



Australian Government

Department of Health

Serious Incident Response Scheme for Commonwealth funded in-home aged care services

Report on outcomes of consultation

24 August 2021

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Background

Purpose of this report

The purpose of this report is to describe the key themes and findings from consultation with stakeholders regarding the key elements of a Serious Incident Response Scheme (SIRS) for Commonwealth funded in-home services.

The outcomes of this consultation will further inform advice to the Australian Government on the development of the SIRS for in-home services, including the requirements of the scheme, alignment and differences between the SIRS for residential care (and reasons for any differences) and the matters to support the implementation of the scheme.

For the purposes of the consultation, in-home services refers to any Commonwealth funded aged care services delivered in the home or community and includes care delivered through home care packages, the Commonwealth Home Support Programme (CHSP) and flexible care delivered in a home or community setting (including Multi-Purpose Services (MPS), Short Term Restorative Care (STRC), National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and the Transition Care Program (TCP).

Proposed model

On 12 July 2021, the Department of Health (the Department) released an online consultation paper seeking public comment on the details of a SIRS for Commonwealth funded in-home services. Online consultation closed on 9 August 2021.

As described in the consultation paper, the SIRS for residential care (including flexible care delivered in a residential setting), which commenced on 1 April 2021, provides a basis for the SIRS for in-home services.

Noting the benefits of adopting a common framework and arrangements across all aged care types, the consultation paper also recognised the significant contextual differences between residential care and in-home services, including:

- providers of in-home services have less control over the care environment, including the nature or set up of a home, where the consumer goes outside their home and who visits consumers
- providers may deliver services through sub-contracted individuals/organisations
- staff from multiple providers may be delivering care and services to a consumer
- a provider's ability to investigate and prevent incidents is more limited where care is delivered in the home (e.g. where the provider has limited day-to-day contact with consumers and where multiple parties may be delivering care and services).

Given such differences, stakeholder feedback was sought on key areas in which changes may be required to ensure the SIRS is appropriate in the context of care and services delivered in a consumer's home. Feedback was sought in relation to five main elements of the proposed scheme:

1. responsibilities for managing incidents and taking reasonable steps to prevent incidents, including through implementing and maintaining an incident management system
2. notifying the Aged Care Quality and Safety Commission (the Commission) of reportable incidents

3. notifying others of incidents (e.g. police, Coroner, etc.)
4. the scope of incidents to be notified to the Commission
5. notification timeframes and priority categories.

Stakeholder feedback in response to the consultation paper was sought through four stakeholder forums (including with consumers, providers and other Government agencies) and through a public online survey undertaken on the Department's Consultation Hub. See [Attachment A](#) for more detailed information regarding the profile of stakeholders responding to the online survey.

Summary of stakeholder feedback

Most stakeholders supported the introduction of the SIRS for in-home services; highlighting that the expansion to in-home services should be aligned as much as possible with the requirements currently applicable in residential services, balanced with the specific nuances and differences of in-home services.

Overall, stakeholders considered the proposed incident management and prevention requirements (consistent with those in residential care) to be reasonable. However, stakeholders felt that the scope of incidents to be captured under the SIRS for in-home services needed to be more tightly defined than in residential care. For example, by tying incidents directly to the actions of the provider or where incidents are a direct consequence of the care and services.

While stakeholders proposed adjustments and clarifications to the proposed definitions of reportable incidents, stakeholders generally felt that all the proposed categories of reportable incidents were applicable for the SIRS for in-home services. Stakeholders also considered that, broadly speaking, the reporting timeframes in the SIRS for residential care were appropriate for in-home services.

Some providers noted that they already have incident management systems in place (consistent with the requirement in Aged Care Quality Standard 8) and undertake reporting as required under other programs (e.g. the National Disability Insurance Scheme (NDIS)), such that the introduction of the SIRS for in-home services would be fairly straightforward. Whereas others highlighted the significant change the SIRS represents for their organisation and emphasised the support and training that would be required to implement it.

Stakeholders highlighted the importance of robust and consistent guidance, particularly to support providers to understand what is and what is not a 'reportable incident'. Stakeholders also considered that communications for providers, workers, consumers and their families would be important to ensure all parties have a consistent understanding of, and expectations regarding, what will be required under the SIRS.

In considering the broader environment, stakeholders noted that the SIRS for in-home services:

- needs to be positioned in the broader context in which many workers have professional standards, providers have duty of care and jurisdictions impose various reporting requirements
- needs to be presented as one component of a broader agenda to tackle elder abuse, highlighting the relevance of other mechanisms for managing and reporting incidents of elder abuse outside the control of the provider (such as by members of consumers' families or household)
- intersects with the role of the Attorney-General, highlighting the need for coordinated government efforts in actioning a national elder abuse plan.

Considerations for implementing SIRS for in-home services

Building on the examples in the consultation paper, stakeholders highlighted a number of differences between residential care and in-home services that should be considered in the design of the SIRS for in-home services:

- providers of in-home services will usually have much more limited interaction with consumers, particularly for some CHSP services (such as transport, maintenance, etc.), impacting the provider's ability to:
 - identify when an incident has occurred
 - assess or investigate an incident, including to identify the perpetrator/cause of an incident and to understand the impact of the incident on the consumer's health and wellbeing
 - respond to and report incidents in an effective and timely way
- providers of in-home services have limited control over the consumer's environment, impacting their ability to prevent and manage risks to the consumer's health, safety and well-being
- some CHSP providers may provide very infrequent (or one-off) services to a consumer (for example, some services may be provided only every four to twelve weeks) and may not always interact with the consumer during service delivery (for example, where garden maintenance services are provided)
- there is the potential of elder abuse in home settings, including domestic violence by those living with, or related to, the consumer
- the potential conflict between the concepts of consumer choice and dignity and mandatory reporting of incidents where consumers do not wish for a report to be made
- consumers are potentially at greater risk of retribution in response to a report being made (to police, the Commission or another body). For example, where:
 - the consumer lives in the same household as the perpetrator of an incident
 - staff who are suspected or alleged to have perpetrated an incident have access to the consumer's home
 - providers may withdraw services, leaving consumers without the care and services they need
- providers are likely to be providing in-home services to a greater volume of consumers than in residential services (noting that some providers are supporting more than one thousand consumers in their homes)
- there may be other individuals/organisations involved in a consumer's care and services, impacting on the provider's ability to manage risks to the consumer and to ensure the provider has appropriate oversight of the consumer's care and services
- in-home services may be provided by a range of workers (including volunteers) who are not necessarily skilled in identifying or responding to incidents due to the type of services they provide (e.g. workers making home modifications that are provided to the community more broadly, such that specific knowledge of expectations regarding incidents is not always well understood)
- in some instances, consumers may have limited or no interaction with others beyond the worker providing their care and services, such that negligent or inappropriate practices/incidents perpetrated by their care worker go unidentified and unreported.

