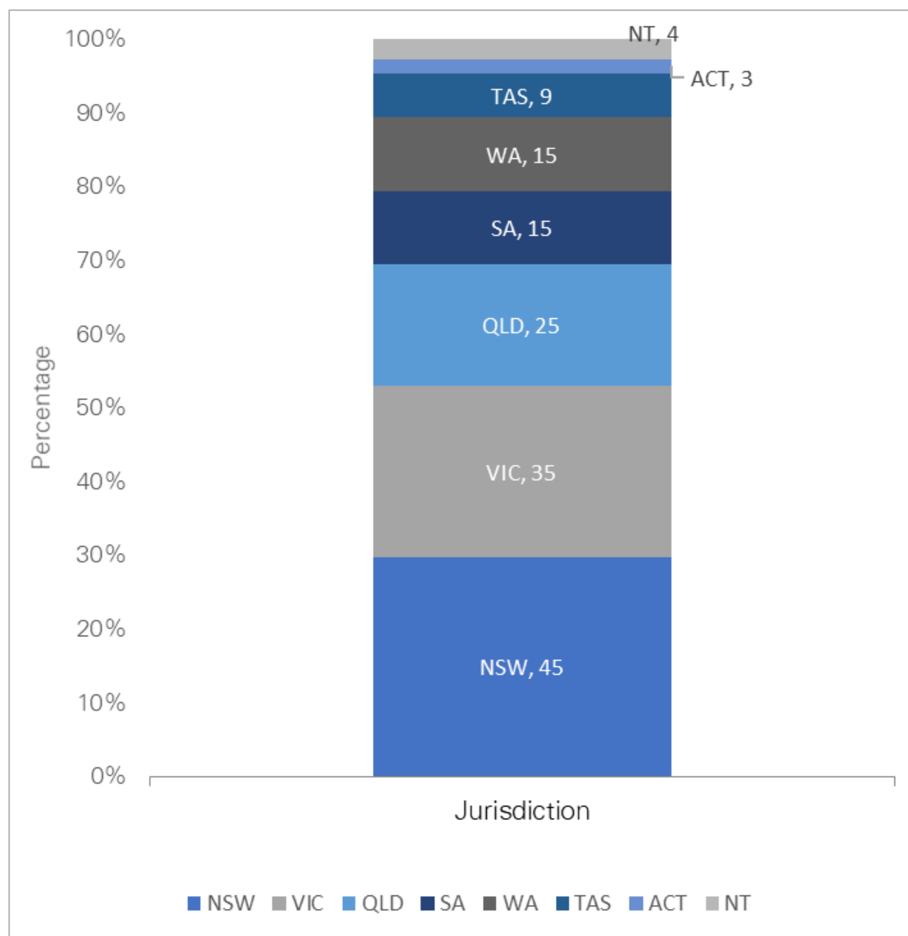
Stratum (jurisdiction)	There are a total 2,078 providers in the broader national population[67]	There were 151 providers in the sample population
NT	44 of 2,078 are from the NT (**2 per cent**)	4 of 151 are from the NT (**3 per cent**)

Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

Nationally, the majority of providers operate within New South Wales (NSW) (32 per cent), Victoria (25 per cent) and Queensland (20 per cent). Similar distributions were reflected in the sample population. Of the 151 providers who participated in this study, 45 (30 percent) are based in NSW while 35 (23per cent) are based in Victoria. This distribution is illustrated in the figure below.

Figure 19: Distribution of participating providers (by jurisdiction)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

Participating providers by remoteness

Major Cities had the highest rate of participating providers, with 109 of 1,199 (nine per cent) providers submitting data. This rate of participation for the participating providers is illustrated in the figure below, demonstrating that participation rates were highest in Major Cities, then Inner Regional and Remote centres, followed by Very Remote areas then Outer Regional centres.