Managing and preventing incidents

As described in the consultation paper, under the Aged Care Quality Standards, all providers are required to have effective risk management systems and practices for preventing and managing incidents. In addition, providers of residential care also have specific responsibilities relating to incident management and prevention.

The consultation paper proposed that these same responsibilities be applied to providers of in-home services in respect of:

*Any act, omission, event or circumstance that occurs **in connection with the provision of care or services** that:*

- *has (or could reasonably be expected to have) caused harm to a consumer or another person (such as a staff member), or*
- *is suspected or alleged to have (or could reasonably be expected to have) caused harm to a consumer or another person, or*
- *the provider becomes aware of and that has caused harm to the consumer.*

Under the proposed requirements, ‘**in connection with**’ is intended to capture incidents that have occurred during the course of providing care and services, or due to the omission of care and services, including 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 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.

Incident management requirements

Broadly, stakeholders supported the proposed requirements for incident management and prevention, noting that requirements for residential care could equally apply in the in-home services context.

Stakeholders commented that:

- “There should be strengthened language around specific provider responsibility for the efficient management of incidents and risk mitigation”.
- “People living in their own home are sometimes more vulnerable than those in residential care where there are many checks and balances and pairs of eyes watching”.

Stakeholders also noted the importance of training and development for workers to feel confident in assessing risk within the home and implementing strategies to mitigate risk and prevent incidents.

Some stakeholders (particularly in-home service providers) were concerned that the proposed requirements were not necessarily feasible in the context of in-home services, particularly noting, for example:

- the nature of service delivery in a consumer’s home limits the provider’s ability to manage and respond to incidents

- a provider’s responsibility to prevent and manage incidents should be proportionate to the services being delivered (noting the variety of service types provided under in-home services)
 - “If a provider provides domestic support or personal care, they would have a greater ability to comply to the new suggested SIRS policy but if provider is transport only or meals only, they would not be able to comply”.
 - “Only providers of home care packages should be required to comply with these requirements as they have a more significant role in providing care for consumers, whereas CHSP providers have minimal contact and care responsibilities and should not be asked to manage incidents for these clients”.
 - “It is important to consider how this applied to providers who deliver non-care related services and who may only provide services one to two times a year or less frequently, e.g. home modifications providers or goods, equipment and assistive technology providers. These providers have minimal interaction with the consumer and while they have the same responsibility to report they should not necessarily be responsible for investigation and ongoing management of an incident”.
- some stakeholders were concerned that a provider’s ability to investigate and assess an incident may be quite limited in this context, including where:
 - there is unlikely to be an independent witness to incidents occurring in the consumer’s home
 - consumers with cognitive impairment do not remember or cannot describe how an incident occurred
 - consumers do not wish for an incident to be investigated or are not willing to be involved in the investigation
 - workers only identify that an incident occurred sometime after it occurred, by which point an investigation may not be warranted.

Stakeholders also noted that, in scenarios where care of a consumer is shared, a key issue for resolution is whether or not providers will be required to record allegations or suspicions relating to another provider in their own incident management system.

Scope of incidents

Stakeholders expressed differing views as to whether the scope of ‘in connection with’ should be tied solely to incidents that have occurred as a result of the actions of the provider, or whether they should also include incidents perpetrated by other parties (such as family members, neighbours or other members of the household). There were also mixed views as to whether the requirements should also include incidents about a person other than the care recipient.

Some stakeholders considered that the proposed scope was too broad or unclear and needed to be tightened, particularly to ensure that providers aren’t required to assert control over aspects of consumers’ lives that they are not involved in. *“It is unreasonable to expect providers to manage incidents in which they have had no part”*.

These stakeholders suggested that incident management and prevention requirements be clarified and more strongly tied to incidents that occur because of the actions (or inaction) of the provider/worker. Stakeholders suggested that incidents to be managed and prevented by providers should include:

- incidents perpetrated by, or resulting from the conduct of, staff of the provider
- incidents that have occurred during the provision of, or as a consequence of, the care and services. For example:

- where a consumer has fallen while being showered by a worker
- where a consumer is dropped while being moved
- where the provider installs a grab rail in the shower and, due to poor installation, it collapses, and the consumer is injured
- incidents that have occurred as a consequence of the provider failing to provide care and services in line with assessed care needs. For example:
 - missed services for consumers where harm may reasonably be assumed to be a risk, e.g. missed transport to renal dialysis
 - services that are not provided as per the consumer's assessed care needs and preferences, e.g. a consumer's wound has increased in size because the worker has not followed instructions regarding how to dress and care for the wound
- incidents that have occurred as a consequence of the conduct of other consumers attending in-home services in the community (e.g. transport services or day therapy services).

Some stakeholders highlighted other incidents that providers/workers may witness or become aware of, including:

- incidents that occur during service delivery that are not connected to the worker and/or the care and services being delivered
- incidents of elder abuse perpetrated by family or other members of the consumer's household
- incidents that are perpetrated by consumers against their informal carers (e.g. where the consumer has dementia).

A number of stakeholders highlighted that most incidents of elder abuse that occur in the home are perpetrated by family members or other members of the household, and that there should be a mechanism for managing and preventing such incidents. However, it was generally agreed that these should continue to be managed through existing mechanisms (such as reporting to police and in line with the national agenda) and that, while providers may choose to include such incidents in their incident management systems, this should not be mandated under the SIRS due to limitations in the provider's ability to manage and prevent such incidents.

It was also generally agreed that the focus should be on incidents relating to the consumer as opposed to:

- incidents impacting another party (e.g. staff), noting that providers may choose to include incidents relating to staff in their incident management system
- incidents involving the consumer but where the provider's staff have not been involved (e.g. where the actions of another party such as neighbours, family, other members of the household have caused harm to the consumer). In this case the provider would still be expected to offer necessary support to the consumer (and any injury to the consumer would need to be considered in terms of how care is delivered) however the incident that gave rise to the consumer's condition would not need to be recorded in the provider's IMS.