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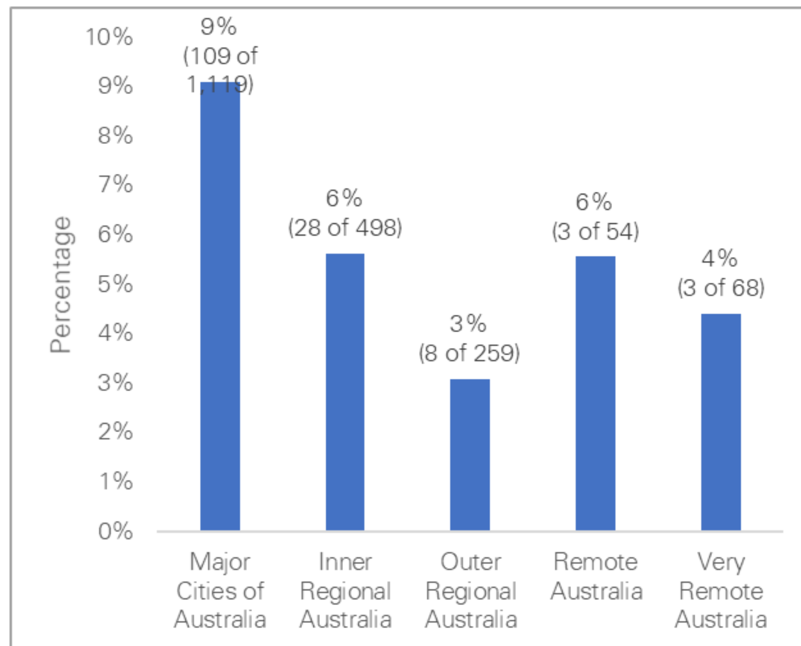
Figure 20: Percentage of participating providers out of total providers (by remoteness)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

The Table 9 assesses how representative the sample population was compared to the broader national population. When comparing the proportions of providers by remoteness categories in the sample and the corresponding proportions of providers by remoteness categories in the broader population, the differences in Remote and Very Remote Australia were around one per cent, in Inner and Outer Regional Australia between five and eight per cent. As an exception, the proportion of providers in Major Cities was 72 percent in the sample compared with 58 per cent in the broader provider population.

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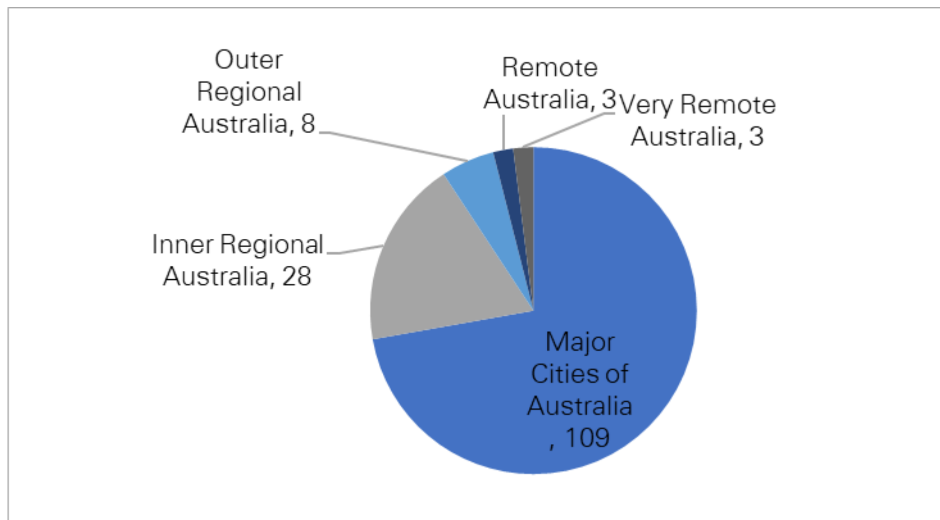
Table 9: Representativeness of the sample based on the relative proportions of providers stratified by remoteness

Stratum (remoteness)	There are a total 2,078 providers in the broader national population[68]	There were 151 providers in the sample population
Major Cities of Australia	1,199 of 2,078 are from Major Cities of Australia (**58 per cent**)	109 of 151 are from Major Cities of Australia (**72 per cent**)
Inner Regional Australia	498 of 2,078 are from Inner Regional Australia (**24 per cent**)	28 of 151 are from Inner Regional Australia (**19 per cent**)
Outer Regional Australia	259 of 2,078 are from Outer Regional Australia (**12 per cent**)	8 of 151 are from Outer Regional Australia (**5 per cent**)
Remote Australia	54 of 2,078 are from Remote Australia (**3 per cent**)	3 of 151 are from Remote Australia (**2 per cent**)
Very Remote Australia	68 of 2,078 are from Very Remote Australia (**3 per cent**)	3 of 151 are from Very Remote Australia (**2 per cent**)

Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

These distrbutions by remoteness across the sample are also illustrated in the figure below.

Figure 21: Distribution of participating providers (by remoteness)



Source: KPMG analysis of Prevalence Study data and data provided by the Department of Health

[68] This includes individuals providers and state health departments.

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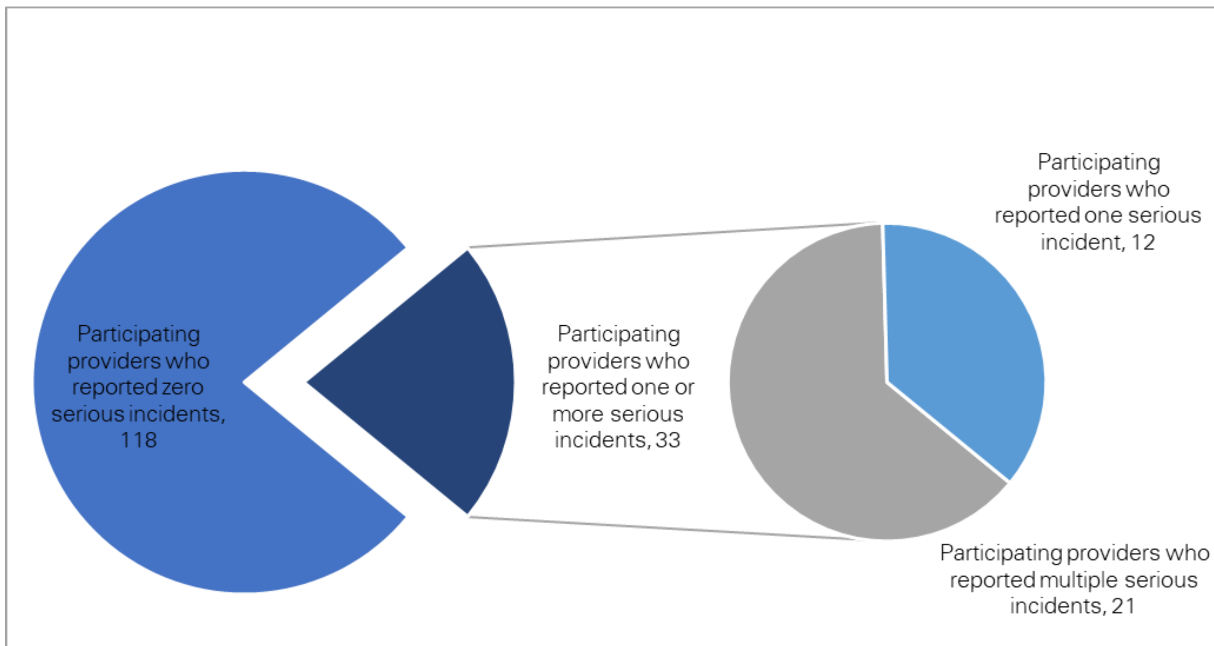
Descriptive analysis of serious incident data

KPMG analysed the serious incident data submitted by participating providers across six months of data collection (1 November 2020 to 30 April 2021) to understand the nature of serious incidents in home and community aged care settings.

Serious incidents reported by participating providers

Of the 151 participating providers, 118 (78 per cent) reported zero incidents and 33 (22 per cent) reported one or more serious incidents. Of the 33 participating providers who reported one or more serious incidents in that timeframe, 12 (36 per cent) reported one incident only and 21 (64 per cent) reported more than one incident. This distribution is illustrated in the figure below.

Figure 22: Count of serious incidents reported by participating providers



Source: KPMG analysis of Prevalence Study data

In total, 161 serious incidents were reported. Twelve participating providers reported they had one incident and of the 21 participating providers who reported more than one serious incident, eight (38 per cent) reported more than five incidents. This is illustrated in the figure below.

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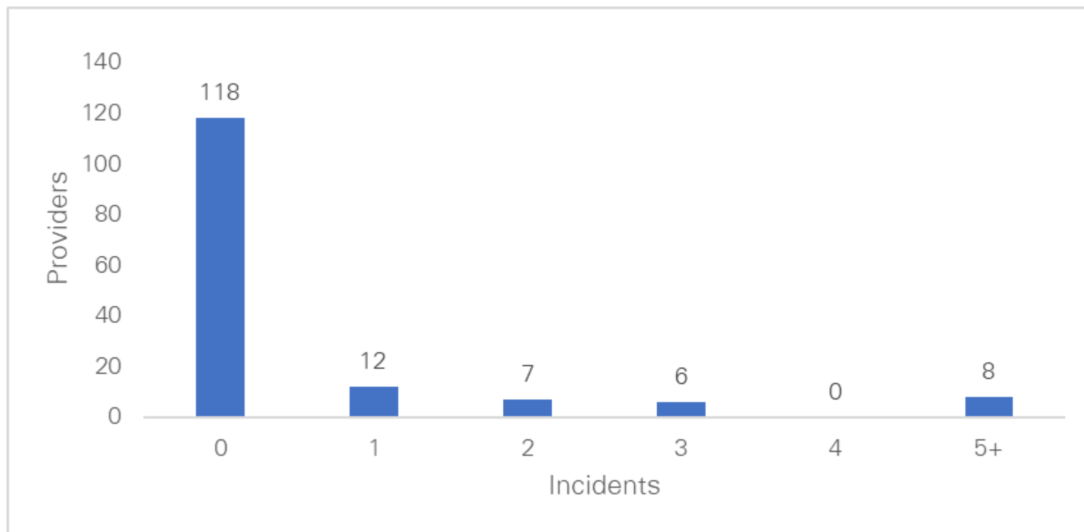
Figure 23: Count of providers who reported an incident by the number of incidents reported