Notifying police and others of incidents

Consistent with current arrangements for residential care (and under any applicable state and territory laws) the consultation paper proposed that:

- if there are reasonable grounds to report an incident to police, a provider of in-home services will be required to notify police of the incident within 24 hours of becoming aware of the incident, irrespective of if they are responsible for the incident
- as part of the requirements for managing incidents, a provider must respond to an incident by assessing whether other persons or bodies should be notified of the incident and notifying them if appropriate.

Generally, stakeholders supported the proposed requirements to notify police and others, with some differing views regarding the consumer's role in reporting and whether a provider may report incidents (to police/others or the Commission) without the consumer's consent.

Consumer role in reporting

A limited number of stakeholders noted that consumers should be able to self-report incidents to police and others (and to the Commission under the SIRS), noting that consumers receiving in-home services (especially those in self-managed packages) usually have sufficient capacity to self-report and should be given autonomy over the reporting of incidents.

Overall, while stakeholders recognised that many consumers have capacity to self-report and there should be no barriers to this, stakeholders recognised the importance of:

- clear requirements regarding who must report, and to whom
- reports being made via a centralised mechanism (or recognised avenue), and
- information being joined up (including within the Commission where a notification is made by a provider via the SIRS or by a consumer via a complaint) to support transparent and consistent treatment of incidents.

Consumer consent

While views on consumer consent were varied, on the whole stakeholders did not consider consumer consent should be a 'precondition' to reporting incidents to police and others (or notifying a reportable incident to the Commission).

Stakeholders reasoned that, while it is important for reporting of incidents to be discussed with consumers where possible, providers should have the ability to make reports without the consumer's consent for a range of reasons:

- some consumers may not be willing or able to provide consent, leaving them at risk of harm, including where:
 - the perpetrator is a family member, member of their household or otherwise has unrestricted access to the consumer's house
 - the consumer does not believe they're at risk of serious harm
 - the consumer is afraid of retribution from the perpetrator
 - the consumer is cognitively impaired
- some perpetrators may use "coercive control" to intimidate consumers and prevent them from providing consent

- workers felt strongly that they have a duty of care to the consumer to report where they witness or suspect an incident has occurred (e.g. where they have reason to believe the consumer has been subjected to harm)
 - “Consumers are vulnerable and should be protected from harm”.
 - “If consumers don’t consent to incidents being reported, it may remain a silent and ongoing issue (e.g. elder abuse)”.
- the provider may be more likely to make a confidential report to police or the Commission rather than raising issues directly with the consumer or their representative/family (e.g. where the situation is sensitive)
 - Some noted the importance of protections for workers who make reports (e.g. where the perpetrator of an incident may seek to intimidate or scapegoat a worker).

Others felt that reports should only be made with the consumer’s consent, variously noting that:

- consumers should have the right to say they do not want something reported and mandatory reporting is in conflict with the concept of consumer empowerment and consumer directed care
 - “This would undermine the consumer’s independence and right to make decisions for themselves”.
- where providers report an incident without the consumer’s consent, the consumer may not wish to participate in any investigation of the incident, such that it can’t be resolved
- where providers report an incident without the consumer’s consent, this could impact on the consumer’s trust in the provider
- consumers receiving in-home services may be more vulnerable to reprisal (e.g. the staff have access to their home, there is a risk that services could be discontinued etc.)
- where a consumer is not capable of consenting, the consumer’s next of kin should be notified to determine appropriate treatment/reporting of an incident (noting that some stakeholders commented on the consumer’s right to not involve their representatives/families in certain matters)
- this may act as a barrier to consumers accessing in-home services – where consumer information may be shared with Government without their consent
- only very serious incidents (e.g. assault, sexual assault, murder) should be reported without the consumer’s consent.

The importance of providers communicating with consumers and their representatives about the purpose of reporting was also noted as key to managing the complexities noted above.

The importance of privacy and confidentiality was also raised in the context of reporting information about a consumer, particularly where there is not consent to report.

Notifying the Commission of reportable incidents

Stakeholders supported the proposal for mandatory notification of a subset of incidents ('reportable incidents') to the Commission within specified timeframes.

Stakeholders suggested that key considerations for applying this requirement in relation to in-home services include:

- situations in which staff members from multiple providers are delivering care to a consumer, raising the need for clarity as to who is responsible for notifying the Commission of the incident and for managing the incident
- use of subcontracted service providers and the need to ensure timely escalation and reporting between the provider and such organisations
- the provider's capacity to investigate, manage and prevent incidents in a consumer's home, particularly where the provider has only limited involvement with the consumer, where there are multiple parties (providers and family members) responsible for the care of the consumer and/or where the consumer does not want the incident investigated further.

Some stakeholders considered that, where there is no evidence to support the alleged reportable incident (described by some as only hearsay or gossip) then more information should be sought before notifying the Commission. Others noted that not having all the information should not delay the notification; additional information can be provided as it becomes available.

Multiple providers

Stakeholders broadly agreed that, where multiple providers are providing care and services to a consumer, the provider to whom the incident is reported or whose worker first identifies a suspected or actual incident should report it.

The majority of stakeholders considered that, where Provider A suspects staff of Provider B may be involved in a reportable incident, Provider A should notify the Commission and the Commission should be responsible for notifying Provider B of the incident (and ensuring that Provider B undertakes appropriate investigation and management), noting that:

- the Commission is best placed to manage incident notifications and ensure relevant parties are made aware
 - The Commission needs to be notified as soon as possible to ensure appropriate investigation/action is undertaken.
 - The Commission can work with the instigator to manage the incident and report back to the original reporter.
 - This should be considered a third-party notification and the Commission should be responsible for accepting the notification of an alleged incident and notifying the other provider as part of the follow up and investigation of a third-party notification.
 - If the matter is serious enough to be taken to the Commission, the Commission should decide how it is communicated to the other provider. One stakeholder noted that 'this minimises the risk of evidence being buried or lost before the Commission has the opportunity to act'.
 - Each provider should be responsible for recording or reporting their own experience of an incident. Differences in reports should be reconciled by the Commission.
- this would help to preserve relationships and reduce conflicts between providers

- It's not appropriate for an allegation to be shared between providers, as this risks care relationships and could encourage pressure from one provider to another managing the allegation.
- Providers need to maintain good working relationships with the other organisations involved in the care of consumers and should not be required to report suspected incidents to other providers.
- Providers are possibly in competition and reporting to each other could be a conflict.
- One provider should not report an incident to another provider as this may compromise an investigation by the Commission or police.
- in practice, Provider A may not know how to contact Provider B
- this assures that the incident is reported rather than “covered up” by the provider.