Source: KPMG analysis of Prevalence Study data

Eight out of the 151 providers (five per cent) reported five or more incidents. These providers reported 117 (73 per cent) of the 161 serious incidents. Of these providers:

- One provider reported five incidents – all staff-to-care recipient incidents
- One provider reported seven incidents – all staff-to-care recipient incidents
- One provider reported seven incidents – six staff-to-care recipient incidents and one care recipient-to-care recipient incident
- One provider reported nine incidents – seven staff-to-care recipient incidents and two care recipient-to-care recipient incidents
- One provider reported 11 incidents - all staff-to-care recipient incidents
- One provider reported 17 incidents – 14 staff-to-care recipient incidents and three care recipient-to-care recipient incidents
- One provider reported 26 incidents – all staff-to-care recipient incidents
- One provider reported 35 incidents – all staff-to-care recipient incidents.

Nearly all reported serious incidents were between a staff member and a care recipient or their carer / family member. Of the 161 reported serious incidents, 151 (94 per cent) were committed by a staff member to a care recipient or their carer / family member while ten (six per cent) were committed by one care recipient to another care recipient in a community setting. This distribution is illustrated in the figure below.

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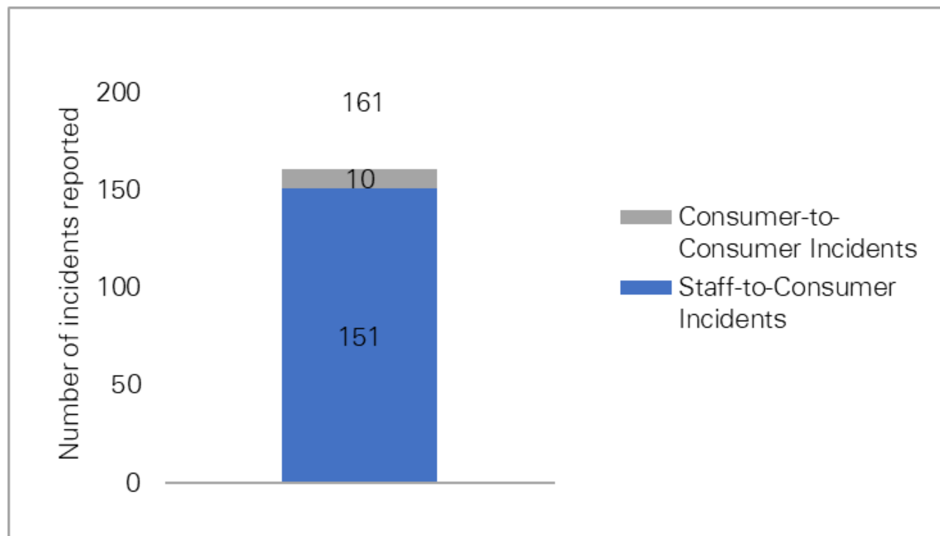
Figure 24: Count of serious incidents reported by participating providers by perpetrator type



Source: KPMG analysis of Prevalence Study data

Reported staff-to-care recipient incidents involving the same perpetrator

Of the 151 participating providers, 33 providers reported staff-to-care recipient incidents (22 per cent). Of these 33 providers, 19 providers reported more than one staff-to-care recipient incident. Of these, 14 provided data on whether the same staff member was involved in more than one staff-to-care recipient incident. Of these 14 providers, three indicated that the same staff member was involved across their multiple incidents in the first reporting period and two indicated that the same staff member was involved across their multiple incidents in the first reporting period. However, the three providers that indicated the same perpetrator was involved during the first reporting period were different to the two providers that indicated the same perpetrator was involved during the second reporting period.

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Table 10: Count of incidents reported by providers with more than one staff-to-care recipient incidents

Provider type	Number of providers	Number of incidents reported
Providers reporting more than one staff-to-care recipient incident	19	137
Providers reporting more than one staff-to-care recipient incident that **provided information** on whether the same perpetrator was involved	14	127
Providers reporting more than one staff-to-care recipient incident **where they reported that the same perpetrator was involved during the first reporting period**	3	33
Providers reporting more than one staff-to-care recipient incident **where they reported that the same perpetrator was involved during the second reporting period**	2	19

Source: KPMG analysis of Prevalence Study data

Reported incidents by program

The program with the highest number of serious incidents reported was HCP. Of the 161 reported serious incidents, 94 (58 per cent) occurred while HCP was delivered, 60 (37 per cent) occurred while CHSP was delivered, and two (3 per cent) occurred while Flexible Care was delivered. This distribution is illustrated in the figure below. There were five serious incidents with an unknown program.