A minority of stakeholders suggested that Provider A should be responsible for notifying Provider B (who would then be responsible for notifying the Commission), noting:

- “Open disclosure should be given to all parties – all service providers have a responsibility to the consumer first and foremost and should ensure open and transparent communication to get the best outcome for the consumer”.
- “The home care industry needs to be accountable for their services and responses accordingly”.
- Providers may need to consult with each other to find out all the details around an incident and determine whether it is reportable.
- This would help to ensure continuity of communication and that both providers are aware of the situation and can address such situations if they occur in the future.

Stakeholders agreed that guidance around the SIRS should include clear communications around the issues of multiple providers and the responsibilities of providers in different scenarios.

Scope of reportable incidents

Reportable incidents

The consultation paper proposed that the definition of a reportable incident under the SIRS for in-home services be as consistent as possible with current arrangements for residential care.

Stakeholder feedback was sought on the proposed definitions for each of the different categories of reportable incident to be used for the SIRS for in-home services.

In addition to feedback on each of the proposed categories of reportable incident, stakeholders also noted that:

- it should be explicit that the definition only relates to actions by workers of the provider, not others
- 'workers of the provider' should include anyone providing care and services on behalf of the provider (including subcontracted individuals or organisations), those managing care coordination, administration, etc. and volunteers (except where explicitly stated otherwise)
- specific guidance should be provided about incidents that occur due to factors outside of the provider's control (e.g. where a consumer is not receiving the care and services they need because they are waiting for higher level of care to become available or where the consumer refuses to receive certain care and services)
- guidance must include examples of what is and is not considered within scope of each category of reportable incident in the in-home services environment
- it needs to be clearer in the in-home services context that reportable incidents are those that have occurred, are alleged to have occurred, or are suspected of having occurred in connection with the provision of care and services to a consumer by the provider.

Unreasonable use of force

Stakeholder feedback was sought on the proposed definition of 'unreasonable use of force':

Unreasonable use of force against the consumer includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force.

Stakeholders broadly considered this definition to be equally applicable to the in-home services context without any adjustment.

Consistent with the views about reportable incidents more broadly, some stakeholders commented that the definition should:

- be explicit that it only relates to actions by workers of the provider
- include examples of what is and is not considered unreasonable use of force in the in-home services environment.

Unlawful sexual contact or inappropriate sexual conduct

Stakeholder feedback was sought on the proposed definition of ‘unlawful sexual contact, or inappropriate sexual conduct’:

Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the consumer includes:

- *If the contact or conduct is inflicted by a staff member or other person providing care on behalf of the provider (such as a volunteer), the following:*
 - *any conduct or contact of a sexual nature inflicted on the consumer, including (without limitation) sexual assault, an act of indecency or sharing of an intimate image of the consumer; or*
 - *any touching of the consumer’s genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the consumer.*
- *any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency, or sharing of an intimate image of the consumer; and*
- *engaging in conduct relating to the consumer with the intention of making it easier to procure the consumer to engage in sexual contact or conduct.*

This does not include consensual contact or conduct of a sexual nature between a consumer and a person who is not a staff member, including another consumer, or a volunteer providing care on behalf of the provider (other than when that person is providing care or services).

For the most part, stakeholders considered this definition to be equally applicable to in-home services and did not require adjustment, noting that “having this definition consistent with the definition in residential care makes sense”.

Some stakeholders considered that adjustments were required to this definition, or that further clarification could be included in guidance. For example, to:

- include those forms of contact that from a cultural/religious perspective may be considered inappropriate
 - “For example: for an Orthodox Jewish woman, shaking hands with a man that is not related to her is considered inappropriate”.
- include consensual acts between consumers and volunteers as a reportable incident, noting there is a power differential between volunteers and consumers (as they are often in a similar position to employees)
- include acts that consumers are wrongly led to believe are being undertaken for medical purposes.

Psychological or emotional abuse

Stakeholder feedback was sought on the proposed definition of ‘psychological or emotional abuse’:

Psychological or emotional abuse of a consumer includes conduct that has caused, or could reasonably be expected to have caused, the consumer psychological or emotional distress.

Conduct that is psychological or emotional abuse includes:

- *taunting, bullying, harassment or intimidations;*
- *threats of maltreatment or retribution, including in relation to making complaints;*
- *humiliation;*
- *unreasonable refusal to interact with the consumer or acknowledge the consumer's presence;*
- *unreasonable restriction of the consumer's ability to engage socially or otherwise interact with people; or*
- *repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which:*
 - *has caused the consumer psychological or emotional distress; or*
 - *could reasonably have caused a consumer psychological or emotional distress.*

Stakeholders broadly considered this definition to be equally applicable to the in-home services context without any adjustment.

Those who considered adjustments could be made, or that further clarification could be included in guidance, noted the addition of:

- inappropriate, rude or obscene hand gestures
- 'gaslighting', i.e. manipulating consumers into doubting their own sanity.

Some stakeholders reported that it can be difficult to prove psychological or emotional abuse due to family dynamics and noted the importance of ensuring that the definition draws a close connection to the provision of care and services by the provider. Others felt that it was challenging for some workers to monitor the psychological or emotional status of consumers and considered that assessment tools may support this.

Unexpected death

Stakeholder feedback was sought on the proposed definition of 'unexpected death':

Unexpected death of the consumer includes death in circumstances where:

- *reasonable steps were not taken by the provider to prevent the death; or*
- *the death is the result of:*
 - *care or services provided by the provider; or*
 - *a failure of the provider to provide care or services.*

Stakeholders expressed mixed views as to whether there should be a category of unexpected death for in-home services.

Stakeholders who considered that this category should be retained for in-home services, felt it should be narrowed such that deaths are only a reportable incident if the death is, or could reasonably be considered, the result of care or services provided.

For example, it was suggested that the definition should not include 'failure of the approved provider to provide care or services' because:

- this could be very broad and capture circumstances well outside the provider's control
- this might inadvertently include where a consumer's services had been cancelled or rescheduled with the agreement of the consumer
- circumstances in which the provider was remiss in their duty of care or had a pattern of missed care services that ultimately led to a consumer's death would be otherwise picked up through other categories such as neglect.