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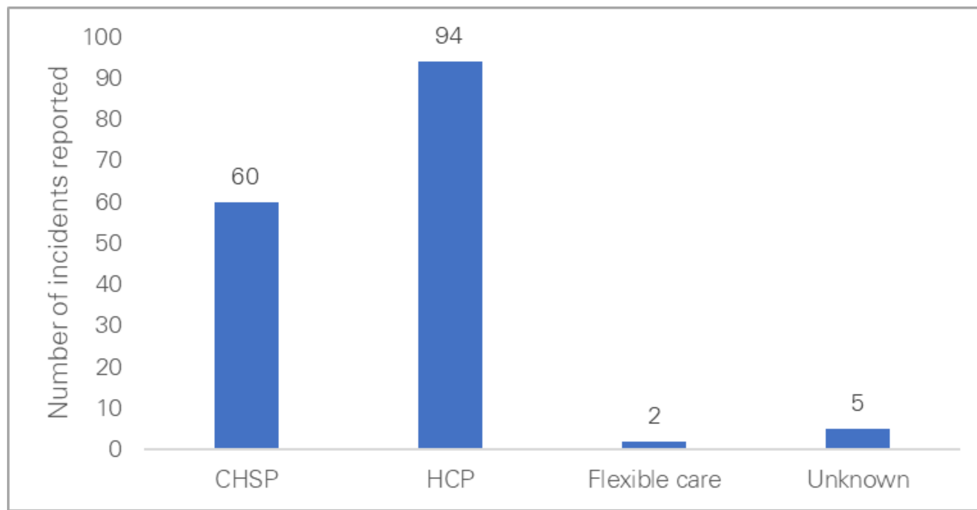
Figure 25: Count of serious incidents (by program) reported by participating providers[69]

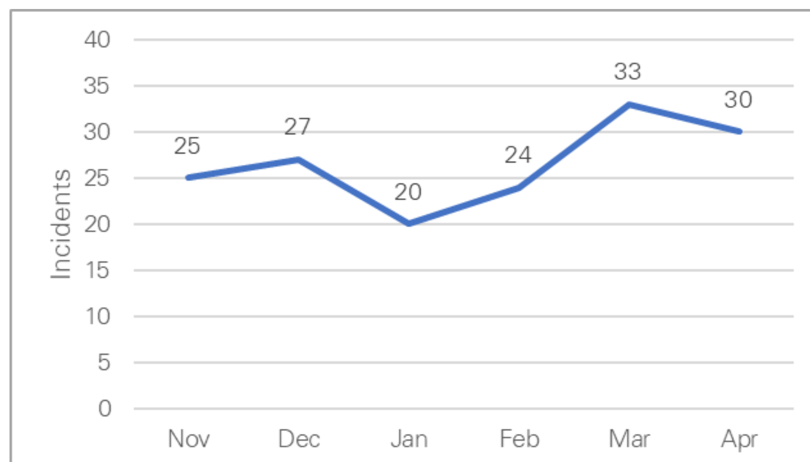


Source: KPMG analysis of Prevalence Study data

Reported incidents by month

The total number of serious incidents reported by participating providers was relatively consistent across the six months of data collection (1 November 2020 to 30 April 2021). On average, 27 serious incidents were reported per month, with slightly more being reported in March and April 2021. This distribution is illustrated in the figure below.

Figure 26: Count of total serious incidents reported (by month) by participating providers[70]



Source: KPMG analysis of Prevalence Study data

Reported incidents by incident type

A list of incident types was presented to participating providers, who were asked to select only one of seven incident types from the list that was perceived to most closely reflect the nature of

[69] For five incidents, respondents did not provide information on the program type, hence were designated as 'unknown'
[70] N=159 because one respondent recorded that a serious incident occurred in December 2021 and one respondent did not provide a date