A number of stakeholders were also concerned about the inclusion of "reasonable steps were not taken by the provider to prevent the death" in the definition, noting that this may place unreasonable expectations on providers (particularly where non-clinical services are provided). Stakeholders noted that if this language was included, guidance should include clear descriptions of the 'reasonable steps to prevent death' that providers would be expected to take (e.g. calling emergency services, making appropriate referrals in response to a consumer's deterioration, etc.).

Some stakeholders suggested other adjustments to the definition. For example, to specify that a death is only reportable where:

- the death has been deemed by police, a medical professional or the Coroner to be due to neglect or force
- the consumer's GP will not sign-off on it
- the consumer is receiving clinical care or personal care
- the consumer is "fully dependent" on their care for activities of daily living
- the provider has knowledge of the death and has reason to believe that the death is, or could have been, the result of care and services provided.

Those stakeholders who considered this category should not apply for in-home services noted:

- given the nature of in-home services provision, it would be challenging for providers to determine whether a consumer's death meets this definition
 - "There are so many extra and unknown variables to the cause of their death that the provider and potentially others won't know about".
- many providers of in-home services would not be aware of a consumer's health issues (particularly where clinical services are not being provided)
 - "Consumers may choose not to disclose health issues relating to an unexpected death to their provider".
- determining cause of death may be particularly difficult where multiple providers, individuals or organisations are involved in a consumer's care
 - "Who determines whether a specific provider was at fault of not taking reasonable steps to prevent the death?".
- incidents that result in an 'unexpected death' of a consumer would be reportable under other categories of incident (e.g. neglect or unreasonable use of force).

Others still suggested that this category should not be applicable to all in-home services providers, particularly where contact with the consumer is very limited or services are non-ongoing, and the provider would have no way of knowing if a death was 'unexpected' (specifically citing home modifications or garden maintenance providers as examples of providers that should be exempt). Stakeholders noted that placing this responsibility on such providers may result in over-reporting of deaths and an increased burden on the scheme.

Stealing or financial coercion by a staff member

Stakeholder feedback was sought on the proposed definition of ‘stealing or financial coercion by a staff member’:

***Stealing from, or financial coercion of, the consumer by a staff member of the provider includes stealing from the consumer 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 consumer’s financial affairs, or unreasonably controls the financial affairs of the consumer.***

Stakeholders broadly considered this definition to be equally applicable to in-home services and did not require adjustment.

Some stakeholders provided additional examples and clarifications that could be included in guidance:

- accessing funds through misusing a consumer’s credit/debit cards
- conduct by a worker that is coercive or deceptive in relation to a consumer’s financial affairs
- a worker’s unreasonable control of the financial affairs of a consumer
- gifts or loans to workers (noting providers require a robust gratuities policy to manage this)
- allowing use of a consumer’s personal property (for example, a consumer lending a worker their car to use for personal reasons).

Stakeholders broadly agreed that the stealing or financial coercion should not have to occur in close connection with the delivery of care and services (e.g. when the staff member is at the home of the consumer) but could occur outside the hours that care is directly provided.

Some stakeholders suggested this definition should include stealing or financial coercion by volunteers, and others felt it should include over charging or fraudulent charging of consumers by the provider.

Some stakeholders queried whether this category should include accusations or suspicions of theft or only proven theft, noting that providers do not have control over who goes in and out of consumers’ homes and that some consumers live in cluttered environments, which may lead to overreporting of cases of suspected theft. It was also noted that repeated accusations of unfounded theft (for example, where the consumer is cognitively impaired) could be considered exempt from reporting.

Neglect

Stakeholder feedback was sought on the proposed definition of ‘neglect’:

- Neglect of a consumer includes:***
- *a breach of duty of care owed by the provider, or a staff member of the provider, to the consumer, or*
 - *a gross breach of professional standards by a staff member of a provider providing care or services to the consumer.*

Overall, stakeholders were supportive of neglect being included as a reportable incident for in-home services and did not want to see the category 'watered down'.

Stakeholders noted several issues in the home setting that make the requirement more complex, including:

- there may be other factors, events and individuals/organisations involved in a consumer's care such that it is more challenging to establish a link between an incident and duty of care or the individual/organisation at fault
 - Various factors can contribute to neglect in the home, including issues relating to the worker's frequency of visits and time spent with the consumer, care/services required or the worker's lack of skills/ability/training.
 - The need for communication between providers/organisations/individuals involved in a consumer's care is critical. For example, where a worker didn't shower a consumer because they refused, and someone later reports that the consumer was not showered.
- neglect that occurs because services were not provided as planned might not be evident to anyone but the consumer and the worker. Which can also mean that the effects of ongoing neglect may not become obvious for some time – by which time, medical issues and secondary medical complications may cause hospitalisation and/or death.

Some examples of neglect that stakeholders considered should be reportable included:

- a worker does not arrive to assist a consumer into bed, so the consumer remains in a wheelchair all night
- failing to take the consumer to the toilet or change the consumer's continence aids in a timely way, impacting their emotional wellbeing as well as their physical wellbeing
- failing to provide personal care such as showering or oral care – noting this may not have a significant impact on the consumer if it occurs once, but where this is ongoing, would impact the consumer's physical and emotional wellbeing
- cancelling, rescheduling or otherwise not delivering care and services without the agreement of the consumer.

Some examples of neglect that stakeholders considered should not be reportable included:

- where a consumer refuses to receive certain care or services or does not wish to partake in activities of daily living (such as showering)
- allowing a consumer to live in cluttered homes or squalor where this is the consumer's choice.

Provider scope of responsibility

Stakeholders emphasised that the provider's scope of responsibility needs to be clarified within the category of 'neglect'. For example:

- consumers may be approved for a higher level of care but are waiting to be prioritised for a home care package or for a residential care place to become available
- consumers may need certain services, but their budget may be insufficient to cover these and the consumer does not wish to pay for these
- the impact of consumer choice (and the choices of families/representatives), including where a consumer may choose to:
 - remain in their own home, even where eligible for/in need of residential care
 - live in squalor/hoarding situations

- live with risk, e.g. by engaging (or not engaging) in certain activities
- refuse a health professional's recommendations or instructions
- some stakeholders considered that families/representatives should also be held accountable for the consumer's wellbeing.

Stakeholders noted that guidance was required for providers regarding the relevant considerations and actions to be taken in the above circumstances.