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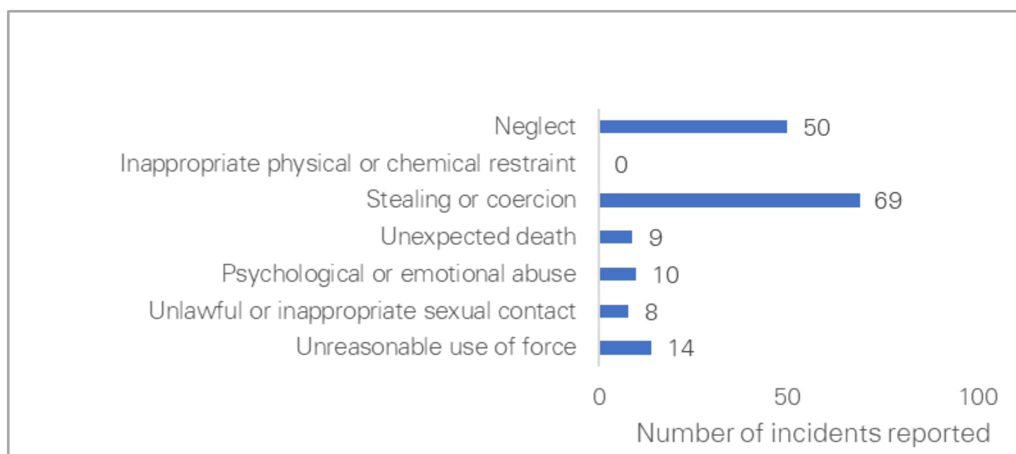
each serious incident they reported. The incident types available for selection were "neglect", "inappropriate physical or chemical restraint", "stealing of coercion", "unexpected death", "psychological or emotional abuse", "unlawful or inappropriate sexual contact" and "unreasonable use of force".

Of the 161 reported serious incidents, 69 (43 per cent) were reported to be either events of stealing or coercion, while 50 (31 per cent) were reported to be neglect. The number of incidents reported as unreasonable use of force, unlawful or inappropriate sexual contact and psychological or emotional abuse were all reported less than 15 times each. None of the 161 reported serious incidents involved inappropriate physical or chemical restraint (one submission did not complete this field). This distribution is illustrated in the figure below. [71]

Figure 27: Count of total serious incidents (by types) reported by participating providers[72]



Source: KPMG analysis of Prevalence Study data

Reported incidents by impact type

A list of impact types was presented to participating providers, who were asked to select only one of six impact types from the list that was perceived to most closely reflect the nature of each serious incident they reported. The impact types available for selection were "fatality or 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", "minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions" and "no impact".

Of the 161 reported serious incidents, 80 (50 per cent) were reported to have no impact on the victim while 66 (38 per cent) were reported to result in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions.

Six serious incidents (four per cent) resulted in fatality or severe permanent physical or psychological impairment, representing reported serious incidents (one submission did not complete this field). The disconnect between the number of unexpected deaths (9) and impacts reported as fatalities is noted. [73]

[71] N=159 because one respondent recorded that a serious incident occurred in December 2021 and one respondent did not provide a date
[72] N=160 because one respondent did not record a serious incident type
[73] N=160 because one respondent did not record a serious incident impact

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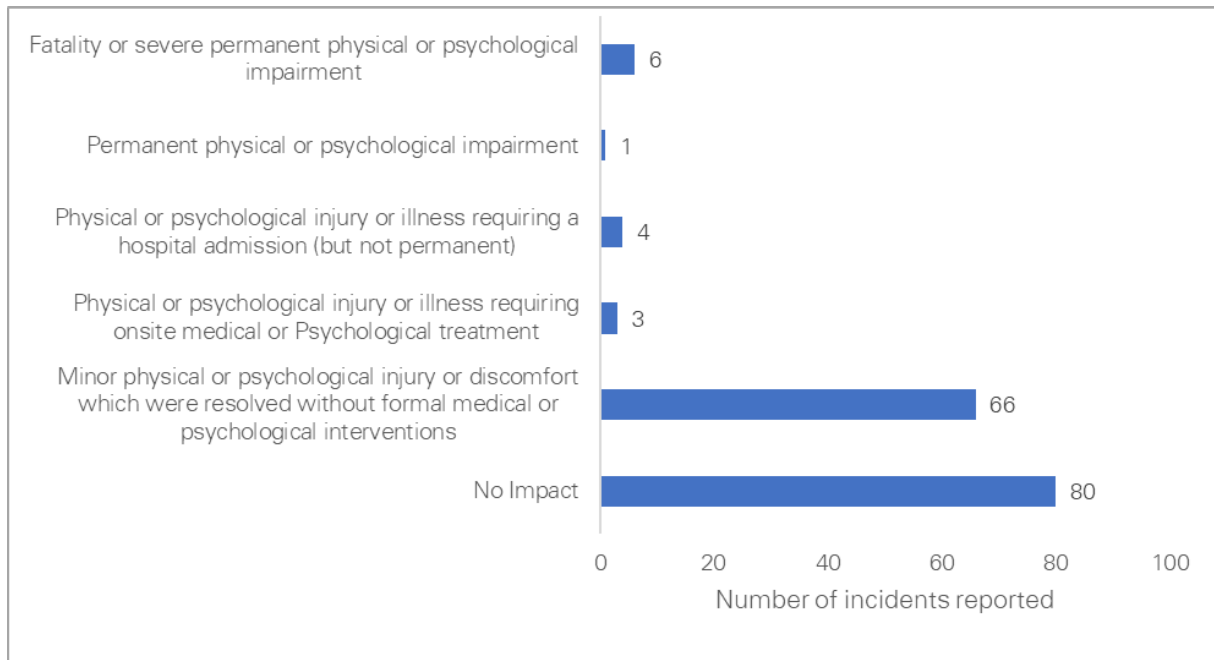
Figure 28: Count of serious incidents (by impact) reported by participating providers[74]