Some stakeholders also considered that more acknowledgement of the provider's role in neglect was required, where matters outside the worker's control can lead to neglectful practice. For example, by a provider:

- having inadequate policies or procedures
- not providing sufficient/appropriate training
- directing workers to undertake tasks outside the scope of their qualifications/training
- not having the right equipment
- not having appropriate rostering or staffing.

Impact on the consumer

With regards to whether the definition should include reference to impact, stakeholders noted:

- if you add reference to the impact on the consumer, the category becomes subjective, and providers may not report incidents that are intended to be included in this category
- "How should impact be measured? For example, losing a certain amount of weight, increasing size of wound, etc."
- "impact" should include impact on the consumer's emotional wellbeing, as well as on their physical wellbeing
- it may be very hard for providers of occasional services to assess impact.

Stakeholders felt that this definition should include "cumulative harm", where one incident may not have a significant impact, but a pattern of repeated incidents may lead to serious harm to a consumer (e.g. missed appointments).

Inappropriate use of restrictive practices

The current definition of 'inappropriate use of restrictive practices' under the SIRS for residential care refers to existing requirements in the Quality of Care Principles that only apply to providers of residential care.

Given that these requirements do not currently extend to providers of in-home services, stakeholder feedback was sought on how a reportable incident relating to inappropriate use of restrictive practices could be extended to in-home services.

While stakeholders had different views on whether this category of incident should apply for in-home services, the majority considered it should be included, noting:

- inclusion of this category is an important reminder to providers that some existing practices must change and "just because it has been the practice for a significant period, does not make it acceptable"

- the same legislative requirements should be applied to both residential and in-home services (with one stakeholder noting that new legislation should be drafted if necessary)
- restrictive practice of any kind should be "banned completely"
- restrictive practices should only be used if informed consent has been provided by the consumer or their legal representative, state laws relating to restrictive practices have been followed, or there is an emergency situation requiring urgent action.

Stakeholders provided a number of examples that should be explored and clarified in any accompanying guidance (including to specify whether they would be considered 'inappropriate use of restrictive practice'), such as:

- limiting/declining access to transport, social interaction, foods etc.
- seclusion or isolating a consumer
- holding a consumer's head in the shower longer they want when washing shampoo out
- use of bed rails or placing a consumer's bed against the wall, as per the consumer's preference
- use of medications that have not been prescribed for the consumer, or overuse of prescribed medications, to control the behaviour of the consumer
- placing a consumer's mobility aids out of reach
- for a community transport provider, ensuring clients wear seatbelts or refusing to transport a client who would not allow their wheelchair to be secured in the vehicle
- services provided that go to keeping a consumer's environment secure
- locking doors or gates to manage behaviours for consumers with cognitive impairment.

Stakeholders also suggested that this definition could be strengthened with examples specific to different types of CHSP services.

Some stakeholders queried what the provider's scope of responsibility would be with respect to use of restrictive practices, noting:

- the definition should only include practices implemented by the provider/worker, i.e. it should not include where a consumer's GP has prescribed psychotropic medications or where a consumer's family uses restrictive practices
- some workers may not know what medication a consumer is taking, nor what is considered a psychotropic medication
- some stakeholders queried whether providers would be required to monitor, assess and review the restrictive practice (as is required in residential care).

Stakeholders who considered this category should not apply for in-home services noted:

- a worker may only be able to cope with a consumer's challenging behaviours/wandering by locking doors, restricting community access, etc.
- this could be covered under the categories of 'unreasonable use of force' or 'neglect'.

Unexplained absence

Stakeholder feedback was sought on the proposed definition of 'unexplained absence':

Unexplained absence of the consumer from the care of the provider means an absence of the consumer from the care in circumstances where there are reasonable grounds to report the absence to police.

A number of stakeholders had concerns regarding this definition and the inclusion of unexplained absence as a category of reportable incident.

Stakeholders felt that the definition could be narrowed such that only unexplained absences that arise during the delivery of care and services are notified, i.e. where a consumer is absent without explanation while in the care of the provider (e.g. when receiving transport services, at a day therapy centre, in overnight respite or while on an outing).

Stakeholders who considered the current definition was not appropriate or that this category should not apply for in-home services highlighted that:

- providers have policies in place to manage instances of consumers not being at home or missing a scheduled visit, including contacting the consumer, contacting representatives/families and requesting police conduct a welfare check as a last resort. These processes are discussed with the consumer and adapted to suit their preferences/circumstances. Introducing a mandatory reporting requirement may contradict consumer choice and impede on consumer privacy
 - “People should be allowed to come and go from their own homes whenever they like without telling anyone. These are private matters. In practice it could be very intrusive on the practical liberties of older people as it currently is in residential care”.
- consumers often forget to cancel their services when they’re away or otherwise occupied and reporting a consumer’s unexplained absence could put extreme pressure on the provider and the scheme
- using a threshold of whether an absence should be reported to police as means for determining reportability requires providers to apply their own notion of risk and may still result in a high number of unnecessary reports.

Notification timeframes and priority categories

Stakeholder feedback was sought on two proposed options in relation to the timeframes for notification:

1. Adopt requirements consistent with residential care, where priority 1 incidents are required to be notified to the Commission within 24 hours and priority 2 incidents are required to be notified within 30 days
2. Have all incidents notified within a consistent timeframe (e.g. 24 or 72 hours).

Stakeholder views regarding incident categorisation and notification timeframes were varied.

However, on balance, the majority of stakeholders considered there should be consistent notification timeframes across residential care and in-home services (as proposed in option 1). This includes retaining a 24-hour notification period (from the time the provider becomes aware of the incident) for the most serious of incidents (known as, priority 1 incidents).

Those in support of option 1 highlighted that:

- requirements for notification should be consistent for residential and in-home services
- tiered reporting exists and works effectively in other sectors (e.g. the NDIS, Child Protection, etc.)
- 24 hours is a reasonable timeframe for notifying priority 1 incidents where there is capacity for the provider to make a "preliminary notification" to the Commission, followed by a more comprehensive report where additional information could be added to the report as it is gathered
- it should be clarified that the 24-hour notification period commences once the provider's management has been notified of an incident, rather than when the worker becomes aware of an incident (noting that providers would need to have robust internal processes to ensure the timely reporting/escalation of incidents within the organisation).