Source: KPMG analysis of Prevalence Study data

Reported incidents by response type

A list of response types was presented to participating providers, who were asked to select all response types from the list that reflected the actual action(s) taken in response to a serious incident they reported. The response types available for selection were "hospital admission for the victim", "onsite medical treatment provided to the victim", "referral made to a general practitioner (GP) (or other health professional)", "report made to the police", "update made to the victim's care plan", "referral made to the Dementia Behaviour Management Advisory service" and "none". Providers were able to select more than one response per incident. Hence, there were 175 counts for responses recorded across the 161 incidents.

The "none" category of response was the most common type of response reported by participating providers. 80 serious incidents (50 per cent) resulted in no response. A small amount of unsolicited feedback, documented from two providers, suggested that potentially, there may be some instances where providers selected "none" as their response type even though they had taken some form of action. This may have occurred, for example, if the provider perceived that their actual action taken did not to align with the response types available for selection.

Sixty-eight serious incidents resulted in only one action being taken. No serious incident resulted in five or more actions being taken. This is outlined in Table 11.

Table 11: Count of response to reported serious incidents (by number of actions)

Number of responses to a reported serious incident	Number of reported serious incidents	Percentage of total reported serious incidents
No response	80	50%

[74] N=160 because one respondent did not record a serious incident impact

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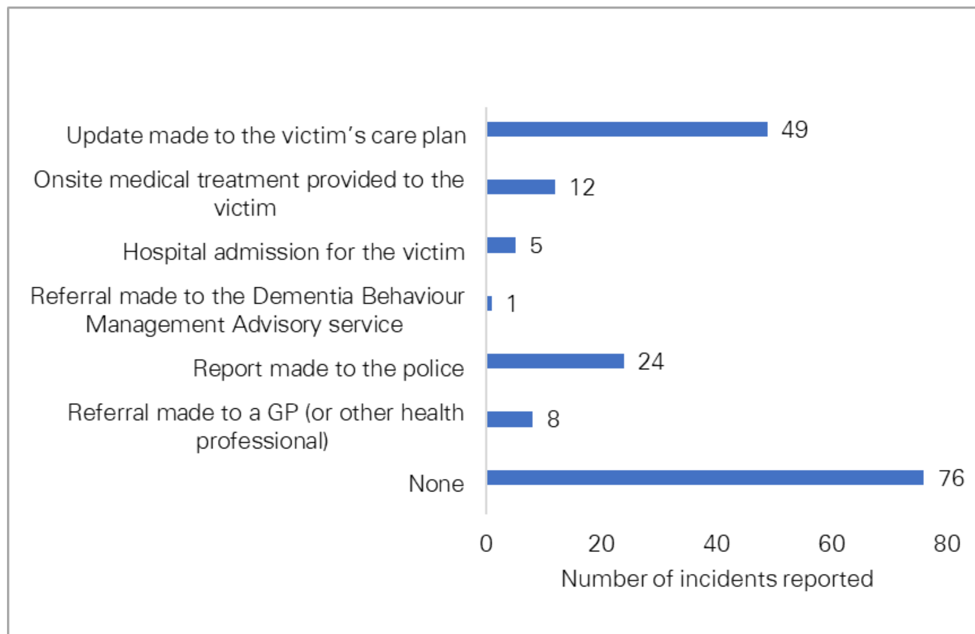
Number of responses to a reported serious incident	Number of reported serious incidents	Percentage of total reported serious incidents
One action	68	42%
Two actions	9	6%
Three actions	3	2%
Four actions	1	1%
Five or more actions	0	0%
Total	**161**	**100%**

Source: KPMG analysis of Prevalence Study data

Of the 175 responses to serious incidents, 49 (28 per cent) had an update made to the victim's care plan and 24 (14 per cent) involved a report to the police. This distribution is illustrated in the figure below.

Figure 29: Count of serious incidents (by response) by participating providers



Source: KPMG analysis of Prevalence Study data

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Impact and response to different types of reported incidents

Table 12 below summaries the impact of the 161 reported incidents by incident type (noting one submission did not complete this field).

Table 12: The impact of different incidents

Incident type	Impact						Total of each incident type
	No Impact	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	
Stealing or coercion	32	37	0	0	0	0	**69**
Neglect	35	13	1	1	0	0	**50**
Unreasonable use of force	8	4	0	2	0	0	**14**
Psychological or emotional abuse	0	9	1	0	0	0	**10**
Unexpected death	2	0	0	0	1	6	**9**
Unlawful or inappropriate sexual contact	3	3	1	1	0	0	**8**
Inappropriate physical or chemical restraint	0	0	0	0	0	0	**0**

Source: KPMG analysis of Prevalence Study data

Table 13 below summaries the 175 responses to the 161 reported incidents by incident type.

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Table 13: The response of different incidents

Incident type	Response							Total number of responses to by incident type
	None	Update made to the victim's care plan	Onsite medical treatment provided to the victim	Hospital admission for the victim	Referral made to the Dementia Behaviour Management Advisory service	Report made to the police	Referral made to a GP (or other health professional)	
Stealing or coercion	34	17	0	0	0	19	2	**72**
Neglect	35	12	5	1	0	0	2	**55**
Unreasonable use of force	3	10	1	2	0	1	1	**18**
Unlawful or inappropriate sexual contact	1	4	1	1	1	2	3	**13**
Unexpected death	3	1	4	1	0	0	0	**9**
Psychological or emotional abuse	0	5	1	0	0	2	0	**8**
Inappropriate physical or chemical restraint	0	0	0	0	0	0	0	**0**

Source: KPMG analysis of Prevalence Study data

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Summary of the impact and response to different incident types.

From Table 12 and Table 13, we can summate that for each incident type:

- *Incidents involving stealing or coercion:* Of the 69 incidents of stealing or coercion, 37 (54 per cent) resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions, the remainder (46 per cent) reported no impact on care recipients. While the most common response to stealing or coercion was no action (33 per cent), 26 per cent of responses to stealing or coercion involved making a report to the police and 24 per cent involved updating the victim's care plan.
- *Neglect:* Of the 50 incidents of neglect, 35 (70 per cent) reported no impact while 13 (26 per cent) reported minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions. Similarly, the most common response to incidents of neglect was no action (35 responses or 64 per cent), but 22 per cent of responses involved updating the victim's care plans.
- *Unreasonable use of force:* Of the 14 incidents involving unreasonable use of force, 6 (43 per cent) were care recipient-to-care recipient incidents. Put another way, six of the ten care recipient-to-care recipient incidents (60 per cent) related to unreasonable use of force. The most common response to incidents of unreasonable use of force was to update the victim's care plan (56 per cent).
- *Psychological and emotional abuse:* Of the ten incidents of psychological and emotional abuse, nine resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions, one resulted in physical or psychological injury or illness requiring onsite medical or psychological treatment.
- *Incidents involving unexpected death:* Of the 161 reported incidents, nine were reported as unexpected deaths (six per cent). Among these nine incidents involving unexpected deaths, the most common reported response was onsite medical treatment provided to the victim.
- *Incidents involving unlawful or inappropriate sexual contact:* Reported serious incidents involving unlawful or inappropriate sexual contact were most commonly perceived either have no impact to the victim (3 incidents, 38 per cent) or to have resulted in minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions (3 incidents, 38 per cent). The most common response was to either update the victim's care plan (31 per cent of actions taken), make a referral to a GP or other health profession (23 per cent) or make a report to police (15 per cent).

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Appendix B – Approach to modelling data

The Horvitz Thompson (or linear unbiased estimator) can be used for any probability sample design.[75] Key statistics, formula and brief descriptions of this approach are outlined in Table 14.

Table 14: Statistics to estimate, formulae and descriptions

Statistic to estimate	Formula	Descriptions
Estimate of total incident	$\hat{Y} = \sum_{i \in s} \frac{N}{n} y_i$	In this situation, we assume that all services have equal weight (N= 2,078 and n=151) and sum the incidents at each provider (e.g. 5 serious incidents) are (yi)
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 = 2,078, n = 151. The sampling fraction f = 151/2,078 and the sample variance S_y^2 is calculated from the total incident data for each provider.
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.

Source: KPMG

Four methods were used to weight the data and calculate national level estimates. All four were based on the linear unbiased estimator. Method One assumed that all services had equal weight, Method Two post-stratified providers into program, Method Three into jurisdiction, Method Four into remoteness category.

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

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