Some also suggested adjustments to ensure the notification requirements are manageable in the in-home services context, including:

- the definition of priority 1 incidents could be:
 - refined to better target the incidents that must be notified within 24 hours
 - adjusted such that the provider does not need to assess level of harm to the consumer
- the information required to be included in the initial notification to the Commission could be adjusted (to acknowledge that providers may not have all the relevant information within 24 hours).

Some stakeholders suggested that any incident of sexual assault should always be categorised as a priority 1 incident, as some consumers may not appear visibly distressed by an incident or a worker may determine an incident to have had a "low" impact on a consumer; however, this "should not detract from the seriousness of the incident".

Those in support of option 2 (reporting all incidents within a set timeframe) commented that:

- the requirement for providers to assess the level harm should be removed
 - "Under the NDIS if a participant dies, is hospitalised while in our care, is subjected to sexual abuse, etc. this MUST be reported regardless of our assessment of harm".

- having one set timeframe is “clear and consistent and does not leave any room for confusion”
- the system should be very simple and focus on genuine serious risk only
- providers of in-home services do not have 24/7 support (as per residential services) and may not be able to notify outside business hours.

Many providers suggested that 24 hours is not a feasible timeframe, noting that:

- it may take time for the staff member to make it known to the provider who then needs to report it
- the provider will need time to investigate what actually happened; timeframes should be adjusted to reflect the requirement to gather information from various sources where communication can be complex and not timely
- some services don't operate every day, so will need longer than 24 hours to report – some stakeholders suggested extending this to 72 hours to account for services that only operate during standard business hours, Monday to Friday
- a provider may be notified of an issue (e.g. through a third-party) and may not be able to verify whether an incident has occurred until their next visit with the consumer.

A number of stakeholders suggested variations on the proposed notification timeframes, including:

- between 24 hours to 72 hours for reporting priority 1 incidents and between 3 to 30 days for reporting priority 2 incidents
- three business days for reporting any incident
- all incidents should be reported within five business days
- all providers should submit a six-monthly SIRS report, which includes all incidents that occurred during the past six months.

Other considerations

SIRS for residential services

Some stakeholders referenced the implementation of the SIRS for residential care and noted the lessons to be learned for the SIRS for in-home services:

- some stakeholders noted that the large number of notifications under the SIRS for residential services demonstrates that it is likely capturing many risks that are “not truly serious” (noting that providers err on the side of over-reporting to avoid compliance action)
- some providers were concerned about the ongoing publication of (or updates made to) guidance materials following the commencement of the SIRS for residential care, noting that this created ongoing challenges for providers in ensuring their systems, processes and training were in line with current requirements
- some stakeholders requested the SIRS for in-home services only be implemented “once it is perfected”
 - “The system needs to be proven before it can be introduced in to home care”.
 - “Implementing SIRS into home services should be deferred until SIRS has been finalised and proven in residential care”.
 - “Fact sheets, webinars and other supports for providers should be published well before the commencement of the SIRS for in-home services”.
- providers were keen to ensure that the online reporting system is not difficult to navigate and does not place excessive burden on small organisations.

Support for providers

Providers expressed some concern regarding the administration time and resourcing impacts of the implementation of the SIRS for in-home services.

Stakeholders consistently emphasised the importance of robust, clear and consistent guidance and support regarding the SIRS for in-home services for providers, workers and consumers.

Participants flagged that communication around the scheme needs to describe:

- clear definitions and guidance regarding reportable incidents
 - This was considered key, with many stakeholders requesting specific and tailored examples of what would be considered in scope and out of scope for reporting to the Commission under each incident type.
- the importance of proportionate response as part of good and effective incident management
- the focus of the scheme is not about reporting (who you are required to tell when), but more broadly about managing the risk to the consumer and preventing instances of elder abuse and neglect
- clear requirements around allegations between providers (particularly where there are subcontracting arrangements in place).

Stakeholders also requested the Department or the Commission provide training resources for workers, noting:

- “An effective SIRS depends on a trained, supervised and well-resourced workforce”.

- support is required to build capability in the sector, as many providers of in-home services and their workers will likely be starting from a lower knowledge base regarding mandatory reporting schemes and will need additional support to understand the requirements
- some of the smaller providers (particularly CHSP providers) may not have the resources or support to develop their own training and guidance (noting the not-for-profit/volunteer-based nature of some of these organisations)
- consistent messaging and training will be critical to understanding the scheme, particularly where subcontracted staff/organisations may be working across multiple providers
- workers may require particular training in:
 - identifying incidents
 - assessing/investigating incidents, noting that many organisations will not have specific staff to undertake this role (as may occur in residential services)
 - how to approach discussions about actual or suspected incidents with consumers
 - seeking consumer consent to report and explaining mandatory reporting obligations to consumers (and their families)
 - liaising with police and others
 - protections for staff (where reports are made without a consumer's consent)
 - ensuring consumers are aware of where they can seek help from advocates, elder support organisations, etc.

"I strongly support an improved system of accountability for reporting but key to effective safeguarding is ensuring workers are supported to develop good assessment skills, to manage and overcome internal and external barriers to reporting and supported to follow up and provide supports to address the underlying cause of the risk/harm where possible. This relies on training and ongoing quality practice support, including a culture of reflective practice and supervision".

Some stakeholders also noted the importance of resources for consumers to help explain the purpose and requirements of the SIRS for in-home services, including:

- requirements for providers to report some incidents, even where consumers do not consent to this
- how private consumer information will be managed under the scheme
- how consumers can access advocates and make complaints to the Commission.

Some stakeholders highlighted the importance of having this information available in different languages.

Role of the Commission

Some stakeholders emphasised that the success of the scheme is dependent on the regulator having the capability, capacity and appropriate resources to assess and manage reports in a responsive and timely way.

Some stakeholders noted that the responsibilities of the Commission in receiving and assessing notifications should be made clear for all stakeholders.

Next Steps

The consultation process has been critical to ensuring the SIRS for in-home services is fit for purpose.

The Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021, introduced to Parliament on 1 September 2021, includes amendments to the Aged Care Act and the Quality and Safety Commission Act to extend the SIRS from residential care to home care and flexible care delivered in a home or community care setting from 1 July 2022.

Further consultations are expected to be undertaken with key stakeholder groups on the detailed design elements of the SIRS to be included in the delegated legislation (subject to timing considerations and Government approvals) and the guidance materials that will support providers, aged care workers and consumers.

Attachment A: Profile of stakeholders responding to the survey

Context

In total, 123 submissions were received in response to the Consultation Paper, *Serious Incident Response Scheme for Commonwealth funded in-home aged care services*.

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

Table 1 Role of stakeholders responding to the survey

Stakeholders were asked what stakeholder category they most identified with. Note that stakeholders were able to select more than one response.

Category of stakeholder	Online survey responses
Consumer	4 (3.25%)
Family	3 (2.44%)
Carer or other consumer representative	2 (1.63%)
Consumer advocacy group	4 (3.25%)
Consumer peak body	2 (1.63%)
Carer peak body	2 (1.63%)
Home Care Packages provider	64 (52.03%)
Commonwealth Home Support Programme provider	69 (56.10%)
Multi-Purpose Service provider	5 (4.07%)
Short-Term Restorative Care provider	13 (10.57%)
National Aboriginal and Torres Strait Islander Flexible Aged Care Program provider	2 (1.63%)
Transition Care Programme provider	8 (6.50%)
Residential aged care provider	14 (11.38%)
Aged care provider peak body	6 (4.88%)
Aged Care Assessment Team/Service	3 (2.44%)
A staff member of an aged care provider	20 (16.26%)
A staff member of a health and/or disability service provider	6 (4.88%)
Health professional	11 (8.94%)
Workforce association or union	1 (0.81%)
Primary Health Network	0 (0.00%)
State or territory government	1 (0.81%)
Local Council	5 (4.07%)
Commonwealth agency	0 (0.00%)
Other	13 (10.57%)

Table 2 Groups that carers or other community representatives identify with

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

Group(s) that carers or other consumer representatives identify with	Online survey responses
People from Aboriginal and/or Torres Strait Islander communities	5 (4.07%)
People from culturally and linguistically diverse backgrounds	12 (9.76%)
Veterans	7 (5.69%)
People who live in rural or remote areas	11 (8.94%)
People who are financially or socially disadvantaged	8 (6.50%)
People who are homeless or at risk of becoming homeless	3 (2.44%)
People who are care-leavers	3 (2.44%)
Parents separated from their children by forced adoption or removal	2 (1.63%)
Lesbian, gay, bisexual, transgender and intersex people	4 (3.25%)
People with disabilities	10 (8.13%)
People with dementia	11 (8.94%)
Other	3 (2.44%)
Prefer not to answer	1 (0.81%)
Not applicable	79 (64.23%)
Not Answered	23 (18.70%)

Table 3 Approved provider type

Stakeholders completing the survey on behalf of an approved provider were asked to select whether their organisation was Nor-for-profit, For-profit, Government or other and how many home care services they are operating.

Type of service	Online survey responses
Not-for-profit	75 (60.98%)
For-profit	11 (8.94%)
Government	13 (10.57%)
Operating a single home care service	12 (9.76%)
Operating 2 to 6 home care services	5 (4.07%)
Operating 7 to 11 home care services	8 (6.50%)
Operating 20 or more home care services	10 (8.13%)
Specialising in servicing particular consumer groups	6 (4.88%)
Providing generalist services	8 (6.50%)
Not Answered	24 (19.51%)

Table 4 Location of stakeholders responding to the survey (where the organisation operates, or where the individual lives)

Stakeholders completing the survey were asked where their organisation operated and were able to choose more than one location.

Location of stakeholder	Online survey responses
NSW	38 (30.89%)
ACT	7 (5.69%)
VIC	31 (25.20%)
QLD	36 (29.27%)
SA	18 (14.63%)
WA	11 (8.94%)
NT	2 (1.63%)
TAS	9 (7.32%)
All states and territories in Australia	14 (11.38%)
Not Answered	0 (0.00%)

Table 5 Location of stakeholders responding to the survey (categorised by metropolitan, regional or remote)

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

Location of stakeholders	Online survey responses
In a remote area	31 (25.20%)
In a rural area	56 (45.53%)
In a regional area	59 (47.97%)
In a metropolitan area or major city	94 (76.42%)
Not Answered	0 (0.00%)

Glossary

Term	Definition
Aged Care Act 1997 (the Act)	The Act is the overarching legislation that outlines the obligations and responsibilities that aged care providers must follow to receive subsidies from the Australian Government
Aged Care Quality and Safety Commission (Commission)	The role of the Commission is to protect and enhance the safety, health, well-being and quality of life of people receiving aged care. The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government, and also resolve complaints about these services
Aged Care Quality Standards (the Standards)	Organisations providing Commonwealth subsidised aged care services are required to comply with, and are assessed against, the Aged Care Quality Standards. The Standards focus on outcomes for consumers and reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services
Another person	In the context of this may include, this is any other person who is not a consumer. This may include, but is not limited to, a staff member of the provider, a family member, a friend, a neighbour, or a member of the public
Consumer	Person who is in receipt of Commonwealth funded in-home aged care services
Department	Australian Government Department of Health
Final Report	The Royal Commission into Aged Care Quality and Safety's Final Report: Care Dignity and Respect
In-home aged care services	Includes Home Care packages and the CHSP and flexible care delivered in a home setting (including MPS in a home setting, short term restorative care, NATSIFACP and TCP in a home setting).
Open disclosure	The open discussion that an aged care provider has with people receiving aged care services when something goes wrong that has harmed or had the potential to cause harm to a person receiving an aged care service.
Priority 1 reportable incident	A priority 1 reportable incident is a reportable incident that has caused, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve. A reportable incident is always categorised as a priority 1 reportable incident where there are reasonable grounds for the reportable incident to also be reported to police, or the reportable incident involves an unexplained absence or unexpected death of the consumer.
Priority 2 reportable incident	A priority 2 reportable incident is a reportable incident that is not a priority 1 reportable incident. In general terms, this means a priority 2 reportable incident is a reportable incident where the consumer was not caused psychological injury or discomfort that requires medical or psychological treatment to resolve

Term	Definition
Provider	An approved provider of a Home Care package or flexible care delivered in a home setting, or a provider of CHSP
Representative	A person nominated by a consumer, who may act on a consumer's behalf. This may include a family member, other significant other, or an independent advocate.
Residential care	Provides a range of care options and accommodation for older people who are unable to continue living independently in their own homes.
Royal Commission	Royal Commission into Aged Care Quality and Safety
Staff member	Staff member is defined in Clause 1 of Schedule 1 to the Act to mean 'an individual who is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruiting agency) to provide care or other services'.
Whistle blower	A person who informs on a person or organisation as engaging in an unlawful or immoral activity.

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All information in this publication is correct as at August 2021

